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edited by
Linwood H. Cousins

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AND
DIVERSITY

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AND
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Manoranjan Mohanty
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Janice M. Moreland
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Devon Morrow
Laurentian University
Terry A. Morrow
Nova Southeastern University
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Howard University
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University of the Pacific
Maura Nsonwu
North Carolina A&T State University
Kathleen Nthakomwa-Cassidy
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Barbara Cook Overton
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Rutgers University
Adem Ozkara
Hitit University Ankara
Alessandra Padula
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University of Florida
Ione N. Paiva
Old Dominion University
Maria-Carmen Pantea
Babes Bolyai University
Hyejoon Park
University of Illinois
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Rollins College
David Patterson
Washington University in St. Louis
Sue Patterson
Lindsey Wilson College
Desmond Upton Patton
University of Michigan
Ben R. Patty
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University of South Florida
James E. Phelan
VA Healthcare System
Daniel Webster Phillips
Lindsey Wilson College
Doshie Piper
University of Incarnate Word
Dyah Pitaloka
University of Oklahoma
Maribel Plasencia
Butler Hospital and Brown University
Cynthia Cannon Poindexter
Fordham University
David Porter
Northeastern State University
Miriam Potocky
Florida International University
Daniel Preston
Syracuse University
Adele Proctor
University of Illinois at Urbana-Champaign
Elizabeth Rholetter Purdy
Independent Scholar
Eloise Rathbone-McCuan
University of Missouri–Kansas City
Stella Resko
Wayne State University
Wylene Rholetter
Auburn University
Karen Rich
Marywood University
David John Rieker
Long Beach Memorial Medical
Gina Marie Robertiello
Felician College
Cara Robinson
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Sylvia Rohlfer
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University of Texas, Austin
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Christine Skubisz
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Laura Smith
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Vicki Smith
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Kevin C. Snow
Old Dominion University
Kayce Solari-Hall
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Melvin Wade
University of Rhode Island
Nelseta Walters
University of Maryland Eastern Shore
Kaori Mori Want
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Edwina Washington
University of Memphis
Jerry Watson
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Michelle Taylor Watts
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University of North Florida
Doe West
Wayne State University
Shantel West
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Ray Wetherell
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Ashley Whittenton
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Lindsey W. Phillips Wilson
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Introduction

Human services are part and parcel of the evolution of people everywhere in the world. Whether formal or informal, grassroots or indigenous, geo-globally Western or Eastern, religious or secular, public or private, what we call human services is the result of the actions of individuals, families, organizations, communities, villages, cities, states, and countries to prevent and solve problems of living in an ever-changing world. Likewise, human diversity—when not reduced to biological differences or truncated into simplistic categories solely along the lines of race, ethnicity, and gender—is an intrinsic part of such an evolution, even while it is growing in scope and awareness and, it is our hope, acceptance. Indeed, human diversity has an intricate and intimate relationship with human services whether in terms of a small village town in Iowa, across the globe in a village in east Africa, or in a large metropolis such as New York City or Mumbai, India. In the end, the problems on which human services and diversity focus are universal, and the social, economic, and political inequities and related causes and effects increasingly overlap and are growing. But perhaps within this shared destiny lay the answers and the hope for progressive human services.

Recently I conducted an observation of Hispanic parents and Hispanic and non-Hispanic school staff and human services workers as they interacted in a workshop focused on increasing parent involvement in students' knowledge and preparation for college or university. Set in a midsize midwestern city with a rapidly increasing Hispanic population, my goal was to evaluate the effectiveness of a community-based human services agency in increasing parent–child involvement in order to improve educational and social-behavioral outcomes. Aside from language, ethnicity, race, educational status, gender, family structure, and age, diversity issues in this case include immigration status and processes, homeland security and law enforcement, and socioeconomic-status challenges related to earning a living wage and securing adequate food, transportation, health care, and shelter. This circumstance is more or less typical of contemporary human services, with remnants of the past and future. Indeed, it anticipates some of the challenges that must be addressed as the field moves forward. However, before addressing the challenges and future of human services and diversity, human services and diversity need to be defined.

Human Services Definition and History

Holding in mind the power and hegemony of developed and industrialized nations both to define realities and enforce scientific uniformity, and taking into consideration less powerful counterparts that are also engaged in human services, human services, in my view, can be only arbitrarily defined. As such, we use as a foundation for a definition the National Organization for Human Services, which says, "The field of Human Services is broadly defined, uniquely approaching the objective of meeting human needs through an interdisciplinary knowledge base, focusing on prevention as well as remediation of problems, and maintaining a commitment to improving the overall quality of life of service populations." Human services encompass a broad array of professional activities to prevent and ameliorate social, emotional, psychological, economic, political, and related difficulties in living faced by individuals, families, and small groups. Some services are delivered in and address neighborhoods and communities and beyond. Many services are interdisciplinary and interprofessional because they involve psychologists, social workers, nurses, and health care and allied health workers, educators, and the like. Many of the entries in this encyclopedia are evidence of the variety and complexity of the field alluded to here.

Historically speaking, the foundation of contemporary human services is built on the tradition of helping and support people have provided to one another in different circumstances across the world. The distribution of food; the provision of security, shelter, education, child care, and medical care; indigenous interventions for mental and social ills and so forth from prehistory to the well-documented Elizabethan Poor Laws of 1601, which codified services for the able-bodied and nonable-bodied poor, are precursors and provided a template for human services in the early United States. The emergence of increasingly formal and complex human services organizations and services could include the YMCA; YWCA; Catholic, Jewish, and Protestant Aid Societies; and penitentiaries and juvenile justice services and reforms of the 1700s and 1800s. Added to this is the development of social, medical, and economic services in postwar periods of the late 1800s to the 1930s (Civil War, World War I, and World War II, for example), leading up to the emergence of the modern welfare state in terms of the U.S. Social Security Act of 1935.

The development of medical interventions and social science theory from the 1950s forward opened pathways for the more deliberate infusion of science into social welfare policy and human services in terms of mental health diagnosis and intervention; intelligence tests; poverty management through nutritional projects, job training, and housing programs (large and small public housing projects); and the eventual attempts to draw research-based correlations among social, economic, and behavioral conditions to prevent, manage, or eliminate undesirable social and behavioral outcomes.

In recent years, the field of human services has grown to include a complex mix of public and private, philanthropically and publically funded, faith-based and volunteer-driven organizations and services. Services are still provided in neighborhoods, communities, states, and at national levels. However, international human services have seen a tremendous increase, based in Western traditions and with sensitivity to the human diversity (e.g., Peace Corps, Oxfam, the United Nations initiatives, etc.). Such changes may be appreciated in terms of the Universal Declaration of Human Rights and Cultural Diversity and United Nations Educational, Scientific and Cultural Organization (UNESCO) membership in the late 1940s (1948 and 1945, respectively). Nonetheless, long-standing and emergent inequities in economic resources and political stability suggest the need for a system of complex and globally responsive human services. Cases in point include economic, social, and political inequality in countries such as Russia and China; the need for clean water, sustainable food sources, disease control, education, and reproductive health in developing countries; the emergent and dire needs for social, psychological, and economic services for people in war-torn places such as Afghanistan, Iraq, and various other countries and regions in Africa; and countries such as Haiti that have been torn by natural disasters.

In short, if there is a common thread running through contemporary human services it would be vast human diversity, but with overlapping social, economic, and political problems. However, if there is a common need it is to develop and deliver services around the notion of political advocacy—what some might call social justice work in human services, centered in "evidence-based" services and "best practices," with sensitivity and knowledge regarding human diversity and social and economic development. This encyclopedia includes entries on such threads and needs.

Diversity and Human Services

Directly connected to the history and practice of human services are the realities of human difference we call here diversity. The conceptualization and delivery of human services is impacted by human diversity in constructive and nonconstructive ways. Diversity has to include simple and complex differences based on place (i.e., different continents, nations, countries, and states and based in rural, urban, and suburban environments), but also based in different traditions, customs, and worldviews aligned with differences of race, ethnicity, age, gender, religion, language, sexual orientation, physical characteristics, socioeconomic status, cognitive and emotional abilities, and the like. It is increasingly clear that human services are most effective in preventing and ameliorating problems when they are delivered in terms of such sensibilities. The entries in this encyclopedia cross the globe and go deep within the dominant Western traditions in the United States and, to a lesser extent, Europe, Asia, Africa, and elsewhere, to provide an array of views on diversity in human services. For example, there are entries on services to groups immigrating to the United States; entries on international variations in attitudes toward issues such as alcoholism, parenting, conflict resolution, and help-seeking; entries on honor killings, the "stolen generation" of children in Australia, and human trafficking; and entries on the Universal Declaration of Human Rights, the United Nations (UN) Declaration on the Rights of Indigenous Peoples, and the UN Convention on the Rights of the Child.

Challenges and the Future

One of the challenges of human services can be thought of in terms of quality that is based on best practices, but with a caveat. This is about reaching those who need services, but who need them delivered competently, which is to say in the context of both human diversity and our best knowledge of the conditions of living on which human services focus. In particular, human services providers and researchers must continue to study and mediate the biases we seem reluctant to overcome as people (e.g., religious, ethnic, socioeconomic-status derived, gender, sexual orientation), especially the biases we continue to propagate through political processes that intentionally and unintentionally divide people in ways that are harmful for humankind no matter the place. Entries on child labor, the lingering effects of colonialism, sweatshop laborers, U.S. citizenship and immigration services, female genital mutilation, migrant workers, and the UN High Commissioner for Refugees point in that direction.

Although I consider diversity a long-standing and current challenge facing human services, a concomitant challenge is technology. The world is flatter and thus there are more cross-continent and cross-border interactions, exposure of commonalities and differences, and the increasing, rapid, and unpredictable emergence of complexities that grow from such interactions. Technology can assist by increasing opportunities to share knowledge as well as modes of services and service providers. For example, the American Public Human Services Association (APHSA) suggests human services can go beyond computer-based determination of eligibility and problem identification to an integrated service delivery process versus the single-service process of the past. Integrated service delivery includes assessing eligibility, determining and planning services, providing case management, and monitoring services and outcomes. It can provide research-based, best practices through comprehensive services, service monitoring, and the measurement of outcomes and impact. It also means making connections between a client's behavioral outcomes and the broader impact on well-being in families, neighborhoods, schools, communities, and the like. The Agency for Healthcare Research and Quality, the International Mental Health Research Organization, and the Youth Risk Behavioral Surveillance System, among many others, point in this direction.

Organization of Entries

The entries in this encyclopedia are wide-ranging and overlap in many areas. We do not cover all areas of human services and diversity, but we do cover many traditional areas as well as many areas that have emerged in recent years. Our arbitrary categorization includes the following:

- *Populations* such as infants, children, adults, and families, women, various racial and ethnic groups, religious

groups, the incarcerated, the elderly, the poor, and so forth.
- *Fields of Focus/Practice* such as mental health, health care, education, aging and adult services, adoption, alternative medicine, and child abuse and neglect.
- *Systems/Organizations*, which includes the Administration on Children, Youth and Families, the Administration for Community Living, the Agency for Healthcare Research and Quality, and the Office of Refugee Resettlement.
- *Practices and Competencies,* which includes adult literacy programs, alcohol and substance abuse services, needs of child abuse and neglect victims, needs of children involved in war, and cultural humility and cultural competence.
- *Processes/Policies* related to acculturation, cultural assimilation, adoption and foster care, Native American/American Indian youth, and the rights of persons with disabilities, veterans, immigrants, and many others.

In sum, the reader will find that all entries in this encyclopedia address to some extent diversity in human services, although there is wide variation in their levels of relevance, significance ,and application. How one views the entries likely depends on one's worldview, experience, and location in the world of human needs and issues. But then there is the future. And in addition to addressing human diversity and evidenced-based services and other needs identified earlier, the future calls for more cross-global entries. The future also calls for entries that address the technological needs of service providers and organizations. In both cases responses must be based in the best of what is known about human needs and issues, but the application must always take into consideration the on-the-ground contexts.

Linwood H. Cousins
Editor

Chronology

1619: A group of 20 Africans are brought to Jamestown, Virginia, making them the first Africans in the Western Hemisphere.

1657: One of the first self-help groups in colonial America, the Scots Charitable Society of Boston, is founded by 27 individuals; by 1690, it has 180 members.

1775: The first abolitionist society in the United States, the Pennsylvania Society for the Abolition of Slavery, is founded.

1833: Oberlin College, in Oberlin, Ohio, becomes the first coeducational college in the United States, allowing men and women to study together.

1848: As part of the Treaty of Guadalupe Hidalgo at the conclusion of the Mexican American War, thousands of Mexicans become Mexican American citizens of the United States.

1849: In *Roberts v. City of Boston*, the Massachusetts Supreme Judicial Court rules that racial segregation in the public school system is permissible.

1849: In Tuolumne County, California, the first anti-Chinese violence recorded in the United States occurs as about 60 Chinese miners are chased out of a mining camp; similar anti-Chinese actions follow in other mining camps.

1850: California enacts a tax on foreign miners, aimed at limiting competition following the migration of large numbers of people following discovery of gold at Sutter's Mill; the new law first applies primarily to Mexicans, but later the Chinese become the focus of the most enforcement.

1850–80: The Chinese population of the United States increases from 7,520 to 105,465.

1851: Harriet Beecher Stowe publishes *Uncle Tom's Cabin*, a novel denouncing the evils of slavery that was influential in bringing more people to the abolitionist cause.

1863: The Emancipation Proclamation declares that slaves in Confederate states are free, although in practice they will not be freed until the Civil War ends in 1865.

1864: The Children's Aid Society, led by Charles Loring Brace, begins putting orphans, and children whose parents are willing to give them up, on "orphan trains," which will take them from New York City to small towns and rural areas that are believed to provide a better atmosphere in which to grow up.

1866: The Fourteenth Amendment to the U.S. Constitution is ratified, giving former slaves equal protection and rights under the law, including, for men, the right to vote.

1868: The American Missionary Association founds the Hampton Normal and Agricultural Institute, a school headed by General Samuel Chapman Armstrong to educate African Americans in the manual trades; the first Native Americans are admitted to the school in 1878.

1869: The first Charity Organization Society in the United States is founded in Buffalo, New York, modeled on a similar organization in London; by 1912, there will be 154 charity organization societies in the United States.

1870: The U.S. Census shows that almost all (96 percent) of foreign-born residents came from Scandinavia, the British Isles, and other countries in northern Europe.

1870: The first federal appropriations are made to support schools specifically for Native American children, and by 1899, almost 20,000 Native American children are being educated in 148 boarding schools and 225 day schools.

1870s: The U.S. Bureau of Indian Affairs begins establishing boarding schools for Native American children, in the belief that such schools will be more efficient in assimilating the children to the dominant American culture and separating them from the culture of their families.

1874: In New York City, Henry Bergh, the leader of the local chapter of the American Society for the Prevention of Cruelty to Animals, intervenes to remove a young girl, Mary Ellen Wilson, from her abusive caregivers; this case leads to the establishment of the New York Society for the Prevention of Cruelty to Children.

1874: Founding of the Chautauqua Movement by John H. Vincent and Lew Miller; originally an outgrowth of a summer Bible camp in western New York, the Chautauqua Movement will grow to include correspondence courses, touring exhibitions, and reading circles.

1879: Captain Richard Pratt obtains support to open a school for Native Americans, the Carlisle Indian Industrial School, in Carlisle, Pennsylvania; the school is financially supported by Congress and continues in operation until 1918, enrolling over 1,000 students in its peak years.

1879: The German Protestant Orphan Asylum Association is founded in Washington, D.C., to assist orphans and half orphans of German descent.

1880s–1924: The first major wave of immigration to the United States of people from Arab-speaking countries, many of whom are Christians from what is now Syria, Israel, Jordan, Lebanon, and Palestine. This first wave of immigration ends with the passage of the National Origins Act.

1881: Spelman College is founded in Atlanta as the Atlanta Baptist Female Seminary to educate African American women who had been slaves, and to prepare women to serve as good homemakers and mothers, as well as educating them to be teachers and missionaries.

1882: The Chinese Exclusion Act restricts Chinese citizens from immigrating to the United States for 10 years; it is renewed and extended many times.

1883: Connecticut makes it illegal to create a boarding school for African American students without obtaining the permission of the civil authorities of the town in which the school is located. This so-called Black Law is aimed at a girl's school run by the abolitionist Prudence Crandall in Canterbury, Connecticut, which accepted both white and African American students.

1887: Under the Dawes Severalty Act, Native Americans can become voting citizens if they become farmers and live apart from other members of their tribe, and shares of reservation land are allocated to families and individuals. Both measures are aimed at destroying the group identity of Native Americans, dispersing them across the country, and breaking the power of the tribe as the key social organization for Native Americans.

1889: Jane Addams founds Hull House, a social settlement house, in Chicago; Addams is involved in a Protestant evangelical church, but sees Hull House as an alternative to traditional churches because it does not divide people based on their religion.

1890: The U.S. Census reveals that 21 percent of European immigrants to the United States are from southern and eastern Europe, an increase from the 5.4 percent found in the 1880 census, but fewer than the 49 percent in the 1900 census.

1891: The U.S. federal immigration bureau has only 28 staff members, a number that will increase by 4,200 percent to 1,200 by 1906.

1893: Hallie Q. Brown founds the Colored Woman's League, a self-help organization for African American women; in 1896, the league joins with the National Federation of Afro-American Women to form the National Association of Colored Women.

1893: The National Council of Jewish Women is founded in Chicago to address the needs of female Jewish immigrants.

1895: In Boston, the infant mortality rate is 216 per 1,000 live births, an extremely high rate attributed in part to poor living conditions in the poor and crowded areas of the city.

1895: The Eight Ward Settlement House is established in Philadelphia specifically to assist African Americans.

1896: The U.S. Supreme Court declares in *Plessy v. Ferguson* that states can require public facilities to be segregated by race, as long as the facilities provided to each race are equal.

1896: The National Association of Colored Women (NACW) is formed by merging the Colored Women's Clubs and the National Federation of Afro-American Women; the NACW will hold its first convention in 1897, and biennially thereafter.

1898: Mary Richmond founds the first professional training program for social workers.

1898: Victoria Earle Matthews establishes the White Rose Mission in New York City to serve the needs of the African American community; it continues in operation until the 1960s.

1899: In Colorado and Illinois, legislation is passed to create the first juvenile courts, a reform effort based on the realization that juveniles in trouble with the law might be better served outside the adult court system.

1900: Thirty-three U.S. cities have populations of 100,000 or more, a substantial increase from 1860, when only eight cities had populations of 100,000 or more.

1900: The U.S. Census includes only two categories for race: white and colored, with the latter category including Native Americans and Asians. About 88 percent of the U.S. population is classified as white, with most of the rest (11 percent) made up of African Americans.

1900s: The first wave of Korean immigration to the United States; most of these immigrants are agricultural laborers, picture brides, students, or political refugees.

1902: John D. Rockefeller creates the General Education Board (GEB), a philanthropic organization designed to improve education in the south without discrimination among students on the basis of race, gender, or religion; the GEB is chartered by Congress in 1903.

1902: Texas adopts a poll tax to discourage Mexican Americans from voting.

1903: The Pensionado Act of 1903 creates a program providing funds to enable Filipino students to study in the United States as a means of fostering goodwill between the United States and the Philippines, and providing impetus for the Philippines to seek its own independence; the program continues until 1928.

1908: Colonel Allen Allensworth founds the town of Allensworth, California; the town, whose population was entirely African American, remains in existence until 1930.

1908: Berea College, in Berea, Kentucky, is convicted of violating a state law by accepting both white and black students; the decision is upheld by both the Kentucky State Supreme Court and the U.S. Supreme Court.

1908: Israel Zangwill's play *The Melting Pot* puts forth the concept that immigrants to the United States, no matter their race or geographic origin, will all unite to form a new type of person—the American—and a new nation.

1909: W. E. B. Du Bois founds the National Association for the Advancement for Colored People (NAACP); the organization grew out of the Negro National Committee, adopting the NAACP name in 1910.

1911: The Phelps Stokes Fund is created by the will of Caroline Phelps Stokes in order to offer improved educational opportunities to the poor as well as African Americans, Africans, and Native Americans.

1913: California passes the Alien Land Act, prohibiting Japanese individuals from purchasing land or allowing children to inherit land already owned; Japanese individuals are allowed to lease land for three years.

1915: The NAACP pickets showings of D. W. Griffith's feature film *Birth of a Nation*, which glorifies the Ku Klux Klan and presents African Americans in extremely stereotypical fashion.

1915: American educator Abraham Flexner declares, in a speech at the National Conference of Charities and Corrections, that social work is not a profession.

1917: The Jones-Shafroth Act makes all Puerto Ricans U.S. citizens and creates a senate in Puerto Rico.

1917: Race riots, aimed at African American residents, break out in East St. Louis, Illinois, and many other U.S. cities, including Chicago; a second wave of brutal mob violence will sweep many American cities in 1919.

1917: In *Social Diagnosis*, M. E. Richmond describes alcoholism as a disease, an opinion that is later adopted in medicine and social work.

1917–20: Hundreds of thousands of African Americans move from the south to the cities of the north, in part to take advantage of jobs available in war industries.

1919: The Jamaican-born African American leader Marcus Garvey founds the Black Star Line, a shipping line intended to transport African Americans back to Africa.

1919: A group of white men found the Commission on Interracial Cooperation in Atlanta, aiming to bring together African American and white leaders and to defuse tensions caused by the return of African American soldiers from World War I; in 1920, the commission begins involving women as well and holds its first interracial women's conference in Memphis in October 1920.

1919: Passage of the Volstead Act, a federal law that enables implementation of the Eighteenth Amendment to the Constitution, which prohibits the production and consumption of alcohol; the Volstead Act is repealed in 1933.

1920: On August 26, the Nineteenth Amendment to the U.S. Constitution is ratified, giving women the right to vote; this day is celebrated around the country as Equality Day.

1920: About 1 percent of the population of Kansas is Mexican American; the 13,770 Mexican Americans in the state represent a substantial increase from the 71 recorded in 1900, and the 8,429 in 1910.

1921: The Quota Act imposes a 3 percent quota on the number of people immigrating from a given country who were in the United States in 1910. This quota is changed in 1924 to 2 percent of the population in the country in 1890, a change that favors northern European individuals as they were heavily represented among the immigrants in 1890.

1923: The U.S. Supreme Court in *Meyer v. Nebraska* overturns a Nebraska law banning the teaching of foreign languages to students below the eighth grade.

1925: The Neighborhood House, a settlement house in Gary, Indiana, votes to begin serving Mexican Americans and begins offering sermons in Spanish.

1927: In *Farrington v. Tokushige*, the U.S. Supreme Court rules that parents have the right to send their children to Japanese-language schools.

1927: In *Gong Lum v. Rice*, the U.S. Supreme Court rules that a Mississippi school district may prohibit Chinese students from attending public schools for white children.

1929: The League of Latin American Citizens (LULAC) is founded in Corpus Christi, Texas, to improve the conditions of Latinos in the United States, including education, economic conditions, and health and well-being.

1929–34: An estimated 400,000 persons of Mexican descent, some of them U.S. citizens, are escorted out of the United States, voluntarily or involuntarily, as part of a repatriation program.

1930s: The number of social workers in the United States approximately doubles, to about 30,000.

1931: Rowland Hazard, a business executive, is advised by Carl Jung that his best hope for curing his alcoholism is through spirituality. Hazard joins the Oxford Group upon his return to the United States, and the principles of that organization influence the formation of Alcoholics Anonymous in 1935.

1932: Beginning of the Tuskegee Syphilis Experiment, an observation study by the U.S. Public Health Service of the progression of untreated syphilis in African Americans; the study continues until 1972, long after effective treatments for the disease have become available.

1932: Myles Horton establishes the Highlander Folk School, later the Highlander Center for Research and Education, in Tennessee to help adults work together to implement strategies to address local concerns such as poverty and bigotry.

1934: The Service Bureau for Intercultural Education is founded by Rachel Davis DuBois to foster the development of cultural pluralism and understanding among different racial and ethnic groups.

1935: The National Council of Negro Women (NCNW) is formed to improve the status of African American women and to help coordinate the activities of other African American women's organizations; Mary McLeod Bethune is the first NCNW president.

1935: Bill Wilson, a recovered alcoholic, begins holding Oxford Group meetings in his home; the spiritual and self-improvement philosophy of the Oxford Group heavily influences the creation of Alcoholics Anonymous.

1939: Bill Wilson and Robert Smith, known within the movement as Bill. W. and Dr. Bob, publish the first edition of *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*, also known as "The Big Book"; among other things, this volume describes the 12-step program, which is a cornerstone of Alcoholics Anonymous.

1940: Founding of the National Federation of the Blind, an advocacy group and membership organization; it is the first civil rights organization in the United States organized around a disability.

1942: Executive Order 9066, signed by President Franklin D. Roosevelt, authorizes the removal and internment of persons of Japanese ancestry (including U.S. citizens) living in some western states; about 120,000 Japanese and Japanese Americans are incarcerated under this order.

1943: The bracero program allows Mexicans to work temporarily in the United States in order to alleviate the wartime shortage of labor.

1943: The Magnuson Act repeals the Chinese Exclusion Act and allows 105 Chinese to immigrate to the United States each year.

1946: In *Mendez et al. v. Westminster School District of Orange County*, the U.S. District Court in Los Angeles rules that segregating Mexican American students from white students in the public school system is a violation of the Fourteenth Amendment's guarantee of equal protection under the law.

1946: The U.S. Supreme Court rules in *Morgan v. Commonwealth of Virginia* that interstate buses must not be segregated. The Congress of Racial Equality (CORE) stages a deliberate test of this ruling in 1947, by sending a bus with eight white and eight black passengers through the south, which results in several passengers being arrested in North Carolina.

1947: The U.S. Court of Appeals for the Ninth Circuit rules in *Mendez et al. v. Westminster School District of Orange County* that requiring Mexican American children to attend different schools from white students is a violation of their rights.

1947: In *Everson v. Board of Education, Irving Township*, the U.S. Supreme Court rules that using public funds to bus children to private schools, including those run by religious organizations, is not a violation of the First Amendment.

1948: The U.S. Supreme Court rules in *Sipuel v. Board of Regents of the University of Oklahoma* that law schools may not discriminate on the basis of race in admissions decisions.

1948: The U.S. Supreme Court rules in *McCollum v. Board of Education* that public schools may not hold religion classes during the regular school day.

1948: The U.S. District Court for the Western District of Texas rules in *Delgado v. Bastrop Independent School District* that public schools cannot segregate Mexican American students in separate schools, although they can provide separate classes as needed for language enrichment.

1948: On July 26, President Harry Truman officially prohibits segregation in the U.S. Armed Forces by signing Executive Order 9981.

1950: In *Sweatt v. Painter* and *McLaurin v. Oklahoma State Regents*, the U.S. Supreme Court rules that African Americans have the right to attend and receive full financial benefits from state graduate schools.

1950–64: The second wave of Korean immigration to the United States, mostly war orphans and wives of American servicemen.

1952: E. M. Jellink publishes "Phases of Alcohol Addiction" in *Quarterly Journal of Studies on Alcohol*; this influential article promotes the concept of alcoholism as a disease.

1954: The U.S. Supreme Court in *Brown v. Board of Education* overturns the "separate but equal" standard established in *Plessy v. Ferguson*.

1954: In *Hernandez v. Texas*, the U.S. Supreme Court acknowledges that Hispanics are a separate class of people who suffer discrimination in the United States

1955: The Daughters of Bilitis, a lesbian organization, is founded in San Francisco. It becomes a voice for both lesbian and women's rights and begins publishing a magazine, *The Ladder*, in 1960.

1955: On December 1, African American Rosa Parks refuses to give up her seat on a Montgomery, Alabama, public bus to a white man. She is arrested, and on December 5, African Americans begin boycotting the city bus system, an action that plays a key role in the Civil Rights movement.

1955: Creation of the National Association of Social Workers (NASW) through the consolidation of seven organizations; the NASW will become the world's largest membership organization for social workers.

1957: The Southern Christian Leadership Conference (SCLC) is founded in Atlanta to work for civil rights, including voter registration for African Americans.

1959: The United Nations General Assembly adopts the Declaration of the Rights of the Child;

among the rights specified are the right to healthy development, education, protection from neglect, freedom from discrimination, and appropriate care and treatment for handicapped children.

1959: The Board of Supervisors in Prince Edward County, Virginia, suspends all public schools rather than comply with the demand to end segregation. The schools are reopened in 1964 by order of the U.S. Supreme Court, as articulated in *Griffin v. School Board of Prince Edward County*.

1960: A sit-in by a group of African American students at a whites-only lunch counter in Greensboro, North Carolina, is given wide publicity and is followed by similar demonstrations in over 50 other cities.

1960: The National Association of Social Workers (NASW) publishes its first code of ethics; as of 1999, the NASW *Code of Ethics* has been revised six times.

1961: The White House Conference on Aging recommends that the states develop adult protective services, through the cooperation of the medical profession, social service agencies, bar associations, and legal aid societies, to protect vulnerable adults from abuse, neglect, and self-neglect.

1961: President John F. Kennedy establishes the Peace Corps on a trial basis with Executive Order 10924; R. Sargent Shriver serves as the first director, developing programs in 55 countries by 1966.

1962: The political scientist Michael Harrington publishes *The Other America*, drawing attention to the large numbers of Americans living in poverty.

1962: In California, Cesar Chavez creates the United Farm Workers Organizing Committee, now known as the United Farm Workers of America; in 1965, it organizes a successful national boycott against the Delano, California, grape growers.

1962: In *Engel v. Vitale*, the U.S Supreme Court rules that beginning a public school day with a prayer is a violation of freedom of religion, even if students are free to not participate in the prayer.

1963: The Equal Pay Act of 1963, a federal law, requires employers to pay men and women equally for comparable work.

1964: The federal Civil Rights Act of 1964 bans discrimination on the basis of race, ethnicity, gender, religion, or national origin and applies to many spheres of life, including education and voting.

1964: The Head Start program is created as part of the Office of Economic Opportunity to provide enhanced educational opportunities and health and nutrition programs for preschool children from poor families; it will become the largest federal program to assist poor children.

1965: Chinese immigration to the United States expands substantially following passage of the McCarran Act of 1950, increasing from 237,393 in 1965, to 1.6 million in 1995, and 2.9 million in 2000.

1965: The federal Voting Rights Act of 1965 prohibits discriminatory voting practices and establishes federal oversight of elections in regions that have a history of restricting some individuals' right to vote.

1965: Beginning of the second wave of immigration from Arab-speaking countries to the United States; these immigrants come from all over the Arab world, and most are of the Muslim faith.

1965: Following passage of the Older Americans Act and the creation of the Administration on Aging, there is substantial growth in the services provided for senior citizens and their families, including establishment of senior centers and adult day care centers, provision of services such as home-delivered meals, and outreach, referral, and case management services.

1966–73: About 10 percent of the population of Cuba migrates to the United States.

1967: The National Welfare Rights Organization (NWRO) is founded to represent the needs of welfare recipients, primarily women with dependent children; goals of the NWRO include a guaranteed annual income for all Americans and increased dignity, justice, and democracy for welfare recipients.

1968: The federal Fair Housing Act bans discrimination in housing on the basis of race, color, gender, religion, national origin, handicap, or familial status; among the barred actions are the refusal to rent or sell, the creation of different terms for rental or sale, and blockbusting.

1968: A Ford Foundation grant of $2.2 million helps found the Mexican American Legal Defense Fund (MALDEF), which aims to protect the civil rights of Latinos.

1968–69: Students and faculty at San Francisco State College strike and present the administration with a number of demands, including increasing minority enrollment and creating ethnic studies programs.

1971: President Richard M. Nixon declares a War on Drugs, motivated in part by the number of military veterans returning from Vietnam with drug addictions; creation of the Drug Enforcement Administration was part of this "war," as were creation of the Special Office for Drug Abuse Prevention and the establishment of methadone treatment facilities across the United States.

1972: Title IX of the Educational Amendments to the Higher Education Act requires that women be treated equally in colleges and universities; the most visible manifestation of Title IX is the creation of many women's sports programs, but it also applies in matters such as academic employment and student scholarships (e.g., the Rhodes Scholarships, formerly for men only, are now available to both men and women).

1973: Founding of the Children's Defense Fund (CDF), a private organization that advocates for the rights of children.

1973: In *Keyes v. School District No. 1*, the U.S. Supreme Court rules that Latinos are a minority group and must be considered in desegregation decisions, and that segregation created by gerrymandering of school districts is illegal.

1974: The Council on Social Work Education (CSWE) implements the first standards to accredit bachelor's programs in social work.

1974: In *Milliken v. Bradley*, the U.S. Supreme Court strikes down a lower court decision ordering the suburbs of Detroit to integrate with urban schools; part of this decision was the ruling that de facto segregation (segregation in fact, but not by force of law) was beyond the jurisdiction of the courts, while de jure segregation (ordered and maintained by the legal system) was not.

1974: Passage of the Child Abuse Prevention and Treatment Act, the first federal law to enforce national standards in measures to prevent and treat child abuse.

1974: U.S. District Court Judge W. Arthur Garrity orders the public school system of Boston to begin busing students to achieve desegregation.

1974: The federal Equal Educational Opportunity Act requires public schools to create bilingual programs and additional assistance in learning English for students who need it.

1975: Large numbers of Vietnamese begin immigrating to the United States following the end of the Vietnam War.

1975: The Indian Self-Determination and Education Assistance Act gives Native Americans more control over the education of their children, provides funds to build public schools on reservations, and creates preferences for Native Americans in the granting of subcontracts.

1975: A group of African American students at the University of Mississippi file a lawsuit in federal court, arguing that the state should provide more equitable funding to traditionally black colleges.

1976: In *Tarasoff v. the Regents of the University of California*, the California Supreme Court rules that preventing harm to third parties may overrule the usual presumption of privacy between a psychotherapist and patient, and that the psychotherapist has the responsibility to inform others (e.g., the police, the patient's family) if there is a reasonable threat that the patient will harm someone.

1978: Two pieces of federal legislation, the American Indian Religious Freedom Act and the Indian Child Welfare Act, recognize the importance of Native American culture to tribal members.

1978: The U.S. Supreme Court in *University of California Regents v. Bakke* prohibits universities from establishing racial quotas for admissions.

1980s: Companies take advantage of the free trade zone or *macquila* along the United States/Mexico border, and begin building factories (*maquiladoras*) there to take advantage of low-cost Mexican labor and proximity to the United States.

1982: The federal Job Training Partnership Act provides summer youth employment programs and funding for training programs for poor adults and young people.

1982: The U.S. Supreme Court rules in *Plyler v. Doe* that undocumented immigrant children have the right to a free and equal public education.

1984: Passage of the Carl Perkins Vocational Education Act, which provides federal funds to develop vocational and technical education programs for young people and adults in order to prepare them for employment; the Perkins Act is reauthorized in 1990 and 1998.

1987: P. B. Baltes publishes "Theoretical Propositions of Life-Span Developmental Psychology: On the Dynamics Between Growth and Decline" in *Developmental Psychology*, putting forth the theory that development is a multidimensional process that continues throughout the life span.

1988: The Office of National Drug Control Policy (ONDCP) is created to help coordinate federal government research, health policy, security, and legislation relating to drugs.

1988: The Civil Liberties Act, signed by President Ronald Reagan, awards reparations of $20,000 to each survivor of the Japanese internment camps set up in the United States during World War II.

1989: Walter Kopp, a student at Princeton University, creates Teach for America to provide an opportunity for graduating college and university students to teach in underserved schools in rural and urban areas.

1990: Passage of the Individuals with Disabilities Education Act (IDEA), a federal law stating that every child has a right to an appropriate public education, and providing funds to states to improve their educational programs for children with emotional, mental, or physical disabilities.

1990: Secondary school educator Kevin Jennings founds the Gay, Lesbian and Straight Education Network to advocate for the rights of individuals of all sexual orientations and gender identities to feel safe and respected in elementary and secondary schools.

1990: Fifty American college graduates form the first corps of Teach for America; as of 2013, about 33,000 people have taken part in the program, which places college graduates as teachers in low-income areas.

1992: Tony Grasso publishes the edited collection *Research Utilization in the Social Services*, arguing for the importance of agency-based research, that is, research conducted within a social service agency and carried out by the agency's staff.

1992: President Bill Clinton raises the position of director of the Office of National Drug Control Policy, also known as the "Drug Czar," to Cabinet status.

1993: Increased attention is focused on human smuggling following the death of eight Chinese immigrants aboard the *New Venture*, a ship attempting to bring them illegally into the United States.

1994: The North American Free Trade Agreement (NAFTA), creating a trade bloc consisting of the United States, Canada, and Mexico, goes into effect.

1994: The International Federation of Social Workers (IFSW) publishes its first code of ethics, *Ethics in Social Work: Statement of Principles*; the IFSW code is revised in 2004.

1996: In *Hopwood v. State of Texas*, the U.S. Court of Appeals for the Fifth Circuit rules that colleges and universities may not use race or national origin as a factor in admissions decisions; the plaintiff, Cheryl Hopwood, is a white student who claimed she was discriminated against in the admissions process at the University of Texas Law School because of her race.

1999: Passage of the Foster Care Independence Act, a federal law providing funding to the states to develop programs to help young adults aging out of the foster care system (typically at age 18) make the transition to independent adulthood.

2002: Kevin Kumashiro coins the term *antioppressive education* to refer to practices and strategies teachers can draw on to counter what he sees as oppressive characteristics of schools.

2002: The Education Sciences Reform Act of 2002 creates the Institution of Education Sciences (IES), a federal organization within the U.S. Department of Education, replacing the Office of Educational Research and Improvement; the IES includes the National Center for Education Research, the National Center for Education Statistics, and the National Center for Evaluation and Regional Assistance.

2004: The National Association of Social Workers (NASW) establishes the NASW Center for Workforce Studies to collect information about the social work labor force, enhance professional development, and disseminate information about evidence-based practices.

2004: Jose Spring publishes *Deculturalization and the Struggle for Equality: A Brief History of the Education of the Dominated Cultures in the United States*, a book arguing that American schools have systematically devalued and disrupted minority cultural values and forced a curriculum, language, and cultural practices based in Anglo-American values on students.

2006: The National Association of Social Workers issues "Standards for Cultural Competence in Social Work Practice"; areas covered include language diversity, cross-cultural leadership, service delivery, empowerment and advocacy, self-awareness, and ethics and values.

2008: The U.S. Census Bureau predicts that minority groups taken collectively will constitute a majority in the United States by 2042, earlier than the previously projected date of 2050.

2010: President Barack Obama signs the Patient Protection and Affordable Care Act, an overhaul of the U.S. healthcare system intended to make health insurance accessible to most or all Americans, with changes to be phased in over a period of years.

2010–20: According to the Bureau of Labor Statistics in the U.S. Department of Labor, the social work profession is expected to grow by 25 percent between 2010 and 2020.

2011: According to a report from the Centers for Disease Control and Prevention (CDC), diabetes continues to disproportionately affect African Americans, with 18.7 percent of non-Hispanic blacks estimated to have diabetes, as compared to 10.2 percent of non-Hispanic whites.

2012: A report by the Pew Institute finds that over half (54 percent) of American Hispanics prefer to be identified by their family's country of origin rather than by the Hispanic label.

2013: In March, the National Association of Social Workers holds a national forum in Washington, D.C., on the "feminization of poverty," a term coined by social work researcher Diana Pearce 35 years earlier.

2013: In June, the National Association of Social Workers issues a statement commending the decision of the U.S. Supreme Court in *U.S. v. Windsor*, which ruled that the Defense of Marriage Act was unconstitutional.

2013: In July, an analysis by Erkan Gören at the University of Oldenburg, Germany, finds the United States near the middle of all nations in terms of ethnic diversity, ranking between Russia and Spain.

2013: In August, the exemption granted to religious organizations that provide health care under the Patient Protection and Affordable Care Act, in which they were temporarily freed from being required to provide contraceptive coverage, expires.

2013: In September, the exhibit "Health Is a Human Right: Race and Place in America" opens at the David J. Sencer CDC Museum, exploring health disparities in the United States.

2013: In October, people begin enrolling in state health insurance exchanges established as part of the Patient Protection and Affordable Care Act passed in 2010.

2013: According to data released by the Organisation for Economic Co-operation and Development (OECD) in 2013, the United States ranked fifth among OECD countries in attainment of a tertiary (post-high school) degree, but only 12th in the 25 to 34 year age group, indicating that other OECD countries are catching up to or surpassing the United States in the percentage of young people attaining a tertiary degree.

2014: According to the Central Intelligence Agency (CIA) World Factbook, the United States ranks 55th among 224 countries with an infant mortality rate of 6.17 deaths per 1,000 live births; by way of comparison, the lowest rate was 1.81 per 1,000 (Monaco). The United Kingdom had a rate of 4.44 per 1,000, and the rate was 4.71 in Canada.

2014: The National Association of Social Workers requests public input for an updated version of its Standards for Social Work Practice in Health Care Settings, with the comment period closing on August 15, 2014.

2014: According to the Bureau of Labor Statistics, the seasonally adjusted unemployment rate in the United States was 6.1 percent, down from 7.5 percent in June 2013, with unemployment higher among teenagers (age 16 to 19; 21.0 percent), blacks and African Americans (10.7 percent), and Hispanics and Latinos (7.8 percent).

2014: In June, the U.S. Department of State releases the Trafficking in Persons Report 2014, noting that victims, prosecutions, and convictions for human trafficking have increased each year since 2008, with 44,758 victims of human trafficking identified in 2013.

2014: According to a report issued in July by the Department of Health and Human Services, the Affordable Care Act (also known as Obamacare) has produced $9 billion in savings on health insurance premiums for Americans since 2011.

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Abandonment

Over the past few decades, the Department of Health and Human Services (HHS) has made substantial advancements in ensuring the public health, safety, and well-being of the American people, and children in particular. Children and youth depend on the adults in their lives to keep them safe and to help them achieve their full potential. However, this has not prevented a plethora of children and youth (who are considered the future workforce), parents, and civic leaders from being at risk of poor outcomes, including low educational attainment, teen pregnancy, ill health, violence, lack of labor market success, premature death, and abandonment. HHS collaborates with state, local, tribal, urban Indian, and other service providers to sustain an essential safety net of services that protect children and youth, promote their emotional health and resilience in the face of adversity, and ensure their healthy development until adulthood is reached.

The global phenomenon of child abandonment has been around for many years. Child abandonment occurs when a parent, guardian, or person in charge of a child leaves a child without any regard for the child's well-being and with the intention of solely abandoning the child. In some cases of abandonment, the person responsible for the child fails to provide necessary care. One of the earliest surviving stories of child abandonment is that of Oedipus, who was left to die as a baby in the hills by a herdsman ordered to kill the baby. Abandonment is a cruelty to children that leaves them vulnerable to abuse and manipulation. Many youth who face abandonment must learn to survive on the streets and take care of their own needs. Stealing, selling illegal materials, and prostitution are a few illustrations of crimes committed by young people who have had the hardship of learning how to take care of their own needs. Along with criminal activities, abandoned children often develop antisocial personality traits. There are many reasons for child abandonment, including poverty, unemployment, and inadequate housing, although many people successfully raise children in these situations. Other examples of abandonment happen when mothers do not believe they have the ability to care for a child or when fathers deny parenthood or do not know of siring any children.

In recent years, there have been cases where abandoned newborn babies are left to die in trashcans and dumpsters. People who heard the babies crying called the authorities and some of the babies survived. Unfortunately, not all abandoned children and babies survive on their own. For these reasons, many U.S. states created laws that allow a parent to leave a baby at a hospital without facing criminal charges. It is difficult to know exactly how many abandoned children live in the United States. Various factors make estimates difficult, including cases where children manage to live on their own without adult care. Estimates have suggested anywhere from 7,000 to 15,000 children annually face abandonment. These estimates include children who now live within government agencies and foster homes. State laws and agencies work together to help families that struggle with basic needs for children. Newly enacted laws help protect children from abandonment and have created stricter penalties for parents who abandon their children.

Assessments for abandoned children and youth should remain sensitive to diverse cultural approaches, while still ensuring that the child's needs are met. In cases where cultural differences play a role in understanding a caregiver's behavior, the protection of the child should remain vital. Research suggests that respecting diverse cultural approaches to caregiving is important, but professionals still need to be able to distinguish between practices that can cause harm and those that are beneficial to the development of a child's cultural identity.

Impact of Abandonment

Children suffer lifelong scares from abandonment. Usually they are not able to trust easily or properly. Trust issues usually develop from the fear that they will be abandoned again. There may also be a feeling of shame that will cause the child to believe the abandonment was their fault. While child abandonment typically involves physical abandonment—such as leaving a child at a stranger's doorstep when no one is home—it may also include extreme cases of emotional abandonment, such as when a "workaholic" parent offers little or no physical contact or emotional support over long periods of time. Unfortunately, abandoned children (also called "foundlings") who do not get their needs met often grow up with low self-esteem, emotional dependency, helplessness, and other issues. A person charged with child abandonment may face felony or misdemeanor charges and other consequences.

Abandoned child syndrome is a behavioral or psychological condition that results from the loss of one or both parents. Parents who leave their children, whether with or without good reason, can cause psychological damage to the child. This damage is reversible but only with appropriate assistance. Abandoned children often may also suffer physical damage from neglect, malnutrition, starvation, and abuse.

The abandoned child syndrome is not recognized as a mental disorder in any of the well-known medical manuals. Symptoms may be physical or mental and may extend into adulthood and perhaps throughout a person's life. These symptoms include but are not limited to alienation from the environment—withdrawal from social activities or resistance toward others; guilt—the child believes that he/she did something wrong that caused the abandonment (often associated with depression), fear and uncertainty—"clinginess" and insecurities; sleep and eating disorders—malnutrition, starvation, disturbed sleep and nightmares; and physical ailments—fatigue, depression, lack of energy and creativity, anger, and grief.

State Statutes on Abandonment

Child abandonment laws vary from state to state. Many states include child abandonment within their child abuse laws and vice versa, while some states have laws specifically targeting the act of child abandonment. Approximately 17 states and the District of Columbia include abandonment in their definitions of abuse or neglect, generally as a type of neglect. Approximately 18 states, Guam, Puerto Rico, and the Virgin Islands provide definitions for abandonment that are separate from the definition of neglect. In general, it is considered abandonment of the child when the parent's identity or whereabouts are unknown, the child has been left by the parent in circumstances in which the child suffers serious harm, or the parent has failed to maintain contact with the child or provided reasonable support for a specified period of time. Not all states define child neglect and abandonment in the same manner, as some states do not even use the terms *neglect* or *abandonment*. A few states include within their definition of "child abuse" or "child endangerment" the concepts of neglect and abandonment. Many states include the definition of abandonment in their neglect laws or vice versa.

All states have some form of statute criminalizing the underlying facets of neglect and abandonment, except the state of Maryland.

- *Mandatory reporting laws*: Because child abandonment is considered child abuse in some states, certain people may be required to report known or suspected cases of child abandonment to the proper authorities.

- *Safe Haven law exception*: Most jurisdictions have exceptions to child abandonment in the form of Safe Haven laws. Safe Haven laws allow mothers to safely abandon their newborn infants in safe locations—such as churches, hospitals, and fire stations—without fear of being charged with the crime of child abandonment.
- *Leaving a child at home alone*: While it is necessary in some instances to leave a child at home alone, states typically offer age guidelines to help parents avoid child abandonment charges. Under some state statutes, leaving a child at home alone may constitute child abandonment, depending on a number of factors, including the age of the child, duration of time the child was left without adult supervision, and economic hardship or illness of the parent or guardian.

Child Abandonment Penalties and Punishment

Depending on the state, a person charged with criminal child abandonment faces a wide range of penalties and sentencing options, depending on whether the state makes it a felony or misdemeanor. Most states classify child abandonment as a felony, which may include situations where a parent or guardian physically abandons a child in any place with the intent of relinquishing all rights and responsibilities to the child. Other states classify child abandonment as a misdemeanor (with lesser penalties), including situations that involve nonphysical acts of abandonment. A court will take the factors listed above into consideration, but the penalties may include fines, termination of parental rights, supervised access to the child, and jail time. In addition, a person may face reckless abandonment charges of a greater penalty if a child dies as a result of the abandonment.

In the criminal context, child abandonment is defined as physically abandoning a child, but may also include emotional abandonment such as failing to provide the necessary needs to a child. In some states, a parent may be guilty of abandonment if they fail to provide necessary clothing, food, shelter, or medical care for their child. In other states, however, parents are only punished for deserting a child with the intention to abandon.

Establishing Child Abandonment

The term *child abandonment* is broadly categorized and used to describe a variety of behaviors. Specific examples of child abandonment vary, but common actions that may lead to child abandonment charges may include leaving a child with another person without provision for the child's support and without meaningful communication with the child for a period of three months; making only minimal efforts to support and communicate with a child; failing for a period of at least six months to maintain regular visitation with a child; failing to participate in a suitable plan or program designed to reunite the parent or guardian with a child; leaving an infant on a doorstep, in trash cans and dumpsters, and on the side of the road; being absent from the home for a period of time that created a substantial risk of serious harm to a child left in the home; failing to respond to notice of child protective proceedings; or being unwilling to provide care, support, or supervision for the child.

Conclusion

Child abandonment is a time-sensitive issue, with state laws differing on what amount of time actually constitutes abandonment. In some states, it is considered abandonment to leave a child for two consecutive days without providing for his or her care. In Minnesota, it is considered abandonment if the child is under 2 years of age and is left in a way that indicates the parent does not intend to return.

Child abandonment is not simply a matter of leaving a child unattended. The age of the child, the time of day or night the child is left, the mental and physical capacity of the child, and whether or not a parent leaves adequate provisions for the child all factor into determining abandonment. The courts may also consider whether or not a child has a way to reach a parent, or whether the child is able to dial 911 in case of emergency.

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See Also: Adolescent/Youth Services: Overview; Adoption and Foster Care Analysis and Reporting System; Adoption and Safe Families Act; Adoption: Infant, International, and Older/Special Need Children: Child Welfare Services; Childhood Trauma; Juvenile Justice System.

Further Readings

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Abduction

Abduction is a heinous crime that can happen to any person or their loved ones in a diverse society. Depending on culture, time, and geography some form of abduction has been an issue of concern across countries and societies throughout history. Statistics indicate that abduction is a serious crime not only because of its direct impact on victims and relatives, but also because of the manner in which it changes the perception of security and promotes the fear of crime. A majority of abduction victims are children. Parental abductions in divorce cases are followed by difficult and long legal disputes that often damage a child’s perceptions and expectations of life. Children can also suffer harms after they have been abducted by strangers or acquaintances.

Definition and Differentiation

The term *abduction* technically refers to the act of taking a person away from where he/she belongs by any form of force or deception for various reasons. Abduction is sometimes interchangeably used with the word *kidnapping*. However, though not clear cut, there are differences between the two concepts. Kidnapping is usually committed to receive some kind of gain such as ransom. Kidnappers make their demands in exchange for the release of the captive.

Abduction differs from kidnapping in that abductors typically do not make demands and usually try to hide their actions. An abductor is mostly interested in the abductee for different reasons, while the kidnapper’s focal point is not the captive, but some other gains through the captive. Even though both actions are considered crimes, punishments may vary depending on the jurisdiction.

The types of abduction vary based on the identity of the abductor, the purpose of the abduction, and other factors. Examples may vary from the abduction of a mature person to claim a ransom to bride abduction and child abduction. Cultural factors may play an important role in the act of abduction, but in general there seems to be a negative correlation between victimization and ability to protect oneself.

According to National Crime Information Center (NCIC) statistics, around 661,500 people were reported missing in the United States in 2012. More than 75 percent of these persons were children under 18, which approximately equals 500,000 individuals. This means an average of 1,370 children per day, or one child every 63 seconds, are reported missing. David Finkelhor and Richard Ormrod found that 49 percent of abductions are committed by family members, while 27 percent are perpetuated by acquaintances and 24 percent by strangers. Most family abductions are committed by parents and abductees are generally younger than 6 years of age. Acquaintance kidnappings are mostly committed by juveniles against teenage females at residences and involve sexual or physical assault and frequently injury. Victims of stranger abductions generally are teenage females or school girls. These crimes primarily occur at outdoor locations and involve sexual assaults and the use of firearms.

Four out of five child abductions by strangers happen around a child’s home. Nearly three-quarters of victims are girls. Kenneth Hanfland, Robert Keppel, and Joseph Weis indicate that most victims of abduction who are found dead are murdered within a short period of time, with 44 percent of victims killed within only one hour after abduction, 74 percent murdered within three hours, and 91 percent killed within 24 hours. Therefore, it is imperative for law enforcement to act quickly in child abduction cases.

Bride Abduction

Bride abduction is the act of abducting a woman for the purpose of marriage. The practice existed in the

Americas, Europe, Africa, Australia, and Asia in the past and continues to exist in some places today.

Based on the existence of an abductee's consent, bride abduction can be divided into two basic types: consensual and nonconsensual. Barbara Ayres makes a more detailed categorization with four distinct types of bride abduction: wife raiding, genuine bride theft, mock bride theft, and ceremonial capture. In the first category, wife raiding, men jointly abduct women from a different community. The second category, genuine bride theft, refers to stealing a woman from one's own community. In this case the groom's family offers various forms of compensation to the woman's family and a marital relationship is established. The third type, mock bride theft, is simply a planned elopement of a girl, who pretends to be helpless and resisting against her abductor(s). Ceremonial capture is a cultural ritual in which all family members are fully aware of the "abduction."

Some of these categories of bride abduction still exist today in different cultures across different parts of the world. Cynthia Werner's field study provides detailed examples of bride abduction in post-Soviet central Asia.

Abduction for Adoption

Abduction for the purpose of adoption is relatively rare compared with other forms of abduction, and the first case of this practice was reported in 1987 in Albuquerque, New Mexico. Victims of this abduction are newborn or unborn babies, and abduction usually happens shortly after birth. This crime is often committed so that a woman who is unable to have children of her own can obtain someone else's child. In such cases, the woman abductor usually fakes a pregnancy so people will not suspect anything after the abduction, which proves that such cases are preplanned.

There are two types of abduction for adoption. In the first, a newborn baby is abducted at a residence, hospital, or other maternity facility. In the second type, called "fetal abduction," a pregnant woman is abducted to force her to have an early cesarean section to remove the baby from her womb. A woman who is a fetus abductor differs from typical child abductors. She typically wants to have children of her own but cannot give birth, and therefore attempts to deliver another woman's baby by performing the cesarean section herself in poor conditions, risking the lives of the baby and mother,

A child abduction alert displayed on an electronic traffic-condition sign above a highway in Pittsburg, California, 2006. In the United States, AMBER alerts (which stands for America's Missing: Broadcast Emergency Response) began in 1996. The alerts were named for Amber Hagerman, a 9-year-old who was abducted and murdered in Texas that year.

as described in a study by Ann Burgess, Timothy Baker, Cathy Nahirny, and John Rabun. The fetus abductor is often a friend or acquaintance of the pregnant woman victim.

Child Abduction

Child abduction accounts for a majority of abduction cases. Children are easier to deceive and exploit by ill-intentioned strangers than are adults, and by their nature are less likely to protect themselves, making them more vulnerable to abduction by both parents and strangers. As the number of divorces has increased, child custody often becomes a subject of dispute between parents, sometimes resulting in one parent abducting their child(ren).

However, not all child abductions are triggered by custodial disputes. There are cases involving other motives, such as ransom. The first ransom case to receive nationwide attention in the United States happened in 1932, when Charles Lindbergh's baby son was kidnapped for ransom and found dead soon after the abduction. There are also numerous cases involving sexual exploitation. Nine-year-old Amber Hagerman was abducted by a man while she was riding her bicycle outside her house, sexually assaulted, and murdered in 1996. The AMBER Alert, which seeks to recover abducted children, was named for her. This system enables all relevant government agencies and the news media to work together to publicize child abductions in the hope of recovering victims.

U.S. Abduction and Kidnapping Laws

Several U.S. laws have been enacted in response to abduction cases. The Federal Kidnapping Act was passed following the Lindbergh kidnapping and paved the way for federal agencies to get involved in certain abduction and kidnapping cases. Another law, the 1968 Uniform Child Custody Jurisdiction Act (UCCJA), aims to prevent parents' manipulation of court orders regarding child custody by simply moving to a different state. The Parental Kidnapping Prevention Act was passed in 1980 in an effort to bolster the UCCJA. The Missing Children Assistance Act of 1984 (MCAA) created a nationwide clearinghouse to better handle the issue of missing children.

As the number of marriages between citizens from different countries increased, abduction assumed an international dimension. In order to deal with abduction cases extending outside U.S. borders, the government passed the International Child Abduction Remedies Act ratifying the Hague Convention. Six years after the MCAA, the National Child Search Assistance Act (NCSAA) was passed; this law was a more comprehensive initiative that required relevant agencies to report all cases of missing children to the National Crime Information Center. The 2003 Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today Act, more commonly called PROTECT, has enabled significant progress to be made in the fight against abductions and resulted in the creation of the AMBER (America's Missing: Broadcast Emergency Response) alert system.

International Aspects

Ease of transportation, new communication technologies, and extensive use of the Internet have made the world a global village, making physical borders of countries almost obsolete. As a result, the number of international marriages has increased both in the United States and abroad. This increase, combined with the availability of international travel, seems to have had considerable impact on the rise of child abduction at an international level. Custody disputes between spouses from different nationalities, cultures, and religions result in international abductions.

Cultural differences also play an important role in shaping the abduction problem at an international level. For example, it is perfectly normal for an American father to keep in touch with and support his child after a divorce, while in Japan a divorce creates the definitive end of a father's relationships with his children, and even his former wife, for the rest of his life. If the mother is a Japanese national in a custody dispute who abducts the child to her homeland, cultural diversity can turn into a child custody dilemma. Statistics indicate that as of 2009, many children of divorced parents were abducted from the United States to Mexico, Canada, the United Kingdom, Germany, India, Japan, and Brazil. A study by the American Bar Association of about 100 families indicated that at least 46 countries had been the sites of child abductions. The Hague Convention aims to resolve these international custody disputes.

Hague Convention

The Hague Convention on Civil Aspects of International Child Abduction is a multilateral agreement signed by 89 countries as of 2013. As specified in Article 1, the convention aims to do the following:

> (a) to secure the prompt return of children wrongfully removed to or retained in any Contracting State; and (b) to ensure that the rights of custody and of access under the law of one Contracting State are effectively respected in other Contracting States.

However, dealing with child abduction issues involving countries that have not signed the convention can be difficult both for individuals and governments. In an effort to fill this gap in the United States, Congress passed the International Parental Kidnapping Crime Act (IPKCA) in 1993. It should be noted that the IPKCA is not a substitute for the Hague Convention and has been rarely used in cases of international child abduction after its enactment.

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See Also: AMBER Alert; Child Abuse Prevention and Treatment Act; Child Abuse/Neglect, Victims of; Childhood Trauma; Human Trafficking; Interethnic Adoption Provision; National Center for Missing and Exploited Children; National Child Abuse and Neglect Data System; Sexual Abuse Survivors; Torture, Survivors of; Trauma-Focused Services; United Nations Convention on the Rights of the Child.

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Ableism

Disability impacts roughly 10 percent of the population; thus, it is vital that human service providers view disability as a positive aspect of human diversity, while understanding societal prejudice toward people with disabilities. Ableism describes the discrimination toward a person or people with disabilities, while simultaneously privileging the able-bodied and is analogous to terms such as racism, sexism, heterosexism, or ageism. Ableism stems from the belief that being able-bodied or "normal" is more desirable than being disabled or "abnormal." Ableist views about disability result in day-to-day reactions, including fear, pity, discriminatory attitudes, and structural barriers that lead to oppression, segregation, and inequitable access to resources.

History

Historically, larger societal contexts have contributed to ableism. Religious views of disability contribute to ableism when disability is seen as a result of amorality, witchcraft, God's displeasure, or holy innocence. Disability has been regarded as something that should be eliminated, healed by God, pitied, or acted upon through mercy and charity.

As medicine and eugenics were legitimized, disability became primarily viewed as a medical problem. Statisticians alongside medical experts quantified the able-bodied/disabled binary, proliferating deficit views of disability while solidifying notions of who could be categorized as disabled. The goal of medicine was to cure or eliminate disability and the only hope for the disabled individual was to become more "normal." Under the medical model, people with disabilities are not the experts of their own bodies, often leading to painful medical procedures, segregation, or an overemphasis on remediation.

Alongside other civil rights movements, people with disabilities identified their own discrimination influenced by medical and moral conceptions about disability and identified and defined ableism. Instead of viewing disability as something to be pitied or seen as a medical deficit, people with disabilities fought to be seen as equal citizens. The disability rights movement centered on the idea that bodily difference itself was not the problem of disability; instead, major hurdles came from ableism, systemic barriers, inaccessibility, exclusion, and negative attitudes. This movement has succeeded in promoting the rights of people with disabilities through the deinstitutionalization of many people with disabilities, the passage of the Americans with Disabilities Act, and the inclusion of many people with disabilities in schools and communities. Although progress has made, ableism persists. Fortunately, human services providers can reduce ableism.

Combating Ableism

High expectations. People with disabilities are often baselessly viewed as being less able than others. Even though disability is only one small aspect of who an individual is (like race, gender, favorite food, eye color), ableist ideas about disability often spread and become the primary focus for how others view the capabilities of the person. When it is understood that all people excel in some areas and need support in others, deficits are no longer the focus and the person with a disability is seen as a whole and complex person with potential.

Example: A professional is working with a child who does not speak verbally, but shows many nonverbal signs of understanding. The professional assumes that the child is capable and diligently works to find a communication system for the child. The child begins to learn to use her new assistive technology device and becomes academically and socially successful.

Removing barriers. Many people feel that the best way to help a person with a disability is to aid them in remediating deficits to become "normal." Assumptions prevail that life for the disabled person will be easier if the person is "fixed" through therapies or medicine. However, many people with disabilities would rather have support in eliminating barriers that prohibit full participation in their community.

Example: An individual diagnosed with dyslexia is looking for employment at an advertising firm. The job description requires that the individual have proficient writing skills. The applicant for the job is a successful writer when given appropriate accommodations. The employer who removes barriers offers to purchase the speech-to-text software requested by the employee.

Break down stereotypes. Many unfounded and negative stereotypes exist about people with disabilities. Disability labels tell little about the strengths, support needs, and individuality of a person. In order to break down harmful stereotypes, people with disabilities should be portrayed as important, productive, and competent members of their communities.

Example: A neighborhood group protests an incoming family who have a child with autism because they fear the child will be violent and disruptive. A sympathetic neighbor explains that all children who have autism are unique and that there are benefits for the other neighborhood children in befriending a child with autism. The neighbors welcome the family.

Promote inclusion. When people with disabilities live, work, learn, and play around others, people with and without disabilities benefit. People with disabilities benefit because they become competent and important members of their communities. They also learn skills and find opportunities when natural connections are made. People without disabilities make new friends, learn to value interdependence, and have a greater appreciation for human diversity.

Example: A teacher advocates for a child with intellectual disabilities when her principal rationalizes that the child would better have his needs met in a self-contained classroom. The teacher explains that the child will excel by emulating his typical peers, will make more friends, and will benefit from higher expectations common in general education classrooms. The teacher shows her knowledge of universal design for learning and differentiation as teaching tools. The child is very successful in her class and earns a standard education diploma.

Conclusion

Ableist ideas and attitudes continue to hinder the civil rights of people with disabilities; however, professionals have opportunities to mitigate the negative ramifications.

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See Also: Americans with Disabilities Act; Developmental Disabilities, Attitudes and Myths in Services for; Disability Services; Disability Studies; Individuals With Disabilities Education Act; Reasonable Accommodations; Sociology of Disability.

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Abuse and Neglect

The National Organization for Human Services promotes social justice with the ability to recognize and support physical, mental, emotional, and spiritual health through an interdisciplinary knowledge base. The human services profession focuses on the prevention and remediation of wellness in all members of the community. Those operating in the field of human services should be educated on the diversity of abuse and neglect. Abuse can be defined as "the infliction of suffering or harm on vulnerable populations," while neglect is the "failure to fulfill a caretaking obligation" of a vulnerable individual. A vulnerable person is one who is capable of being physically or emotionally wounded; they tend to not have the capability of defending themselves in their own environment. Knowledge of the diversity of abuse and neglect requires an awareness of its forms as well as its differences.

The definition of abuse and neglect is influenced by the mores and values in a given time period. Not only is this influenced by legal and contemporary standards but the culture of the individuals should also be considered. Abuse and neglect take many different forms and can involve children, adults, the elderly adults, and anyone with disabilities. It is important for those in the field of human services to be able to recognize and report abuse and neglect in the individuals they serve. The following sections outline the awareness of and aspects of intervention, prevention, and recognizing and reporting of abuse and neglect in vulnerable populations.

Child Abuse and Neglect

Federal legislation defines child abuse and neglect as "any act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm." Although physical abuse is the most recognizable, other types of abuse can also have lasting effects. Physical abuse, emotional abuse, and neglect are all forms of child abuse.

Health professionals are required by law to report any suspicion of abuse or neglect of children to legal authorities. Many professionals experience challenges in the reporting process. Some of the difficulties include education and training to recognize abuse and to understand the reporting process. Table 1 describes some signs to help professionals recognize the presence of abuse and neglect in children.

Adults and Elderly Abuse and Neglect

Abuse and neglect is never okay. It can be seen in adults as well as children. As adults become older, their physical abilities change and they are less able to defend themselves against abuse and neglect. An elder person can be someone between the ages of

Table 1 Signs that may signal the presence of child abuse or neglect

The child	The parent
• Shows sudden changes in behavior or school performance	• Denies the existence of—or blames the child for—the child's problems in school or at home
• Has not received help for physical or medical problems brought to the parents' attention	• Shows little concern for the child
• Is always watchful, like something is going to happen	• Demands a level of physical or academic performance the child cannot achieve
• Lacks adult supervision	• Looks primarily to the child for care, attention, and satisfaction of the parent's emotional needs

60 and 65, depending on the jurisdiction. Abuse is defined as "the infliction of suffering or harm on vulnerable populations"—whereas neglect is the "failure to fulfill a caretaking obligation" of a vulnerable individual. A vulnerable elder adult is someone with an impairment that prevents him or her from adequate self-care and protection. Abuse and neglect can take many forms. The different types of elder abuse include physical abuse, emotional abuse, sexual abuse, neglect or abandonment by caregivers, financial exploitation, and health care fraud and abuse. Recent estimates indicate between 1 and 2 million people over the age of 65 have been abuse, harmed, or exploited by those they depend on. Abuse and neglect of elderly adults can take place in their own home, a relative's home, and facilities responsible for their care. Those working in the field of helping professionals must educate themselves with the skills to prevent and recognize abuse. While recognizing abuse is important, the following three things will help prevent elder abuse and neglect: listening to the elderly and the caregivers responsible for their care, intervening and reporting any suspicion of abuse or neglect, and educating others in the community on how to recognize and report elder abuse and neglect.

Additionally, elderly abuse and neglect tend to go unidentified by clinical professionals—because of a lack of appropriate screening and assessment. A human services agency should report any suspicion of abuse or neglect if (1) there is any evidence of mistreatment without sufficient clinical explanation; (2) there is a subjective complaint by the elder; (3) the human services professional believes there is high risk of probable abuse, neglect, exploitation, or abandonment. Finally, history has shown that individuals with disabilities are frequently discriminated against. They are seen by society as incapable and helpless—denied opportunities for jobs and education. Discrimination and discrimination by the community puts individuals with disabilities at risk of abuse and neglect. The law requires the reporting of abuse and neglect of adults with developmental and physical disabilities.

Working With the Abused and Neglected Population

Individuals tend to seek services when they are in a state of distress. They often seek help when they are unaware of how to help themselves and need assistance from social service professionals. This is a vulnerable time for anyone who may have admitted they cannot navigate their own lives and their own healing. Problems and issues come up later in life and it is sometimes difficult to share these with other people, especially when an individual is unclear about how to deal with the core issues. Before getting to core issues, it might sometimes be helpful to decrease arousal if the client is experiencing fear during the session. Paying attention to where an individual is in terms of their needs while being aware of the social service worker's own needs is also important to decreasing arousal.

Professionals who work successfully with this population have learned to honor individual needs and the desire to keep a lid on his or her feelings at times. The most effective process can involve swinging back and forth between uncovering feelings and covering them back up again, and it is precisely this ability to modulate their feelings. People must feel secure that their ability to close their emotions down will never be taken away from them but instead will be honored as an important tool for living.

The initial goal of human services professionals is to advocate for individuals while helping them move more freely through their difficulties with the assurance that they can find distance from them again if they begin to be overwhelmed. Once an individual receives the help they are seeking and becomes confident that the human services professional will not strip them of their survival mechanisms, they are most likely to allow their feelings to emerge.

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See Also: Abandonment; Adoption and Safe Families Act; Child Abuse Prevention and Treatment Act; Child Abuse/Neglect, Victims of; Childhood Trauma.

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Accommodation

Accommodation can be generally understood as a set of behaviors or strategies aimed at adjusting to conditions, situations, or norms characteristic of groups of people or individuals. Accommodation can take place with regard to verbal and nonverbal behavior, with communication being simultaneously the determinant and outcome of accommodative processes. Thus, communication not only shapes adjustment processes but also is influenced by accommodation taking place between interlocutors. The methodology of accommodation is described in communication accommodation theory (CAT), a cross-disciplinary framework developed by Howard Giles that explains how adjustments in communication are created and how they influence communication flows and distance between discourse participants. CAT is applied in various disciplines and is used in different contexts to study how people change their behavior in communication.

Functions of Accommodation

Accommodation helps establish a common set of rules since it facilitates the negotiation of a system of norms meeting the needs and expectations of diversified participants. In addition, accommodation helps understand various approaches and attitudes, as well as facilitates the exchange of knowledge between participating entities. Looking at the issue of accommodation from an individual's perspective, it broadens one's ability to perform successfully in diversified environments.

Types of Accommodation

Accommodation can be divided into different categories by taking into account an individual's attitude toward accommodation. Voluntary accommodation takes place when someone wants to accommodate to another person's verbal and nonverbal behavior and supports the processes of accommodation. Involuntary accommodation occurs when someone is against accommodative activities that are conducted against his or her will. Neutral accommodation takes place when someone is neither for nor against accommodation; the processes of adjustment are of no importance to the individual.

Accommodation can also be divided into linguistic and nonlinguistic accommodation, and some subtypes of linguistic accommodation can be enumerated. Literal linguistic accommodation concerns the linguistic processes of adjustment encompassing the choice of nouns, verbs, adjectives, and pronouns in order to absorb to some extent one's way of communicating. Figurative linguistic accommodation concerns situations in which one uses symbolic language, such as idioms and metaphors, to accommodate to the repertoire of the interlocutor. In using metaphors, one is relying on well-known domains in the presentation of new concepts and ideas to facilitate the processes of knowledge flows and interactions. In addition, technological linguistic accommodation concerns the linguistic adjustment to conditions taking place in the online setting. It may involve using such forms of communication as emoticons as well as focusing on the economical and short forms of expression.

Accommodation can also be divided by taking into account the level on which it operates. Accommodation at the microlevel functions at the word level and seeks to find the term that makes one accommodated in a social situation. An example can be the use of vocabulary strictly connected with a specific industry, domain, or profession, in which the application of a specialized term is used to facilitate knowledge exchange. Accommodation at the mesolevel operates at the text level and is concerned with choosing a type of text that would accommodate the needs of the target audience. Accommodation at the macrolevel encompasses communication styles and languages.

Taking into account the role of identity in modern discourse, accommodation can be studied through the perspective of calibrated linguistic identity proposed by Magdalena Bielenia-Grajewska. Calibrating in the case of linguistic repertoire involves copying the linguistic behaviors of others and adding some new language-related elements (also subconsciously) to the individual linguistic personae. The notion of calibrated linguistic identity is especially important nowadays, when interactions often involve people from different countries and cultures and the processes of accommodation are important for efficient intercultural communication. The mentioned linguistic image from the perspective of accommodative processes can also be studied from the perspective of hybrid linguistic identity researched by Bielenia-Grajewska. This form of identity enables one to highlight how accommodation leads to the coexistence of different linguistic identities and the formation of a more complex linguistic entity benefiting from different linguistic codes.

Accommodation can also be divided by taking into account the personal-group dichotomy. Individual accommodation encompasses the verbal and nonverbal activities conducted by a person to accommodate to the environment. Group accommodation focuses on the way a given community adjusts its communicative behaviors to the conditions present in the environment.

Professional Accommodation

Professional accommodation can be divided into workplace and consumer accommodation. Workplace accommodation encompasses actions that are related to accommodation taking place in professional settings. It is an important part of organizational learning because employees master the corporate culture and its norms by observing others and to some extent imitating their behaviors. Workplace accommodation may involve accommodation to speakers' knowledge and experience. Thus, when speaking with a person who is not familiar with a given industry, a specialist will calibrate the message to make it understandable to the target audience by using terminology or syntax recognized by the interlocutors. Accommodation at work also concerns the characteristics of some professional situations. For example, speaking with a customer or negotiating involves different communicative behaviors than taking part in informal chats in the lunchroom during breaks at work.

Consumer accommodation consists of all the communicative behaviors aimed at meeting customers' needs and expectations. Thus, in advertising and direct communication a linguistic repertoire is selected that aims to facilitate the cognition of merchandise and increase the sale of products.

Educational Accommodation

Adjustments can be observed in learner-teacher interactions because teachers have to accommodate to learners' abilities and needs. Information has to be adjusted to the interlocutors' knowledge, abilities, and needs. For example, in the case of teaching English for special purposes, teachers have to focus on the aspects of specialized terminology that are needed by the professionals who attend the course. Teachers also have to accommodate to the conditions they face in their teaching environment. Thus, when some equipment is missing, teachers have to conduct classes with only the tools available. Accommodation may also concern the linguistic skills of the class. Thus, in the case of conducting lessons or training in foreign languages, the level of language used in instruction should correspond with the abilities of learners. Accommodation in education also concerns the method of instruction, since online and off-line schooling involve different teaching methods. When providing instruction in cyberspace, teachers have to accommodate to the characteristics of a given setting, taking into account the economical aspects of exchanging data on the Internet or in the different time zones of the students participating in a Webinar.

Media Accommodation

Accommodation can also be observed in contemporary media. Those participating in online interactions have to adjust themselves to the codes valid in Web discourse. Taking into account the notions of similarity and difference in group formation, accommodation leads to both homophily and heterophily in online networks. Homophily, or being represented in forming communities with people who are similar in terms of education, background, profession, hobbies, or age, is visible by forming homophilic relationships as a result of accommodative activities. On the other hand, heterophily in online settings is exemplified by sustaining individual communication preferences and perceiving personal communicative tools as superior to those of other people in the processes of accommodation.

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See Also: Communication Styles, Ethnic and Cultural Differences in; Cross-Cultural Skills; Linguicism.

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Acculturation

Acculturation was originally defined as a change or shift in a person's or a racial/ethnic group's behavior, language, and beliefs when continuous, firsthand contact with a differing culture occurs. Acculturation can occur willingly among those who have selected to immigrate or migrate to a region that maintains a culture different from their origins. It can occur through force when dominance and/or subjugation is exerted over another differing culture. The act of acculturation over time, regardless whether it is voluntary or by force, results in the modification of a person's or group's language, behaviors, beliefs, and perceptions; ultimately, acculturation has an impact on a person's or group's life, health, and ability to thrive in the new culture and will result in the changing of health risk and protective factors. Specifically in the context of human services, providers must consider the level of client acculturation and its influence on perceived benefit of services, cultural appropriateness of services, and compliance with recommendations. Level of acculturation is influenced by the individual's beliefs, feelings, and connectedness to the dominant culture. Individuals who perceive their interactions with the dominant culture to be temporary or forced are less likely to demonstrate high levels of acculturation and may continue to identify primarily with their native culture.

Assimilation

Assimilation occurs when the act of acculturation eclipses the originating culture and there is a loss of cultural heritage, language, behaviors, and beliefs. It is a complete loss of the originating culture and results in the loss of associated risk and protective factors that are attributed to the originating culture. The total erasure of the originating culture is often perceived as deleterious and has been found to be associated with familial stress, negative health impacts, a disenfranchisement of the person who is perceived to assimilate, and health disparities in the United States. Often assimilation occurs through generational exposure; the primary generation does not assimilate but the next generation born in a differing culture more readily accepts the behaviors, beliefs, and perceptions and this results in the aforementioned outcomes.

Adaptation

Adaptation occurs when there is a mixing of the cultural beliefs, behaviors, and perceptions of historical culture and the newly exposed. Adaptation provides a platform for reconciliation of the past culture and the current culture in which a group or person currently exists. It is the seamless combining of multiple cultures and provides the platform for acceptance and feelings of belonging among those who have migrated and those of the culture they are being exposed to. However, because adaptation is a merging of multiple cultures, it has been hard to identify and employ as a construct in behavioral or mental health research and has been employed in discussions relating to communication and the linguistic modification of instruments utilized in research.

Reaction

Reaction is interconnected with oppression and the subjugation of the group that is being newly exposed to another culture. Reaction is a rejection of the new culture and compensation for the perceptions of superiority forced upon the adopting culture to their past culture. The people who have rejected the new culture often display zealous pride in their heritage and adopt or reemploy behaviors of their originating culture. Additionally, generations removed from the initial inoculation of the current culture often return to the cultural behaviors and beliefs of past generations. The pride in one's originating culture to the point of rejecting the current culture is often called ethnocentrism. The return to a person's culture of origin or of their heritage, when associated with subjugation and oppression, has proven to increase feelings of belonging and self- esteem and often a reduction of health risk behaviors among youth.

In current behavioral and health research, acculturation has become a variable based on the perceived cultural norms of the race or ethnicity. The validity of the variable has been challenged; however, there remains empirical evidence that the maintaining of a person's originating culture has a significant impact on physical and mental health, as well as their socioeconomic status. Specifically how acculturation is defined within the context of specific research determines whether acculturation has a positive or negative effect on the measured outcome. The interaction between all of these constructs in the current globally centered society has great implications for social services. Porous ethnic and cultural boundaries combined with geographic flexibility have resulted in many people working through various levels of acculturation, assimilation, adaptation, and reaction. The current porous and flexible society can result in individuals being faced with the challenges of each construct at various times and simultaneously throughout the life span. As a result, practitioners are charged with demonstrating adequate cultural competence. It is important to note that acculturation, assimilation, or adaptation should not be directly associated with language acquisition and/or expressive language fluency. Host language acquisition is best viewed as a key component in measuring the aforementioned constructs.

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See Also: Assimilation; Cross-Cultural Knowledge; Cross-Cultural Service Models; Cultural Paradigms; Ethnic Diversity and Values; Ethnicity, Definition of; Ethnocentrism; Race, Social Definitions.

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ADHD, Services for Individuals With

Individuals who display symptoms of attention-deficit hyperactivity disorder (ADHD) typically have significant difficulty attending to and completing tasks, or they may act impulsively and have extreme overactivity in their behavior, or they may display both types of symptoms. These behaviors are normally evident in individuals prior to starting school and must cause significant impairment in two or more settings, such as the home/family setting, the community setting, the educational setting, the vocational setting, or any other setting in which attention to staying on task is required for success.

These various symptoms of ADHD tend to interact, furthering the difficulties of the individual to perform well in school, interact appropriately with others, and behave in a socially acceptable manner. Also, research has indicated that children do not "grow out of" ADHD and that these symptoms create significant lifelong problems with individuals' perceptions of their self-worth, which can lead to further psychological and behavioral difficulties. Therefore, individuals diagnosed with this disorder must have a treatment plan that adjusts to their own development throughout the life span and is sensitive to their individual backgrounds and diversity. Environmental factors, such as culture and social norms, should always be taken into account to effectively plan for the lifelong treatment of these difficulties. The most common approaches for treatment of individuals with ADHD are drug therapy and/or behavioral therapy.

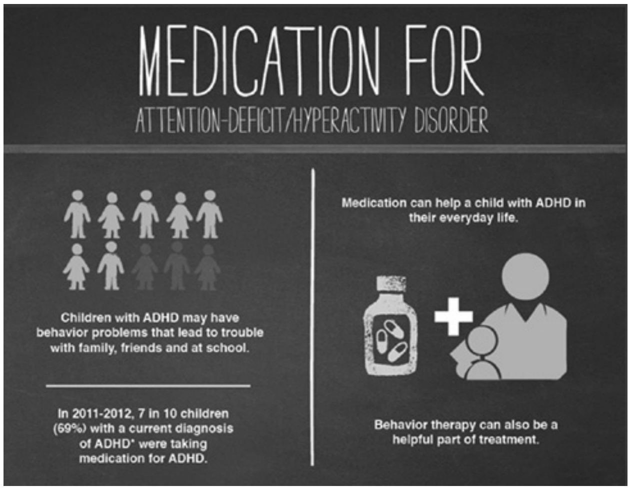
Drug Therapy

A majority of children, adolescents, and adults with ADHD are treated medically with stimulant medication, such as methylphenidate or other stimulants, which is prescribed by a medical doctor. These medications are known to improve the maladaptive behavior of individuals with ADHD and improve their functioning in a variety of environments. In addition, drug therapy has the effect of calming individuals, allowing them to focus, improving their performance at school and work, and controlling aggressive and fidgety tendencies. Furthermore, children with ADHD who have not been treated with stimulant medication are more likely than their medicated peers to suffer from social problems, have problems with the law, and use illicit drugs as they grow older. Treatment with stimulant medications is not without risk, however. Research has indicated that stimulant medication stunts a child's physical growth, requiring the use of "drug holidays" to allow the child to catch up to his or her peers. In addition, some individuals, especially those with high blood pressure, should not take stimulant medication because of risk of heart attack.

Behavior Therapy and Educational Services

Behavior therapy has been shown to be useful in many cases of ADHD. Typically, teachers and parents are trained to reward behavior that is adaptive to the environment, such as paying attention to class lectures or doing homework until completion. Behavioral techniques require target behaviors to be clearly defined, excellent communication among all the individuals, and delivering reinforcement consistently across all environments. Although behavioral treatment can be successful by itself, most research has indicated better outcomes when combined with drug therapy.

Besides behavior therapy, some individuals who are diagnosed with ADHD have symptoms severe enough to impact their educational progress in the classroom. If the symptoms of the diagnosis are significantly interfering with their attainment of educational goals, students can be classified for special education and receive services in the school setting. Typically, in addition to academic goals and objectives, behavior plans are put in place to help provide positive reinforcement for staying on task, completing tasks, and complying with teacher requests. In addition, these students can be given extra time to complete tasks and reminders about homework assignments due.



Individuals with attention-deficit hyperactivity disorder, a condition that is typically diagnosed at a young age, are often treated with a combination of drug and behavioral therapy.

Cultural Disparity in Diagnosis and Treatment

Drug therapy is currently the treatment of choice for ADHD, and the number of children and adults receiving stimulant medication for this disorder is increasing, although recent research indicates that ADHD is overdiagnosed in the United States. Moreover, there appears to be a significant discrepancy between minority children and white children. Research indicates that white children are more likely to be evaluated for and receive a diagnosis of ADHD and be treated for this disorder. In addition, for those minority children who do receive an ADHD diagnosis, they are more likely not to receive treatment needed to be successful in their day-to-day environments.

It appears that this disparity between ethnicities concerning diagnosis and treatment stem from economic issues. Recent studies reveal that those children who come from a family of lower socioeconomic status are less likely to be identified as having ADHD or to be treated for this disorder. Moreover, research indicates that stereotyping and bias may play a part in the racial differences in diagnosis and treatment. One recent study argues that teachers may view symptoms of ADHD in white children as a medical problem, while the same symptoms displayed by African American or Hispanic American children may be seen as behaviors related to poor parenting skills, low IQ, substance use, or violence.

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See Also: Children With Special Needs; Cultural Competence, Human Service Providers and; Educational Services; Educational Support Services; Intelligence Testing; Psychiatric/Psychological Assessment; Special Education.

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Administration for Community Living

The U.S. Administration for Community Living (ACL) is the federal agency responsible for increasing access to community support and focusing attention and resources on the unique needs of older Americans and people with disabilities across the life span. It was formed in 2012 from three previously existing federal agencies: the U.S. Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the Department of Health and Human Services Office on Disability.

The ACL is part of the U.S. Department of Health and Human Services, and its mission is to, "Maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers." The ACL's Web site states the agency's vision is that, "All people, regardless of age and disability, live with dignity, make their own choices, and participate fully in society."

ACL comprises three units that focus on specific populations; the administrator of each unit reports to the ACL administrator, who in turn reports to the U.S. secretary of health and human services. The units are the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the Center for Disability and Aging Policy. Each unit is supported by the ACL Center for Management and Budget and the ACL Office of Regional Operations.

Administration on Aging

The Administration on Aging (AoA) assists older adults and caregivers by providing services and information including: elder rights services; health, prevention, and wellness programs; culturally sensitive programs for Native and Tribal communities; a National Family Caregiver Support Program; a National Clearinghouse for Long-Term Care Information; nutrition services; and support services to help older adults live independently in their communities. The majority of these services are provided through the National Aging Network consisting of local units called Area Agencies on Aging and State Units on Aging.

AoA services are primarily authorized by the Older Americans Act of 1965 (OAA). OAA was enacted with the aim of creating nationally coordinated services to support the dignity and welfare of older persons. The Aging Network of Area Agencies on Aging provides a method for distributing federal funds to local agencies that support services such as information and assistance, meals at senior centers, home-delivered meals, health and homemaking services in the home, and wellness programs. AoA supports the national Eldercare Locator service, which can be accessed online or by phone.

Administration on Intellectual and Developmental Disabilities

The Administration on Intellectual and Developmental Disabilities (AIDD) funds services and is an advocate for individuals with intellectual and developmental disabilities and their families. AIDD's responsibilities were specified in the Developmental Disabilities Assistance and Bill of Rights of 2000.

AIDD programs include: state councils on developmental disabilities; state protection and advocacy systems; national projects to enhance individual opportunities; a national network of university centers for excellence in developmental disabilities education, research, and service; the President's Committee for People with Intellectual Disabilities; and grants to make polling places accessible to voters with disabilities. The 57 U.S. protection and advocacy systems work at the state level to empower individuals with developmental disabilities to advocate for themselves. These systems provide legal support for the protection of civil rights, especially for those in underserved populations. The state councils provide planning, training, and coalition-building to promote self-determination, integration, and inclusion. The university centers advance research, training, and community services to address the needs of individuals with developmental disabilities and their families.

Center for Disability and Aging Policy

The Center for Disability and Aging Policy (CDAP) provides planning and support to advise the ACL administrators. CDAP includes the Office of Integrated Programs; the Office of Policy Analysis and Development, which provides technical assistance; and the Office of Performance and Evaluation.

The Office of Integrated Programs focuses on common concerns for older adults and individuals with disabilities. It coordinates the Aging and Disability Resource Centers Program, which focuses on streamlining access to long-term care services and support. The centers are a collaborative effort of the Administration for Community Living, the Centers for Medicare and Medicaid Services, and the Veterans Health Administration. These facilities strive to create a person-centered, community-based environment to offer resources and services for individual and family caregivers. Much of the work of the centers has focused on care transitions, especially the transition from a hospital to the community.

CDAP also supports a program for veterans at risk of being placed in skilled nursing homes that attempts to keep these people in their homes and provide them with community-based services. The CDAP Lifespan Respite Care program is also available in some areas to assist family caregivers. Additionally, CDAP supports research on coordinated transportation systems for people with disabilities and older adults. The Office of Performance and Evaluation offers the public online information on evidence-based programs for older adults and individuals with disabilities. This information is intended to help individuals and service providers determine the services that best meet their needs. Interventions are in the categories of caregiver and family support; employment; health and wellness; legal, justice, and elder abuse; long-term care services and support; and mental health promotion.

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See Also: Adult Day Care; Aging and Adult Services; Developmental Disabled Individuals; Disability Services; Home and Community Services; Home Care Services; National Institute on Aging; Senior Services.

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Administration for Native Americans

The Administration for Native Americans (ANA) is a division of the U.S. Department of Health and Human Services. Established in 1974 through the Native American Programs Act, the ANA encourages social and economic independence for all Native American populations. The ANA does so through community-based funding and technical training for American Indians, Alaska Natives, Native Hawai‘ians, and Native Pacific Islanders.

Groundwork for the ANA was first laid by President Lyndon B. Johnson. In 1964, Johnson declared a War on Poverty, which resulted in the Revenue Act of 1964 and the Economic Opportunity Act. Shortly after the Economic Opportunity Act was signed into law, the Office of Economic Opportunity (OEO) began awarding grants, with Native Americans being among the primary beneficiaries. One particularly successful grant resulted in the formation of the Rough Rock Demonstration School located in Rough Rock, Arizona. Rough Rock was awarded nearly $550,000 by the OEO during its first two years of existence and became the first modern U.S. school system to be controlled entirely by Native Americans. The success of Rough Rock Demonstration School resulted in the formation of Navajo Community College, which eventually led to the formation of more than 30 similar institutions of higher education. The OEO was eventually abolished; however, its positive impact on the Native American population laid a foundation for the ANA.

The ANA was officially founded in 1974 as part of the Native American Programs Act. Its mission is to promote self-sufficiency among Native American children and families in order to reduce their long-term dependency on public assistance. The ANA does so via grant funding in three distinct areas: Social and Economic Development Strategies, Environmental Regulatory Enhancement, and Native American Language Revitalization/Continuation. ANA’s Social and Economic Development

Strategies use competitive grants to focus on locally determined community goals. Environmental Regulatory Enhancement provides resources for Native Americans to protect their native lands and water, and Native American Language Revitalization/Continuation promotes the survival and continued vitality of Native American dialects. The initiative to preserve Native American languages also resulted in the Esther Martinez Native American Languages Preservation Act in 2006. The law amended the original Native American Programs Act of 1974 to involve elders in language immersion and restoration projects.

Today, the ANA is viewed as a prominent leader in the Native American community. The ANA currently represents more than 5 million people, spanning the continental United States, Alaska, Hawai'i, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands. The organization's guiding philosophy is based on three core beliefs: the belief that self-sufficiency is necessary in order to meet the needs of its members, the belief that such sufficiency must be founded on local leadership and community-based governance, and the belief that progress toward self-sufficiency should be consistent with the community's long-range goals. In recent years, this philosophy has resulted in numerous partnerships with federal agencies and other nonprofit organizations, including the Interagency Working Group on Indian Affairs, Intradepartmental Council on Native American Affairs, Administration for Children and Families Native Affairs Work Group, and Tribal Law and Order Act Interagency Working Group.

In summation, the Administration for Native Americans (ANA) was founded in 1974. As a division of the U.S. Department of Health and Human Services, and stemming from Lyndon B. Johnson's War on Poverty, the ANA encourages social and economic independence for American Indians, Alaska Natives, Native Hawai'ians, and Native Pacific Islanders. It does so by offering community-based funding and technical training for over 5 million Native Americans. As a result, the ANA is now well established in the Native American community, with interorganizational partnerships spanning the United States and its territories.

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See Also: Alaskan Natives; American Indian Movement; Department of Health and Human Services, U.S.; Hawai'ian Native Americans; Indian Boarding Schools; Life Skills Training; National Congress of American Indians; Native Americans; Native Americans, Suicide Among; Pacific Islanders; Self-Determination and Education Assistance Act; Tribal Social Services; Tribal Sovereignty; United Nations Declaration on the Rights of Indigenous Peoples; War on Poverty Programs.

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Administration on Children, Youth and Families

An agency of the U.S. Department of Health and Human Services (HHS), the Administration on Children, Youth and Families (ACYF) handles issues related to children, youth, and families. An office of the Administration for Children and Families, ACYF is headed by a commissioner who is appointed by the president. ACYF is divided into two bureaus—the Children's Bureau and the Family and Youth Services Bureau—each of which is headed by an associate commissioner. Together, these two bureaus help service providers by offering research support as well as evaluations of the effectiveness of various programs.

Background

The Administration for Children and Families is the federal agency within HHS that provides leadership to assist families in leading economically and socially productive lives. To that end, the agency supports a variety of programs, each of which is intended to assist children in developing into healthy adults. The agency also works with communities so that they can become more prosperous and supportive of their members. With a budget of nearly $60 billion, the Administration for Children and Families runs 65 programs that provide assistance with a broad range of issues, including adoption, child abuse, child care, child support enforcement, foster care, and welfare. ACYF is an office of the Administration for Children and Families that is charged with administering and evaluating certain programs within the larger agency.

ACYF works to ensure that a variety of federal programs are run as smoothly and effectively as possible. Programs under the agency's control include social services, protective services, and adoption services. Social services agencies receive encouragement and support to promote the positive development of children, youth, and families. Protective services groups are assisted in their efforts to provide shelter and other services to children, youth, and families in at-risk situations. In addition, adoptions of children with special needs are buoyed by material and logistical support provided by the ACYF.

ACYF supports these goals via a variety of methods. It provides financial assistance to academic institutions, community-based groups, and states for a variety of activities. These activities include demonstration and educational programming, research, and specific services. Funds from the ACYF also allow the dissemination of information related to effective practices, technical assistance, and training of personnel employed by numerous federal, state, and local agencies. ACYF operates two bureaus, the Children's Bureau and the Family and Youth Services Bureau. Each of these bureaus is headed by an associate commissioner and each divides the United States into ten regions. These regions each have an office responsible for administering bureau programs in that area.

Children's Bureau

Founded in 1912 by President William Howard Taft, the Children's Bureau was the first federal agency that worked to improve the lives of children and families. Since its founding, the Children's Bureau has engaged in a number of projects aimed at benefiting children. These projects involved issues such as abuse and neglect, child labor, delinquency and juvenile courts, family economic security, foster care, health and recreation, infant and maternal death, and orphanages. As a result of the bureau's work, great improvements have been made in each of these areas. To achieve these goals, the Children's Bureau has collaborated with private and government agencies to ensure children's welfare, provided assistance to collaborating agencies to support their programming, funded research and the analysis of data to learn the best approaches to problems, disseminated this information to interested stakeholders, and provided leadership to all who are working to improve conditions for children.

The changes effected as a result of Children's Bureau activities have been many. The infant mortality rate in the United States, for example, was approximately 1 in 10 in 1912; 100 years later that rate had dropped to fewer than 7 per 1,000. Juvenile courts, which were rare in 1912, are now present in all 50 states and the District of Columbia, providing children with a different judicial experience than adults. While orphanages once allowed children to be used as laborers by farmers and manufacturers, today child welfare agencies work so that every child is placed with a permanent family. Child labor, which was common at the beginning of the 20th century, similarly has been practically abolished as a result of Children's Bureau efforts.

Family and Youth Services Bureau

The Family and Youth Services Bureau works to provide stability and to promote safety and well-being for families and children. Charged with working especially with those at risk as a result of neglect, trauma, or violence, the bureau supports state and local agencies that provide children, adults, and families with community services, prevention education, and shelter. Focusing on positive youth development, the Family and Youth Services Bureau works to support positive influences in the homes, communities, and schools where at-risk children are present. As a result of these positive influences, the bureau helps children to overcome obstacles and prepare effectively for college, work, and life.

To achieve its goals, the Family and Youth Services Bureau administers three grant programs through two divisions. The Division of Family Violence Prevention and Services administers the Family Violence Prevention and Services Program. This program is the primary federal funding source to assist victims of domestic violence and their children. The program funds emergency shelters and provides other assistance, such as counseling and emergency funds, to women and children affected by domestic violence. A national domestic violence hotline is maintained, which permits anyone dealing with domestic violence to have access to advice, crisis interventions, and local service providers.

The Division of Adolescent Development and Support similarly works to administer two national grant programs, the Runaway and Homeless Youth Program and the Adolescent Pregnancy Prevention Program. The Runaway and Homeless Youth Program works to assist children who are either asked to leave their homes or those who leave on their own accord. To that end, the program provides a street outreach program, transitional housing, maternity group homes, and a model and funding support for basic center services, such as medical care, shelter, counseling, recreation programs, and aftercare.

The Adolescent Pregnancy Prevention Program works to curtail pregnancies and sexually transmitted diseases among adolescents. This is done through a variety of approaches, including distribution of birth control, emphasizing the importance of personal responsibility, and promoting abstinence. While all groups of adolescents are served, the program especially targets those who are living in foster care, homeless, from minority groups, or living in rural areas. As a result of these programs, children, youth, and families have been able to lead healthier and safer lives.

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See Also: Adoption Agencies and Services; Child Abuse/Neglect, Victims of; Child Support Agencies and Services; Foster Care Agencies; Home and Community Services.

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Administration on Intellectual and Developmental Disabilities

The Developmental Disabilities Act enforced by the Administration on Intellectual and Developmental Disabilities (AIDD) authorized major initiatives to institutionalize resources for significant federal activities along with financial support for individuals and families living with developmental disabilities. Originally authorized in 1963 and last updated in 2000, AIDD's stated purpose is to ensure that families have access to and fully participate in all aspects of their family members' school, daily life, and vocational activities by providing individual intervention plans and the resources essential in fulfilling these ideals. The AIDD specifically refers to "self-determination, independence, productivity, and inclusion in all facets of community life." The AIDD represents a federal system that funds, coordinates, and advocates best practices in the field of developmental disabilities. It is a key decision maker whose priorities are to identify future trends in the field by sponsoring research and analysis.

AIDD solidified federal programs for persons with developmental delays and their families to ensure best treatment practices, to protect human and civil rights, and to create opportunities for a better quality of life. Although services and programs were available for this population in the United States for many decades, only when President John F. Kennedy created the President's Panel—then Committee—on Mental Retardation did the field become a major focus for any administration to advocate for the needs of families and individuals with developmental disabilities.

The Administration on Intellectual and Developmental Disabilities was created from federal programs offered under a number of departments within the federal system of health and human services, health and welfare, rehabilitation services, and Office of Human Development; the AIDD remains under the umbrella of the Department of Health and Human Services Office of Children and Youth Services.

The attitudes and culture changed as parents became strong voices for their children. At the same time, the voices of people with developmental disabilities were also heard fighting for equal protections and for equitable treatment and more resources. These efforts emulated those from the civil rights and disabilities rights movements of the 1960s, recognizing that the worth of people with developmental disabilities was emerging. During this time period, the way in which care and treatment were provided was also shifting from the medical model of treatment in which the patient was never in charge of his/her care to a social model in which the individual had a voice in treatment practices. At the same time, large institutional models also evolved into opportunities for more family-like homes in community settings. Other federal legislation greatly enhanced the lives of people with disabilities, including special education laws, the Rehabilitation Acts, Social Security programs, funding of supportive housing, protecting civil rights through Bill of Rights mandates, and access to work initiatives titled the Ticket to Work program.

The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD ACT) created key organizations in each state with the primary tasks to establishing standards of practice, providing human rights protections and family resources, sponsoring research in the field, and ensuring full community inclusion for vocational opportunities. The following organizations were established:

- State councils on developmental disabilities
- National Network of University Centers for Excellence in Developmental Disabilities Education, Research and Service
- Projects of national significance to create opportunities for people with developmental disabilities and their families to contribute to and participate in all facets of community life
- The President's Committee for People With Intellectual Disabilities (DD ACT)
- Protection and advocacy systems

State councils, appointed by the governors, were formed in each state and territory, with a mandate to include people with developmental disabilities and their families. The councils' role is to be a voice for people with developmental disabilities, to identify the most pressing needs for this constituency, to offer comprehensive program planning, and to advocate and be a change agent within the system of state care. Areas of concern may include the rights and dignity of the consumer, educational resources, access to health care, and employment opportunities. State councils form networks to work for integration and inclusion in all aspects of the community.

Protection and advocacy systems (P&As) are mandated to empower, protect and advocate for the human and civil rights of persons with disabilities. There are 57 P&As in the federal system and they are independent of any service provider. P&As review incidents of rights abuses and conduct assessments to determine whether the rights of an individual have been violated; they then recommend resolutions to the problems reviewed. They also provide training to organizations and to self-advocates to facilitate the voice of the individual or family being served. Lastly, they advocate for special education systems to obtain the least restrictive program and inclusive settings available. P&As are strong voices for those unable to defend their own rights.

University Centers for Excellence have a primary purpose to comprehensively assess the needs of the consumer and his/her family and to identify specific goals to meet these needs. University centers work in interdisciplinary models with students and professionals to ensure that needs of consumers and their families are effectively and efficiently met. These centers are usually affiliated with university systems, where they provide research, facilitate staff training and technical assistance, conduct research, and share research and information findings.

Projects of national significance denote federal government–sponsored discretionary funding to meet specific needs within states. Projects may include conferences as well as development of federal and state policy. Family support programs are also funded. Individuals with developmental disabilities typically live with their families; as families age, different levels of support are needed. The family support programs help coordinate resources for in-home care.

Other projects have collected and disseminated data concerning access to employment, residential information, and ongoing data collection to evaluate and compare public financial programmatic trends in developmental disabilities services and supports.

The Administration on Intellectual and Developmental Disabilities identifies the federal system that funds, coordinates, studies, and advocates best practices within the field of developmental disabilities.

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See Also: Developmental Disabilities, Attitudes and Myths in Services for; Developmental Disabled Individuals.

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Adolescent/Youth Services: Overview

Prevention, treatment, and wellness promotion for young people 11 to 25 years old has been a growing objective for U.S. social service, education, juvenile justice, child welfare, and medical fields for the past century.

These services target the emotional health; substance abuse; and the social, behavioral, academic, and/or vocational functioning of adolescents and young adults. Improving the ability of youth to attain success in school; promoting mental, social, and emotional health and well-being; facilitating growth-fostering relationships; and equipping youth to achieve developmental milestones including the establishment of a stable and sustainable living environment are common goals among adolescent and youth service providers.

Historical Context

Mental, emotional, and behavioral health services for adolescents and youth in the United States share an intimate relationship with juvenile corrections services. Their common history dates back to the late 1800s, when the state of Illinois established the nation's first juvenile court in Chicago. In the years that followed, a group of concerned women on the board of directors of Jane Addams's Hull House began investigating juvenile delinquency and, in 1909, created the Juvenile Psychopathic Institute to study adolescent brain functioning, IQ, and psychological factors impacting troubled youth. Their approach inspired the opening of many child guidance centers across the United States in the early-to-mid-20th century.

The Child Study Center at Yale School of Medicine was created in 1911 and served as an innovator in the study of child and adolescent development. During World War II, the drafting of teenagers and young adults from diverse ethnic and socioeconomic backgrounds contributed to data on the relationships between a youth's mental health and ability to function in the world. This spawned a new interest in adolescent health and wellness, and in 1948, a nationwide collaboration of child guidance clinics organized to form the American Association of Psychiatric Clinics for Children (AAPCC) to advocate for effective adolescent/youth services. In 1953, the American Academy of Child Psychiatry was founded, and in the 1960s the National Institute of Health awarded its first grant to study pediatric psychopharmacology.

In 1982, Jane Knitzer released a groundbreaking study, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*. The study was the first of its kind examining on a large scale the effectiveness of mental health services for children and adolescents in the United States. A key finding of the Knitzer study highlighted the importance of family and parent inclusion as an essential component to the success of youth services. In 1984, the National Institute of Mental Health established a Child and Adolescent Service System Program, which was later shifted to the Substance Abuse and Mental Health Services Administration (SAMHSA). The program encourages states to develop a more comprehensive system of care for troubled adolescents, prioritize community-based treatment, facilitate collaborative efforts among state agencies and stakeholders, and increase parent and family involvement in adolescent services.

The Special Education Pupils Program, enacted in California in 1984, provided a new framework for youth mental health care by mandating that special education students be provided adequate mental health services in a collaborative manner between educators and mental health providers. This significantly increased access to mental health services for youth through school individualized education programs (IEPs) and enabled troubled teenagers to remain in home and in their home school, while building necessary services into their weekly schedule.

In 1988, an Alabama court case, *R.C. v. Hornsby*, placed a spotlight on youth in state custody who were committed to psychiatric hospitals, despite never having received any diagnoses. Parents and families in these instances were often denied visitation rights. The legal agreement in this case mandated the creation of a system of care for young people currently experiencing mental health disorders or at risk of being involved with the child welfare system, and established family preservation as a priority for these youth.

The Federation of Families for Children's Mental Health was established in 1989 to promote a family-driven, youth-guided system for adolescent mental, social, and behavioral services. A decade later, in 2001, the *Jason K. v. Eden* settlement in the state of Arizona further galvanized these improvements to the provision of child behavioral health. In the settlement, the state adopted a vision that placed youth and families at the center of care delivery systems. Principles established by this settlement included (1) collaboration with the child and family; (2) adoption of evidence-based practices; (3) cross-system collaboration; (4) maximizing service accessibility; (5) strength-based, family and youth-tailored services; (6) a focus on stable child placement; (7) respect for youth and family cultural background; and (8) anchoring and connection to natural supports.

In 2003, *Katie A. v. Bonta* further challenged the detrimental and common practice of placing foster children with mental health problems in hospitals and residential facilities when instead they could be enabled to remain in homes in their communities if adequate services were available. The settlement of this lawsuit provided the framework for the expansion of wraparound services and evidence-based practices being made available to foster children with the intention of preventing future institutionalization.

Terminology

An "adolescent" is generally defined as a young person 11 to 17 years of age. "Family-driven care" indicates that families take a primary role in making decisions regarding the mental, social, emotional, and behavioral services their children need and receive, as well as contributing to the formation of the policies and procedures governing the larger systems responsible for funding, driving, and providing those services. "Youth-guided care" refers to an emphasis on the rights of adolescents and young adults receiving mental, social, emotional, and/or behavioral care to be educated, informed, and empowered to take a decision-making role in their own services, and to contribute to the formation of the policies and procedures governing the larger systems providing those services. "Evidence-based practice" refers to a service approach that has been evaluated using a criteria base to determine the level of its empirically demonstrated effectiveness with a certain population. In order to be considered an evidence-based practice (EBP), the approach must have documented outcomes in two or more randomized, controlled outcome studies comparing the target approach to an appropriate alternative where a significant advantage was found.

"System of care" refers to comprehensive community-based services and supports consisting of research-informed programs, strong interagency collaboration, and sustained funding. "Least restrictive environment" is a standard established by the 2004 Individuals with Disabilities Education Act (IDEA) that dictates that youth be served when at all possible in their home school, permitted to reside at home with their family, and receive services in the most natural, diverse, and culturally relevant setting possible. "Custody relinquishment" refers to the practice of "voluntarily" giving up one's child or children to the child welfare system, juvenile department, and/or state in order to access mental health services for them. "Wraparound services" refers to a concept established in the 1980s to prevent out-of-home placements and promote care in the least restrictive environment. The aim of wraparound services is to provide youth with serious and/or complex mental, emotional, or behavioral problems an intensive, individualized care plan involving collaboration between the adolescent, family, natural supports, service providers, and community agencies that enables them to remain in their homes and communities.

Differentiation From Adult Services

Historically, adolescent/youth services such as behavior modification and substance abuse intervention mimicked the psychodynamic and aggressive/confrontational approaches being applied to adults with similar presenting problems. Psychiatric, psychological, corrective, and substance abuse recovery programs initially designed for adults were liberally applied to adolescents with little alteration. The Stockton Developmental Center, which functioned as an insane asylum for the state of California in the 1800s, is an example of the institutions that placed children in the same hospital wards as adults, with no separate accommodations.

In the 1950s, certain U.S. medical and social service facilities began to recognize that adolescent behavior problems such as substance abuse and delinquency did not necessarily mirror those of adults. Despite a growing understanding of the unique features of the adolescent brain, youth were still subjected to the same service approaches as adults through the 1980s. Currently, youth service providers recognize the now large body of research demonstrating that adolescent and adult mental, emotional, social, and behavioral problems manifest differently and are best treated differently. Owing to their unique developmental stage—socially, physiologically, and neurologically—adolescents in need of services cannot be treated as merely younger versions of adults. Reinforced by research on the most effective ways of serving teenagers and their families, treatment programs developed specifically for youth emerged slowly in the 1990s.

Settings

Youth services in the United States are provided in a variety of community-based settings including home-based services, school-based services, juvenile correction departments, community clinics, foster-care homes, and medical and residential facilities. Based on statistics from 2007, 3.1 million youth or almost 13 percent of 12- to 17-year-olds in the United States annually receive counseling or psychotherapy intervention in a specialized mental health setting—either outpatient, inpatient, and/or with a combination of in-home services. Another 12 percent receive services in a school-based setting.

Statistics show that approximately 13 percent of 12- to 17-year-olds receive some form of psychotherapy intervention and more than 2 million become part of the juvenile justice system.

Approximately 3 percent receive mental health services in a general medical setting, and over 5 percent receive services in multiple settings.

In 2002, the American School Counseling Association established a framework for the provision of youth treatment and prevention services in school-based settings. School counselors utilize evidence-based approaches to provide individual, group, and family-oriented interventions to students through high school, designed to promote academic, social, emotional, and behavioral health.

Currently, more than 2 million U.S. teenagers annually become formally involved with the juvenile justice system and millions more benefit from prevention services aimed at deterring youth from needing juvenile correction involvement. The vast majority of youth enter the juvenile corrections system with at least one diagnosable mental health need. In some communities where access to mental health care and preventative care is limited, children are referred to the juvenile justice system because general mental health services for youth are unavailable or limited in their area.

Evidence-Based Practices for Youth Services

Adolescent/youth services include a variety of different approaches depending on the preferences of the youth and family, the diagnosis, the level of severity of the problem, and the availability of equipped service providers. Common prevention services include group therapy, psychosocial support, peer and adult mentoring, psycho-education, and prosocial extracurricular activities. Typical intervention services may include individual, group, and/or family therapy with an array of evidence-based practices and possible psychiatric evaluation and medication, along with care coordination/case management.

Empirical research on the effectiveness of youth services has contributed to a growing body of literature on evidence-based practices for prevention and intervention for adolescents. Cognitive behavioral therapy, motivational enhancement therapy, multidimensional family therapy, multisystemic therapy, and brief strategic family therapy are a few examples out of dozens of empirically supported approaches for providing effective services for adolescents and their families. The Substance Abuse and Mental Health Services Administration maintains a list of evidence-based practices and programs in the delivery of effective youth services in the United States.

Obstacles to Accessing Effective Youth Services

Studies of service access and effectiveness consistently reveal ongoing disparity between youth of different racial/ethnic and socioeconomic backgrounds, as well as gender differences. At present, African American youth are more likely to be placed out of home and discharged from residential treatment into foster care than their peers. Males are consistently found more likely to be placed in residential facilities than their female peers. An estimated 40 percent of the boys and nearly 30 percent of the girls placed in residential treatment could have been treated effectively in their home community, based upon their level of risk severity, if adequate community services were made available.

Controlling for risk factors and all other variables equally, adolescents treated in residential facilities and out-of-home placements are more likely than their peers to have suicidal tendencies, comorbid mental health conditions, and experience abuse and neglect. Research indicates that in the United States as much as 75-80 percent of children and adolescents in need of mental health services do not receive them at all, or receive them in an inadequate manner or frequency. Barriers to accessing adolescent/youth services can include stigma preventing the youth and/or family from seeking help; lack of culturally relative services available; language barriers between youth, families, and service providers; inadequate funding; transportation difficulties; and/or shortage of trained providers.

Current Trends

In 2006, the National Center for Children in Poverty released findings from Unclaimed Children Revisited, an initiative highlighting the best state policy practices across the nation in adolescent/youth service delivery, including an emphasis on developmentally and culturally appropriate services, family and youth engagement, and evidence-based services. The study revealed the following trends in U.S. youth services: (1) increased inclusion of parents and families in policy, procedure, and implementation of youth services; (2) decreased funding and practice of approaches shown to be harmful or ineffective for youth; (3) increased use of evidence-based practices and best-practice approaches informed by research on youth health and wellness; and (4) a growing focus on prevention and promoting protective factors that lead to resiliency for youth and families.

The growing interest in protective factors and resiliency development represents a shift in the field of youth services away from a concentration on mental illness and toward strength and wellness. Closely related to this shift is a growing awareness of the importance of language and culture-specific services—adolescents and their families can be best understood and served within the context of their home culture. Resiliency is a strength-based concept that emphasizes the promotion of relationships, activities, skills, and values that serve to prevent and protect a youth from negative consequences, risky behaviors, and environmental challenges.

Stress-relieving and resiliency-building activities can include spiritual practices; problem-solving; practicing positive interactions with family members, teachers, and peers; service to the community; leadership development; team sports; and the arts. Family-based treatment interventions, often provided in the home, outpatient clinics, and/or school, can serve to facilitate positive interactions between troubled youth and their parents, siblings, and extended family and tend to consistently demonstrate good empirical outcomes. Evidence-based practices empower families and youth to learn relational skills, practice creative approaches to solving conflict, reflect on their family culture and values, and identify natural strengths the youth and family can draw upon to achieve their health and wellness goals.

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See Also: At-Risk Youth Services; Mental Health Services, Children; Wraparound Services/Systems of Care.

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Adoption: Infants, International, and Older/Special Needs Children

Adoption is not a new phenomenon; it is spoken about in the Bible and there are accounts of adoption thousands of years ago in Greece, Rome, and Egypt. The history of adoption in the United States can be traced to the 1850s with the passage of the first adoption law in Massachusetts in 1851. This law, the Adoption of Children Act, recognized adoption as a social and legal activity based on children's welfare rather than on adults' self-interest. The law directed judges alone to ensure that adoption rulings were "fit and proper." The 1850s were also the era of the orphan trains, which relocated children from New York to live with families throughout various states and within Canada. In the early history of adoption in the United States, adoption records were not confidential and, thus, there were no legal protections for the adoptive families and biological parents. In the 1930s through 1950s, birth and adoption records were sealed for the first time, and thus, the adopted children had no legal recourse to access information about their birth parents.

Current adoption practices distinguish between closed and open adoptions. In the past, most adoptions were closed. However, closed adoptions are relatively rare in contemporary society. Closed adoptions occur when the adoptive parent(s) do not know the adoptee's birth parents. In closed adoption, files are generally physically sealed. Despite this, many states have created procedures and protocol for family members to "open" a closed adoption file (the procedures vary from state to state).

Open adoptions are increasingly more common in the United States; they are also most likely to involve adoptions of infants either independently or through a private organization. In open adoptions, the adoptive parents usually meet and stay in contact with the birth parents. Today, many adoption agencies encourage open adoptions, but the degree of openness varies according to the needs and desires of the adoptive parents and birth parents. For example, contact can differ in terms of frequency and duration of birth parents' visits. Further, families can decide on different forms of contact (i.e., information, pictures, gifts, letters, phone calls, face-to-face visits). Adoption is a common phenomenon in the United States. It is estimated that more than 1.5 million children live with adopted parents and between 2 to 4 percent of American families have adopted a child. This figure includes children who are adopted as infants, children adopted internationally, and adoptees that are older and/or have special needs. Additionally, some adoptions are considered transracial adoptions.

Infant Adoption

Researchers maintain that 2 percent of adoptions are of children who are 1 year old or younger, while 45 percent are of children 1 to 5 years old. A majority of adoptive parents may prefer to adopt an infant.

The orphan train mural in Delmar, Iowa. The history of adoption in the United States can be traced to the 1850s with the passage of the first adoption law in Massachusetts in 1851. The 1850s were also the era of the orphan trains, which relocated children from New York to live with families throughout various U.S. states and within Canada.

However, the waiting time for a healthy infant can be as long as two years or more. Adoptions of healthy infants commonly are arranged with private agencies and can cost from $5,000 to more than $40,000. Evidence shows that strong attachments, solid families, and positive communication about adoption issues contribute to the success of adopted infants. This evidence remains true independent of the child's age or the race of the family and child.

International Adoptions

Every year, U.S. citizens adopt children from other countries and families from other countries adopt U.S. children. International adoptions are popular in the United States but they usually come with additional costs, longer waiting periods, and strict regulations. Wait times for international adoptions can range from approximately three months to two years. The costs associated with international adoptions vary considerably, ranging from nothing to over $60,000. The regulations for international adoptions are largely based on the Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption. This is an international agreement to safeguard international/intercountry adoptions. The United States signed the convention in 1994 and it became enforceable in 2008. The convention applies to every adoption involving the United States and any other country that has also signed the convention.

Older/Special Needs Children

Recent reports indicate that two-thirds of the children in foster care are over the age of 5, and many of these children may have additional health problems and/or special needs. Adopting an older child or a child with special needs may bring additional stressors and/or challenges. The older the child, the more likely the chance of a disrupted adoption; thus, adoptive parents are encouraged to have realistic expectations. Additionally, adoptive families with older children are urged to make use of postplacement family counseling early in the adoption process, maintain sibling bonds, make all transitions gradually, and allow the children to bring their own customs and personal choices to their new family. An unhealthy integration often occurs with the adoption of older children when the family makes minimal changes and compromises and expects the adoptee to change. In the context of adoption, the term *special needs* takes on a unique definition. The term does not necessarily refer to medical, physical, or emotional disabilities. In adoption, special needs is the term used to determine eligibility for federal financial assistance. While definitions of special needs vary by state, a child with special needs may have one or more of the following factors or conditions: having a particular ethnic or racial background; being an older child; being a member of a sibling group needing to be placed together as one unit; and having medical conditions and/or physical, mental, or emotional disabilities, and/or any condition that makes it more difficult to find a potential adoptive family.

Transracial Adoption

Transracial, transcultural adoption refers to the placement of a child who is of one race or ethnicity with an adoptive parent of another racial or ethnic group. The majority of transracial adoptions within the United States involve African American or interracial children adopted by Caucasian parents and/or the adoption of interracial children by African American or other parents of color. Conversely, the transracial adoptions of Caucasian or Native American children are relatively uncommon. Researchers argue that children adopted transracially do as well as same-race adoptions when parents are aware of the unique issues these children may encounter. For example, transracial adopted children are likely to thrive when the adoptive parents provide information and education and expose the child to his or her racial background and heritage.

Summary

The policies and procedures related to adoption have changed considerably over the years. Infant adoptions, international adoptions, the adoption of older/special needs children, and transracial adoptions are common in contemporary culture. Each of these adoptions creates an opportunity for a child to thrive with their adoptive parents.

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See Also: Adoption, Special Needs; Adoption Agencies and Services; Adoption and Foster Care Analysis and Reporting System; Adoption and Safe Families Act; Families, Nontraditional; International Adoptions and

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Adoption, Special Needs

The term *special needs adoption* refers to the adoption of children who are considered hard to place for a variety of circumstances. Typically, hard to place children are those with physical handicaps, mental handicaps, or behavioral issues; from large sibling groups; older children (often identified as age 7 or above); and children from racial minorities. Historically, such children were kept in orphanages or institutions and little to no effort was made to place them. Currently, laws have been enacted to secure the rights of such children to obtain permanent homes, if at all possible.

History

Before the late 1940s, children identified with special needs were often housed in orphanages or other institutions and little to no attempt was made to have them placed in families. However, after World War II there was a shift in ideology and a move to have children placed in homes within a community rather than an institution.

Social service agencies were expected to develop a foster care system in which the children could be placed out in the community and to identify permanent homes for children who could not be reunified with their biological families. At this time, the focus was on reunifying children with their biological families and the right of the parent to regain custody of the child was the primary concern.

In 1997, the Adoption and Safe Families Act (AFSA) was enacted. AFSA addressed the difficulties involved in adopting children with special needs. Prior to this law, the states attempted to reunify children with their biological families, and children could spend years in foster care before parental rights were terminated and the children were identified as ready for adoption. AFSA provided time limits of up to two years for biological parents to regain custody of their children, at which point the children would be ready for adoption. AFSA also provided extensions in support and health care coverage, which was a major concern for families of special needs children. AFSA formalized the shift in focus to the rights of the children to be in loving homes over the rights of the parents to regain custody.

In 2008, the Fostering Connection to Success and Increasing Adoptions Act became law. This law enabled children in foster care to find permanent homes through providing support and improvements in education and health care to support adoptions. The law also included support for children up to age 21 and provided help for these young people to be successful once they were ready to leave foster care. Families that adopted special needs children typically needed extra time and support services to get their children to a point of optimal functioning.

Special Concerns

Families that adopt special needs children require some form of preparation for what they are going to do. This often takes the form of foster care training, in which the parents are prepared to be foster-to-adopt parents. They also are assigned a case manager who meets with the families and seeks to help them identify and connect with a special needs child. When placing a special needs child in a permanent home, community supports are vital to help the family provide the kind of intervention the child will need in order to do well.

Children who have physical disabilities require medical treatment, with parents who are prepared to take care of such things as tube feeding, hospital visits, and support services such as physical and occupational therapies. Parents might need to have their home adapted for a wheelchair, understand how a blind child navigates a room, or learn sign language in order to meet the needs of the child placed with them. The local school would need to develop an individualized education program (IEP), or a more specialized school program would need to be identified to help the child grow and fully develop.

Children with mental or developmental delays require parents who are able to help them develop their skills in a supportive fashion. Adoptive parents who take in such a child will need to work with the school to develop an IEP and advocate for the child if needed. Such children often have physical disabilities and might require specialized medical care as well. As the child gets older, some form of transitional program might be needed to help him or her to become as independent as possible.

Children with emotional or mental health disabilities/behavioral issues require therapy, psychiatric care, and support services and may need hospitalization. Such children often appear to be fine, but may have serious mental health issues that can lead to disruptive or troubled behavior. Parents of such children will need support and training in how to handle and manage a difficult child. Because of their troubled behavior, such children often need IEPs and may end up in trouble with the law when they become teens. Parents might have to be prepared to go to court, the police station, or juvenile detention agencies and facilities with such children. There might be a need to place the child in a residential mental health or behavioral facility for extended period, as well. This presents very difficult challenges for parents in loving homes who want to remain involved with their child.

Older children who are adopted might have difficulty trusting or bonding with their adoptive family. They also will need to be prepared for the adult world (getting a job, learning to drive, finishing school, etc.). However, older children often are motivated to attain their goals and often do not provide much difficulty for the adoptive family.

Sibling groups require adoptive parents who can effectively handle two or more children who may have some other special needs. The needs of two or three (or more) children will have to be addressed and met. Two-parent homes or a home in which the parent does not need to regularly leave might be more successful with a larger sibling group.

Children who are minorities often face the challenge of being placed in homes that do not match their own racial or ethnic heritage. They might have to adapt to a different culture and may have identity issues related to being in a home so unlike their biological one. They may have to live in communities where they do not look like the other children and might face bullying or some form of stigma or low self-esteem because of this. The adoptive family would need to make sure the children remain in touch with their heritage and culture and provide opportunities for the children to celebrate their racial or ethnic heritage.

Conclusion

Adopting a child with special needs can be a very rewarding and positive experience if the adoptive family is given guidance and support by the adoptive or social service agency making the placement. The school, community, and professionals involved in the care and welfare of each child need to work in a cooperative fashion to meet that child's needs. Children with special needs can become loving members of a family and often thrive in a healthy, balanced home.

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See Also: Adoption: Infants, International, and Older/Special Needs Children; Adoption Agencies and Services; Adoption and Safe Families Act; Biracial Children; Case Management; Children in Foster Care; Children With Special Needs; Disabled Clients; Fostering Connections to Success and Increasing Adoptions Act of 2008; Multiracial Children; Special Education.

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Adoption Agencies and Services

Adoption is a process whereby a person inherits permanent and full parental rights, as well as responsibilities, for a child. Whereas guardianship or other systems designed for the care of children are temporary, adoption is permanent custody, which warrants public recognition. Contemporary systems of adoption are for the most part governed by thorough statutes and regulations. Most recently, adoption serves the needs of homeless, neglected, abused, and runaway children. Adoption is noted as being a social, emotional, lifelong, and legal process in which children who will not be raised by their birth parents become complete and permanent legal members of another family. While the practice of adoption has been around for decades, the recent history of adoption in the United States can be traced to the 1850s, with the passage of the first adoption law in Massachusetts that recognized adoption as a social and legal process based on the child's well-being rather than the adult's interests.

Transracial or transcultural adoption means placing a child who is of one race or ethnic group with adoptive parents of another race or ethnic group. Adoptive parents choose to adopt transracially or transculturally for a variety of reasons. Some prospective adoptive parents feel connected to a particular race or culture because of their ancestry or through personal experiences such as travel or military service. Others simply like the idea of reaching out to children in need, no matter where they come from. A number of sources have provided statistical estimates, which reveal the percentage of transracial or transcultural adoptions in the United States is significant. For instance, one source estimates that Caucasian families adopt 1,000 to 2,000 African American children each year. Data from the Immigration and Naturalization Service show that U.S. families adopted 7,088 children from other countries in 1990. This means that there were roughly 8,500 transracial or transcultural adoptions in 1990. In that same year, there were almost 119,000 adoptions of all kinds. Since approximately half of the adoptions in any year are stepparent or relative adoptions, in 1990 there were about 59,500 nonrelative adoptions. The percentage of transracial/transcultural adoptions (8,500 of 59,500) then comes out to more than 14 percent.

Essentially, preparation for adoption is important for all families considering this life-changing commitment. It is more crucial for parents considering transracial or transcultural adoption because it will introduce these parents to all aspects of adoptive parenthood, help the adoptive parents learn about adoption issues, and help them identify the type of child desired to parent. Any adoption agency that conducts and supervises transracial or transcultural adoptions should provide this important service. For those independent adoptive parents, they should seek counseling and training in these areas. Independent adoptive parents should also read as many articles and books as possible on the subject.

Forms of Adoption

Open adoption allows distinguishing facts to be transferred between adoptive and biological parents, as well as interaction between the two parties. In most cases, adoptees have the right to access their birth records. Open adoption can be an informal arrangement subject to termination by adoptive parents who have sole authority over the child. In some jurisdictions, the biological and adoptive parents may enter into a legally enforceable and binding agreement concerning visitation, exchange of information, or other interaction regarding the child.

Closed adoption seals all identifying information, maintaining it as secret and preventing disclosure of the identities of adoptive parents, biological parents, and adoptees. Nevertheless, closed adoption may allow the transmittal of nonidentifying information, such as medical history and religious and ethnic background. In states that honor the "safe haven" law, infants can be left, anonymously, at hospitals, fire departments, or police stations immediately following birth. Closed adoption, lack of medical history, and the broken thread of family continuity can have a disadvantageous effect on an adoptee's mental, emotional, and physical health.

Ethical Issues in Adoption

Adoption involves the rights of the birth parents, the child, and the adoptive parents. It is imperative that professionals working in adoption are ethical to ensure the rights of everyone involved as the adoption develops. Professionals working with birth parents involved through either voluntary relinquishment or involuntary termination of parental rights must ensure that relinquishments are truly voluntary and that ethical standards and procedures are followed in all termination of parental rights proceedings. Ethical adoptive family recruitment requires that accurate information about a child's background, to the extent allowed by law, be shared from the beginning. This information should be shared first during the initial introduction as permitted, before the family's final decision to adopt. Ethics are also important after an adoption is legally confirmed. Ethical practice in balancing the birth parents' right to privacy with an adopted person's desire to know their history is imperative in postadoption practice.

Types of Adoption

Most probable adoptive parents have to decide whether to adopt on a national or international level. Some of the considerations in deciding between domestic and global adoption include the importance of having access to the child's medical and biological history and the amount of contact with the child's birth family. The following elaborates on the various types of adoptions.

Domestic adoption may allow services with a public agency, a licensed private agency, an attorney, or an adoption facilitator or an unlicensed agency. Public and licensed private agencies are regulated by state laws and have more supervision to guarantee quality services. Many public and private adoption agencies provide free orientations, which allow the adoptive parents to gain an overview of their available services before the adoptive parents are obligated to retain services. Whether an infant or an older child is adopted, likely a more extensive history and background about the child who lives in the United States than the child who lives in another country is shared with the adoptive parents. Domestic adoptions make it more likely that adoptive families will be able to arrange for some degree of contact between the two families (birth family and adoptive family) after the adoption. This practice of adoption is known as openness. The numerous categories of domestic adoptions (public agency adoption, licensed private agency adoption, independent adoption, and facilitated/unlicensed agency adoption) and intercountry adoptions (Hague Convention adoption and non–Hague Convention adoption) are described below.

To begin, public agency adoption primarily deals with the adoption of children in state custody (foster care). There are multiple reasons why foster children can be removed from their families, which involve abuse or neglect. Most foster children have experienced trauma because of the separation from their biological family. These children range in age from infants to teens. Licensed private agency adoption involves causes for the birth parents to relinquish their parental rights to the agency and adoptive parents to receive adoption services from the agency. These agencies are required to adhere to licensing and procedural standards. Many prospective parents work with licensed private agencies in order to adopt healthy infants. The length of time required to adopt an infant is unpredictable—some adoptive parents have waited for years. In the United States, agency criteria for prospective adoptive parents are often more restrictive for infant adoptions than for adoptions of older children, mainly because fewer infants are available.

In independent adoption, attorneys assist prospective parents with the adoption process, which usually involves the adoption of an infant. Families adopting independently identify the expectant parent(s) without an agency's help. Some adoptive parents and expecting mothers find each other and make a plan within a week, while other adoptive parents search for years. This adoption process allows the adoptive parent to interact with the expectant parents or their attorney. Birth parents typically provide a written consent for the adoption that must be approved by the court.

Facilitated/unlicensed agency adoption is an adoptive process that is accelerated by facilitators and unlicensed agencies. A facilitator is any person who links prospective adoptive parents with expectant birth mothers for a fee. Facilitators may or may not be regulated in their state and may have varying degrees of expertise in adoption practice. Some states prohibit adoptions by paid facilitators.

Intercountry adoption differs in several substantial ways from domestic adoption. Children who qualify for intercountry adoption are faced with the restriction of having lost their birth parents to death or abandonment. Intercountry adopted children can also qualify if their birth parents can prove that they are incapable of meeting their basic needs. For example, some children adopted through intercountry adoption may have been raised in orphanages or institutional settings. Children adopted from another country, especially older children, require cultural responsiveness with respect to the changed environment (i.e., language, food, customs, societal expectations). The permanency process for intercountry adoption fluctuates, based on the agency. The country in which the child was born and the country's Hague Convention status should be considered. Often, adoptive families are asked to take several trips to the child's country of origin to actually gain custody of the child.

The Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption (Hague Convention) was sanctioned in 2008. The ratification of the Hague Convention amended a number of requirements for adoptions of children from international countries that are members of the Hague Convention. The Hague Convention was enacted to safeguard children and families involved in intercountry adoption. It includes but is not limited to requirements for adoption agencies, home studies, and parent training. Adoptive parents who decide to proceed with a Hague Convention country must use the services of a provider who is approved or accredited specifically to provide Hague Convention adoption services. Parents need to identify the desired country before obtaining a home study, and they will have to complete at least 10 hours of approved training. Children adopted from Hague Convention countries must be qualified by their country of origin and must meet the definition of a Hague Convention adopted person. Before entering the United States, the child must obtain an immigrant visa.

Parents adopting from a non-Hague Convention country may obtain a home study before choosing the country from which to adopt as long as the home study meets state and federal requirements. The adoption agency must be licensed in their home state. Parents may or may not be required to complete training before adopting. The child identified for adoption must meet the U.S. Citizenship and Immigration Services definition of an orphan and must obtain an immigrant visa before entering the United States.

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See Also: Abandonment; Adoption, Special Needs; Adoption and Foster Care Analysis and Reporting System; Adoption and Safe Families Act; Child Welfare Services

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Adoption and Foster Care Analysis and Reporting System

The Adoption and Foster Care Analysis and Reporting System (AFCARS) collects case-level evidence from state and tribal Title IV-E agencies on all children in foster care and those who have been adopted with title IV-E agency involvement. AFCARS is managed by the Children's Bureau, a federal agency under the supervision of the U.S. Department of Health and Human Services' Administration for Children, Youth, and Families. Examples of data reported to AFCARS include demographic information on the foster child as well as the foster and/or adoptive parents, the number of removal episodes a child has experienced, the number of placements in the current removal episode, and the current placement setting. Title IV-E agencies are required to submit AFCARS data twice a year by a set deadline. Title IV-E agencies that fail to meet any of the standards set forth in federal regulation 45 CFR 1355.40 (a-d) are considered noncompliant with the requirements of the Title IV-E plan and are notified in writing of their noncompliance.

The Children's Bureau provides national leadership and direction in planning, managing, and coordinating the administration and financing of a broad range of comprehensive and supportive programs for children and families, including child welfare programs. These programs are, in large part, carried out by state, tribal, and local agencies. The Children's Bureau retains responsibility to monitor and evaluate the programs to ensure they are being operated in compliance with federal law and regulation. This includes the assessment of statutorily required data and automated information systems operated by Title IV-E child welfare agencies that support the programs under Titles IV-B and IV-E of the Social Security Act.

AFCARS Assessment Reviews

The purpose of the AFCARS assessment review (AAR) is to conduct an in-depth assessment and evaluation of how an agency gathers, records, extracts, and submits its AFCARS data. AAR is an arduous process, which examines Title IV-E agencies' information systems and allows a review team to identify problems, investigate the causes, and suggest solutions during the review. The "Guide to an AFCARS Assessment Review" offers detailed information on the AAR process and can help Title IV-E agencies prepare for a review. It can assist Title IV-E agencies with developing or redesigning a case management information system. The guide can also be used as a technical assistance document and self-assessment tool to support the development of the business requirements needed to create the AFCARS data file.

The Children's Bureau is committed to providing assistance to Title IV-E agencies in order to support the collection of high-quality adoption and foster care data. To this end, the AAR was developed to evaluate the accuracy and reliability of the foster care and adoption data. The Title IV-E agency's methodology for collecting and reporting AFCARS data is assessed against the AFCARS requirements in the federal regulation, issued policies, and AFCARS technical bulletins. A second focus of the AAR is to assess timeliness, accuracy, and quality of data entry by caseworkers.

Background and History

In 1982, the American Public Human Services Association implemented the Voluntary Cooperative Information System (VCIS) to annually collect aggregate information about children in foster care and special needs adoption from state child welfare agencies. Despite efforts by states to report data, by 1986 underwriters recognized there were a number of challenges in VCIS. To be precise, VCIS was criticized by the states for intermittent reporting, the use of a variety of reporting periods, the lack of common definitions for data elements, the lack of timeliness and the poor quality of the data, and the collection of aggregate data with limited analytic utility. To address these challenges, President Ronald Reagan on October 21, 1986, signed legislation that added Section 479 to Title IV-E of the Social Security Act.

Section 479 described the series of steps that the Department of Health and Human Services was required to take to establish a national data collection system for adoption and foster care. The department was mandated to develop a system that avoided unnecessary diversion of resources from agencies responsible for adoption and foster care. This mandate was meant to ensure that data would be collected with standardized definitions and methodologies and would be reliable and consistent over time. Ultimately, the mandate required the data collection system to offer inclusive demographic physiognomies of adopted and foster children and their parents (biological, foster, and/or adoptive). The sought-after data included the status of the foster care population (e.g., the number of children in foster care, length of placement, type of placement, availability for adoption, and goals for ending or continuing foster care). The data also included the number and characteristics of children placed in or removed from foster care, children adopted or with respect to whom adoptions have been terminated, children placed in foster care outside the state that has placement and care responsibility, and the extent and description of aid provided by all authorities.

The Omnibus Budget Reconciliation Act of 1993 was enacted on August 19, 1993. A provision of this act offered states the opportunity to obtain Title IV-E funds to plan, design, develop, and implement a Statewide Automated Child Welfare Information System (SACWIS). An AFCARS ruling required states to submit to AFCARS on a semiannual basis certain data about children in foster care and adoptions that involve the state agency. The rule required states that chose to develop a SACWIS to ensure that their system could report information to AFCARS. States were obligated to report the first AFCARS data in 1995. Nevertheless, AFCARS's financial penalties for a state not complying were not implemented until 1998, at which point the data became stable enough to use for a variety of reasons.

The Adoption and Safe Families Act of 1997 required the use of AFCARS data for two specific activities: the calculation of adoption incentive payments (Section 473A of the Social Security Act) and the child welfare outcomes annual report (Section 479A of the Social Security Act). Since that time, data from AFCARS also have been utilized to provide samples for child and family services reviews (CFSR) and title IV-E reviews. Furthermore, the data are utilized to develop outcome and performance measures for the CFSR, the Office of Management and Budget's Program Assessment and Rating Tool (PART), and the Government Performance and Results Act (GPRA). The data from AFCARS are also utilized to calculate state allocations for the John Chafee Foster Care Independence Program (Section 477 of the Social Security Act), to generate budget projections, to conduct trend analyses for program planning, and to respond to requests for information about children in foster care and children being adopted. In early 2002, the practice of withholding federal funds for a state's failure to comply with AFCARS requirements was halted because of a settlement of numerous states' appeals of AFCARS penalties. Nonetheless, in 2003 the Adoption Promotion Act of 2003 was signed into law, which required specific financial penalties for a state's noncompliance with AFCARS requirements.

Child Welfare Outcomes

To some extent, AFCARS was created because of apprehensions regarding the scarce national information available on children in the child welfare system. The data required by AFCARS are information that would normally be collected during the course of a child welfare assessment, planning, and service provision, so that additional information does not need to be collected solely for the purpose of meeting AFCARS requirements. The Children's Bureau prepares child welfare outcomes data and makes it available online, and publishes an annual Child Welfare Outcomes Report to Congress, a requirement of the Adoption and Safe Families Act. The report highlights each state's performance in seven outcome areas. Data from AFCARS offer an opportunity to examine how states use foster care and adoption subsidies to help achieve goals of permanency, safety, and well-being for children.

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See Also: Administration on Children, Youth and Families; Adoption: Infants, International, and Older/Special Needs Children; Adoption Agencies and Services; Adoption and Safe Families Act; Case Management; Center for Native American Youth; Child Abuse Prevention and Treatment Act; Child and Adolescent Needs and Strengths; Child Welfare Services; Children in Foster Care; ChildStats; Family Pregnancy Planning; Family Services; Foster Care Agencies; Fostering Connections to Success and Increasing Adoptions Act of 2008.

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Adoption and Safe Families Act

The Adoption and Safe Families Act (ASFA) was passed in 1997 in an attempt to address a number of problems that had existed in the child welfare system for decades. The passage of the Adoption and Safe Families Act marked a significant shift in child welfare thinking, placing a much stronger emphasis on the safety of children as opposed to previous child welfare policies that emphasized family reunification. Rising rates of poverty, teen pregnancy, and substance abuse disorders contributed to a significant rise in the number of foster children in the 1980s and 1990s. In addition, children remained in foster care longer, many eventually emancipated from care at age 18. The central aim of the ASFA is to address these larger caseloads and longer stays in foster care by adopting measures that would achieve timely permanency, moving children from foster care to more permanent families.

The ASFA has had and will continue to have strong implications for the human services field. While the act eventually passed with bipartisan support, the strict permanency measures and stronger emphasis on terminating parental rights continue to be a source of contention among many child welfare policy makers and practitioners. Many professionals and policy makers have expressed concerns that many African American and Hispanic families are disproportionately impacted by the emphasis on expediting the permanency process; therefore, this policy has strong implications for human services and diversity.

The ASFA contains a number of major provisions, addressing numerous areas of child welfare policy. The major provisions in the policy include (1) moving children promptly to permanent families, (2) ensuring that a child's safety is a primary concern, and (3) improving innovation and accountability throughout the child welfare system.

Moving Children Promptly to Permanent Families

Prior to the signing of the ASFA there had been no comprehensive attention to federal child welfare policy in nearly two decades. Authors of the legislation were most concerned with the safety of children, and many expressed concerns that the previous policies requiring states to make "reasonable efforts" to keep families together often resulted in reuniting children with parents who could potentially harm them. At the same time, lawmakers wanted to ensure that the law did not go too far the other way, leading to arbitrary removals of children from their families. Among the most notable provisions in this act seeking to "fast track" permanency for children is the requirement that states seek termination of parental rights of children who have been in foster care for 15 of the previous 22 months. A number of circumstances were identified in which exceptions could be made to this requirement, including instances in which the child is being cared for by another relative, the state has not provided necessary services to the child and family to return home, and instances when the state feels it is not in the child's best interest to file for termination of parental rights.

In an effort to efficiently establish a plan of permanency for children placed in foster care, the Adoption and Safe Families Act requires permanency hearings to be held no later than 12 months after a child is initially placed in foster care. In these hearings states are required to address the question of whether a child would be returning home, placed for adoption, or referred for legal guardianship. Furthermore, it is the intention that this provision will ultimately end long-term foster care as an acceptable permanency goal.

Another seminal provision of the ASFA is its expansion of the adoption incentive program. In an attempt to address the rising number of older children who have been in the foster care system for a number of years, authors of the legislation doubled the incentive payments for older children and for adoptions of special needs children. Similarly, it provided additional incentives to states that improve their rates of adoption. Several analyses of the ASFA suggest that the legislation has been effective in increasing rates of adoption of all children in foster care, including older children and children with special needs.

Ensuring That a Child's Safety and Well-Being Are Primary Concerns

Among the most prominent provisions to emphasize children's safety as a vital concern in child welfare decision making is the clarification of the term *reasonable efforts*, as well as the identification of exceptions to the reasonable efforts requirements. The most notable of the exceptions includes instances in which a child's safety could be at risk; therefore, reasonable efforts are not required.

The act also includes a provision aimed at ensuring that the policy does not disrupt family life inappropriately, intrude upon reasonable parental discipline, or prescribe a method of parenting. This is referred to as the preservation of reasonable parenting provision.

In addition to children's safety, the law also seeks to make children's well-being a significant focus. Requirements are outlined to ensure that states provide children in foster care with quality services to protect their health and safety. Furthermore, states are required to create health coordination plans for children in foster care, as well as education coordination plans designed to ensure that all children in foster care are in school full time or have completed secondary school.

Improving Innovation and Accountability Throughout the Child Welfare System

A long-standing critique of the child welfare system prior to the passage of the Adoption and Safe Families Act was the system's inability to adequately and efficiently track the outcomes of the children and families who were served. Two key provisions were created in an effort to better track outcomes and evaluate programs. A universal set of outcome measures is included to evaluate each state's performance in the areas of child protection and child welfare. Furthermore, each state's funding is tied to its performance in these outcome areas.

In addition to developing outcome areas to assess state performance, the Adoption and Safe Families Act set out to shift the outcomes to be more positive and empowering for children and families. Similarly, outcomes are geared to fit more closely with the goals of permanency, safety, and well-being. States are also required to document their efforts to move children into adoptive placements.

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See Also: Administration on Children, Youth and Families; Child Welfare Services; Children in Foster Care; Fostering Connections to Success and Increasing Adoptions Act of 2008; John H. Chafee Foster Care Independence Program.

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Adult Day Care

The provision of adult care during daytime periods was initially implemented as an innovative approach to meet the needs of psychiatric patients moving from hospitals to the community during the midcentury era of large-scale public mental hospital deinstitutionalization. Adaptation of this program concept as a care option for frail, chronically ill elderly and disabled adults began limited implementation in the 1970s. Throughout the following decades this type of community-based long-term supportive service (LTSS) expanded to typically offer some health and many social services in a group setting as this service became ever more available to disabled individuals residing with family members or other informal caregivers.

The concept has proven to be highly flexible and adaptable in meeting the needs of very diverse participant groups. Program activities to satisfy cultural diversity among center clients is one of the greatest challenges to programs in large urban areas with immigrant populations and economically marginal persons with access restrictions that preclude their enrollment in alternative services. Adult day care centers (ADCC) operate as either nonprofit or for-profit entities. They are typically open during all weekdays for participants transported to the site according to an individual participation schedule. At the center, participants engage in a wide range of therapeutic socialization activities, share meal times with foods that meet dietary requirements, and enjoy leisure and needed rest. Each person has an individual care plan structured according to personal physician orders as well as the results of an in-depth initial biopsychosocial assessment and taking into account family caregiver needs. Center staff members give personal care as part of the daily routine of hygiene, dispense medications, provide cognitive stimulation, and frequently make available specialized physical and other therapies as prescribed. A prevailing care philosophy is participant-centered with effective and efficient care in a safe and nurturing environment supportive of personal independence and choice.

In the United States there are 5,000 or more adult day care centers (a current estimated number given by the National Adult Day Service Association) that serve adults across the disability spectrum with a combination of physical, sensory, cognitive, and/or developmental impairments. The prevalence of dementia, often in combination with other serious chronic illnesses among participants over 70 years of age, is very high. Each center establishes its own admission criteria as related to the degree and type of disability that can be appropriately accommodated. Final admission decisions are usually made after participation capacity has been observed and evaluated. Sometimes participation extends over many years, while in other cases attendance is very brief. Participant satisfaction and that of their caregiver tend to increase as the environment becomes more familiar to the participant and caregiver expectations are met. Sometimes the availability of day care is the only viable alternative to residential placement.

Increasing Diversification of Adult Day Care Centers

When the first adult day care centers offering geriatric care opened, a few received federal funds designated as cost-effectiveness demonstration projects. There was much interest in comparing day care center per diems with nursing home daily costs. Approaches for calculating costs were difficult because a participant's time at a center was approximately eight hours, compared to the 24-hour care of a residential facility. There was considerable confusion over the distinction between senior citizen centers providing structured recreation and meals and adult day care centers providing health and social services. As different types of organizations started day care centers, distinctions were made among social, health, and medically oriented programs. Centers were identified as "freestanding," operating as independent single organizations, or "affiliated," operating under a parent organization such as a health/medical facility, social service agency, or within a church/synagogue setting. Some centers are now highly specialized and provide emphasis on rehabilitation, serve only persons with Alzheimer's disease and dementia, or outreach to specific underserved cultural and linguistic groups. Major urban centers have a sufficient population base to support many centers of varying types. Smaller communities are often served by centers that have more diverse participant groups who share needs for health and social services. Rural communities continue to be seriously underserved because of the very limited adult day care center availability.

Service Costs and Payment

Current national estimates for the average daily cost of adult day care are not yet available. The 2009 average daily cost was $67, and throughout the United States there was a wide cost range—between $27 and $150. The annual cost increase for this service is generally lower than a nursing home, assisted living, and home care. Centers vary in the extent to which they have "add-on" charges that are determined by a participant's usage of special services.

For example, a center may add a transportation cost into the daily per diem or may charge for daily or bill separately for special therapeutic services available through a contractual arrangement. Family members costing-out day care center charges before making an enrollment decision should be clear about such costs as admission deposits, billing arrangements, cancellation fees, sliding fee schedules, and minimum weekly enrollment requirements. Throughout the country, Medicaid is the single greatest source of center participation coverage. While each state develops its own Medicaid coverage plan, always approved at the federal level by the Center for Medicaid within the U.S. Department of Health and Human Services, there is wide variability in the reimbursement rate paid by each state. Many state Medicaid plans apply a Medicaid Home and Community-Based Waiver (HCBS) payment option because adult day care participation helps participants with higher levels of functional impairments to remain in the community. At the present time Medicare does not cover this long-term care service option. Centers also provide private-pay participants short family respite periods of longer-term participation.

Future Growth of Adult Day Care

The enactment of the Patient Protection and Affordable Care Act (PPACA) provides states with several new options for Medicaid coverage under the HCBS category. Each state determines which new PPACA option(s) may be negotiated in order to take advantage of the additional federal funding. As more employers make long-term care insurance a provided or at least available health benefit, it will become an expanded source of adult day care center care. Throughout the country, well-organized advocacy efforts are under way to encourage states to take advantage of the greater amount and funding flexibility. Throughout the country, there continues to be strong advocacy to pass federal legislation that would amend federal Medicare coverage when adults are making the transition from hospital to home.

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See Also: Aging and Adult Services; Developmental Disabilities, Attitudes and Myths in Services for; Medicaid; Medicare; Respite Care.

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Adult Education Programs and Services

Adult education programs and services include a wide variety of formal and informal continuing education programs designed to promote the personal, educational, and professional development of adult learners. Adult education is voluntary and requires both self-motivation and a willingness to participate in an ongoing learning process.

Culture, globalization, and productivity demands create culturally and economically mandated educational requirements. Adult learners often attend adult education programs as an employment requirement (e.g., work-related training and workshops), to meet basic employment standards (e.g., college degree), or to compensate for an incomplete education (e.g., high school diploma or general education diploma). The development of newer, more complex technologies and information systems require a more skilled and educated populace. Therefore, individuals must seek continuing education in order to adapt to these innovations and thrive economically. Gaining economic and personal advantages are a driving force behind adult education programs. Economic advantages include better job opportunities, higher wages, and a more competitive skill set. Personal advantages include higher self-efficacy, higher self-esteem, increased knowledge, and goal attainment. At a societal level, a highly educated population brings about economic and technological developments that lead to advantages such as increased global competiveness.

Lifelong learning is a form of sustained adult education and is a highly valued concept among industrialized countries. It focuses less on economic competition and more on personal development and inquiry. Many traditional colleges and universities offer lifelong learning programs for those who have reached retirement age, while others offer schools of continuing education open to any adult learners who wish to complement their formal education with noncredit courses, certificate, and licensure programs.

Federal- and State-Implemented Adult Education Programs

With educational standards rising, it has been a concern that many are not prepared to meet these standards. Government-funded adult education programs arose from President Lyndon B. Johnson's War on Poverty. As part of his Great Society program, Johnson called for an expansion of educational opportunities as one way to help reduce the national poverty rate and combat illiteracy. This initiative led to the passage of the Economic Opportunity Act (EOA) of 1964. Through this legislation the Office of Economic Opportunity (OEO) was authorized to provide federal grants to states in order to provide basic adult education programs that would allow adults to overcome their educational deficits and increase job skills and competencies.

In 1981, during the Ronald Regan administration, both the EOA and the OEO were repealed and abolished. However, individual states have created OEOs that continue to provide grants for adult education and other social welfare programs. Currently, various state education departments provide basic adult education services and provide adult learners with community resources in order to address the many educational challenges faced by adult learners. Basic adult education services often address English as a Second Language (ESL), literacy, mathematics skills, writing, and adult secondary education.

Participation in adult education programs saw an overall decline from 46 percent in 2001 to 44 percent in 2005. Work-related courses composed 27 percent of adult education participation, followed by personal interest courses (21 percent), part-time college/university courses (5 percent), and other adult education activities (3 percent). Overall, females participated in more personal interest (24 percent) and work-related (29 percent) adult education programs than did males (18 percent and 25 percent, respectively). Individuals aged 16 to 24 participated in more adult education programs than other age groups. African Americans and Caucasians had higher rates of participation than their Hispanic counterparts. Individuals with higher levels of education (bachelor's degree or higher) and professional or managerial occupations had higher rates of adult education participation (70 percent) than those with some college or high school diplomas, those who work in service/support positions (48 percent), and trade positions (34 percent).

Other Adult Education Programs

Many adults hold full-time jobs, have families, and/or lack the resources necessary to attend classes in a traditional format. Community colleges, traditional colleges, and universities offer night and online classes in order to provide more flexibility for adult learners. E-learning is a major asset to adult education programs and services. Online educational programs can provide adult learners with convenient opportunities to further their education. Traditional colleges and universities offer many e-learning educational programs, which can be asynchronous or synchronous, and allow the adult learners to participate in a more self-directed learning process.

Distance learning is a way for adult learners who have transportation issues or wish to attend classes in another state to take part in continuing education. Recent developments in distance learning include massive open online course (MOOC) providers that partner with traditional universities and offer free online courses in order to promote knowledge, community, and open access of information. While many of these courses are not for traditional college credit, they do promote the essence of lifelong learning and continuing education.

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See Also: Education and Training Vouchers; Educational Services; Educational Support Services.

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Adult Literacy Programs

While literacy skills remain a key factor in the economic well-being of many adults, those who lack these competencies often find themselves at a severe disadvantage when competing for employment, housing, or other goods or services. In an effort to remedy these inequities, adult literacy programs attempt to provide students a grounding in both the foundational competencies required for reading as well as life skills training. While of great importance to both those who struggle with reading and the society in which they live, adult literacy programs often struggle for funding, as the groups they serve often lack strong advocates. Although adult literacy programs are important for all populations, this is especially true for members of diverse populations, especially as defined by race and ethnicity, those with a home language other than English, adult learners, and those who live in rural and urban settings. Adult literacy programs, when successful, provide a tremendous service, as they assist individuals in getting jobs and making sense of credit applications, and with skills related to basic citizenship, such as voting.

Background

Reading and writing skills are crucial in enabling an individual to negotiate employment and daily living tasks. Illiteracy is the inability to read or write sentences in any language, whereas functional illiteracy involves the inability to negotiate these tasks in a manner that permits management of one’s personal and vocational life. Many consider the inability of an adult to read above the fourth-grade level to be an indication of functional illiteracy. The consequences of being functionally illiterate are harsh, as this greatly increases the chances that an individual will live in poverty or be incarcerated. Over 40 percent of adults who are functionally illiterate live below the poverty level as defined by the U.S. government. Of adults who are incarcerated, over 60 percent are functionally illiterate, a figure that increases to over 85 percent for juvenile inmates. Those who perform below basic levels of literacy have somewhat different characteristics than the general population. African Americans, Latinos, women, those over 65, and those from low socioeconomic backgrounds are overrepresented in the group that is deemed to perform below basic proficiency levels on literacy assessments. Individuals with lower levels of educational attainment also struggle disproportionately at tasks demanding proficiency with literacy.

The problems with illiteracy are often evident at an early age—nearly 70 percent of children who are not proficient readers by the end of the fourth grade will end up receiving government assistance or will be incarcerated as adults. Teenage girls from low socioeconomic backgrounds who are not proficient readers are six times more likely to have a child out of wedlock than are their counterparts who are more literate. Over time the situation has improved: in 1820, 20 percent of the Caucasian and 80 percent of the African American population in the United States were illiterate, while by the late 20th century these rates had narrowed, but concerns about the achievement gap continued. Beginning in 2001, the No Child Left Behind Act directed additional resources to K–12 schools in an effort to raise reading achievement. Despite these efforts, many adults remain functionally illiterate, and private and public adult literacy programs exist to help these individuals improve their ability to read.

Adult Education

Adult education involves programs and practices to educate those who are no longer eligible to be involved in K–12 education programs. Formal or informal, adult literacy programs are run by volunteers and paid professionals and may take place in a variety of settings. These settings include libraries, the workplace, colleges and universities, churches, social organizations, and public schools. Adult literacy programs focus specifically upon improving students' ability to read, write, and communicate orally. The specifics of each program vary, although certain commonalities exist across various efforts.

Targeting native-English-speaking nonreaders, English language learners (ELLs), and those who seek to improve their proficiency, adult literacy programs seek to balance individual and group norms. Adult literacy programs that focus upon individuals who read at the sixth-grade level or lower, for example, concentrate upon offering one-on-one tutoring as well as small group sessions that focus upon the fundamentals of reading. The fundamentals of reading instruction may consist of phonemic awareness, phonics, fluency, vocabulary, or text comprehension, depending upon the needs of the learners. Adult literacy programs also place a strong emphasis upon integrating practical skills with the literacy instruction, as many learners prefer to see immediate benefits from their investment.

The emphasis of adult literacy programs will generally vary based upon the desired outcomes of participants. Some adult literacy programs focus upon basic literacy, others upon teaching English as a second language, and still others upon preparing students for the General Educational Development (GED) exam, a high school diploma equivalency program. The backgrounds and readiness levels of students enrolled in each of these types of adult literacy programs may vary greatly. For example, while most students enrolled in a basic literacy class will have low levels of proficiency, some of these will have not had much, if any, prior exposure to literacy instruction or education, while others will have specific learning disabilities, often undiagnosed, that have impeded their previous experiences with schooling.

While some ELLs have a great deal of formal education, and thus high levels of literacy in their primary language, others will begin English as a second language classes while still struggling with literacy in their home language. Similarly, some GED candidates will have left high school for personal reasons that have little if anything to do with their academic aptitude, while others will have failed to obtain a diploma because of educational deficiencies.

Many adult literacy programs are staffed by volunteers and others without a formal teaching background. A variety of national and local organizations, including the Council for Advancement of Adult Literacy (CAAL), ProLiteracy, Literacy Chicago, and others, exist to support those working with adult literacy programs. This support can involve training for tutors and instructors, certification programs for volunteers, and accreditation for programs. Some colleges and universities have also developed programs that permit those interested in working as adult literacy teachers to be trained and certified. Generally, those programs that have better-trained teachers enjoy better results, making instructors' previous preparation and ongoing professional development opportunities goals for most adult literacy programs.

Many adult literacy programs are formed in an effort to appeal to the needs of special populations: persons of color, ELLs, women, parents, the elderly, and other groups that have higher than normal literacy problems. When appealing to such diverse groups, special considerations often are required. For example, classes are often offered in locations such as churches and community centers that are convenient to and comfortable for the desired student population. While teachers need not be members of the target population, they must have skills in working with such groups and understand the special needs of each group. Because success for diverse groups in adult literacy programs is frequently reliant upon their continued attendance at these classes, special consideration must also be made to assure that the classes are convenient, relevant, and focused upon their needs.

In addition to their primary goals, many adult literacy programs offer ancillary classes to support the needs of their students. These ancillary classes may focus upon computer literacy, financial literacy, health literacy, or other topics of interest to the students enrolled in the program. Such ancillary programming is offered both to support the language and literacy offerings provided by the adult literacy program and to meet other needs of the adult learners. Adult learners differ from their younger counterparts in many ways, and it is important that adult literacy programs take these differences into account. Adult learners have accumulated prior knowledge and experience that add to their learning. Because most adult literacy programs are voluntary in nature, the participants in these programs are generally more motivated than students in K–12 classrooms. Another difference in educating adults is their need to be able to apply knowledge learned in a practical fashion. Because adult learners have an expectation that attending an adult literacy program will assist them in accomplishing certain goals, well-run programs will allow students to see that this is happening. As more attention is paid to adult literacy programs, the best practices of the more successful endeavors are likely to be adopted by others.

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See Also: Adult Education Programs and Services; After-School Services; Department of Education, U.S.; Life Skills Training; Literacy Testing; No Child Left Behind Act.

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African Americans

African Americans are unique as a group, in part because their historical roots were tied to involuntary immigration. Africans endured centuries of capture and enslavement from the 17th through the 19th centuries. These oppressive, intergenerational experiences have served as a basis for complex behavioral and psychological trauma as well as resilience. An understanding of African Americans' rich and complicated history is warranted among human services professionals.

From Africa to the United States

The transatlantic slave trade brought an array of different cultures and ethnicities to the United States from Africa. The African American population that developed from the slave trade has been in the United States for over 350 years, first arriving in Virginia and surrounding areas. This population now lives in all regions of the United States; however, the majority of the African American population lives in the southern region of the country.

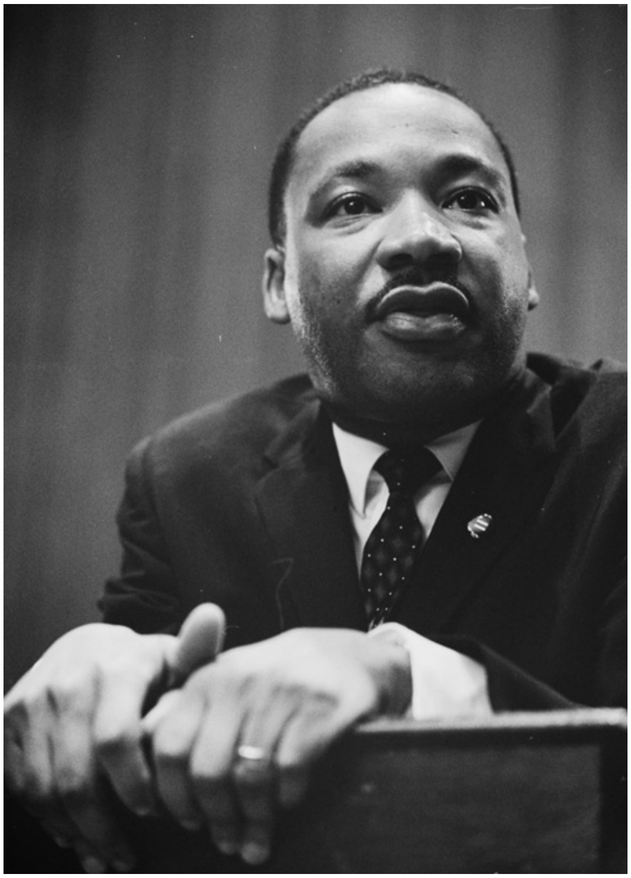
The term *African American* describes a population of people who are of African descent. This term derived in the 1970s, when many blacks began to remove themselves from the negative connotation of the words *colored* and *Negro*. Often, the term *black* is interchangeably used to describe this population and other populations of the African diaspora (i.e., Afro-Caribbean, Afro-Latin Americans, and black Canadians).

Throughout history, this population faced many issues. However, issues with income, employment, and education continued to cause many hardships for African Americans. Slaves worked for their masters for free and were threatened to be killed if they attempted to educate themselves. In 1865, after passage of the Thirteenth Amendment, which outlawed slavery in all states and territories, the literacy rate for African Americans was around 10 percent and employment was scarce because of racism and continued oppression. Although educational attainment, employment, and the ability to gain income has slightly changed for the better, gaps throughout each of these areas continue to exist in the African American community.

Although there is documentation of an African presence in the Americas well before Europeans initiated the slave trade, the sociopolitical narrative about African Americans is dominated by the slave experience and subsequent outcomes. West African empires, such as the Songhay and Mali civilizations, and entrepreneurial Moors spread scientific knowledge throughout the Mediterranean and the Americas during the 14th, 15th, and 16th centuries. The massive capture and enslavement of Africans that became known as the transatlantic slave trade fueled economies in the New World. Sometimes referred to as the *ma'afa* (a Kiswahili word for "horrific trauma"), slavery in the Americas, a centuries-long oppression, is believed to be the foundation for transgenerational effects, such as social marginalization, community disempowerment, health disparities, familial disconnections, and educational underachievement.

However, even with these challenges African Americans have been shown to demonstrate effective coping mechanisms to counter the pervasive acts of oppression. Records of slave narratives reveal acts of resistance: flights to freedom, attempts to take over ships to return home, and slave revolts. Following emancipation, during the Reconstruction era African Americans amassed wealth and developed commerce in major U.S. cities, such as Memphis, Tennessee, and Tulsa, Oklahoma.

Rather than view African Americans from a deficit-oriented perspective, human service professionals should consider their strengths. Despite centuries of oppression, African Americans have been attributed with significant scientific patents, architectural contributions, business expansions, and major influences in the performing arts. More important, African Americans have demonstrated resilience in their ability to maintain a sense of community and to organize family life in order to endure. Other forms of resilience are seen in African Americans' involvement in the political arena. From the slave revolt of Rev. Nat Turner to the work of civil rights activist Rev. Dr. Martin Luther King, Jr., religious leaders have been at the forefront of resistance efforts within the African American community. Human service professionals should incorporate African American clients' strengths into their conceptualization of presenting problems.



Martin Luther King, Jr., was one of a number of leaders who spearheaded African American resistance efforts. Religious leaders like King have often been at the forefront of such efforts.

Throughout history the African American population has experienced many forms of oppression. Oppression can be defined as the exercise of authority or power in a burdensome, cruel, and unjust way. Beginning with slavery, African Americans have been denied education, access to resources, equal employment and pay opportunities and lack of physical and mental health care, and have experienced a voting discrimination. These different levels of oppression have led to health disparities, family and education issues, and an overall disenfranchisement of this population.

With the many negative implications of slavery and the history of African Americans, there were many leaders among this population that empowered others to push toward a better life. Well-known figures such as Harriet Tubman, Sojourner Truth, and Frederick Douglass have become the faces of slavery, but there were many other freedom fighters that helped empower others to seek a more prosperous life.

There were also major historic events that impacted the African American community in the past and present. These events include the Emancipation Proclamation in 1863, which modified some of the laws on slavery; *Brown v. Board of Education* (1954), the U.S. Supreme Court decision which desegregated schools; and the Civil Rights movement, which fought for equality for all. Although each event was significant, the African American community continues to struggle with different systems of oppression. Graduation rates from high school and college continue to fall short of other ethnic groups, the incarceration rate of many African Americans continues to rise, and their economic status is not equivalent to other racial groups.

African-Centered Mind-Set

As stated earlier, history has created a platform for many outside and within the African American community to view this population from an inferior or deficit lens. For years this population was told they were intellectually, physically, and mentally inferior to whites. The message was received that African Americans were also deficient in regard to intelligence, family structure, and cognitive styles. However, many African American scholars began to question the validity of these claims and to rewrite the understanding of the African American community using a new lens, with African culture and ideals as the center of their analysis.

This new African-centered approach made its way into research, counseling, and the overall wellness of the African American community. Scholars such as Joseph White, Asa Grant Hilliard III, Molefi Kete Asante, Na'Im Akbar, Thomas A. Parham, and many others have all written about and/or adopted this critical lens.

The African-centered approach unifies African principles, values, and traditions. It believes the spirit permeates everything; the universe is an interrelated, communal consciousness and the collective ancestral element. When scholars use this perspective in research and clinical practice, they must take into consideration history, culture, social context, client/participant perspective, and an understanding that a deconstruction of learned Eurocentric perspectives may be present. African-centered ideology allows one to answer the question, "Who am I," while acknowledging African culture and behavior, which for so long were neglected and placed behind Eurocentric values.

Given prior work in the area of culture-centered counseling, several African-centered counseling theories have emerged. NTU psychotherapy, the African self-consciousness model, Daudi Ajaniya ya Azibo's nosology, and the transcendence model offer alternatives to conventional Western or Eurocentric counseling approaches. Frederick K. Phillips's NTU (pronounced in-too) psychology focuses on authenticity and balance, while K. K. K. Kambon's African self-consciousness model focuses on countering oppression. Azibo presents an alternative to the American Psychological Association's diagnostic system, suggesting that the *Diagnostic and Statistical Model of Mental Disorders* is flawed in its Eurocentrism. Wade W. Nobles proposed a model for interventions with African American clients that involves three phases: improvisation, transcendence, and transformation.

Facilitating client empowerment is a core task for human service professionals to address African Americans' presenting problems. Client-focused interventions help clients toward a speedy resolution of their concerns.

More information about African Americans as culturally diverse clients can be found in resources across several disciplines that disseminate the unique experiences of this client population. In particular, *Born in Slavery: Slave Narratives From the Federal Writers' Project, 1936–1938*, located in the Library of Congress, provides accounts from 2,300 emancipated African Americans about their enslavement experiences.

Additionally, human service professionals can learn more from books written by clinical researchers that disseminate evidence-based practices reflecting the cultural mores of African Americans as a group. Finally, it is useful to identify community referents who are willing to share personal information about the strengths and challenges of local communities and how those issues influence individuals and their day-to-day challenges. In general, human service professionals need to be aware of the sociopolitical contexts when working with African American clients.

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See Also: Critical Race Theory; Cross-Cultural Skills; Cultural Competence, Human Service Providers and; Ethnicity and Clients; Racism, Long-Term Effects of; Rites of Passage; Slavery and Lasting Cultural Effects of Social Biology/Biological Determinism.

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African Immigrants

People immigrate to other countries for a variety of reasons. Some people migrate for economic reasons and are typically referred to as voluntary migrants. Some people immigrate because they have to, often because protracted civil conflict forces them to leave their homes and prevents them from returning. These migrants are often referred to as forced migrants. Many of the world's immigrants originate from Africa, and most of the immigration from that continent is the result of forced migration, so a majority of African immigrants are thus considered refugees. But Africa is a large continent, with 56 countries (two of which are not officially recognized) and nine territories, and the people who live on the continent represent a wide range of cultures, with divergent histories, traditions, and norms; speak different languages; and practice a range of religions.

African immigration is typically organized by time (or era) and region. The earliest wave of African migration to countries in the Global North was during the African slave trade, which occurred from the 16th to 19th centuries. Subsequent waves of African immigration were generated for a variety of reasons, including economics, natural disaster, and conflict. The most recent wave of African immigration is often considered the fourth wave of migration, which began after colonization ended. Many Africans have migrated to countries in the Global North for better education and labor opportunities. This trend is often referred to as the "brain drain" because many bright and competent people in developing countries leave because of limited educational and career opportunities.

Many African immigrants were forced to leave their home countries because of conflict. Many countries in central Africa and the Great Lakes Region, in east Africa and the Horn of Africa, and in west Africa have experienced numerous cycles of protracted violence that have resulted in millions of people migrating to safer regions—either within Africa or to countries in the Global North, such as the United States. For instance, in 2011, over 2.5 million people in Africa became refugees, 1.5 million of whom were from east Africa and the Horn of Africa, which includes Sudan, South Sudan, Ethiopia, Eretria, Djibouti, and Somalia. About 500,000 refugees came from central Africa and the Great Lakes region, which includes Kenya, Uganda, Rwanda, Burundi, and the Democratic Republic of the Congo (DRC).

Africans who have migrated to countries in the Global North have needs that are as varied as the cultures they represent. Voluntary migrants from north and south African countries that have not experienced as much conflict as countries in sub-Saharan Africa, and that tend to be more "Westernized," may need only minimal assistance in the resettlement process. However, African immigrants who have migrated because of violence in their home countries may need significant assistance, particularly if they have experienced severe trauma and loss.

African refugees who are resettled to countries in the Global North because of homeland conflict are likely to need the most assistance from human services providers, particularly if they lived in refugee camps prior to migrating to their final host country. This is because of the trauma and loss many refugees have experienced, both in their home countries and in refugee camps. Many African immigrants have been caught in a cycle of migration and resettlement, being forced out of their home countries because of conflict, going back home and being repatriated when conditions allowed, only to be forced out of their communities when conflict erupted again. Many individuals who are caught in the crossfire of protracted civil conflict and are forced to leave their communities are resettled into refugee camps until a more permanent solution can be found. Many refugees remain in refugee camps for generations and permanent solutions are elusive because of the nature of the conflict, limited resources, and the large number of refugees generated from various conflicts in certain African countries. For instance, hundreds of thousands of people were forced into refugee camps because of conflict in Burundi in 1972, and three decades later these refugees remained in camps in Tanzania waiting a permanent solution. Similar dynamics can be found throughout Africa, such as Rwandan refugees in the DRC and Somali and Sudanese refugees who were in Kenya for decades.

When Africans from conflict zones who have lived for decades in refugee camps are relocated to the United States and other nations in the Global North, human service agencies provide much-needed practical assistance, such as teaching recently arrived refugees how to operate a Western-style stove, how to enroll their children in public school, and how to navigate the new nation's social service system. Human service providers also offer important mental health services, such as providing trauma counseling, which is a particularly vital service since many African immigrants have experienced significant trauma, including being victims of physical and sexual violence, as well as the loss of family members and friends through conflict and life-threatening environmental conditions (e.g., lack of food, disease, etc.).

Human service providers working for immigration and refugee resettlement agencies also provide much-needed services in the area of legal advocacy, which is often needed when immigrants migrate outside of the refugee program. Providers also need to help immigrant families adjust to the significantly different cultures of their host countries. For example, immigrants from cultures in which women have few rights and violence against women is permitted, may have to adapt to the United States, where domestic violence is illegal, and human service providers can help families learn new ways of relating that are egalitarian in nature.

In summary, African immigrants constitute a heterogeneous population with a wide range of needs. Human service providers assist immigrants with all aspects of the resettlement process, which may include help finding housing and employment and learning the English language. Human service providers also provide more in-depth assistance to immigrants with histories of violence and trauma in order to address their wide-ranging psychosocial needs.

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See Also: Diaspora; Displaced Persons; Refugee Assistance.

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Aftercare Services for Children Aging Out of Foster Care

Over the last decade, there has been considerable debate about the long-term benefits and impact of foster care, including residential group care and independent living programs, because of reports of poor adult outcomes for youth who have "aged out." In most state jurisdictions, this occurs at age 18, although many states continue to provide some level of independent living services. In 2011, however, 26,000 of 407,000 children in care were youths "aging" out of the foster care system. Lagging behind their peers who are reared and transitioned into adulthood by their families, many of these young persons are likely to require tailored social supports and aftercare services as they chronologically move into adulthood once the caretaking role of government programs ends.

Numerous studies suggest that youth who experience out-of-home placement because of child maltreatment or other family limitations, and who transition out of the foster care system as young adults, do not experience success. Perhaps because of a history of multiple and temporary placements, extended length of stay in out-of-home care, the instability of their biological family, or lack of adult involvement, these youth do not have the crucial opportunity to test their interdependence or establish self-sufficiency through an appropriate trial and error process. Developmentally, they are not able to take the risk to "push off" from their own family, a normative phase of growing up. As a result, many do not possess a viable sense of adult identity, values, and vision of how they will take care of themselves in the future by the time they are legally adults. Transition planning, in most instances, has been too little, too late. Not surprisingly, and too often, after discharge from the system these young people are confronted with housing instability, unwanted pregnancy, under- or unemployment, poor academic or vocational progress, and lack of quality health and mental health care. These young people are at risk for incarceration and welfare dependency, homelessness, substance abuse, domestic violence, and poor parenting. Research regarding the efficacy of aftercare services for these graduates of the child welfare system is inconclusive and suggests that more emphasis should be placed on identifying and addressing the individualized needs of such youth postdischarge.

Transition Planning for Youth Exiting Care

Focus on transition and aftercare services began with the Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), which targets services for older youth. Section 477 of the act provides funding for independent living programs. The Foster Care Independence Act of 1999 (Public Law 106-169) enables services to be provided to youth who exit care at age 18 but have not reached 21. Adolescents receiving these services directly participate in designing their own activities to prepare them for independent living and are required to accept personal responsibility for their part in this process. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (FCA; Public Law 110-351) provides states with federal support for older youth in high school or who are engaged in postsecondary education, an employment program, or working for at least 80 hours monthly, or who are incapable of any of these activities because of a medical condition. FCA also requires a transition plan at least 90 days before a youth's emancipation from the system. Because of the documented lack of adequate preparation of older youths for their full transition into self-sufficiency, public policy groups advocate allowing older youth to have an extended stay in foster care to developmentally prepare them for transition into adulthood, with permanent adult connections.

Key Elements of an Aftercare Services Model

Older youth aging out of foster care may be discharged from a variety of settings. These placements include traditional family foster care, therapeutic family foster care, group homes, therapeutic group homes, independent living programs, residential or drug treatment facilities, psychiatric hospitals, and secure detention facilities. In addition to the variations in these placements' restrictiveness, both the youth and the family of origin vary in their service needs, access to personal and community resources, and their level of resiliency. Aftercare services may be designed within a positive youth development (PYD) framework that emphasizes a strengths- and needs-based assessment process directed by the young person, whose own influence in the planning balances the professional contribution. This increases the likelihood that the youth will take responsibility and ownership of plans she or he created with adults. In addition, a trauma-informed approach takes into account the impact of not only the history of child maltreatment that the youth may have experienced, but also the trauma of separation from the family and the need to grieve over the loss. The youth must feel sufficiently safe, with at least one adult to share concerns about his or her transition into adulthood; the nature of the designated aftercare supports; and what may be required for his or her success, including addressing challenges to self-esteem, personal confidence, and effective decision making.

Aftercare Services Domains

Transition planning is an individualized process that relies on not just the adolescent's motivation and initiative, and the availability of organizational and community resources, but also on culturally competent, highly skilled, and collaborative professionals who work together to support the youth. The following areas are typically addressed:

Education. Youth who are on track educationally and are involved in postsecondary college or vocational training have considerably enhanced life outcomes. In contrast, youth without a high school education or who have not passed the General Educational Development (GED) Test are at high risk for involvement in illegal activity and incarceration. Identifying specific barriers to educational/vocational achievement is a high priority.

Employment. Workforce readiness and job placement supports are indicated for most youth exiting the public child welfare system. Former foster care youth are less likely to be employed, and typically earn less income than young people who have not been in this system.

Housing. Locating and retaining affordable housing, selecting and living with roommates (or family members), understanding tenant rights, adhering to community living standards, and managing landlord relations are fundamental for sustaining housing stability.

Life skills. Basic living skills that must be mastered include: household maintenance, grocery shopping, cooking, cleaning, navigation of community resources, and parenting and child care (when applicable).

Financial literacy. Youth must possess basic money-management skills, such as budgeting, paying bills, credit repair and maintenance, and utilizing checking and savings accounts.

Health. Includes concerns that are key to overall physical well-being, such as health insurance, preventive health care and self-care, reproductive health, and diet and nutrition education.

Mental health. Youth aging out of the foster care system are at an elevated risk for substance abuse, depression, anxiety, and post-traumatic stress disorder. Access to affordable, quality, community-based mental health services may be a necessary aftercare service.

Social support and recreation. A network of trustworthy adults and friends encourages prosocial behavior, prevents social isolation, and cultivates a healthy lifestyle, which involves stress reduction, physical activity, emotional support, and appropriate entertainment.

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See Also: Child Welfare Services; Foster Care Agencies; Group Homes for Children.

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After-School Services

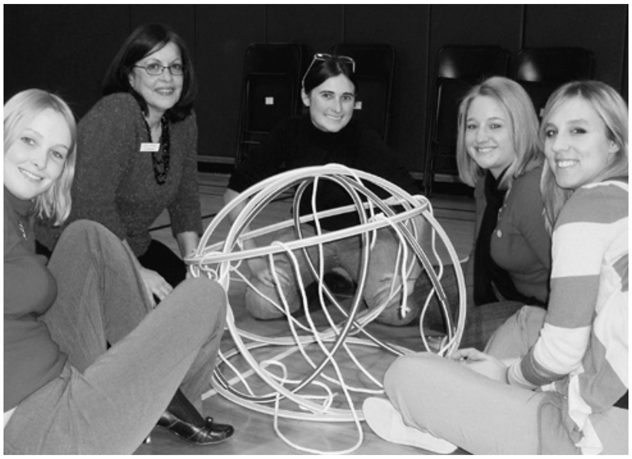
After-school services are safe and structured programs for kindergarten through high school–age children. These programs are designed to positively develop children's socioemotional well-being and academic performance by providing extracurricular activities before and after school, on weekends, during school holidays, and during the summer school break. Most after-school services operate approximately two to three hours per day, four to five days per week. The following terms—*school-age care*, *out-of-school time*, and *expanded learning opportunities*—are interchangeably used with "after-school."

After-school services are typically organized by public schools, private schools, community organizations, for-profit businesses, or government agencies, such as municipal parks and recreation departments. They provide structured curriculum activities, healthy snacks, academic assistance, and/or various enrichment activities (e.g., physical recreation, arts, and music). High-quality after-school services offer a variety of programs and activities in an adult-supervised environment.

After-school hours can be very risky for children who are left unsupervised. Children living in high-risk environments are more likely to be exposed to violence, delinquency, sexual activity, smoking, and alcohol and drug abuse—all of which can compromise their academic performance and achievement. After-school services prevent these children from developing behavioral problems and experiencing academic failure by supplying supervised and constructive activities. Funding for the services or programs typically comes from the federal, local, and state government as well as private foundations. In 2009, the U.S. Department of Education spent approximately $1 billion for after-school activities.

Types of After-School Services

There are two types of after-school services: community-based and school-based. Community-based services are implemented by organizations, such as the YMCA/YWCA, 4-H, public agency-sponsored programs, libraries, youth organizations, religious institutions, and cultural centers. Some programs have specialized goals, such as to improve youth development, promote social skills, increase community involvement, or combat substance abuse problems.



Staff at the Just for Kids after-school program in Buffalo, New York, receive education training and team building activities to support children and encourage holistic youth development.

The YMCA is the most recognized after-school service. Historically, the YMCA has provided access to physical activities such as swimming pools, karate lessons, and sports facilities. In recent years, however, the YMCA has begun to recognize the importance of children's academic development and has subsequently implemented programs designed to assist children with academic difficulties. Additionally, the Boys and Girls Club, similar to the YMCA, is a federation of local chapters with independent boards and largely self-financed. This organization provides recreational centers and activities in urban areas

Community and religious organizations offer after-school activities in their neighborhoods. These organizations establish joint collaborative efforts with other agencies (e.g., parks department, public schools) to obtain loans for facilities. In collaboration with religious institutions, some after-school services also provide religious activities and education. Physical facilities hosting after-school programs vary widely, and many after-school activities take place in buildings that were not initially designed for after-school activities. In general, community-based services aim at encouraging holistic youth development.

School-based arrangements have been used extensively for the purpose of child care or youth development under initiatives of the No Child Left Behind Act. In addition, 21st Century Community Learning Centers, which have been supported by governmental funding, have increased the number of after-school services. In particular, because No Child Left Behind emphasizes narrowing the achievement gap in public schools, school-based after-school services have put a lot of emphasis on improving children's academic levels. School settings are the preferred location for after-school services for families because schools are conveniently located and have many resources on hand, such as computer labs, books, and other school materials.

Suggestions for Improving the Quality of Services

In order to further after-school services' success, a system of continuous evaluation should be put into place. Using this system, partners are able to discuss the activities' quality and success, which leads to better decision making on matters concerning program design and funding. Consistently monitoring and understanding service goals enables staff to maintain focus, improve effectiveness and accountability, ensure parent and participant satisfaction, and identify necessary changes. Therefore, designing effective evaluations, including multiple and rigorous testing measures, leads to the success and meets the goal of the service. Furthermore, special attention should be given to evaluating both community-based and school-based services separately.

In addition, building affordable, high-quality after-school care in economically disadvantaged communities is imperative. After-school services have significant and positive effects on children from low-income families, particularly low-income minority children who do not have as many opportunities to participate in extracurricular activities or enrichment programs as children from middle- and higher-income families. Through after-school services and programs in the community, economically disadvantaged children are able to participate in various activities that would otherwise not be available.

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See Also: Educational Support Services; No Child Left Behind Act; Recreation Services.

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Age and Clients

Understanding developmental factors is integral in the accurate assessment of client needs and resources. To identify medical, social, and emotional issues, it is necessary for human service professionals to know what is normal and healthy at each stage of development and to maintain an adequate store of interventions to address developmental deficits.

Overview of Development

Since 1950, Erik Erikson's theory of psychosocial development has been the template for understanding development in stages. Erikson, building upon Sigmund Freud's psychoanalytic theory, purported that a psychosocial crisis occurs at every stage of development, and if that crisis is adequately resolved through a prescribed central process, a prime adaptive-ego quality results. Unresolved crises result in the emergence of core pathologies. Erikson conceptualized the stages of psychosocial development with each stage building upon another, but this continuous model has not stood the test of time. Healthy life expectancy has increased significantly since his seminal work, so later life has broken into distinct substages. Furthermore, in Western culture the tasks of adolescence described by Erikson are not accomplished until the 1920s and early 1930s.

In addition to the age-related factors described by the developmental theorists, history-related factors have a heavy impact on development. Age cohorts refer to groups that have lived through the same era together. Historical events, advances in science and technology, and social cultural dynamics affect how people of all ages develop. A 50-year-old from the baby boom cohort, for instance, is different than a 50-year-old in an older generation. Urie Bronfenbrenner's ecological theory considers these contextual factors in a model of near-to-far influences, from the microsystem of family and community to the overarching influences of culture and society in the macrosystem.

The life span development theory goes beyond development to adulthood and promotes the concept of development throughout the life span until death. Life span theorists do not regard development as a continuous sequence of stages building upon another, but rather as a discontinuous process, in which many aspects of development progress independently. The life span theory accounts for acceleration in some areas of development and normal or delayed progression in others.

Many prominent developmental theorists focused on a single factor in development. Freud, for example, focused upon psychosexual development in his identification of oral, anal, phallic, latent, and erogenous stages. Jean Piaget identified the sensorimotor, preoperational, concrete, and formal operational stages of cognitive development. Lawrence Kohlberg identified preconventional, conventional, and postconventional stages of moral development. Considering the child as apprentice, Lev Vygotsky defined a zone of proximal development, which is the difference between the maximum a child can achieve independently and the maximum the same child can achieve with the guided participation by an adult. He identified this process as scaffolding. Parents, teachers, peers, and human service workers can provide scaffolding.

Age-Appropriate Services

Every age group has specific strengths and specific risk factors. Effective human service providers are capable of conducting assessment, intervention, treatment, case management, and follow-up services for clients of all ages. Access to the entire spectrum of human services is critical for vulnerable populations. Advocating for clients is often within the human service providers' scope of practice. In addition, many human service providers are in a position to teach clients who are capable how to advocate for themselves. Effective human service providers help mobilize resources in their clients' immediate and extended families, neighborhoods, communities, and cultures. When more than one age group is represented, developmental factors in all members of the identified client's system can affect outcomes.

Before Birth

Whenever a client is pregnant, her unborn child is a silent consumer of professional services. The health and well-being of the prenatal client often sets the stage for his or her entire life. Critical factors to the unborn child are the age of the mother, teratogens, and socioeconomic status. Older mothers have more risk of Down's syndrome, and younger mothers have a higher risk for poor nutrition, trauma, and preterm birth. Teratogens, which are toxic agents, also place the development of the fetus at risk. Maternal exposure to tobacco, alcohol, prescription and recreational drugs, and pollution can have a profound effect on a child's birth weight and subsequent health. The extent of risk to the fetus is a product of the length of exposure and the number of teratogens. Socioeconomic status also has an effect on the unborn child, owing to the availability of nutrition and medical care, and resources for coping with stress. Intervention with expectant mothers is the key to assisting the unborn child. Human services workers often encounter the unborn child as a secondary client when working with adolescents, substance abusers, and victims of domestic violence. Crisis workers, counselors, and social workers have an opportunity to serve the unborn child by providing the mother education, support in stress management, and referral to medical and nutritional services.

Infancy

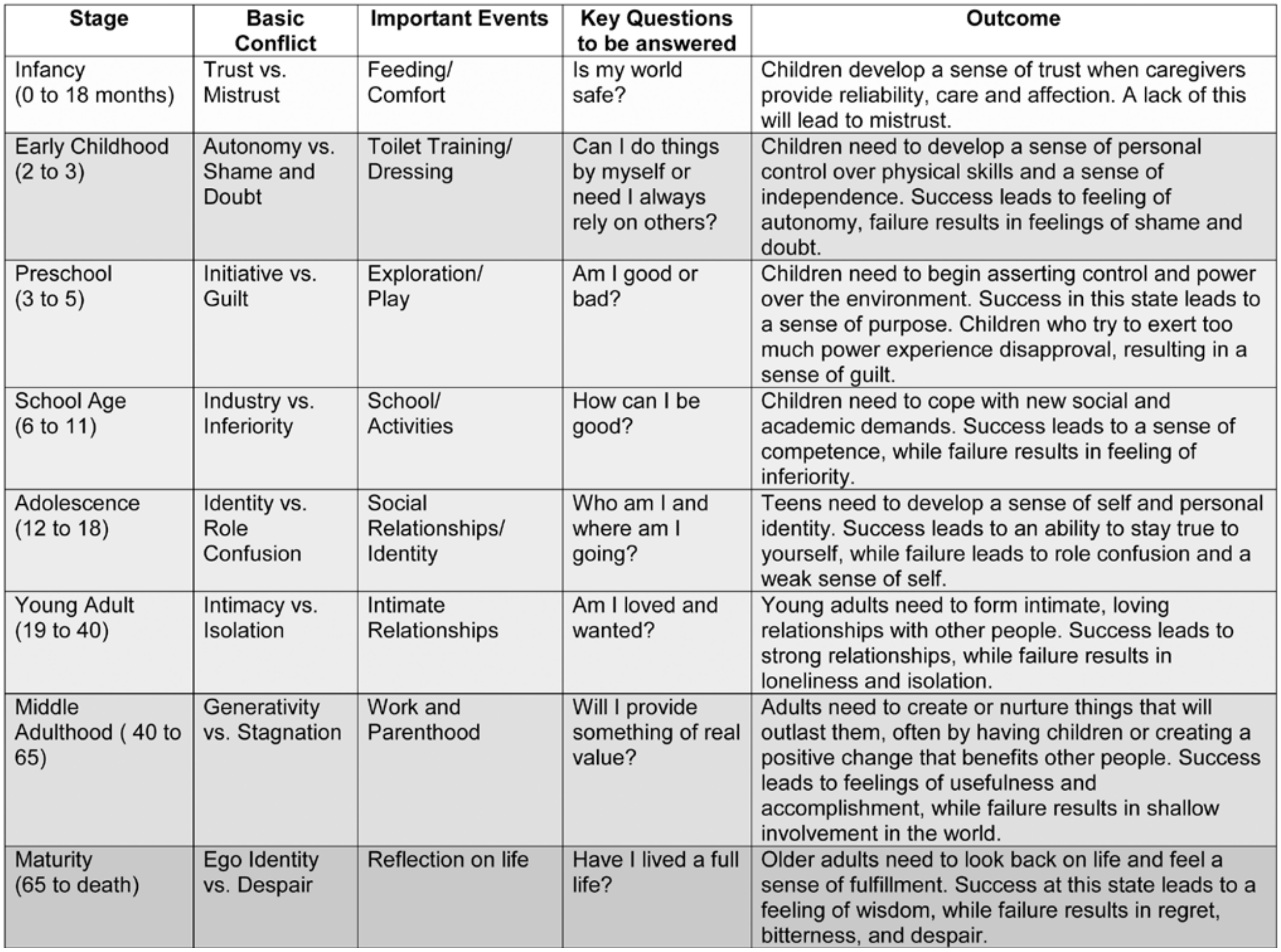
Infancy is a critical period in development. Erikson identified the developmental crisis of infancy as trust versus mistrust. Facilitated by the primary caregiver's involvement, infants who successfully negotiate this stage develop the capacity to hope.

Those who are unsuccessful withdraw. Although the infant client cannot verbally communicate, professionals handling their cases can assist in the negotiation of this important phase. Trust is the ability to predict, and teaching primary caregivers to be consistent in their interactions with the infant can make the difference between hope and withdrawal.

Synaptic exuberance refers to the abundant production of neural connections in a baby's brain in preparation for learning. If this experience of expectant learning does not occur during optimal periods of exuberance, the synaptic connections are pruned from the brain. For example, humans are programmed to acquire language before the age of 6, after which new language acquisition becomes more difficult. Affordances are learning opportunities. In infancy, contact, stimulation, and variety stimulate learning. Although not all parents have the resources to provide new toys or colorful environments, even disadvantaged parents can be instructed on using what is available to give an infant experiences that promote and sustain development. Referring poorly prepared parents to parenting programs promotes infant development, as does involving extended family for support and direction. Additionally, social workers, case managers, and counselors working with at-risk groups can include materials for infant development in their offices, using teachable moments to promote caregiver engagement.

Early Childhood

According to Erikson, toddlers face the psychosocial crisis of autonomy versus shame and doubt, during which they develop a sense of personal control.



Stage	Basic Conflict	Important Events	Key Questions to be answered	Outcome
Infancy (0 to 18 months)	Trust vs. Mistrust	Feeding/ Comfort	Is my world safe?	Children develop a sense of trust when caregivers provide reliability, care and affection. A lack of this will lead to mistrust.
Early Childhood (2 to 3)	Autonomy vs. Shame and Doubt	Toilet Training/ Dressing	Can I do things by myself or need I always rely on others?	Children need to develop a sense of personal control over physical skills and a sense of independence. Success leads to feeling of autonomy, failure results in feelings of shame and doubt.
Preschool (3 to 5)	Initiative vs. Guilt	Exploration/ Play	Am I good or bad?	Children need to begin asserting control and power over the environment. Success in this state leads to a sense of purpose. Children who try to exert too much power experience disapproval, resulting in a sense of guilt.
School Age (6 to 11)	Industry vs. Inferiority	School/ Activities	How can I be good?	Children need to cope with new social and academic demands. Success leads to a sense of competence, while failure results in feeling of inferiority.
Adolescence (12 to 18)	Identity vs. Role Confusion	Social Relationships/ Identity	Who am I and where am I going?	Teens need to develop a sense of self and personal identity. Success leads to an ability to stay true to yourself, while failure leads to role confusion and a weak sense of self.
Young Adult (19 to 40)	Intimacy vs. Isolation	Intimate Relationships	Am I loved and wanted?	Young adults need to form intimate, loving relationships with other people. Success leads to strong relationships, while failure results in loneliness and isolation.
Middle Adulthood (40 to 65)	Generativity vs. Stagnation	Work and Parenthood	Will I provide something of real value?	Adults need to create or nurture things that will outlast them, often by having children or creating a positive change that benefits other people. Success leads to feelings of usefulness and accomplishment, while failure results in shallow involvement in the world.
Maturity (65 to death)	Ego Identity vs. Despair	Reflection on life	Have I lived a full life?	Older adults need to look back on life and feel a sense of fulfillment. Success at this state leads to a feeling of wisdom, while failure results in regret, bitterness, and despair.

Figure 1 Erik Erikson's Psychosocial Stages of Development. Since 1950, Erikson's theory, which built upon Sigmund Freud's psychoanalytic theory, has been the template for understanding development in stages.

Through the central process of imitation, the child who successfully negotiates this stage develops the quality of will. Those who are unsuccessful develop the core pathology of compulsion. In early childhood, through the central process of identification, young children develop the prime adaptive-ego quality of purpose. Failed negotiation of this stage results in the core pathology of inhibition. Strong central figures to imitate and identify with are crucial to healthy development in early childhood.

Toddlers and young children often become clients because of the lack of competent caregiving. As clients, young children are incapable of understanding their problems, and they lack the cognitive abilities to benefit from verbal intervention. They build skills, express emotions, and resolve problems through play. Play therapy is the standard intervention for young children, in that it offers them freedom to choose materials, act out traumatic events, and experience a safe, steady relationship with an adult. Family therapy can lead to the identification of family dynamics that are troublesome to young children and the generation of strategies to build a more healthy system.

Young children often present in therapy for behavioral issues, poor emotional modulation, or learning difficulties. Caregivers may make a lay diagnosis of attention deficit disorder when, in fact, anxieties, inadequate sleep, neglect, or abuse might better account for the behavior. Stress can stall development or cause regression to bed-wetting, thumb sucking, or other behaviors associated with an earlier stage of development. Social problems that precipitate childhood problems include domestic violence, parental incarceration, homelessness, parental substance abuse, or family disruption. Professionals providing services for any of these social issues have an opportunity to intervene. Effective intervention for this vulnerable population is contingent upon obtaining an accurate diagnosis, mobilizing family and community resources, and providing adequate follow-through.

Middle Childhood

The central process of education lays the groundwork for children from ages 6 through 12 to be evaluated against their peers. During the psychosocial stage of industry versus inferiority, successful children develop the ego quality of competence. Relationships with schoolmates facilitate this process. School-age children who become clients require support in maintaining a sense of competence even as they receive social services. Contemporary social issues often precipitate failure at this stage. Homelessness, divorce, poverty, substance abuse, abandonment, and domestic violence often require a child to miss school or change schools, interrupting education and disrupting essential peer relationships, fueling a sense of inferiority and the core pathology of inertia. Mastery builds self-esteem, so task-based interventions for presenting problems may also provide developmental support. Effective behavioral interventions for children often involve token economies, earned privileges, and physical challenge programs.

Frequently, school-age children present for services because of behavior problems, attention deficit disorder, and learning difficulties. When parents or teachers report behavioral and cognitive problems, school-age clients should also be assessed for co-occurring anxiety, depression, and substance use. Bullying, abuse, neglect, and parental substance use can precipitate clinical and behavioral issues. Family engagement is critical for school-age children. If parents are not available, efforts should be made to mobilize the extended family and community resources.

Adolescence

Identity versus role confusion is the psychosocial crisis of adolescence. Peer relationships are extremely important through adolescence and lay the groundwork for developing fidelity, the ego quality associated with successful negotiation of this stage of development. Adolescents normally explore a number of identities before making a commitment to a single, stable identity. Identity diffusion occurs when an individual has not yet formed his or her identity or determined a life path. Identity foreclosure is when an individual commits to an identity and life path with minimal consideration in deference to familial or cultural expectations.

Increasing freedom and poor impulse control often bring adolescents into the human services system. The prefrontal cortex, which governs judgment, is not fully developed in the adolescent brain, putting adolescents at risk for accidents, substance abuse, sexually transmitted diseases, and pregnancy. Most adolescents harbor an infallibility fable, believing they are indestructible, irresistible, and omnipotent. Hormone production in both males and females causes a high level of emotionality. Depression in adolescent males manifests as anger and may be difficult to identify in adolescent clients who enter the human services system for violent or illegal behaviors. When adolescents present with multiple problems, it is essential to treat what is most lethal first.

Brief strategic family therapy and cognitive behavioral approaches are most effective for adolescents. In treatment, adolescents often appear to understand and agree with a treatment plan, but fail to follow through. Human services providers, therefore, should assure that a network of family, friends, and community programs are in place to support compliance with treatment recommendations.

Young Adulthood

Erikson identified intimacy versus isolation as the psychosocial crisis of young adulthood. Clients in their 20s often are facing issues surrounding family relationships, intimate relationships, and parenthood. When young adults are unprepared for the challenges of adult life, they may benefit from cognitive therapy, interpersonal skill building, and referral to community agencies to assist with educational and occupational issues. Protracted issues of adolescence often extend into the 20s, and an understanding of the four identity statuses can be useful when serving a client in this age group.

Identity diffusion is the status in which an individual has not formed an identity or determined a life path. For the identity-diffused client, ego strengthening will be a precursor to determination of a life course. The identity status of foreclosure indicates that the individual has settled upon an identity and life path in deference to familial or cultural expectations, and without personal processing. A young adult who has foreclosed may need support in resolving issues of cognitive dissonance. Identity moratorium occurs when a young person has an identity crisis. Unable to determine an identity, the young adult is often stalled in determining a life course. A skilled worker will assist the client in defining the emerging identity before promoting life course decisions. Young adults who have reached the status of identity achievement are more likely to become clients when their chosen path is blocked, or when psychosocial stressors have exceeded their coping resources.

Mental disorders often emerge during the early 20s; therefore, anxiety, depression, schizophrenia, or bipolar disorder may be the focus of clinical attention. Rates of alcohol and recreational drug use, as well as prescription drug abuse, are highest among young adults, so all clients in this age group should be screened for drug and alcohol use. Mental disorders and substance abuse are chronic conditions that persist throughout adulthood.

Middle Adulthood

As life expectancy increases, the issues of middle adulthood become more complicated. The developmental crisis of adulthood is generativity versus stagnation. Clients aged 30 to 70 often require support in maintaining a productive life as they continue to struggle with chronic conditions and life challenges. From a sociocultural standpoint, delivering services to clients in later-middle adulthood is an emerging crisis. When the baby boomers began reaching middle age, an already taxed human services system became overburdened. Baby boomers are historically large consumers of mental health services.

As people age, physical and mental problems increase and often exceed the diminishing resources of the aging individual. Delivering effective services to middle-aged clients requires an understanding of complicating social factors. Even though 10,000 baby boomers per day reach retirement age, a fluctuating economy has forced many middle-aged persons to postpone their retirement, challenging their physical health and increasing their levels of stress. Millions of grandparents are raising their grandchildren because of the parents' deployment, incarceration, or addiction. In many areas, an adequate spectrum of social services is not available to accommodate the demand created by these population dynamics. Many middle-aged people are part of the generation sandwich in their responsibility for taking care of their children and grandchildren during the same years they are taking care of their parents and grandparents.

Although almost half of the people seeking mental health treatment have substance-related disorders, substance abuse problems are often undiagnosed in middle-aged clients. Baby boomers are historically large consumers of recreational drugs, and as such have a higher risk of substance-related disorders throughout life. It is relatively easy for a middle-aged person to obtain addictive medications for anxiety, pain, and sleeplessness. Middle-aged patients often see many physicians without coordination of care or monitoring of medications. They often present themselves at pain management clinics, urgent care centers, and emergency rooms for the sole purpose of obtaining drugs. Drug-seeking clients can be difficult to identify and difficult to treat, indicating a need for human services workers in all areas to receive training in the areas of both aging and substance abuse.

Old Age

The aging baby boomers will cause an unprecedented demand on human services in the next 30 years. Although older adults will experience more years of healthy life, the number of elderly people requiring assistance with housing, transportation, health care, and activities of daily living still grows at a rate that is bound to overwhelm social services. Serving the aging client is complicated by ageism among human service professionals. The assumption that the elderly are in fast decline diminishes others' expectations of them, and may even prevent acknowledgement of individual differences in the aging process. Health care providers believing that deterioration is inevitable with advanced age might overlook other causes of declining functioning, such as illness, depression, or social factors. Ageism, therefore, diminishes how younger people regard and treat older people. In that younger generations provide care for the elderly, the misconceptions associated with ageism can prevent accurate diagnosis and effective treatment.

Cognitive impairments caused by dementia and Alzheimer's disease have a gradual onset and slow progression that requires several phases of intervention. Wernicke and Korsakoff syndromes are cognitive impairments associated with alcohol dependence. Advanced age tends to decrease suspicion of substance abuse in older clients, resulting in errant diagnoses of dementia or mental illness. Ideally, physicians, nurses, social workers, counselors, and caregivers work in concert to accurately diagnose elderly clients and execute care that aids the elderly in remaining independent as long as possible, and eases the transition from independence to total dependence.

Older people often have difficulty adjusting to change in the period of life when change is imminent. Human service professionals not only orchestrate the changes but also facilitate the associated adjustment to a loss of independent living. When resources for assisted living and skilled nursing are limited, families may assume the caregiving responsibilities. Education and support to caregivers creates another area of needed services in an already taxed service arena.

End-of-life services include palliative care for the dying person and supportive services to the families. Families have difficult decisions about whether to have terminal care in the home or at a facility. The issue of life support, if not made in advance by the patient, is often difficult for family members to agree upon and accept. All family members become clients at this critical time, and the professionals who serve them best assist all members of the family in supporting the dignity of the dying patient.

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See Also: Adolescent/Youth Services: Overview; Aging and Adult Services; Drug and Alcohol Screening; Early Childhood Development; Infant/Toddler Development; Life Course Approach.

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Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality (AHRQ) was established in 1989, and its mission, according to its Web site, "is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans." AHRQ is housed within the U.S. Department of Health and Human Services. The agency's budget for the 2012 fiscal year was $405 million, with about 80 percent of this amount dedicated to supporting contracts and grants with an emphasis on improving health care. AHRQ comprises four offices and five centers: Center for Delivery, Organization, and Markets; Center for Financing, Access, and Cost Trends; Center for Outcomes and Evidence; Center for Primary Care, Prevention, and Clinical Partnerships; and Center for Quality Improvement and Patient Safety. The AHRQ annual conference, launched in 2007, is one platform in which AHRQ works to fulfill its mission. The annual conference was held consecutively through 2012. However, AHRQ suspended its 2013 and 2014 conferences to enable the agency to leverage its experience from the prior conferences in order to examine both the features and design of the 2015 conference and the best means to further the agency's mission.

Portfolios of Research: Comparative Effectiveness Research

AHRQ focuses on seven "portfolios" of research: comparative effectiveness research, cross-agency communications, health information technology, innovations and emerging issues, patient safety, innovation and care management, and value. The comparative effectiveness research (CER) portfolio is especially of use to both professionals and consumers. CER is designed "to inform health-care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care." The results of the research are shared through effectiveness and comparative research summary guides for consumers, clinicians, and policy makers. These guides provide an overview of the research findings, specifically on the harms and benefits of different treatment options.

Web Site Educational Resources

The most striking feature of AHRQ's Web site is the vast array of information available to a variety of audiences—consumers, clinicians, and policy makers, with separate tabs for each audience on the organization's home page. An array of health research information tools is available, including one called State Snapshots. These summaries provide an overview of health care quality information and disparities for a specific state and offer suggestions for various ways to improve each state's health care delivery. These summaries are derived from information collected for the National Healthcare Quality Report (NHQR). A map of the United States appears on AHRQ's home page and users may click on a specific state to access the state snapshot.

Fact sheets for a variety of health topics are provided under the Research, Tools & Data section. Examples of topics include aging, children's health, coronary heart disease, diabetes, health information technology, Medicare and Medicaid, mental health, minority health, patient-centered care, quality, and women's health. Full research reports are also available, such as "Guide to Patient and Family Engagement," and various outcome reports on pharmaceutical outcomes research, such as "Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement: Institute of Medicine Report."

Another Web site resource of interest is the Comparative Effectiveness Portfolio, featuring 123 reviews outlining the benefits or harms associated with different treatment options. These reviews are based on the results of research studies that compared various health care interventions. In 2007, AHRQ initiated a new consumer-oriented program called Healthcare 411. This program provides audio news on AHRQ's most recent research information, news, and findings. Podcasts and videos are available, both in English and Spanish, on a number of health topics, such as featured podcasts on autism, chronic hepatitis C, and monitoring blood sugar.

The Funding and Grants tab includes funding opportunity announcements; research policies; funding priorities and contacts; the grant application, review, and award process; and postaward grant management. National Advisory Council meeting summaries, transcripts, and presentation slides from meetings are also available. In addition, users can learn about recent AHRQ news and events, including access to newsletters, conferences, and columns, under the News & Events tab.

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See Also: Health Care, Disparities in; Health Care Delivery, Models of; National Healthcare Disparities Reports.

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Aggression Replacement Training

Over time, significant efforts by several entities within the field of human services have been devoted to forming effective approaches and systems to control antisocial, delinquent, and illegal conduct. There have been many attempts to develop techniques and programs to improve self-control, especially among children and adolescents. Aggression Replacement Training (ART) is a cognitive-behavioral intervention program to aid children and adolescents convalesce social aptitude and moral reasoning, convalesce anger management, and diminish aggressive behavior. The program was initially designed for habitually aggressive children and adolescents aged 12–17. Drs. Arnold P. Goldstein, Barry Glick, and John Gibbs developed ART. ART has been implemented in schools and juvenile institutions, and is being introduced to adult correctional institutions on a national and international level. The program is offered for 10 weeks, which includes 30 sessions of intervention training, and encompasses three components. The three components offer training in social skills, anger control, and moral reasoning. On a weekly basis, participants engage in a one-hour session in each of these modules (components). Layered knowledge, confirmation schemes, and facilitated group discussions enrich skill attainment and reinforce the modules in the curriculum. ART is currently a model program for the U.S. Office of Juvenile Justice and Delinquency Prevention and the United Kingdom Home Office. The U.S. Department of Education has categorized ART as a promising approach to address students who struggle with aggression.

Culturally responsive treatment holds the most promise for reduced recidivism. It is often defined as interventions that maintain respect for, and attention to, diversity in both people and programming. Gender, age, and ethnic origin intersect to produce consistent statistical patterns of offending. At a minimum, ART facilitators should be aware of their personal cultural identifications and biases, always showing respect and understanding for client diversity and differences in social learning experiences.

Conducting research in the field of human services with diverse populations is an effective method to determine the cultural responsiveness of a model of treatment. For example, the Wilder Research Center conducted an evaluation summary of ART between fall 2002 and fall 2004 with 295 youth who received ART. Four agencies provided the services, including a residential program, a school-based program, and two community-based programs. The youth were racially and culturally diverse (39 percent black, 28 percent white, 24 percent Asian, 6 percent Latino, and 3 percent of another or mixed race). A total of 92 percent were male, mostly between the ages of 14 and 17. According to this research study, positive feedback was received from the youth and their families concerning their satisfaction with the services and staff who provided ART.

History

Starting within the school setting, ART was considered a psychoeducational approach to working with students who displayed antisocial behavior. ART originated as Skillstreaming by Goldstein, and it transpired into a three-component model. Goldstein recognized that the complex problems of youth could not be addressed by a one-dimensional approach. With Glick and Gibbs, he formulated a three-part multimodal approach to address problems in behavior, emotions, and thinking. Skillstreaming targets behavior, Anger Control Training focuses on emotions, and Moral Reasoning is a cognitive intervention. Goldstein and his colleagues encouraged the extension and modification of the program to new settings, client populations, and causes. The program is now accessible in revised forms for other types of antisocial behaviors and populations, for instance, adult violent offenders.

Social learning theory was a vital inspiration because it relates to theoretical viewpoints, which influenced the design of ART. This theory seeks to understand the complex interactions between an individual's thoughts, emotions, and actions within a given social environment. Social learning theory is parallel with cognitive behavioral methods. In addition, the ecological perspective inspired the blueprint of ART, describing aggression as a person-environment combination. The ecological theory influence can be understood as macrolevel aggression displayed at the national or regional level; mesolevel violence at the neighborhood level; and microlevel aggression found in settings such as the home, school, and peer groups. Both the theory and practice underpinnings of ART are comprehensive and accomplished a variety of criteria for evidence-based practice. Research shows that the three major areas of Skillstreaming, Anger Control Training, and Moral Reasoning address key dimensions in helping participants acquire prosocial behavior, thinking, and values.

ART as a multimodal program with three modules was first implemented and appraised in schools and juvenile delinquent residential facilities in 1978. Since that time, an extensive progression of studies has validated its skill-learning, anger-control, and recidivism-reducing influence. It has gained popularity in schools, juvenile complexes, and other agencies concerned with the reduction of school violence and aggression by youth. In 1981, ART evolved in the United States and is now used in human service systems, including juvenile justice and adult corrections systems throughout North America, Europe, South America, and Australia. The revolutionary curriculum is known as an empirical-based, effectual methodology for working with perplexing youth. The revised and expanded edition is the culmination of over 30 years of use in schools, community agencies, juvenile institutions, and other milieus. The developers expound on the procedures and tactics for each of ART's three modules, illuminating the theory behind the interventions and offering practical recommendations for optimal results. They present program strategies in the form of sessions, including systematic instructions for leading each group meeting.

Three Components

ART introduces three synchronized and assimilated modules. The first module is Skillstreaming, which educates youth on what to do, helping them to replace antisocial behaviors with positive substitutes. The next component is Anger Control, which imparts to youth what not to do, helping them to react to anger in a socially acceptable manner, without aggression, and to reconsider anger-provoking circumstances. The last module, Moral Reasoning, increases youths' levels of fairness, justice, and concern for the needs and rights of others. ART consists of a 10-week, 30-hour intervention, administered to groups of eight to 12 participants three times per week. The program relies on repetitive learning and transfer-training techniques to teach participants to control impulsiveness and anger so that they can choose to use more appropriate and prosocial behaviors. In addition, facilitated group discussion addresses destructive thinking. All three interrelated components come together to promote an inclusive aggression-reduction curriculum. Each module concentrates on a distinctive prosocial behavioral technique, including action, affective/emotional, or thought/values.

Skillstreaming (the action component) is intended to teach social skills through social interaction and skills are disseminated using direct instruction, role play, practice, and performance feedback. This is expected to give participants the opportunity to practice prosocial responses to potentially arduous situations, such as responding to failure, handling accusations, and responding to others' emotions. This method derived from the social learning theory of Albert Bandura. The curriculum offers a skill checklist of 50 preferred skills to identify skills that the participants are missing, sequentially; the program targets those lacking skills. Each skill is broken down into its behavioral components, which the trainer demonstrates, and participants role-play during the session. A skill such as comprehending someone's feelings is considered complicated, whereas priming for a difficult conversation is less challenging.

Anger Control Training (the affective/emotional component) helps participants recognize external and internal triggers for aggression signals and how to control anger using various techniques. Participants bring to each session one or more descriptions of recent anger-arousing encounters (agitations), and over the duration of the program they learn to use exclusive skills to better control angry impulses. The anger control training has its foundation in the early anger control work of R. Novaco and D. Meichenbaum. Anger control training is a multistep sequence in which participants are taught to understand how they typically perceive and construe the behavior of others in ways that arouse anger. Therefore, in the first lesson, attention is directed toward identifying the external and internal triggers that initiate the anger. The self-control sessions identify triggers and likely consequences of anger and aggression. The self-awareness of triggers and arousing feelings of anger is then used to cultivate replacement prosocial strategies. The trainer demonstrates the proper use of anger reduction techniques, such as deep breathing and backward counting.

Moral Reasoning Training (the thought and values component) is expected to address the reasoning aspect of aggressive behavior, and is specifically designed to enhance values of morality in aggressive participants. Techniques in this component allow participants to learn to reason in a more advanced manner concerning moral and ethical dilemmas, providing participants with opportunities to discuss their responses to issues, taking perspectives other than their own that represent a higher level of moral comprehension. This component derived from Lawrence Kohlberg's model of moral development, with the purpose of raising the individual's level of moral reasoning in order to make more mature decisions in social situations. In ART, moral reasoning is stimulated by in-group discussions of moral dilemmas. The trainer presents a moral problem, in which the participants can choose between various options. The participants choose one position each, and discuss their position with the group. The curriculum provides 10 problem situations designed to create opportunities for participants to consider the perceptions of others.

Intervention Programs

Goldstein and colleagues emphasized that aggressive behavior and other forms of antisocial behavior can be discovered in three factors. Those three factors are the lack of prosocial behavior (personal, interpersonal and social-cognitive skills), poor anger control, and undeveloped morals. ART teaches an array of prosocial and psychological skills to participants who have specific areas of need. Training is delivered in a series of structured learning groups, where participants are shown examples of expert use of the behaviors that constitute the skills in which they are deficient (i.e., modeling). In addition, participants are given guided opportunities to practice and rehearse these competent behaviors (i.e., role-playing). Participants are provided with reinforcement, reinstruction, and performance feedback on how well they perform their role-playing enactments. Furthermore, participants are encouraged to engage in a series of activities designed to increase the chances that skills learned in the intervention setting will endure and transfer in real-world settings, such as home, neighborhood, and school. The authors proclaim that these components together provide a platform that will help the participants to function prosocially.

ART concentrates on the development of individual competencies to address various emotional and social aspects that contribute to aggressive behavior. Program techniques were designed to teach clients how to control their angry impulses and take perspectives other than their own. The main goal is to reduce aggression and violence by providing them with opportunities to learn socially acceptable skills in place of aggressive behavior. The multicomponents of ART promote prosocial behavior by addressing factors that contribute to aggression, including limited interpersonal social and coping skills, impulsiveness, overreliance on aggression to meet daily needs, and egocentric and rigid values. A cost-benefit analysis by the Washington State Institute for Public Policy finds that this program results in reduced illegal behavior and cost reductions. An outcome evaluation from Washington State showed, for example, that when completely delivered, ART has positive outcomes, with estimated reductions in 18-month felony recidivism of 24 percent, compared to the control group.

The ART program is aimed at individuals with a history of serious aggression and antisocial behavior and can be applied across several different populations. Some potentially eligible populations include incarcerated juvenile offenders and youths with clinical behavioral disorders. Recommendations suggest that potential participants be screened for risk and severity of aggressive/antisocial behavior before implementation to assess eligibility for inclusion. This type of assessment often includes the use of clinical instruments to examine the degree of problematic behavior. In the juvenile court setting, ART can be implemented by court probation staff or private contractors after they receive formal ART training. A juvenile offender is eligible for ART if it is determined from the results of a formal assessment tool administered by juvenile court staff that the youth has a moderate to high risk for reoffense, and has a problem with aggression or lacks skills in prosocial functioning.

ART is a long-standing intervention program. Since the 1990s, it has been provided across the world within a wide variety of social, educational, and correctional services, secure units, community services, and prisons. Teachers, counselors, youth care workers, social workers, and correctional officers are examples of people who become trainers. Using repetitive learning techniques, participants develop skills to control anger and use behaviors that are more appropriate. In addition, facilitated group discussion is utilized to modify antisocial thinking, which precedes dilemmas that can be problematic.

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See Also: Adolescent/Youth Services: Overview; At-Risk Youth Services; Childhood Trauma; Educational Support Services; Juvenile Delinquents.

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Aging and Adult Services

Historically, older adults and adults with developmental disabilities faced limited community-based service options. Services were largely available through institutionalized settings, which often required people to leave their homes and live within state-run hospitals or nursing homes. With the passing of federal legislation, advocacy from stakeholders, and social change movements like deinstitutionalization, services for health, mental health, and daily living needs are now more widely available through community-based providers, thus allowing older adults and adults with disabilities to safely remain in their homes as long as possible. For a portion of people who are unable to live independently, specialized interventions such as Alzheimer's units in nursing homes, assisted living, group homes, and short-term rehabilitation are available to meet the unique long-term and short-term needs of this population.

Many of today's community-based services for older adults emerged out of the passing of the Older Americans Act of 1965 and for adults with developmental disabilities out of the Rehabilitation Act Amendments of 1978, which are federal legislation that, in part, supported the development of population-specific community-based social services. The Administration on Aging, Administration on Intellectual and Developmental Disabilities, and Administration for Community Living are federal departments that disseminate grants to states that aim to create and improve services within the community as a means of providing older adults and adults with disabilities with the resources they need to live independently. Although federal funds support a large portion of these services, states have the flexibility to design systems of care and allocate funding in accordance with the unique needs of their communities.

Health and Mental Health Services

Health and mental health services are generally provided in-home or through community-based clinics and local hospitals. Adults who are able to safely live independently and are relatively mobile may choose to access health care services through clinics and local hospitals. Gerontologists—doctors who specialize in treating diseases and conditions that impact older adults—are available for ongoing health care maintenance for aging adults. Community clinics and hospitals provide a multitude of health care services including routine physicals, consultation with specialists, management of chronic diseases, physical therapy, chronic disease management, occupational therapy, and surgery. Clinics and hospitals are also equipped to serve the mental health care needs of older adults and adults with disabilities by conducting mental health assessments and providing mental health therapy, supportive counseling, family therapy, substance use treatment, psychiatric medication management, and case management.

Some people living in the community are homebound or have difficulty traveling to clinics and require in-home health care services. Home health care is prescribed by a physician and can include nursing, social work services, and physical and occupational therapy. Homebound adults can access a number of services offered in clinics in-home through home health agencies. For example, wound care, medication management, short-term physical and occupational therapy, speech therapy, mental health therapy, and podiatry are a few examples of health care services that can be provided in-home. Home health is beneficial for many homebound adults because it expands access to services for this vulnerable population; people who are homebound may be at risk of falling if they leave their homes without assistance. Further, home health allows providers to see people in their home environment. Although there are a number of benefits to in-home care, the drawback is that many services cannot be provided in-home, such as invasive surgical procedures and the use of nonportable technologies.

For a portion of older adults and adults with disabilities, living independently is not possible. Assisted living and nursing home facilities offer longer-term services for people who cannot live in their own homes but who do not need 24-hour skilled nursing care. Assisted living facilities generally provide a small studio apartment for residents and an array of services that may include meal preparation, assistance with cleaning the apartment and clothing, self-care, coordination of medical care, medication management, and transportation. Many assisted living facilities coordinate with medical providers who provide routine care at these facilities. Although the assisted-living staff are available 24 hours a day, most facilities transport residents in need of urgent medical attention to the hospital or a connected skilled nursing facility.

A 2013 St. Patrick's Day party at a nursing home. The Older Americans Act of 1965 led to many community-based services, such as nursing homes and assisted living facilities.

Alternatively, for people who require extensive care and/or rehabilitation, nursing homes provide skilled nursing services 24 hours a day, seven days a week. Nursing homes have general medical floors and may also offer specialized care on floors for people with neurocognitive disorders or Alzheimer's disease. Nursing homes are equipped to provide many health care services within the facility; however, for more urgent care, residents may be transported to a local hospital for assistance.

Finally, federal funding also supports state-run ombudsman programs for older adults and their families. Ombudsmen advocate for the protection and safety of older adults living in long-term care facilities, such as nursing homes and assisted living. If residents, families, or advocates are concerned about the services provided by a long-term care facility or the conduct of long-term care facility staff, a report can be submitted to the ombudsman for investigation.

Community Services

A number of nonhealthcare-related community resources are also available for older adults and adults with disabilities. These services are intended to maximize self-sufficiency, health, and in-home safety so that people can continue living in their homes and within their communities despite physical or mental limitations that could interfere with independent living. One of the most common services is homemakers. Homemakers are people who work with older adults or adults with disabilities who need assistance with activities of daily living. Homemaker services are individualized so that supportive services are offered in the areas of daily living that a person most needs. Homemakers can assist with cleaning homes and laundry; self-care activities like getting dressed, meal preparation, and shopping; and running errands like going to the post office or picking up prescription medications. Homemakers can also accompany their clients to the doctor's office or out in the community for walks.

In addition to homemakers, a number of services intended to assist older adults and adults with disabilities are available to help improve quality of life; reduce financial stressors related to low, fixed-incomes; and improve safety within the community. For example, many communities provide lower-income, older adults and adults with disabilities reduced bus fare, discounted license plates, subsidized taxi vouchers, discounted legal services, and free or low-cost tax preparation. Low-income adults may also be eligible for the Low Income Home Energy Assistance Program, which provides eligible individuals with a small grant to help cover the cost of electric bills. Although not available in all states, circuit breaker or benefit access programs also provide low-income older adults and adults with disabilities a return of a portion of their property taxes or rent paid per calendar year. Many community senior centers also provide socialization opportunities with dinner clubs, sponsored activities like game night, and light physical and mental exercise.

State departments on aging offer home-delivered meals for individuals who are homebound or have difficulty preparing nutritious meals independently. Many state departments also provide adult day care services. Adult day care promotes social interactions and provides mental stimulation, therapy, educational activities, and exercise in a structured environment. Many people attending adult day care have caregivers in their home; the day program allows participants a chance to engage socially and offers a break from caregiving. State departments also run adult protective services, which investigate abuse and neglect allegations for older adults and people with disabilities. Finally, in an effort to promote in-home safety, many states also subsidize in-home emergency response systems for low-income, older adults. In the event a person falls and is unable to phone someone for assistance, emergency responders are notified when a person in need pushes a button on a necklace worn around his or her neck. When a button is pushed, an operator speaks through an intercom within the person's home and asks if emergency personnel should be dispatched for assistance.

Funding for Health and Mental Health Services for Aging Adults

Medicare, Medicaid, and private insurance largely cover the cost of health and mental health services. Older adults who do not qualify for Medicaid often opt for insurance policies called Medigap plans, which are offered through a number of private insurance companies to help cover the cost of medical care that is not covered by Medicare. A combination of Medicare and private insurance covers a portion of the cost of nursing home care. People with lower incomes can apply for Medicaid coverage for the remaining cost of nursing home care, but people with assets and higher income often pay for a portion of skilled nursing services out of pocket. Most people residing in assisted living facilities must pay out of pocket; however, some states offer financial support through Medicaid to low-income individuals in need of assisted living. The cost of assisted living varies considerably from facility to facility. Funding for community-based services for older adults and adults with disabilities is largely supported by a combination of federal and state funding.

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See Also: Alcohol and Substance Abuse Services; Case Management Services; Counseling and Psychotherapy Services; Elder Care/Geriatric Services; Home Care Services.

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Aid to Families with Dependent Children, Historical Role of

Aid to Families with Dependent Children (AFDC) is a former public assistance program established under Title IV of the Social Security Act of 1935 as Aid to Dependent Children (ADC). The program was funded and administered by the federal and state governments to provide short-term financial assistance for needy children. More than half (55 percent) of the total cost of AFDC payments are funded by the federal government, leaving the remaining balance to be covered by the states. Each state managed its own program and determined who received benefits and the amount families received. As a means-tested program, AFDC recipients' eligibility status was based on the following: (1) having a dependent child who is under age 18 and living with the family (an 18-year-old who is expected to complete secondary school or its equivalent before turning 19 could also be covered); (2) being deprived of financial support from one parent because of the parent's death, continued absence, or incapacity (this includes children in two-parent families in which the principal family earner was unemployed); (3) being a resident of the state they lived in; and (4) being a U.S. citizen or an immigrant who is permanently and lawfully residing in the United States.

Historical Timeline

AFDC program grew out of the passage of the Social Security Act of 1935 as Aid to Dependent Children (ADC). The 1935 Social Security Act, however, was not the first government income support provided to poor children in the United States. In most cases, ADC added federal aid to state mothers' pension programs, which were already assisting poor mothers. These local and state-funded mothers' pensions programs were established to provide cash aid to help children remain in their homes when mothers experienced financial hardships. Both programs (mothers' pension and ADC) were designed to be short term in nature and to address a specific need.

Several features of the new ADC program kept states from abandoning their efforts following the passage of the Social Security Act. Federal ADC aid was contingent on state contributions, and states were given considerable discretion to determine ADC eligibility and grant levels. For example, a state could continue to require that only children living in "suitable homes" could receive assistance. The "suitable home" criteria was very subjective and often used to exclude potentially eligible families on the basis of race, ethnicity, language, religion, and country of origin. States also introduced the "man-in-the-house rule" to regulate or enforce the morality of public aid recipients. The rule was based on the belief that women receiving public assistance might allow able-bodied men to spend time in their homes without assuming any responsibility for the well-being of their children. This lack of responsibility and the perception that these men were also indirectly benefiting from the ADC aid were viewed as immoral and illegal and enraged those who wanted to ensure that benefits were being spent only to care for needy children. This rule resulted in the practice of "midnight raids" or home visits to welfare recipients late at night. These raids were to ensure that no able-bodied adult male resided in the household, even if the man in question was a blood relative of the mother, such as her father or her brother. Until these rules and practices were struck down in 1960, these requirements were used to exclude "undesirable" families from aid, particularly children of women who had never married.

During the 1960s several important modifications to the program were made: the name was changed to Aid to Families and Dependent Children (AFDC) to include the family as a unit, and AFDC-Unemployed Parents (AFDC-UPS) was enacted. This program came about primarily because of the recession and lack of work resulting in the parent's unemployment. This change addressed concerns that the program's eligibility criteria discouraged the establishment and maintenance of two-parent households in poor communities. This criticism was never adequately resolved, in part because of the fact that half the states, particularly in the south, failed to implement the AFDC-UPS program.

Another significant criticism levied against the AFDC program for many years was the inherent lack of attachment to work for benefit recipients. For nearly four decades, several programs were implemented to encourage work and job readiness for AFDC recipients. In 1968, Congress established the Work Incentive (WIN) program, which provided education, training, and subsidized employment for AFDC participants. The Jobs Opportunities and Basic Skills Training (JOBS) program was established in 1988 to prepare welfare recipients for work and reinforce social services support to families. Each program encountered many challenges and did not yield many positive outcomes. The lack of success can be partly attributed to the "hard to serve" or core group of recipients who were dealing with enduring limitations related to illiteracy and/or limited English proficiency, mental and physical health issues, as well as simply not having minimum job skills.

In the 1990s criticism of AFDC continued, supported by a body of research that highlighted conservatism (specific to family values, individual responsibility, and the value of work), that led to sweeping changes in legislation that forever changed the face of public assistance. In 1996, the Aid to Families with Dependent Children (AFDC) program was eliminated as a federal program and ended the highly criticized entitlement to means-tested cash assistance for poor families in the United States. The Temporary Assistance for Needy Families (TANF) program replaced AFDC.

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See Also: Family Services; Poverty; Temporary Assistance to Needy Families.

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AIDS/HIV Programs

HIV (human immunodeficiency virus) is an infectious agent, a human retrovirus causing a lifelong, life-threatening condition (HIV disease, HIV infection, or HIV illness), the final stage of which is AIDS (acquired immunodeficiency syndrome). HIV is responsible for a worldwide devastating plague, and its effects concern all human services workers and organizations. Since the existence of the pandemic was realized in 1981, more than 75 million people worldwide have tested positive for HIV and almost 36 million have died of HIV-related causes.

HIV can infect any person, regardless of age, origin, ethnicity, occupation, religion, sexual orientation, gender, or gender identity, so it is vital that respectful, appropriate services be available for persons with HIV at every health care or social service organization. No matter the setting or population, human services workers should assume that they are or will be working with persons who have HIV (whether they know it or not), are at risk of becoming infected with HIV, have friends and family members with HIV, or have questions about HIV. Every human services worker should ask about HIV concerns as part of general helping and be prepared to listen nonjudgmentally to experiences and fears, make appropriate referrals, and educate people about how to avoid getting HIV or passing it on to others.

HIV Transmission

A man, woman, teenager, or child can get HIV through the infusion of specific infected fluids (blood, semen, vaginal secretions, or breast milk) into his or her bloodstream. The most common forms of passing HIV from one person to another are (1) vaginal or anal intercourse without a condom; and (2) sharing syringes (some blood remains in the syringe). It is possible for a fetus or newborn to get HIV from the mother. HIV will not pass through air, clothing, or unbroken skin. Tears, perspiration, saliva, and urine do not transmit HIV. No one has ever been infected with HIV through casual contact, such as hugging, holding hands, or sharing food, beverages, dishes, or linens.

HIV Disease

A person learns whether he or she is HIV-positive through a blood or saliva test. HIV attacks the immune system, diminishing the body's ability to fight infections and cancers. A person with HIV can live for years without having any symptoms of the illness. When persons develop HIV symptoms, they can maintain good health and functioning for years if they have good medical care, nutrition, stress management, and social support. Much progress has been made with medical care and anti-HIV medicines, so where and when health care is available, people with HIV are living longer and fuller lives than possible before. Still, there is no cure, so HIV remains a serious, chronic, life-threatening, difficult-to-manage illness.

History

The retrovirus was probably undetected among humans for over a century before the symptoms were noticed and reported in the United States in 1981 by physicians who were treating young gay and bisexual men who were dying rapidly from mysterious infections and cancers. At the same time, scientists from all over the world reported similar unexplained life-threatening illnesses in men, women, and children. In the United States, the disease initially became associated primarily with gay men. Because traditional medical, governmental, pharmaceutical, and charitable organizations were not appropriately serving people with HIV, early AIDS service organizations (ASOs) were founded and run by men and women in the gay community; many of the men were themselves ill from HIV complications. The early response to HIV in the United States is a model for community organization and policy advocacy.

Language

An HIV-positive person can also be referred to as an HIV-infected person or a person living with HIV (or AIDS). The last term is generally preferred. At a Denver conference in 1983 (before the causative agent HIV had been discovered), an advisory committee of persons living with AIDS developed the Denver Principles, which remain important in HIV services. The writers of the document condemned labels that put the disease before the person, asking to be called "people with AIDS." In the HIV field it is considered respectful to use words such as "person," "man," and "woman" rather than "client" or "patient."

Treatment

It is important for a person with HIV to have and keep up with good medical care, with a specialist if possible. With careful monitoring, anti-HIV medications (antiretrovirals or ARVs), wellness strategies for the immune system, and medicines to prevent infections, HIV can be better managed. Treatments can cause side effects that, at best, make life unpleasant and, at worst, make it almost impossible for people to continue taking the medicines. Good medical care, along with social support and social services, can help people address side effects and stick to (adhere to) the medications. Adherence to the medicines as prescribed is critical because HIV will become resistant to a medicine that is not taken as prescribed and the drugs will not be able to keep HIV in check.

Psychosocial Concerns

HIV disease carries a stigma (social disgrace), so people with HIV may be hesitant to tell others about the diagnosis out of a fear of being judged, rejected, or shunned. HIV stigma may keep people from learning about transmission risks, getting an HIV test, seeking medical care, approaching a human services or mental health agency, asking friends and family for help, or disclosing to sexual or drug partners.

Living with HIV can cause ongoing emotional turmoil and multiple crises. Most people with HIV experience periods of stress, fear, uncertainty, depression, grief, and feeling out of control. Often HIV comes as an additional blow on top of previous traumas or ongoing challenges (e.g., extreme poverty, physical and sexual abuse, addiction) and the person can be too overwhelmed to address HIV at all.

Human Services Roles

A helper must be prepared to provide information about HIV transmission and prevention, HIV testing, and HIV services and counseling. Preparation might mean seeking more education, doing more reading, or honestly exploring one's own attitudes.

Because of HIV stigma, people with HIV as a whole are an oppressed group. In addition, people with HIV are an enormously diverse group, and having HIV is a very personal experience. Working with people with HIV requires that one be respectful, nonjudgmental, and culturally humble. Human services workers must keep a high level of confidentiality when working with persons with HIV, and must be prepared to assure people repeatedly about their privacy rights and the agency's protections.

Human services workers should work in partnership with persons with HIV and, from the beginning and at every step, ask what the person needs to be well and safe at a basic level. These individuals may need s services such as HIV testing, health insurance, medical care, medication, support to adhere to ARVs, shelter, food, employment assistance, mental health care, support groups, family or couple counseling, addiction services, or legal aid.

One of the worker's toughest jobs, but one of the most important, is to help maintain a delicate balance between hope and despair. Unrealistic hope can lead to ignoring the seriousness of having HIV and thus, to doing nothing about it; unrealistic despair can lead to paralyzing fear and depression.

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See Also: Bias in Service Delivery; Cultural Humility, Model of; Health as a Human Right; Pandemics; Partner Notification Programs in HIV/AIDS.

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Alaskan Natives

Alaska is the 49th state in the United States and became a state on January 3, 1959. It is home to over 700,000 people, of whom 15 percent identify as Alaska Native. The majority of Alaska is surrounded by water. The northern part of the state is surrounded by the Arctic Ocean, (e.g., Beaufort Sea and the Chukchi Sea). The Gulf of Alaska and Pacific Ocean are to the south and the Bering Sea is to the west of the state. In addition, eastern and southern Alaska is bordered by Canada. The total area Alaska covers is 656,425 square miles, making it the largest state and more than two times the size of Texas, which is the second-largest state in the nation.

The term *Alaska Native* encompasses distinct cultural linguistic groups, which are often divided into five major groupings: the Aleut/Alutiiq (Southwestern Aleutians), Athabascan (Interior Indians), Inupiat (Northern Eskimos), Yup'ik (Southern Eskimos), and Tlingit/Haida/Tsimshian (Southeastern Coastal Indians). Each of these groups is culturally distinct through important differences in cultural practices, including variation in kinship networks; developed subsistence hunting and gathering practices; unique languages; belief systems; and spirituality, art, music, and dance traditions. The groups all honor and respect the land and waters upon which their lives depend, have respect for the fish and animals, value community over individuality, and respect and learn from their elders.

In many regions of the state, Alaska Native people still hunt, fish, and gather the same plants and animals they have for centuries, practicing their traditional culture as passed down to younger generations through the stories, teachings, and life examples of their elders. Subsistence foods make up a majority of their diet, including the diet of those living in the urban centers of Anchorage and Fairbanks. It is common to see traditional culture celebrations and ceremonies practiced in communities, and many of the elders continue to pass on their traditional knowledge of activities such as hunting, gathering, survival skills, ivory and wood carving, and beadwork.

Health and Mental Health

The overall health (physical and mental) of Alaska Native people has improved over the last few decades with progress in health care practices, medical advancements, and increased healthy behaviors. However, when compared to the nonminority population in the United States or with other racial and ethnic minority groups, Alaska Natives' health still remains poor compared to the rest of the U.S. population. For many health indicators, Alaska Native people have the poorest health and greatest health disparities of any population in the nation, along with American Indian populations. The Alaska Native mortality rate is over three times the national average, with a significant percentage of deaths related to alcohol. Alaska Native youth smoke cigarettes at a rate that is four times higher than other youths. Alaska Native children are more likely to be neglected or abused, and Alaska Native women suffer higher rates of domestic violence and sexual abuse compared with the national average. More than one-third of Alaska's prison population is made up of Alaska Natives. The seemingly common denominator between Alaska Natives and these health outcomes is the high use of alcohol and other drugs.

Working With Alaska Native Clients/Communities

It must be noted that working with Alaska Natives as culturally different clients entails a focus on the individual within his or her community. Alaska Natives are becoming aware and have recognized that addressing the problems caused by typical lifestyle behaviors (e.g., eating unhealthy foods, drinking too much alcohol, and smoking) requires multiple interventions. Small Alaskan communities have voted to control alcohol use, with some voting for a total ban on alcohol. There has been a growth in health and mental health facilities, which employ trained professionals and send mental health professionals to Native Alaskan villages.

While there are differences of opinion regarding the best health and wellness practices within Alaska

Alaskan women scraping salmon from the skin using traditional methods. Following the teachings of their elders, many native Alaskans have continued to fish, hunt, and gather food.

Native communities, established, evidence-based treatments for Alaska Native clients require some kind of adaptation process prior to implementation. For instance, some Alaskan Native communities could view the problems of alcohol, drugs, smoking, and overall poor health as the result of their community losing their traditional, sacred ways and being forced into European lifestyles. Using a standard medical model to treat a psychological problem rather than approaching this as a holistic and historical problem would seem an illogical, best-practice technique. Partnering with community members to better understand local practices and traditions paves a way for "actual" best practices when working with Alaskan Native clients. Professional practices should be grounded and offered in the social context of each unique Alaskan community.

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See Also: Ethnic Groups and Drug and Alcohol Use; Ethnicity and Clients; Health Care, Disparities in; Indian Child Welfare Act; Indian Civil Rights Act of 1968; Native Americans; Native Americans, Suicide Among.

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Alcohol and Substance Abuse Services

Based upon epidemiological data individuals from diverse populations are statistically overrepresented in the alcohol and drug abuse treatment population. Compounding this data is the lack of consensus of the term *diversity* as meaning culture, ethnicity, race, gender, and/or sexual orientation.

In the arena of substance abuse treatment, the majority of programs define diversity as being those clients identified as African Americans, Asians and Pacific Islanders, Hispanics and Latinos, women, and gays/lesbians. Further, specific alcohol and drug abuse treatment programs, based upon state and federal funding priorities, have targeted older adults, children of alcoholics, adolescent Native Americans, athletes, members of the military, the criminal population, and those with disabilities under the concept of diversity. Each of these groups brings to their substance use disorder a unique set of etiologies and needs.

Education and Credentialing Standards

In most states, trust territories, and many foreign countries, treatment of those having alcohol and drug abuse disorders is provided by therapists specifically certified or licensed in alcohol and drug abuse. In most states there is not a specific requirement for education/training in diversity and the varying treatment strategies necessary to effectively treat those from diverse populations. Ethical standards in alcohol and drug abuse counseling do infer the need to be sensitive to diversity in the treatment population, but these ethical standards do not require specific competencies in this arena.

Most states require a written examination to be certified or licensed as an alcohol and drug abuse therapist. In the majority of cases this examination is provided by the International Certification and Reciprocity Consortium. While this test is comprehensive to etiologies and the behaviorally defined 12 core competencies required of an alcohol and drug abuse therapist, it does not explicitly address diversity or specific diverse populations.

In all jurisdictions certifying or licensing alcohol and drug abuse therapists, recertification is required on a periodic basis with documentation of approved continuing education. In many states, this approved continuing education can, but is not required to, address specific diverse populations.

Practicing Alcohol and Drug Abuse Treatment

The majority of alcohol and drug abuse therapists work in detoxification, inpatient, residential, or outpatient programs. In conducting assessment, diagnosis, treatment planning, and implementation of the treatment plan, the therapist must be aware of the specific culture and cultural prohibitions related to the individual client. Only by addressing these cultural considerations relating to the diversity of the client can an effective treatment plan be developed and implemented.

Research has indicated that alcohol and drug abuse clients tend to respond to treatment more positively when the therapist is culturally similar to the clients. As this is not always possible in alcohol and drug abuse treatment settings, research has shown that training therapists on the needs of clients from diverse populations will enable the therapists to assist these clients toward treatment goal attainment.

Alcohol and drug abuse therapists develop treatment plans that address the lifelong recovery paradigm for their clients. As recovery is a lifelong process it is imperative that postformal aspects of the treatment plan return the diverse population client into his or her culture with a bridge to sober living. This also requires the alcohol and drug abuse therapist to have knowledge of and appreciation for the diverse culture in which the client will live the rest of his or her life.

Treatment Funding and Access

Federal data indicates that those individuals from diverse cultures tend to be overrepresented in lacking traditional health insurance or the ability to pay for alcohol and drug abuse treatment services. Unfortunately, state and federal funding for fiscally disadvantaged populations has remained stagnant for the last decade. Alcohol and drug abuse treatment agencies, and therapists, have to be creative in finding access to effective and client-matched treatment for many clients from diverse populations. This means relying on charitable organizations, religious-based charities, or the provision of a set percentage of pro bono services.

Managed care is an overlay of alcohol and drug abuse services provided through Medicaid funding. Many times this requires treatment failure at a less intense treatment setting prior to stepping up to a more intense treatment. As diverse populations are overrepresented in the Medicaid population there is also a higher failure rate for first treatment episodes because of these requirements.

Recovery-Oriented Systems of Care

Recovery-oriented systems of care is the evolving treatment paradigm for alcohol and drug abuse treatment. This paradigm views the formal treatment episode as only the start of recovery. Lifelong recovery is the goal and ongoing assistance from the alcohol and drug abuse treatment organization becomes mandatory. In this recovery-oriented systems of care paradigm, a new form of treatment agent, called a recovery coach, becomes the focal point for the alcohol and drug abuse client postformal treatment. The recovery coach acts in a manner as most coaches, but he or she assists their clients in maintaining their specific recovery plans on a long-term basis. A recovery coach does not need the extensive education and training of an alcohol and drug abuse therapist. Instead this new position requires insight into recovery, and the coach should be from the diverse culture to which the alcohol and drug abuse client will return postformal treatment.

Relapse Prevention in Treatment

Of great concern in the provision of alcohol and drug abuse treatment is the client being able to maintain achieved treatment goals postformal treatment. The recovery-oriented systems of care model addresses one element of this concern. Still, the use of a recovery coach continues to have the client rely on external sources of support. The alcohol and drug abuse therapist must also work with the client to shift this external locus of control to an internal locus of control. This is the basis for relapse prevention treatment and the need for this as part of formal treatment.

Relapse prevention treatment is an educational technique that focuses on significantly increasing the client's coping skills in high-risk situations for relapse. The alcohol and drug abuse therapist takes the client through individual, specific behavioral rehearsals of high-risk situations until the client can positively cope with a sense of comfort in these situations.

With diverse populations it is imperative that the therapist not only be aware of the client's specific diverse culture, but also have a positive appreciation of how individuals in that culture handle stress and coping. Research has shown those alcohol and drug abuse clients coming from diverse cultures enter treatment with more coping skills than those from the majority population. While theories focus on the increased stressors and the necessity for learned coping in diverse populations, the alcohol and drug abuse therapist must access the level of coping skills the client brings to the treatment setting and build from this assessed foundation.

Prevention of Alcohol and Drug Abuse

It is only logical to want to prevent the onset of alcohol and drug abuse, rather than having to intervene and treat these disorders. In providing alcohol and drug abuse prevention services the prevention professional must select or adapt the prevention strategy to the culture of the targeted population. For prevention, the diversity of the targeted population is the most critical variable.

The alcohol and drug abuse prevention professional must be able to adapt the prevention program's content to accommodate the needs of the specific diverse consumer group. In doing this, the prevention agent matches intervention materials and messages to observable characteristics of the diverse target population. This can overtly involve the use of culturally identifiable people, locations, language, music, and products familiar to the diverse target populations. Covertly, this involves focusing on the social, cultural, environmental, and historical aspects of the diverse target population.

Future Directions

While there has been extensive research indicating necessary modifications to traditional alcohol and drug abuse treatment and prevention methods and techniques, for diverse populations this research is only now being integrated into general treatment and prevention models. Additionally, the lack of required diversity education/training specific to the provision of alcohol and drug abuse treatment and prevention services also delays the application of the evidence-based research to actual practice. With the workforce research regarding alcohol and drug abuse therapists and prevention professionals indicating the need for many new professionals (because of the aging of this professional population), it is expected that diversity research will accelerate into practice at a much faster rate.

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See Also: Alcohol Consumption, International Variations in Attitudes Toward; Drug and Alcohol Screening; Ethnic Groups and Drug and Alcohol Use.

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Alcohol Consumption, International Variations in Attitudes Toward

Alcohol consumption kills more than 2.5 million people annually, meaning that more people die from alcohol than from AIDS or other diseases. But because of human diversity and with regard to the specific country of origin of a person, there are variations in consumption and in attitudes toward alcohol in general. As a consequence, alcohol-addicted people need a special kind of human service, which deals with the various reasons of their addiction as well. The term *alcohol* is used here for all kinds of alcoholic drinks like beer, wine, whiskey, or other spirits. Because of this definition, alcohol is one of the most dangerous reasons for the death of many people in many different countries. And in some, the death rate is even increasing. This is not a well-known fact, because alcohol is depicted as "cool" and harmless in the media and daily life, especially by the young generation, which is confronted with alcohol in daily life in many different situations, like parties, the most known being the U.S. spring break season. Celebrities drinking in public create an image of "coolness" in relation to the consumption of alcohol.

A report from the World Health Organization in 2011 stated that globally, people drank an average 6.1 liters of pure alcohol per person in 2005. This amount is dangerous, because that much alcohol consumption is bad for health, causing many people to suffer from diseases caused by alcohol abuse. As a result, health experts from around the world are calling for a more global and standardized regulation of alcohol consumption. This would be a dramatic change, as there are differing attitudes toward alcohol consumption among countries, which are mainly consequences of different regional parameters. There are economic, social, and religious reasons that caused the above-mentioned differences in international attitudes toward alcohol consumption.

A long tradition of alcohol production, the social background, and daily life, as well as religious beliefs, are responsible for the levels of alcohol consumption in different drinking regions around the globe. According to the World Health Organization's report, eastern European states are especially high consumers; however, western European nations are not far behind the per capita consumption of these countries, including the former Soviet republics. Especially with regard to the age limit, which generally ranges between 16 and 21 years, the average age of the purchaser of alcohol (on-premise service or off-premise purchase) is very low (16). This fact is just a consequence of economic influences, determining the direction of the European alcohol industry.

Economic Reasons

Alcohol consumption is an economic factor that is important for the wine and beer industries in many countries. It is not astonishing that countries with an extensive tradition in beer-brewing like the Czech Republic, Ireland, or Germany show a high per capita beer consumption, ranging from 7 to more than 9 liters per person per year. The same tradition is traceable in wine-producing countries like France, Portugal, or Italy, where the annual wine-drinking per capita ranges from 7 to over 9 liters per person per year as well. What could be applied to wine and beer is also effective in the case of whiskey. Irish and Scottish people, especially, drink a lot of whiskey, which is produced in these countries. Because of the mentioned trends, it is obvious that these countries gain money by placing alcohol taxes on the sales of beer, wine, or whiskey. Furthermore, the economies of the mentioned countries are dependent on alcohol sales or exports to other countries. This makes it clear that such countries, which are alcohol-producing nations, are not too strict in their policies against alcohol consumption. There are lobbies for beer, wine, and pure spirits, whose members are eager to circumvent an aggravation of national policies against excessive alcohol consumption. But there is not only an economic origin of increased alcohol consumption in several countries; there are social reasons as well.

Social Reasons

Generally speaking, well-educated people with a stable social background drink less alcohol than poorer people in an unstable social environment. Unemployment, a lack of prospects, or increasing poverty pave the way for higher alcohol consumption, especially in the member states of the former Soviet Union, where the per capita consumption of alcohol is very high. Young people without a rosy perspective tend to start drinking at a younger age. When parents are heavy drinkers, children begin to imitate their habits as well. This is not the only problem in deprived nations, where more people are dying from alcohol consumption. Poverty is forcing people to produce alcohol on their own, which might cause a faster death by alcoholic cirrhosis. This unrecorded and so-called moonshine accounts for 30 percent of alcohol consumed globally. The home-brewed liquors are often responsible for dangerous diseases or deaths, because most "brewers" use prohibited substances to extend the strength of the self-made alcoholic beverages.

In addition to the danger of unofficially produced alcohol, a higher rate of young alcoholics is traced to such countries, which often do not have a national alcohol policy at all. Where the state is not trying to regulate alcohol consumption using laws or stricter control of young people's drinking habits, more youths become addicted and finally harmed by alcohol abuse. Only 31 percent of the World Health Organization (WHO) members possess such a policy, but a policy alone does not guarantee a decrease in alcohol consumption. The United States attempted to forbid the consumption of alcohol during the years of Prohibition, which led to criminalization. Furthermore, the illegally sold alcohol was more harmful than the officially sold brews. In countries like Finland, where the prices for alcohol are very high, the per capita consumption is not lower than Russian consumption. There is no traceable formula to define the per capita rate of alcohol consumption for a given country, but there is one decisive factor. The lowest alcohol consumption rates can be found in North Africa, the Middle East, Pakistan, and Indonesia. The reason for these statistics does have a religious origin: Islam.

Religious Reasons

In countries where most people are of the Islamic faith, the alcohol consumption per capita per year is at the lowest level. The explanation for this is simple: Islam forbids the consumption of alcohol, especially in countries where sharia provides the fundamental law, it is forbidden to drink wine, beer, or pure spirits at all. Since the establishment of Islamic religious beliefs during the time of Muhammad, Muslims have not been allowed to drink alcohol. The sharia is very strict in cases of disregard for this prohibition. This leads to an almost totally abstinent society in these countries. Consequently, the populations in Islamic countries do not suffer from deaths related to alcohol abuse, even if there are some more liberal Islamic states where the consumption of alcohol is increasing. In contrast to this, in Christian-dominated countries, alcohol consumption is not forbidden by religious beliefs, shown by the comparison of the per capita consumption rate between Islamic and Christian nations.

Solutions

There are different parameters defining the grade of alcohol consumption in countries around the globe. To obtain a unified international attitude toward alcohol consumption, the WHO has to deal with the above-discussed reasons. There should be more member states adopting national policies against alcohol consumption, and at first glance, there is a higher need for preventive measures. People, especially children, need to be informed about the consequences of excessive alcohol consumption. Liver cirrhosis, renal diseases, and other longtime consequences should be discussed in schools and at home to prevent children from getting into contact with alcohol. The state has to regulate the opportunities to buy alcohol. There must be strict age restrictions in combination with more active clarification of the negative facts of alcohol consumption. Furthermore, the international community has to act in agreement to protect future generations from becoming alcohol addicts.

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See Also: Abuse and Neglect; Adult Education Programs and Services; Alcohol and Substance Abuse Services; Behavioral Health Disparities for Racial and Ethnic Minority Populations; Children of Substance Abusers; Children With Special Needs; Health Care Delivery, Models of; Health Care, Disparities in; Health Insurance; Health Promotion Services; Medical Necessity; Youth Risk Behavior Surveillance System.

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Alloparenting, Cultural Aspects of

The term *alloparenting* originated in a sociobiological context and was coined in 1975 by the evolutionary biologist Edward O. Wilson. The word *alloparent* comes from the Greek root *allo*, which means other, and the Latin root word *parens*, which means parents. Wilson paired these two words to designate any person other than the biological mother or father who cares for a child an “allocare,” or “other parent.” In the field of human services this type of parenting is called alloparenting. Alloparenting is defined as being part of a parenting system in which individuals other than the actual parents act in a parental role to children who are not their own. In Western culture this largely refers to grandparents and siblings.

About a decade prior to the word’s derivation, British geneticist William D. Hamilton proposed that as part of the parenting process, individuals who are not biological relatives should help parents by taking on parental roles when the benefits to children who receive this form of child care outweigh the costs. From this theory, he coined the term *Hamilton’s rule*, which is often preferred to “allocare” because it is a better description of child care by individuals other than relatives. The individual who typically takes on this parental role is a relative, but this is not always the case.

Why Provide Allocare?

The concept of acting as a parent to a child that is not one’s own can seem like a waste of time to some; moreover, the logic of alloparenting can seem maladaptive, and sometimes it is. To some people it makes more sense to have a family of their own; however, research shows that despite these assumptions, the human species continues to show the opposite behavior.

When examining the reasons why an individual would choose to provide allocare it is important not to assume the act of alloparenting is always an altruistic behavior—a genuine act of good for the welfare of the child. Alloparents can have ulterior motives for choosing to care for children who are not their own, such as the hardwiring of the brain to display this type of care for others, or being driven by emotions that stimulate self-interest (education and play, reciprocation, and genetic interest). Research suggests that often young, childless women will spend time around mothers looking for an opportunity to have contact with their children. This can be seen as an opportunity for an immature individual to have a chance to “practice” mothering. Some provide allocare with an expectation of reciprocation, which may create positive social bonds within the social unit.

Finally, children who receive alloparenting may benefit more than their nonalloparented counterparts. Rather than being guarded from danger or harm, children can be exposed to caretakers who are invested in their well-being. This also provides the child with exposure to a variety of individuals, which may demonstrate what is and is not acceptable behavior from a parent.

Cross-Cultural Perspective

Several cross-cultural studies have looked at the effects of alloparenting. Studies have shown that multiple allocarers are a common feature in many societies and this form of parenting appears to work. Western culture, however, is not as certain about this. Some research challenges this notion and states that children who spend more time in child care (cared for by multiple people) are more likely to display more aggressive and antisocial behavior when attending elementary school. On the other hand, children who spend more time in child care can demonstrate higher levels of cognitive functioning and linguistic development.

Although the evolutionary evidence may suggest otherwise, the North American and European psychological and social welfare literature is focused on the nuclear family as a support system. The nuclear family includes the biological mother and father, children, and sometimes grandparents. Conventionally, Western culture makes assumptions about how biological parents should parent their children, and society as a whole is likely to negatively judge any pattern in parenting that does not include the biological parents. This causes all kinds of agonies for biological parents and nuclear families.

When examining the culture of alloparenting—if it exists—several factors to consider include, but are not limited to: socioeconomic status, age, family size, and education. The extent to which alloparenting may or may not take place can be determined by some of these factors. For example, someone living in a household with several children, step-children, grandparents, and sometimes even grandchildren might have another adult relative take care of the small children. This can be because of the biological parents' minimal income, work schedules, or minimal parenting skills.

As a final note to alloparenting, there is not one "right" way to provide parental or alloparental care. Instead biological parents and other caregivers integrate a variety of approaches and methods that are dependent on specific cultural, economic, and ecological conditions. Many authors write about approaches to parenting that are better or worse than others, and while this may work well in one context or for one family, it may not work well for another. One of the most important things to consider in the field of human services is the long-term well-being and health of individuals and their family system. Finally, the biggest challenge in understanding alloparenting across cultures is not to alter different perspectives—if they exist—but to find ways to wade through transitions and different understandings while being aware of one's own.

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See Also: Cultural Competence, Human Service Providers and; Kinship Care; Kinship Care, Cultural Aspects of; Parenting Styles, Cultural Differences in.

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Alternative Medical Systems

Academic medicine is no longer the only way to treat people who are suffering from pain or chronic diseases. A growing number of men and women prefer to use alternative medical systems to cure or palliate their illnesses. Some of these alternative medical systems, like ayurvedic or traditional Chinese remedies, have their origins in Asia; some, like homeopathy and naturopathy, were established in Europe. No matter where these systems originated, more and more patients are willing to use alternative treatments to get rid of their pain. For this reason, it is not strange that these systems are a growing factor in the medical field in Europe and the United States. In general, all of these methods are regularly used because they are meant to heal the body by using the body itself or natural essences. All of the aforementioned alternative systems are traditional ones, but each has its own origins and methods. Despite their diversity, all alternative systems can look back on a long tradition.

Ayurveda

The ayurveda medical system can be traced to ancient India, where it was developed. Today it is widely used in India, Nepal, and Sri Lanka, but there is a growing Western community whose members prefer this form of Indian medicine to the academic one. According to ayurveda theory, there are different energies and temperaments, the so-called three *doshas* (*vata* for wind, *pitta* for fire, and *kapha* for earth), for each part of the body. If the balance of these three body-influencing factors is disordered, a person will become sick. The ayurveda medical system aims to renew the balance of these three *doshas* to cure the illness. To achieve this goal, ayurveda massages, a special diet, spiritual yoga, and the healing abilities of medical plants can be used. Regarding the diet and medical plants, ayurveda practices have some overlap with the traditional Chinese medical system.

Traditional Chinese System

As the name makes obvious, this medical system was developed over the last two and a half millennia in China. It was used in one form or another throughout eastern Asia, especially in Vietnam, Korea, and Japan, where special variants of the Chinese system are still in use. The patient is cured by a mixture of different methods, which in combination should strengthen the body‘s *qi*—the most basic substance of which the world is composed. In addition to medicine, acupuncture; moxibustion; massages like shiatsu, *qi gong*, or tai chi; and a special diet are used to cure several diseases. The Chinese traditional system uses hundreds of different substances as medicines, including parts of snakes and other animals, minerals, or medical plants that are able to help the patient if they are used in the correct way, for the right disease, and in combination with other methods. In contrast to the Chinese medical system, which involves curing with a combination of substances, homeopathy uses another method of healing.

Homeopathy

This medical system was invented by the German doctor Samuel Hahnemann (1755-1843) and was published as early as 1796. Hahnemann wanted to cure diseases using medicine that had similar, harmful elements to the patient’s disease. His basic belief was *similia similibus curentur*—“likes are cured by likes”—and this philosophy is still used for the creation of homeopathic medicine today. Homeopathic medicines are chosen for their influence on healthy persons, as these treatments arouse the same symptoms of an ill person. To select the correct medicine, Hahnemann created medical tables that provided special medicines for each disease.

To create homeopathic medicine, the fundamental elements are potentized (usually using the proportion of 1 to 10 or 1 to 100) repeatedly, using water, ethanol, and sugar found in milk. This process was vital, because many substances were poisonous in their original form. Supporters of academic medicine criticize homeopathy because most of the elements are not traceable after the process of potentialization; but many people continue to buy and use homeopathic medicine because they believe in its effects. There are definitely cases when this kind of medicine can help the patient.

Naturopathy

Other alternative medical methods include the Asian variants that are used by naturopathy, which aims to activate the self-healing ability of the body. This should be done using natural medicines or impulses, like sunlight, fresh air, movement, relaxation, water, earth, controlled breathing, and even emotions or one’s own will. All these impulses are able to influence the body‘s healing process. During this process, natural medicine made of plants is used as an additional element of treatment. The definition of treatment is not always exact, which makes it difficult to determine the naturopathy needed for each individual case because there are similar therapies used by other systems that could be defined as naturopathy. The pioneer of this field was Christoph Wilhelm Hufeland (1763-1836), a German physician who made the first experiments with naturopathy. Today there are different methods of naturopathy such as hydrotherapy, diets, or aromatherapy, which can be helpful in treating different ailments.

Growing Popularity of Alternative Medical Systems

All of the aforementioned alternative medical systems are popular today. More and more people are doubtful about academic medicine, which is why a growing number of patients are asking for an alternative method of treatment. There are research centers for alternative systems, especially for the Asian traditional systems used by Western physicians. As a consequence of the ease and locality of different alternative systems, people tend to try these new forms of medicine. Many hospitals and health resorts currently offer both academic and alternative medical systems. People have to decide which medical treatment is most suitable, because some people may be cured by alternative methods, while others do not believe in their success. Because of human diversity, human services professionals, and especially medical service providers, need to be open to alternative approaches, originating from a range of cultural heritages, that can be used for traditional and alternative medical systems in Asia and Europe.

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See Also: Health and Sickness, Differing Attitudes Toward; Health as a Human Right; Health Care Delivery, Models of; Medicaid; Medical Necessity; Medical Social Workers, Racial and Ethnic Issues for; Medical Supplies, Access to; Medicare; Outpatient Medical Care; Pain Management; Public Health.

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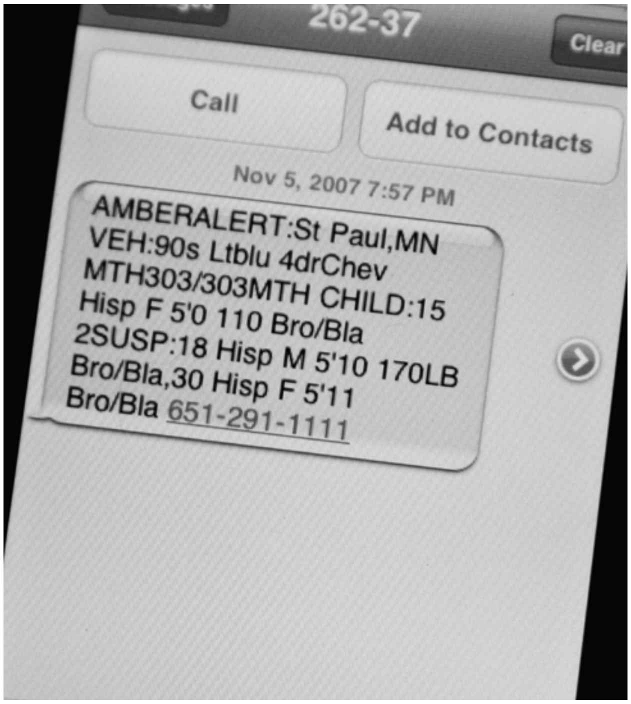
AMBER Alert

AMBER Alert is a human services instrument that aids families and law enforcement agencies in diverse communities and nations in order to find missing children whose lives are in danger. In addition, public programs of AMBER Alert have made use of diverse disciplines in order to improve the programs as well as investigate child abductions through establishing working teams that include law enforcement, legal agencies, social services agencies, communications, emergency management personnel, and others. Even though communities and nations have their own versions of AMBER Alert programs, they seek the same goal and follow the same basic practices, having been adapted from a sample that was developed following a tragic event that occurred in the United States.

Amber Hagerman, a 9-year-old girl, rode her bike near her home in Arlington, Texas, in 1996, when a stranger in a black pickup truck abducted her. The stranger killed Amber and dumped her body in a drainage ditch near her home. Amber's abduction and murder horrified parents, and soon elected officials and policy makers responded. Amber's killing prompted public discussions about whether an emergency alert system might have saved her life. Local broadcasters and police in Dallas, Texas, implemented the AMBER Alert Plan a year later. AMBER was soon adopted and spread across Texas and throughout the United States. The AMBER Alert Plan diffused across national borders and spread to Europe and Australia, among other places, and many countries retained the name: the AMBER Alert Plan.



Nov 5, 2007 7:57 PM

AMBERALERT:St Paul,MN
VEH:90s Ltblu 4drChev
MTH303/303MTH CHILD:15
Hisp F 5'0 110 Bro/Bla
2SUSP:18 Hisp M 5'10 170LB
Bro/Bla,30 Hisp F 5'11
Bro/Bla 651-291-1111

In addition to television and radio stations, AMBER alerts are now redistributed over the Internet and via wireless to specific targets such as cell phones and e-mail accounts.

The program's objective is clear: rescue abducted children whose lives are in danger. The AMBER Alert Plan activates an early warning, public dissemination campaign through AMBER Alerts transmitted over communication networks. The AMBER Alert Report issued by the National Center for Missing and Exploited Children (NCMEC) reported in 2011 that the system saved hundreds of lives. A few research studies to date have investigated the effect of AMBER Alerts on abducted children's rescue operations.

AMBER Alerts operate on the premise that public notification mobilizes people by increasing citizens' hypervigilance and likelihood of reporting tips that assist in the rescue of children within the first critical hours after abduction. M. K. Brown and colleagues found that a majority of murdered children are killed within the first critical three hours. Authorities argue that as time passes after the abduction, the likelihood of a successful recovery decreases. Research supports authorities' argument: homicide investigations of abducted children stress action within the first three hours after abduction to increase the likelihood of recovering these children.

The American version of the AMBER Alert Plan, known as America's Missing: Broadcast Emergency Response, was codified into federal law by the 2003 Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today (PROTECT) Act. Endorsed by federal law, AMBER Alert plans operate by local, regional, and state governmental agencies through AMBER Alert communications networks. The coordination of AMBER Alert planning was provided by the U.S. Department of Justice (DOJ) (see http://www.amber-net.org; http://www.amberalert.gov) in cooperation with the NCMEC, which serves as a national resource center and information clearinghouse on missing children.

The criteria recommended by the DOJ for issuing an AMBER Alert include law enforcement agencies' belief that an abduction of a child aged 17 years or younger has occurred and that a child faces imminent danger of serious bodily injury or death. There must be sufficient descriptive information on the victim and incident in order to help receive citizen tips. The AMBER Alert system broadcasts on alerts on television and radio stations and relies on the coordination between voluntary broadcasters and law enforcement agencies. Television and radio broadcasts and electronic highway signs are a main source for the public notification of the most serious child abductions. Alerts are redistributed through the Internet and wireless devices to specific targets, like truck drivers in specific areas, e-mail accounts, and cell phone and other wireless consumers.

An AMBER Alert may be issued by law enforcement on a state, regional (multiple counties), or local level as well as multiterritorial levels. The geographic area of an alert is determined based on law enforcement's investigation. Law enforcement agencies empower the AMBER Alert Plan. Thousands of police agencies across America gather information and respond immediately to locate a child. A rapid and public response to abduction frequently increases scrutiny of an abductor. Some abductors have felt the pressure of public scrutiny and released the child or surrendered to law enforcement.

Some evidence indicates the success of the AMBER Alert program, but scientific studies are lacking. A majority of success stories usually do not include life-threatening circumstances: abduction by a noncustodial parent. A rapid recovery of an abducted child has not been shown to be a direct effect of AMBER Alerts. Research indicates that life-threatening child abductions are rare, and that law enforcement agencies overuse the alert system.

Questions about AMBER Alert's effectiveness remain: (1) Do alerts mobilize the public to action? (2) How does public mobilization occur? (3) Are stunned bystanders able to process sufficient information to initiate an alert and convey accurate information about a victim and perpetrator? (4) Does the public feel sufficient empathy to report their sightings of an allegedly abducted child? (5) Does overuse of the alert system adversely affect the chance of recovering abducted children? (6) Are there potentially effective alternative strategies and approaches for the public dissemination of information about child abduction? These questions await answers, and until then, the AMBER Alert Plan remains active in the unfortunate cases of child abduction.

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See Also: Abduction; Child Protective Services; National Center for Missing and Exploited Children.

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American Academy of Social Work and Social Welfare

The formation of the American Academy of Social Work and Social Welfare (AASWSW) was announced on Friday, November 6, 2009. This milestone development resulted from years of planning and discussion among professional social work organizations, which included mostly the Saint Louis Group and the Council on Social Work Education. The academy is viewed as a mechanism that will enable the profession of social work to better respond to the growing demand for vigorous circumspection that can guide effective human services policies, programs, and practices.

The academy is an honorific society. Membership in the society is composed of distinguished practitioners and scholars in the field of social work and social welfare who are dedicated to achieving excellence through high-impact work that advances social good. The academy's board of directors is responsible for developing a process to solicit nominations and make the selection of new fellows. The board also provides oversight of the business operations of the academy that promote its success and sustainability. Included in the board's vision is that the academy will strengthen social work's capacity to provide benefits to the wider society.

The academy was established to perform the following functions:

- Encourage and recognize outstanding research, scholarship, and practice that contribute to a sustainable, equitable, and just future
- Inform social policy by serving as a frontline source of information for the social work profession as well as Congress and other government agencies and nongovernment entities charged with advancing the public good
- Promote the examination of social policy and the application of research to test alternative policies, programs, and practices for their impact on society
- Celebrate excellence in social work and social welfare research, education, and practice

As an independent entity, the academy is registered with the state of Ohio with a virtual office located at the Mandel School of Applied Social Sciences of Case Western Reserve University in Cleveland. The commitment of the academy to social work as a profession and to social welfare from a policy perspective is influenced by a history of social welfare development in the United States.

The Academy and Social Work Profession

Among the motivations for the formation of the academy is the dedication to achieving excellence in the field of social work and thereby contributing to the reduction of societal problems. The profession of social work was born of a desire to provide needful human services to those without resources of recompense. Social work aims to ameliorate social problems. Social workers respond to the problems that hinder optimal functioning for individuals, families, groups, organizations, and communities. A challenging profession, social work helps people address such problems as poverty, marital conflict, parent-child conflict, delinquency, health and mental issues, substance abuse, and abuse and neglect.

Social work can be said to have originated in ancient times, when all major religions encouraged people to help the poor. Therefore, social work began thousands of years ago, when human beings started to perform charity work. Modern U.S. social work has its roots in the mass migrations of the 19th century and the Industrial Revolution era that led to a number of social problems in England and the United States. Jane Addams was one of the first social workers in the United States, who in 1889 with Ellen Gates Starr founded a settlement house in Chicago, called the Hull House, to work with the poor and immigrant communities. Modeled after the Toynbee Hall settlement house in London, Hull House utilized a family focus and advocacy approach to influence the community to correct the dolorous social conditions under which the poor were living. The influence of the Charity Organization Society and the settlement movement sparked the beginning of modern U.S. social work, which is regarded as one of the most efficient and effective practices in the world.

The Academy and Social Welfare

The academy is dedicated to performing actions that influence social policy and the social welfare system and contribute to a sustainable, equitable, and just future. Social welfare encompasses those goods and services that are collectively believed to fulfill the social, economic, health, and recreational needs of everyone in a society. The history of social welfare in the United States began long before government welfare programs were created. The British Elizabethan Poor Law of 1601 was imported to the American colonies. This legislation was the major codification dealing with poor and disadvantaged people in England and became the basis for dealing with the poor in colonial America.

Prior to the 1850s, most social services in the United States were delivered by religious organizations, family-based groups, and private charities. During the 1850s and 1860s, the federal government established the Freedman's Bureau. Many mental asylums, orphanages, and poor houses were also established at the state level. In 1862, a Civil War pension was created for veterans and their families. The history of modern American social welfare began with the stock market crash in 1929, and the resulting Great Depression of the 1930s.

During the depression, millions of people suffered from extreme hunger and poverty. People lost all of their savings and means of income, and many resorted to looting and violence to feed themselves and their children. More than 31 million single mothers, people with disabilities, and the elderly were starving. There was unusual turmoil, unrest, and a heightened amount of criminal activities. President Franklin D. Roosevelt proclaimed a New Deal in 1933, which established numerous major social welfare programs to address poverty and unemployment. In 1935, the Social Security Act was enacted. In 1996, under President Bill Clinton, the Aid to Families with Dependent Children (AFDC) portion of welfare benefits was replaced with the Temporary Assistance for Needy Families (TANF).

The American Academy of Social Work and Social Welfare, through its membership of accomplished scholars, provides leadership and gatekeeping through research, education, and practice. The academy is committed to strengthening the safety net for American people, families, and communities.

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See Also: *Code of Ethics* of the National Association of Social Workers; Council on Social Work Education; International Federation of Social Workers; Social Welfare Policy, Cultural Competence in; Social Work, Diversity Practice in; Social Work Practice and People of Color; Social Workers.

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American Correctional Association

The American Correctional Association (ACA) is the world's oldest and largest international correctional association. Representing and serving all disciplines within the correctional profession for more than 140 years, the ACA has championed the cause of corrections and correctional effectiveness. ACA serves as a comprehensive resource that can assist with a broad spectrum of correctional services, including professional development, networking, consulting, employment, certifications, standards, accreditation, publishing, research, technology, testing, and conferences. The ACA has a constitution and bylaws, a code of ethics, and a set of general operating principles.

ACA professional membership is composed of individuals, agencies, and organizations involved in all aspects of corrections, including adult and juvenile services, community corrections, probation, parole, and jails. Adult and juvenile correctional facilities, jails, and corrections programs throughout the world are accredited based on compliance with standards established by ACA's Commission on Accreditation for Corrections. The standards are used widely by correctional practitioners and administrators and address all aspects of confinement, housing, health care, supervision, and professional training. In 2013, the ACA had approximately 20,000 individual members in the United States, Canada, and other nations, and included approximately 75 chapters and affiliates representing other countries, states, provinces, regions, and professional specialties. The association also has 20 standing committees and 18 ad hoc committees that help achieve its vision and mission. Each year at its winter and summer conferences the association presents awards to recognize professionals who have dedicated their careers to ensuring the integrity and vitality of the corrections profession. The association also maintains an active job bank accessible from its Web site, http://www.aca.org.

The American Correctional Association has a vision statement, a mission, and eight goals that were approved by its Delegate Assembly at the 132nd Congress of Corrections in 2002. The vision statement is: "The American Correctional Association shapes the future of corrections through strong, progressive leadership that brings together various voices and forges coalitions and partnerships to promote the concepts embodied in its Declaration of Principles." The mission is: "The American Correctional Association provides a professional organization for all individuals and groups, both public and private that share a common goal of improving the justice system." The eight current ACA goals relate to the following areas: (1) expanding membership; (2) promoting diversity; (3) providing professional development opportunities; (4) ensuring the integrity of standards and accreditation processes; (5) collaborating on research and education activities; (6) promoting a positive public perception of corrections; (7) developing international relations; and (8) promoting ethics within the justice profession.

The American Correctional Association's current constitution and bylaws were approved and implemented by its membership in August 2013. The constitution and bylaws provide guidance, goals, and a sense of the spirit that drives the association. These materials reflect 143 years of revisions, changes, and challenges, documenting shifts in perceptions and policies while remaining true to the association's values.

History of the Association

Founded in 1870 as the National Prison Association (NPA), the American Correctional Association is the oldest association developed specifically for correctional practitioners. In 1907, the NPA was renamed the American Prison Association (APA). At the 1954 Congress of Correction held in Philadelphia, Pennsylvania, the name of the APA was subsequently changed to the American Correctional Association to reflect the expanding correctional philosophy and the organization's increasingly important role within the community and society as a whole. During its first organizational meeting in 1870, the ACA assembly elected Rutherford B. Hayes as the first president of the association. At that time Hayes was governor of Ohio, and he was later elected the 19th president of the United States. ACA developed its Declaration of Principles at its inaugural meeting in 1870; this document went on to become the correctional guidelines used in the United States and Europe. Successive generations of corrections practitioners revised the principles in 1930, 1960, 1970, and 1982.

The American Correctional Association believes that the principles of humanity, justice, protection, opportunity, knowledge, competence, and accountability are essential to the foundation of sound corrections policy and effective public protection. Guided by its Declaration of Principles, the ACA seeks to benefit from the heritage of the past, plan and prepare for the future, and lead and serve the correctional profession.

The ACA's principle of humanity asserts that, "the dignity of individuals, the rights of all people, and the potential for human growth and development must be respected." The principle of justice states, "Corrections must demonstrate integrity, respect, dignity, fairness, and pursue a balanced program of humaneness, restoration, rehabilitation, and the most appropriate sanctions consistent with public safety."

The protection principle maintains, "Corrections has a duty to ensure the protection of the public, offenders under corrections supervision, corrections workers, and victims and survivors of crime." The principle of opportunity affirms that, "Corrections is responsible for providing programs and constructive activities that promote positive change for responsible citizenship."

The knowledge principle states, "Corrections must be committed to pursuing a continual search for new knowledge, technological advances, and effective practices that strive toward excellence and positive change." The principle of competence stipulates, "Corrections administrators, supervisors, and line employees must be professionally competent and committed to conducting their responsibilities in accordance with professional standards." The accountability principle asserts, "Corrections officials shall ensure accountability in regard to the treatment and management of offenders, selection and performance of staff, and the interface with the community and victims."

Because ethical conduct is paramount in the corrections profession, ACA established a Committee on Ethics. In August 1994 the Board of Governors and Delegate Assembly formally adopted the ACA's Code of Ethics.

The American Correctional Association works to shape public policy on correctional issues in a manner consistent with its' founding principles, constitution and bylaws, vision statement, public policies, and resolutions. The Government and Public Affairs Department (GPAD), in partnership with the Legislative Affairs Committee, develops the association's position on public policy issues and represents the association before Congress, federal executive agencies, state and local governments, advocacy and interest groups, the media, and the general public. GPAD is responsible for monitoring, tracking, and analyzing legislative activity for the association and disseminating information to policy makers, advocacy groups, and the media as well as ACA members.

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See Also: Community Corrections; Jail Diversion Programs for Children and Adolescents; Juvenile Justice System; Prisoner Reentry Programs; Probation and Parole Officers.

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American Indian Movement

The American Indian Movement (AIM) emerged in the summer of 1968. Months earlier, on April 4, Martin Luther King Jr. was assassinated in Memphis, Tennessee. A few days later, on April 11, President Lyndon B. Johnson signed the Civil Rights Act of 1968. Senator Robert F. Kennedy was assassinated in June. Amid this atmosphere of unrest and demands for social change, Dennis Banks and George Mitchell organized a meeting to discuss the issues faced by American Indians. The meeting would launch a civil rights movement that focused national attention on the discrimination and injustice faced by American Indians.

Initially AIM focused on local police brutality and later expanded its goals to include treaty rights. The group participated and organized several occupations, most notably a 71-day standoff at Wounded Knee, South Dakota. With AIM's increased visibility, frustrated family members of Indian victims approached the group for assistance in seeking truth and justice. AIM filled the void when tribal councils and the U.S. Bureau of Indian Affairs (BIA) did not intervene. Today, AIM is still engaged in promoting Indians' rights, spirituality, education, leadership development, and sovereignty in urban areas and on reservations.

The Beginning

On July 28, 1968, a community meeting took place in the basement of a rundown church in the American Indian ghetto in Minneapolis, Minnesota. Dennis Banks and his friend from boarding school, George Mitchell, organized the meeting to discuss concerns of American Indians. The two organizers shared the experiences common to their generation. At that time, Indian children were forced to attend white boarding schools and forbidden to retain their traditional ways of life (in today's view, a form of cultural genocide). BIA agents bused these children away from their familiar homes and communities. At the boarding schools, Indian children had to learn white people's language and culture, yet they later found they were blocked from securing good jobs. For example, Banks held various minimum-wage jobs and barely got by. In May 1968, he was just released from the state prison at Stillwater. The original charge was stealth of 16 bags of groceries to feed his family of 10. He had been sentenced to five years imprisonment, whereas a white accomplice had received two years of probation. His experience was a microcosm of American Indians' lives: desperate poverty was rampant, unsanitary housing conditions were the norm, health care was lacking, unemployment was chronically high, and alcohol-related arrests were common.

During the 1960s, when American society was experiencing social and political unrest (e.g., the civil rights movement, protests against the Vietnam War, student strikes), Banks questioned: What were the roles of American Indians amid the waves of citizens' calls for change? This question was the reason he decided to organize a community meeting. He hoped to have 40 to 50 attendees, however, nearly 200 people showed up. Clyde Bellecourt was present at the meeting, as were Mary Jane Wilson, Eddie Benton-Banai, Harold Goodsky, Francis Fairbanks, Girlie Brown, and others. Banks, Bellecourt, and Benton-Banai had all served time in the state prison at Stillwater for various charges. The Minneapolis American Indian community was ready for an Indian rights organization to address concerns and seek solutions. AIM was born, and AIM Patrol was formed to protect local Indians from police brutality and racist treatment. Bellecourt was the first chairman of AIM and Banks the first field director.

Police brutality in Minneapolis came in the form of a manhunt of Indians based on a quota system. The police arrested about 200 Indians every week. Every Saturday night at 10 o'clock the police would raid two Indian bars and arrest the customers for drunk and disorderly conduct. The "lawbreakers" would be ordered to work without pay as punishment for their "offense." Only when the work was completed would the free laborers be released from the workhouse, farms, or city projects. The Indians made up about 1 percent of the state population, yet they were overrepresented in the state's incarcerated population (more than one-third of prison inmates were Indians). In addition, one-third of American Indians in Minnesota resided in the city slums of Minneapolis (most of them were from the Anishinabe tribe). To make matters worse, the Minneapolis police chief denied his department engaged in racist practices.

AIM Patrol members were on a mission. They wore red jackets and drove red cars to pull drunken Indians from the bars and take them home before the police arrived. As a result, arrests decreased considerably. AIM Patrol also collected evidence of racist treatment and police brutality toward American Indians for the police chief's reference.

Expansion and Networking

In the two years after the initial meeting, AIM's membership grew to 5,000. In 1969, AIM expanded to Cleveland upon Russell Means's invitation. Months later, the Cleveland chapter of AIM was established and Means joined AIM. Then, Herb Powless requested to set up a chapter in Milwaukee. In five years, AIM had 71 chapters in the United

States and eight chapters in Canada. Hence, AIM expanded from its local focus to become an international organization.

With AIM reaching out beyond the city limits of Minneapolis, Banks started searching for and acquainting himself with Indian spirituality. This was a period of cultural and spiritual enlightenment for him and AIM's other young leaders. They were removed from their native cultures, and the cultural gap between Indian elders and youth was as wide as a gulf. Gradually, medicine men (spiritual leaders), sweat lodges, Sun Dances, sacred ceremonies, powwows, drums, and Ghost Dances were integrated with AIM activities. Spirituality, leadership, and sovereignty became the pillars of AIM.

AIM accomplished several firsts for American Indians. The organization was responsible for creating the first Indian Health Board in Minneapolis (1969), which provided direct health care; the first Legal Aid Society (1970); an Indian housing and moving program; a radio station, KUXL, which broadcast programs on Indian issues; and the first alternative schools for Indian children—the Red School House in St. Paul, Minnesota, and the Heart of the Earth Survival School in Minneapolis (1972). In addition, the Indian Education Act was adopted in 1972; Title IV of this law provides a legal foundation that Indian education should be based on Indian culture and a culturally sensitive curriculum. American Indians desperately wanted their own survival schools rather than having to attend white boarding schools. At the time, this goal was unique and contradictory to the ongoing desegregation and busing in American public schools.

First Exposure

On November 9, 1969, Richard Oaks and 40 members of the Bay Area Council of American Indians (CAI) landed on Alcatraz Island, an abandoned federal property. Among them were Means, his father, his cousin Madonna Gilbert/Thunderhawk (Oglala Lakota), and Belva Cottier (Lakota). Means grew up around the San Francisco Bay area of California. His family had been relocated from South Dakota via the federal relocation program. On November 20, 1969, 90 more American Indian students (including two informants for the Federal Bureau of Investigation) joined the original group to live on Alcatraz for 19 months. The occupiers called themselves Indians of all tribes in honor of the more than 56,000 Indians from various tribes who supported their action.

The Indians on Alcatraz sought to set up an Indian culture center. Means, Mitchell, Bellecourt, and other AIM members stayed on the island for a few days to show their support. It was there that Banks met John Trudell, who would become AIM's chairman in the 1970s. Hollywood stars Jane Fonda, Marlon Brando, Anthony Quinn, and Candice Bergen visited the island during the occupation, as did Federal Bureau of Investigation (FBI) informants and infiltrators. Eventually the occupiers were removed on June 11, 1971.

The occupation of Alcatraz raised political awareness and helped empower American Indians. Although it ended without success, its symbolic meaning influenced subsequent local and regional occupations. It also prompted AIM to take on the issue of reclaiming tribal lands under the Treaty of Fort Laramie (the Sioux Treaty of 1868). The post-Alcatraz occupations that AIM organized included the takeovers of an abandoned naval station at the Minnesota/Saint Paul International Airport, an abandoned Coast Guard station on Lake Michigan, Mount Rushmore (1970), and Plymouth Rock in Boston. The latter gained national news coverage of AIM. However, it was the occupation of the BIA building that put AIM in the spotlight of national and international attention.

The Occupation by Chance

The occupation of BIA had not been planned. AIM had organized The Trail of Broken Treaties march to Washington, D.C., before the presidential election in November 1972. AIM leaders (including Leonard Peltier) planned to give presidential candidates The Twenty Points, a list enumerating issues of concern to American Indians. Three caravans (from Seattle, Las Angeles, and Oakland) drove through reservations in different states to pick up followers en route to Washington. After more than 300 people and 85 cars arrived at the Capitol Building during the predawn hours on November 2, 1972, they were faced with broken promises from the federal government, which had previously agreed to arrange escorts, accommodations, and meetings. Instead, the marchers were rushed to a rundown place infested with rats and having no heat, beds, or food.

Gradually, they moved out and gathered at the BIA building. Some found the cafeteria inside the building and started cooking meals to feed the group. BIA Commissioner Louis Bruce (half Sioux and half Mohawk) did not take part in the demonstration, but he agreed with many of its goals and he stayed inside the building with the protestors for 24 hours. (His actions led him and two other top BIA officials to be fired in December 1972.) When riot police tried to remove protestors from the building, the latter, armed with office furniture, fought back to push the police out to the streets. The protesters then sealed the building.

It was during the seven-day occupation that AIM members found BIA files revealing the widespread involuntary sterilization and other abuses of American Indians. Means, with his cousin Madonna Gilbert/Thunderhawk, collected 1.5 tons of these files. Finally, high-ranking governmental officials agreed to hold meetings and negotiations with AIM leaders and to provide travel money for protestors to return home. But the entire group had to wait until the day after the election to leave Washington.

Troubled Waters

After returning from Washington, AIM refocused its attention to the state of South Dakota. The Indians' relationships with whites in Rapid City were tense; the son of Sarah Bad Heart Bull (Lakota) was stabbed to death and his white killer charged with only involuntary manslaughter; and the Pine Ridge Indian Reservation was at a boiling point after a failed attempt to impeach tribal chair Dick Wilson, whose opponents claimed was corrupt and abusive. Older tribal women, many of whom lost their children or grandchildren during Wilson's rule, asked AIM to discuss the situation. In February 1973, Banks, Means, and other AIM members arrived at Pine Ridge. The women suggested occupying Wounded Knee (the site of a historic Indian massacre in 1890) near the reservation to protest tribal governance and the federal government's failure to comply with treaties it had negotiated with the Indians. U.S. Marshals and the FBI cordoned off the area. A 71-day standoff and armed conflict pitting the occupiers against U.S. law enforcement agents followed. The siege ended on May 8, 1973. A total of 565 occupiers were arrested and tried in federal court. After an eight-month trial, they were acquitted of wrongdoing in 1974 because of the FBI's unlawful handling of witnesses and evidence. Peltier was sentenced in 1977 for killing two FBI agents on the reservation during the occupation.

Living conditions at the reservation worsened after the occupation. Wilson's private army became a death squad. Killings of AIM supporters continued. In February 1976, Anna Mae Pictou Aquash, an AIM activist from Canada, was found dead in an execution-style murder. Her death commenced a lengthy dispute among AIM leaders regarding who killed her.

Later Years and Division

In February 1978, Banks organized the Longest Walk from San Francisco to the Capitol Building to protest proposed legislation calling for the abrogation of

After a five-month march from San Francisco to the National Mall in Washington, D.C., in 1978, a tepee is placed at the National Mall to symbolize threats to tribal lands.

treaties with Indian nations. Protestors reached their destination five months later. A tepee was set up near the White House and became a symbol of the demonstration. The walk received much media attention and the proposed legislation was later defeated. In 1991, AIM organized the National Coalition on Racism in Sports and Media to challenge the use of Indian names of sports teams and Indian figures as team mascots without tribal approval. The following year, AIM staged a demonstration during Super Bowl XXVI, in which the opposing teams were the Washington Redskins and the Buffalo Bills.

In 1993, AIM split into two camps: AIM Grand Governing Council (AIMGGC) in Minneapolis, led by Clyde Bellecourt and his brother Vernon, and American Indian Movement of Colorado, led by Russell Means and Ward Churchill. Some believe the constant presence of FBI agents/infiltrators and informants deepened the internal divisions among American Indians and created dissension within AIM.

In 2008, Banks planned a second Longest Walk to commemorate the 30th anniversary of the original event. Although time and society have changed, the organization's historical and spiritual walks maintain the goal of promoting awareness of American Indians' concerns and unity. Today, AIMGGC focuses on leadership development, education, and spiritual practices through its annual events such as the International Youth and Elders Cultural Gathering and Sundance (in Pipestone, Minnesota) and Clyde H. Bellecourt Endowment Scholarship Fund and Awards Banquet (in Minneapolis, Minnesota).

Nearly 30 years after Aquash's death, both Arlo Looking Cloud, a member of AIM's security staff, and AIM member John Graham were indicted for murder in 2003. Arlo Looking Cloud was convicted the following year. During his trial, Kamook Nichols, Banks's former wife, was a witness and revealed she had been a paid FBI informant since 1988, wiretapping communications among AIM leaders and collecting information against the organization. Graham was convicted of felony murder in 2010.

Conclusion

AIM's grassroots activism and advocacy were instrumental in raising awareness of American Indians' fight for cultural integrity, identity, spirituality, respect, and strength. At times AIM was depicted as a militant group. However, it should not be forgotten that "warrior" and "patriot" have sacred meaning in the Native culture.

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See Also: Administration for Native Americans; Center for Native American Youth; Discrimination and Institutional Racism; Ethnic Diversity and Values; Ethnic Groups and Drug and Alcohol Use; Indian Boarding Schools; Indian Child Welfare Act; Indian Civil Rights Act of 1968; Indian Health Service; National Congress of American Indians; Native Americans; Native Americans, Suicide Among; Tribal Social Services; Tribal Sovereignty.

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Americans with Disabilities Act

The Americans with Disabilities Act (ADA) of 1990 is a nondiscrimination law that mandates the removal of physical barriers, discriminatory practices, and negative stereotypical attitudes as a means to promote greater social integration and equity for people with disabilities. The ADA serves a similar function as other nondiscrimination laws in terms of its desired outcomes; however, it differs in its approach by mandating that people with disabilities receive different treatment. The ADA defines a person with a disability quite broadly. Under the law three criteria must be met: an individual must have a physical or mental impairment that limits one or more major life activities, have a record of the impairment, and be regarded as having such an impairment. The ADA mandates employers and public and private establishments to provide reasonable accommodation to a person with a disability. Reasonable accommodation refers to making existing facilities readily accessible and usable by people with disabilities through the provision of assistive technology to improve communication and/or changes to the physical environment. The ADA addresses issues of access for people with disabilities through almost all areas of social life: the workplace (Title I), state and local government (Title II), public accommodations (Title III), and telecommunications services (Title IV). The ADA is important to the issue of diversity in human services because it identifies people with disabilities as a protected class and mandates their equal treatment.

Discrimination, Social Exclusion of People with Disabilities

According to the 2010 U.S. Census, 56.7 million (18 percent) of the population is living with a disability. People with disabilities are often the subjects of discrimination because of stigmatizing stereotypes, attitudes, and beliefs about their abilities. Stigmatizing attitudes and beliefs marginalize people with disabilities from full participation in society by denying them opportunities to go to school, participate in social activities, access affordable health care, and engage in meaningful work. This results in loss of human potential, income, and social participation among people with disabilities.

Disability has historically been defined through the medical model, which viewed disability as the result of individual dysfunction requiring medical intervention and rehabilitation. People with disabilities were only seen in terms of their disability, viewed as dependent on able-bodied society, and excluded from mainstream society, often in institutional settings. Segregating people with disabilities by removing them from society was seen as a necessity for the good of the individual and society. The civil rights movement provided the opportunity for people with disabilities to begin to question their unequal status in society. Key legislation, coupled with shifts in thinking about disability, changed the way that people with disabilities were treated. The Rehabilitation Act (RA) of 1973 and the Individuals with Disabilities Education Act (IDEA) of 1975 heralded the beginning of a shift in public policy that changed the way that people with disabilities were treated by the larger society. The RA mandated that people with disabilities could not be denied federal services or benefits, and for the first time recognized people with disabilities as a distinct class of individuals. The IDEA mandated early intervention, special education programs, and services for children with disabilities through public schools.

The independent living movement and the shift to viewing disability through a social model precipitated demands within the disability community for protections from discrimination in all areas of their lives. The independent living movement focused on asserting the rights and responsibilities of people with disabilities through self-determination. Self-determination refers to the rights of people with disabilities to identify their needs and control the actions to support them to live independently. The social model of disability views disability as a result of the limitations in the environment seen through societal attitudes and beliefs. These beliefs translate into stigmatization, limited opportunities, and environmental obstacles, which inhibit participation of people with disabilities in social life. Stigmatization is found in the way that people with disabilities are viewed as less than abled-bodied individuals because of their altered abilities. Limited opportunities for people with disabilities are found in educational and vocational prospects because of the way that both are constructed around an able-bodied ideal. Buildings built without accessible ramps preclude an assumption that people with physical disabilities do not need to enter them, thus environment obstacles exist for people with disabilities, which inhibit their participation in society.

The Americans with Disabilities Act

The purpose of the ADA was to protect people with disabilities from discrimination by addressing issues of access, which impact their inclusion into wider society. Title I of the ADA forbids employers to discriminate against a qualified applicant with a disability through job application procedures, hiring, termination, compensation, job training, and advancement opportunities. Title II covers the activities of state or local governments, such as providing public housing, licensing, education, transportation, parks and recreation, detention, emergency response, and police. Title III extends protections to public accommodations, such as restaurants, hotels, theaters, convention centers, retail stores, shopping centers, private schools, day care centers, office buildings, factories, and warehouses. Title IV covers all aspects of telecommunications.

Within each regulatory section provisions are made to ensure that people with disabilities receive services in integrated settings, and that unnecessary standards or rules that might deny a person with a disability equal opportunity to enjoy a program or service are eliminated, unless these standards are deemed necessary for the provision of the program or service. Integrated settings are defined as those that are located in mainstream society and provide individuals with disabilities access and opportunities to interact with nondisabled individuals through shared activities. Necessary standards are defined as safety procedures needed for the operation of the program that are based on actual risk and not on speculation, stereotypes, or generalizations about people with disabilities.

Entities under the ADA are also required to make reasonable modifications in policies, practices, and procedures to ensure that an individual with a disability is ensured equal access. Allowing service dogs into a government building as an exception to a rule that restricts animals from public areas is an example of a modification. Public and private entities must also ensure effective communication with individuals with disabilities through the use of appropriate auxiliary aids, new construction free of architectural barriers, and consideration of barriers when retrofitting existing buildings. Auxiliary aids are defined as services like qualified interpreters or devices such as assisted listening headsets, video-text displays, and large-print materials. These aids must be offered at no cost to the individual with a disability.

Under Title I, a qualified applicant is someone with a disability who, with or without reasonable accommodation, is able to carry out the essential job functions for which the job requires. Reasonable accommodation in this instance refers to having employers make existing facilities readily accessible and usable by people with disabilities. Restructuring job functions, allowing schedule changes, or reassigning a worker with a disability to another position are other examples of reasonable accommodations. Acquiring or modifying equipment or devices, training materials, and providing qualified readers or interpreters are other examples of reasonable accommodations. The ADA covers employers with 15 or more employees in both public and private sectors of the workforce.

Employers are not required to provide reasonable accommodation if they can demonstrate that doing so would incur an undue hardship. An undue hardship is described as any action requiring substantial exertion or expense in relation to other factors such as the employers' size, resources, or the nature and structure of the work. The Equal Employment Opportunities Commission (EEOC) is responsible for enforcing Title I of the ADA. The U.S. Department of Justice (DOJ) is responsible for enforcing Titles II, III, and IV of the law.

Impact of the ADA on People With Disabilities

Twenty years after the ADA was first enacted, its impact on the lives of people with disabilities has been uneven. While people with disabilities and advocacy groups point out that the law has been successful in changing some of the barriers to participation, they also point to the fact that people with disabilities are still not fully integrated into society. Consider that a recent survey by the Kessler Foundation and the National Organization on Disabilities found that people with disabilities are much less likely to be employed (21 percent versus 59 percent) or to complete college (19 percent versus 27 percent) than people without disabilities. People with disabilities are still more likely to be living in poverty compared to people without disabilities.

The ADA itself has been criticized for its broad definition of disability and limited scope. Disability is defined as something discrete within the ADA, when in fact it is not. Some critics contend that people with disabilities are a heterogeneous group as variations within and across disabilities render disability an individualized experience. Intersectionality with other identities such as gender, class, race/ethnicity, sexual identity and orientation, and religious affiliation will also interact with disability to produce different social experiences and outcomes. The scope of the ADA has also been challenged, with some critics contending it does not do enough to address access issues related to health care for people with disabilities. Accessing adequate health care has been found to be a significant issue for people with disabilities because of the provisions of private and public health insurance regarding income requirements, service caps, and preexisting conditions.

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See Also: Accommodation; Assistive Technology; Deinstitutionalization; Disability Services; Individuals with Disabilities Education Act; Reasonable Accommodations.

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Americans with Disabilities Act of 1990

The Americans with Disabilities Act (ADA) has long been considered a crucial step in the acquisition of equality for persons with disabilities. The federal statute passed in 1990 mandates that action be taken by employers, public and private entities (including educational institutions), transportation providers, and communication companies so that otherwise qualified individuals have access to the same opportunities available for public use. The ADA also allows qualified individuals to file suit and seek protection against discrimination should these actions not be taken. Since its passage, debates by disability activists and scholars have been fueled by court interpretations that lead to varied applications of the law. Protection under the statute is determined by a three-prong evaluation, and the language used by the ADA's original framers ensures its flexibility as well as the reasons for differing opinions on the intentions of the law.

Protection Under the ADA

The ADA allows legal claims to be made by "qualified individuals with disabilities" who seek action against public entities that have excluded or mistreated them in some way. In order to receive the protection of the ADA, a person must meet one of these criteria: (1) have an impairment that severely limits a major life function; (2) have a record of such impairment; or (3) be perceived as having such impairment.

Framed after both the Civil Rights Act of 1964 guaranteeing nondiscrimination on the basis of race, gender, religion, or national origin, as well as the Rehabilitation Act of 1973, which was written to prevent work- and education-related discrimination against "handicapped persons," the ADA expands the goals of those two acts by subdividing the statute into five titles, each covering unique aspects of public engagement, as well as including specifications regarding public transportation and the provision of telecommunication devices for the deaf (TDD) in Titles II and IV, respectively. The most commonly recognized applications of the law regard employment, education, and current construction practices.

Under the employment regulations (Title I), the law provides an otherwise qualified individual access to fair employment and requires entities to make what the statute refers to as reasonable accommodations in order to grant such access. This may be achieved by providing an alternate workspace for a person who uses a wheelchair, or allowing a cashier with arthritis to take periodic breaks to sit down.

Public entities and public transportation are covered by Title II, which provides regulations for any entity that receives federal money to function. Because universities and public schools receive federal aid from the students admitted, the educational provisions are provided in this title and follow the reasonable accommodation standard as well.

Commercial spaces and public venues are the subject of Title III. This section of the ADA governs access to, for example, restaurants, religious institutions, and hotels. The architectural guidelines for public entities that make up the heart of Titles II and III require that new construction as well as any major renovations to existing construction taking place after 1992 must meet specific access requirements. Therefore, housing developments are required to grant leases to persons who use wheelchairs, and municipal buildings are required to have elevators and accessible entry points. Courts have generally upheld these requirements unless the defendant can show an undue hardship—that it would be unreasonably expensive or harmful to comply with the requirements.

As part of the 20th anniversary celebration of the signing of the ADA, representatives of the Paralyzed Veterans of America take part in a flag procession.

Finally, Title V of the statute provides further definition and clarification for the earlier titles.

Interpretation

Much of the flexibility of the statute exists in the interpretive value assessed within defining disability itself and the use of the key phrases "severely limits" and "major life function." As many scholars have noted, each of these phrases raise particular questions regarding the intentions of the original drafters of the law. The merit of a claim is based on the legal strategies deployed to satisfy these meanings, and on the courts' willingness to follow the precedent of other cases as well as the specific guidance set out by the U.S. Department of Justice and the Equal Employment Opportunity Commission (EEOC). Jurists, however, are not required to adhere to such guidance. Hence, the rulings that have been delivered follow predictable patterns only insofar as the jurists who deliberate them. The passage of the ADA Amendments Act in 2008 is meant to clarify some of these questions by providing further examples of what constitutes major life function.

Additionally, the preamble of the ADA states that at least 43 million Americans are living with some form of disability. It was the hope of the framers that these Americans be treated with the respect and given the opportunities that the general public is offered. However, logic suggests that each of these Americans will have differing levels of impairment and limitations. Therefore, it becomes reasonable that the law cannot assess all individuals with disabilities to be equal in terms of what the courts should provide for them. This has left many wondering if there is an implied hierarchy to resolutions under the ADA, and whether, for example, favorable outcomes are more common for certain impairments.

Lastly, because lawsuits can only be filed by individuals with disabilities and determinations are made on a case-by-case basis, debates continue regarding whether the ADA represents a law interested in the civil rights of the individual or has a wider and more comprehensive effect on public policy. Legal as well as policy decisions to date suggest that both are true.

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See Also: Administration on Intellectural and Developmental Disabilities; Americans with Disabilities Act; Children With Special Needs; Convention on the Rights of Persons with Disabilities, United Nations; Individuals with Disabilities Education Act; Reasonable Accommodations.

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Ansell-Casey Life Skills Assessment

The Ansell-Casey Life Skills Assessment (ACLSA) is a strengths-based measure of both tangible and intangible capabilities and behaviors generally viewed as important life skills for children ages 8 to 19. The measure assesses for both tangible (i.e., skills needed for daily living, self-maintenance, and obtaining and sustaining gainful employment) and intangible (i.e., skills needed for interpersonal relationships and for maintaining employment, such as decision-making, problem-solving, planning, communication, self-esteem, anger and grief management, and social skills) self-sufficiency and life skills. The measure was originally designed for youth in out-of-home placement care, but the ACLSA has been found to be appropriate for use for youth regardless of living circumstance.

Background on Life Skills Assessment

A variety of instruments assessing tangible and intangible independent living skills have been developed, including the Daniel Memorial Independent Living Skills System, the Life Skills Inventory: Summary Report Form, and the Independent Living Skills Assessment Tool. However, these instruments were developed without norming group data, and the reliability and validity of these instruments were not established during the development. Other instruments, such as the Vineland Adaptive Behavior Scales, had known psychometric properties but were limited in use to youth with developmental delays. Additionally, the previously described measures did not allow for multiple collateral sources (i.e., youth, caregivers, and treatment providers) to complete the measures independently in order to obtain multiple data points regarding the youth's skill level. In fact, some of the measures did not capture the youth's perception of his/her own skill level across domains. As a result, the ACLSA was developed in response to the limitations of the previous life skills.

Development of the ACLSA

The goal guiding the research and measurement design of the ACLSA was to create a reliable and valid instrument that would assess current levels of life skills knowledge. Another goal was to create an instrument designed for use in both individual case planning and program development surrounding self-sufficiency for independent living in order to increase the practicality of the instrument. The Independent Living Committee at the Casey Family Program generated items for the instrument following an extensive literature review. Experts in the field of self-sufficiency then critiqued those items, and focus groups of youths, caregivers, and child welfare professionals revised the items and format. Consultants also assisted to ensure that items were developmentally appropriate across gender, culture, and ethnicity. Additional focus groups and pilot studies were conducted in both rural and urban populations.

Versions of each ACLSA were field-tested with youths served by a private, out-of-home care agency and their caregivers to assess the strengths and limitations of youths in care while also examining the instrument's psychometric properties. Differences in general areas of competency and skill levels were assessed for further development. Differences in demographic variables, such as age, gender, and ethnicity, were examined, as well as variations in risk or protective factors. Revisions were made based on the empirical analyses and the ACLSA's field-test version, as well as consumer and professional feedback, leading to the most current version.

The ACLSA version 2.0 was developed to assess youth at different developmental points. Four versions of the ACLSA were created for youths of different ages and focus on life skills attainment based on developmental theory. Four versions of the ACLSA are available: ACLSA-I for ages 8 to 9 (containing 37 items), ACLSA-II for ages 10 to 12 (56 items), ACLSA-III for ages 13 to 15 (81 items), and ACLSA-IV for ages 16 to 19 (118 items). While some items are identical across ACLSA versions, others become progressively more sophisticated for older children. Age differences are typically found, with older children scoring higher than younger children, across all versions of the ACLSA. Each version of the ACLSA can be administered to youth and their caregiver(s). The measure is currently available in both paper and Web-based format. Youth respond to items on a three-point Likert scale, with response options ranging from "not like me" to "very much like me," while caregivers respond to item options ranging from "not like the youth" to "very much like the youth." Administration time is approximately 40 minutes.

The ACLSA assesses life skills across a variety of domains, including Social Development, Educational and Vocational Development, Physical Development, Moral Development, and Money, Housing, and Transportation. The Social Development scale is divided into five subscales, including Leisure Time, Social Relationships, Communication, Emotional Well-Being and Self Awareness, and Parenting. The Educational and Vocational Development scale comprises three subscales, including Decision Making, Career Planning and Employment, and Work and Study Skills. The Physical Development and Self-Care scale comprises Health and Safety and Pregnancy Awareness subscales. The Moral Development scale is captured by a Values, Rights, and Responsibility subscale. Lastly, the Money, Housing and Transportation scale contains four subscales, including Money Management, Housing, Household Management, and Transportation and Mobility. A youth's performance is compared to the domain of possible skills to see how well the person has mastered each skill set. Since the ACLSA was designed as a strengths-based measure, it is expected that most scores would fall in the mid- to high range, especially for youth with developed or learned independent living skills.

However, critics noted that evaluation of the reliability and validity of the ACLSA was needed to ensure revisions have not affected the psychometric characteristics, particularly predictive validity of the measure. The developers of the ACLSA conducted a normative study in order to further test predictive, construct, and concurrent validity. Tests of the stability (i.e., test-rest reliability, alpha reliability) were also planned.

The Casey Life Skills Assessment (CLSA or ACLSA v.3) was created and now assesses youth ages 14 to 21; it comprises 113 items categorized within eight areas of skills, knowledge, and awareness. The domains include Daily Living, Self-Care, Relationships and Communication, Housing and Money Management, Work and Study, Career and Education Planning, Looking Forward, and Permanency. The measure also converted from a three-point Likert scale to a five-point scale in order to give youth more choices. Additional assessment tools are now available that address specific life skills and transition concerns for specialized populations (Healthy Pregnancy; Parenting Infants; Parenting Young Children; Youth Assessment Level I: Elementary Age; Youth Assessment Level II: Middle School Age; Gay, Lesbian, Bisexual, Transgender, and Questioning; Homeless Youth; American Indian; Education: Upper Elementary School; Education: Middle or Junior High School; Education: High School; Education: Postsecondary or Training; and Educational Supports). Empirical studies regarding the psychometric properties are currently in progress.

Overall, identified strengths of the ACLSA formats include its initial psychometric properties, ease of access (i.e., free for public use), and options for administration (i.e., choice of pencil-and-paper or Web-based version).

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See Also: Daniel Memorial Institute Independent Living Skills System; Foster Care Agencies; Life Skills Training.

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Antilocution

The term *antilocution* was introduced by Harvard psychologist Gordon Allport to identify forms of speaking that damage out-groups. This neologism appears throughout his well-known text *The Nature of Prejudice*, published in 1954. For Allport, the antilocution is the most elementary form of prejudice. Thus, profanity is not, in itself, antilocutionary until it is directed at a demarcated and marginalized group—a race, an ethnicity, or a gender, for example. Allport's term is important to diversity studies because it establishes a category for speech that, at some level, inhibits tolerance, diversity, and, ultimately, social justice.

For Allport the antilocution is the first and least-damaging form of prejudice, followed by avoidance, discrimination, physical attack, and extermination—each one being, in his view, more harmful than the ones that precede it in this, his prejudice scale. It is likely, given current attitudes toward out-group-malediction and its consequences, that contemporary readers will take issue with Allport's full description of the antilocution, which would, for example, regard hate speech as occasionally cathartic and thereby defusing of the prejudicial situation at hand. Scholars might also disagree with Allport's benign conclusions, not conceiving the antilocution as the mere base of a prejudice pinnacle but as a *noxia* present in every other step, serving as the scaffolding as well as the foundation for all forms of prejudice. All the same, both readers and scholars might appreciate Allport's pioneering recognition of the role language plays in prejudice and discount his oversights, given he wrote during an era when out-group malediction was common and well tolerated—the era of the lyrical aphorism "sticks and stones may break my bones but names will never hurt me." In the song "Rudolph the Red-Nosed Reindeer," written around the time Allport wrote, for example, no judgment is ever made against the other reindeer that tortured Rudolph because what Allport refers to as the "mild" persecution of out-groupers, be it the consequence of ethnicity, race, or color of the nose, was normative, both for the persecutor and the persecuted. The power of ideology to hide and promote prejudicial inclinations is nowhere better demonstrated than in the happy singing of this Christmas song by public school children, even in the midst of the antibullying movement. Changing that ideology is a gradual and ongoing process.

Despite the lack of an explicit framing on Allport's part, his meandering usage of the term throughout the text provides some opportunity to decipher his understanding of its range—thus, Brian Mullen and Tirza Leader suggest Allport recognized how it could (1) express hostile prejudice, (2) promote exclusion, (3) precipitate violence, and (4) directly harm the referent. All this overlooks, however, the fundamental effect of the antilocution: that it establishes and reinforces the social conventions that (1) demarcate a group, (2) thematize the character of its members, (3) mythologize its history, and (4) propose conventions governing how it might be handled. In terms of this issue, Allport's failure to establish a typology for the antilocution has crippled research aimed at understanding it and its influence. Unfortunately, since the time of his writing, the many who have referenced his term and cite his work take the idea no further than he did—where they have given the title of antilocution to out-group-malediction, they have made no effort to elaborate on the antilocution's nature.

Consequently, Mullen and Leader point out that there has been no systematic study of the association between antilocutions and violence, which is ironic, given sociologists like Randall Collins place out-group malediction at the heart of ethnic conflict, for example. Understanding the structural characteristics of the antilocution with respect to each marginalized group would render the term its appropriate position in sociological research on prejudice, diversity, disability, and so forth. For that reason, some of the characteristics of antilocutionary discourse are set forth below.

Antilocutionary Force

Antilocutions have power—the power to harm. That said, there are two essential ways that antilocutions build and express their power: (1) naming, that is, focusing their audiences on a summing-up term that capitalizes on the cultural associations already in place with respect to that out-group; and (2) normativizing, that is, proposing new associations for the out-group referenced, thereby expanding the prejudices associated with them. Antilocutionary naming is exemplified by the slur while philippics (e.g., *The Jews and Their Lies*, by Martin Luther and significant passages of Adolf Hitler's *Mein Kempf*) provide a most elaborate illustration of antilocutionary normativizing. These antilocutionary powers express themselves in both qualitative and quantitative fashion. Qualitatively, antilocutions form a tapestry of prejudicial identity around out-groups, causing everything done by and done to those groups to be filtered through the frame of reference generated by the prejudicial attributions. Quantitatively, the repeated delivery of antilocutions increases the presence of prejudice until it saturates the discursive sphere within which out-group maledictions are spoken. Together, the quality and quantity of these maledictions represent the antilocutionary forces directed at the out-group addressed. Tacitly understood by those who employ them and those who welcome them, such antilocutionary forces are nothing less than an insidious instruction manual, tailored to the specific out-group; and discovering what those instructions might be would amount to cataloging the antilocutionary forces in play. How is this done?

Probing the nature of antilocutions with respect to a particular out-group involves the application of research methods as they are already understood within the social sciences. Certainly it cannot be done here. However, the fact that antilocutions establish distinct normative associations with particular out-groups can be loosely demonstrated from results gained by typing an out-group name into a Google search followed by the word *should* or *are*. After typing the words *the poor are . . .* into a Google search, for example, Google completed the statement with the word *lazy*; and, after typing "The poor should . . ." Google completed the statement with "learn to go without," "die," "not have kids," and "help themselves."

Whereas each out-group carries its own distinct collection of normative associations, properly deciphering group-specific, antilocutionary codes should be nothing less than a subfield of research for sociologists concerned with diversity, disenfranchisement, disability, and so forth. The principal value of the concept of antilocutions will only be recognized when researchers establish the antilocutionary force that is brought to bear against each out-group through research into the conventions of antilocutionary language.

Antilocutionary Forms

Where does the antilocution exert its influence and where can it be studied? Everywhere. Language expresses itself in a myriad of forms, and antilocutions may be created in any of them. A single word can be antilocutionary, as is the case for derisive out-group naming such as "n----r", "k--e", and "w-p", examples used by Allport. An antilocutionary word, however, must rely heavily on pre-inscribed cultural associations to be meaningful when spoken alone; uttered within a group unfamiliar with the language in which it is spoken, it will be (except for its tone and the events surrounding its usage) meaningless. Antilocutionary statements also rely on cultural associations, but they may also supplement or reinforce those associations by virtue of their explicitness, as for example, "They'll catch that n----r tonight and whale the life out of him." Already one can see the scaffolding effect of antilocutionary discourse in this sentence: the out-grouper is derisively named (i.e., n----r) and a pattern of out-group treatment is reinforced as normative for that out-group (i.e., catching and whaling).

The statement "Mary was asking for it," is also an antilocution of this form—one that blends gender, violence, and blame into an ideological tumor so damaging and familiar that an educational film on sexual consent has been titled with the expression. Note within this example, as well, that a statement may be out-group antipathetic though a single person named in the statement if the rationale of the statement is group- rather than person-based. The two-stage structure (i.e., naming and normativizing) for the antilocution, named immediately above, can also be found in antilocutionary conversations, with one or both parties using maledictions. In addition, an individual may pontificate, expounding and even expanding at some length on antilocutionary norms. Thus, it is that the nature of informal everyday communication, including spoken words, sentences, conversations, and diatribes, may all be antilocutionary. One can threaten, gossip, swear, cry, lie, cajole, mock, insult, brag, exaggerate, confess, suggest, deny, praise, and even pray in an antilocutionary fashion.

A culture's linguistic arts can be antilocutionary as well. Poetry, rhymes, jokes, riddles, proverbs, and prophecies might be antilocutionary. The limerick, for example, is a standard rhythmic and rhyming form for antilocutions. Even great literary works can be antilocutionary—the classic example being William Shakespeare's *The Merchant of Venice*, but one should not disregard *The Taming of the Shrew*, or even *Othello*, for that matter.

These three plays are deeply embedded in anti-Semitism, misogyny, and racism—in that order. The famous *Tales of the Arabian Nights* is viciously antilocutionary, particularly with respect to women and dark-skinned people; no parallel can be reasonably drawn between it and the fairy tales collected by the Grimm brothers. Short stories and novels can also be antilocutionary in part or in overall design. Both Joseph Conrad's *Heart of Darkness* and Mark Twain's *Huckleberry Finn* can be examined with respect to the antilocutionary nature of the texts; and there are misogynistic, anti-Semitic, prejudicial, racist, and homophobic characterizations in books and stories. Song lyrics can be antilocutionary and quite damaging, given the manner that music saturates contemporary environments. The song "Short People" by Randy Newman was singled out for this reason; however, a good part of rap music is couched in this sort of speech as well, for example the Jay Z song, "99 Problems." Comic books, video games, television programs, movies, advertisements, posters, pamphlets, Web pages, blogs, Facebook posts, Twitter pages—all these may also have antilocutionary content because the antilocution affirms and elaborates an attitude, and this can be done through any medium using whatever forms that medium allows.

Alongside creative works, reportorial forms of discourse can be antilocutionary. Such works are distinctly damaging in that they do not merely propose an attitude, as is the case for creative works, but also purport to reveal the facts of the case. Newspaper articles can be antilocutionary—explicitly so, as they were in Nazi Germany and in the American south before the Civil Rights Act—but also subversively antilocutionary in, for example, news articles reporting the skin color of a criminal only when the color is black. Indeed, even scholarship can be antilocutionary: *The Bell Curve*, by Charles Murray and Richard Herrnstein, was largely regarded as antilocutionary by virtue of the manner that the authors racialized IQ and recommended social policies with respect to their conclusions. Antilocutions also can be found in an essay by deconstructionist Paul de Man.

The antilocution can also be delivered through tonality, by gesture, or even through an act of silence. When one person refuses to greet another in word or even in handshake, for example, the effect may be antilocutionary if the person scorned is a member of an identifiable out-group and the context of the event allows it to be understood as a symbolically meaningful discriminatory act.

It is important to note that users of antilocutions are often unaware of the damage they do by employing them. A child, for example, may hear an adult speaking in antilocutionary fashion and imitate that speech without comprehending its nature or consequences. Even where adults are concerned, not all malignant out-group malediction is malicious because the norms governing the conventions of discourse precede the conscious awareness of what is being done. This fact speaks to the importance of educating publics with respect to malediction and harm to others.

So much antilocution exists that no finite limit can be set around it. Nevertheless, it is possible to probe its range and nature with respect to a particular group, a particular form of communication, a particular mediated form, and a particular historical epoch, as has been cursorily set out with a few illustrations above. In this sense, the term *antilocution* might yet open to social scientists concerned with issues such as disability, diversity, minority status, and so forth a context within which to frame research aimed at measurably studying the relationship between speech that diminishes out-grouper status and extrasymbolic forms of maltreatment.

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See Also: Discrimination and Institutional Racism; Prejudice, Theories of; Racial Microaggression.

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Anti-Semitism

Anti-Semitism, the discrimination against Jews for reasons associated with their racial heritage, has been present in the North American continent since the first community of Israelites settled in Manhattan in 1654. However, it was only after the Civil War, when immigrants from Europe increased considerably in numbers, that a racist attitude toward Jews started gaining ground. Discrimination against and hatred of Jews peaked during the interwar years, but they never reached the same levels of paroxysm and magnitude as in Europe. With the United States being a heterogeneous multiethnic society, Jews found themselves to be a minority alongside many others, and consequently they have been spared the role of natural and exclusive target of racial hatred that was common in European societies. This explains why no indigenous theorization of anti-Semitism has developed in the United States. However, the perception of widespread diffidence toward them shaped the attitude of American Jews in connection to human and social services; communal self-help was seen as the most feasible way to provide for the needs of the population. The prominent role of *tzedakah* (in Judaism, the religious obligation to charity) also drove Jews in the United States to seek help from their own ranks rather than ask the government.

The first Jewish community in America dates back to 1654, when a small contingent of Israelites arrived in the then Dutch colony of Nieuw Amsterdam (later New York) from Recife, another Dutch settlement on the Brazilian coast that had been snatched by the Portuguese. Memories of the violence and massacres perpetrated against their kind during the Iberian inquisition persuaded these Jews to move to more tolerant shores. In fact, these immigrants were granted permission to stay in Nieuw Amsterdam by the Dutch India Company, although the then governor Peter Stuyvesant, a devout Christian, opposed the decision and considered Jews "hateful enemies and blasphemers of the name of Christ."

One remarkable case of anti-Jewish behavior took place in 1733 when the trustees of the Georgia Charter pressed the colony's leader, James Oglethorpe, into denying Jews permission to settle in the territory. Oglethorpe, however, opposed the decision and granted Jews permission to stay.

The American Revolution marked a turning point in the history of American Jews. The First Amendment to the Constitution provided that the republican government would not interfere nor legislate on matters concerning religion, while a 1790 letter by George Washington to the Jewish community of Newport, Rhode Island, assured its members that "the children of the Stock of Abraham, who dwell in this land" would do well so long as they would "demean themselves as good citizens." This latter formulation, according to recent scholarship, has to be seen as a foreboding of the trials and ordeals to come, as it implied that Jews would fare well in the United States only as long as they would comply with white Protestant standards of citizenship; and, during the course of American history, Jews would often find themselves to be beyond these standards.

Starting from the latter half of the 19th century, anti-Semitism shifted its focus from religion to the social sphere, as attacks would target the cultural and racial differences of Jews in relation to the Anglo-Saxon norm. The rise to prominence of a significant number of German Jewish businessmen and financiers, together with a huge increase of Ashkenazi newcomers from eastern Europe, caused concern among the white elite: the former were seen as uncouth upstarts whose enormous wealth could challenge their social exclusivity, while the latter appeared an alien tribe responsible for all kinds of social evils, from crime to political radicalism. Aversion and fear of the aliens became the nurturing ground of a nativist movement that advocated the end of unrestricted immigration—with no distinctions between Jews and gentiles, Europeans and Asians.

Discrimination took a variety of forms. In 1866, after a series of fires destroyed warehouses and workshops belonging to Jews, the insurance companies believed the owners had set fires to their own property in order to collect indemnity; as a consequence, they agreed to stop underwriting Jewish assets. Ivy League institutions, such as Yale and Harvard, imposed quotas that limited the enrollment of Jewish students, while forms of unofficial exclusion were in place in hospitals, law firms, companies, and department stores, which often opted to pass over Jewish applicants. One particularly significant incident occurred in 1877 in Saratoga, New York, when millionaire Hugo Seligman was denied accommodation at the Grand Hilton Hotel. The case of Seligman, who had been a friend of Abraham Lincoln as well as an intimate of President Ulysses S. Grant, showed American Jews that no matter how rich, assimilated, and well-connected they might become, U.S. society would always regard them as different and inferior. Working-class newcomers, too, would generate resentment among American peers as their willingness to work for low pay was mistaken for a deliberate effort to depress wages and steal jobs from them.

The press started to run reports documenting the unhealthy conditions of immigrant neighborhoods, implying how all major problems—filth, overcrowding, child labor, vice—stemmed from the inability of newcomers to comply with Anglo-Saxon standards of hygiene and property, flaws believed to depend on cultural traits peculiar to immigrants. Newspapers and magazines also featured cartoons that overemphasized physical attributes associated to Jews, such as hooked noses and sidelocks, or targeted stereotypes like lust for money and duplicity. Anti-Semitism from Europe found its way into the United States as an increasing number of articles were translated and published in the American press.

Racist propaganda occasionally degenerated into violent attacks. In 1902 in Manhattan, mourners at the funeral of Rabbi Jacob Joseph, recognized leader of the Orthodox community, were assaulted by employees from companies along the procession route and later clubbed by police agents who had come to break up the riot.

The Jewish community reacted to the unwholesome climate by establishing organizations that could help enhance a pro-Jewish agenda and improve the status of American Jews. It was in this period that the community started to organize a network of institutions that would cater to the needs of the community, caring for the sick, elderly, orphaned, unemployed, poor, and so forth. So massive was this organizational effort that some scholars have singled it out as one hallmark of American Jewish identity.

The wealthy and assimilated German Jews believed that the anti-Jewish rhetoric depended on the cultural backwardness of their Russian coreligionists. Therefore, a group of prominent businessmen founded the Educational Alliance in 1893, with the purpose of providing services and classes on civics, religion, personal hygiene, English, and sports that could help newcomers accommodate to American society. In spite of the noble purpose, however, scholarship has underlined how such paternalistic efforts created a divide in the Jewish community, pitting rich assimilated "Germans" versus poor ignorant "Russians." Further, by stressing the desirability of adherence to Anglo-Saxon norms in order to fit into American society, institutions such as the Educational Alliance insinuated uneasiness, even aversion, toward traditional eastern European Jewish culture between attendees, especially younger ones. The generational divide between "backward parents" and "modern children" would feature in the work of many early 20th-century American Jewish writers, such as Anzia Yezierska.

Another important effort to improve the status and reputation of Jews was the founding, in 1893, of the National Council of Jewish Women (NCJW), with the aim of educating female immigrants on topics like birth control, civil liberties, human rights, and suffrage. In 1909, after *McClure's* published "Daughters of the Poor," an article by muckraking journalist George Kibbe Turner accusing Jews of controlling prostitution in New York (one of many that depicted Jews as pimps), the NCJW reacted by launching a series of antiprostitution initiatives, in particular by reaching out to young, unaccompanied female immigrants, especially vulnerable to the lures of ruthless individuals. The foundation of Kehillah, similarly, responded to the outcry provoked by New York Police Commissioner Hiram Bingham, who publicly complained about the excessive rate of Jewish crime in the city. Kehillah's manifold activities would challenge the flood of anti-Jewish press by collecting data on crime, investigating illegal activities, and helping Jews in trouble.

The same pattern was replicated in 1913 with the Leo Frank case and the birth of the Anti-Defamation League. Frank, a Jewish engineer working in a factory in Atlanta, was accused of having raped and murdered a young employee at the plant. When Frank was sentenced to death, the verdict was met by public jubilation; however, when the sentence was commuted to life imprisonment two years later, the local population expressed outrage and a crowd of armed men kidnapped Frank from prison and lynched him. The flood of anti-Semitic articles and editorials that appeared during the trial convinced 15 members of the Chicago chapter of the B'nai B'rith, a mutual aid society founded 60 years earlier, to create the Anti-Defamation League, an organization devoted to the dissemination of correct information about Jewish cultural heritage and to counter the racist language of the press and politicians. The choice was fitting as the Progressive era marked an intensification of racist propaganda blaming Jews for all kinds of social evils, from political radicalism to sexual libertinism. A typical instance of the bad press of the period was Burton J. Hendricks's "The Great Jewish Invasion," a series published by the prestigious *McClure's* magazine that gave a racism-infused account of the emergence of Jewish immigrants as successful businessmen and manufacturers: Hendricks's view of Jews was summed up by comments such as "no people have had a more inadequate preparation, educational or economic, for American citizenship."

Madison Grant's *The Passing of the Great Race* (1916) condensed the mood of Anglo-Saxon anxiety over the survival of American civilization. The essay bemoaned the fate of old-stock Americans as their blood was threatened by the arrival of inferior people from southern and eastern Europe, and was particularly harsh on Jews, as they seldom adopted Christian religion or understood American ideals. The Roaring Twenties saw a white, middle-class backlash over the evil forces of modernity, with Congress passing legislation that restricted immigration (National Origins Act, 1924), limited the production and consumption of alcohol (Volstead Act, 1919), and censored inappropriate behavior and morals in movies (Hays Code, 1930). The conservative reaction also led to crackdowns on trade unions and radical groups, in response to a worldwide threat heralded by the Russian Revolution. As some prominent members of the Bolshevik party, like Leon Trotsky, were Jews, the November 1917 uprising came to be seen as a Jewish conspiracy against capitalism. Henry Ford, the car manufacturer, was one of the most assertive in making the claim. In 1919 he bought the *Dearborn Independent*

Leo Frank on trial for the rape and murder of a young employee in 1913. This case and the many editorials related to it led to the creation of the Anti-Defamation League.

and turned the newspaper into a platform to promote his racist views. The paper supported the idea of an "international Jewish conspiracy" and in 1920 published a series titled "The International Jew: The World's Foremost Problem," which detailed how Jews controlled both world finance and radical movements and manipulated diplomacy to cause wars in which Christians died and Jews got rich.

The situation got worse during the Depression, as Jews took the blame for economic hardships. However, it was not just the Anglo-Saxons who targeted Jews; as economic conditions got worse, other minorities became more vocal in their resentment. When riots erupted in Harlem in 1935, mobs of African Americans attacked and destroyed neighborhood shops owned by Jews.

The significant presence of Jews in President Franklin D. Roosevelt's administration (such as Henry Morgenthau, Jr., and Felix Frankfurter) induced opponents of New Deal legislation to single out Jews as the mastermind behind these policies. Many prominent figures spoke out against Jews. Joseph P. Kennedy, father of future president John F. Kennedy, while ambassador in England, complained to German officials that Roosevelt had fallen into the clutch of Jews. Father Charles Coughlin, who hosted a popular radio show and published a newspaper, the *Social Justice*, lectured his audience about the Jewish domination of America. Charles Lindbergh, the pilot of transatlantic fame, spoke at rallies organized by America First, a noninterventionist movement, and blamed Jews for instigating involvement in the war against Germany. Philip Roth's *The Plot Against America* (2004) draws on Lindbergh's role as spokesperson for anti-Semitism to paint a picture of the discrimination endured by the Jewish community of Newark during the 1930s.

In spite of all these occurrences of racist behavior, the situation posed little personal threat to Jews, particularly in comparison to what was happening in Europe at the same time. Although it caused personal pain and communal discomfort—as historian Hsia Diner put it—most American Jews remained safe as individuals and as members of a community.

However, the economic strains took a heavy toll. The Jewish organizations, once the pride of the community, struggled to deal with the huge numbers of people in need, and many had to turn to the public relief roll. The diminished possibility of providing relief sparked the fear that destitute Jews would turn to crime and illegal activity to provide for themselves, and that, in turn, would increase the already significant level of animosity and resentment toward the community. Also, many considered public welfare unreliable and feared that anti-Semitic attitudes would sooner or later prevail and relief funds for Jews would be ultimately terminated. Others were concerned that hostility toward Jews would surface in the very delivery of service, with lower standards of quality. Jewish agencies reacted by rationalizing fund-raising and allocation of services, and by pioneering strategies, such as psychoanalysis, casework, and counseling to target social problems.

The postwar years are usually considered a golden age for American Jewry, as the community assimilated into the middle class and the Holocaust aroused a wave of sympathy toward the plight of Jews. New pieces of legislation, such as New York's antidiscrimination bill (1945) and the Fair Education Practices Act (1948), addressed discriminatory behavior that had been carried out in the previous decades. Anti-Semitism, however, would occasionally resurface. During the civil rights era, for instance, Jews and Jewish institutions in the south became the target of segregationist whites, with synagogues bombed in Nashville, Atlanta, Charlotte, Gastonia, Jacksonville, and Miami. In the wake of the Hollywood witch hunt and McCarthyism, the left-wing activism of many Jews occasioned the employment of anti-Semitic rhetoric. Since 1967, the strong bond between Israel and American Jews has become a major originator of anti-Semitic attitudes. Transnational Jewish solidarity was frequently framed in the context of an occult Zionist power secretly dominating the world, while African American nationalist groups equated Israel and its supporters to a colonialist lobby exploiting colored people. However, anti-Semitism remains today at the fringes of American public discourse, relegated to private prejudice and informal discrimination.

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See Also: Antilocution; Discrimination and Institutional Racism; Jewish Americans; Prejudice, Theories of.

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Appalachia and Human Services

People of Appalachia possess a rich cultural heritage that is often misunderstood by outsiders. Many of their cultural values center on family, community, and religion. Although some Appalachian communities have experienced economic growth, much of the rural Appalachian regions are fraught with high unemployment, poverty, poor health, and disparities in education. People of Appalachia traditionally try to solve their own problems, but the severity of some of the challenges faced by its people has increased the need for human services.

Appalachia

Appalachia refers to the region along the Appalachian Mountains in the eastern United States running from southern New York to northern Alabama and Mississippi. According to the Appalachian Regional Commission, the region includes all of West Virginia and portions of 12 other states including Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia. Forty-two percent of the 420 Appalachian counties are rural, compared to 20 percent nationally.

Once exceedingly dependent on mining, agriculture, chemical industries, forestry, and heavy industry, the Appalachian economy now includes a number of service and manufacturing industries. These gains have transformed Appalachia from widespread poverty to a region of economic contrasts with focused areas of high unemployment, acute educational disparities, and poor health and other areas experiencing a surge of economic vitality through the development of new industries.

Appalachian Culture

People of Appalachia are often misunderstood. They are less prone to be viewed as a cultural minority. This is likely because outwardly, they do not appear to be different from mainstream Americans. This is especially true of urban Appalachians, those who migrated to urban areas such as Chicago, Cincinnati, and Detroit.

Appalachian culture is centered around the Appalachian people and the influence their values have on their attitudes, lifestyle, and behavior. Their value system has evolved partly because of their early settlement in isolated geographic regions of the mountains. There is no consensus about what it means to be a person of Appalachia. Whites, blacks, and Native Americans are represented in the people, but Celtic immigrants are believed to have had the greatest influence on their culture because of their clan social framework. The influences from these diverse cultures have led to the development of various distinct cultural traits and values that differ from mainstream Americans. Some cultural traits include their influence on music, particularly bluegrass and gospel music; their arts and craft skills, especially in quilting and woodworking; and their various regional dialects.

The cultural values of the Appalachian people include a strong work ethic; rich cultural heritage; patriarchal socialization; a strong conviction for equality and independence; identity dependent on their family, extended family, and their community; a strong connection to their land; and commitment to their religious worldviews. In the large area of Appalachia, there are regional differences, but much of the cultural commonalities of its people remain the same.

Appalachia and Human Services

Some Appalachian communities have made great strides in income growth, employment, educational attainment, and infrastructure. However, many people of Appalachia face numerous challenges including poverty, unemployment, obesity, cancer, high rates of disease including infectious diseases, prescription and illicit drug abuse, alcoholism, domestic violence, and depression.

Rural Appalachia has experienced historic shortages of health and community services. Perhaps because of their history of isolation, suspicion of people and systems not affiliated with their inner social network, loyalty to "in-groups," and the outside exploitation of its people and culture, people of Appalachia tend to distrust outsiders. This mistrust, coupled with the fear of being taken advantage of by outside organizations, provide a unique challenge for human service delivery. Primarily, human service practitioners may find it difficult to gain entry into the Appalachian community. Practitioners who adhere to strict organizational mandates that are ineffective for people of Appalachia can lead the Appalachian community to view such helpers as insensitive.

For the people of Appalachia, social networks support safety and physical and psychological health. Feelings of shame, privacy concerns, lack of transportation, family and/or cultural issues, and lack of funds to pay for services are some of the major obstacles to service delivery.

Service delivery for Appalachian people must be based on the genuine needs as expressed by the people themselves. Whatever services are provided, there must be recognition that the Appalachian culture is real and operational. Gaining the trust of the people and the community is essential and can be achieved through honesty, humility, compassion, and the display of respect for the culture and its people. Practitioners who demonstrate cultural competency; value community diversity; respect local knowledge; and collaborate with family networks, other professionals, the local community and its churches are more apt to gain the confidence and respect of the people of Appalachia and their communities.

When working in Appalachian communities, network development and service collaboration is fundamental. A variety of different agencies and organizations, both governmental and nongovernmental, and expertise in the community is needed in order to identify best practices in service delivery within a framework of limited resources. In many cases, human service practitioners may work as part of a team of care providers to deliver services to the people of Appalachia. The team may include counselors, physicians, case managers, social workers, support staff, community consultants, and clergy. Some key approaches to service delivery center around prevention services, community education and participation, provider training, and assessment.

People of Appalachia traditionally try to manage their own problems and do things for themselves; however, some of the challenges that face the Appalachian community may be too large and complicated to manage without the assistance of human services. Human service delivery must take into account the social, cultural, economic, and political contexts of Appalachia. Collaborative and integrated efforts of service delivery are necessary in order to provide services tailored to meet the unique needs of the people of Appalachia.

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See Also: Community Health, Racial and Ethnic Approaches to; Cross-Cultural Knowledge; Community-Based Services; Cross-Cultural Skills; Cultural Competence, Human Service Providers and; Economic Support and Services; Educational Support Services; Employment/Career Assistant Services; Ethnic Diversity and Values; Ethnic Groups and Drug and Alcohol Use; European Americans; Family Services; Mental Health Service Delivery, Cultural Characteristics of; Overweight and Obese Adults and Children; Poverty; Rural Communities; Spirituality/Religion and Diversity.

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Arab Americans

The term *Arab American* has been defined in various ways in different disciplines. Taken simply, an American-born (or naturalized) citizen with ancestry from most Middle Eastern countries could likely be considered Arab American. Previous publications use membership in the Arab League to determine which nations would be "Arab." In this article, however, the challenge of defining Arab (and by extension Arab American) primarily based on membership in a political organization is deepened by the fact that member states of the Arab League are from parts of Asia and Africa—continents of origin that the U.S. Census determines as two different races—while defining Caucasian to include people of the Middle East. The Arab nations are included with other ethnic groups and nationalities (i.e., Persians from Iran, Turks in Turkey, etc.) in the understanding of the geographic and cultural term *Middle East*. Therefore, geography and nationality become secondary in the basic understanding of Arab Americans as a culturally different group. The commonality of the Arabic language—though present in multiple dialects—and a common shared cultural heritage that is patriarchal and traditionally conservative become more salient.

The Role of Religion

The prevalence and influence of Islam in the Arab world is clear; however, when considering Arab Americans as a group, there is conflict between reality and the generalization of Arabs to Arab Americans. Although the majority of the world's Arab population is Muslim, approximately two-thirds of the Arab American community is Christian. Data collected through the U.S. Census and other means have documented these accounts of Arab Americans. Research in the field of counseling, social psychology, and sociology has shown that Arab Americans who are Christian tend to assimilate into American culture with less consternation because they are able to negate the negative stigmas associated with Islam in the United States. Regardless of which religion a person or family follows, religion is a salient point of identity for Arab Americans, and thus service providers should be cognizant of possible conflicts of religious and cultural beliefs between social norms and American culture.

External Services

Like many minority populations in the United States, Arab Americans are less likely to view outside counseling services as an option for social and emotional issues because of cultural norms. These norms often associate personal issues with "matters of the home" that need to be handled within the nuclear and/or extended family. This view is similar to that of black and Latino/a counterparts whereby the communal nature of the family solving problems together is valued more than the individual seeking his/her own resolution from outside the family; seeking help outside is viewed as a sign of weakness and a poor reflection on the family. Help seeking becomes more likely the further removed a person is from the point of ancestry, meaning these issues will likely be more prevalent if someone is a first-generation Arab American than if someone is a third- or fourth-generation Arab American. Service providers should explore a person's background and ancestry to assess how removed a person may be from their familial point of ancestry.

Furthermore, service providers will find their ethical obligations to the Arab American population mirror the obligations to any other minority group and the importance of cultural competence becomes salient. Like other minority groups in the United States, Arab Americans are subject to different sociocultural bias emphasized in mainstream media outlets. Arab Americans may internalize these often-negative views through a phenomenon known as stereotype threat. Stereotype threat is described as the internalization of a negative stereotype associated with one's group membership. Human services workers must be aware of these possible internalizations while eliminating their own personal bias in order to maintain the ethical obligations to ensure the safety of these clients as outlined in certification and licensure standards.

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See Also: Discrimination and Institutional Racism; Muslim Americans; Prejudice, Theories of.

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Asian Americans

It has been well documented in literature and professional guidelines that there is a need for both direct human service providers and organizations to provide culturally appropriate services. Culturally appropriate services are aimed at providing care or services to people by addressing, rather than ignoring or merely being sensitive to, cultural factors such as ethnic heritage, nationality of family origin, values, or beliefs. To better aid individuals, families, and communities of a nondominant culture, service providers must consider the cultural lens in which individuals of nondominant backgrounds may view and engage the world, while simultaneously attempting to make the process of engaging in services welcoming and helpful. Despite some efforts of human service providers and organizations, several nondominant racial and ethnic communities continue to be underserved, including Asian Americans.

Asian Americans are people originating from or whose ancestors are from an Asian country, including people from Bhutan, China, Pakistan, India, Indonesia, and Singapore. Part of the complexity of serving the Asian American population is because of its intragroup diversity. The Asian American population is extremely heterogeneous and comprises 43 different ethnic groups who use over 100 different languages. There are also differences within each ethnic group. For example, within the Asian Indian community there are more than 25 languages, 200 different dialects, and at least seven religions. To best address how Asian Americans are culturally different as clients and the barriers that are present in engaging in mainstream services, it is beneficial to have a fundamental understanding of the culture and how it may manifest itself in contemporary human service delivery.

Asian Culture

As humans and human behavior are shaped by biological and sociological experiences, it is critical to have a general understanding of the variety of cultural differences that exist. Despite the intrinsic differences that are present in each of the Asian cultures, the subgroups share common characteristics such as collectivism and familism. A significant influence of these shared characteristics is Confucianism, which emphasizes the betterment of the family unit over the individual. This collectivist belief creates a cultural environment conducive to interdependence, contrary to most Western countries' individualist perspectives. There exists a general consideration in Asian cultures that if someone were to face a problem, the family would help them on their path to resolution. Similarly, should an individual fall on difficult economic times, there would be communal assistance among the extended family with the latent expectation that the same would be done in return for any member. Juxtaposed against the value of family are the trust of intrafamily members and a mistrust of outsiders.

Along with the emphasis placed on the growth and development of family and community, there is also the parallel cultural value of endurance and restraint. Individuals, particularly first-generation Asian Americans, are prepared to have a harder life in the new country in order to establish themselves and provide for the family. Endurance and restraint are generally viewed as admirable traits among Asian Americans, often manifesting as bearing a burden, such as physical or mental illness, without assistance. This value can also be seen in the low rates of community service participation, even within Asian Americans' nations of origin, as it is often considered strength to not tax the community by presenting a need. An additional Asian value of note is the emphasis on "saving face," defined as one's prestige in the society. Asians strive to avoid potentially negative stigmatizing labels that may bring shame to the family name. Stigma and shame have been suggested as barriers to help-seeking among minority groups. Some Asian cultures view an individual or family seeking aid as shameful, as they are demonstrating that they are incapable of caring for themselves and or for their family.

When Asian Americans settle in the United States and are often removed from their extended family, they may favor individuals who look, act, or present with similar beliefs to their own. This subtly prohibits other cultures and values from permeating their own and, inversely, encloses communities in an insulated sphere of nonengagement. In contrast, some immigrants may embrace acculturation and assimilation, which either blends their culture of origin with a host culture, or adopts the culture in which new migrants find themselves, respectively. Given the culture of Asian immigrants' homelands, there are significant differences between their culture of origin and the Western culture that create conflicts in which they operate as Asian Americans. Some of the barriers that exist among Asian Americans accessing services in the United States are a result of discordance between their native culture and Western culture. A challenge is also seen by poor integration into the mainstream communities in which Asian Americans reside.

Implications for Service Providers

In addition to cultural values as an essential element when examining Asian Americans as culturally different clients, mainstream service structures and the unique differences that each client possesses should also be examined. Contemporary mainstream service structures create barriers that prevent Asian Americans from utilizing services. Language barriers are a common problem for Asian Americans with limited English proficiency, as most Asian Americans are first generation. Enlisting the aid of interpreter services or human service providers who speak the same language may increase service use. Another suggestion for serving the Asian American population is cultural brokering, the use of a bicultural individual who understands and can explain the two cultures to both clients and service providers, and who comprehends how each of the cultures may influence both viewpoints relating to service provision.

Age and length of time in the United States may play a role in access to and utilization of services among Asian Americans. Younger first-generation Asian Americans are often taught English as a secondary language in their home culture or are able to learn English quickly once they are in the United States, enabling them to communicate and seek services when they desire and removing the language barrier to accessing services. In addition, younger Asian Americans often have Western influences in their upbringing, including interactions with peers and portrayal in the media, such as on television, in movies, and online. This larger Western influence in their acculturation competes with adherence to traditional cultural values and may facilitate an easier transition into mainstream society, and thus mainstream services.

Contrast this with older Asian Americans, who may have their first exposure to Western culture upon immigration. The process of acculturation can be very different for older Asian Americans given the myriad of obstacles they face, including language barriers, systemic discrimination, and cultural conflicts of values. It is not surprising that there are sometimes clashes between generations of Asian Americans depending on factors such as level of acculturation or how long they have been in the United States. In providing services to Asian Americans, it is of the utmost importance to recognize the confluence of factors that shape individuals' entry into the service system, whether they be new immigrants or established citizens, and where they may be on the spectrum of acculturation.

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See Also: Asian Immigrants; Asian Indian Immigrants; Chinese Americans; Community Health, Racial and Ethnic Approaches to; Cultural Broker; Cultural Competence, Human Service Providers and; Cultural Services; Ethnicity and Clients; Filipino Americans; Hmong Immigrants; Race and Clients; Social Work, Diversity Practice in.

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Asian and Pacific Islander American Health Forum

The Asian and Pacific Islander American Health Forum is a national health policy organization for Asian Americans, Native Hawai‘ians, and Pacific Islanders. It advocates for increased recognition, inclusion, and engagement of these ethnic groups within policies and programs that sustain and improve their health and general well-being. The forum serves the interests of some 17 million Asian Americans, Native Hawai‘ians, and Pacific Islanders living in the United States and its jurisdictions. The forum's programs operate in conjunction with community organizations, health providers, and advocates to provide technical assistance and training. The organization's efforts led to the creation of the White House Initiative on Asian Americans and Pacific Islanders. The forum advocated strongly for the passage of the Patient Protection and Affordable Care Act and continues to campaign for the routine inclusion of Asian Americans, Native Hawai‘ians, and Pacific Islanders in the collection and dissemination of local, state, and national health data sets.

Pursuant to its overall purpose, the forum engages in a range of policy work in relation to the expansion of health care, the improvement of health care quality, and the expansion and improvement of data pertaining to the health and well-being of the communities in which Asian Americans, Native Hawai‘ians, and Pacific Islanders live. The forum endeavors to affect policy decisions through the analysis of current and prospective policy issues, the building of pertinent and pragmatic coalitions, the systematic engagement of relevant policy makers, and the coverage of its goals and activities in the media. The work of the forum is facilitated by a number of partnerships with a range of community-based organizations, researchers, and specialist health advocates.

Improving the Access to Health Care

The forum focuses on a range of connected policy priorities. First, it is concerned with access to health care, noting, for example, that one in three Korean Americans and one in four Native Hawai‘ians and Pacific Islanders lack health insurance. The forum maintains that as a group, Asian Americans, Native Hawai‘ians, and Pacific Islanders are more likely to be uninsured than non-Hispanic whites. According to a report released in 2011, the forum noted that although 71.7 percent of Asian Americans have insurance coverage compared with 67.4 percent of the general U.S. population, the rates for many groups within the Asian American community are far lower; for example, only 52.1 percent of Cambodians, 46 percent of Hmong, and 44.2 percent of Bangladeshis have health insurance. In addition, 22.5 percent of Bangladeshis lacked health insurance, as did 21.3 percent of Cambodians, 22.3 percent of Koreans, and 22.9 percent of Pakistanis.

According to the forum, one of the reasons for the high rates of uninsured individuals is that a greater-than-average number of Asian Americans, Native Hawai‘ians, and Pacific Islanders either own or work for small businesses. For example, 27 percent of Asian Americans who own or work for small businesses lack health insurance, compared with only 10 percent of Asian Americans who own or are employed by large businesses; similarly, 25 percent of Native Hawai‘ians and Pacific Islanders employed or owning small businesses are uninsured, compared with only 6 percent who own or are employed by large businesses. While public programs such as Medicaid and the Children's Health Insurance Program help reduce the number of uninsured Asian Americans, Native Hawai‘ians, and Pacific Islanders, these individuals continue to experience language and cultural barriers in the insurance enrollment process and difficulties understanding the criteria for insurance eligibility.

Improving the Quality of Health Care

Second, the forum works to ensure that the health care provided for Asian Americans, Native Hawai‘ians, and Pacific Islanders is of sufficient quality, which in the context in which the forum operates refers primarily to health care providers developing mechanisms to allow for the delivery of culturally and linguistically appropriate patient care. The forum maintains the cultural and language barriers faced by the communities it represents exacerbate their health issues since Asian Americans, Native Hawai‘ians, and Pacific Islanders often fail to receive appropriate levels of preventative care, medical advice, counselling, or general health care.

In its 2011 report, the forum stated that the vast majority of Asian Americans (70.5 percent) speak a language other than English at home, a rate higher than that of all other racial and ethnic groups, with the exception of Hispanics/Latinos (76.8 percent). Among Asian American groups, Bangladeshis had the highest proportion of people speaking a language other than English at home (91.5 percent), followed by Hmong (91.3 percent), Pakistanis (85.7 percent), and Vietnamese (84.2 percent). Because these groups speak a language other than English at home, many Asian Americans lack proficiency in English and this undoubtedly results in the language barriers that impede access to quality health care.

The forum's advocacy on behalf of Asian Americans, Native Hawai‘ians, and Pacific Islanders recognizes the need to appreciate these groups' respective cultures and histories and to recognize the impact of each in determining and monitoring their health status. To that end, the forum advocates that ethnic-specific data should be collected, collated, analyzed, and disseminated. However, the relatively small populations of Asian Americans, Native Hawai‘ians, and Pacific Islanders render it somewhat difficult to locate data of sufficient quality and comprehensiveness to provide significant determinations of important health issues and for appropriate levels of intervention.

To that end, the forum seeks to increase research and data collection regarding Asian Americans, Native Hawai‘ians, and Pacific Islanders by supporting a standardized collection of pertinent data on race, ethnicity, and primary language; by increasing the effectiveness of endeavors to collect data in the form of health surveys and within hospitals and other health care organizations; by advocating for the increased collection and dissemination of data by federal agencies; and by seeking to ensure that an adequate range and level of resources are applied to the systematic collection of health data on Asian Americans, Native Hawai‘ians, and Pacific Islanders.

Improving Health Care Equity

Third, the forum is concerned with achieving a level of equity in relation to health care; that is, ensuring that every individual, from every ethnic or cultural group, has a fair opportunity to attain the best standard of health available through the provision of health care. To that end, the forum advocates that data and research need to be undertaken in order to ascertain whether and to what extent health care resources are being applied in an equitable manner; and when there appears to be a disparity in that allocation, the forum believes the socioeconomic factors that might account for this disparity must be effectively addressed.

The forum suggests a range of approaches that might assist in this data collection and analysis, for example, recommending the use of disaggregated data on Asian American, Native Hawai‘ian, and Pacific Islander communities because such data might reveal disparities in health status and/or access to appropriate health care for certain groups within those broader communities. It would follow, the forum argues, that specific rather than generic data such as this would allow policy makers to target health care delivery more effectively, and to set appropriate and more meaningful health care priorities together with the necessary and identified resources. For the forum, the systematic engagement in community-based participatory research would create data that were based upon the direct and relevant experiences of the communities with which the research was concerned.

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See Also: Asian Americans; Asian Immigrants; Hawai‘ian Native Americans; Health Care, Disparities in; Health Insurance; Pacific Islanders.

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Asian Immigrants

Recent history has witnessed an influx of Asian immigrants to the United States. Asian immigrants have become an integral part of various aspects of American society by redefining the nation's identity and reshaping its economy. The Asian immigrant population features strong diversity in terms of national origin, ethnicity, culture, socioeconomic backgrounds, and immigration statuses. Some of the largest Asian immigrant groups come from India, Philippines, China, Vietnam, and Korea. These countries differ in language, culture, and immigration statuses.

Depending on their country of origin and circumstances, Asian immigrants migrate to the United States as refugees, asylees, temporary or permanent residents, or undocumented people. Oftentimes, their various migration experiences have socioeconomic and psychosocial impacts on their acculturation to the United States. There are vast implications for the human services needs of the Asian immigrant population because of its growth and diversity. Culturally competent and accessible human services for the Asian immigrant population is not only valuable for an individual immigrant's successful resettlement but also for the long-term social and economic success of the United States from cultivating productive citizens.

Issues Asian Immigrants Face in the United States

Regardless of origin, immigration status, or any other demographic factor, most immigrants experience general stressors of leaving behind a familiar environment to enter a new country with unfamiliar culture, language, climate, social system, and behavioral norms. Immigrants have to navigate through the different aspects of their new surroundings, including finding employment, housing, and addressing any health care needs. However, the considerable diversity within the Asian immigrant population creates varying magnitudes and different sets of issues. For example, an Asian refugee will face more challenges in establishing financial stability than an Asian immigrant coming for a job opportunity. Thus, understanding the Asian immigrant population as heterogeneous acknowledges how differences in their social histories, socioeconomic statuses, and cultural characteristics impact their experiences as immigrants in a new country.

The immigration status of Asian immigrants is especially telling of potential hardships they might experience in adjusting to their new environment. For example, the refugee population face unique and substantial challenges in their immigration to the United States. Refugees are people who flee or are forced to leave their country of origin because of persecution or fear of persecution. The refugee experience can be challenging to their psychological and social acculturation in the United States. Personal losses of friends and family members, country, and familiar way of life can cause severe psychological distress—especially when this occurs abruptly, as is often the case with refugee evacuation. Learning a new language, adapting to a new culture, lack of social network support, and having to establish economic self-sufficiency can compound refugee acculturation stresses. For example, Asian refugees may face challenges in accessing medical care because of financial hardships, transportation problems, language difficulties, and lack of medical insurance.

Human Services Needs of Asian Immigrants

Immigration legislation and policy have been enacted to address some of the human services needs and ameliorate the above-mentioned social and economic challenges. These services often depend on immigrant statuses. For example, the Refugee Act of 1980 provides refugees special assistance with the ultimate goal of economic self-sufficiency. These services include relocation assistance, medical care, English language services, employment counseling and placement, and financial assistance. They are also entitled to Supplemental Security Income, Aid to Families with Dependent Children, Medicaid and Children's Health Insurance Program, and food stamps. For immigrants with permanent residence, the services available are more restricted. For example, a sponsored immigrant qualifies for these economic services based on their own income plus the income of their sponsors.

As Asian immigrants adapt to their new environment, their human services needs change. Once immigrants acquire their immediate needs of food, shelter, information, and basic language skills, they transition to intermediate needs of training and education for employment, health services, and housing. Long-term needs may include participating in U.S. society as equals with the native-born population and citizenship.

Barriers and Gaps in Human Services Needs of Asian Immigrants

Important to human services for Asian immigrants are the cultural competency of delivery and the accessibility of services. Although there are human services available to immigrants in the United States, Asian immigrants face many barriers to accessing these services. The main types of barriers to service utilization are informational (awareness of existing and available services), financial, linguistic, cultural, and systemic barriers (policies and structures that keep marginalized groups from gaining access). For example, there are barriers to mental health services for the Asian immigrant population. Studies have found that Asians view mental health services as a last resort and are less likely than their Caucasian counterparts to be referred by any social support system, whether that be family and friends or the criminal justice system. There is a need for programs focused on assisting and connecting Asian immigrants to human services and resources.

How human service programs are administered can address the disparities in human services utilization. Implementation of cultural competency within services, such as health care, can alleviate the barriers by approaching immigrant patients with appropriate and culturally sensitive intervention techniques. Culturally competent techniques can include materials available in the immigrant's native language, bilingual staff or interpretation services, and cultural awareness in those providing services. Closing the barriers and gaps to human services can help Asian immigrants meet their basic needs and improve well-being.

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See Also: Acculturation; Community-Based Services; Cross-Cultural Service Models; Cultural Competence, Human Service Providers and; Culturally Diverse Practice, Definitions of.

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Asian Indian Immigrants

Asian Indians are the third-largest Asian American ethnic group in the United States, constituting 1 percent of the U.S. population, or about 3.18 million people, according to the 2010 U.S. Census. Among all ethnic groups Asian Indian immigrants possess the highest household income. After enactment of the Immigration and Nationality Act of 1965 and the Immigration Act of 1990, the Indian community carved a niche in American society as highly skilled professionals. The percentage of Asian Indians who are below the federal poverty line is 10 percent, compared to 12 percent of all Americans. About 67 percent of Asian Americans hold graduate degrees, making them one of the wealthiest and best-educated populations in the country. However, Asian Indians experience the same problems as any other immigrants. Moreover, some of these people are taxi drivers, small shop owners, messengers, newspaper hawkers, domestic workers, and waiters in restaurants who are in dire need of service support. All Asian Americans irrespective of their status or nationality are confronted with prejudice and racial discrimination. Child abuse, domestic violence, mental as well as physical health, the plight of senior citizens, single mothers, and lack of communication skills are some of the major problems present in the Asian Indian community.

Prejudice Against Asian Indians

Asian Indians who have settled in the United States have often been the target of racial and other forms of discrimination. Antimiscegenation laws were enacted in the 19th century, and federal legislation adopted in 1882, 1917, 1924, and 1934 categorized persons on a racial basis, dividing people into whites and nonwhites. However, the Immigration Act of 1990 represented the culmination point in the liberal era of immigration policy formulation. As a result of this law, Asian Indian immigrants, along with their children, became more visible in American politics, society, economy, and culture. At the same time, there was division in the Asian Indian community because of the reluctance of many immigrants to enter mainstream American society. An anti-immigration atmosphere was created in some quarters after the act was passed, and there was a sustained campaign by protectionist groups with their slogans of “Hindu invasion” or “Turban tide” against the Indians. The Asian Indians have also become easy targets because of the prejudice of some U.S. residents who see these immigrants as taking jobs away from American citizens.

After September 11, 2001, Asian Indians again became targets of ethnically biased attacks, causing mental trauma for the victims. However, these indiscriminate attacks were condemned by the public and many organizations. The hate crimes against the community became a major concern for Asian Americans, and organizations such as South Asian Alliance for Action and South Asian American Leaders for Tomorrow were established to prevent such crimes.

Service Needs of Asian Indians

The needs of Asian Indian immigrants pertaining to human services are more or less similar to other minority groups coming to the United States from Asia, Africa, and Latin America. The social and economic profile of Asian Indians has become very complex with the increasing influx of immigrants, resulting in the proliferation of human service requirements as well as human service providers. In the health care system, the immigrants sometimes face negative interaction with health care agencies. Lack of information, barriers in language and culture, as well as economic deprivation have restricted the immigrants from obtaining proper health care. Some people receive alternative treatments not only from traditional healers within the Asian Indian community, but also take recourse to Indian ayurvedic medicine. A low level of education and economic constraints among poor immigrants also prevent them from receiving health insurance benefits.

Among the Asian Indians, one of the major causes of mortality is coronary heart disease, which is more common in this population than in other ethnic groups. The comparative prevalence of this heart disease is because of obesity, lack of physical activity, genetic risks, and other medical problems. In order to prevent heart disease, health educators should also look into psychological and social factors. Psychological and behavioral disorders are a major problem in American society, and Asian Indians are not immune to it. Their psychological well-being has become a major concern, as many face difficulties in adjusting to American life. Some develop emotional disturbances like anxiety disorders, schizophrenia, and other types of mental diseases. Under the Community and Mental Health Centers Act of 1963, mental health centers were established throughout the country offering services such as inpatient care, partial hospitalization, and consultation.

The children of Asian Indians also face physical and emotional problems, which are a concern for human service agencies. These difficulties include the plight of children living in single-parent families. Child abuse is another serious problem for some children. Senior citizens with low incomes are provided with low-cost housing, food stamps, and benefits from Old-Age, Survivors, and Disability Insurance (OASDI). Newly arrived women immigrants with low levels of education work as child care assistants, taking care of the children of working parents. Some of them also work in homes making packaged foods to be sold in grocery stores. Even educated immigrant women are not paid as well as their white counterparts. Domestic abuse against women is increasing, and organizations like Manavi, Sakhi, Apna Ghar, and Maitri have been set up in New Jersey, New York, Chicago, and San Francisco.

Social service agencies have been established to mitigate the plight of persons working in low-wage service positions. The oldest of these agencies, the National Association of Indians in America, was established in 1967, and has provided assistance to immigrants. Other agencies and human service providers teach new immigrants the basic skills of communicating in English. About 5,000 attorneys are members of the North American South Asian Bar Association, and this organization represents Asian Indians who are charged with criminal offenses or denied fundamental rights. Taxi drivers of South Asian origin formed the New York Taxi Workers Alliance in 1996 to obtain better working conditions.

The various human service groups that have sprung up to assist immigrants have an important task to perform. A competent human service provider dealing with Asian Indians from diverse cultures should be familiar with special culture-centered counseling techniques. An empathic understanding will also alleviate the sufferings of Asian Indians; the human service needs of this client group will be better addressed and immigrants will face an even better future in the United States.

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See Also: Aid to Families with Dependent Children, Historical Role of; Asian Americans; Asian Immigrants; Equal Opportunity and Civil Rights; Health Promotion Services; Social and Economic Justice; Substance Abuse and Mental Health Services Administration.

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Assimilation

Globalization, described as the movement of people across national borders, presents both opportunities and challenges with regard to how migrant hosting nations, ethnic cultures, and, indeed, service providers deal with issues of identity and difference. It is increasingly evident that theorists, policy makers, and practitioners will have to grapple with issues that arise within this "crucible of cultures" brought about by increasingly high levels of cross-border activity in the contemporary forms of migration. For politicians, social workers, and other practitioners, the increasing heterogeneity of ethnocultural identities and differences has triggered a plethora of theories and strategies for appreciating, understanding, and dealing with difference. Thus, assimilation is one such alternative, choice, concept, or approach to dealing with intercultural relations.

Within the past two centuries, following significant levels of migration, assimilation was thrust into the forefront of social academic theorizing, research, and political discussion, predominantly in America and Europe.

Assimilation at its basic level means the process by which immigrant individuals, ethnocultures, and groups adjust or are made to adjust their behavior (socially and economically) in order to assume the dominant or host or native culture. On the face of it, it may seem that considerable consensus exists regarding the meaning of the concept of assimilation. Yet when the range of points of view are interrogated, the extent of the differing perspectives around both the process and the meaning of the term *assimilation* emerge. Indeed, the meaning of the term has at times been notoriously elusive for many reasons: first, because it has been contested that the original meaning and model attributed to the phenomena of the interaction between groups was viewed as far too simplistic, inept, or inadequate in explaining how new minority groups blended into the majority (normally native) groups within immigrant hosting countries over the past century. The second argument comes from concerted longitudinal studies and also a reexamination of group behaviors and community relations that revealed other equally enriching perspectives and insight into intergroup ethnocultural and social relationships and the process of arriving at a point in time where they seem to blend. These ongoing developments present new and equally valid grounds for reappraising earlier propositions, thereby contributing to the existing body of knowledge.

Thus, as a further extension of the points made above, assimilation may also be defined as the point in time at which evidence of full understanding (social and structural engagement) between the minority and majority groups becomes evident. The Chicago school of sociology in particular brought this discussion to another level at the beginning of the 20th century. During the initial theorizing assimilation was portrayed as a process that was linear, or a continuum with one end of the line depicting a distinct and definable migrant ethnic group that holds clear home cultural values, while on the other end of the continuum the groups will have adjusted into a host (native) culture enough as to be indistinguishable from that of the host ethnic/cultural group.

Perhaps it is important to state that although a sociological focus on the model of assimilation seemed to wane in the 1970s, its resurgence has been brought about by increased voluntary or involuntary migration worldwide. Voluntary migration involves the movement of people from their home country to another for economic reasons, including employment. Involuntary migration also involves the movement of people to another country, but there is an element of being forced by circumstances such as conflict, environmental disasters, displacement, or other forms of disaster. People affected by involuntary migration may seek asylum in a stable country and may be granted refugee status.

Discussions around assimilation have often been framed within the context of cross-border movements, that is, migration. Yet migration has been taking place for thousands of years. The expansion of the Greek, Roman, and Carthaginian empires, for example, was an exercise in some form of assimilation. The efforts by explorers such as Vasco da Gama, Ferdinand Magellan, and Christopher Columbus and the expansion of the British Empire in the 19th century resulted in some form of social and economic contact and interaction between explorers and natives (i.e., indigeneous groups), rulers and the ruled, the colonizers and the colonized.

Perhaps the key factors that shaped and continue to impact the discussion about assimilation relate to three key aspects: (1) the definition and redefinition of democracy over time, individual and other rights in an increasingly human rights–driven era; (2) the significantly lower levels in previous migrations as compared to the post-20th-century migration; and (3) resource pressures brought about by rising population numbers and migration over time.

Thus, it can be observed over time that perfectly legitimate demands on the part of immigrants on the basis of human rights may run counter to perceived and sometimes real economic, social, and political insecurities and pressures from within the migrant hosting nations. For reasons of perceived and real cultural and economic insecurities and pressures, nothing short of assimilation was generally expected to inform political, development, and social policies in the 19th and 20th centuries. The inability to stem migration—whether in Europe or Australia—brings back the discussion to assimilation.

The concept of assimilation is essentially a race and cultural relations concept discussed as such by many social researchers. First used in the United States, the concept has generally been credited to the work of Robert Park, who researched extensively into race relations theory. Park depicted the race relations cycle in terms of four distinct stages: contact, competition, accommodation, and assimilation. It has generally been accepted that the concept was first used in America in referring to the process that minority cultures undertook in settling among the dominant white race. Indeed, the context within which these debates have taken place in recent decades does provoke a debate worth considering.

Migration constitutes one of the most striking global developments of the last century and has exerted a phenomenal social and cultural impact with regard to geodemographics in a number of countries in the world. The majority of the people who are displaced by wars, political instability, and environmental change migrate to neighboring countries. However, a significant number fleeing from conflicts seek asylum in countries far away from their country of origin. The farther afield people travel to seek asylum and migrate, the greater the likelihood that they will encounter a culture significantly different from their own, or that the immigrant culture will be wildly misunderstood or misrepresented by a majority or host group. Thus, the

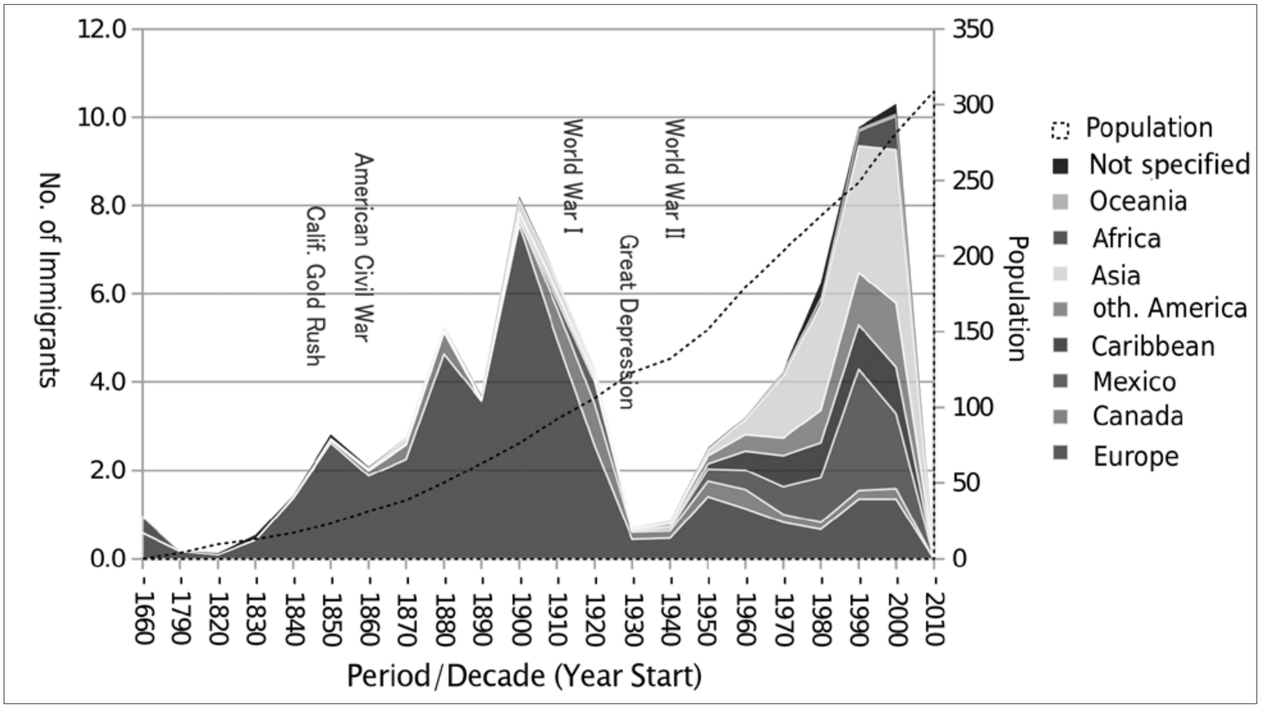

Figure 1 Immigration to the United States (Between 1660 and 2009 in millions). Assimilation at its basic level means the process by which immigrant individuals, ethnocultures, and groups adjust or are made to adjust their behavior in order to assume the host or native culture.

Sources: U.S. Department of Homeland Security 2011 Yearbook of Immigration Statistics. Data prior to 1820, "History of Immigration to the United States." http://en.wikipedia.org/wiki/History_of_immigration_to_the_United_States.

host society, who are mostly politically and socially powerful and influential, may seek to set a framework within which to integrate the migrants. Yet the host community and nation may largely draw these frameworks for engagements around their cultural and national values. While some critics may rightly argue that assimilation may be desirable or essential for proper functioning of a community or nation, immigrants may argue that assimilation places unnecessary constraints on them.

From the above discussion, it is not problematic to see why assimilation has a number of critics in that it creates perhaps a forced notion of "the host knows it all" situation. Thus, assimilation essentially revolves around the expectation that minority ethnocultural groups and mostly migrants will blend into the dominant culture or host nation of which they have become a part. This progressive process is associated with immigrant individuals and groups reconfiguring their behavior in order to be deemed fit by the host nation and ethnocultural groups. The process is associated by demands, articulated or not, from the host nation or culture for immigrants to become and behave "native and host nation cultured." Thus, assimilation is often also referred to as "cultural assimilation" within the diversity discourse.

Often central to the discourse about assimilation is its effect on the minority groups as they adjust to be incorporated into the majority cultural group. The identity of members of the minority group is undermined and threatened as the distinct role and values that have served them well previously in their home countries/cultural groups are subjected to change or extinction. Thus, for example, in response to such outside pressure, a member of a minority group may seek other forms of identity within in-groups of their home minority ethnic group with a view to retaining aspects of their values and culture that have previously proven to sustain them. External cultural threats to a minority ethnic cultural group may not necessarily be detrimental to a minority group. On the contrary, pressures from the majority and the powerful to assimilate may provide the impetus to and rationale for resorting to their own cultural and group values to help them make sense and cope with challenges facing them in the host nation/community context.

It has been suggested with proponents of an assimilationist perspective that immigrants will inevitably become like the main group over time, and the immigrant having lived the longest in a given place or within a host culture will display fewer characteristics that can be traced to their home/cultural group than newer immigrants. Yet others have argued that the journey by immigrants toward assimilation is characterized by barriers and roadblocks against migrants to which host nations, cultural groups, or nations are oblivious. Thus, the issue is often advanced by some critics that this relates to a relative disadvantage faced by migrants that host communities often ignore in policy making. The argument states that the journey to assimilate for migrants and often minority groups may be punctuated by economic and cultural blocks from the majority because of discrimination and ethnocentric tendencies. Confronted with such hurdles in the new context and environment, it has been suggested that it ought to be acknowledged that minorities should be able to celebrate and develop links and avenues to cope or circumvent challenges in the new environment. Indeed, structural barriers such as institutional barriers may present obstacles and impede the assimilation process.

The above does make it necessary to consider some arguments and propositions about how the level of assimilation may be measured. The level of assimilation and the process of assimilation may be measured around the following dimensions, though this is by no means exhaustive:

1. *Social status*: This aspect centers on the experiences of immigrants around occupation, levels of income, education prospects, and attainment and how these measure up to those of the host community.
2. *Language*: The loss of home-nation language and adoption of the host community's language has sometimes being associated with assimilation. The more likely a minority group is able to speak the language of the host nation and community has been attributed to the process of assimilation.
3. *Spatial separation*: This relates to the patterns that develop over time between the host and immigrant communities. It has been suggested that as the process of assimilation takes hold, the usually concentrated patterns of settlement by immigrants will gradually decrease as the

immigrant community settles among the host community areas.

4. *Intermarriage*: This is a critical feature that has been attributed to assimilation. Second generations and third generations of immigrants may show characteristics of intermarriage with the locals and in the process display intimate and improved relations with the host community.

Although at the outset this discussion seems to suggest that assimilation is the relationship between the majority determining the course of events and the minority, it is a more complex concept. In certain cases it may simply revolve around the powerful cultural minority exercising power over minority groups. In certain cases it may be the powerful minority expecting, and to an extent requiring, that the majority they forcibly occupy, for example in a colonialist context, assimilate to the minority culture, social expectations, and values.

The process of globalization, the free movement of people, and the right to life for those fleeing persecution and conflict (generally known as protection) mean that there will always continue to be discussions on what forms intergroup relations must take to uphold human rights and the civil liberty of migrants. In the final analysis, this discussion does not seek to suggest a preferred option for dealing with identity and cultural difference brought about by migration.

Indeed, for example, although the countries in the European Union share common ideals of democracy and free society, nationally each one of the countries pursues vastly different approaches to migration between them—assimilation being just one of many alternatives. Perhaps the most critical point worth considering is how policies and practices at national or local levels and service provision take into account human rights and the civil liberties of migrants in an increasingly mobile and ethnically diverse world brought about by migration.

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See Also: Immigrant Populations, Human Service Needs of;; Immigration: Human Service Issues; Immigration Law, History of U.S.; Pluralism.

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Assistive Technology

Assistive technology has been used to assist humans in everyday tasks throughout history. However, the systematic use of the term *assistive technology* has emerged only recently. Formal definition of assistive technology (AT) was first published in the Technology-Related Assistance for Individuals with Disabilities Act of 1988 (commonly known as the Tech Act), which was amended in 1994 and replaced with the Assistive Technology Act of 1998 (AT Act) and remains in effect today via Public Law 100–407. Since 1988 this legal definition has been used in other federal legislation authorizing services and supports for persons with disabilities. For example, the Individuals with Disabilities Education Act (IDEA) includes P.L. 100–407.

In the United States, according to the Assistive Technology Act of 1998, AT refers to any "item, piece of equipment, or system, whether acquired commercially, modified, or customized, that is commonly used to increase, maintain, or improve functional capabilities of individuals with disabilities." Assistive technology, also called adaptive technology, can be used in the home, workplaces, schools, nursing facilities, hospitals, museums, and numerous community buildings and locations.

AT tools include assistive, adaptive, and rehabilitative devices that promote independence for individuals with disabilities by enabling them to increase their mobility, comprehension, and access to learning and to accomplish daily tasks and perform basic functions. For instance, there are keyboards with colors and large keys, as well as ergonomically designed computer mouses and speech recognition computer software to improve writing and listening for people with limited hand and body movement and visual, hearing, and speech impairments.

AT devices can be low tech, medium tech, or high tech. In addition to new technologies and computer software, AT can include simple tools and devices such as ergonomically designed pencils, enlarged text, traffic sounds, echoes, pedestrian signals, the texture of the sidewalk, hearing aids, text telephones (TTYs) and telecommunication devices for the deaf (TDDs), walkers, and prosthetic body parts. It is now the law that federally funded Web sites must be Section 508-compliant, or accessible to those with disabilities. Assistive technology for homes, workplaces, schools, and nursing homes may include any of the following:

- AT for motor aspects of writing, such as adapted tool grips, stabilized materials with nonslip materials, slantboards, and raised lined paper;
- AT for reading, such as book easels, enlarged text, color overlays, books on tape, e-texts and books, screen readers, picture symbols, highlighter tape, screen magnifiers, enlarged text, and braille;
- AT for study and learning, such as picture schedules, highlighter tape, outlining and scheduling programs, handheld recorders, and visual timers;
- AT for mobility, such as gait trainers, standers, walkers, braces, power and manual wheelchairs, scooters, canes, and adapted tricycles;
- AT for daily living, such as adapted eating and drinking utensils, adapted personal hygiene tools, switch-operated cooking devices, picture task analysis for chores, environmental control units, and adapted swings;
- Augmentative communication devices, such as speech-generating devices and voice amplifiers, speech recognition devices, eye-gaze boards, and object communication boards;
- Medical equipment and medical supplies, such as patient lifts, orthotics and prosthetics, hearing aids, electric larynxes, and sip-and-puff systems—activated by inhaling or exhaling;
- Special equipment and AT for work, study, and recreation, such as enlarged computer keyboards, text-to-speech (TTS) and speech-to-text software, voice recognition software, amplified telephones, magnifiers, adaptive sport equipment, keyguards, minimouses, touch screens, trackballs, and joysticks;
- AT for hearing, such as classroom amplification systems, personal amplification systems, captioning, and TTY/TDD conversion modems;
- Equipment and AT for community access and accessibility adaptations, such as ramps, stair glides, lifts, accessible public transportation, talking automatic teller machines (ATMs), and voting machines for the visually challenged;
- AT for writing, such as word cards, handheld spell checkers, tablet personal computers, sentence strips, tape recorders, talking word processors, graphic organizing software, and word processor accessibility features;
- AT for mathematics, such as talking calculators, graph paper to organize math problems, and recorded work problems; and
- AT for seating and positioning, such as nonslip surfaces on chairs, bolsters, and adopted chairs or wheelchairs.

Assistive technology serves people with communication disorders, impaired mobility, hearing and visual impairments, and cognitive and learning disabilities. AT includes the selection of appropriate devices and services, training in how to use them, solutions for caregivers, and ideas for future research and development. In addition to improving the daily tasks and functions of people with disabilities, AT provides security and support for people at risk and experiencing difficulty, such as the personal emergency response system (PERS) that triggers an alert for assistance.

Who Benefits From Assistive Technology?

Assistive technologies have been developed to help many different types of people with a vast variety of challenges. These challenges are not limited to low vision, a voice or speech disorder, cognitive impairment, hearing impairment, brain injury, progressive degenerative diseases, developmental delay or disorder, attention issues, autism, and social, emotional, and behavioral challenges. AT also assists people who have difficulty learning English as a second language and other learning disabilities, as well as those with performance challenges in school and in the workplace or with temporary difficulties because of health issues, aging, and accidents.

History of Assistive Technologies

Several world events have impacted the need for and development of assistive technologies. Following the American Civil War and World War II, there were major developments in medicine and science and advancements in orthopedic devices, such as prosthetic limbs and wheelchairs. The advent of new technologies since the 1970s also had a major impact on the advancement of assistive technologies. For example, educational software was developed for improving literacy, mathematics, and reading text out loud.

Hearing aids were first patented in the 1890s and improved in size and quality following World War II and the Vietnam War because of the fact that hearing damage was the leading disability for military personnel. Tremendous effort and funding for the development and advancement of new technologies to improve hearing loss was supported by the U.S. military and other federally funded initiatives. AT is continuing to develop in the 21st century in response to an increasing number of soldiers who are returning to the United States with motor and cognitive impairments and other neurological disorders, including traumatic brain injury, as well as mobility, hearing, and sight loss.

The field of AT is improving at a very rapid pace with the help of new technologies and innovations in telecommunications, nanotechnologies, biotechnologies, and robotics, as well as the demand and the necessity for inclusive education and business models. As the outdoor navigation technologies such as talking traffic signs and global positioning systems (GPS) improve, they provide directional cues for persons with visual impairments.

There is a growing emphasis on developing inclusive, transformative educational resources and products that can be used by everyone. It is easy to create lesson plans using the universal design for learning (UDL) that was developed by the Center for Applied Special Technology. UDL provides a template for creating flexible learning goals, methods, educational resources, and assessment models that differentiate education and accommodate learners with different abilities.

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See Also: Americans with Disabilities Act; Americans with Disabilities Act of 1990; Convention on the Rights of Persons with Disabilities, United Nations; Individuals with Disabilities Education Act; Meaningful Access; National Database for Autism Research; Special Education; Universal Access/Universal Design.

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Association for Multicultural Counseling and Development

The Association for Multicultural Counseling and Development (AMCD)—a division of the American Counseling Association (ACA)—is an organization that strives to encourage counseling practitioners and other mental health providers to be aware of and understand multiculturalism and the influence of the multicultural counseling approach.

Multiculturalism has been recognized as the "fourth force" in the counseling profession. Its basic principle is that society and communities learn to accept the cultural differences of their populations and strive to provide equality of protection for individuals from varied backgrounds to include race, ethnicity, ability, sexual orientation, religion, national origin, and culture. More recently, multiculturalism has expanded to include training of counselors in the United States and establishing multicultural counseling competencies as a guide to becoming proficient in this area. Today, counselors are trained in the skills that enable them to become aware of cultural differences in themselves and others.

History

The AMCD was originally the Association of Non-White Concerns in Personnel and Guidance (ANWC), which was established in 1972. Several years before that, the members of what would become the ANWC asked the American Personnel and Guidance Association (APGA)—the former name of the American Counseling Association—to create a separate division that would focus on nonwhite concerns. Although ANWC members paid their dues to the APGA, they had experienced limited representation and had no voting rights on the APGA's board of directors or senate. Despite recommendations pointing out the need for a multicultural perspective in counseling and education, APGA officials did not believe there was a need for a division to focus on minority issues. After long discussions and several meetings between the ANWC and APGA, APGA denied the ANWC's request.

The interested members of ANWC continued to have their own sessions and group meetings. The group expanded its membership and elected its own officers. Group members also raised funds to accomplish their goals. However, the members still experienced a lack of help or encouragement from APGA. The interested group members of ANWC continued to expend their efforts toward their goal. The members elected agents and kept disseminating information to group members who were interested in becoming a division of APGA. They also provided information concerning current progress and what was happening within the APGA.

The interested group members of the ANWC found out that the APGA could not provide any assistance to the group. Three weeks prior to the APGA national conference in 1972, the elected officers of ANWC visited the APGA headquarters in Washington, D.C., to discuss their request to become a separate division. The ANWC members and APGA officials had many long discussions about the name, tax-exempt status, membership, and other details.

However, the APGA officials did not immediately approve the request and continued to vacillate. But at the APGA's 1972 national conference in Chicago, ANWC members finally achieved their goal of establishing a separate division. Over 400 ANWC members attended a preconference to show their support for the new division. The ANWC division was officially chartered at the Chicago convention. The name of the division was changed to the Association for Multicultural Counseling and Development in 1985.

Leadership

Samuel H. Johnson was the most significant leader of the ANWC. He and his colleagues made a great effort to develop the ANWC and influenced people in the community to educate themselves about multicultural concerns. The ANWC became one of the most recognized and respected organizations for minority groups in the helping professions. Johnson was the president of ANWC for two terms and later became president emeritus of the AMCD.

Past and current leaders of the AMCD have continually focused on the development and goals of the organization. The leaders have worked hard to improve human and civil rights development. The current concerns of the AMCD are to create an ongoing international outreach to mentor graduate students, provide guidance to new professionals, and publish materials with active, multicultural-competent helping professionals.

Mission

The Association for Multicultural Counseling and Development aims to create programs that assist counseling practitioners and students in attaining awareness and understanding of cultural and ethnic differences. The organization has recognized the need for establishing multicultural competencies and standards for counseling practitioners who work with diverse client groups. The AMCD promotes opportunities among counseling trainees, supervisors, and practitioners for the development of multicultural competence. The association also makes an effort to educate and train counseling professionals and students in order to improve their knowledge of ethnic, racial, and cultural diversity.

The AMCD promotes the counseling profession and other mental health professions in being aware of and understanding the impact of cultural and ethnic differences on the counseling process. The organization's focus is to enhance criteria and guidelines for providing development-counseling services to people of all cultures and ethnic diversity groups. The AMCD also encourages counselors and students from diverse cultural backgrounds to advance and sustain personal growth through improved educational programs. Moreover, the AMCD identifies and advocates for eliminating conditions that develop barriers that could harm or risk the development, health, and wellness of people from a diversity of cultural and ethnic groups. In addition, the AMCD publishes a newsletter four times a year, which contains information about ethnic concerns of interest to group members, and produces a quarterly publication, the *Journal of Multicultural Counseling and Development*, which focuses on and addresses various topics such as race, culture, ethnicity, gender, religion, sexual orientation, ability, acculturation, and social class, among others.

Multicultural Counseling and Development

The AMCD has emphasized the importance of multicultural counseling competencies and ethnic and racial comprehension to mental health practitioners and students across a variety of professions. Several authors in the field of multiculturalism write about multicultural counseling to include different forms and ways of human interaction, engagement, and innovations across different backgrounds. Multicultural counseling recognizes that counseling practitioners should respect individuals' race, ethnicity, ability, sexual orientation, religion, national origin, and culture while working with diverse populations.

The AMCD identifies multicultural counseling competencies across three domains: attitudes and beliefs, knowledge, and skills. The AMCD maintains that culturally skilled counselors must be aware of their own cultural values and biases. It is important for counselors to have knowledge about their own racial and cultural differences to avoid having a negative effect on clients. The AMCD believes that culturally skilled counselors should understand clients' worldview. Culturally skilled counselors are also fully aware of the particular group with which they are working in order to eliminate negative reactions in counseling. Additionally, counselors should become familiar with the historical and current sociopolitical influences that may impact the lives of racial and ethnic minorities. The AMCD affirms that counselors need to be aware of culturally appropriate intervention strategies. Culturally skilled counselors respect clients' religions, beliefs, and values because they relate to interventions and strategies helpful in working with specific groups.

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See Also: Cross-Cultural Service Models; Cross-Cultural Skills; Cultural Competence, Human Service Providers and; Cultural Competence, Professional Standards of; Cultural Competence, Training in; Culturally Diverse Practice, Theories of; Education for Diversity in Human Services.

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Association of Administrators of the Interstate Compact on the Placement of Children

The Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) was established in 1974 and consists of members from all 50 states, the District of Columbia, and the U.S. Virgin Islands. The AAICPC has authority under the Interstate Compact on the Placement of Children (ICPC) to promulgate rules and regulations to more effectively carry out the terms and provisions of this compact. The AAICPC obtains its secretariat services as an affiliate of the American Public Human Services Association.

The secretariat to AAICPC provides administrative, legal, and technical assistance to individual states that administer the compact. The secretariat also offers resources and information for resolving problems of mutual concern and formulating common policies, practices, and goals. The secretariat does not generally handle questions about individual cases, and these questions should be referred to the public human service agency or private child placement agency responsible for the case.

The Compact’s Process

The Interstate Compact on the Placement of Children is an agreement between all 50 states, Washington, D.C., and the U.S. Virgin Islands. The compact provides for the movement and safe placement of children between states when the children are in the custody of a state, being placed for private/independent adoption or, under certain circumstances, being placed by a parent or guardian in a residential treatment facility (RTF). The process involves several steps. In order for an ICPC placement request to get started, a caseworker (or adoption entity) in the state in which the child is located creates a packet that includes such items as the child’s social, medical, and educational history and the current status of any court case involving the child. The packet will also include information about the person who is being considered for placement of the child in the receiving state, so that the receiving state will know whom they should be evaluating for possible placement. Once the local person in the sending state creates the placement request packet, it is sent to the central ICPC office in the sending state (usually the state capital, e.g., Austin, Texas).

The ICPC central office in the sending state makes sure everything is in the packet, approves it to be sent out, and then transmits it to the ICPC central office in the state where the child would be placed. Once it arrives in the central office of the receiving state, that office also looks at the packet and, if all is in order, the central office will send it to the social services agency office in the community where the home of the prospective placement is located. Someone from the social services agency will then visit the home, meet with everyone in the home, conduct background screening, and make a determination as to whether the home should be approved for the child to come and live there.

A completed home study report is then sent from the local agency to the central ICPC office in that receiving state and the placement request is either approved or denied based on the recommendation of the home study report. The packet is then sent from the receiving state to the central office in the first state for review. Finally, the local office that started the placement request is sent a copy of the completed home study, along with documentation of the receiving state’s decision to either approve or deny the placement request. If the request has been approved by the receiving state, the child can be placed in the chosen home.

While there is much more detail to the process in terms of the forms, financial arrangements for the child, and licensing that may need to be put in place, this is a simple overview of each of the steps that the placement request process will take to go from the local level in one state, through the central office of each state, to the local level in the other state and back again. The process ensures that when children are placed out of state, they are placed in a safe and nurturing environment that can meet their particular needs.

The Compact's Purpose

The primary purpose of the ICPC is to ensure that children placed out of state are placed with caregivers who are safe, suitable, and able to meet the child's needs. The ICPC requires an assessment of these factors before a child is placed out of state. Individual state statutes are not enough to ensure that such an assessment takes place before placement because the authority of an individual state and its statutes end at the state's border. As a legally binding agreement between all states, the ICPC ensures that children enjoy a uniform set of protections and benefits, regardless of which state they are moving to or from.

Another critical function of the ICPC is to ensure that the person or entity that places a child out of state retains legal and financial responsibility for the child after the placement occurs. This directly benefits children by eliminating any question of who is ultimately responsible for the child's well-being and for meeting the child's needs following placement. The ICPC also protects the interests of states by ensuring that individual states are not put in the position of having to take on the legal and financial burden of caring for children placed within their borders from other states.

The Compact's Protocol

The ICPC governs the following types of placements: (1) the placement of a child in the care or custody of a state public child welfare agency with a relative family, a foster family, or an adoptive family in another state; (2) the placement of a child by any individual or entity into another state if the placement is for the purpose of adoption; (3) the placement of a child by any individual or entity into a licensed residential treatment center located in another state; and (4) under certain circumstances, the placement of a child with the child's parent or parents located in another state.

The ICPC does not govern the following types of placements: (1) the placement of a child by the child's parent, stepparent, grandparent, adult sibling, adult uncle, adult aunt, or legal guardian with any such relative or guardian located in another state; and (2) the placement of a child into a medical facility, a psychiatric institution, or a boarding school located in another state.

The Interstate Compact for Juveniles (ICJ) is a contract between the states that regulates the interstate movement of children who are under court supervision or who have run away from home and left their state of residence. The ICJ provides for states' supervision and return of youth who (1) have run away from home and left their state of residence; (2) are on probation, parole, or under supervision, and have escaped to another state; (3) have been accused of an offense in another state; (4) are in need of institutionalization or special services in another state; and (5) are offenders who have been released into the community and wish to relocate to another state.

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See Also: Adolescent/Youth Services, Overview; Association of Juvenile Compact Administrators; At-Risk Youth Services; Child Welfare Services; Childhood Trauma; Educational Support Services; Gangs: Social Issues and Intervention; Gangs in Schools; Juvenile Delinquents; Juvenile Detention Centers; Juvenile Justice System, The.

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Association of Juvenile Compact Administrators

In 1954, magazine articles began to publicize the epidemic of runaway juveniles. Oftentimes juvenile runaways crossed state lines to ensure their whereabouts remained undiscovered. Because of the recognition that action required, various organizations sought to develop counteractive legislation. Efforts were directed toward devising an interstate agreement to cover manifold state problems implicating juveniles.

To devise an interstate agreement, needs were identified that included procedures to permit the return of runaways, absconders, and escapees who were discovered in other states. In addition, to devise an interstate agreement a system under which juvenile offenders could be supervised in other states had to be implemented. The Council of State Governments, with the assistance of many other groups, undertook the task of drafting a compact to meet these needs. Among the organizations that worked with the council on this task were the National Probation and Parole Association, the U.S. Children's Bureau, the Senate Subcommittee on Juvenile Delinquency, the National Association of Attorneys General, and the Parole and Probation Compact Administrators Association. The Association of Juvenile Compact Administrators (AJCA) came from the work group's efforts. AJCA oversees the Interstate Compact for Juveniles (ICJ) for the United States. The deputy compact administrator of each state is a member of the association and responsible for the daily ICJ activities for his/her state.

Model

AJCA comprises compact administrators and deputies appointed by each state and other participating jurisdictions. It is responsible for developing and adopting the rules and regulations that currently govern the administration of ICJ. Also, AJCA actively participates in stipulating the uniform, cooperative, interstate supervision of juveniles on probation and parole; provides for the prompt return (from one state to another) of juveniles who have run away from home and/or escaped from institutions; promotes education about the compact and probation and parole practices; provides training to juvenile justice professionals; and provides additional measures to protect juveniles and the public. Furthermore, the national AJCA may identify failures to comply with established rules.

AJCA was modeled after the successful operation of the Interstate Compact for the Supervision of Parolees and Probationers (Adult Compact), which served to encourage the compact approach for interstate action on juvenile problems. The Adult Compact came about after Congress enacted the Crime Control Consent Act in 1934. Subsequently, the final draft of the Interstate Compact for Juveniles was approved in 1955, and the first organizational meeting of the compact administrators was held in 1956. By 1986, all 50 states, the District of Columbia, the Virgin Islands, and Guam had ratified the ICJ. Today the ICJ continues to provide for the welfare and protection of juveniles and the public.

AJCA Role and Function

AJCA is dedicated to cooperation among states and jurisdictions that are part of the ICJ. The AJCA provides for the well-being and safety of juveniles as well as the community, promulgates rules and regulations, and ensures that the provisions of the compact are homogeneously administered in all states and jurisdictions that have adopted the compact.

The role of the AJCA is to provide for the uniform cooperative interstate supervision of juveniles on probation or parole. Also, the role of AJCA calls for the punctual return, between states, of juveniles who have run away, escaped, absconded, or fled to avoid prosecution; declaration of rules and regulations as empowered by the governing statute; and effective means to carry out the terms and provisions of the ICJ. Likewise, the role of AJCA is to cooperate with the sending states' terms of supervision while maintaining the quality supervision that the receiving state would provide to its own juveniles, in addition to promoting education and offering training to its members and other juvenile justice professionals.

The AJCA's role with the national commission is to closely support a smooth, seamless transition for successful implementation of the new compact. It is the AJCA's goal to assist noncompact states and the national commission to provide uninterrupted services to youth and families during this critical transition period. The AJCA's role with the national commission is to provide specialized and specific training on compact issues, provide education and consultation on daily compact operations, and reinforce compacting and noncompacting states to continue to operate in an accommodating fashion to safely transfer and return juvenile offenders under joint supervision agreements. Correspondingly, AJCA's role is to continue to provide support to the noncompacting states and to communicate issues to the national commission in an effective manner.

As it relates to functionality, the state juvenile compact administrator is responsible for ensuring implementation of statutory mandates for the ICJ in his/her home state. Additionally, this individual or designee represents the state in the national AJCA. While organizational structures vary and daily allocation may occur, duties that must be completed include ensuring all runaways, absconders, escapees, or fugitives are returned in accordance with the ICJ statutory provisions, AJCA rules, regulations, and local juvenile procedures. The state juvenile compact administrator analyzes incoming and outgoing youth case material to ensure completion and compliance with ICJ and ensures the processing of completed referrals to receiving states or local supervising authorities. In addition, the state juvenile compact administrator is responsible for authorizing or rejecting of cooperative supervision for parole or probation supervision based on local recommendation and ICJ statutes, as well as ratifying completion of travel permits authorizing temporary youth movement between states. Furthermore, the state juvenile compact administrator tracks and reviews progress reports and case closures to ensure youth are supervised in compliance with the ICJ; he/she also establishes a liaison with other ICJ offices and all local supervising jurisdictions. Moreover, the state juvenile compact administrator develops policies and procedures in compliance with the statute; compiles required reports and statistics on youth served through the ICJ; and assumes other duties, although not statutorily mandated, that constitute best practice and are mandated in the AJCA rules and regulations. Additionally, the state juvenile compact administrator must assist local juvenile probation and parole, court, and law enforcement departments or other agency staff by providing information regarding ICJ; attend required meetings provided by national AJCA; and provide training to juvenile justice professionals in ICJ law, AJCA, and state rules and regulations.

The Association of Juvenile Compact Administrators (AJCA) was formed in 1954 to help combat the epidemic of juvenile runaways. Interstate Compact for Juveniles, overseen by the AJCA, is used in 20,000 to 30,000 transfer and supervision cases of juveniles on probation or parole annually.

New AJCA

Compact administrator and deputy compact administrator roles and functions will change under the ratification of the new compact. This change will mean AJCA will support the implementation of the new ICJ law in each state. AJCA will also assist both noncompacting and new compacting states to work closely together to serve youth and families under the ICJ. The new roles under the new compact will be to serve as the respective states' national commissioner or designee; provide consultation or serve as an adviser to individual state commissioners; serve as the administrator for daily operations of the state ICJ office; serve as the liaison to his or her respective state council; and provide education, training, and consultation to council members on the old and new compact. Furthermore, the new roles will include developing internal policies and administrative rules for ICJ operations within states and require a strong working knowledge of the new compact rules and regulations and an understanding of each state's individual statutory requirement. In addition, he/she will work with state and national commissioners to develop "best practice" models for effective case transfers, case management, and treatment intervention services, and promulgate rules while acknowledging potentially conflicting individual state and federal laws.

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See Also: Adolescent/Youth Services: Overview; Association of Administrators of the Interstate Compact on the Placement of Children; At-Risk Youth Services; Child Welfare Services; Childhood Trauma; Educational Support Services; Gangs: Social Issues and Intervention; Gangs in Schools; Juvenile Delinquents; Juvenile Detention Centers; Juvenile Justice System.

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At-Risk Youth Services

The state of African American male educational attainment and society's perception of black males are matters of concern. There are a multitude of forces and pressures impeding the progress of African American males in education, which has a residual effect on their educational opportunities and, potentially, their life experiences. For example, black males are more likely to underperform on standardized tests, undergo suspension from school, experience special education placement, and eventually drop out of school. In the past 100 years, approximately 400 publications have been written about black males. In many instances, these publications report that black men have been characterized as endangered, uneducable, dysfunctional, and dangerous given their various challenges and unfortunate dealings with the educational and judicial systems.

In 2006, while African American male youth accounted for a little over 1 percent of the U.S. population, they were implicated in 25 percent of the homicides and composed 15 percent of homicide victims. Consequently, many black males are missing from school because they are completing prison sentences, mostly for drug-related offenses. Only 47 percent of black males who enter ninth grade earn a high school diploma. Additionally, they are often overrepresented in special education and alternative education programs, and underrepresented in gifted and talented programs and advanced placement classes. Black males have much to contend with, and these myriad issues often intersect with their other identities, such as residents of low-income communities. Drastic measures must be taken to alleviate such adverse educational and life experiences; otherwise, the progress of black males will continue to decline. Specific interventions such as role modeling and mentoring and educational programming have proven to combat the inability of educational progress and to create positive experiences among black males.

Need for Role Models and Mentors

Role models in and outside the classroom, such as black male teachers and other professional black men, are important to the self-esteem and positive identity development of African American males. The dearth of role models affects male children and their conceptions of a prosperous future. In an anecdote, a young man explained the overwhelming and sometimes mixed messages about being a black man in America. He attributed his experience of parenting a child out of wedlock, dealing drugs, and landing in prison to his lack of clarity on how to obtain success in his life as a black man. Thus, having strong role models and mentors contribute to enabling black male students to feel valued and connected.

Likewise, the recent emergence of African American male mentoring groups and networks are garnering national attention and support. Formal mentoring programs such as the Student African American Brotherhood (SAAB) and Collegiate 100 operate national mentor initiatives that are effective for students. The benefit of such programs is that they provide a vehicle for students to more easily develop mentoring relationships, which could positively impact black male students' transition from high school to postsecondary education. Matching students to mentors at the beginning of the mentoring program signifies the importance of mentoring to the student's success.

Need for Educational Workshops

Helping students to develop their noncognitive skills would be advantageous to their high school completion efforts, college persistence, and degree completion. Workshops that inform students about time management, note taking, goal setting, and study skills would significantly improve the performance of black males in high school and in college. In fact, these skills warrant development as early as their elementary school years.

Conclusion

African American males face numerous challenges to ascertaining success in American society. They are often the victims of broken homes, poor education, and an unrelenting justice and penal system. The life trajectories of black males can be significantly altered with the appropriate support; however, this support should be provided prior to high school completion. Failing to address their needs early could leave them unprepared for high school, college, or a career. Additionally, since many black male youth live below the poverty line, their chances of being exposed to strategies for success in the school environment or community are minimal. Those who are in positions to provide financial, socioemotional, and academic resources to African American male youth should by all means move forward and act.

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See Also: African Americans; Juvenile Justice System; Youth Risk Behavior Surveillance System.

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Autism and Asperger's Syndrome, Services for

Autism was first reported by Leo Kanner in 1943, and since then there have been varying definitions and understandings of the disorder. The American Psychiatric Association (APA) has revised the *Diagnostic Statistical Manual of Mental Disorders* (DSM; fifth edition) because understanding the nuances in each of the spectrum disorders is confusing and difficult to delineate. Redefining the description of the different diagnostic labels and all of the labels associated with autism will fall under autism spectrum disorder (ASD). The diagnosis will fall under levels (i.e., 1, 2, and 3) indicating the severity of symptomology. With the entire diagnosis falling under one label, the DSM-5 seeks to simplify or clarify the discrepancies among the labels autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. Clarifying the definitions hopefully will help determine services needed to treat the disorder. The revised 2013 definition by the American Psychiatric Association is that, "Autism

Spectrum Disorder is a range of complex developmental disorders that can cause problems with thinking, feeling, language, and the ability to relate to others. They are neurological disorders, which means they affect the functioning of the brain."

Listed below are the characteristics that are typically applied to those diagnosed with autism spectrum disorders:

- Communication problems: difficulty using or understanding language. Some children with autism focus their attention and conversation on a few topic areas, some frequently repeat phrases, and some have very limited speech.
- Difficulty relating to people, things, and events: trouble making friends and interacting with people, difficulty reading facial expressions, may not make eye contact.
- Repetitive body movements or behaviors: hand flapping or repeating sounds or phrases.

Diversity and Prevalence in Autistic Spectrum Disorders

The most recent data by the Centers for Disease Control and Prevention (CDC) cites that one in 88 children in the United States are estimated to have an autism spectrum disorder. ASD diagnoses cut across socioeconomic, race, and ethnic lines as the prevalence of occurrence is typically the same for different racial/ethnic and socioeconomic groups. However, there are gender differences: males have a four-times-higher ASD diagnoses rate than females. Treatment disparities exist for underprivileged and racial/ethnic groups; for example, African Americans are typically diagnosed later than Caucasian groups. This also is true for other racial and ethnic groups. This delay may result in services being offered later, which will require more intensive services because of the delay. Also, research has not been adequately conducted on different racial groups, which may mean that a phenotype has not been developed for these groups and they typically are underrepresented in ASD randomized controlled trials. Further, researchers may not be culturally sensitive to the issues that confront families of different cultures. Currently, there are no statistical data that differentiates the spectrum disorders based on racial or class differences.

Provision of Services

Essential to finding services for children with autism spectrum disorder is to first get an assessment that will correctly diagnose them, and that assessment should be completed in a timely manner (the earlier the better). Most states have early intervention services in which comprehensive evaluations are conducted for the purpose of determining the correct diagnosis for a child, and the diagnosis will provide a basis for determining which services are appropriate.

Children suspected of having a disability can be evaluated as early as infancy. However, symptoms for autism spectrum disorder may not be evident until early toddlerhood. Additionally, all school systems must evaluate children suspected of having a disability per the federal Individuals with Disabilities Education Act (IDEA), which was last reauthorized in 2004.

There are two ways to approach the acquisition of services, and one of the approaches is to access information through advocacy groups that provide information and support for people seeking services. The second is knowing the type of interventions and services that are available and having the opportunities to select an intervention that best suits the child. However, a caution to parents or other caregivers is that access to interventions is sometimes limited and not as available to all those seeking it. There are a number of interventions, and one should inquire if they are research-based or practice-informed to ensure the best possible outcomes for children and adults who fall under the diagnosis of ASD.

Parents are concerned that the DSM-5 changes may result in fewer services for their children who have previously been identified as having one of the five syndromes listed above. The crafters of the DSM-5 argue that this simplified categorization represents a more accurate process of identifying persons with ASD.

Family Advocacy

Advocacy work is crucial in working with persons with disabilities. Some examples of the advocacy groups are as follows:

- The Autism Society's services include public awareness and advocacy across the life span.

- The National Autism Association's services are autism research funding, advocacy, support, and education.
- Autism Speaks' services include funding research for both prevention and intervention and advocacy.
- The Online Asperger Syndrome Information and Support (OASIS) Center along with MAAP Services for Autism and Asperger Syndrome (OASIS @ MAAP Web site) is a resource for families, individuals, and medical professionals who work with or are challenged by people with autism spectrum disorder.

Examples of Treatment Options

Parent education and training: Parent (and other family members/caregivers) training is essential in that it is the parent/guardian who will spend the most time with their offspring and as a result must be able to work with them to support and supplement treatment options.

Social skills training and speech-language therapy: These skills can be gained through participation in social skills groups and speech language therapy.

Cognitive behavior therapy (CBT): This method of intervention helps individuals with Asperger's (or other ASD symptoms) regulate their emotions, develop impulse control, and improve their behavior.

Applied behavioral analysis (ABA): Has been used by hundreds of therapists to teach communication, play, social, academic, self-care, work, and community living skills, and to reduce problem behaviors in learners with autism. Over the past several decades, different treatment models using ABA have emerged and all use strategies that are based on the work of B. F. Skinner. The ABA model is one that is commonly used as an intervention for children diagnosed with Asperger's syndrome. ABA methods use the following three-step process:

1. An antecedent, which is a verbal or physical stimulus such as a command or request. This may come from the environment or from another person, or be internal to the subject.
2. A resulting behavior, which is the subject's (or in this case, the child's) response or lack of response.
3. A consequence, which depends on the behavior. The consequence can include positive reinforcement of the desired behavior, or no reaction for the incorrect response.

Sensory integration/occupational therapy: In sensory integration therapy (SI), occupational therapists work with children to stabilize their senses and their reactions to external stimuli. This therapy can help children gain better control over their bodies, and thus can reduce clumsiness and instability and improve hand-eye coordination. SI therapy can also reduce anxiety in children.

Medication: No medications specifically treat autism/Asperger's syndrome. However, some children with autism/Asperger's experience symptoms that can be controlled by medication for depression, anxiety, attention deficit, or hyperactivity.

TEACCH method: A type of educational intervention that places great emphasis on structured learning by using visual prompts, and this invention can be administered at day care programs as well as in the home.

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See Also: Autism Diagnostic Observation Schedule; Children With Special Needs; Psychiatric/Psychological Assessment.

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Autism Diagnostic Observation Schedule

Autism spectrum disorder (ASD) is a neurodevelopmental disability that is described as impairments in social interaction and communication and has unusual or restricted behaviors. Symptoms most commonly arise in early childhood and are usually observed before 3 years of age. Age of onset is usually around 2 years but may be earlier if more severe. Worldwide reports of incidence of ASD are about 1 in 100. As of 2008 the Centers for Disease Control and Prevention (CDC) reports an overall incidence in the United States of 1 in 88 children, with 1 in 54 boys and 1 in 252 girls having a diagnosis of ASD. ASD occurs in all races and socioeconomic groups.

According to the CDC study the estimated prevalence among non-Hispanic white children was 12 per 1,000, non-Hispanic black children was 10.2 per 1,000, and Hispanic children was 7.9 per 1,000. Estimates for Asian/Pacific Islander children ranged from 2.2 to 19 per 1,000. As for socioeconomic status, prevalence of ASD increased with increasing socioeconomic status (SES). About 10 percent of these individuals have a comorbid diagnosis of Down syndrome and about 38 percent have an intellectual disability (IQ of less than 71).

The diagnostic assessment of ASD is based on the the criteria of fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The criteria include (1) persistent impairment in social interaction; (2) restricted, repetitive patterns of behavior, interests, or activities; (3) symptoms present in early development; (4) impairment in functioning related to symptoms; and (5) impairment not more appropriately explained by intellectual disability or global developmental delay as sole diagnosis; comorbidity can occur but social development should be lower than expected development level.

Clinically, the diagnosis is based on observation, assessment, and behavioral history. One difficulty with diagnosis of ASD is because of the high variability of presentation. ASD is a constellation of symptoms, and rarely the same presentation is seen in two children. There are observable differences in developmental level, language use, and IQ that are all freely variable to the individual child. Multiple structured assessments have been developed to establish standard observable findings. Assessments of note are the Autism Diagnostic Observation Schedule (ADOS), Autism Diagnostic Interview Revised (ADI-R), Screening Tool for ASD in Toddlers and Young Children (STAT), and the Diagnostic Interview for Social and Communication Disorders (DISCO). ADOS and ADI-R are the two assessments frequently used in evaluating a suspected individual. These are evaluated through activities that allow the examiner to observe if clinically relevant behaviors are present. ADI-R is a comprehensive interview that normally lasts 1.5 to 2.5 hours that gathers past history and current history of the suspected individual's history from parent or caretaker. The interviewer inquires specifically about the level of the functioning of the suspected individual based on the DSM-5 criteria. The ADOS and ADI-R, along with consensus in a multidisciplinary team, is thought to be the best estimate of clinical diagnosis.

As implied by the name, the ADOS is a semi-structured observational test. In contrast to the ADI-R, which relies on historical information and self-report, the ADOS is an "in vivo" test that allows for real-time observation of a child's behaviors. One benefit of the ADOS is its utility across a broad spectrum of developmental ages and abilities. While the lower limit of the ADOS is relegated to a nonverbal developmental level of 12 months or higher, and an ability to walk independently, it can be used through adulthood. Four distinct ADOS modules are available, but only one is administered to a particular patient. Which module is chosen is dependent upon patients' chronological age and expressive language ability—module 1 is for those without phrase speech, module 2 is for those who are not verbally fluent, module 3 is for fluent children, and module 4 is reserved for verbally fluent adolescents and adults. Although each module contains different activities, they all assess social and communication behaviors central to the diagnosis of autism through the use of a variety of "presses" that elicit the behaviors of interest.

An ADOS module is conducted over 30 to 45 minutes, during which time observations are recorded. Following administration, observations are coded into realms of communication, reciprocal social interactions, play, and stereotyped behaviors. A total score includes the sums of the communication and reciprocal interaction metrics, whereas play and stereotyped behaviors are excluded due to the difficulty in accurately assessing these areas given the limited time window of observation. Each of the above-mentioned realms are rated on a score from 0 to 3, with the higher numbers corresponding to worsening severity and clinical impairment. These numbers are compared to predefined cutoffs for each realm—if each realm's cutoff is met, a diagnoses of autism is conferred. In contrast, lower threshold cutoffs may correspond to a diagnosis of autism spectrum disorder in lieu of a pure autism diagnosis.

The ADOS has proven to be a reliable instrument in diagnosing autism and ASD, with Catherin Lord demonstrating sensitivities exceeding 90 percent and specificities between 80 and 90 percent. Clinical experience with this patient population should not be underemphasized when employing the ADOS, however, and can enhance the reliability of the scale, particularly when dealing with atypical or "difficult" cases. Combined with excellent reliability, the ADOS, when appropriately administered, is timely and cost-efficient and is applicable to a broad patient population, making it a useful clinical diagnostic instrument.

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See Also: Autism and Asperger's Syndrome, Services for; Children With Special Needs; Psychiatric/Psychological Assessment.

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Behavior Modification and Residential Treatment Facilities

Behavior modification and residential treatment facilities, which are also known as youth residential treatment centers or teen boot camps, are facilities that have been established to deal with American youths who exhibit antisocial behavior or mental illness or who are abusing alcohol or drugs. Within such facilities, behavior that has been deemed inappropriate or disruptive is modified by using both positive and negative learning tools to teach skills that ostensibly improve abilities to function within the home, school, and community.

Government-operated youth group homes tend to hire well-trained staff and are regulated by both state and federal laws. Contrarily, approximately 700 behavior modification and residential treatment facilities operating in the United States and abroad are privately owned and operated. Thus, there is little government oversight. Staff at these facilities frequently lack training in either medicine or psychology. Since parents are required to sign contracts giving staff full authority to act as their representatives, residents of these facilities are extremely vulnerable to both physical and mental abuse. Thousands of abuses have been reported, and several facilities in Mexico have been shut down by government authorities. The U.S. State Department has basically adopted a hands-off policy concerning behavior modification facilities abroad, but officials have warned parents to be aware of the potential for abuse and advise parents to visit facilities before consigning their children to them. Human service professionals are on the front line of reporting abuses and play a major role in raising public awareness about the existence of such abuses.

Behavior modification and residential treatment facilities usually adopt behavior modification techniques that use both positive and negative reinforcement. Residents are rewarded with points, privileges, or increases in status when they conform, and they are punished with time-outs, loss of privileges, lengthened stays, and decreases in status when they fail to conform. Some facilities use corporal punishment, and many resort to what may be considered torture. In general, youths exhibiting antisocial or destructive behavior are referred to psychiatric hospitals for short-term crisis management and to residential centers when long-term behavior modification is deemed appropriate.

Background

By the turn of the 20th century, some states had begun to reshape the behavior of children and youths by placing them in state-operated institutions. The most notorious of these institutions may be the Arthur G. Dozier School for Boys in Florida, which served as the state reform school for over a century before it was shut down in 2011 after mass graves were found on the premises. Subsequent investigations uncovered physical and mental abuse, forced labor, rape, and even murder. Traumas experienced by children as young as 5 were detailed by Roger Dean Kiser, a former resident, in *The White House Boys: An American Tragedy.* Even before the book, a number of lawsuits filed by adults who had been incarcerated at the Marianna, Florida, facility had raised questions about widespread abuse. Such reports caused many parents and professionals who deal with troubled youths to look for other ways to modify disruptive behaviors.

In the 1960s and 1970s, the focus on high rates of juvenile delinquency led governments to devote considerable resources to dealing with troubled youths, and human services professionals spent a good deal of their time dealing with such cases. In 1967, Montrose Wolf introduced the concept of teaching youths by positive reinforcement and using time-outs rather than corporal punishment to deal with negative behavior. Wolf established the first group home based on this principle.

In the 1980s, many desperate parents began turning to behavior modification facilities that took on the aspect of harsh training experienced in military boot camps. In addition to those located within the United States, facilities for modifying the behavior of troubled American teens were established in Mexico, Jamaica, Costa Rica, and Samoa. In the United States, the best-known facilities are those operated by the Utah-based World Wide Association of Specialty Programs and Schools and the Colorado-based Aspen Education Group, both of which focus on therapeutic rehabilitation. Some residents in these programs are placed by their parents, but others are placed there by court order as a way to avoid incarceration.

All behavior modification and residential treatment facilities tend to be isolated, and residents have only limited contact with the outside world. The majority of human service professionals believe that these facilities fail to teach youth the necessary skills for modifying their behavior because harsh environments are not always conducive to learning the social skills needed to survive outside the facility.

Repercussions

In the first decade of the 21st century, the Mexican government began shutting down behavior modification facilities located in Baja California, Mexico, by the American-based U-Turn for Christ program. When the last one in the area was shut down on December 5, 2005, officials cited a range of violations that included physical and mental misconduct by staff, lack of staff training, absence of medical professionals, and insufficient bathroom, shower, and recreational facilities. Inspectors also found that teens were suffering from insect bites that had been left untreated and discovered a large stock of expired medicines. The previous year, four youths who had run away from another facility had first called attention to the abuses in Mexican facilities; they had run away to escape mistreatment.

The vulnerability of teens placed in behavioral modification facilities has now begun to be widely recognized, as reports of abuses have continued to surface. In 2007, the Government Accounting Office issued a report citing thousands of abuses in teen residential facilities based on incident reports from state agencies and the U.S. Department of Health and Human Services between 1990 and 2007. In 2005 alone, 1,619 abuse incidents were reported in 31 states. In May 1990, a 15-year-old female died while being forced to go on a hiking expedition because the facility's staff lacked the necessary training to recognize symptoms of dehydration. In September 2000, a 15-year-old male died from a severed artery after being held face down in the dirt by staff for 45 minutes. Staff members were charged with homicide. In July 2002, a 14-year-old male died from hyperthermia during a hike while a staff member watched from behind a tree because he thought the teen was "faking it."

In 2008, the extent of abuse at some behavioral modification and residential treatment facilities led Democrats in Congress to introduce the Stop Child Abuse in Residential Programs for Teens Act. The purpose of the act is to stop physical, mental, and sexual abuse in all residential centers for teens and to prevent staff from using such methods as denying water, food, clothing, shelter, and medical care. The act also calls for an end to physical restraints except when necessary for a teen's safety and provides greater transparency and accountability. The act failed to pass Congress.

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See Also: Behavior Support and Management; Group Homes for Adults; Group Homes for Children; Torture, Survivors of.

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Behavior Support and Management

"Behavior support and management" are umbrella terms for several treatment approaches that are often used with students as well as people with intellectual and developmental disabilities. Behavior management approaches are used with people of all ages and with varying types of disabilities. Recipients of these services are from all ethnic and racial groups and may have a variety of developmental and mental health issues. In addition to this wide breadth of consumers, people seeking self-improvement may also utilize these modalities. Behavior support may include direct implementation of a behavior support with a goal of modifying client behavior, or it may include indirect consultation to a consultee (e.g., a parent, caregiver, or teacher), who would then implement the objectives of the behavior support plan with the client. Behavior support is used widely within schools, institutions, and treatment centers, though the approaches may vary.

Behavior support is based on the field of behaviorism and can be used proactively to present challenging behavior or in response to behavior that is identified as challenging. Challenging behavior is culturally situated but is generally behavior that creates an unsafe situation for the person exhibiting the behavior or those in the vicinity. Behavior of this intensity, frequency, or duration may also limit a person's usual activities or the availability of community opportunities or privileges. Behavior may emerge in childhood and persist into adulthood, though in some cases challenging behavior may arise in adulthood.

This behavioral pattern may be functional, adaptive, and/or communicative in nature, and these factors should be taken into account when attempting to understand why a behavior may be occurring. When determining the function of the behavior, it is imperative to conduct a thorough medical screening to be sure that an acute or chronic medical condition is not the precipitant or cause of the behavior.

Types of Behaviorism

There are four general types of behaviorism: methodological, psychological, analytical, and "radical."

Methodological behaviorism. In the methodological model, psychology is argued to be the science of behavior, as opposed to the science of the mind or mental states. Making reference to beliefs or desires of an animal or a human would be absent in this model, and as in psychological behaviorism, external stimuli, responses to such stimuli, and reinforcements to maintain or extinguish behavior would be the predominant areas of inquiry and concern.

Psychological behaviorism. Psychological behaviorism was often elucidated in the writings of Ivan Pavlov, Edward Thorndike, and, perhaps most famously, in the work of B. F. Skinner. Psychological behaviorists argued that intelligent behavior is the result of associated learning. When associations or pairings occur between experiences and thoughts, a person gains knowledge of the world or their immediate environment and this informs their behavior.

Psychological behaviorists are concerned with trying to predict how a person's behavior might change if certain variables in their environment are changed or manipulated. Behaviorists often used the word *conditioning* to describe the process or way in which people create new associations. Operant conditioning is learning about the relationship between events.

A reinforcement (such as food or a preferred activity) may be presented to increase the frequency of a desired behavior. An example of operant conditioning may be an experiment in which a lab animal learns that once it pushes the lever, food (reinforce) will appear. The animal becomes conditioned to press the lever for food. In thinking about human behavior, this might be the distribution of an allowance or monetary reward when a child completes his or her chores. The term *reinforcer* has also been the subject of controversy as it is defined as something that will increase the frequency of a behavior; however, the presentation of a reinforcer may have no observable effect. In application, the person or animal may also become desensitized to the reinforce, leading to a neutral effect or a decrease in response over time. A behaviorist may at that time substitute a higher value reinforcer in determining that the original reinforcer has lost the desired potency or effect.

The idea that behavior may only change depending on the reinforcements provided has also been criticized through the research of Albert Bandura. Bandura, in his social learning theory, demonstrated that people can and will learn through observing others and subsequently imitating their actions. Absent any reinforcers, people may change their behavior after observing another person. In this way, Bandura developed a theory that added psychological process to the interaction between environment and behavior that behaviorists had thus far solely focused their theories on.

Analytical behaviorism. In analytical behaviorism, mental states or terms describing these states are used, though behavioral terms are often substituted for the mental states at their closest estimate. If someone were to have a belief or thought, analytical behaviorists might reframe this as a behavioral tendency that may inform the researcher as to how the person might behave in a certain situation. This point has not been without controversy, however, as analytical behaviorists almost always used mental terms even in the behavioral reframe, and as a result it was questioned whether the dialogue on mental states can truly be replaced with solely behavioral terms.

"Radical" behaviorism. Skinner engaged in what many would call "radical" behaviorism and this mode of study often fused methodological, psychological, and analytical behaviorism. While behaviorism was once a ripe and robust research field, it has been in decline owing to the criticisms surrounding the absence of acknowledgment or concern for mental states and the idea that behavior can be changed solely through manipulation of the environment.

Assessment

The interventions contained within behavior management are generally designed to increase the frequency of certain behaviors (generally positive or desirable) while decreasing or eliminating (usually problematic or maladaptive) behaviors. After a behavior is identified, a behavior analysis is conducted by a trained behavior analyst or other similarly trained specialist. This is done with either an informal or formal functional behavior assessment. This assessment can take the form of interviews, observational information, interviewing the individual, and interviewing the team. The goal is to decide if the behavior in question (the "target") is actually a problem and to subsequently create a hypothesis about why this behavior may be occurring. The hypothesis should include the setting event, the trigger or antecedent, an observational or operationalized description of the behavior, and the consequence or reward that may be serving to maintain the existence of the behavior. During the time period in which a clinician is attempting to understand the behavior and is conducting a functional behavior assessment, data should be collected to establish a baseline. The intervention follows the assessment and is an attempt to eliminate the behavior, modify the situation and/or the behavior, or reduce the frequency to a nonproblematic level. This response can be proactive or reactive.

Interventions can take a myriad of forms and functions. In some cases, one may add structure to the environment. This can clarify and define responsibilities and tasks as well as expectations and roles. This may include reminders, schedules, and teaching about limits and what is acceptable or not for the setting in question. Much of this intervention includes the addition of clarity and predictability to people's lives. Environmental interventions include modifying the surroundings to remove a bothersome noise or object, changing residence, changing aspects of the home environment depending on preferences and/or sensory sensitivities and/or tolerances, and helping people to stay connected and engaged.

Treatment

From a mental health perspective, medication is often used to assist in the alleviation of symptoms. Caution is advised, however, as medications have also been used as chemical restraints in the past and, in some cases, currently. Counseling is also utilized to augment a behavior modification plan and may include such interventions as "desensitization procedures" in order to provide a systematic method to decrease negative reactions to objects or situations that may be an inevitable part of the person's life.

In some cases aversive interventions have been or still are used. Aversive behavioral interventions may be painful, intrusive, or uncomfortable stimuli or actions with the purpose of inducing pain or discomfort. These interventions arise out of the work of Pavlov and Skinner. The theory arises from the idea that if an individual presents a negative reaction or situation to an undesirable behavior, then behavior will stop or will be extinguished. The person or animal may proactively come to expect this negative response and is expected to refrain from the behavior before the negative application becomes necessary. Examples of aversive behavioral interventions include applying lemon juice or hot sauce to a person's lips, restraints or mechanical movement limitation (i.e., tying a child to a chair, or time-out rooms or closets), and electrical shocks. In some cases embarrassment has been used, such as calling attention to the person in a group by forcing them to wear a helmet as a consequence for their behavior. Food contingencies programs have also been used, in which case calorie deprivation is applied as a consequence. Aversive behavioral interventions are controversial and many school systems, institutions, and state governments have now placed a moratorium on the use of such interventions. Research has aligned with the stance, showing that once the negative response is no longer consistently applied, the individual will generally revert back to the undesirable behavior. Thus, the avoidance of the negative stimuli is not generalized for application in natural or community settings and the decrease in undesirable behavior may have been an effort to avoid the negative stimuli as opposed to a sustainable change. Further criticism of this approach includes the fact that those implementing aversive behavior plans are not clinicians but staff or day support workers who are not educated at a level required to implement such plans. Another criticism is that these plans are often implemented on an intermittent basis, and due to the inconsistency involved they can be viewed as punishing rather than therapeutically beneficial.

Positive behavioral support is a particular approach to behavior management and support. This approach to behavior support emerged out of and in reaction to the controversy surrounding the use of aversive behavioral interventions. In this approach, there are no aversive responses or consequences to behavior. There is also minimal risk to the person in terms of physical or psychological harm, and it does not include significant physical exercise or physical restraint or enforcement given a person's active resistance. The focus in positive behavioral support is often on a proactivity and manipulation of antecedent or setting events, as opposed to reacting to a behavior and then responding with reinforcement upon the display of the behavior. Emergency procedures are still used; however, these are expected to decrease over time given the proactive focus of this model. Social validation is also a consideration, as is maintaining the dignity of the recipients of these services. While positive behavior support continues to focus on increasing desirable behavior and decreasing undesirable behavior, the aims also include increasing quality of life or a positive lifestyle. Positive behavior support, much like other forms of behavior support and management, emphasizes empirically derived conclusions, such that data collection is an important aspect of both monitoring and deciding on the next course of action. Positive behavior support also includes valuing the rights of people with disabilities, something that the behavioral community appeared to be silent on in the past or at the very least did not explicitly acknowledge. In addition to the values aforementioned, positive behavior support emphasizes respect, person-center planning, inclusion, and normalization as well as self-determination.

Positive behavior support plans are generally implemented system-wide, in that the person who is the focus may be in the middle of a much larger system of supports, all of which would participate in and implement the behavior support plan. Positive behavioral support is gaining ground in school systems across the United States. These behavior support plans are implemented throughout the school. The focus is on the preferred behavior as opposed to the undesirable behavior. Typically, three to five targets are chosen and presented to staff to ensure at least 80 percent acceptance. An example of these targets may be for individuals to respect themselves and others: in the restroom, flush the toilet after you use it; and in the cafeteria, wipe the area with a cloth after using it. All staff at the school, from the principal to the teachers to the janitors, would be involved in the implementation and success of the plan. Behavioral expectations are taught, just as math, science, or any other subjects are emphasized. Children in the school system are rewarded for demonstrating the expected behaviors and this is shared with other members of the school as well as with the child's parents as an additional reinforcement level. Parents are aware of the school-wide expectations and buy-in and support are expected from those at home as well.

In addition to its uses with students and those within the disability services communities, behavior support and management extends to parent training as well as to job performance management. Studies have shown a decrease in teenage risk-taking behavior, even in the presence of genetic risk, when a parent training program is also implemented. In addition, parent training programs have demonstrated the ability to assist divorced single mothers and those coping with children with conduct disorder.

In terms of job performance, an assessment of an employee's strengths and deficits is conducted and from that report a behavioral plan to increase job performance is implemented. This may include positive reinforcements for completion of timely work product, a decrease in mistakes, or an increase in overall productivity. Typically in this system, negative reinforcement is not used, with the overall emphasis placed on positive behavioral support. Negative reinforcement in this environment may lead to employee resentment and anxiety, and so positive supports have been found to be more industrious and rewarding, increasing the frequency of positive and productive employee behavior and performance.

Behavior support and management has evolved much since its introduction in 1911 (through the work of Edward Thorndike) and the subsequent research of the 1940s and 1950s. Though once a mainly laboratory endeavor, through the work of applied behavior analysts behaviorism now focuses on application and behavior change of those in community settings. Based upon the successes found in those settings, particularly in use with those with autism spectrum disorder, behavior support has now branched out to include organizational behavior change and modification. Behavior analysts are now employed in a wide breadth of settings and their consultation and expertise is sought after by schools, institutions, and corporations.

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See Also: Behavior Modification and Residential Treatment Facilities; Chemical Restraints; Counseling and Psychotherapy Services; Developmental Disabilities, Attitudes and Myths in Services for; Developmental Disabled Individuals; Disability Services; Disabled Clients.

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Behavioral Health Disparities for Racial and Ethnic Minority Populations

The quality of health care has and continues to be a topic of much interest and debate within the United States. Poor access to health care, limited availability to medical facilities, and impoverished neighborhoods all contribute to a lower quality of health. Both racial and ethnic minorities tend to report lower quality of health and fewer health care opportunities. With lines of race and ethnicity dividing the quality of health in the nation, it is important to understand what is causing the disparity and what can be done to reduce and eradicate it. Behavioral health issues cross boundaries of race, ethnicity, gender, and socioeconomic status; however, minorities are still the larger population that has the most limited access to medical and psychological services.

Products of The Environment

Health disparities for racial and ethnic minority populations are simply the differences in health outcomes for them. These health differences are tied to social conditions that offer either advantages or disadvantages depending on the community where one lives, goes to school, and works. Families and individuals who face social and economic disadvantages encounter far more challenges in obtaining and maintaining healthy lifestyles. In understanding the environment of an individual and the many roles he/she takes on, it is important to see the individual in a complete image. Learning about the individual's education, geographic location, employment, and living circumstances all offer assistance in understanding health conditions and disparities.

There are two types of disadvantages that greatly affect the quality of health reported and possibly access to health care. Living with the constant experiences of social and economic disadvantages severely limits and, in some cases, prohibits someone from enjoying the best quality of health possible. Attaining levels of optimal health is severely reduced when individuals face discrimination within their social and economic status, which may include (but is not limited to) disability, age, gender, sexual orientation, race, ethnicity, religion, and geographic location. At times the barriers to health are far greater than one's ability to overcome them and achieve health benefits. Health benefits cannot be solely rested on the individual's labor, try as they might.

In the United States, socioeconomic status is generally measured by two variables: the first is income and the other is education level. Those who are financially stable can afford health care insurance, copays, specialists, medications, and everything that comes with being proactive with their health. While taking these necessary steps, they are far more able to sustain a healthier life than someone who is poor and has to choose whether to handle their medical needs or instead attempt to secure their basic needs along with those of the family.

A great divide between the poor and the financially secure is that of their general approach to health. The socioeconomically disadvantaged population often have no other choice but to take a reactive stance in regard to their health. An example of what this could involve is having access to an antibiotic medication to fight an infection: by the time they have received medical services, they might have to sustain an amputation. The poor are more likely to encounter drastic medical accommodations due to their inability to obtain quality health care. One of the few choices the poor have is to be reactive with their health: they simply cannot afford a non-necessity when so many basic needs are barely—if at all—being met. While this cycle continues, those who can and do achieve a higher quality of life have the means, resources, and limited barriers to do so.

Education has been another measure that can offer a view into the behavioral health disparities among race and ethnicity. Individuals who did not graduate from high school often suffer from poor quality of health and inaccessibility to health care. Those who have achieved a greater educational level have far less barriers to overcome in obtaining quality health services. Those individuals who are economically disadvantaged and do not graduate from high school face the worst health circumstances compared to those who are educated and not poor.

Not only are adults at risk for health disparities but also are the children living in low socioeconomic status and geographically disadvantaged areas. Children who are raised in an environment of limited education, resources, and role models for healthy living are disadvantaged throughout both childhood and adulthood. Lack of information regarding healthy choices, lifestyles, and fitness all accrue to further driving the disparity between ethnicity and race. Reports show that the less education the parents have, the higher the levels of poor health in children.

Cultural differences within the nation's behavioral health disparities have in fact been influenced by social factors. The greater the social and economic advantages one has corresponds with the greater health quality, access to health care, and overall healthy living one will experience. Racial and ethnic differences in behavioral health can be understood by the experiences that an individual faces in his/her environment. Whether one grows up in an advantaged or disadvantaged environment due to their ethnicity and/or race undoubtedly affects their chances of attaining an optimal quality of health. Research shows that the average white adult will be among the least likely to report experiencing poor quality of health. Health disadvantages in relation to income decrease as the amount of an individual's income increases. This means that the more income and financial resources one has, the fewer challenges they will face in achieving the best health outcomes possible.

Historically and currently, the majority of black and Hispanic individuals grow up and live in disadvantaged areas. Their neighborhoods generally contain higher crime rates, government housing complexes, higher pollution levels, poor school systems, and less than adequate health care services. These factors of socioeconomic status reflect discrimination among both ethnicity and race in every aspect of health care, including the area of mental health. Health inequalities can be viewed in the neighborhoods with greater amounts of poverty, which include those areas with higher numbers of black and Hispanic populations.

Currently it is against the law to segregate and discriminate on the basis of race or ethnicity, but due to the inequalities of the past, individuals currently find it difficult to escape the socioeconomic status they were born into. It is very challenging for an individual to rise above their parents' status when they constantly face disadvantages. Opportunities are few and far between in economically challenged neighborhoods due to minimal employment opportunities and the lack of good schools that allow for economic and social growth. Lack of resources and poor-quality government housing are additional factors that contribute to the many harmful conditions that disadvantaged minorities face in their economically challenged neighborhoods.

The Impact of Health

Health is influenced by a multitude of factors that include biological, social, and economic characteristics. While one cannot alter the biological factors of individuals, something can be done about the social and economic factors of health. Reducing health disparities is essential for disadvantaged adults and children. Increasing awareness and distributing health information evenly for individuals is just the first step the nation has taken to show how choices affect health.

Learning about the society in which an individual lives is essential to understanding the behavioral health disparity. If all one can buy in their neighborhood is liquor and cigarettes as opposed to a frozen yogurt treat, then perhaps the limited resources in the neighborhood should be examined. It is likely that a frozen yogurt shop is even unheard of in the neighborhood and all the children know is the liquor store on every corner. Social environments affect an individual's opportunity for choice and resources. Individuals learn and function within their environments with what they have and what is available to them. If every child had the opportunity to be offered a yogurt treat instead of being approached to sell drugs, their understanding of health would be completely altered. Children in poorer communities suffer from more physical, emotional, and economic disadvantages. The children in these poorer communities attend schools that lack funds for resources for after-school programs, healthy snacks, textbooks, and group sports. The parents of these children are sometimes non–high school graduates who tend to be less educated on health-related issues. This leaves the children with inadequate health resources, including a positive, healthy role model. When children do not know what "healthy" looks like as a child, they will surely encounter difficulty when they try to navigate or create a healthy outlook as an adult.

Individuals facing daily economic and social challenges constantly encounter the greatest health-related consequences when compared to the average person. Individual stress, along with the environment where one lives, works, and grows, feed the behavioral health differences between race and ethnicity. Greater than the social or economic factors that are the cause of so many disadvantages are the barriers related to affordable and accessible health care. The lack of health care insurance is the most influential obstacle and highest-ranked characteristic in the minority population that completely affects their quality of health. It is important to recognize that racial and ethnic minorities are the defining populations who do not have health insurance to assist them in making quality choices about their health. Reports show that even when minorities do receive health care, their experiences include additional barriers to and poorer quality of care. For those 24 million adults who do not speak English, constant challenges related to their behavioral health issues exist. At times, there are few if any translators or behavioral health specialists who speak the native language of the minority. Without quality communication, the patient–provider relationship is severely damaged.

Meeting in the Middle

The shortages of mental health professionals, physicians, psychologists, and other health professionals in disadvantaged communities greatly impact the health of ethnic and racial minorities. The racial and ethnic minorities are not able to receive the preventive or acute treatment they need if behavioral health services are not even offered in their community. In order to reach the underserved populations and reduce the racial and ethnic health disparities, health services either must go into the community that needs the services or transportation must be provided for the disadvantaged population to travel to the needed services. Either way, to close the gap in health disparities, a bridge must be created to connect those in need with the services that should be available to everyone.

Those living and working in poorer communities often encounter more limits in obtaining healthy lifestyle choices and are at greater risk for higher rates of physical and emotional challenges. Steps needed in order to reduce the large ethnic and racial disparity include a transformation in health care. To live in a society where access to health care can be obtained by every individual, offering health insurance coverage even to those in the most disadvantaged circumstances would reduce disparities in behavioral health. Another dimension to take into consideration is that of strengthening multicultural awareness of health care professionals. By training the professionals to be aware of racial and ethnic behavioral health disparities, they can become better equipped to serve and minimize the disparity by further understanding the underserved communities.

Serving the poorer communities will take an increase in the availability of services that can be shared through community-based programs and policies. Programs and policies can be requested by individuals in the community, elected officials, health care professionals, outreach programs, and nonprofit organizations. By working together, communities can create safer and healthier opportunities for children and adults who lack and desperately need both preventive and acute care. Children who grow up learning a healthy lifestyle will apply what they learn in their adulthood. Healthy adults will create less strain on the health care system and the chances of full participation in society increase by eliminating or severely reducing illness, disability, and suffering.

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See Also: Community Health Centers, Poverty; Community Health, Racial and Ethnic Approaches to.

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Bias in Service Delivery

The effective delivery of direct services is fraught with opportunities for human bias, both conscious and unconscious, simply due to its well-established reliance on human interpersonal exchange and the professional utilization of various assessment and intervention methodologies. Preconceived notions about an individual, an ethnic or racial group, a religion, a specific social class, a social lifestyle, or a political affiliation, as examples, may trigger human service professionals to unwittingly respond subjectively and even unfairly and destructively. Operationally, bias represents the opposite of open-mindedness and neutrality. In many instances bias may be viewed as prejudicial or discriminatory when judgments or decisions are made that are not based on factual, accurate information or objective criteria and do not accommodate differing or varying viewpoints. Discussion in the human services field suggests that often professionals are subjected to implicit biases that are negatively associated with groups that are different than they are (outsiders), despite a stated commitment to equalitarian values.

Minimizing Bias: NASW Code of Ethics

To ensure professional accountability in the practice of social work and to avoid the harmful reliance on biases and any form of professional conflict of interest, the National Association of Social Workers (NASW) formulated a Code of Ethics. The code comprises six fundamental principles that support competency in addressing social diversity and oppression regarding: race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability. These guidelines focus on the parameters and values related to: (1) serving people in need and addressing social problems; (2) challenging social injustice; (3) respecting the inherent dignity and worth of the person; (4) recognizing the central importance of human relationships; (5) behaving in a trustworthy manner; and (6) practicing within areas of competence while developing and enhancing professional expertise. Although these principles are not prioritized in order of importance, the third principle directly identifies the prominent need for professionals to treat each person respectfully while managing and celebrating differences and cultural and ethnic diversity. To support clients' "socially responsible self-determination," a core value of the profession, practitioners must be aware of their hidden biases and monitor undesirable behaviors and their potential negative effects on service delivery.

Blaming the Victim: Disparities and Disproportionality

Not surprisingly, there has always been an undercurrent of discussion in the human services field regarding the intersection of social policy and service delivery, especially identifying who is "worthy" or entitled to services and under what terms. Some advocates have protested that systems have a tendency to blame the victims themselves for poor social or psychological outcomes, while compounding complex factors that contribute to predictable, obstructionistic barriers to appropriate service delivery. Class, race, gender, age, geographic location, educational attainment, sexual orientation, disability, perceived motivation, and legal status are examples of factors that may trigger an individual's negative assumptions and perceptions based on prior experiences and preexisting biases. Humans categorize their life experiences and stereotype others as a way to create order and make life simpler. Fundamentally, biases, especially unconscious or hidden biases, become ways of coping with complexity and forming automatic ways of surviving. Sometimes formed out of ignorance, fear, or hatred, biases can lead to pervasive discrimination and prejudices, which harm others and project them as inferior or substantially different than the normal group. It is very difficult to unlearn biased attitudes because individuals have a tendency to accept what they already believe, regardless of conflicting evidence or new and different levels of exposure.

Social activism, which dates as far back as the 1960s, also reflects bias backlash due to the implications for social policy, which were viewed as discriminatory and unjust, leading to the inequitable distribution of social/economic resources. These movements have targeted: civil rights, women's rights, gay rights and marriage equality, child abuse and neglect reporting and prevention, workplace harassment, reproductive rights and abortion, fetal rights, gender equality in athletics, the Indian Child Welfare Act, affordable health reform, immigration rights, Head Start and early childhood education, juvenile delinquency prevention, teen pregnancy, the permanency movement in child welfare, the protection of human subjects in research (mentally ill, minority, incarcerated, poor, disabled), and family advocacy in the military. In each instance, members of the affected groups carried a stigma that posed challenges to their ability to gain equal access to services and social entitlements. Such barriers reinforce the individual, family, or community's inability to thrive and benefit from societal privileges.

Bias may lead to extreme stereotypes, which can foster blatant discrimination or even hate crimes. When traditional crimes are enmeshed with hatred and prejudice, one can witness the overt expression of bias against groups from lynching to cross burnings to vandalism of synagogues to violence and murder. Although a shameful historical aspect of U.S. history, the term *hate crime* was not coined until the 1980s, when emerging hate groups like the skinheads engaged in a wave of bias-related crime. Unfortunately, hidden biases are more difficult to address, and well-intentioned social service policies and personnel may enact prejudices and beliefs in the delivery of critical resources. Illustrations of such beliefs include the following statements:

- Black male adolescents are frightening; they are violent and steal.
- Gay men are likely to be pedophiles.
- Latina females make babies and allow themselves to be dominated by older men.
- Immigrants want a free ride in this country.
- Individuals of color do not use mental health services and always wait until the last minute to see a doctor.

Bias represents a conscious and unconscious inability to be neutral or consider a view other than one's own and reflects a closed mind. This may be directed at a social class, religion, race, ethnicity, or political party. Bias keeps one in his or her own comfort zone and may prohibit the delivery of quality services to those most in need. Bias may negatively inform public policy making because it impedes objectivity, and so priorities may be skewed or programmatic strategies and resources may not be best aligned with optimal outcomes. The policy failure therefore is assigned to those who were served. Recently the child welfare community has addressed the overrepresentation of African American children in comparison with their numbers in the nation's child population in the foster care system. Since research has established that there is no difference between races regarding rates of child maltreatment, the question has been raised: Why is there a racial bias in removing children from their biological families, when family and community risk factors are held equal? Such removal rates have exposed poor African American children to higher levels of trauma due to separation from their parents as well as the poor outcomes of the child welfare system itself, for example, homelessness, lack of education, and underemployment.

There remains a pressing need for human services professionals, through self-examination, authentic dialogue, processes of accountability to service mission, and relevant research, to address biases in service delivery at both the macro/administrative/policy and micro/direct services levels. NASW's Code of Ethics presents a framework for avoiding the institutionalization of distorted beliefs and for passing on unconscious biases systemically, thus causing harm and deprivation over time and for future generations.

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See Also: Code of Ethics of the National Association of Social Workers; Cross-Cultural Skills; Cultural Competence, Human Service Providers and; Diversity in the Workplace; Education for Diversity in Human Services; Hate Groups; Health Care, Disparities in; Juvenile Justice System; Multiethnic Placement Act of 1994; Multiculturalism; No Child Left Behind Act; Parenting Styles, Cultural Differences in; Poverty; Power, Race/Ethnicity and; Racial Microaggression; Racism, Long-Term Effects of; Size Discrimination; Social Determinants of Health; Social Work Practice and People of Color; White Privilege.

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Biculturalism

Biculturalism is a word that is very widely defined. It changes its connotations from person to person and from culture to culture. Many times the words *bicultural* and *biculturalism* have been used for denoting the same trend in society. The meaning of biculturalism, therefore, is often misunderstood. One can say that in the case of a society or state comprised of several cultures, both prominent and latent, with many intercultural networks and orientation, the practitioners in the system for successful living conditions have to adopt what is called biculturalism, and with the passage of time the state has to lawfully ratify it for the welfare of larger numbers of population at a larger stage for a longer time.

The two cultures then flow side by side, and the citizens find themselves free to accommodate and adapt according to the patterns of both. Biculturalism can be applied to the aptitude and understanding of a person with relation to the two cultures in context, and to the policy of equal treatment for two cultures in any nation, as well. If one calls a person "bicultural," it denotes the person's ability to accommodate two different cultures—not only culturally but also with regard to the value system and identification patterns, as appears to be the case with Indian Americans, Chinese Americans, Japanese Americans, etc., living in the United States, who are acculturated in Indian, Chinese, and Japanese cultures respectively, along with being acculturated in American culture. On the other hand, biculturalism is also used to describe a condition in a country or geographic region in which two distinct cultures simultaneously become visible and flow seamlessly. Thus, it indicates the presence of two different cultures in the same region.

The word *biculturalism* was officially used for the first time in Canada on July 19, 1963, as a neologism, when the Royal Commission on Bilingualism and Biculturalism, popularly known as the Bi and Bi Commission and the Laurendeau-Dunton Commission, was established by the then Canadian government under the premiership of Lester B. Pearson. The commission was appointed to "inquire into and report upon the existing state of bilingualism and biculturalism in Canada and to recommend what steps should be taken to develop the Canadian Confederation on the basis of an equal partnership between the two founding races, taking into account the contribution made by the other ethnic groups to the cultural enrichment of Canada and the measures that should be taken to safeguard that contribution." The reference to "biculturalism" had been made earlier in 1929, when Graham Spry, a Quebecoise Canadian, used it in a speech to the Canadian Club of Quebec and focused on the "bicultural character of the Canadian nation."

Later, the issue of biculturalism became popular in New Zealand in 1982 with reference to the issues of clash and reconciliation between two major cultural and ethnic groups—Maori and Pakeha New Zealanders. The term also gained momentum in Africa and Belgium with reference to the cultural clash of Anglophone white South Africans and the Boers in South Africa, and that between the Walloons and the Flemish in Belgium. The case of Parsis in India is also similar, as they manifest their heritage Parsi culture and collective Indian culture at the same time. The practitioners of biculturalism manifest the salient elements of their ancestral culture vis-à-vis identifying themselves in the other dominant culture of the political/geographical region, and make themselves distinct from the acculturated people. Sometimes this trend brings a new culture of integration. It is evident in Indian Hindu-Muslim culture popularly known as *Ganga Jamuni Tehzeeb*, manifesting the values and belief systems of the two.

The policy of biculturalism is adopted by countries as a diplomatic step to appease two belligerent and rival cultures. When one analyzes the history of countries with bicultural practices, like those of Canada, Belgium, and New Zealand, it records that there has been a continuous national or ethnic conflict between the settlers and the indigenous people or between the two rival colonizing groups in which neither of the parties has achieved complete victory. Studies in biculturalism analyze the issues of class, ethnicity, gender issues, and biculturalism. They also undertake the bicultural experiences: exploring how the bicultural experience may connect to ideas of acculturation, assimilation, marginality, bush tradition, cultural clashes and communication barriers, identity, ambivalence, superordinate, subordination, and issues related to insiders and outsiders. The legislature and executive in a bicultural scenario always are challenged to create a middle path for both prevailing cultural groups.

Analyzing the process of biculturalism in different parts of the globe, it is visible that some of the U.S. states have faced cultural tensions. The movement for Chicano rights, or the Mexican American civil rights movement, is an important but less focused segment in American history that demanded a bicultural policy with regard to Mexican Americans. The main rights that this movement sought in its agenda of consideration were restoration of land grants, farmworker rights, better wages, better communities, better working environments, enhanced avenues for education, and granting of voting and political rights to Chicanos. In Belgium the clash of French- and Dutch-speaking populations put two cultures in confrontation that later gave way to the nation's adopting a bicultural policy. The Republic of Vanuatu, an island nation located in the South Pacific Ocean, has a unique case of biculturalism in which the rivalry between France and Great Britain in administration and colonization brought them together to annex the territory, creating a British-French Condominium in 1906. It led to a bicultural state of dominantly English and French cultures. The case of the Polish-Lithuanian

A statue in an Ottowa, Canada, park of Lester B. Pearson, prime minister of Canada. Pearson established the Royal Commission on Bilingualism and Biculturalism in 1963. The commission was created to "inquire into and report upon the existing state of bilingualism and biculturalism" and to develop equality and cooperation between the founding races of Canada.

Commonwealth established a biculturalism of Polish and Lithuanian cultures due to the impact of two major forces for years. The Swiss Confederation, a landlocked nation surrounded by Germany to the north, France to the west, Italy to the south, and Austria and Liechtenstein to the east, has recognized biculturalism with two major impacts—those of French and German cultures.

The Republic of Paraguay, a landlocked nation in South America, bordering Argentina in the south and southwest, Brazil in the east and northeast, and Bolivia in the northwest, has observed two simultaneous and parallel-running cultures: the indigenous Guaraní and the colonizing Spanish. In the same way, South Tyrol, or Alto Adige, is an autonomous province in Italy that is dominated by German and Italian cultures and realizes smooth biculturalism. As discussed above, the case of New Zealand is a landmark, where the indigenous Maoris and early British settlers have established biculturalism.

As far as Canada is concerned, it is a classic example of biculturalism. From the time of the earliest settlement and foreign presence in Canada, many international cultural players have realized their sway there. With the passage of time, French and English culture emerged as the two most powerful forces there. Canadian Prime Minister Pierre Trudeau, after passing the Official Languages Act, declared Canada a bilingual nation in 1969, which is a reflection of biculturalism. Canadian administration has provided equal status to English and Anglophone and French and Francophone cultures in the governance of Canada.

As far as the concept of biculturalism among individuals is concerned, a bicultural individual is capable of blending one's heritage with the acquired culture, which becomes visible with all cultural practices, values, and identifications. It also suggests that a bicultural person not only finds him/herself capable of understanding the two cultures but also reflects their ethos and icons in his or her behavior as well. Biculturalism develops in the sociocultural contexts and environment of the individual. A bicultural individual keeps a modest balance between the heritage culture and the acquired culture; for example, one can find the behavior of diaspora populations in many countries who observe the cultural baggage along with accommodating them in the acquired land, which is manifested many times in emotional biculturalism. Terms such as Spanish American, German American, Chinese American, Indian American, or Asian American are self-explanatory as far as biculturalism is concerned. Biculturalism, thus, manifests the mutual relations and the presence of two distinct cultural groups, usually of perceptible difference in status and power, in a locale united by sociopolitical and economic interests.

The cult of biculturalism implicitly has many good and bad traits simultaneously. The imminence of rivalry between two cultures can harbor cultural clash. It is natural when they take a negative turn. Their healthy and constructive relationship can develop a sustainable and mutually respectful relationship between the cultures. A well-managed structure of biculturalism in any nation can bring healthy competition, which may increase gross national product and all-around development.

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See Also: Cultural Determinism; Ethnoentrism and Ethnorelativism; Subcultures.

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Biracial Children

Biracial children have parents who are of different racial heritages. The 2010 U.S. Census reported that approximately 3.5 million children are of more than two racial heritages. Researchers, who in the past mainly focused on black and white biracial children, noted these children were mentally and physically weak. This biased view, which was once popular, was called the hybrid degeneracy theory and contributed to the stereotype of biracial children as socially misfit. The theory has since been disproved and deemed scientifically wrong. Another factor that affected biracial children negatively was the antimiscegenation laws adopted by some states. These laws prohibited interracial marriages, and the offspring of such marriages were regarded as socially unacceptable. These laws were struck down by the U.S. Supreme Court in 1967, and biracial children are no longer deemed unacceptable in society. The social environment surrounding biracial children has improved, yet biracial children still have problems.

Supporting the Identity Formation of Biracial Children

Some biracial children look physically ambiguous. For example, if a child has a Japanese American mother and an African American father, the child may look African American. Due to the child's physical appearance, she may be identified as African American by others although she wants to identify herself as Japanese and African American. If this happens, she will have an identity formation problem. In order to avoid the identity problem, scholars point out that what is necessary for the healthy identity formation of biracial children is: informing them of their biracial heritages, living in a racially diverse area, and giving them names that reflect their biracial heritages.

Parents can provide information on children's biracial backgrounds by talking about them with their children and practicing their respective cultures at home. For example, consider a case of a biracial child whose mother is Chinese American and whose father is Irish American. The mother can cook Chinese food at home and speak Chinese to the child. In this way, the child can be familiarized with the mother's cultural heritage. The father can do similar things with the child to reflect his Irish culture. If the child is familiar with both parents' cultures, even if others tell her she does not look Chinese, she will be comfortable with who she is.

People usually celebrate holidays or cultural traditions with their relatives. If biracial children can share these occasions with relatives of both parents, they will be more confident of who they are. However, some biracial children suffer from the rejection of their relatives. Similarly, some biracial children are raised by single parents and do not know of the other parent's racial heritage. In both cases, biracial children do not have enough access to their biracial heritages.

However, there are many support groups for biracial children throughout the United States. These groups offer occasions such as picnics, summer camps, and parties through which biracial children can learn about their biracial heritages and interact with other biracial children. Through various activities at home and in the community, biracial children can incorporate biracial heritages and achieve biracial identity.

The community in which they live is also important for biracial children. If a child has an Indian American mother and a Caucasian father and lives in a predominantly white neighborhood, she may find it difficult to embrace her mother's cultural heritage because of the dominance of the white culture. Some parents of biracial children move to areas where the racial/ethnic population is more diversified, but not all parents can do so. In this case again, support groups help biracial children get to know their biracial heritages through participating in the events or activities these groups hold.

Names play an important role for the identity formation of the biracial child. Some biracial people look racially ambiguous, but if their names reflect their biracial heritages, people can easily recognize that they are biracial. For example, a child has a Greek American mother and a Vietnamese American father, and she looks Caucasian. But if she only has a Vietnamese name, people will wonder what she is. "What are you?" is a question biracial children are often asked. If the child has a name that reflects both her Greek and Vietnamese heritages, she could easily answer this question by simply telling her name. Some biracial children are given names reflecting only one of their parents' heritages, but they tend to alter or combine the other parent's heritage with their names when they grow up so that the names match their physical appearance as well as their identity.

By carefully providing information on their biracial heritages and choosing the location of residence and names, parents can help achieve a healthy identity formation for biracial children.

School Life and Dating

Children at American schools often form cliques based on race. African American children, for example, befriend other African American children; Korean American children are with other Korean American children. If this is the case, biracial children cannot find any clique in which to fit. As a result, some try to pass as one of their parents' race, but this betrays their true biracial identity. When biracial children grow up, they also confront dating issues. Like friends, dating partners are chosen based on race. Some biracial children say they feel like they are betraying one of their parents if they choose their dating partners from the other parent's racial group. In order to solve these problems, some students launch clubs for biracial peers at high schools or universities. These clubs function to support biracial children who are isolated from classrooms or who feel like they betray their identity and parents when they choose a dating partner. Some schools have counselors who support the special needs of biracial children, yet there are few schools that have these support systems.

Health Issues of Biracial Children

Biracial children face urgent health issues when they have leukemia or blood cancer. As part of their treatment, leukemia or blood cancer patients may need a bone marrow transplant from someone who matches their racial group. . Biracial children have to find a donor who completely matches their biracial background. For example, if a child's parents are African American and Native American, a donor has to have the same biracial background. However, only 2 percent of the donors who register with the National Marrow Donor Program are biracial. There is a great need for prospective registrants to be informed about the special health needs of biracial people in order to increase the number of biracial donors participating in the program. In addition, many U.S. health statistics are based on the racial categories contained in the census, which does not include biracial children. It is also imperative for people who deliver health and medical services to pay more attention to biracial children.

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See Also: Biracial Couples; Multiracial Children; Multiracial Individuals and Families.

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Biracial Couples

Interracial marriage was legally banned in many places in the United States until the U.S. Supreme Court in 1967 struck down all antimiscegenation laws in the *Loving v. Virginia* case. Because of these laws, biracial couples were regarded as socially unacceptable. Biracial couples are couples who are of different racial backgrounds, such as a Chinese American wife and an African American husband.

According to the 2010 U.S. Census, approximately 5 million Americans have racially different partners. In the past, biracial couples were shunned by society because there was a social assumption that marriage should be between people of the same race. Being excluded from many aspects of social life, some biracial couples had to live an isolated life. Some biracial couples faced prejudice, discrimination, and ostracism from their families, friends, communities, and society. Biracial couples had a difficult time, but with the help of their peers and support groups, they have survived the difficult time together, raised children, and contributed to American racial tolerance and diversity.

Loving v. Virginia Ruling

The environment surrounding biracial couples was difficult before antimiscegenation laws became illegal as a result of the Supreme Court ruling in *Loving v. Virginia* (1967). An antimiscegenation law was first enacted in Virginia in 1662, and many other states later adopted similar laws. These laws basically banned marriage between a Caucasian and a non-Caucasian. Some states banned marriages between different non-Caucasian groups, such as a marriage between a Chinese American and a Mexican American, but these marriages were usually tolerated. It is therefore pointed out that the purpose of these laws was to keep the Caucasian race from being mixed with other races and to maintain white supremacy.

The antimiscegenation laws banned biracial marriages for a long time and functioned to justify discrimination against biracial couples. However, the Virginia statute was challenged by a biracial couple, Mildred and Perry Loving, in 1963. Mildred was part African American and Native American; Perry was Caucasian. They were brought up in the same neighborhood in Virginia, and became lovers later on. Since Virginia had an antimiscegenation law, the Lovings went to Washington, D.C., and lived there for a while. However, they wanted to live in their hometown in Virginia and moved back there. When they returned, the Virginia police arrested them because they violated the antimiscegenation law. The state ordered the couple to leave Virginia for 25 years, but the Lovings wanted to live in their own community, and began a legal battle against Virginia with the support of Robert F. Kennedy and the American Civil Liberties Union (ACLU). Two ACLU lawyers, Bernard Cohen and Philip Hirschkop, represented the couple, and on June 12, 1967, the U.S. Supreme Court ruled that antimiscegenation was unconstitutional and ordered Virginia to approve the couple's marriage.

Networking of Biracial Couples

The *Loving* case eased the restrictive environment for biracial couples. However, there continues to be misunderstanding and prejudice against biracial couples, such as other people staring at them, starting rumors, or calling them names, To deal with these problems, some biracial couples have moved to areas where biracial marriages are more tolerated and have tried to find couples like them for mutual support. The 2010 U.S. Census illustrated that cities such as New York City, San Francisco, and Honolulu have relatively large multiracial populations. Biracial couples can easily find people like themselves in these places. Some biracial couples have launched either face-to-face or Internet-based support groups in order to extend help and understanding to other biracial couples and to provide helpful information for biracial couples throughout the United States. These groups provide outreach and support to biracial couples who live in racially homogeneous areas and who cannot find people like them.

Biracial couples need mutual support because they share similar problems. Some face rejection from their families and cannot introduce their children to their respective families. Some biracial couples report neighborhood harassment such as name-calling, stares, harmful rumors, property vandalism, and threats. Prejudice is accelerated when couples have children. Some people tell biracial couples that their children will suffer identity dilemmas because the children will have no place in any racial group, and therefore couples should not have children. Some biracial couples find that their children do not look like them, and people have trouble identifying parents and children as a family, which negatively affects family unity.

In order to fight against social bigotry, biracial couples need support groups that understand their problems. These support groups' activities are various. Some offer opportunities for biracial couples to learn how to deal with the unpleasant experiences they face in society and how to raise children. Workshops or information on childrearing are beneficial for biracial couples because it is sometimes difficult for them to understand the feelings or problems of their children due to their monoracial backgrounds. Some support groups are politically active. Some of these groups lobbied the government to change the U.S. Census so that their children could mark their biracial heritages on the census. This lobbying is called the multiracial movement and it succeeded in persuading the government to change the census. Before the movement, biracial people had to mark only one of their racial heritages, and some biracial couples found this "mark only one race" feature of the census detrimental to the development of their children's identity formation and self-esteem. Beginning with the 2000 U.S. Census, all biracial people can mark more than one racial category. These various activities not only help biracial couples but also encourage Americans in general to get rid of their negative images of biracial couples.

Changing Social Atmosphere and Human Services Needs

After the *Loving* ruling, biracial couples were no longer illegal and society has gradually changed its attitude toward them from rejection to acceptance. In 1980, the number of interracial marriages was only 6.7 percent, but the 2010 U.S. Census revealed that approximately 15 percent of all new marriages in the United States were interracial marriages.

Further evidence of how the increasing number of biracial couples positively affects public views can be found in a 2012 Pew Research Center study on interracial marriages. The study reported that 43 percent of respondents stated that interracial marriage was a positive change for society, and 63 percent answered that it was fine with them if their family members "outmarried" into another racial group. On the other hand, the same data illustrate that some Americans still cannot accept biracial couples, with 11 percent of respondents stating that interracial marriage was not a good change for society, and 14 percent believing that intermarriage was a bad thing. While the public's attitude toward biracial couples is getting better, there are people who maintain their negative views toward biracial couples, with continuing reports of harassment against biracial couples. Human services for biracial couples will be necessary until the day all Americans can embrace biracial couples as a part of their society.

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See Also: Biracial Children; Critical Race Theory; Multiracial Individuals and Families; Race, Social Definitions of; Race and Ethnic Categories, U.S. Census.

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Blindness and Low Vision

Across the globe, there are numerous definitions of blindness and low vision, each with the intent of defining a person's eligibility to receive certain benefits such as income assistance, disability support, and various rehabilitation services.

The concept of "legal blindness" in the United States was promulgated by the American Medical Association in 1934 and adopted by Congress as part of the Aid to the Blind program in the Social Security Act of 1935. The law defines legal blindness as having a visual acuity (measured by the Snellen test) of 20/200 or less in the better eye, with

Sightless Among Miracles*, a bronze sculpture created by R. T. Wallen, was donated to the Carter Center River Blindness Program. The program has assisted in the delivery of more than 35 million treatments of a drug donated by Merck and Company to families in Africa and Latin America who, for hundreds of years, have been stricken with river blindness.*

best correction or widest diameter of visual field subtending an angle of no greater than 20 degrees. Since 1935, this definition has been used as a criterion by which a person in the United States may be deemed eligible for public services.

This is not only true in North America, but also in most of Europe. For example, in the United Kingdom (UK) blindness is defined using the Snellen test, but is measured in meters, with 6/60 in meters the U.S. equivalent of 20/200 in feet.

The U.S. Centers for Disease Control and Prevention (CDC) and Americans with Disabilities Act (ADA) Amendments Act of 2008 use the term *visual impairment* and refer to it as a disability if: (1) it substantially limits a major life activity; (2) it was substantially limiting in the past; or (3) an employer regards or treats an individual as having a substantially limiting vision impairment.

The World Health Organization's (WHO) International Classification of Diseases (ICD-10) defines blindness as having a visual acuity of less than 3/60 (the metric equivalent of Snellen's 20/200). The WHO takes this definition one step further by adding the category of low vision, defining it as a visual acuity with best correction of less than 6/18 (roughly 20/63 Snellen equivalent) and/or a corresponding visual field loss of less than 10 degrees. Furthermore, the WHO identifies four levels of visual functioning— normal vision, moderate visual impairment, severe visual impairment, and blindness—and takes a more functional perspective.

Prevalence

According to 2010 U.S. Census data, of a total population of 142.6 million persons age 40 and over, 4.2 million Americans have a visual impairment, while 1.3 million are blind. Approximately 60 percent of the 4.2 million visually impaired persons have functional low vision. On a global basis, the World Health Organization estimates that 285 million people are visually impaired, with 39 million of those blind and 246 million having low vision, or approximately 80 percent who have functional low vision. These are important data as they help inform public policy decisions and help direct private and governmental service providers to the information required to best serve individuals with visual impairments.

For example, while there are overlaps among services for people who are blind and those with low vision, there are services that may be unique to each of the populations. People who have no functional vision can negotiate activities of daily living by using nonvisual techniques, such as braille and computer screen reading programs, among other devices and techniques. Those with low vision will use devices and techniques that capitalize on their residual vision, such as computer screen magnification software, telescopes, handheld magnifiers, and video magnifiers.

Services

Services for people who are blind or have low vision may be categorized as: financial benefits; rehabilitation or compensatory strategies to perform activities of daily living, such as adaptive kitchen skills, braille and other tactile systems, orientation and mobility, communication, adaptive computer skills, use of remaining vision, and psychosocial adjustment to vision loss; and employment.

Financial benefits. By 1919, 13 states had approved specific procedures for providing financial aid to individuals who were blind. In 1935, the Social Security Act provided grants to states to provide "aid to the blind." Provisions of this law remain intact today in U.S. and state governments, resulting in supports and services such as Supplemental Security Income, Medicaid, and federal income tax deductions for those who are legally blind. The UK provides financial benefits such as the Personal Independence Payment (PIP), Employment and Support Allowance (ESA), and certain tax credits. In Germany, people who are blind receive cash benefits, while people in Ireland who are blind are able to receive a pension. In Australia, the Disability Support Pension (Blind) is issued to men and woman who are legally blind. This pension is free of income and asset testing and is not taxable. Assistance is also available in Australia for the purchase of equipment to improve an individual's independence.

Rehabilitation. In the United States methods and techniques to provide people who were blind with the skills necessary for independent living originated with Dr. William Moon in the mid-1800s. Through home-based instruction, he worked with people to assist them in learning what would later become known as home teaching. By 1926, 25 states had adopted these services. Today, every state provides services through a combination of public and private agencies.

Globally, the organizations providing services to people who are blind or have low vision are too numerous to list. Examples across the globe include the Spanish National Organization of the Blind (ONCE), which provides training in daily activities, education, and leisure activities; the Polish Association of the Blind, a public-benefit organization, offers support for activities of daily living across the country; the South African National Council for the Blind provides community-based rehabilitation services; and the Nippon Lighthouse in Japan offers services in the areas of personal adjustment training, adaptive communication, and orientation and mobility.

Employment. The fundamental supposition in the United States during the 1920s and early 1930s was that people with visual disabilities had little potential for competitive employment and were relegated to either sheltered workshops or home industry settings. However, with the passage of the Randolph-Sheppard Act of 1936 and the Wagner-O'Day Act of 1938, opportunities for people who are blind began to expand. People who were blind were allowed to operate vending stands on federal property, and it became mandatory for the federal government to purchase designated products from workshops that employed people who were blind. Today, people who are visually impaired are employed as lawyers, accountants, computer programmers, teachers, and many other occupations. However, unemployment and underemployment continue to be an issue. Recent U.S. statistics (2011) conclude that noninstitutionalized persons aged 21 to 64 years with a visual disability have an employment rate of only 36.8 percent.

According to a World Blind Union (WBU) presentation in 2012, people who are blind or have low vision are the group least likely to attain employment. The WBU finds that in many countries people who are blind are five times more likely to be unemployed than the general public. The WBU has undertaken three initiatives to help dispel employers' previously conceived notions about the capacities of people who are blind/partially sighted and the relatively simple modifications that can be made in the workplace: (1) employment mentoring and peer support programs; (2) microcredit and microenterprise programs; and (3) the establishment of employment resource banks.

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See Also: Americans with Disabilities Act; Americans with Disabilities Act of 1990; Assistive Technology; Disabilities, International Variation in Attitudes Toward; Disability Services; Disabled Clients.

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Blue Collar/Pink Collar/White Collar

Jobs are classified into categories by the conventional dress of the workers—blue, pink, and white collars. This stratification system is actually based on the level of education and training required, pay, social prestige, nature of work activities, and the setting in which the workers perform their tasks.

"Blue collar" refers to work or occupations that are manual and craft-related, found in factory or outdoor settings. Formal schooling or apprenticeship training is generally required for entry into these occupations. Due to the manual (or craft) nature of their work activities, workers wear blue work shirts, uniforms, or jumpsuits. Jobs that are labeled "blue collar" range from construction workers, carpenters, nurses, electricians, plumbers, assembly plant workers, and sanitation workers to police officers. All of these are traditionally male-dominated occupations, except for nursing.

"Pink collar" is a label used to capture the emergence of a new group of workers in clerical and service work in the mid-1950s. During this period, there was an influx of women into the labor markets, taking up jobs as secretaries, waitresses, child care providers, and telephone operators. The growth of the service economy and technological development has facilitated the expansion of these "female occupations" in industrialized nations.

"White collar" refers to jobs or work performed in office settings that necessitate the wearing of white shirts or business attire. Managerial, supervisory, and professional jobs that require college or advanced training and/or licensing fall into this category. High paying and high status, these jobs were historically dominated by whites and men. Racial minorities and women were historically barred from receiving education as well as from participating in these occupations.

Technology, Prestige, and Inequality

Due to a lack of the means of production, such as capital and technology, individuals are compelled to sell their labor for wages in the labor markets. Industrialization has brought stability and change in the stratification system. Generally, white-collar (intellectual, knowledge-based) workers command the highest respect in the society, followed by blue-collar (technical/manual, craft) workers. Pink-collar (clerical or service-oriented) workers are at the bottom in terms of occupational prestige. In addition to education, skills, and pay, gender composition in a field serves as an indicator of occupational prestige. Jobs with a relatively high concentration of women or perceived as "women's work" tend to be low paying, low prestige, and low security.

White-collar and most blue-collar work are considered as "desirable" or "good jobs" because of their relatively high pay and career prospects. In contrast, due to their low pay and poor career prospects, pink-collar work is considered as "least desirable" or "bad jobs." Further, the possibility of moving from the "bad-jobs" sector to the "good-jobs" sector is close to zero, due to the requirements of higher education and/or specific skills for white- and blue-collar work.

The distinction between white-collar (middle-class/managerial) and blue-collar (working-class/technical) workers is blurred because automation in factories and information technology has turned many manual and craft jobs into relatively clean, responsible, and clerically oriented work. Technology has de-skilled some workers and upgraded the skills of other workers. However, technological changes have provided freedom of movement and reduced time pressures for blue-collar workers. Technology has also transformed communications and, in turn, relationships between white- and blue-collar workers. To a large extent, technology has reduced inequality between blue- and white-collar work in terms of the production and delivery of goods and services.

The same cannot be said about pink-collar jobs. In fact, the opposite is true. Technology has de-skilled many clerical jobs and allowed employers to recruit women into secretarial and service-oriented work. The perception that women are a docile and subordinate workforce has made them an ideal source of labor in office settings and service industries.

Job Security and Satisfaction

Historically, individuals performing intellectual and technical work have enjoyed job security. Requirements for higher education and specialized skills and the need for on-the-job training make worker replacements costly for employers. Further, most if not all manual and craft workers are unionized and protected by seniority rules from arbitrary discipline or exploitation by employers. White-collar workers report a higher level of job satisfaction thanks to financial rewards, career prospects, and autonomy. By contrast, working conditions and physical demands of the job lower the level of satisfaction among blue-collar workers.

The civil rights and women's movements have resulted in racial and gender integration in many previously white-male-dominated occupations. High school education is the minimum requirement for entry into blue-collar jobs such as firefighting, union construction, and subway operation. Newcomers in fire service, construction, and transit operation receive formal training or apprenticeships. However, historically disadvantaged groups (women and racial minorities) continue to face substantial informal barriers in these fields. The obstacles range from white and male workers' opposition and resistance to women and minorities in firefighting and union construction to harassment, assaults, sabotage, and threats to personal safety.

Most white-collar jobs can no longer provide job security. Hiring at the entry level from outside and being promoted from within has created an internal labor market for many organizations and companies. Firm-specific skills and knowledge may have protected incumbents from external competition for promotions. As a result, they have a competitive edge in getting ahead within their firms. However, cuts in government spending and corporate restructuring have resulted in massive layoffs of white-collar workers, especially those occupying middle-level managerial or administrative positions. Industrial restructuring and recent economic recession has resulted in a permanent loss of these white-collar jobs and created a cadre of "collarless workers."

Having previously worked from "9-to-5" in office settings with regular paychecks, benefits, and ladders of upward mobility, many white-collar workers are now self-employed at home or work as independent contractors for previous employers or for other companies. To keep themselves employable in the fluctuating job markets, these "collarless workers" have to maintain and expand their networks.

Job Appeal

What makes blue-, pink-, and white-collar jobs appealing? The nature of manual labor or craft requires workers to do physically demanding, repetitive, and sometimes dangerous tasks. The physical toll is high for those who do these jobs. But the "costs" and danger associated with most blue-collar work are compensated by high financial rewards. In contrast, pink-collar workers pay a high psychological and emotional toll. Dead-end, labor-intensive, and nonunionized, many "female occupations" are oriented to serving the public or providing supportive roles in companies, human services agencies, and private residences. With the emergence of the service economy, especially the proliferation of call centers worldwide, women have taken up the bulk of work as office or sales clerks, waitresses, telephone operators, beauticians, maids, nannies, and home care providers. Compared to blue- and white-collar work, pink-collar work is intellectually and technically less challenging. However, these "female occupations" provide part-time employment, flexibility, and freedom to engage in other activities after work. Unlike their counterparts in blue- and white-collar jobs, pink-collar workers do not enjoy job security or high pay. Seldom unionized, these low-wage workers perform routine work without the job benefits and prestige associated with blue- and white-collar work.

A similarity shared among blue-, white, and pink-collar workers is that an increasing number of workers are hired on short-term contracts. Instead of being salaried workers, a large proportion of managerial, professional, and service workers are now being paid by the number of hours worked and/or being assigned to a specific job location to serve a client.

Technological changes have allowed multinational corporations to set up international call centers or data entry processing centers in developing counties and to hire a large number of female workers at low wages. This global trend has driven down the wages of these feminizing occupations and turned these jobs into "ghettos" for women worldwide.

Generally, a pleasant work environment and relatively high pay make white-collar work attractive. Due to the nature of work and career prospects, job satisfaction of white-collar workers tends to be higher than that of blue- and pink-collar workers. However, fierce competition for jobs and downward mobility has become a reality for many white-collar workers. Restructuring and economic recession in recent decades has eliminated many white-collar managerial jobs. Information technology has expanded the scope and nature of work outside office settings. White-collar workers are now expected to check their e-mail, make and answer telephone calls, and participate in meetings when they are at home and on vacations. The Internet, smartphones, and other electronic devices have completely shattered the boundary between work, family, and leisure. Information overload and loss of privacy have become a fact of life for many doing white-collar work. Thus, long hours and stress may result in higher rates of "burnout" among workers with higher education or specialized skills.

The Future of Blue-, Pink-, and White-Collar Work

In spite of technological changes and restructuring, there is no evidence of massive and well-organized efforts among workers to protect their job security and privacy. These changes collectively might have benefited a specific group of workers. There are more women in the labor force than ever. It is not because women have suddenly grown stronger or greedier than before. Many of them are compelled to enter the labor force by economic needs. Women's participation in the labor force has expanded into the service economy. Women are as willing and able as men to do a variety of work. They enter intellectually, physically, and emotionally demanding jobs to support themselves and their families. The notion of femininity can be considered an asset instead of a liability for women in seeking employment opportunities on a global scale.

As more women complete higher education, they will continue to enter the labor market in large numbers. As an economic force to be reckoned with, it will be difficult for employers to continue to treat women doing white-, blue-, and even pink-collar work the way they did. Women's presence and their demands for equal and respectful treatment in corporate board rooms, on construction job sites, or at their client's residences will continue to erode male dominance in blue- and white-collar work and improve the status of women holding pink-collar jobs. However, changing the work cultures in male domains requires organization, resources, and support of coworkers and supervisors. History has revealed that without support at the institutional level (from the government, unions, and media), it is difficult for women to improve their plight in male (blue-and white-collar) and female (pink-collar) jobs.

Implications for Human Services and Diversity

An increase in the participation of women in white-, blue-, and pink-collar jobs creates new human services needs and delivery. The society will shift its economic and support services from male workers to a female workforce. Workplace diversity suggests that more women will take on the role of sole economic provider or coprovider in American households. As an economic force to be reckoned with, women have become an agent of diversity in human services and care. There have been increasing demands for child and senior services by working mothers with the responsibilities of taking care of children, elderly parents, and sick relatives. Workplace diversity, coupled with demographic shifts, have compelled governments and corporations to pay attention to gender and family issues. As providers for their families, female and (young) male workers have to juggle family and work. For working parents, day care and after-school services are indispensable. Employing domestic help with child care, housework, and elderly care has become a common practice among professional women. This may contribute to the legitimization of personal concierges and the entry of more workers, especially women, into service-oriented jobs. Long-term residential or home care for elderly parents and community-based services for seniors will be needed to meet the growing needs of employed women or working mothers to take care of parents with special needs.

A shrinking of the organizational ladder has resulted in the demand for employees' education. Former holders of high-paying, high-status, white-collar jobs may need to update their knowledge or upgrade their skills. A proliferation of online college credit–bearing courses, continuing education, or new career training is a direct outcome of rising demands by working professionals or those who want to make career changes.

Economic restructuring and recent recessions have led to an extended working life expectancy of many "baby boomers." To make up for the income loss as a result of career interruptions or to recoup investments in additional education or training, they tend to delay retirements. Thus, an increasing number of workers in their 50s and 60s may face stiff job competition in a diverse workforce. Their extended participation in the labor force will result in tensions for human services and delivery. Employers will have to come up with the resources to address the issue of skills obsolescence and the health care needs of an aging workforce. At the same time, many of these "baby boomers" will find themselves working side by side with younger workers who share different values and work and lifestyles. How to help a diverse workforce develop and maintain cultural competence constitutes a challenge for governments and corporations.

After obtaining new career training or retooling, some former holders of white-collar jobs may take up blue-collar jobs or work as self-employed (independent) contractors for a diverse clientele here and abroad. This group of "freelancers," young and middle-aged, will generate demands for new human services catering to their unique (flexible) work and lifestyles.

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See Also: Aging and Adult Services; Elder Care/Geriatric Services; Home and Community Services; Home Care Services; Long-Term Residential Care.

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Blue Vein Society/Paper Bag Test

In order to conceptualize the Blue Vein Society, it is imperative to first examine its evolution. This article discusses eugenics, the mulatto hypothesis, and the one-drop rule, which serves as the circumference for understanding the Blue Vein Society. The article concludes with a review of information on the Blue Vein Society. This article is significant for human services because it illustrates the magnitude of diversity even within a single ethnic or racial group. Moreover, it seeks to assist in eradicating a monolithic notion that is subject to fostering prejudices and stereotypes about certain groups of individuals.

Eugenics

Eugenics is a term coined by Francis Galton in 1883. Galton defined eugenics as the study of all agencies under human control that can improve or impair the racial quality of future generations. Eugenics is the philosophy, theory, and practice of improving the human race by promoting the increase of people with desired traits and decreasing the reproduction of people with undesired traits. The eugenics era lasted from the start of the 20th century to well into the 1970s. It continues to influence the thinking of much of the scientific and social communities in the United States. The science of eugenics was based on the shared belief that the genetically and socially elite of human evolution culminated in the white Anglo-Saxon Protestant race. More specifically, it was also a widespread belief that those who were least developed were doomed by heredity to be not only genetically inferior but also socially unfit.

Some racist individuals and groups in the United States used the science of eugenics to imply that African Americans were inherently inferior in every way to whites. Consequently, there was far less value placed on the lives of African Americans. Those African Americans who would commingle with other African Americans would continue to perpetuate an inferior race of people. However, those African Americans who joined with white people would only improve the status of the race. The ideology became a pathway to understanding the mulatto hypothesis.

The Mulatto Hypothesis

The mulatto hypothesis is theoretically couched in the science of eugenics. A mulatto may be defined as the offspring of an African American and a Caucasian. Initially, the product of these racially different people was considered an anomaly. This was attributed to the notion at that time that commingling the people of the African American race with those of the Caucasian race was taboo. Moreover, mulatto people were often perceived as a violation to the purity and immaculacy of the race. African Americans in every aspect were considered inferior. Some suggested that African Americans were of subhuman status and even were the missing link between man and ape. Consequently, this notion defined the subservient role that African Americans assumed in society.

The revised version of the mulatto hypothesis indicated that in order for African Americans to improve the quality of their race, they had to increase the amount of their Caucasian genetic heritage. Therefore, lighter-colored African Americans had the advantage over those African Americans with darker-colored skin (from two African American parents). Caucasians who were the offspring of two white people were undoubtedly considered superior in every way.

One-Drop Rule

One factor with a tremendous influence on the formation of the mulatto hypothesis had to do with what was called the one-drop rule. The one-drop rule suggested that if a person had as little as one drop of African American blood in their ancestry, that person was an African American. It was also known as the one-black-ancestor rule, or the traceable-amount rule, or the hypo-descent rule. This meant that racially mixed people were assigned the status of the subordinate group. In this case, African Americans were the group with the lower status.

Ironically, during the antebellum period, people of mixed ancestry who were free and appeared Caucasian were legally and socially immersed into the majority white community. This was the circumstance if the person had up to one-quarter (one African American grandparent) or even one-eighth (one African American great-grandparent) African ancestry. Moreover, if the person's physical appearance was that of a Caucasian and they were perceived by others as Caucasian, they were then accepted in society as white.

It was not until the 20th century that the one-drop rule was adopted as a law. This law was mostly proposed and supported by those white people who were trying to maintain a sense of white supremacy and purity of their ancestry. The Racial Integrity

Mulattoes sitting on the porch of country store near a cotton plantation in Melrose, Louisiana, in 1940. Such men could have been given the paper bag test used by upper-class African American societies in the early 1900s to determine if a black person was white enough to gain admittance or acceptance. Anyone with a skin tone darker than a paper bag was not allowed into the group.

Act of 1924 was the first law to initiate such ancestry standards. Enacted in Virginia, this law required that a racial description of every person be recorded at birth. Once that identification occurred, the person was divided into one of only two categories: white and colored. The Racial Integrity Act of 1924 defined "colored" as a person with African or Native American ancestry.

The Society

The Blue Vein Society became known as a group of people generally of mixed African–African American and white Anglo-Saxon heritage. This combination produced a population of people whose physical traits and complexion were different from those of traditional African–African American as well as white Anglo-Saxon people. However, by definition they are African American. This occurrence also promoted a class system for the children stemming from the two individuals who represent separate ethnic groups.

The term *Blue Vein Society* is also associated with a perceived aristocratic group that had wealth, privilege, and high social status. In a broader sense, Blue Vein Society signifies the historical phenomenon found among some African Americans in which individuals with lighter complexion and loosely curled, wavy, or straight-textured hair occupy positions of favor, while darker-skinned African Americans rank lower on the social scale. Technically, the term *blue vein* was attributed to having less pigmentation in the skin until one could see the blue veins that were in the volar forearm. Moreover, the Blue Vein Societies continued to develop, particularly in the southern region of the United States for decades following the Civil War.

As the members of the Blue Vein Society continued to exist throughout the larger African American community, they began to epitomize nearly another racial/ethnic group in society. The main objective of the Blue Vein Society was to maintain their lighter complexion, physical features, and privileged social status in the greater African American community. This has been known in more recent times as "colorism." For example, the members of the Blue Vein Society may have been employed in the same company as many darker-skinned African Americans. However, the lighter-skinned African Americans often avoided any intimate social contact with the darker-skinned African Americans once the workday was over. Within the work environment, the darker-skinned African Americans often occupied the physically labor-intensive positions, while the lighter-skinned African Americans were likely to serve in a leadership capacity. This concept was perpetuated and supported by the white company owner. Because the physical appearance of the Blue Vein Society members more closely resembled that of white people, they were also perceived as being more intelligent than the dark-skinned workers. Thus, they were considered more suitable for their employment position.

In certain social, educational, and religious settings, members of the Blue Vein Society executed behaviors that fostered colorism in the African American community. Common practice in these venues were called the brown paper bag test and the fine-tooth comb test. An applicant could be denied admission into certain organizations, schools, and even churches if their skin color was darker than that of a brown paper bag. If the texture of a person's hair was so course that a fine-tooth comb could not smoothly pass through it, that person failed the test.

In summary, the Blue Vein Society is generational groups of African American people who have mixed African–African American and white Anglo-Saxon heritage. They generally have physical traits and complexion different from those of traditional-looking African–African American as well as white Anglo-Saxon people. They were also perceived as an aristocratic group that had wealth, privilege, and high social status within much of the African American community.

The Blue Vein Society continued to exist during the post–Civil War era. Its conceptualization began with the science of eugenics. The Blue Vein Society was supported by the mulatto hypothesis and enhanced with the one-drop rule. For many in the African American community, the ideologies of the Blue Vein Society continue to exist. There are those who still carry out covert and subtle practices. However, in present times, the Blue Vein Society fails to subsist as a solidified nationally recognized organization.

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See Also: African Americans; Biracial Children; Race, Social Definitions of; White Privilege.

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Boarder Babies

Every year in the United States thousands of newborns and infants are abandoned at hospitals by troubled or ill-equipped mothers who leave it to the health care system and human services agencies to care for their babies. These abandoned newborns and infants are commonly referred to as "boarder babies" because they effectively become boarders at the hospitals and youth services agencies that support them. Most of these children end up as dependents in the foster care system.

The main approach used by human services agencies to address the boarder babies issue is twofold. The primary goal is to prevent abandonment. Addiction, abuse, poverty, and illness are leading causes of baby abandonment. Providing broader and better access to supportive social services and affordable housing for women facing these situations is considered critical as a way to reduce the risk of baby abandonment by troubled mothers. When prevention is not possible, the secondary goal is to facilitate and expedite safe and suitable permanent placement for the babies who have been abandoned. All of these efforts involve participation and coordination by health services, social services, and the courts.

Conceptual Approaches

Three main ideas are critical to contemporary efforts to resolve the boarder babies situation in the United States: collaboration, training, and process improvement.

Collaboration among health care facilities and child welfare agencies may help reduce the incidence of baby abandonment in the first place, and can also help speed permanent placement when abandonment of a child does occur. Specifically, by establishing a mutual understanding or formal protocol between human services agencies and hospitals, critical information about high-risk abandonment situations can be exchanged more swiftly and easily among all parties involved. The same free flow of information can assist when performing due diligence in cases where identification of an abandoned child, biological parent, or caregiver relative is required.

Training is another way to ensure open and ongoing communication among human services agencies, health care providers, and legislative constituents. Training focused on issues tied to child abandonment can facilitate a comprehensive and consistent approach among the diverse service providers and legal participants involved in boarder babies cases. This is especially true when it comes to identifying risk factors for abandonment, ensuring understanding about voluntary relinquishment and termination of parental rights, performing diligence searches prior to placement, and adhering to state and federal child welfare laws.

Process improvements throughout the various organizations that are involved in responding to the needs of the nation's boarder babies also can help establish consistency in procedures and responsive actions. The implementation of protocols and checklists for specific situations, for example, can make it easier to identify required actions, time frames, and participants tied to a given abandonment case. As such, all parties involved in that action can become aware of every step in the process and can see how each step is interconnected within and among the various agencies associated with the case.

Practical Approaches

In addition to the conceptual components behind efforts to address boarder babies and child abandonment issues, there are also practical elements that often are applied to help alleviate the situation.

Manageable caseloads for child welfare workers are critical to ensuring comprehensive and effective services to support fewer instances of abandonment and to facilitate placements when a child is abandoned. It is important that caseworkers, for their part, communicate candidly, clearly, and in an unbiased way with families who are potentially confronting an infant abandonment/relinquishment situation. This interaction often takes the form of one-on-one mentoring between a caseworker and family members. In these sessions, the child welfare agent strives to make the family fully aware of the consequences of terminating parental rights, the details and time frames involved in the child protection process, and the types of permanent placement options that might come into play, such as legal adoption of the child by another family. It is of paramount importance that the communication be neutral but complete.

Early intervention with medical and mental health services for infants and children who have been abandoned or who are at risk of abandonment also is very important. Toward that end, human services workers must carefully assess the child's physical, developmental, behavioral, educational, and social needs as part of the process when determining whether a parent is able to meet the child's needs. This same scrutiny also is helpful when trying to identify an appropriate placement for an abandoned or at-risk baby. The goal is to place the infant in a home that may be suitable for permanency as soon as possible, so understanding the child's physical and emotional status makes it easier to determine the best long-term match for a potential caregiver and home environment.

In the event that an at-risk parent has been identified by a hospital, court, or human services organization, it is important that child welfare agencies identify and deliver a broad range of tailored services designed to help prevent abandonment or, if necessary, to expedite permanent placement for the child who is risk of being abandoned. Such services could include anything from alcohol or drug treatment services for family members to information and services designed to aid in a smooth transition to a biologically related caregiver, unrelated legal guardian, or adoptive family. Additionally, some tools and strategies are available to help uncertain parents make decisions about child abandonment in a timely manner so as not to extend the child's at-risk or impermanent situation.

First, it is critical for hospitals and human services agencies to identify as early as possible those children who are unlikely to benefit from being reunited with their parent or family unit. For example, this may occur when a child's safety is in question. If family reunification seems plausible, case-workers may employ a process known as concurrent planning. Concurrent planning enables a family to work toward unification while simultaneously creating an alternate plan for permanent placement of the child elsewhere. The successful implementation of concurrent planning involves in-depth case-work with the at-risk family, including frank discussion with the biological family about the importance of safe permanent placement for the child, types of permanency options, and consequences of deciding to keep or relinquish the child. It is also important for child welfare workers to participate in diligent search efforts to identify parents and relatives in cases of infant abandonment and to perform frequent and exhaustive case reviews. Subsidized guardianship is sometimes used to encourage relatives to care for abandoned babies who might otherwise remain in the foster care system for an extended period of time.

Voluntary relinquishment offers parents the opportunity to participate in adoption planning for their children. This empowers the parents to make decisions about the child's well-being while avoiding the potentially adversarial and costly processes involved with involuntary termination of parental rights through the court system. Smoothing the process can help speed up permanent placement for the child and save vital time and resources of human services agencies and the courts.

Mediation and family group conferencing, also known as family group decision making, is sometimes used to present the idea and details of voluntary relinquishment to parents and to expedite permanency. Mediation is a way to provide a structured, legal discussion without involving the formal court system. When the courts do get involved, they can help prevent abandonment by imposing legal accountability and mandatory services, such as drug counseling, to help support maintenance of custody by the parent. When necessary, the courts can also expedite termination of parental rights and speed the adoption process once parental rights are terminated.

Family group conferencing involves meetings hosted by child welfare specialists in which immediate and extended family members of at-risk children are encouraged to cooperate, collaborate, and communicate with each other and with the child welfare worker in a nonconfrontational way to make decisions and develop plans for the child's immediate and future safety, well-being, and placement.

The Abandoned Infants Assistance Act was passed in 1988 to help fund intervention programs for families and caregivers. The passage of the Adoption and Safe Families Act in 1997 approached the issue from the other end by putting parameters in place to pressure human services agencies and the court system to find permanent placement for boarder babies in a shorter period of time, typically one year or less. These legislative mandates, however, are only part of the solution to the boarder babies problem in the United States. To move closer to the goals of preventing infant abandonment and rapidly placing abandoned children into safe and nurturing homes requires a collaborative, consistent effort by all parties involved. The multidisciplinary efforts include comprehensive communication and coordination of administrative and procedural practices to help identify and support at-risk families and, if necessary, to permanently place abandoned/relinquished infants and children.

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See Also: Abandonment; Abuse and Neglect; Administration on Children, Youth and Families; Adoption and Safe Families Act; Alcohol and Substance Abuse Services; Case Management Services; Counseling and Psychotherapy Services; Department of Health and Human Services, U.S.; Early Childhood Development; Family Permanency Planning; Family Services; Foster Care Agencies; Group Homes for Children; Hospitals; Infant/Toddler Development; Legal Services; National Child Abuse and Neglect Data System; National Organization for Human Services; Parenting Skills Training; Protective Services for Children; Social Workers.

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Boot Camps

The notion that offenders, particularly juvenile delinquents, would benefit from military-style boot camp regimes dates from the late 1980s. It was hoped that such a setting would "build character" as it is thought to do in true military contexts and that the harsh discipline encountered there would serve as a form of "shock therapeutic corrections," which would jolt the minor offender and delinquents into a more conformist state of mind. It should be noted that such facilities were often created at former military bases and were significantly cheaper to run than were traditional juvenile facilities. Boot camps also served to reduce overcrowding at existing more custody-based facilities. At base, however, the philosophy that underlies correctional boot camps is not primarily economic; it is essentially a punitive response to the growth in urban crime in that period and reflects the notion that all that is needed to curb delinquency is harsh discipline that would put an end to the assumed permissiveness of the juvenile's parenting.

It was thus implicit that such a regime would build accountability and pride in achieving modest goals through teamwork. Some facilities put a heavy emphasis on literacy and ensuring that those who completed the program were also academically on track. Offenders with alcohol and drug problems were to receive specially targeted therapeutic intervention in some programs. The sad fact is that after boot camps for both juveniles and adults had been established in the 1990s, numerous evaluative studies showed that they had little or no impact on significant behavior variables once the juveniles left the treatment milieu. Although the focus of most literature on correctional boot camps concerns those operating in the public sphere, it should be noted there are privately operated, commercial juvenile boot camps ("brat camps") in some areas. While some of these facilities deal with court referrals, many are the last resort of relatively affluent parents with ungovernable children. Many of these have a "wilderness" approach involving much outdoor exercise and work with domestic animals. A few have a religious orientation that involves heavy immersion in biblically-based discipline and scripture.

While Georgia opened the first boot camp for adults in 1983, Orleans Parish, Louisiana, began the first boot camp for juveniles in 1985. By the 1990s there were 70 juvenile boot camps in 30 states, most employing a program similar to that of military boot camps. Inmates went through a degrading intake procedure in which their heads were shaved, they were given military-type garb, and issued bunks. They were subject to extremely early rising (often to the tune of a bugle), calisthenics, and drills. As in the military, misbehavior or an error by one member of a squad resulted in punishment for the entire squad or individual drill collectively. Punishment usually consisted of running laps or performing meaningless exercises. Some instances have been reported of food and water being denied and sleep deprivation being used as punishment.

Much effort was expended on verbal abuse and humiliation from "drill sergeants" who had squads participate in "team- and character-building" activities that many participants found degrading and pointless. Some shocking instances of abuses by guards and instructors have been reported. It should be noted that many instructors were former drill sergeants, retired from the military. Camps

A Recruiting Station Twin Cities' Mini-Boot Camp gives drill instructors a taste of Marine Corps Boot Camp. Correctional boot camps resemble military boot camps by emphasizing basic training activities such as vigorous exercise, strict rules, and manual labor. It was hoped that such a setting would build character, as it is thought to do in the military.

differed widely in how much time was devoted to education and therapeutic intervention. It has been alleged that both education and therapy were strictly subordinate to the rigors of the boot camp milieu and the demands of custody. This, however, varied from facility to facility. It is notable that some camps made real efforts to educate, counsel, and help those offenders with special needs. Aftercare and reentry programs were generally lacking given the little attention paid to the young offenders' need to transition to the real world and the streets.

Outcomes have not been encouraging. In general, recidivism was about the same for juvenile boot camp graduates as it was among those who went through traditional types of correctional interventions. Some studies even suggested that juvenile boot camp graduates actually committed more crimes after release. As might be expected, those programs that emphasized treatment approaches had somewhat better outcomes than those focused more on security and instilling discipline. Even when aftercare has been provided, however, results are not very positive, and in practice boot camps have turned out to be 10 times more expensive than traditional juvenile aftercare. So, although they are less expensive to operate than traditional custodial facilities, they are more expensive than most community-based alternatives.

Why Did Juvenile Boot Camps Fail?

One reason that military boot camps succeed is that everyone who participates (in the volunteer armed forces at least) is there because they want to work toward common goals. While that primary goal is arguably to serve one's country, another more significant goal for many is to raise one's status and to qualify for postmilitary preferential hiring and educational opportunities, and thus to achieve upward mobility and rise in the esteem of the community generally. Moreover, when one completes boot camp in this context, there is a dramatic ceremony replete with awards and one is no longer a "boot," but is a soldier, a sailor, or in the case of the U.S. Marines, a lance corporal. One literally can wear badges or patches signifying that upward movement.

In correctional boot camps, however, once one "graduates," with or without a ceremony, he or she is simply back on the streets, even if some aftercare is forthcoming. They are former offenders with no additional rewards or status conferred within the world of the streets. They get no preferential treatment from employers or the state. They are simply back to where they started. Many have returned to dysfunctional families and neighborhoods singularly lacking in legitimate opportunities for law-abiding youth, let alone former offenders. There is no community support for the graduates of juvenile boot camp programs. Thus, correctional boot camps suffer from a lack of sensible goal-directedness. The punitive goals of shocking the juvenile into conformity or forcibly instilling discipline simply cannot inhere in the absence of any short-term, tangible, or even eventual reward for having played the game.

Another problem results from hiring drill sergeants from the military. They are used to aggressively dealing with motivated young people and being rewarded for getting fast results. The lack of motivation and drive that they encounter when dealing with young offenders in juvenile boot camps is galling to these hardened professionals. Some are perhaps, at times, overenthusiastic in drilling, in the application of discipline and punishment, and in their general expectations insofar as this singularly unmotivated or negatively motivated audience of young people is concerned. Hiring more qualified personnel who are more oriented toward juvenile work should be a priority. Hiring criminal justice and social work professionals would demonstrate that more emphasis should be placed on education and therapy rather than on instilling discipline. Also, more selectivity should be exercised in terms of recruiting participants. It is clear that previously incarcerated juveniles and hardened offenders should not be included in such a program and that such programs should focus on less serious offenders. Furthermore, boot camps should focus on better postcompletion placement, reentry strategies, and aftercare. Some have suggested that the entire boot camp approach, with its focus on harsh discipline and unquestioning obedience to authority, simply encourages rage, defiance, and hostility.

That notwithstanding, the "get tough," "scared straight" mind-set still exerts a powerful appeal to both the public and politicians. Juvenile courts have used boot camps as a tool and parents have used them as a threat. The public as a whole believes, erroneously, that boot camps, like Scared Straight programs, work. Thus, though it is clear from years of research that these approaches do not work, boot camps (and Scared Straight programs) are still operating in some jurisdictions due to their popular and political appeal and their undeniable mediagenic qualities. In the face of the reality of program limitations and failure to produce, and due to the fact of some serious abuses by staff members, some states, such as Maryland, Georgia, and Arizona, recently closed some juvenile boot camps. Florida abandoned them altogether. But as late as 2003 there were still 3,000 inmates serving time in over 54 boot camps in the United States.

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See Also: At-Risk Youth Services; Juvenile Delinquents; Juvenile Detention Centers; Juvenile Justice System.

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Border Communities

The United States-Mexico border communities are defined as the area of land 100 kilometers north and south of the border and stretching approximately 2,000 miles east and west from the southern tip of Texas to California. The United States-Mexico border region is one of the most active regions in the world in regard to migratory movements, creating a cultural space defined by hybridity of culture, identity, and language. However, border communities face significant social and economic problems such as poverty, poor access to health care and education, and violence. It is critical that human service professionals understand the challenges faced by border communities, the development of border theory, and practices that can help alleviate social problems in border communities.

Geography and Demographics

The border region comprises 14 sister cities in four U.S. states and six Mexican states. Two-thirds of the border region lies in Texas. The population for the border region is estimated to be approximately 13 million and is expected to double by 2025. In fact, two of the fastest-growing metropolitan areas in the United States are Laredo and McAllen, two cities located on the Texas-Mexico border. In general, educational attainment is lower in the U.S. border region when compared to the rest of the United States. With the exception of San Diego, 25-year-olds in the border counties average two to three fewer years of school than their counterparts in the United States as a whole. The border region contains three of the 10 poorest counties in the United States and 21 counties designated as economically distressed.

On the Mexican side of the border, due to rapid industrialization the communities have less access to water and sanitation services than the rest of the nation. On the U.S. side of the border region, *colonias* (rural unincorporated settlements) are reflective of Third World communities. Although the majority of residents are U.S. citizens, they lack basic educational and employment opportunities and have limited infrastructure, leading to diseases that are controlled in most parts of the world. When U.S. border communities are considered as one geographic area, they provide the least health care access, report the lowest per capita income, and have the highest number of uninsured children and children living in poverty than any U.S. state. Along with health needs and poverty, the border region also suffers from violence and pollution.

Colonias are settlements on unincorporated land. Land plots in the *colonias* are typically sold through a contract-for-deed system, which means that a developer sells the land for a low down payment, but the buyer has no title until the last payment is made. Approximately 1,800 *colonias* can be found in the U.S. border region. *Colonias* are characterized by isolation, and lack of sanitary water, paved roads, and other necessary public services. The average yearly income of $14,000 for families living in the *colonias* is well under the poverty line and unemployment ranges from 40 to 50 percent. Residents of these areas must travel long distances to reach churches and other education or health services. They may have to drive up to 30 miles in order to find drinkable water, plaguing the *colonias* with problems such as outbreaks of dysentery and hepatitis A.

Violence in Border Communities

There have been elevated rates of violence on the Mexican side of the border due to drug trafficking. Women in particular have been victims of sexual exploitation, kidnappings, and murder, while the perpetrators of these crimes act with impunity. For example, the femicides in Cuidad Júarez have received international attention from human rights activists demanding justice for the women and their families. Despite these dire circumstances, there are many human rights activists on the Mexican side of the border calling attention to these crimes and demanding accountability. In addition, many of these activists have developed organizations intended to meet the needs of children and youth orphaned as a result of this violence.

The U.S. government claims that violent crime related to drug trafficking has not "spilled over" to the U.S. side of the border. However, it has been difficult to determine actual statistics regarding "spillover" violence due to the lack of a formal definition of this violence and the potential for geographic dispersal beyond the border region. Nevertheless, current data suggests that there is no significant difference in violent crime in U.S. border communities compared to previous years.

Border Theory

Despite the social problems, the border region has contributed to the rich body of work known as border theory. Culturally, border communities are known as spaces of hybrid cultures and areas of separation and contact. These borderland spaces have become metaphors for Mexican identity in the United States. Border theory spans almost every discipline including psychology, education, geography, social work, and sociology. For Mexican Americans, the borderlands signify daily challenges of constructing an identity in the face of racism, discrimination, and an anti-immigrant sentiment as well as the intersection of various identities such as gender, race, and sexuality. Thus, those that learn to exist within this borderlands identity are skilled at negotiation and at moving among social and cultural groups.

Solutions

Much of the work related to health issues along the border is focused on prevention methods. For example, *promotoras,* or community health workers, help address lack of access to health care services by emphasizing health literacy. However, without increases and sustained governmental and private funding for health programs, infrastructure, and education, progress in these areas will be limited. Human service professionals can play a critical role in documenting social problems in these areas, collaborating with public health workers, and assisting residents in accessing services. Finally, human service professionals must understand the strength of a border identity and what this means to individuals of Mexican origin psychologically and metaphorically.

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See Also: Biculturalism; Cultural Competence, Human Service Providers and; Global South/Global North; Health Care, Disparities in; Health Disparities, Role of; Mexican Americans; Poverty.

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Bullying

Although bullying has likely occurred throughout human history, it was only in the latter part of the 20th century that data was collected on the scope and extent of the problem. These data show that bullying is widespread, both inside and outside school settings. Bullying is damaging not only to victims but also to the school atmosphere. Legislation, policies, and prevention programs have been enacted to help eliminate bullying.

Definition and Scope

According to the U.S. Department of Health and Human Services' Web site, Stopbullying.gov, "Bullying is unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time."

Bullying takes many forms. Stopbullying.gov delineates three types of bullying: verbal, social, and physical. Verbal bullying refers to saying or writing mean things and includes behaviors like name-calling, taunting, inappropriate sexual comments, teasing, and threatening. Social bullying, also called relational bullying, is hurting someone's reputation or their relationships. This might include purposely leaving someone out, spreading rumors, telling others not to be friends with someone, and publicly embarrassing someone. Physical bullying is hurting someone's body or their things. This includes hitting, pinching, kicking, spitting, tripping, pushing, taking and/or breaking someone's things, and making mean gestures.

Bullies may target anyone. They often target those they see as marginalized or vulnerable; thus, data shows that young people who are or are perceived to be lesbian, gay, bisexual, or transgendered

According to the 2011 Youth Risk Behavior Surveillance System, 20 percent of students in grades 9 through 12 had been bullied. Bullies often target those they see as marginalized or vulnerable. Most research shows that bullies have often been bullied as well, meaning the lines between bully and victim are more fluid than many think.

(LGBT) are more frequently targeted. The Gay Lesbian & Straight Education Network (GLSEN) conducts a biennial National School Climate Survey in which they measure how frequently bullying of LGBT students occurs and the responses to it. The 2011 survey includes responses from 8,584 students between the ages of 13 and 20; students were from all 50 states and the District of Columbia and from 3,224 unique school districts. Results indicated that eight out of 10 LGBT students (81.9 percent) experienced harassment at school in the past year because of their sexual orientation, three-fifths (63.5 percent) felt unsafe at school because of their sexual orientation, and nearly a third (29.8 percent) skipped a day of school in the past month because of safety concerns.

Importantly, both boys and girls can be bullies, although the methods used and the types of behaviors exhibited may vary. Studies show girls are more likely to target other girls because of their looks and are more prone to use verbal, emotional, and social forms of bullying. Girl-on-girl bullying, as exemplified in popular films like *Mean Girls,* has also been called relational aggression. Youth with disabilities may also be at risk for experiencing bullying. A 2012 study found that 46.3 percent of teenagers with autism spectrum disorders had been bullied. Further, bullying of students because of their racial or ethnic background is common. Additionally, some maintain that abusive dating relationships, or dating violence, is simply another form of bullying.

It is important to recognize that it is not just students who can be bullies or bullied. Teachers, too, can be both bullies and victims of bullying. It is difficult to know precisely how often this occurs because there are no specific tools devoted to measuring it. Youth who are bullied by teachers are often hesitant to report it because they are embarrassed, fearful that the teacher will give them poor grades or fail them, or do not think anyone will believe them. Finally, most research shows that bullies have often been bullied as well. That is, the lines between bully and victim are more fluid than many think.

According to the 2011 Youth Risk Behavior Surveillance System coordinated by the Centers for Disease Control and Prevention (CDC), 20 percent of students in the ninth through 12th grades reported being bullied. Bullying is also common among the college-aged population, where it may occur between two students, between a student and a teacher, or between two teachers. One study found more than 60 percent of college students reported witnessing a peer being bullied by another student, and more than 45 percent reported witnessing a student being bullied by a teacher. In another study, almost 25 percent of respondents reported having been bullied by another student, and 19 percent reported having been bullied by a teacher.

Cyberbullying

Today, many bullies utilize technologies in what is called cyberbullying. Stopbullying.gov defines cyberbulling as "bullying that takes place using electronic technology. Electronic technology includes devices and equipment such as cell phones, computers, and tablets as well as communication tools including social media sites, text messages, chat, and Web sites." Cyberbullying differs from traditional bullying in that it can happen 24 hours a day, seven days a week. Someone can be cyberbullied even when he or she is at home alone. Some technologies allow perpetrators to remain anonymous, making it difficult for authorities to identify the bully if the behavior is reported. The 2011 Youth Risk Behavior Surveillance System found 16 percent of ninth through 12th grade students had been cyberbullied.

Signs of a Potential Bully

Stopbullying.gov has identified warning signs of a potential bully. Youth who are involved in many verbal or physical fights, hang around with friends who are bullies, are frequently in trouble at school, blame others for their problems, are excessively competitive, and are hyperworried about their reputation are most likely to bully others.

Warning signs of bullying include, but are not limited to, frequent headaches and stomach aches; changes in eating habits and/or rapid weight loss or gain; unexplained injuries; lost or destroyed property, such as clothing and books; difficulty sleeping or nightmares; developmental delays or regressions; sudden loss of friends or avoidance of social situations; decreased self-esteem; and self-destructive behaviors, such as talking about suicide, self-mutilation, sexual promiscuity, and running away. Victims are more likely to skip school and thus may have lower grades. Several studies have found bullying to be predictive of later involvement in abusive dating and/or domestic relationships. Both bullies and victims are more likely than other students to carry weapons to school, increasing the likelihood of criminal activity on school grounds. After the Columbine massacre in 1999, the U.S. Secret Service reviewed 37 school shootings and found bullying had been a factor in two-thirds of them.

Research has shown that only one-third of youth bullying victims tell an adult. There are many reasons why young people do not talk about the bullying, including fear of retaliation; feelings of humiliation, shame, and hopelessness; concern that they will not be believed; and fear of rejection from friends.

Antibullying Legislation and School Policies

Legislation can help address school bullying. Bullypolice.org offers ratings of states based on their bullying legislation. As of April 2014, all states except Montana had some type of legislation prohibiting bullying. In December 2010, the U.S. Department of Education reviewed state bullying laws and identified 11 key components. State laws should: (1) include a purpose statement that outlines the effects of bullying and declares it to be unacceptable; (2) contain a statement of scope, which delineates where the policy is applicable; (3) specify the prohibited activity; (4) enumerate specific stakeholders; (5) direct every local educational agency (LEA) to develop and implement a policy prohibiting bullying; (6) instruct LEAs to include specific components in their antibullying policies, such as a definition of bullying consistent with state law, reporting mechanisms, sanctions for violating the policy, referral processes, and procedures for investigating, responding, and maintaining written records; (7) include a provision for review of local policies, allowing the state to ensure that such policies are consistent with state law; (8) develop a communication plan for notifying students, their families, and staff; (9) include a provision requiring school districts to offer training for school staff responding to bullying; (10) require LEAs to regularly provide data about incidents of bullying to the state and to make this data available to the public; and (11) include a statement that victims have the right to other legal recourse.

In addition to having clear policies and procedures, schools can help prevent bullying by implementing prevention programs. Many prevention programs utilize a bystander prevention approach. This approach recognizes that in any bullying situation, there is likely to be three key players: the bully, the victim, and bystanders, or others who witness the incident. Bystanders can be passive or active. Passive bystanders are those who do not say or do anything to encourage or discourage the bullying. Active bystanders can be either hurtful or helpful. Many times, active bystanders egg on the bullies. Bystander prevention programs aim to empower bystanders to actively disrupt the bullying.

One of the most widely utilized bullying prevention programs is the Olweus Bullying Prevention Program (OBPP). OBPP is designed for elementary through high school youth. It has been evaluated many times and has been found to reduce bullying, improve the classroom climate, and reduce related antisocial behaviors, such as vandalism and truancy. It has received endorsements from the U.S. Department of Education and the American Academy of Pediatrics.

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See Also: Adolescent/Youth Services: Overview; At-Risk Youth Services; Childhood Trauma; Peer Pressure.

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Business Incubator

A business incubator accelerates and systematizes the process of creating successful entrepreneurial companies through a range of comprehensive support, developed and coordinated by incubator management. This support typically includes access to finance, exposure to business and technical support services, shared office services, flexible leases, and expandable space.

Incubation is different than other forms of business support in that it provides an integrated, tailored, hands-on business support environment under one roof (often called a “one-stop-shop”) for entrepreneurs. The high-level business development resources are provided by both an on-site incubation team and an off-site network of contacts. Incubation is a resource-intensive activity; therefore, most incubators are selective. Some, for instance, expect entrepreneurs to have a fully developed business plan, whereas others require a less developed idea and provide assistance with business plan development. Others may target only women entrepreneurs or people of color. The purpose of incubation is not to provide support indefinitely; start-ups typically complete the process and “graduate” within three years.

An incubator’s foremost goal is to produce successful ventures, that is, start-ups that are financially viable and able to operate independently after graduating. By offering their clients services on a one-stop-shop basis and allowing overhead to be reduced by sharing costs, incubators notably improve the survival and growth prospects of their start-ups. Moreover, incubators are viewed as a means of meeting a range of socioeconomic policy needs, which may include: (1) creating employment and wealth for local communities; (2) transferring technology between client start-ups and their host incubators; (3) promoting innovation; (4) enhancing links between universities, research institutions, and the business community; and (5) encouraging women or minority entrepreneurship.

Incubators’ Origin, Growth, and Types

Business incubators formally developed in the United States in the 1960s and later expanded in Europe through a range of related models, such as innovation centers, technopoles, or science parks. At present the United States has the largest number of incubator programs in the world. The growth of U.S. incubation has been rapid, from only 12 business incubators in 1980s to over 1,250 incubators in October 2012. In addition, there are currently thought to be around 900 incubators in Europe. The estimated number worldwide is 7,000, with very few focused on minority-group entrepreneurs.

Incubators vary in the way they deliver support in their different start-up environments, methods of operation, and sponsorship. Traditional business incubators pursue economic development as their primary goal, promoting entrepreneurship, innovation, job creation, and growth. Most of these incubators are run by national or local authorities. They often provide general services, while specialized incubators are established by universities or private-sector organizations.

Since the late 1990s there has been an accelerated growth in for-profit incubators, especially those fostering the formation and growth of information and communication technology (ICT) start-ups. The growth of these so-called new economy incubators is reflected in the strong increase in information technology-related incubator clients. Sponsors of these for-profit incubators are typically consultancies and technology solution providers able to offer a complete array of technological, advisory, and other business support services. These new economy incubators differ significantly from their traditional counterparts in respect to the goals pursued. They focus primarily on high-tech and Internet-related activities, and unlike traditional incubators do not have employment creation or the promotion of minority-group entrepreneurship as their principal objectives.

Based on the principle that innovation will come from diversity, and with the objective of targeting social issues, a few incubators provide support and resources specifically to minority-group entrepreneurs. Women and people of color often face higher barriers of entry to incubators. While some argue that these barriers originate in the education system, the scarce research available indicates other factors that impede creation of women- and minority-focused incubators, such as the perception that entrepreneurship is a male domain and the lack of information, self-confidence, mentors, role models, and finances.

Impact and Effectiveness of Business Incubators

The literature analyzing the impact and effectiveness of incubators is divided into two approaches. A normative approach examines the best practices of incubators, with the aim of making recommendations for improved incubation processes, including the quality of management and the services provided to incubate start-ups, among other goals. With respect to minority groups, best practices would include targeting minority-group university graduates, using the craft-skills tradition to create business opportunities for women, and mentoring by women and people of color, among others. These studies are controversial because they assume a priori that incubators improve the performance of incubated companies. Moreover, they tend to be heavily influenced by (1) their objectives, particularly when they aim to justify public funding for incubator; and (2) their methodology, because they often ignore the influence of external factors on the performance of incubated firms and the restricted empirical base.

By contrast, the positivist research approach analyzes the value added by incubators. In other words, is there conclusive evidence that growth in the small-business sector or amelioration of social issues would not have occurred without incubators? Such measurement has largely been made by reference to the number of start-ups using incubators, including minority-group incubators, without examining whether these new business ventures would have existed, survived, or grown without incubation.

Another issue given extensive attention in the research is how a business incubator´s performance should be judged, particularly regarding its wider socioeconomic impact. Research suggests that apart from financial indicators and the routine assessment of service delivery against quality standards, most incubators (and research papers) do not go beyond the use of indicators such as start-up success-failure rates. Fewer studies contain an assessment of incubated companies' growth rates or the wider socioeconomic impact, apart from calculating the number of employees in incubated start-ups or the number of women entrepreneurs using incubators. Only recently has research focused on the views of incubated entrepreneurs themselves about the value added by being located in an incubator. Furthermore, the postincubation period is much neglected with little evidence in most studies that a client´s performance after graduation has been analyzed.

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See Also: Employment/Career Assistance Services; Microlending Programs; Social Capital, Role of; Social Innovation.

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Caribbean Immigrants

Caribbean peoples' migration to the United States has been ongoing since the 1800s. Presently, over 3.5 million Caribbean immigrants live in the United States. They are a major immigrant group in Florida, New Jersey, and New York. These states contain over 70 percent of the Caribbean immigrant population in the United States. The human services needs of Caribbean immigrants include legal support to adjust their immigration status as necessary and to avoid exploitation, abuse, and criminal victimization in employment, and efforts to access human services. They also encompass social and psychological support to adjust to a new country and, eventually, political empowerment to advocate for the heterogeneous ethnicities that comprise Caribbean immigrants. Immigrants also need access to medical care, education, and transportation to promptly and constructively assimilate into society.

The Caribbean includes a number of countries, each with its own cultures and subcultures. Languages include English, Spanish, French, Dutch, and dialects; therefore, English language instruction in the United States is a human services need for many Caribbean immigrants. The main source countries of immigrants are Cuba, Dominican Republic, Jamaica, Haiti, and Trinidad and Tobago, respectively. Many relocate to raise their economic status through employment and or education, and others move for family reunification.

Moving to a new country often means a change in social standing, friends, and other familiarities. Services that facilitate the adjustment of immigrants into legitimate networks of opportunity are to the benefit of the newly constituted community. When such opportunities are not apparent, as is more likely the case for immigrants who do not speak the language of their new country or who might lack desired skills or education necessary for a legitimate existence in a marginalized state, illicit niches of opportunity can become more appealing to some. In 2009, researchers Mamdi Corra and Sitawa Kimuna found that English-speaking Caribbean immigrants generally do better economically than their non-English-speaking counterparts.

Often families immigrate in part; thus, family reconciliation in the new country is a priority. Census numbers indicate that approximately 54 percent of Caribbean immigrants to the United States have been women. For a parent in the United States, assistance with child care in the absence of the other parent and extended family is often a great need. Indeed, it is not uncommon for Caribbean immigrants to send unruly children back to the Caribbean for more traditional socialization. Small matters necessary to exist, such as having a Social Security card to secure employment and being able to open a bank account, are challenging if the immigrant is undocumented. For persons from the Caribbean who are more likely to enter the United States by air than by land or sea (such as immigrants from Central America), their U.S. presence is more likely to be the result of an overstay on a temporary visa.

There can be a mental health toll to navigating two cultures—the old and the new—and, for many, coming to terms with becoming a "minority" in the United States. In 2007 David Williams and colleagues analyzed data from the National Study of American Life, which included 1,621 Caribbean blacks. They found that first-generation Caribbean blacks had fewer mental health problems than their second- and third-generation counterparts. This was attributed in part to accepting the impact of stresses associated with being black in the United States. The suggestion is that with time and generations, the impact of the foreign culture fades.

Deportation may intensify the need for human services. It is problematic in two major ways: (1) when it involves persons who no longer have familial ties in their country of origin, so the act is like banishment to a strange land, devoid of support; and (2) when a deportation action separates a family in the United States, thus punishing not only the person who is deported but also his/her kin. Deportation became more of a concern for some Caribbean immigrants with the passage of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996. The law facilitates deportation for crimes of moral turpitude (for example, spousal abuse, animal fighting, theft, and fraud) and restricts social services benefits. In so doing, the law increased the need for legal services for many Caribbean immigrants, forcing several with permanent-resident status to reluctantly pursue U.S. citizenship in order to protect themselves against deportation.

Caribbean immigrants to the United States are not usually the poorest or least educated, as legal access to the United States normally requires some demonstration of means of support. Some Caribbean immigrants are eligible for Temporary Protected Status (TPS). After the 2010 earthquake in Haiti, over 40,000 Haitians in the United States were eligible for human services given their application for TPS. TPS allows persons to stay in the United States if temporary conditions in their home nation (due to natural disasters, war, etc.) prohibit their safe return. These circumstances present special human services needs in adjusting, locating housing, obtaining basic supplies, and assistance in building lives after what are often devastating circumstances.

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See Also: Children, Youth, and Human Trafficking; DiversityRx; Dominican Americans; Ethnicity and Clients; ICE Detention Centers, Services in; Migrant Workers; National Center for Cultural Competence.

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Case Management

The provision of case management in mental health care has long been regarded as the preferred mode of service delivery. However, in recent years it has also expanded into other arenas, thereby demonstrating its clinical value and transferability. At its foundation, case management refers to the coordination of community services by a single professional who is responsible for assessing a client's needs, developing and implementing appropriate care plans based on this assessment, and then evaluating the care plan through ongoing follow-up. In some cases, case managers will also be responsible for transitioning clients to other services when they move or no longer meet program or diagnostic criteria. This approach originated in the United States and evolved following the deinstitutionalization of psychiatric patients in the 1950s and 1960s. In this mental health care context, case management is usually implemented for individuals with serious and persistent mental illnesses who require ongoing support with illness management, employment, socialization, and maintaining community tenure.

In the United States, the term *case management* is also applied in the primary care realm as a component of managed care, and it has also been adapted for use in the care of the elderly, in acute health care settings, correctional services, child welfare, social housing, and employment support programs. In all cases, the goal is to develop a comprehensive psychosocial assessment in collaboration with service recipients, who will then access community resources on an ongoing basis to meet their needs. The case manager, also known as a service coordinator, will complete referrals to these programs.

Because community resources can almost universally operate at a lower cost than institutionalized care, case management is a cost-effective paradigm since a single professional, ideally knowledgeable about community resources, serves as the primary contact for the client. This reduces the prospect of duplicating service, which would occur if each program served as its own entry point for the client. This unique structure is particularly valuable for clients with complex needs as their service coordinators can develop an intricate knowledge of their strengths, deficits, and required needs for successful community-based illness management. Additionally, this coordinated care has become more important in recent years as clients' needs have become more complex. Among other factors, this increasing complexity occurs because of an aging population, poverty and legislative restrictions, insufficient community resources, often overlapping mental health and health care needs and, ironically, the involvement of multiple agencies itself.

Case management is both a professional and organizational endeavor. While any number of regulated professionals can serve as case managers, including, for example, nurses, social workers, and occupational therapists, effective service delivery also requires a commitment by their employing organizations to provide resources that promote case management activity. This includes investing in programs and staff and monitoring quality through ongoing program evaluation. In British Columbia, Canada, an integrated case management framework has even been adopted by government ministries to promote seamless, integrated service delivery and information-sharing since clients typically receive multiple government benefits at once. According to the National Case Management Network of Canada, there are five guiding principles of case management: (1) it supports client rights, (2) it is purposeful, (3) it is collaborative, (4) it supports accountability, and (5) it strives for cultural competency.

Regardless of the sector in which case management services are provided, core components include assessment, care planning, service implementation, and evaluation. Case management is a collaborative approach that should solicit client input as much as possible. Community service providers are encouraged to be flexible and accommodating and recognize that clients are often involved with multiple providers and addressing complex needs. As a component of best practice, agencies are encouraged to invest in case management programs and the employees who are performing case management activities.

From a diversity perspective, culturally sensitive case managers participate in an ongoing process of increasing self-awareness to ensure that service recipients are treated with genuine concern, respect, and appreciation for their unique identities. Although diversity is often thought of in terms of racial differences, it is equally important to recognize social and economic differences, the influence of gender and class, and sexual orientation. Case managers are encouraged to learn principles of cross-cultural communication, strengths-based assessment, and divergent perspectives about illness, disability, or dysfunction. Practitioners are required to work collaboratively to ensure that these perceptions, which often vary by culture and may clash with the clinician's own understanding, are not a barrier or impediment to proper treatment.

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See Also: Case Management Services; Mental Health Services, Adult; Partial Care Services for Adults, Mental Health.

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Case Management Services

"Case management services" refers to the range of assistance provided to a person, making sure that he/she has access to quality services and support systems in the areas of social, health care, education, and economic skills for gainful employment. The Case Management Society of America in its 2009 definition states, "Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes." The focus of case management is to ensure "personalized" attention and support to an individual, leading to achievement of the intended purpose.

A wide range of contexts and issues may require such services, ranging from general to specialized care. Case management in the context of human services could be, for example (1) ensuring an autistic child is provided with the necessary educational, medical, and social support; (2) providing a patient admitted to a hospital with an ailment with the specific treatments needed for recovery; or (3) training an unemployed youth in the skills desired and necessary to ensure he/she has a better chance in the job market. Case management services is the process of service to the individual rather than a particular component of a specific service. This article explores the various characteristics of effective case management services and describes the generic process involved in case management and the group of people who are central to case management—the caseworkers.

Core Criteria for Successful Case Management

Goal oriented. A case management service must be focused on the overall goal it aims to achieve for the person, in due course of time and/or after the due processes and intended activities to support are completed. While it is possible that the intended goal may change in the process and duration of the case (depending on the individual's responses, which may vary from person to person), it is still worthwhile to set a clear and realistic goal at the beginning, which will determine the nature and extent of services the person will receive.

Beneficiary as the central focus. The interest and benefit of the individual beneficiary (and his/her family, if relevant) need to be the core purpose around which the entire case management process and procedures should be designed. There is also a critical need for understanding the diverse needs and preferences of different population groups within the community based on their background and origin (e.g., gender, age group, race, culture, religion, sexual preferences, occupation categories, socioeconomic standards, geographic origins, urban or rural, etc.). Unless understood at the outset, these could become potential barriers in effective delivery of services. The case management service must be able to adapt to these different needs of the diverse populations it intends to serve.

Accountable. The case management system and the individuals operating it must remain accountable to the beneficiary. This is essential in order to achieve quality. Accountability could be enforced and measured both internally within the agency providing case management service through setting clear performance objectives and benchmarks for individuals and groups and review of the same at periodical intervals. Beneficiary satisfaction surveys or discussions are another effective way to elicit information from the clients about the services they received and feedback. Done on a periodic basis, these surveys and/or discussions serve as a transparency and accountability measure for the case service provider. Care has also to be taken to seek feedback from diverse population groups so that the case provider can know whether their services are meeting the specific needs of these groups.

Comprehensive: Each case management system needs to be as comprehensive as possible, ensuring that the individual benefits from the synergy of different services. This also avoids the situation where services from different units within the system work at a cross-purpose with each other. At the same time, the system needs to be well understood and simplified, for both the recipient and the provider, to ensure that it can be implemented as intended.

Integrated. Case management needs to be integrated within the overall operating system of the service provider and not be a stand-alone system.

Coordinated. Case management also makes sure that multiple services and providers are coordinated within themselves, usually by a caseworker (who also identifies the need for these services and providers in the first place).

Standardized and evidence based. As much as possible, case management services need to be standardized based on evidence that has been created over time. This helps avoid unnecessary delays and gives the individual the opportunity to be taken through a system that has worked for most other individuals. Improvisations as necessary can be introduced depending on the need of the specific individual.

Flexible to the need of the client. Taken from the point above regarding need for standardization of the processes and practices, care has to be taken to make sure that the specific needs of the individual are considered and changes effected based on these. Such changes, if carefully documented and monitored over a period of time, can lead to making this part of the standardized practice for individuals who closely resemble each other on a range of attributes (e.g., age, sex, marital status, occupation, race, income group, education qualification, past disease history, lifestyle, etc). This helps develop understanding of diverse groups, avoid a tendency to develop services with a "one size fits all" mind-set, and establish service protocols and standards that the beneficiaries will value and participate in effectively. Challenging and avoiding responses based on stereotypes (for different groups) is vital.

Cost-effective. One of the key attributes for an effective case management system is cost-effectiveness, both for the individual seeking support (by providing comprehensive support services) and for the institution providing the service (by ensuring that the case managers follow set guidelines and procedures that are optimized, avoiding waste).

Sustained. Services need to be sustained over a period of time until the overall goal set at the beginning (and reviewed midcourse if need be) is achieved. Also, a successful case management system needs to have the capability to be repeated again and again by the institution providing service and by the caseworkers.

Other crucial elements of quality case management services include (1) privacy and confidentiality of the individual's personal information, limiting access only to those on a strict "need to know" basis; (2) use of best professional skills in identifying the needs of the individual and using a multidisciplinary approach involving various experts; (3) building a culture of learning wherein the various steps and processes used for an individual are reviewed and lessons analyzed to inform improvements for the future; (4) termination of case management as necessary to avoid dependency; and (5) being in line with the legal and regulatory frameworks so as not to jeopardize the interests of the client or the organization providing support.

Central to an effective case management system are the caseworkers. The caseworkers have the central role to manage the "case files" of individuals and play the coordination role in a case management system. Some of the essential skills caseworkers need are the ability to conduct quality interviews to elicit information in a diligent way, effective communication, analytical thinking, the ability to build collaboration with different teams, and clear understanding of the standardized processes and systems.

The caseworkers also need to be aware of the diversities (and stereotypes associated with specific groups) that exist within the community and develop skills to communicate and interact with these populations at ease, irrespective of their own personal beliefs and value systems. Cross-cultural competence of the social workers is a key requirement and is included in most of the academic training programs, and that is furthered with experience working with the community. Some of the behavior competencies for the caseworkers include empathy, nonjudgmental attitude, friendly and nonthreatening manner, and ability to instill confidence in the person who is seeking assistance.

The caseworkers need to undergo periodic training in order to remain up to date on the various aspects of the support and service system and processes involved in the case management process. Given the sensitive nature of some of the services provided, some of the caseworkers may need additional counseling support to remain professional and in order to take care of their own well-being (e.g., caseworkers working with survivors of gender-based violence such as rape and domestic abuse are subjected to harrowing accounts from the survivors and these may be difficult for them to cope with in the long run).

Setting up a case management system varies among organizations, depending on the focus. The following are some of the generic steps and good practices involved:

1. Understanding the background of the potential “client base” and their particular support needs is crucial in setting up a case management system. This can be based on a review of research on the issue, information collected at the community level through social workers, as well as by building up a strong information and knowledge base of the individuals who are supported. Careful client review needs to also establish the inherent diversity that may be present within the community.
2. Preparing a comprehensive policy and standard operating procedures (SOP) manual is important to ensure that individuals receive standardized services and to enable the caseworkers and others to all read from the same script. Changes to the manual and procedures need to be constantly and adequately communicated to the staff through orientation, training, and refresher courses.
3. Involving caseworkers and other staff in review and feedback is essential to ensure that ineffective practices are removed as the case management system goes through improvements. This also ensures that staff members remain involved with the process, feel motivated, and willingly implement all the agreed-upon standard procedures.

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See Also: Case Management; Partial Care Services for Adults, Mental Health; Targeted Case Management.

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Center for Native American Youth

The Center for Native American Youth (CNAY), a nonprofit policy program at the Aspen Institute, was founded by former U.S. senator Byron Dorgan in 2011 and is headquartered in Washington, D.C. The mission of CNAY is to promote the well-being of Native American youth through both policy development and communication in order to ensure that Native American communities have access to education, housing, health care, and law enforcement services. Additionally, CNAY identifies tribes in need of funding and helps secure resources from the federal government and private sector, as many services to these communities are frequently underfunded. Most important, CNAY seeks to address the unique challenges faced by Native American youth, such as high rates of suicide, violence, gang activity, and alcohol and drug abuse.

Social and Historical Context

The U.S. government currently recognizes 566 tribes. These tribes are acknowledged as sovereign nations and act as self-governed communities. Historically, the federal government established treaties promising equal protection of Native American citizens' rights in exchange for the land that many tribal communities were forced to relinquish. Despite these agreements, the living conditions of many Native Americans are below the national standard.

Furthermore, a large economic disparity exists between American Indians/Alaskan Natives (AI/AN) and the general population. Although programs currently exist to assist AI/AN, many are unable to provide adequate aid. The Indian Health Service, for example, was established as a federally funded health care program for AI/AN communities. The monetary appropriations set aside for this program, however, only meet about 52 percent of health care needs. This is problematic as tribal communities have the highest rates of Type II diabetes, higher-than-average rates of obesity among infants, and five times the cases of tuberculosis than that of the general population.

Historical trauma resulting from loss of native lands along with underfunded programs has resulted in many unaddressed issues among Native American communities, inspiring Dorgan to donate $1 million in unused campaign money to found CNAY. CNAY's current goals for policy development and implementation are to address these issues as well as those that affect Native American youth, the most at-risk population in this community.

Challenges Faced by Native American Youth

The center identifies AI/AN between the ages of 15 to 24 as the most at-risk population. Native American youth—those under the age of 18— compose about 28.3 percent of the Native American population. According to the 2010 Census, approximately 32.4 percent of this subpopulation lives in poverty. Various forms of violence, including suicide, homicide, and intentional injuries, account for 75 percent of deaths among Native American

On Wednesday, April 2, 2011, Secretary Tom Vilsack met with 30 Native American youth students from eastern and western tribes, southeast Alaska, and Tuba City, Arizona, at the Roots of American Agriculture garden. The purpose of the day, as is this mission of the Center for Native American Youth, was to encourage young people to pursue healthy lifestyles.

youth ages 12 to 21. Additionally, Native American communities have high rates of alcohol and drug problems. Specifically, alcohol mortality rates among the Native American community are 514 percent higher than that of the general population, and approximately 22.9 percent of AI/AN over the age of 12 report the use of alcohol. Sixteen percent of Native American youth report substance dependence or abuse as well as the highest rates of methamphetamine use in the country.

In addition to high rates of violence and substance use, Native American youth face many barriers with regard to education. Approximately 50 percent of Native American students graduate from high school compared to 76.2 percent of white Americans. The center works directly with schools and students to gather information regarding the conditions of schools in Native American communities. CNAY works to ensure that schools are up to national standards, encourages academic success, and provides opportunities for youth such as internships, scholarships, and dialogues in which they can openly voice their concerns.

One of the primary objectives of CNAY is to reduce the high rate of suicide, as it is the second-leading cause of death among Native American youth. Native American teens have the highest rate of suicide compared with any other group in the United States. CNAY provides mental health resources and referrals to Native American youth who may be experiencing suicidal ideation or have lost friends or family members to suicide. CNAY also focuses extensive energy and resources on suicide prevention efforts.

Strategies Employed by CNAY

The Center for Native American Youth serves as a source of information and education about conditions in tribal communities. It compiles research and statistics on issues specific to Native American individuals and highlights legislation and federal agencies that exist to serve this community. These efforts are designed to impart knowledge regarding the rights of individuals in Native American communities and to call attention to the disparities that these individuals encounter on a daily basis.

The Center for Native American Youth has created many programs to foster positive changes. For example, the center's Champions for Change program identifies five Native American youth who serve on the advisory board to promote cancer awareness, language preservation, academic success, and leadership, among other concentrations. Individuals at CNAY regularly visit schools to converse with youth and to understand the issues they find most important. The center uses this information to directly inform the legislature of the problems faced by this population. Additionally, the center frequently holds roundtable discussions and summits that unite youth and many federal agencies to provide opportunities for listening and collaboration.

Part of the center's mission includes highlighting the successes of Native American youth. CNAY features personal stories submitted by Native American youth who have overcome hardships or reached personal goals, operating with the belief that youth have the ability to enact inspiration and change through storytelling. Ultimately, CNAY works to form strong, trusting relationships with tribal leaders and youth in an effort to collaborate and produce positive outcomes within the Native American community.

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See Also: Alaskan Natives; Child Support Agencies and Services; Child Welfare Services; Indian Child Welfare Act; Indian Civil Rights Act of 1968; Indian Health Service; Native Americans; Native Americans, Suicide Among.

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Central American Immigrants

Because of the unique immigration patterns of Central Americans, it is important to consider the human service needs of this group separately from other Latino groups. Within the United States, there are nearly 3 million foreign-born Central Americans and nearly 5 million people who identify as Central American diaspora. Over two-thirds of those identifying as Central American are from El Salvador and Guatemala. The circumstances surrounding how and why Central American immigrants come to the United States, as well as the type of reception they receive, can impact their adaptation and long-term outcomes including mental health, education, and employment. Therefore, human service professionals should familiarize themselves with the context of immigration of Central Americans including the legacy of war as well as the particular challenges they face once in the United States.

Central Americans

Central America is considered to include the countries of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. Although Belize and Panama are part of this region geographically, they have distinct histories. Belize is an English-speaking republic that gained its independence from Great Britain in 1981. Panama has a South American indigenous culture and was part of Colombia until 1903. It is also important to note that Guatemala has a significant Maya population that was not eliminated to the same extent as in other countries during Spanish colonization. Guatemala continues to have a significant Maya population who remain culturally and linguistically distinct.

The Context of Migration

Central American migration flows have been significantly influenced by the danger and instability caused by war, U.S. foreign policy, and a continued legacy of poverty. Central Americans have become a major source of migration flows, particularly after a decade of armed conflicts in El Salvador, Nicaragua, Guatemala, and Honduras between the 1970s and 1990s. Because many Central Americans were forced to leave their country due to war, many argue for their refugee eligibility. However, unlike other immigrant groups entering the United States from war-stricken countries, few Central Americans are granted refugee status.

The recognition of Central Americans as refugees was complicated by the U.S. policy decisions regarding these armed conflicts. The United States was concerned about the spread of communism, which led to restrictive immigration policies toward Central Americans as well policy decisions that supported the increased use of military force and violence in Central America. For example, during the Reagan administration, there was enthusiastic support for the Contra rebels in Nicaragua who opposed the socialist Sandinista government. In Guatemala, Ronald Reagan was sympathetic to then dictator Efraín Ríos Montt, who was later tried in the Guatemalan courts for genocide. Also, the lack of recognition of economic repression as a tool of warfare in these countries makes qualifying for refugee status difficult because Central Americans are considered economic migrants instead of refugees. Due to the difficulties in being recognized as refugees, combined with continued political unrest and economic hardship in Central America, there continue to be high rates of undocumented immigration; nearly half of Central Americans lack legal immigration status.

Adaptation and Acculturation

Migrating to another culture disrupts individuals' familial and social networks, cultural behavioral norms, expectations, and values. The process of acculturation can be stressful and is affected by the circumstances involved in emigration, including exposure to trauma and experiences of political and economic oppression. Despite the end of the armed conflicts, Central American countries continue to feel the impact of the legacy of war. For example, survivors of genocide in Guatemala describe the legacy of poverty, family conflict, loss of land, and the continued impact of trauma on their daily lives. Once in the United States, Central American immigrants exposed to war-related trauma exhibit high levels of mistrust, identity confusion, and isolation; these factors, in turn, are related to immigrants' well-being. Central Americans demonstrate significantly higher levels of acculturative stress compared to that of other Latino groups. Thus, human service professionals should recognize the importance of avoiding the generalization of experiences of Latin American immigrants, and instead treat Central Americans as a group with unique characteristics, premigration experiences, and stressors.

In addition to the impact of war, Central Americans experience challenges due to their immigration status. Central Americans are sometimes referred to as "unrecognized exiles" because they share characteristics with refugees, such as feeling pushed from their country of origin and the experience of traumatic events prior to migration. However, because they are not legally recognized as refugees they do not have access to the social services and financial assistance that is given to refugees to assist in the resettlement process. Occasionally, Central Americans have been granted temporary relief from deportation with multiple deadlines and confusing application procedures. This "straddling" of Central Americans between the status of documented and undocumented creates a long-term uncertainty, impacting them in different social and personal spheres such as the family or work. Human services professionals should be aware of the various immigrant statuses within the same family and the impact this legal status can have on access to services as well as the adaptation process.

Human Service Provision

In order to ease the acculturative stress experienced by many Central American immigrants and support their adaptation process, services provided should be culturally appropriate and accessible. Services should recognize the importance of family in the Central American culture, the effect of war on immigrants' social network and psychological well-being, their status as unrecognized political refugees, and the migration experience. Political and economic repression has left deep wounds, which can be transmitted multigenerationally. Families are often reluctant to discuss what they witnessed or experienced and there may be family conflicts, loyalties, or alliances related to these "untold" stories. Often some family members migrate first, leaving behind those who must assume new roles and responsibilities. When the family is reunited, family members must reorganize and develop new structures and roles once again. Human service providers should acknowledge the impact of trauma on the family and explore the impact on family relationships, as well as support families in the process of renegotiating roles.

Even when services are culturally and linguistically appropriate, Central Americans may still have difficulty accessing services. The fear developed during their civil war experiences creates isolation from social networks, impacting access to social services. In addition, the combination of high illiteracy rates and language barriers make it difficult for Central Americans to access services. Efforts must focus on reaching the Central American community by creating awareness of the availability of services, providing linguistically appropriate services, and making services accessible despite a lack of health insurance or immigration status.

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See Also: Assimilation; Children of Undocumented Aliens; Cultural Competence, Human Service Providers and; Hispanic Americans; Hispanic Immigrants; Immigration Law, History of U.S.; Torture, Survivors of; Undocumented Immigrants

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Changing the Client Versus Changing the Environment

Conventional approaches to working with clients in mental health and other therapeutic settings primarily involve the use of psychotherapy and/or medication to bring about changes in the clients that presumably allow the clients to better adapt to their life circumstances. However, in recent years there has been a shift in this perspective among several groups of practitioners who instead favor an approach that views the source of emotional suffering as residing in the environment rather than in the client. This focus assumes that it is not necessarily most beneficial to alter the client. In this alternative approach, the guiding principle is the need for social change rather than individual change.

This shift has been influenced by a number of developing trends in the disciplines of psychiatry, psychology, social work, and allied helping professions. There is growing recognition that current dominant approaches to mental health care have not resulted in a decrease in rates of mental illness. Moreover, evidence of the dangers, adverse reactions, and side effects of psychiatric medication is becoming more readily acknowledged both within and outside the medical community. As such, clients and clinicians alike are seeking alternatives to current mainstream models of care.

Alternatives to Psychotherapy and Medication

The active search for alternatives to conventional mental health care has led to the development of innovative approaches that have been used across a spectrum of conditions and problems. A key group in this work is the International Network Toward Alternatives and Recovery (INTAR). This group consists of clinicians, patients, and researchers who explore progressive models of care that are situated largely in communities rather than in traditional clinics or hospitals. The communities vary widely and include peer-support group housing and teams that respond to first-episode psychosis by entering the client's home and working closely and intensely with the client and his or her family and community members to avoid hospitalization. These approaches follow the assumption that medication and psychotherapy serve to mask the underlying problems that stem from the person's environment. Emerging evidence indicates that these supportive alternatives can be highly successful in leading clients back into a daily life of well-being and positive functioning.

In her book *The Myth of the Chemical Cure*, psychiatrist Joanna Moncrieff outlines the risks of the mainstream psychiatric approach and argues that the current overreliance on psychiatric medication serves the interests of the psychiatric and pharmaceutical industries rather than the needs of clients. Similarly, psychologist Paula Caplan has been highly influential in raising awareness of the risks associated with psychiatric labeling and diagnosis. Caplan argues that psychiatric labels can be used to justify to clients and families the use of harmful medications and to provide courts with a rationale in custody and other cases to deny rights to those diagnosed as mentally ill. These critiques of mainstream psychiatry demonstrate clearly the risks of focusing solely on the client as the locus of change.

Empowerment Therapy

To many clients and practitioners, the outright rejection of psychotherapy is both unrealistic and unnecessary. Therefore, psychotherapists have worked to develop models that are responsive to the critiques of those who maintain that alternatives are crucially needed. One of the more widely recognized models is the feminist empowerment therapy developed by Judith Worell and Pamela Remer. This model is highly useful not only for female clients but also for members of marginalized groups generally, including low-income clients and clients of color. The empowerment therapy approach assumes that stressful environments bring about psychological and emotional suffering that is often mistakenly framed solely as symptoms of mental illness. Worell and Remer argue that these "symptoms" should instead be viewed as manifestations of social ills that clients should be empowered to combat in their daily lives. Empowerment therapy thus contains tenets that focus on the development of individual empowerment as a means to create transformative, permanent changes in one's environment. These tenets include the belief that the interface between the personal and the political in the clients' lives must always be considered in therapy sessions such that prevailing social and political forces are critically examined as possible obstacles to psychological well-being. Another key tenet is the belief that the therapist must model an egalitarian relationship with the client; this modeling serves to encourage the client to adopt an empowered stance in taking on the task of social change.

Critiques of Changing the Environment Instead of the Client

While there has been growing support for the range of alternative approaches developed in recent years, most practitioners adopt the belief that working with a client must involve making individual changes in the way the client thinks, acts, and reacts. The approach of changing the environment rather than the client is to them a foreign notion. Most clinicians are trained in a model that is highly individually focused and, indeed, the scope of their training rarely includes a consideration of the social ills that give rise to what is diagnosed as mental illness—including poverty, violence, and various forms of discrimination.

Moreover, clinicians see before them an individual who is distraught and who may be in crisis; their training equips them to deal with the emotions entailed by the crisis more than attending to the outside factors that are at play. Therefore, approaches to changing the environment remain on the periphery of models of care. In the end, clients and clinicians must choose for themselves the approach that is best suited to their goals and to their ideological assumptions about the causes and cures of human suffering.

Future Directions

The various existing alternative approaches are a long way from being widely accepted. There are a number of ongoing challenges that necessitate new ideas about what it means to "treat" mental illness. One key issue is the need for systematic research on how helpful these alternatives are for clients. Most mental health scholars are trained in the same approaches and philosophies as mainstream clinicians and therefore use as their variables of interest only individual, noncontextualized factors. This approach to research represents only one part of the host of influences that impact mental health problems: the focus is on the pathology of the client, not on the dangers in her or his environment. This model is particularly dangerous when examining the psychological impact of trauma. Trauma survivors, such as combat veterans and victims of sexual assault, are too often viewed as psychologically weak rather than as exhibiting responses aimed at adapting to life-threatening environments.

Another key issue is the need for scholars and clinicians to partner with activists and advocates in working to change the social conditions that give rise to psychological suffering. University-based and hospital-based teams can identify local groups that work to change such conditions as unsafe housing, inadequate protections for domestic violence survivors, and discriminatory practices used against veterans and racial and sexual minorities. Lastly, the training of practitioners needs to be expanded to develop not only clinical competency but also social and structural competencies that support them in their ability to work with clients to identify sources of emotional danger in their environments.

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See Also: Counseling and Psychotherapy Services; Mental Health Services, Adult; Mental Health Services, Children; Psychiatric/Psychological Assessment.

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Chemical Restraints

A chemical restraint is a type of medical restraint in which a drug is used to limit the movement or freedom of a person, often by sedating them. Chemical restraints are sometimes used in medical settings such as emergency rooms, inpatient medical departments, and psychiatric settings when patients are disrupting their medical care, trying to harm themselves, or attempting to hurt others. The use of chemical restraints in nonmedical settings like foster care, group homes, and juvenile detention centers has been documented as well. Drugs such as benzodiazepines (e.g., Xanax, Valium, Klonopin, Halcion), antipsychotics (e.g., Haldol, Thorazine, Compazine, Zyprexa), and dissociative anesthetics (e.g., Dextromethorphan, Ketamine) can be used as chemical restraints. Currently, there are no drugs approved by the U.S. Food and Drug Administration (FDA) for use as a chemical restraint, though off-label use of medications is not limited.

While the use of chemical restraints to keep people from harming themselves and others can be part of their medical treatment, chemical restraint use has been criticized. Criticisms include mismanagement of the chemical restraint by health care workers for the convenience of staff rather than the benefit of the patient. This mismanagement can lead to loss of activities of daily living (ADL) function, loss of cognition, aggression, and hallucinations. A patient's quality of life may be affected, with reduced social contact, decreased participation in activities, loss of independence and control, increased problems with eating and sleeping patterns, and loss of dignity.

Ethical issues must be considered around the use of chemical restraints. The right of the patient to be free of chemical restraint must be placed above discipline or the convenience of staff. Health care workers must, in conjunction with their supervisors, be able to safely and adequately care for patients assigned to them. This is often where the team approach to health care is beneficial. Patients also have the right to autonomy. By using chemical restraints, often without patients' consent, patients are denied the ability to make their own health care choices. Larger concerns around the use of chemical restraints include the use of drugs for FDA-indicated conditions and the appropriate prescription of medications for off-label uses. Other considerations for off-label use include questions about appropriate dose and duration and assuring the patient is monitored for any adverse effects of the medication. There are unresolved issues around chemical restraints including questions if chemical restraints are ever appropriate and what are the standards for their use. Currently, there are no federally mandated standards to cover their use.

The Omnibus Budget Reconciliation Act (OBRA) of 1987 created a national minimum set of standards of care and rights for people living in certified nursing facilities. This landmark legislation mandated that residents be free from physical or chemical restraints imposed for the purposes of discipline or convenience. OBRA states that restraints may only be used to ensure the physical safety of the resident or other residents and only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used. This does not preclude the use of assistive devices when deemed medically necessary and/or appropriate. Also, OBRA required the regulation of certain drugs in nursing homes and limited the use of as-needed (PRN) medication orders. Additionally, the Omnibus Budget Reconciliation Act of 1990 mandated the regulation of certain drugs used in nursing homes and the establishment of a drug utilization program in these facilities. This mandate refocused the role of the pharmacist in becoming an active participant in reducing potential drug therapy problems in nursing homes.

The use of chemical restraints on persons with disabilities is an important point of consideration. While there is little evidence of chemical restraints used to intentionally harm, there are concerns that persons with disabilities have been chemically restrained as an alternative to addressing communication barriers or frustrations. The use of chemical restraints is often attributed to staff not having time or not being trained to communicate effectively with patients who experience communication barriers. This is often attributed to staffing shortages. Medicating a person perceived as "difficult" or "challenging" is seen as a convenient mechanism or cultural norm for understaffed and overworked facilities.

Children are another group with special issues around chemical restraints. There has been an increase in the prescription of antipsychotic medication to children, often for developmental disorders, attention deficient hyperactivity disorder, or disruptive behavior disorder. Children do have mental health disorders that need treatment; however, attention continues to be focused on the rapid increase in children taking antipsychotic medications, as well as the children who receive medication but do not receive standard mental health assessments or visit a mental health professional while taking the medication. Like other patients that receive medication, children must be offered alternative ways to limit disruptive behavior, not be medicated for control or punishment, and monitored while on medications. Chemical restraints of children continue to be a problem in the foster system and juvenile justice system, often because of understaffed facilities, cutbacks to mental health services, and inadequate staff training.

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See Also: Ableism; Abuse and Neglect; ADHD, Services for Individuals With; Adoption, Special Needs; Adult Day Care; Aging and Adult Services; Americans with Disabilities Act; At-Risk Youth Services; Behavior Support and Management; Child Welfare Services; Children in Foster Care; Day Care for Children; Disability Services; Early Childhood Development; Emergency Medical Care; Family Therapy; Foster Care Agencies; Hospitals; Medical Necessity; Medicare; Mental Health Services, Adult; Mental Health Services, Children; National Institute of Mental Health; National Institute on Aging.

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Child Abuse Prevention and Treatment Act

Child abuse and neglect is a significant social concern. Children who experience abuse and/or neglect are more likely to have developmental delays and impaired language or cognitive skills; be identified as "problem" children (with attention difficulties or challenging behaviors); be arrested for delinquency, adult criminality, and violent criminal behavior; experience depression, anxiety, or other mental health problems as adults; engage in more health-risk behaviors as adults; and have poorer health outcomes as adults.

As different cultures come into contact with each other, conflicting cultural child-rearing practices create a situation ripe with the potential for disputes concerning what constitutes child abuse or neglect. The apparent threat is the mishandling of a child maltreatment case due to bias toward particular cultural views, standards, and norms. In order to respond to child abuse and neglect effectively, increased attention must be given to the role of families' race and culture, and appropriate threshold trainings must be routinely incorporated to establish a professional standard of cultural competence.

The key federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted on January 31, 1974 (P.L. 93-247). This act was amended several times and was most recently amended and reauthorized on December 20, 2010, by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). Congress enacted the Child Abuse Prevention and Treatment Act (CAPTA, P.L. 93-247) to create a single federal focus for preventing and responding to child abuse and neglect. As a condition of receiving state grant funds under that act, states are required to have procedures in place for receiving and responding to allegations of abuse or neglect and for ensuring children's safety.

CAPTA provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations, including Indian tribes and tribal organizations, for demonstration programs and projects. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and mandates Child Welfare Information Gateway. CAPTA also sets forth a minimum definition of child abuse and neglect.

The Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, is the federal agency charged with supporting states, tribes, and communities in providing programs and services to protect children and strengthen families. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and mandates the National Clearinghouse on Child Abuse and Neglect Information.

The primary goals of federal child welfare programs are to ensure the safety of children; to enable them to be part of strong, permanent families; and, in doing this, to foster the well-being of children and their families. CAPTA is the only federal child welfare program focused solely on preventing child abuse or neglect as well as responding to allegations of abuse or neglect. Funding for CAPTA state grants is provided to help states improve their child protective services systems and may be used for a range of purposes specified in the law. To be eligible to receive these state grant funds, a state must submit a plan including certain assurances related to how it will operate its child protective services system; establish and support citizen review panels; and, to the "maximum extent practicable," annually supply to the U.S. Department of Health and Human Services certain child abuse and neglect data. The statute provides that any funds appropriated for these purposes must be distributed to all eligible states by formula.

Each year, the Exchange Club of Flagstaff, Arizona, displays an annual Field of Hope, Healing Field, which posts blue ribbon flags as a memorial to Arizona's children who have lost their lives because of child abuse and neglect.

State Grants to Improve Child Protective Services

Funds are provided to state child welfare agencies and may be used to improve their system of child protective services. To receive these funds, a state must provide assurances that it has procedures or policies (1) to receive and respond to allegations of child abuse or neglect, ensure children's safety, and provide appropriate referrals; (2) for the appointment of an appropriately trained guardian ad litem (attorney or volunteer) for each child victim involved in a court proceeding; (3) to maintain confidentiality of child abuse and neglect records; and (4) for improving training to workers. States are also required to establish and support citizen review panels to evaluate the effectiveness of child protective services policies and practices and must, "to the maximum extent practicable," submit certain child abuse and neglect data to the U.S. Department of Health and Human Services each year.

Research, Demonstration, and Technical Assistance

Funds are awarded competitively to support an ongoing research program and other work related to better identifying, preventing, and treating child abuse and neglect and for required federal efforts to collect and disseminate child abuse and neglect data, operate an information clearinghouse, and provide technical assistance related to child abuse and neglect prevention and treatment. A few of the projects and activities currently funded (in whole or in part) include the Child Welfare Information Gateway Web site, annual publication of "Child Maltreatment," the National Resource Center for Child Protective Services, the National Quality Improvement Center on Differential Response, and the initiative on Supporting Evidence-Based Home Visitation to Prevent Child Maltreatment.

Community-Based Grants for the Prevention of Child Abuse or Neglect

Funds are provided to a designated lead entity in each state for support and development of community-based programs and activities that prevent child abuse and neglect. The lead entity must make an inventory of unmet preventive services needs in the state, foster a continuum of family support and strengthening services at the community level, leverage nonfederal funds to support prevention programs and activities, and provide technical assistance to funded community-based groups. Community-based groups that receive subgrants from the lead entity must provide, directly or by referral, core family resource and family support services. These services include parent education and parent mutual support groups, community and social service referrals, voluntary home visiting, and respite care.

Children's Justice Act Grants

The Children's Justice Act makes funds available to each state to improve systems related to the investigation, prosecution, and overall handling of child abuse and neglect cases with particular focus on cases involving child sexual abuse and exploitation, child abuse– or neglect-related fatalities, or maltreatment of children with disabilities. To receive these funds, a state must establish a multidisciplinary task force to study state administrative, judicial, and investigative practice related to child abuse and neglect cases; receive recommendations from this task force in the initial year that grants are funded (and every three years after); and implement those recommendations (or an alternative plan). In addition, a state must meet all the requirements for receipt of CAPTA state grants.

There is a multitude of individual, organizational, community, environmental, and contextual factors that all come into play for the grantees and the families they are serving; these factors can facilitate or impede implementation efforts. Nonetheless, there is no escaping the fact that a transformed child welfare system that focuses on safety, permanency, and well-being outcomes requires parent and family engagement and family support. Parent and family involvement within a system of care requires mutual respect and meaningful partnerships between families, professionals, and communities. For the future, child welfare activities must be focused more on supporting families and communities in ways that will ultimately prevent child maltreatment and keep children within their families and communities.

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See Also: Child Abuse/Neglect, Victims of; Child Protective Services.

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Child Abuse/Neglect, Victims of

The maltreatment of children is a serious social problem with unique implications related to diversity, especially with regard to socioeconomic status and race/ethnicity. Child abuse and neglect are defined in U.S. law as "the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child by a person who is responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened thereby." In most states, professionals who work in health care, mental health services, and kindergarten-through-12th-grade (K–12) education are mandated by law to report situations of child abuse and neglect to state or local child protection agencies. Children and families of color are disproportionately reported for child maltreatment due to institutional racism, because child maltreatment is often triggered by other social problems, and because, on average, families of color have more exposure to professionals who comply with mandated reporting requirements. Moreover, reported cases involving families of color are disproportionately substantiated and trigger a more punitive response from the child welfare system. However, most research indicates that when other social problems are controlled for and estimates are based upon population surveys, not official reports, caretakers of color are not more likely to maltreat their children.

The Extent of Child Maltreatment

Each year for the last 10 years, approximately 3 million cases, involving between 5 and 6 million children, have been officially reported for child maltreatment, a rate of about 45 reports per 1,000 U.S. children. Child neglect, that is, the failure to provide adequate food, clothing, shelter, supervision, or medical care, is by far the most commonly reported type of child maltreatment, representing approximately three-fourths of substantiated cases. Physical abuse accounts for less than 20 percent and sexual abuse about 10 percent of cases substantiated by the child welfare system. Between 1,200 and 1,500 children die as a result of child maltreatment every year, most often as a result of neglect.

Child Maltreatment, Poverty, and Race/Ethnicity

Of all types of child maltreatment, neglect is the most highly correlated with poverty. Caretakers may fail to provide adequate food, clothing, shelter, supervision, and medical care because they lack the resources to do so. Thus, a poor family may be evicted because they do not have rent money and end up living in their car. Alternatively, poor parents may choose to spend their limited funds unwisely, for example, on a car, and then not have money for food, whereas middle-class parents can afford a car and groceries. One of the most frequently reported types of neglect is lack of adequate supervision. A single mother working at a minimum-wage job may not be able to afford appropriate child care. In all the situations described above, caretakers will be defined as neglectful.

Families of color are more likely to be poor. The proportion of African American (greater than 22 percent), Native American (30 percent), and Hispanic (greater than 22 percent) families with incomes below the poverty level is more than twice that of white (less than 10 percent) families. For Native American families the rate is three times that of white families. The only exception is Asian American families, who have the same poverty rate as white families. Because of this disproportionality in poverty levels, families of color (except Asian American) are more vulnerable to neglecting their children, simply because they lack resources.

Child physical abuse, the next-most common form of maltreatment, is also associated with poverty, but is also linked to situational stress, such as having a special needs child, multiple children, partner conflicts, work-related problems, racial/ethnic discrimination, and child misbehavior. It is well documented that poor families experience a greater number of these life stresses. For a complex set of reasons including economic hardship, these situational stresses are more likely to occur in families of color. Indeed, sexual abuse is the only type of child maltreatment not found at higher rates among poor and stressed families.

Race/Ethnicity and Substantiation of Child Maltreatment Reports

Of the approximately 74 million children in the United States, 68 percent are white, 14 percent African American, 1 percent Native American/Alaskan Native, 23 percent Hispanic, and 4.4 percent Asian American. Given the disproportionate number of families of color living in poverty, it is expected that they would be more likely to be reported for child maltreatment. In terms of the ethnicity of the substantiated cases of child maltreatment, in 2011 21.5 percent were African American, 22.1 percent Hispanic, 43.9 percent white, 1.1 percent Native American, and 0.8 percent Asian American. These figures demonstrate the overrepresentation of African American children and the underrepresentation of white and Asian American children substantiated for child maltreatment. Although the proportions of Hispanic and Native American children are only slightly higher than their proportions in the general population, Hispanic and Native American children, like African American children, are removed from parental care at much higher rates than the percentage of these children in the overall population.

Racial/Ethnic Bias and Child Maltreatment

Of concern are findings from studies that examine the relative severity of child maltreatment and case circumstances for white families versus families of color and child welfare interventions. When maltreatment severity and case characteristics are held constant, these studies document that not only are children of color more likely to be removed from the home, but they are also placed in more restrictive settings when compared to white children. For example, a Native American single mother with a history of substance abuse is more likely to have her children removed from her home than a white mother with the same history. An African American youth whose parents are not adequately supervising him, resulting in school truancy and curfew violations, is more likely to be placed in a group care facility than a white youth with the same history, who may be placed with a relative. These examples demonstrate the impact of institutional racism.

Part of the reason families of color are more likely than white families to be reported for child maltreatment is because they are more likely to seek services from professionals who honor their mandated reporting obligations, such as public-sector workers providing financial assistance, food assistance, and health care services. In contrast, white families, who are more likely to be middle class, seek services from professionals who are less likely to honor their mandated reporting responsibilities, such as therapists in private practice or private health care providers.

In addition to these effects of institutional racism, dominant societal assumptions about optimal families and living situations for children affect how child maltreatment is defined. For example, in Native American culture the community or tribe is responsible for its children. Because of this, it is not uncommon for children to be in the care of an adult who may be a cousin, an aunt, or a tribal elder. These living situations constitute "improper custody," considered a type of neglect in the child welfare system, and for this reason an Indian child is in danger of being removed from that living situation. Another example of institutional racism is how services to assist families and children are structured to address child maltreatment. For example, caretakers are often sent to "counseling" based upon an assumption that they have deficiencies in functioning, when in fact they may just lack resources. The counselor is likely to be middle class and white. If a caregiver's first language is Spanish, that parent may be precluded from receiving the service he or she needs to have children returned because there is no Spanish-speaking counselor. The intent is not to discriminate against racial or ethnic minorities, but that may nevertheless be the effect.

There are federal efforts to address the differential impact of the child welfare system on families of color, such as the Indian Child Welfare Act of 1978. But there are other federal statutes that deny the realities and complexities of racial inequality, for example, the Multiethnic Placement Act of 1994.

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See Also: African Americans; Asian Americans; Child Welfare Services; Children in Foster Care; Critical Race Theory; Discrimination and Institutional Racism; Foster Care Agencies; Indian Child Welfare Act; Multiethnic Placement Act of 1994; Native Americans; People of Color: Service Delivery, Psychological Assessment, Cultural Issues; Protective Services for Children.

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Child and Adolescent Needs and Strengths

Prevention, treatment, and wellness promotion for young people ages 11 to 25 has been a growing objective for U.S. social service, education, juvenile justice, child welfare, and medical fields for the past century. These services target the emotional health, substance abuse, and social, behavioral, academic, and/or vocational functioning of adolescents and young adults. Improving the ability of youth to attain success in school; promoting mental, social, and emotional health and well-being; facilitating growth-fostering relationships; and equipping youth to achieve developmental milestones including the establishment of a stable and sustainable living environment are common goals among adolescent and youth service providers.

Historical Context

Mental, emotional, and behavioral health services for adolescents and youth in the United States share an intimate relationship with juvenile corrections services. Their common history dates back to the late 1800s, when the state of Illinois established the nation's first juvenile court in Chicago. In the years that followed, a group of concerned women on the board of directors of Jane Addams's Hull House began investigating juvenile delinquency and, in 1909, created the Juvenile Psychopathic Institute to study adolescent brain functioning, IQ, and psychological factors impacting troubled youth. Their approach inspired the opening of many child guidance centers across the United States in the early to mid-20th century.

The Child Study Center at the Yale School of Medicine was created in 1911 and served as an innovator in the study of child and adolescent development. During World War II, the drafting of teenagers and young adults from diverse ethnic and socioeconomic backgrounds contributed to data on the relationships between a youth's mental health and ability to function in the world. This spawned a new interest in adolescent health and wellness, and in 1948, a nationwide collaboration of child guidance clinics organized to form the American Association of Psychiatric Clinics for Children (AAPCC) to advocate for effective adolescent/youth services. In 1953, the American Academy of Child Psychiatry was founded, and in the 1960s the National Institute of Health awarded its first grant to study pediatric psychopharmacology.

In 1982, a groundbreaking study was released by Jane Knitzer titled *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*. The study was the first of its kind examining on a large scale the effectiveness of mental health services for children and adolescents in the United States. A key finding of the Knitzer study highlights the importance of family and parent inclusion as an essential component to the success of youth services. In 1984, the National Institute of Mental Health established a Child and Adolescent Service System Program, a program later shifted to the Substance Abuse and Mental Health Services Administration (SAMHSA), encouraging states to develop a more comprehensive system of care for troubled adolescents, prioritize community-based treatment, facilitate collaborative efforts among state agencies and stakeholders, and increase parent and family involvement in adolescent services.

The Special Education Pupils Program passed in 1984 provided a new framework for youth mental health care by mandating that special education students be provided adequate mental health services as a component in a collaborative manner between educators and mental health providers. This significantly increased access to mental health services for youth through school individualized education programs (IEPs) and enabled troubled teenagers to remain at home and in their home school, while building necessary services into their weekly schedule.

The case of *R. C. v. Hornsby* (Alabama, 1988) placed a spotlight on youth in state custody who were committed to psychiatric hospitals despite never having received any diagnoses. Parents and families in these instances were often denied visitation rights. The legal agreement in this case mandated the creation of a system of care for young people with mental health disorders currently or at risk of being involved with the child welfare system, and established family preservation as a priority for these youth.

In 1989, the Federation of Families for Children's Mental Health was established to promote a family-driven, youth-guide system for adolescent mental, social, and behavioral services. A decade later, in 2001, the *Jason K. v. Eden* settlement in the state of Arizona further galvanized these improvements to the provision of child behavioral health. In the settlement, the state adopted a vision that placed youth and families at the center of care delivery systems. Principles established by this settlement included (1) collaboration with the child and family, (2) adoption of evidence-based practices, (3) cross-system collaboration, (4) maximizing service accessibility, (5) strength-based family and youth-tailored services, (6) focus on stable child placement, (7) respect for youth and family cultural background, and (8) anchoring and connection to natural supports.

In 2003, *Katie A. v. Bonta* further challenged the detrimental and common practice of placing foster children with mental health problems in hospitals and residential facilities when they could be enabled to remain in homes in their community if adequate services were available. The settlement of this lawsuit provided the framework for the expansion of wraparound services and evidence-based practices being made available to foster children with the intention of preventing institutionalization.

Terminology

"Adolescent" is generally defined as a young person 11 to 25 years of age. "Family-driven care" indicates that families take a primary role in making decisions regarding the mental, social, emotional, and behavioral services their children need and receive, as well as contributing to the formation of the policies and procedures governing the larger systems responsible for funding, driving, and providing those services. "Youth-guided care" indicates an emphasis on the rights of adolescents and young adults receiving mental, social, emotional, and/or behavioral care to be educated, informed, and empowered to take a decision-making role in their own services, and to contribute to the formation of the policies and procedures governing the larger systems providing those services. "Evidence-based practice" refers to a service approach that has been evaluated using a criteria base to determine the level of its empirically demonstrated effectiveness with a certain population. In order to be considered an evidence-based practice (EBP), the approach must have documented outcomes in two or more randomized controlled outcome studies comparing the target approach to an appropriate alternative where a significant advantage was found.

"System of care" refers to comprehensive community-based services and supports consisting of research-informed programs, strong interagency collaboration, and sustained funding. "Least restrictive environment" is a standard established by the 2004 Individuals with Disabilities Education Act (IDEA) that dictates that youth be served when at all possible in their home school, permitted to reside at home with their family, and receive services in the most natural, diverse, and culturally relevant setting possible. "Custody relinquishment" refers to the practice of "voluntarily" giving up one's child or children to the child welfare system, juvenile department, and/or state in order to access mental health services for them. "Wraparound services" refers to a concept established in the 1980s to prevent out-of-home placements and promote care in the least restrictive environment. The aim of wraparound services is to provide youth with serious and/or complex mental, emotional, or behavioral problems an intensive, individualized care plan involving collaboration between the adolescent, family, natural supports, service providers, and community agencies that enables the adolescent to remain in his/her home and community.

Differentiation From Adult Services

Historically, adolescent/youth services such as behavior modification and substance abuse intervention mimicked the psychodynamic and aggressive/confrontational approaches being applied to adults with similar presenting problems. Psychiatric, psychological, corrective, and substance abuse recovery programs initially designed for adults were liberally applied to adolescents with little alteration. The Stockton Developmental Center, which functioned as an insane asylum for the state of California in the 1800s, is an example of institutions that placed children in the same hospital wards as adults, with no separate accommodations.

In the 1950s, certain U.S. medical and social service facilities began to recognize that adolescent behavior problems such as substance abuse and delinquency did not necessarily mirror those of adults. Despite a growing understanding of the unique features of the adolescent brain, youth were still subjected to the same service approaches as adults through the 1980s. Currently, youth service providers recognize the now large body of research demonstrating that adolescent and adult mental, emotional, social, and behavioral problems manifest differently and are best treated differently. Owing to their unique developmental stage—socially, physiologically, and neurologically—adolescents in need of services cannot be treated as merely younger versions of adults. Reinforced by research on the most effective ways of serving teenagers and their families, treatment programs developed specifically for youth emerged slowly in the 1990s.

Settings

Youth services in the United States are provided in a variety of community-based settings, including home-based services, school-based services, juvenile correction departments, community clinics, foster care homes, and medical and residential facilities. Based on statistics from 2007, 3.1 million—or almost 13 percent—of youth aged 12 to 17 in the United States annually receive counseling or psychotherapy intervention in a specialized mental health setting—either outpatient, inpatient, and/or with a combination of in-home services. Another 12 percent receive services in a school-based setting. Approximately 3 percent receive mental health services in a general medical setting, and over 5 percent receive services in multiple settings.

In 2002, the American School Counseling Association established a framework for the provision of youth treatment and prevention services in school-based settings. School counselors utilize evidence-based approaches to provide individual, group, and family-oriented interventions to students through high school, designed to promote academic, social, emotional, and behavioral health.

Currently, more than 2 million U.S. teenagers annually become formally involved with the juvenile justice system and millions more benefit from prevention services aimed at deterring youth from needing juvenile correction involvement. The vast majority of youth enter the juvenile corrections system with at least one diagnosable mental health need. In some communities where access to mental health care and preventative care is limited, children are referred to the juvenile justice system because general mental health services for youth are unavailable or limited in their area.

Evidence-Based Practices for Youth Services

Adolescent/youth services include a variety of different approaches, depending on the preferences of the youth and family, the diagnosis, the level of severity of the problem, and the availability of equipped service providers. Common prevention services include group therapy, psychosocial support, peer and adult mentoring, psycho-education, and prosocial extracurricular activities. Typical intervention services may include individual, group, and/or family therapy with an array of evidence-based practices, possible psychiatric evaluation, and medication, along with care coordination/case management.

Empirical research on the effectiveness of youth services has contributed to a growing body of literature on evidence-based practices for prevention and intervention for adolescents. Cognitive behavioral therapy, motivational enhancement therapy, multidimensional family therapy, multisystemic therapy, and brief strategic family therapy are a few examples of dozens of empirically supported approaches for providing effective services for adolescents and their families. The Substance Abuse and Mental Health Services Administration (SAMSHA) maintains a list of evidence-based practices and programs in the delivery of effective youth services in the United States.

Obstacles to Accessing Effective Youth Services

Studies of service access and effectiveness consistently reveal ongoing disparity between youth of different racial/ethnic and socioeconomic backgrounds, as well as gender differences. At present, African American youth are more likely to be placed out of home and to be discharged from residential treatment into foster care than their peers. Males are consistently found more likely to be placed in residential facilities than their female peers. An estimated 40 percent of the boys and nearly 30 percent of the girls placed in residential treatment could have been treated effectively in their home community, based upon their level of risk severity, if adequate community services were made available.

Controlling for risk factors and all other variables equal, adolescents treated in residential facilities and out-of-home placements are found more likely than their peers to have suicidal tendencies, comorbid mental health conditions, and experience abuse and neglect. In the United States, research indicates that as many as 75 to 80 percent of children and adolescents in need of mental health services do not receive them at all, or in inadequate manner or frequency. Barriers to accessing adolescent and youth services can include stigma preventing the youth and/or family from seeking help; lack of culturally relevant services available; language barriers between youth, families, and service providers; inadequate funding; transportation difficulties; and/or shortage of trained providers.

Current Trends

In 2006, the National Center for Children in Poverty released findings from Unclaimed Children Revisited. The initiative highlights the best state policy practices across the nation in adolescent/youth service delivery, including an emphasis on developmentally and culturally appropriate services, family and youth engagement, and evidence-based services. The study revealed the following trends in U.S. youth services: (1) increased inclusion of parents and families in policy, procedure, and implementation of youth services, (2) decrease in funding and practice of approaches shown to be harmful or ineffective for youth, (3) increase in use of evidence-based practices and best practice approaches informed by research on youth health and wellness, and (4) growing focus on prevention and promoting protective factors that lead to resiliency for youth and families.

The growing interest in protective factors and resiliency development represents a shift in the field of youth services away from a concentration on mental illness and toward strength and wellness. Closely related to this shift is a growing awareness of the importance of language and culture-specific services—adolescents and their families can be best understood and served within the context of their home culture. Resiliency is a strengths-based concept that emphasizes the promotion of relationships, activities, skills, and values that serve to prevent and protect a youth from negative consequences, risky behaviors, and environmental challenges.

Stress-relieving and resiliency-building activities can include spiritual practices; problem solving; practicing positive interactions with family members, teachers, and peers; service to the community; leadership development; and participation in team sports and/or the arts. Family-based treatment interventions, often provided in the home, outpatient clinic, and/or school, can serve to facilitate positive interactions between troubled youth and their parents, siblings, and extended family and tend to consistently demonstrate good empirical outcomes. Evidence-based practices empower families and youth to learn relational skills, practice creative approaches to solving conflict, reflect on their family culture and values, and identify natural strengths the youth and family can draw upon to achieve their health and wellness goals.

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See Also: Mental Health Services, Children; Partial Care Services for Children, Mental Health; Wraparound Services/Systems of Care.

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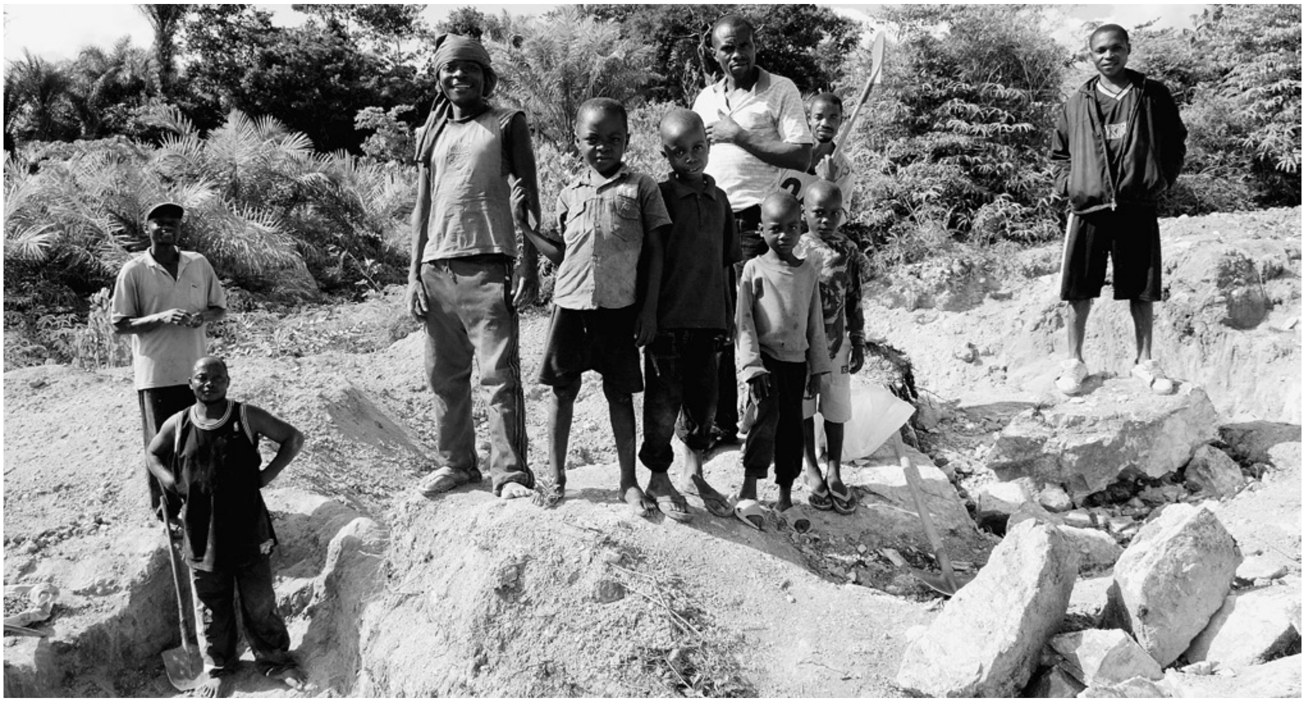
Child Labor, International Variations in Attitudes Toward

Nearly every child throughout the world participates in various levels of work. Much of this work is developmentally positive for youth, leading to a positive well-being and improved quality of life.

For example, by earning money helping parents or neighbors with various chores, children can learn important lessons on the work ethic and social and fiscal responsibility. However, many children throughout the world are forced to work laborious hours that deprive them of childhood. The International Labour Organization (ILO) defines child labor as work that harms children as it deprives them of childhood and dignity and that is detrimental to physical and mental development. Child labor is further characterized by work that interferes with proper education by (1) preventing children from attending school, (2) forcing children to leave school prematurely, or (3) having children combine schoolwork with excessively long and heavy workloads. In other words, any work that hinders a child's development can be regarded as child labor. Due to immeasurably negative effects, there is a growing consensus regarding the need to eliminate child labor worldwide. In fact, a majority of countries have ratified two of the most important ILO conventions on child labor: convention No. 138 on the minimum age for admission to employment and work and convention No. 182 on the worst forms of child labor. Despite these positive advancements, the eradication of child labor has not been supported in all parts of the world. Indeed, child labor remains an ongoing and widespread problem in many developing countries, where attitudes favorable to its use are often commonplace.

Child Labor in Developing Countries: Asia and Sub-Saharan Africa

Although estimates of child labor from diverse international organizations and nongovernmental organizations (NGOs) vary, it has been reported that approximately 250 million children are forced into child labor. The two regions with the worst forms of child labor are Asia and sub-Saharan Africa. Indeed, these two areas account for 90 percent of all forms of child labor, from working on the family farm to the hazardous industry sector. In sub-Saharan Africa, more than 40 percent of all youth between the ages of 5 and 14, or about 48 million children, work for survival. According to recent estimates by the United Nations, there are more than 34 million orphans in sub-Saharan Africa, indicating that many children are in danger



Mining "conflict minerals" wolframite and casserite in Kailo, Democratic Republic of the Congo. In sub-Saharan Africa, children work alongside their parents. In this mine, children help pan for ore and help carry and sell goods. Child labor remains widespread in many developing countries, where traditional attitudes in favor of its use and conditions of economic necessity are commonplace.

of being exploited as potential laborers. The Asia-Pacific region also shows high rates of child labor, with 122 million children between the ages of 5 and 14 compelled to work. Most of these children are employed by their parents on the family farm or enterprise, as opposed to outside factories or other industrial settings. Approximately 8 percent of children work in the latter.

Economic Causes of Child Labor in Developing Countries

As child labor is particularly prevalent in developing countries, it can be assumed to have a close association with the economic development of a nation. That child labor is negatively related to gross domestic product (GDP) per capita has been shown by Kaushik Basu, the chief economist of the World Bank, who demonstrated that a rise in national income relates to a proportional decrease in child labor. In fact, financially struggling parents often oppose laws prohibiting child labor, making enforcement difficult and costly in developing countries. Some parents in developing countries might need additional income from their children to survive extreme poverty, albeit at the expense of the short-term toll on children's health and long-term consequences to their education and career potential.

Parents' Attitudes on Child Labor

Even though the condition of extreme poverty plays an important role in maintaining child labor in developing countries, another crucial determinant of child labor is parents' attitude toward children in the household. Household survey data obtained from developing countries point to the importance of cultural and social factors in influencing child labor, including parents' educational attainment, household heads' religion, cost of education, balance of bargaining power between father and mother, and parents' attitudes toward child labor. The probability of child labor increases when parents display a lack of concern for their children's welfare and safety. Also, children from male-dominated households tend to work more than children from households where the mother has greater bargaining power. In general, whether due to cultural practices or religious norms, men in developing countries tend to have greater bargaining power than their female counterparts. Indeed, a household survey conducted in rural India suggests that a father's preference for child labor, in part, is predictive of whether or not a child works. Theoretical research on child labor is grounded in the general assumption that parents are altruistic, and that the reason for parents making their children work is solely concerned with the poverty level. However, recent empirical research and experiences from activists working to change the situation in developing countries indicate that, when it comes to implementing policies against child labor, changing parents' attitudes toward child labor is crucial.

Attitudes Toward Child Labor in Developed Countries

Up until the middle of the 20th century, child labor had been a persistent and serious problem in the Western world as well. The rapid economic growth spurred by the Industrial Revolution coupled with increasing concern for child welfare made it possible for developed countries to enact laws against the use of child labor. Attitudes toward child labor in developed countries are well reflected in initiatives to control child labor even though it is no longer a pressing issue: the two most notable examples are a consumer boycott and trade sanctions of imported goods "tainted" by child labor. A consumer boycott means that a consumer is willing to pay higher prices to buy "child labor–free" products, as goods produced though child labor often retail at lower prices because of the lower wages demanded by children. To maintain international labor standards and decrease child labor in developing countries, such consumer activism is popularly considered desirable because it does not call for government intervention.

However, due to the consumer boycott in the Western world, an adverse reaction that causes child labor to increase has been reported. Lower wages resulting from the consumer boycott mean that children will have to work more and harder to obtain the higher incomes needed to survive. Also, unless trade sanctions are complemented with alternative options for working children, restrictions on child labor could end up making some children worse off as they relocate to unaffected industrial sectors. Therefore, to curb child labor effectively, the use of consumer activism should be matched with alternative policies that afford more educational opportunities for children in developing countries. For example, in Latin America, a dramatic increase in primary school enrollment was achieved by designing and implementing the monetary reward program (e.g., the PROGRESA program in Mexico) to compensate for the loss of income when children go to school instead of work. Free school meals, supplies, health care, education vouchers, and even cash stipends were utilized.

Conclusion

To help children involved in hazardous and laborious work, numerous governments, NGOs, and individuals have developed measures and implemented policy to eliminate or reduce the harms of child labor. By understanding the importance of societal and parental attitudes in contributing to the continuation of child labor, and by working alongside relevant agencies, human service providers can assist in the eradication of child labor and associated harm.

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See Also: Children, Youth, and Human Trafficking; Fair Labor Standards Act; Poverty.

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Child Protective Services

Children are the most vulnerable of all human beings, and the younger the child, the more vulnerable he/she is to child neglect and abuse, which federal law defines as a failure to protect children from death, serious physical or emotional harm, sexual abuse, or exploitation.

Children with special needs that result from disability, mental retardation, visual or hearing impairment, learning disabilities, physical disabilities, and behavioral problems are also particularly vulnerable to both neglect and abuse. Approximately half of all children in protective care have been removed from their homes because of neglect and abuse, and the other half are in protective care because of physical and medical conditions. In 1992, the Children's Bureau of the U.S. Department of Health and Human Services (HHS) began maintaining the National Child Abuse and Neglect Data System. HHS is also responsible for maintaining the Child Welfare Information Gateway, a clearinghouse for information on child protection and child welfare. Protecting the lives of children and ensuring their safety becomes a priority for child protective service workers who are trained to identify children who may be neglected or abused. These professionals pay regular visits to homes on which reports have been made and to foster homes and residential facilities. The basic authority for this oversight of child welfare is derived from the Child Abuse Prevention and Treatment Act of 1974 (CAPTA) and relevant state laws.

As long as states comply with federal requirements, they may apply for CAPTA funds to be used for prevention, assessment, investigation, prosecution, and treatment. CAPTA also offers funding to nongovernmental organizations (NGOs) dedicated to educating the public about child mistreatment. In general, state laws recognize four types of child mistreatment: physical abuse, sexual abuse, emotional abuse, and emotional neglect. A number of states also recognize educational and medical neglect as forms of child mistreatment. Those considered most closely responsible for protecting children include parents, guardians, relatives, foster parents, and caregivers. Other individuals who mistreat children are likely to be accused of violations of criminal law rather than child protection laws. Twenty-seven states require child protective service workers to notify law enforcement of suspected abuse by a nonfamily member or in the case of sexual abuse or severe physical injury.

Early History

Throughout most of history, patriarchal systems have dictated that male heads of households held virtually total authority over other members of their family. This authority gave them the right to use corporal punishment against children, adult females, and servants. Some societies even tolerated infanticide. By the late 15th century, this had begun to change in the more developed nations. In Britain, for instance, Parliament passed the Poor Law Act of 1601, giving government the right to separate girls under the age of 16 and boys under the age of 21 from their parents and place them in service. The Tenures Abolition Act of 1660 extended the rights of British nobles, giving landlords control of the property of minor children of tenants living on their property. The law also allowed fathers to appoint guardians for their own children, which meant that widows were vulnerable to losing control of their children and their children's property.

Since the law in the American colonies was generally based on British common law, both American and British courts often stepped in to protect the interests of children. Since it was assumed that children were not intended to be idle, children who became wards of the court were often placed in involuntary apprenticeships or in asylums alongside delinquents. The reform movement of the early-to-mid-19th century produced private institutions such as the New York House of Refuge, which received government funding to house orphans and delinquents. By 1850, reforms had resulted in the practice of moving children away from institutions and into foster homes outside large cities. In 1875, New York became the first state to enact child protection laws. Determining that poor immigrants were not fit to care for their own children, by 1879 the state had taken 48,000 children away from their parents in what was deemed their best interests. The 20th century ushered in a family preservation movement, and both federal and state laws were passed to protect children through mitigating conditions that led to mistreatment.

Twentieth Century

In the early 20th century, children began to be viewed as individuals with an inherent right to enjoy childhood. Mandatory education laws and the abolishment of child labor improved the quality of life for most children, but many were still vulnerable to mistreatment from those they looked to for protection. However, it was not until the 1970s that the issue of child neglect and abuse was placed on the public agenda. Investigations revealed that children in institutions, group homes, foster care, and day care were often at high risk for mistreatment. Within those settings, disabled children were twice as likely as other children to be neglected or abused.

In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was signed into law (P.L. 93-247) in response to "battered child syndrome" being identified as a valid medical condition. Before that time, state laws had focused on the mistreatment of children living with their own parents or guardians and virtually ignored the safety of those living in institutions and residential facilities. The National Center on Child Abuse and Neglect sponsored a comprehensive study that examined the vulnerability of children in such settings.

Congress amended CAPTA in 1984 to require states to investigate child mistreatment, report their findings to the federal government, and take corrective action. Since state funding and commitment to protecting children was inconsistent, results were mixed. CAPTA was again amended in 1988, 1992, 1996, and 2003. The 1996 amendment required states to submit a child protection plan to the federal government, detailing provisions, procedures, and programs designed to keep children safe. That same year, passage of the Protection and Advocacy for Mentally Ill Persons Act offered greater protection to mentally ill and emotionally disturbed children living in residential homes. Since 1997, HHS standards have dictated that in order to receive federal funds, states must ensure that the incidence rate of children mistreated by foster parents and facility staff members is no higher than 57 percent.

A series of court cases throughout the 20th century solidified the right of children to be protected. From the early to mid-1980s, the focus was on removing children from homes where they had been mistreated. This often meant putting mistreated children up for adoption, and Congress passed the Adoption Assistance and Child Welfare Act in 1980 and the Adoption and Safe Families Act in 1997. However, *Santosky v. Kramer* (455 U.S. 745,

1982) placed the burden of proof on states before parental rights could be permanently terminated. States receiving federal aid for child protective services are required to enact laws that are consistent with federal laws. Efforts to preserve families led to the passage of Family Preservation and Support Program of 1993 and the Keeping Families Safe Act of 2003.

Twenty-First-Century Data

In 2009, data from the National Child Abuse and Neglect Data System indicated that some 36 million reports of abuse and neglect had been recorded, and 905,000 had been classified as neglect. Seventy percent of these children lived with one or both parents. In 10 percent of the cases, the mistreatment was perpetrated by a foster parent, legal guardian, unmarried partner, day care staff, or residential staff member.

In 2010, 78.3 percent (538,557) of cases reported to child protective services involved neglect, 17.6 percent (121,380) involved physical abuse, 9.2 percent (63,527) involved sexual abuse, 8.1 percent (55,405) involved psychological maltreatment, 2.4 percent (16,209) involved medical neglect, and 10.6 percent (72,910) fell outside these categories or were unknown. In 81.3 percent (578,821) of the cases, the person who mistreated a child was a parent. Thirty-four percent of the mistreated children were from birth to 3 years old. In most cases, child mistreatment is first recognized by professionals. In 2010, 57 percent of all reports of child mistreatment originated with teachers, law enforcement, legal personnel, and social service workers. Other cases were reported by parents, neighbors, friends, or other relatives. Of 3.3 million reports in 2010, only 19 percent of the cases were substantiated. Child protective service workers responded to substantiated reports of child mistreatment by monitoring families within their homes or removing the child/children from the home. In 2010, 229,000 children were placed in foster care. That same year, 1,537 children died from neglect or abuse.

In 2011, there were approximately 3.4 million reported cases of children being mistreated, and 60.8 percent of those were screened. Three-fifths of the reports had been filed by professionals such as teachers, police officers, lawyers, and social services workers. The highest rate of mistreatment was among children from birth to 1 year old, with a rate of 21.2 percent per 1,000 of that population. Almost 79 percent of the cases of mistreatment involved neglect, 17.6 percent involved physical abuse, and 9.1 percent involved sexual abuse. There were 1,545 fatalities among mistreated children in 2011, and 81.6 percent of the victims were under 4 years of age. In more than 78 percent of the cases, the perpetrator was a parent, and 88 percent of those were biological parents. Eighty-five percent of these parents were between the ages of 20 and 49, and more than half were female. Also in 2011, Congress passed the Child and Family Services Improvement and Innovation Act, which amended the Social Security Act and provided continued funding for the Child and Family Services Program.

Current Status

As a result of national and state cooperation, the Office of Justice Programs of the U.S. Department of Justice partnered with the National Center for State Courts, the American Bar Association, and the National Council of Juvenile and Family Court Judges to produce the Court Performance Measures in Child Abuse and Neglect Cases Toolkit in 2004 as a means of improving courts' responses to cases involving the mistreatment of children. In 2005, 2007, and 2009, the National Center for State Courts and private organizations sponsored the Judicial Child Protection Summits, where state officials and judicial leaders met to develop plans for working with parents and children in individual court cases and creating state judicial commissions devoted to protecting children. Using grants from the Children's Bureau, states are now able to promote stability through foster care.

The fact that children are still being neglected and abused despite all efforts to protect them makes it clear that children will continue to be vulnerable to the people who are supposed to love them and keep them safe. Child protection services workers are often blamed for returning children to dysfunctional homes after they have been removed as a result of mistreatment. However, they are often bound by state laws that emphasize family reunification. Most child protective service caseworkers are underpaid and overworked, and worker burnout is common. Many states prefer dedicating resources to other avenues, since children are not able to vote. Experts suggest that caseworkers should have greater flexibility in serving the best interests of children to whom they are assigned because they are the ones with firsthand knowledge of individual cases.

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See Also: Child Abuse Prevention and Treatment Act; Child Abuse/Neglect, Victims of; Child Welfare Services; Children With Special Needs.

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Child Support Agencies and Services

A child support agency is a government establishment intended to promote parental responsibility of custodial and noncustodial parents. Each year, approximately 17 million children are served by child support agencies within the United States. The purpose of this article is to explore the historical origin and present-day functioning of child support agencies and services.

History

In 1975, Congress began the federal child support program to reduce public expenditures on welfare, to pay back benefits from the government's welfare program, and to reduce the need for welfare assistance. In 1996, Congress changed the program as part of the new welfare reform laws to expand the inclusion of technology and increase the certainty that children are the direct recipients of paid parental support. It has since emerged to be a family support program providing a variety of prevention and intervention services. The federal Office of Child Support Enforcement (OCSE) is the government entity that oversees the child support program. OCSE does not provide services directly to families, but families receive services from state, tribal, and local support agencies. A majority of states work with prosecuting attorneys, law enforcement agencies, and officials of family or domestic relation courts to carry out the program at the local level.

Administration of Services

The Office of Child Support Enforcement helps child support agencies to develop, manage, and operate their programs effectively and according to federal law. Services are administered through a variety of initiatives to include financial support of child support program operations, providing grants for state visitation programs, providing policy guidance and technical assistance, conducting audits and educational programs, supporting research and program improvement, operating the Federal Parent Locator Service and the National Directory of New Hires, working with states to provide limited enforcement services, working with employers and other private and public partners, and helping with intergovernmental child support cases. The OCSE requires that child support programs provide supportive services for both welfare and non-welfare families and requires the states to publicize information about available services.

Child support programs are run by each state and/or tribal community. Despite variance from state to state, the federal government plays a key role in the design features of state programs. Services are available to all parents who need them. Functions of state and tribal child support programs include locating noncustodial parents, establishing paternity, establishing and enforcing support orders, modifying orders when appropriate, collecting and distributing child support payments, and referring parents to other services. The actual establishment and enforcement of child support orders are handled by local family and domestic courts and administrative agencies. Other issues that may exist between parents, such as property settlement, custody, and access to children, are not handled by the child support program but by local courts.

More than 17 million U.S. children receive services from child support service agencies. Functions of state and tribal child support programs include locating noncustodial parents.

Method of Operation

There are certain methods of operation that child support programs use to ensure children receive the support they need. In order to have appropriate access to information, the federal government operates location services that include the Federal Parent Locator Service, the Federal Case Registry, and the National Directory of New Hires. These entities are not only used to locate noncustodial parents but are available for noncustodial parents whose children have been hidden from them in violation of a custody or visitation order. If necessary, state and tribal child support programs will provide paternity and/or genetic testing to establish parentage.

Population Served

Any parent or person with custody of a child who needs help to establish child support and/or medical support or to collect support payments can apply for child support services. Those who receive assistance under the Temporary Assistance for Needy Families (TANF), Medicaid, and federally assisted foster care programs are automatically referred for child support services free of charge. For all others seeking child support services, a fee of up to $25 may be charged, although some states waive all or part of the fee or collect payment from the noncustodial parent. Either parent can receive help to have a child support order reviewed every three years or whenever there is a substantial change in circumstances to ensure that orders remain fair. Child support caseloads are driven by the increasing number of children born to unmarried parents, which is nearly half of all births.

Demographics of Child Support Services

The Office of Child Support Enforcement (OCSE) collects little information concerning demographic and economic characteristics of those who utilize services but instead works in conjunction with the U.S. Census Bureau to collect this type of data. The "2010 Census Survey Report" indicated that a majority of custodial families utilize child support services. Moreover, females overwhelmingly maintain the majority of custodial families, making up nearly 90 percent of all families receiving services. Parents who were never married, separated, black, Hispanic, had less than a high school education, had one child, or were high school graduates had child support awards or agreement rates of approximately 45 percent. Furthermore, custodial parents who were either non-Hispanic white, divorced, married, had some college education, had at least a bachelor's degree, or lived with two or more children from an absent parent had slightly higher child support awards or agreements of approximately 55 to 60 percent. Considering specifically economic characteristics, approximately 36 percent of families who utilized child support services were poor, and nearly half were 150 percent below the poverty line.

Services

To improve the reliability of child support payments, child support programs utilize family-centered strategies—economic stability, health care coverage, family violence collaboration, healthy family relationships, engagement of fathers from birth, and child support prevention. The child support program helps noncustodial parents find and keep work, and may connect custodial and noncustodial parents to resources that help them achieve and maintain economic stability. The program assists with the establishment and enforcement of private health insurance or public health care coverage requirements against either or both parents; the establishment and enforcement of cash payments by either parent to fund premiums, copayments, and extraordinary or uncovered medical expenses; and cash payments for Medicaid cost reimbursement.

The child support program has played a critical role in supporting healthy marriage and couples skill-building programs by using a variety of strategies to promote healthy marriages, teaching skills that help parents work together to successfully manage conflicts and challenges. They intentionally seek to engage fathers from birth by operating in-hospital paternity establishment programs to ensure that every child has a legal father and has the same rights and privileges as children born to married parents. The child support program can also partner with programs designed to engage fathers during pregnancy and at the birth of the child, conduct outreach, and work closely with other community-based programs that promote father involvement.

The most ideal situation for parents and children is prevention of services. In order to prevent the need for services, child support programs often partner with middle and high schools, fatherhood programs, and pregnancy prevention programs to reach young people through educational tactics. Child support education explores the financial, legal, and emotional responsibilities of having children outside marriage and may be combined with programs on related issues, such as reducing teen or unplanned pregnancies, preventing family violence, teaching parenting skills, and helping teen parents improve their relationship skills. Similar strategies are used to reduce the risk of family violence and help family violence survivors pursue child support safely.

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See Also: Adoption Agencies and Services; American Academy of Social Work and Social Welfare; Child Welfare League of America; Child Welfare Services; Department of Health and Human Services, U.S.; Family Planning Services; Family Preservation Services; Family Services.

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Child Welfare League of America

The Child Welfare League of America (CWLA) is an agency with a nearly 100-year history of advocating for the rights of children, whose age and legal status make them vulnerable members of U.S. society. While CWLA has maintained the core of its purpose, the agency's structure and activities have expanded and changed over time, along with the changing landscape of the U.S. child welfare system. In its work to advance best practice standards in the field, CWLA has encountered many intersections and divides in attempting to reconcile the best interests of children and the concerns of a diverse American population.

CWLA in the Beginning

Prior to 1920, the year the CWLA was established, the nation's child welfare efforts were led largely by local, private charitable organizations. These organizations, including religion-based orphanages and almshouses, children's aid societies (CSAs), and societies for the prevention of cruelty to animals (SPCAs), varied vastly in their approaches to the protection and care of children in need.

For example, many of the orphanages and almshouses viewed their purpose as the need to reform and discipline children separated from their families. Concerned about the treatment of children in these institutions, children's aid societies began using a substitute family model of caring for children. This model closely resembled the modern foster care system in that children whose biological families were not allowed or not able to care for them were placed in private homes, rather than residential facilities. However, a mainstay of this system was the idea that these children should be moved out of urban centers into rural areas, leading to the practice of relocating children far from their home communities, sometimes across the country.

It wasn't long before concerns about this type of child fostering arose, with some child advocates questioning whether children needed to be removed from their families of origin. Many advocates began bringing to light the fact that many children were removed simply because their parents were extremely poor and lacked adequate resources and support to safely care for their own children. These advocates found comrades in animal rights advocates. In fact, SPCAs in cities like Boston and Cleveland became important child protection agencies in the early U.S. child welfare system. Workers began applying preventative methods to the protection of children that were similar to those they'd been using with animals. They employed the approach of offering case management services to children and their parents to prevent the need for an out-of-home placement.

As the federal government started to recognize the problems of poverty, abuse, and neglect and began to take a more active role in both prevention and intervention in families, government officials began bringing together representatives from the vast array of child service agencies for forums to discuss major issues in the field. It was during the first White House Conference on the Care of Dependent Children in 1909 and subsequent conferences that a need for unifying standards of care across agencies was recognized and the roots of the CWLA were established.

Initially made up of 68 member agencies and seven paid staff members, CWLA structured itself so as to set standards that were entirely voluntary and to become a central resource for information on best practices in child welfare. As such, besides adopting the first written Standards of Excellence focused primarily on foster care, the agency also began publishing one of the nation's first scholarly journals concerned with disseminating research on children's issues, *Child Welfare*, and providing training programs to member agency staff.

It was also not long after the agency's inception that it found the need to become intimately involved with the specific welfare of immigrant children, who made up a significant portion of the population of poor children. While CWLA was instrumental at the time in campaigns to find adoptive homes for these children, the Western European makeup of the immigrant population and the purview limits of the Standards of Excellence kept the agency from having to take a formal stand on controversial issues, like racial matching versus transracial adoption, until later in its history.

Later History

In the mid-20th century, CWLA found itself straddling controversy, taking actions that represented different extremes in the debate among child advocates on the cross-cultural raising of children. On one hand, the agency participated in an experiment with the U.S. Children's Bureau, which eventually affected over 600 Native American children who were removed from their tribes and adopted by non-Indian families—an action that later prompted CWLA to formally apologize to tribal organizations. On the other hand, in the 1958 revision of the Standards of Excellence, matching the racial background of a child freed for adoption to the racial background of a prospective adoptive family was promoted as a best practice.

CWLA Today

Today, the published mission of the now 800-member organization remains consistent with its historical roots. Yet, the activities of this complex organization have expanded dramatically, and CWLA's positions on issues related to diversity have become explicit. CWLA continues to update and expand the Standards of Excellence, now reaching beyond foster care into 12 other child welfare practice areas, including, but not limited to, adoption, child care, health care, administration, and independent living. In addition, *Child Welfare* continues to be a leading research journal in the field, and the agency continues to be a major provider of worker training and education through conferences, technical assistance, and consultation.

In addition, CWLA is now well known for both its legislative advocacy efforts and its role as the hub for collection and analysis of data about the child welfare system. These two present-day activities have helped establish a more clear position of the agency in the ongoing concerns related to the confluence of culture and child welfare. CWLA now issues data reports and policy statements and provides congressional testimony on a wide range of topics, including disproportionality and disparity of outcomes for children of color in child welfare, same-sex parenting and adoption, the needs of LGBTQ (lesbian, gay, bisexual, transgender, and queer) children in care, Native American child welfare, and immigration and deportation policy.

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See Also: Adoption Agencies and Services; Case Management Services; Child Welfare Services; Children in Foster Care; Indian Child Welfare Act; Multiethnic Placement Act of 1994; Protective Services for Children.

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Child Welfare Services

Since the establishment of the U.S. Children's Bureau in 1912, the federal government has maintained interest in child welfare services and responsibility for the safety, stability, and well-being of the nation's children. While hardly without controversy or debate in shaping priorities, federal and state interests in children are multipronged, including maltreatment investigation, advocacy, research (and data collection), policy and procedure setting, workforce preparation, system maintenance, and service coordination.

Few experts would argue against the notion that the child welfare system evolved along a series of pendulum swings involving best interests, (e.g., of the child, parents, and the family), sources of funding (and control namely, state versus federal responsibility), and legislative provisions that extended beyond child welfare and instead were more inclusive of the welfare of the child. Today, child welfare is challenged to balance a desire to preserve families that often includes keeping children in the home and in their communities. When not deemed safe, the call for services becomes drawn to the need to develop substitute care to accommodate the multiple and complex health, mental health, and educational needs of these children and their families. The ultimate goal is to restore the children to long-term, permanent care, inclusive of adoption or permanent placements that best prepare them, as most families prepare their children, for lifelong personal responsibility and responsible civic engagement. Much of the controversy about the child welfare system has focused on the overwhelming number of children of color entering its services. More than half of maltreated children in out-of-home care are nonwhite, which represents a sizeable change in the composition of children placed in foster care during the late 20th century and early 21st century. Today, with the steady wave of immigrant families seeking refuge in the United States, increasing poverty and associated risk factors of parental stress and child vulnerability to neglect and abuse, and constant displacement and disruption in affordable living among racial and ethnic minority families, child welfare and human services overall are overwhelmed and underfunded.

Concepts like overrepresentation, disproportionality, and disparities have emerged to characterize the landscape of child welfare, all the while evidencing discriminatory practices that differentiate child welfare treatment along racial and ethnic minority lines when compared to white children. "Overrepresentation" denotes that a particular group of children constitutes a larger proportion in the child welfare system than it does in the general population. "Disproportionality" characterizes a situation in which a particular racial or ethnic group of children constitutes a higher percentage of those in foster care than other racial or ethnic groups. The terms *disproportionate treatment* and *disparities* refer to disparate or inequitable treatment or patterns of service utilization (e.g., in terms of types, quality, availability, and accessibility of services at various decision points). Disparity comparisons are usually made between children of color and similarly situated white children. All told, child welfare has demonstrated a limited capacity to redress the growing number of children of color who are essentially raised by government systems independent of their own families.

Social Justice Perspective

The need for child welfare services has evolved around four forces—social justice, culture, systemic practices, and research (i.e., accountability). A social justice perspective brings into the center of the discussion the very real social concern about the disproportionate number of children of color vulnerable to harm, instability, and insecurity. Social victimization has readily been attributed to negative neighborhood effects, high crime, and exposure to interpersonal and community violence, drugs, crime, and so on that undermine the foundation upon which all children thrive—safety, trust, support, and hope. Child welfare services are fundamentally aimed at restoring these foundational pillars without which no child can survive.

Linked to this discussion are durable inequalities, almost exclusive to families of color that prevent their social and economic mobility. The long-standing achievement gap remains a serious impediment to basic social welfare. The social consequences accompanied by poverty, inadequate access to resources, and the like have strong correlates to child maltreatment. A social justice perspective, within the context of unequal distribution of power (and privilege), draws attention to an ongoing societal racialization that has historically disadvantaged some and advantaged others in ways separate from but intersecting with class and other social identities. A social justice perspective argues that the overrepresentation of children of color quite possibly reflects social barriers and obstacles that impair parents' ability to raise their children in a home and neighborhood environment free from the imposition of stress and strain that interferes with their efforts to develop and maintain a nurturing environment.

As the need for public assistance increases, so, too, does the likelihood that dependent families increase the scrutiny and intrusion that goes along with asking for help. In this sense, child welfare services are an unanticipated consequence of general helping that allows access into the homes of the most vulnerable, perhaps fostering perceptions of need.

Cultural Perspective

A cultural perspective challenges the field of child welfare to consider the parenting practices of families of color not as pathological child caring, but as some combination of best cultural intentions and culturally specific safeguards against being consumed by other social control forces. For example, parenting practices that do not conform to mainstream child-rearing practices are often consistent with values, beliefs, and attitudes unique to culturally different families. These families may further implement disciplinary practices targeted at safeguarding their children from either cultural assimilation or engaging in behaviors inconsistent with their cultural upbringing and for which there are even harsher social consequences. For cultures that are impassioned by their family bonding, it is hard to imagine a worse consequence than to lose a member to social forces that are perceived as adversarial, prejudiced, and operating outside their control. Overall concerns have been repeatedly expressed about the lack of appreciation of cultural differences in expressions, family decision making, and distributing consequences for breaches in cultural expectations.

A cultural perspective argues that child welfare services must promote more open discussions about differential parenting responses that may be embedded in cultural beliefs. More open dialogue with families about their cultural views on discipline is argued to engage families more in the helping process, reshape perceptions of cultural practices that might otherwise be misperceived as abusive or neglectful, and ultimately promote relevant services that are applicable to the families receiving these services. A cultural humility perspective is called for to support the consideration that if families are seriously considered as having an essential role in raising their children, then workers must weigh more heavily the power imbalance imposed on such families, especially in regard to cultural matters about which these families are far more knowledgeable. Engaging families can also serve to educate the child welfare workforce about the cultural values and beliefs parents hold regarding child raising.

Issues of Concern

Child welfare system responses themselves have, since their inception, warranted attention from initial reporting through to the eventual case closing and beyond. Concerns raised in the literature call on research to better understand ambiguities in assessment, maltreatment substantiation, and decision making about who to remove or leave in their own home. The child welfare "system," other systems, larger policy enactment, agency procedures, and caseworker decision making have also garnered extensive attention in discussions of discrepancies in child welfare practices, particularly when focused on children of color. System-response concerns include differential criteria for maltreatment substantiation, rationale for placement of children of color outside the home and into less desirable environments, differential duration of out-of-home placement, differential referral to the juvenile justice system for behavioral problems, referral to inadequate public-sector social services rather than utilizing private-sector agencies, and lack of in-home or other support services.

In terms of service delivery, concerns have been raised about the range and quality of services, service availability and accessibility, and ongoing support and resources for families living in their own communities, designed to prevent further child maltreatment. Additional challenges include the low number of adoptive homes and other permanency options; older youth aging out of the system without adequate preparation, life skills, or resources to sustain themselves; high need for special services; and other barriers and obstacles that maintain children in the child welfare system of care.

Child welfare services are further complicated by large caseload size and inefficiency in caseload management, high caseworker turnover, caseworker bias, insufficient professional training, systemic assumptions governing caseworker-family matches, lack of linguistically proficient staff, poor or nonexistent interpreter services, and inaccessibility of other health and human services (e.g., substance abuse treatment). Social policies favoring placement rather than family preservation, promoting termination of parental rights over reunification, and sanctioning financial incentives for nonkinship rather than kinship connections reflect larger, institutional forces that complicate a holistic understanding of child welfare services and their limitations.

Quality of Research

The quality of research sheds additional light on the number of children of color receiving child welfare services. Critiques about child welfare research focus on the low quality of data, nonexistence of data, limited geographical scope of studies, lack of comprehensive nationwide studies, ambiguous findings, methodological differences in measures and units of analyses, combining different sources of data (i.e., mixing findings from administrative or cross-sectional data with longitudinal data), insufficient population size, and inadequate analytic strategies. The use of race as a categorical variable rather than considering racial and cultural meanings associated with race (or ethnicity) is problematic. Viewing children of color, in general, as homogeneous groups is in itself problematic because generic race or ethnicity categories fail to differentiate these children according to ancestry, language, geographic region, economic and immigrant status, generation, and other important sociodemographic characteristics. Moreover, in many state and national reports, categorizing racial and ethnic minority children ignores the increasingly biracial and multiracial ancestry of these groups of children. This lack of clarity and relative diffusion pose a serious challenge to the child welfare system's ability to accurately count and account for the growing number of racial and ethnic minority children in its care.

In terms of maltreatment definitions, the lack of common definitions across states compromises a fuller appreciation of national data since the metrics for operationalizing child maltreatment types differs. Finally, concerns regarding data reporting, summarizing, and outcome dissemination focus on assumptions about within-group differences of racial and ethnic groups, lack of acknowledgement of variation of family contextual functioning, failure to account for race or ethnic-specific dynamics (e.g., recentness of migration and geographic location), culturally and linguistically biased data collection instruments, and other problems that have been leveled to either discredit or deem suspect causal explanations and implicit assumptions about race.

As funding remains scarce, more and more intersystem efforts are underway inclusive of child welfare, juvenile justice, mental health, health, and education. This joining is not without additional complications since tracking procedures, data management, constituencies needing specific information, and the like greatly influence what data is reported and for what purposes.

Conclusion

Child welfare service challenges are clearly multiple and difficult to disentangle. Few experts would disagree that there needs to be an alignment of the multiple, intersecting perspectives about child welfare. The cumulative effects of disadvantage, cultural influences, systemic assumptions and possibly capricious decision making among service providers, and research challenges are all implicated as barriers to change in a system that has far-reaching importance in the lives of children in need. It is likely that the future will hold even more complications in terms of child welfare needs as human trafficking, cyberpredation, the reduction of sexual mores that increasingly expose children to vulnerable social situations, immigrant children, and so on must all become part of the anticipated change in service needs with greater implications for relevant service delivery.

Child welfare services is called on to engage in a more comprehensive approach that is more inclusive of the child and family voices upon whom these services are applied. Clearly, services inclusive of a focus on the welfare of the child that engage the multiple child service constituencies have far more value to family preservation than current efforts that arise only when families are in trouble. The true test of the nation's commitment to children and families will be in efforts to undertake the kinds of reforms that encompass the foundational pillars of safety, trust, support, and hope of all children, and when any of these pillars are breached, serious efforts are undertaken to restore these pillars—to restore these children and families as a public commitment and promise.

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See Also: Adolescent/Youth Services, Overview; At-Risk Youth Services; Biracial Children; Child Abuse/Neglect, Victims of; Child and Adolescent Needs and Strengths; Child Support Agencies and Services; Child Welfare League of America; Children, Youth, and Human Trafficking; Children in Foster Care; Children of Incarcerated Parents; Children of Substance Abusers; Children of Undocumented Aliens; Children With Special Needs; Children, Youth, and Human Trafficking; Kinship Care; Kinship Care, Cultural Aspects of; Mental Health Services, Children; Protective Services for Children.

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Childhood Trauma

It is estimated that in 2011, around 676,000 children were victims of abuse and neglect. Of this number, approximately 21percent of the children were African American, 22 percent were Hispanic, and 43 percent were white. Moreover, 26 percent of children in the United States will either experience or witness a traumatic event before they reach the age of 4, according to the National Center for Mental Health Promotion and Youth Violence Prevention. The Centers for Disease Control and Prevention conducted a study that revealed a link between childhood trauma and adult onset of mental illness, violence, and chronic onset. Childhood represents a significant period of development because it is the time children learn how to cope and receive guidance and nurturing from their parents or guardians. Children represent the population at the highest risk for being impacted by trauma, especially trauma occurring sometime during childhood. The topic of childhood trauma has largely been neglected in the literature, thus making the understanding of how children are impacted across their development largely unstudied. When trauma occurs in childhood, problems or behaviors that manifest are due to the traumatized child attempting to alleviate their distress.

Though many children have stressful experiences in childhood, such as a death of a loved one or divorce, these experiences are not considered traumatic in nature. "Trauma" is defined as an event that is sudden or unexpected that poses a threat to the child's life or body integrity and gives the child the feeling of intense terror, horror, and/or helplessness. Examples of childhood trauma include but are not limited to child sexual abuse, physical domestic abuse, neglect, natural disasters, man-made disasters, and life-threatening illness. Whether a child will have difficulty adjusting following trauma is dependent on the child's developmental level, ability to cope and foster resiliency, sources of familial support, social support, and environmental support.

Trauma Impact and Symptomology

All children process traumatic events differently; thus, each child presents a unique set of symptomology in reaction to that trauma. A child can be stunted in their developmental stage and unable to transition into adulthood, while another child can transition into adulthood with minimal manifested symptomology. Factors that determine how a child mitigates the effects of childhood trauma are the emotional, social, and physical resources that are available to the child. Another factor that determines how children process traumatic events is their parents' reaction to the traumatic event. If the parents are coping well (i.e., good coping skills and resilient behaviors) the child is more likely to model that behavior and develop coping skills and resilient behaviors.

Trauma symptomology encompasses the behavioral, physical, emotional, and cognitive difficulties that manifest for the child following the traumatic experience. Some children after traumatic experiences may begin to see themselves, their surrounding environment, and the people in their environment differently. Children who have experienced traumatic events sometimes exhibit a fear of being separated from their primary caregiver, clinginess, loss of previously accomplished developmental skills, and sexualized behaviors that are not age appropriate. Affective symptomology includes depression, fear, anger, and mood changes. Behavioral symptomology includes avoidance, modeling, aggression, and destructive behaviors. Some cognitive symptoms include distorted cognitions and irrational beliefs.

Post-traumatic stress disorder (PTSD) is also associated with childhood trauma. Symptomology occurs in three clusters: reexperiencing, avoidance, and hyperarousal. Reexperiencing involves having intrusive thoughts or dreams about the traumatic event. Oftentimes the reexperiencing is expressed by children by reenacting the traumatic event via play or experiencing psychological distress when exposed to reminders of the traumatic event. Avoidance behaviors and emotional numbing refers to the child avoiding situations, people, and places that are reminders of the traumatic event. The child can present detachment and a flat affect that speaks to the emotional numbing that can occur following a traumatic event. Hyperarousal symptomology associated with PTSD includes angry outbursts, irritability, startle reaction, hypervigilance, and sleep disturbance.

Resilience as a Factor

Some children after experiencing a traumatic event are resilient and are able to lessen the development of any long-term effects of childhood trauma.

Resilience refers to a child's ability to positively cope despite the trauma. In order to be deemed resilient, the child has to have been exposed to a significant traumatic event and have a positive outlook and coping skills in spite of the trauma. Factors that determine whether a child develops resiliency include a strong support system, the parent–child relationship, the child's temperament, and the child's cognitive ability.

Treatment

Common treatment strategies for childhood trauma include cognitive behavioral therapy, expressive therapy, narrative therapy, trauma-focused therapies, and psycho-educational treatments. Treatment of childhood trauma requires that mental health professionals remain cognizant that children must be conceptualized within the social, contextual, and familial systems in which they live. Additionally, clinicians must be mindful that each child experiences trauma and its related stressors differently, thus the treatment provided must be tailored to the specific child. It is imperative that clinicians treating childhood trauma be aware of any cultural bias they might bring in therapy selection, assessments, and interventions to ensure that they are using therapy and techniques that are most beneficial to the child to whom they are providing treatment. Children impacted by traumatic events should not be looked at as if they will always be impacted by the stressors caused by the trauma, but rather that there are ways to lend support to aid in managing and overcoming the traumatic stressors.

Culturally Responsive Services

In order to work effectively with diverse children populations impacted by trauma, it is imperative those providing services operate through a culturally responsive lens. Helping professionals must take into account the role of culture, family, race, and ethnicity in the child's coping mechanisms following the traumatic event. To provide interventions to which the child is responsive, it is also important to incorporate the child's culture, family, and all the systems of which the child is a part when selecting the best treatment options and understanding the issues that arise following the traumatic event.

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See Also: Abuse and Neglect; Child Abuse/Neglect, Victims of; Domestic Violence, Victims of; Trauma-Focused Services.

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Children, International Variations in Attitudes Toward

Several theories refer to global, cultural, and socioeconomic conditions among the critical causes responsible for the international variations in people's attitudes toward children. Factors leading to comparable or diverse patterns of attitudes on this subject include such variables as gender, age, marital status, education, employment, and religiosity. Furthermore, the essential role of the family is generally recognized as the prime factor fostering positive or negative attitudes.

Positive attitudes toward children indicate that children are not only a source of joy, but also essential (central) to people's cultural, social, emotional, and economic lives. People who have children are generally considered happier than childless people. People with negative attitudes view children as problematic or as noncentral to their lives (e.g., a drain on economic resources or difficult to find time for within busy work environments and responsibilities).

Using material from a study conducted in 1988 of six European countries (Austria, Great Britain, Ireland, Italy, the Netherlands, and the former West Germany), researchers found that Europeans do not share common attitudes toward children. Within these countries, however, three characteristics were identified as being related to positive attitudes: traditional attitudes toward women's roles, lower levels of education, and the joint experiences of marriage and parenthood. There are some variations across nations in the overall level of support for the centrality of children. For example, while Italians and Austrians held the most favorable attitudes toward children, Dutch respondents showed the least favorable attitudes. The responses for West Germany, Ireland, and Great Britain fell somewhere in between these opposing attitudes.

Regarding gender, women held stronger beliefs than men in considering children as essential or central to their lives. Concerning marital status, although married people with children, regardless of gender, exhibited more favorable attitudes toward the centrality of children than never-married, childless people, there were certain variations in the six European countries. For example, in only two countries, Ireland and the Netherlands, did persons who were married with children and those who were married without children express higher levels of support than never-married, childless respondents.

However, marriage did not affect individual orientations toward children in Austria, Great Britain, Italy, and West Germany. On the other hand, the lack of religious orientation had a negative impact on attitudes toward the centrality of children in all six countries. For example, in Great Britain, Italy, and the Netherlands, individuals who did not adhere to any religion were significantly less likely to view children as central than persons who identified with a specific religion.

Studies dealing with attitudes toward children in seven eastern European countries divided the countries into three groups, with the former East Germany being the most egalitarian country, Bulgaria and Hungary being the most traditional societies, and Poland, Slovenia, Russia, and Czech Republic falling on the continuum between them. In these studies, people who had traditional views about family and gender roles, and who considered marriage as being important for their happiness and security, held positive attitudes toward children and viewed them as being a central part of their lives. These studies pointed out that Bulgarians and Hungarians have the most traditional and favorable attitudes toward children, while former East Germans and Russians view children less favorably than people in the other countries being studied. It is interesting to note that traditional attitudes toward children in eastern Europe are similar to those in two southern European countries, Greece and Italy.

Results from another comparative inquiry of attitudes toward children in six Western societies (Austria, West Germany, Great Britain, Ireland, the Netherlands, and the United States) maintained that older people, advocating traditional forms of marriage, hold positive attitudes toward children. The elderly viewed children as more central to their lives than did younger adults. In these six countries, individuals who were unmarried, better educated, employed, and less religious experienced changes in attitudes toward children and held less favorable or less traditional views about them. Similarly, in Croatia (at the crossroads of central Europe, south Europe, and the Mediterranean) work- and success-oriented women, impacted by urbanization, do not perceive children as a joy and decline to submit to social pressure to have children.

A survey on attitudes concerning the statement that "people without children lead empty lives," showed that support for this statement declined gradually between 1988 and 2002 in Great Britain, the United States, and Ireland. American women were more accepting of childlessness and, therefore, viewed children as less central. British and Dutch women held lower levels of support than men for the centrality of children.

Traditionally and despite social pressure for married couples to bear children, people living in Arab countries show sincere affection and positive attitudes toward their offspring. Although there are many differences among Arab countries, people share a common perception that children are God's beloved beings (*ahbāb Allah*). Arabs, both men and women, deeply love children and express that love openly. To display this love, parents and relatives frequently communicate and interact with children, kissing and hugging them and gently tapping their heads and shoulders. It is a common practice that when Arab persons meet parents accompanied by their children, they say, "May Allah protect and keep them for you." The centrality of children to Arab people is reflected in the fact that parents support their children financially and socially, even when the children grow up and become adults or get married.

In Japan, children have become a high-priced commodity. It is not only expensive to have children in Japan, but the cost of educating them obliges parents to limit their number of offspring to two. Japanese fathers have little time to converse with their children on a daily basis; 37.4 percent of fathers interviewed stated they had no contact at all with their children during the working week.

Both Arab and Japanese parents view and want their children to be obedient, docile, well brought up, and emotionally mature, while American parents encourage their children to display qualities of independence, autonomy, and leadership. Unlike Western people, Arabs use an informal but polite and respectable way to address parents or people who have children by using the term *father* or *mother*, followed by the name of the oldest child. For example, a father whose eldest son is named Kareem is addressed as *abu Kareem* (father of Kareem), while the mother is addressed as *umm Kareem* (mother of Kareem). Most Arabs desire to have children, especially male children, to enhance their social status and to have someone to help them when they grow old. However, in Japan parents have no guarantee that their children are going to look after them in old age. A study conducted by Japanese researchers in 1997 examined six countries (Japan, the United States, Great Britain, France, Thailand, and Korea) and concluded that Japanese parents did not want to be dependent on their children, but they nevertheless hoped to live with them one day.

Understanding international variations in attitudes toward children helps people recognize not only the richness of human experience, but also certain patterns of people's behavior. For instance, while in Austria or France the principal motivation for having a child is to enjoy child-rearing, in Japan having children arises from a sense of duty to society or the family rather than being considered a pleasure in its own right. Based upon these various studies, it is evident that worldwide attitudes toward children have changed considerably in the last few decades, augmenting international variations in these attitudes.

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See Also: Child Support Agencies and Services; Child Welfare League of America; Child Welfare Services.

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Children, Youth, and Human Trafficking

Human trafficking is trade in humans, whether through force, persuasion, or misrepresentation. It is not to be confused with human smuggling, which is the illegal transportation of people across national borders without proper immigration procedures, but often it includes smuggling. Smuggling is a crime against the state; trafficking is a violation of human rights. Trafficking has the end goal of putting the trafficked victims to work, either in forced labor or especially as prostitutes; human trafficking for the purposes of organ theft or forced surrogacy are rare but noteworthy exceptions. The victims of human trafficking are often children or young adults, forced to work in brothels. The United Nations (UN) protocol concerning human trafficking is the Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, part of the 2003 Convention Against Transnational Organized Crime. (Trafficking is also explicitly condemned in other UN documents like the Universal Declaration of Human Rights and the Convention on the Rights of the Child.) In 2010, human trafficking revenue was estimated at about 5 percent of all illegal international trade revenue. About a third of trafficked victims are under age 18. Though reports often indicate that many victims of human trafficking are Americans, this is largely a reflection of the chaos and uncertainty faced in developing nations where many victims originate, and which makes it less likely for them to be reported as missing or abducted.

Human trafficking into the United States is unfortunately common. The I-10 corridor is the major trafficking route in the United States, according to the U.S. Justice Department. The highway runs from one coast to the other, connecting numerous southern cities like Los Angeles, Houston, San Antonio, and New Orleans. One of the largest originating cities—cities where international traffickers first arrive with their victims before leaving for other parts of the country—is Wichita, Kansas. Cities near major airports often see human traffic passing through but can also be destinations for victims of human trafficking who have been forced into sex work, due to the demand for sex workers associated with business travel, national and international conventions, and major sporting events.

Victims of trafficking may be forcibly abducted, threatened with force or harm to their family, coerced by playing on their vulnerability (especially in the case of children), or simply tricked into being smuggled into another country, thinking they have secured a legitimate job—in many cases, even thinking they have legitimately immigrated—only to discover that the employment waiting for them is as a forced sex worker. In some cases the victim even paid fees for the trip and for fake passports, work permits, or other documents, defraying the operating costs of the trafficker. In other cases, the victim may incur debt to the trafficker in return for the victim's passage to the new country, resulting in the need to work the debt off through bonded labor.

Common in the past—this was the way many Asian Americans came to the United States in the 19th century, for instance—this is an infrequent arrangement today. Forced labor under threat of violence (to the victim or the victim's family) or exposure to immigration authorities is more common, especially for male victims, who may be put to work in sweatshops, factories, or farms, though forced laborers are also found in the service industry and domestic service. In recent years, the International Order for Migration has found an increase in forced labor by human traffickers, which in 2010 exceeded for the first time the number of human trafficking victims trafficked for sexual exploitation.

The International Labor Organization estimates that 1.2 million children are trafficked every year. Children are trafficked for purposes including sexual slavery (whether as prostitutes, for child pornography, or as brides in early marriages, especially in cultures where that is traditional), labor in the illegal drug trade, to serve as child soldiers, and as part of the illegal international adoption trade, particularly in the case of infants. Children may be abducted or may be purchased from parents, which makes the trafficker's work easier. Some critics of international adoption find the line between legal and illegal adoption to be a fine one at times, as when an adoption agency is negligent in ensuring that the child was legally given up for adoption by his/her parents, or when children with missing parents are presented as orphans and adopted accordingly (when, in fact, natural disasters and political instability can make it exceptionally difficult to find people and result in parents and children being separated).

In cases where a country's government and infrastructure have regularly proven unable to regulate the adoption industry and prevent illegal adoptions, countries on the receiving end of adoptions—usually the United States and western Europe—have suspended international adoptions from that country. Nepal and Guatemala are notable examples. Activists have also called for suspension of adoptions from Cambodia and Laos, and several organizations called for a halt to adoptions of Haitian children after the 2010 earthquake, due to the tendency of traffickers to exploit such periods of chaos.

In poor states, children may be purchased for as little as $20, and when sold into slavery in other countries, may command prices as trivial as $350. Forced labor remains one of the prime motives for trafficking children. Child slaves abducted or bought from African countries have been used on cocoa, cotton, and coffee farms in Côte d'Ivoire since the late 1990s at least, and in the early 2000s several authorities estimated that 15,000 trafficked children were thus used. Some had been beggars who were abducted and forced to work. Others had been sold by their families or sent to the farms to work with the intention of sending remittances home. Many were from Togo, Burkina Faso, and Mali. New agreements in the cocoa industry have been adopted in response to the negative publicity, but child labor continues to be used both in it and other African agricultural industries. Trafficked children have also been known to work in mines,

38 Degrees, one of United Kingdom's largest campaigning communities, joined with Anti-Slavery International and the Independent *in 2011 to hand in a more-than-45,000-signature petition to the British prime minister's office. The petition asked the British government to opt into the new Eurpean Union Directive on Human Trafficking, which provides further protection for trafficking victims.*

particularly mining copper for Chinese firms working in the Congo and mining for gold in Mali, and in factories for the textiles and clothing industry, which is how the incredibly high demand for clothing is not matched by equally high prices. Most child laborers are between the age of 5 and 14.

Sex work is another common motive for human traffic. Despite efforts to end the practice, the law often lags in this area. For instance, though the U.S. Supreme Court has held that because children cannot legally consent to sex, they cannot be party to the crime of prostitution but rather only its victims, children under age 14 cannot be prosecuted for prostitution. But the court extended this protection only to young children. Adolescents age 14 to 18, who are minors, may still be prosecuted and may not seek help out of fear of being arrested themselves.

Contrary to popular assumption, as many boys as girls are abducted for sex work. Once sold by the trafficker, children sold into sexual slavery usually do not work for a traditional pimp but rather for an older and more experienced child who is also a prostitute and has secured living arrangements. While most customers are older, wealthy white males, surveys of child prostitutes have found that about half the boys and a tenth of the girls have also served female customers, sometimes exclusively. Women also make up about a third of traffickers.

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See Also: Abduction; Adolescent/Youth Services: Overview; At-Risk Youth Services; Child Protective Services; Children, International Variations in Attitudes Toward; Human Trafficking.

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Children and War

Wars always create victims, but children are especially vulnerable and need special human services to address the traumatic experiences of war. Experiences can differ from case to case, as children, especially those involved in conflicts in postcolonial Africa, are used as child soldiers; become homeless and have to flee from their native towns or villages; or are victims of rape, which became an instrument of war in Rwanda and the Democratic Republic of the Congo. During the recent civil wars on the African continent, more and more children were recruited to serve in rebel forces and militias, and over 20,000 children had to flee during the Second Sudanese Civil War (1983–2005), becoming known as the Lost Boys of Sudan. Even today, Congolese children are being victimized by rape, which emerged as an instrument of war during the civil war of the Hutu against the Tutsi in Rwanda.

Child Soldiers

The idea of using children as soldiers is neither modern nor did it originate in Africa. In previous centuries, armies recruited young males when there was danger or a lack of adult soldiers. This phenomenon occurred globally. During World War II, boys were recruited by the Red Army in the Soviet Union as well as by the Nazis, who wanted to mobilize their last remaining forces—the so-called *Volkssturm*—to prevent an occupation of Germany. With the end of World War II and Europe‘s long-lasting period of peace, children were no longer part of European armies.

However, with the decolonization in Africa and Asia, more and more children were forced into the newly formed rebel armies as a consequence of the postcolonial ethnic conflicts in several countries. Even when the United Nations General Assembly adopted a treaty to prohibit the use of children (under the age of 18) in combat, in 2000 there were still countries in which children were fighting as soldiers. These children, mainly young boys, are manipulated into joining the conflict and are given a weapon to fight for their adult leaders.

During the First and Second Congo Wars (1996–97 and 1998–2003), child soldiers were recruited and are still being recruited as a consequence of the ethnic conflicts within Congolesian society. Many rebel groups, such as the Mai Mai Bakata-Katanga,

The Jowle Camp in September 2013, in Garowe, Somalia, was created in 2011 for the displaced refugees of the Somalia Civil War. It is estimated that over 10,000 refugees live here, mostly women and children who lost their family members in combat. Before the camp opened, displaced Somalis were spread among smaller settlements around Garowe.

whose members are active in the province of Katanga, continue to recruit boys between the ages of 8 and 17 into their troops to fight against the province's secession. Girls are also forced to join the rebel forces.

Lost Boys of Sudan

In contrast to children serving as soldiers, children more often become victims who are forced to leave their homes and flee from the cruelties of civil war. The Lost Boys of Sudan is one of the most well-known examples of these types of victims. Over 20,000 young boys who belonged to the ethnic groups of Nuer and Dinka were forced to leave their homes during the Second Sudanese Civil War. They fled with, or in case of their parents‘ death, without their parents to international refugee camps, where they got their name from aid workers. For most of these children (who were girls as well as boys, even if the name suggests otherwise) the Sudanese Civil War laid the ground for a diaspora, which did not end until 2005, when many of the former children returned to Sudan to help rebuild the country, although their hope for a better future remained unfulfilled. More recently, as a consequence of the battles after the secession of South Sudan, children of the border region of Sudan and South Sudan were forced to flee in fear of becoming victims of the area's new civil war. These children feared being killed in the violent conflict or being raped by soldiers, as systematic rape had become an instrument of war, especially on the African continent.

Rape as an Instrument of War

During the civil wars in Rwanda and the Democratic Republic of Congo, rape became a systematic weapon used against the enemy. The Tutsi in Rwanda used rape as a weapon against the Hutu, employing a kind of mass sexual violence as a means of weakening their opponents. An environment was thus created in which rape became an acceptable procedure with which to fabricate a strong community of rapists, which favored the ruling ethnic group. These practices were introduced to the Congo from Rwanda when different groups entered the Congo to fight over Congolese raw materials. As of 2013, about 15 different ethnic groups were involved in the combat, seeking to destroy opposing ethnic groups. Sexual violence against women or systematic rape is one way to achieve this aim, because rape diminishes an opponent‘s strength. Rape not only harms the victim, but also harms the entire opposing society, which is weakened by this act of sexual warfare. For this reason, it is commonly believed that Hutu militia, who fled from Rwanda, introduced the war practice of rape into the Congo. Many women and girls are now suffering from this practice, which has been adopted by different rebel groups that are active in the Congo today.

As a consequence of their traumatic African civil war experiences, child victims of these conflicts are in need of special human services, no matter if these children were recruited to kill people of another ethnic group, orphaned and forced to flee from their homes, or victims of systematic rape. No matter what their experience, they are still children and need help to overcome their traumatic memories. With children as the victims of conflicts in Mali, Sudan, the Congo, and Syria, this problem is very grave and of the highest importance.

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See Also: Child Abuse/ Neglect, Victims of; Childhood Trauma; Children With Special Needs; Colonialism, Lingering Effects of; Diaspora; Displaced Persons; Hate Groups; Rape as an Instrument of War.

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Children in Foster Care

The current U.S. fosterage system emerged from early child welfare reformers who witnessed the brutal impact of 19th-century poverty on poor, orphaned, half-orphaned, neglected, and abused children. In urban areas these children grew up on the streets, fending for themselves, or were placed in crowded, poorly staffed, and poorly funded orphanages. Institutional life was intentionally harsh. Routines and norms, guided by fiscal efficiency, sought to reform children out of poverty and produce a working class that could provide manual or domestic labor in a growing industrial economy. While middle- and upper-class children were imbued with sentimental value, poor children had instrumental value. Thus, their care and their care needs were seen through an economic lens.

Cognizant that the poor conditions of institutional care failed to produce the kind of workforce envisioned, Charles Loring Brace and other “child savers” asserted that these children’s need for labor could benefit rural families. The result was orphan trains, which transported children from urban areas to the U.S. farm belt, where they were added to farm families as dependents, but paid for their care through their labor. From its inception, children entering U.S. fosterage fell outside middle-class ideals of sentimental children emerging from intact nuclear families. This difference continued through the 19th century but began to shift in the 20th century, when changing child labor laws and increased industrialization led the way to cultural ideals extolling women’s noneconomic domestic labor, a nuclear male-headed family, and children’s decreased instrumental value. Consistent with these ideals, the 20th century saw a shift in the locus of the problem from homeless, abused, or neglected children as a threat to the social order that needed reform, to children as victims of their parents’ circumstances who needed protection. This shift intersected the professionalization of child welfare workers mainly through nongovernmental-sponsored agencies and the emergence of casework. Professional caseworkers were charged with assessing risk, protecting children, and monitoring their care through fosterage.

Fosterage initially was considered a substitute family that could socialize children and convert their social difference through love and nurture. However, as foster care became an economic activity commercializing the ideal of a mother's love and nurture, foster families themselves and foster mothers fell outside the ideal of family life. This is important because it established foster families as a board and care service and social workers as the real experts in assessing and providing for children's needs. "Best interest of the child," a phrase echoed in much of the literature, is assessed through the lens of professionals. While family care is privileged to institutional care, "family" is steadfastly defined in policy and practice as a legal or blood relationship and children's needs are defined through their need for kinship and permanence. Fostering is a short-term solution to a child's care but not a "real" family. Foster parents are licensed and regulated by the state and their care is categorized according to the service they provide (e.g., short term, long term, therapeutic care). Kinship through foster care is only seen as possible through adoption, and long stays in foster care are deemed deleterious to a child's development.

Contemporary Discourse and Themes

Throughout the 20th century children's needs and experiences in abusive or neglectful families was the center of discourse through voluminous studies on the impact of trauma, separation, lack of nurture, issues with attachment, and family disruption. The assumption upon which the majority of these studies lies is that children require very particular familial environments in order to thrive. This includes routine, constancy of caregivers, physical and emotional safety, and an environment that is attentive to their physical and emotional development—all constructs that ultimately privilege an idealized nuclear, middle-class family form and function. The dominant discourse finds the intersection of poverty, chronic neglect, abuse, and trauma artifacts of poor parenting and family dysfunction. Through this lens children in foster care require specialized behavioral psychological intervention rather than reform or nurture.

The emphasis of contemporary child welfare social work is reuniting biological families or releasing children to new families through adoption. Thus, part of all casework with children entering care is some form of permanency plan. This means that casework also extends to working with children's families of origin to help them conform to social child-rearing norms. Kinship care emerges as a central theme of 20th century discourse, premised on the belief that a child's care is improved and their chances for a successful placement are increased by finding a blood or legal relative to provide care. Non-biologically or legally-related foster parents are not considered kin, and a disjuncture emerges between the work of foster parenting as foster parents construct it, which is to provide love, nurture, and care to children, and state-sanctioned policy and social worker practice to find a "real home" for children. Few foster care studies include foster parents' subjectivities and instead focus on the children in care. When foster parents are included in the literature they are discussed in terms of their utility to social workers. This includes their grief responses, parenting styles, training needs, and retention patterns.

Failures in the Foster Care System

Most analysts agree that the current foster care system is in crisis stemming from an increased number of children who need placement, the chronicity of family issues requiring children to stay in care longer, a shortage of foster and adoptive families, and burgeoning social worker caseloads. In short, the system's demands far exceed its capacity. Conditions that lead children to foster care have not received adequate policy or practice attention, and funding for prevention or rehabilitative family work has been dramatically cut, leaving complex social problems to become entrenched and endemic.

Additionally, long-term studies of children who emerge from foster care suggest that they suffer lasting developmental delays and experience psychological damage resulting in poor employment, educational, and life satisfaction outcomes. This is systemically induced as children experience multiple placements without benefit of long-term relationships that promote emotional attachment. Most child welfare professionals call for broad policy changes that can reform the way foster care is administered and the ways in which families receive service. While there are pockets of innovation, such as better diagnostic tools to help social workers determine who needs care, or children's villages that attempt to provide a permanent home and keep siblings together, the basic paradigm for care has not changed substantially.

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See Also: Adoption and Foster Care Analysis and Reporting System; Aftercare Services for Children Aging Out of Foster Care; Child Welfare Services; Foster Care Agencies; Fostering Connections of Success and Increasing Adoptions Act of 2008; John H. Chaffee Foster Care Independence Program.

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Children in Special Living Arrangements

Children around the world are being raised in various socioeconomic, technological, and cultural contexts that account for tremendous variation and shifts in children's living arrangements. In addition to living with their biological parents, children can be found in various other traditional and nontraditional special living arrangements.

Unwed parents continue to be one of the largest contributors to children in special living arrangements, that is, single-parent homes. However, there are changing cultural norms related to sexual behavior and family formation that increasingly denote the single-parent household as common, normal, and adaptive compared to other more dysfunctional arrangements where both parents are present (parental discord and physical violence). Increases in pregnancies outside marriage and decreases in the urgency to marry have both increased the chances of a child being born outside marriage and into a living arrangement with a custodial parent. After the child is born, the living arrangements for the child commonly may or may not include both parents or either parent, this decision being determined based upon cultural traditions and beliefs.

On average, those who have children out of wedlock are younger and less educated and have lower yearly income compared to parents who are married. As a result, the children of parents who are unmarried are more likely to live in poverty and have poor developmental and educational outcomes. Adolescents living with single unmarried mothers are more likely to experience greater delinquency and lower grade point averages than those living with cohabiting stepparents. Additionally, research has found that children who live in nontraditional households (single parent, stepparent, no parent) are more likely to have unhealthy eating habits. The above research suggests that relationship dynamics may play a role in academic and health outcomes of children.

Divorce also contributes to children living with a custodial parent or in a special situation with a stepparent. Blended families are often a by-product of the remarriage or cohabitation of partners who both bring children from previous unions or the combination of children from both previous and current relationships. Notably, 16 percent of all children live in a blended family.

There are racial, ethnic, and cultural differences in the likelihood of a child living in a special arrangement. According to information from the U.S. Census of 2011, black or African American unmarried women had the highest percentage of births at 67.8, and unmarried Asian women had the lowest percentage of births at 11.3. Hispanics make up a large part of new immigrants in the United States. Immigration may affect the kind of household children grow up in, as other relatives living in the home may provide an extended household arrangement.

There are many reasons why biological parents may not be the primary caregivers for a child. Parental mental disabilities, physical disabilities, drug abuse, and military duties are a few of the reasons children may end up in special living arrangements. Children may also be removed from the homes of their biological parent or parent due to sexual, physical, or emotional abuse or neglect. Oftentimes, these children may live with their grandparents or other relatives or with nonrelated adults such as foster parents, adopted parents, the families of their friends, or people associated with their parents. This can be difficult for a child to process; however, it may be a better environment than the child's parents would be able to afford. Many grandparents step in to fulfill the roles of parents for their grandchildren due to the biological parents' incapacities. It has been shown that psychological distress among grandmothers can predict behavior problems of children.

Nonrelatives including but not limited to stepparents, adopted parents, and foster parents are also responsible for the care of many children. When a child's biological parents are unable to take care of the child due to any of the reason listed above, the child may be adopted or placed in a foster home. Adoptive and foster parents make up a smaller percentage of homes raising children in a special living arrangement. Because there are more children in need of an adoptive or foster home than there are prospective adoptive or foster families, other viable options are explored for homes for these children. Some children are placed in foster homes or adopted by families of a different race and some children are adopted by gay and lesbian couples. Some gay and lesbian potential adoptive or foster parents are faced with seemingly unjustifiable obstacles in their efforts to adopt or foster a child. These obstacles exist despite a body of research suggesting that the personal and social development of children of gay and lesbian couples is not compromised when compared to children of heterosexual parents. In fact, the qualities of family relationships may be more important than the sexual orientation of parents.

Multigenerational families provide another special living arrangement for children. Children are living with relatives other than their biological parents, such as grandparents, aunts, uncles, siblings, and cousins. Also, as a result of the development of adaptive strategies of multigenerational families such as role flexibility, children in this special living arrangement often develop an ancestral worldview, biculturalism, and come out of the environmental trials of ethnic stratification status. The developmental outcomes of and sensitivity to cultural gaps are enhanced for ethnic minority children in this type of living arrangement. This is aided by the adaptive strategies geared toward the child-rearing goals of positive thoughts and feelings about the ethnic group and socialization for interdependence.

Living with a nanny as one of the primary caregivers is yet another special living arrangement for some children. When examining this type of living arrangement, different aspects of many other living arrangements may come into play. A nanny most often is a nonrelative paid to provide care for a child or children. This person oftentimes is of a different race than that of the child or family and may or may not be of a different culture. Because the child's nanny spends a great deal of time with the child, sometimes more than the parent or parents, the nanny's morals, values, and culture may more likely be instilled in the child and a blending of ideals may occur.

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See Also: Children in Foster Care; Co-Parenting, Cultural Aspects of; Families, Nontraditional; Family Structure, Diversity of.

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Children of Incarcerated Parents

The problems of children of incarcerated parents are of such global concern that in 2011 the United Nations held a general day of discussion to address the issue. The assembled group produced a list of recommendations, the top two being that children of incarcerated parents should have the same rights

The incarceration of a parent often leads the child to face financial instability, changes in family structure, and myriad psychological, social, health, and development problems.

as other children and the best interests of the child must be a primary consideration in all actions that will affect the child when a parent is incarcerated. Nowhere is caring for and protecting the rights of these children more of a challenge than in the United States, which has the highest incarceration rate in the world.

More than half of those incarcerated have children, and over 2 million children in the United States have one or both parents in prison. This number has steadily increased. Over half of the children of incarcerated parents are 9 years old or younger, one-quarter are younger than 5 years of age, and black and Hispanic children have a disproportionately higher risk of having a parent incarcerated. Parental incarceration increases the probability that children will live in poverty and leads to a myriad of psychological, social, health, economic, and development problems. These children have been called the hidden victims because they are harshly punished for their parents' crimes, and their plight goes largely unnoticed.

Special Needs

It is clear that removing children from their parents by means of incarceration has detrimental effects. Research has focused on psychological health, physical health, developmental issues, and social problems for children of incarcerated parents. More men are incarcerated in the United States than women, so more children have a father in prison than a mother. However, research has more often examined the impact of maternal incarceration, as these women are likely to be the primary, and often sole, caregivers of minor children. The literature has shown a higher likelihood of children of incarcerated mothers being moved from one family member to another or being in foster care, creating safety and stability concerns for children and adverse events in these settings. It is clear, nonetheless, that the incarceration of either or both parents creates special needs for their children.

Children of incarcerated parents often suffer one or more traumas. The first trauma often occurs when the parent is arrested in front of the child. According to reports, between 20 and over 80 percent of children witness their parents being arrested one or more times. This event has been linked to elevated risk of post-traumatic stress disorder (PTSD), confusion, and negative emotions, particularly if there was a violent altercation during the arrest. Adults frequently do not explain such scenes, leaving the children to create their own scenarios and explanations. This may lead to further experience of negative emotions and PTSD.

Once removed from their parents' care, children experience the further trauma of separation. More than 70 percent of incarcerated women had at least one minor child living with them at the time of their arrest, so separation from a child's mother is very common. A child's limited contact with his or her incarcerated mother prolongs the separation and creates great uncertainty about when and if the child will see their mother. Children who have mothers in prison are likely to have a father in prison. Having a parent in prison is an ambiguous loss, without closure, which leaves children confused and unsure of their future. Prison visits can be surrounded by stress and emotions by adult family members, which can also create stress for children.

According to attachment theory, maternal separation can lead to long-term impairment, the severity of which can depend on the quality of the attachment, age, and gender. Negative outcomes for children include feelings of resentment, abandonment, loneliness, shame, and anger. A sudden disconnection of their relationship with their parent can also leave children worried about who will take care of them. These concerns are well founded. Children of incarcerated parents may be moved from one family caregiver to another, especially in the case of a lengthy incarceration. These caregivers often experience stress with their new responsibilities. For example, children often live with grandparents, some of whom are not physically able to take on all caregiver roles. In the case of maternal incarceration, research has shown that the vast majority of women have been victims of violence and sexual assault. Therefore, a child in the care of the mother's family may be exposed to the same abuse or to violence. In their new homes children are also at higher risk for poverty.

At school children of incarcerated parents face many significant challenges. The stigma of having a parent in prison can create problems in peer relationships including mistrust, feelings of shame, rejecting friendship with other students, and feeling as though they do not belong. Studies have reported that children and adolescents with incarcerated parents may have decreased interest in academics, earn failing grades, and report delinquency, expulsion, and dropout. They have an increased risk for offending, substance use, and mental health problems. Children of incarcerated parents are also at high risk for health problems. Although studies differ, some research suggests that children of incarcerated parents have twice as many serious health problems as other children. These health problems can also interfere with their academic performance.

Conclusion

Unfortunately, some people focus on the outcomes of children of incarcerated parents as being further evidence of biological bases of crime, with the children being the bad seeds. This belief and the stigma attached to having a parent incarcerated contribute to the unaddressed needs of these children. In recent years, more research specifically looking at the needs of these children has started to emerge, separate from the literature on parental separation and loss and on women in prison. Programs such as U.S. Dream Academy, a mentoring and after-school program for children of incarcerated parents, which served 970 children in 2011, are well received but only serve a small percentage of the children in need. There is still a great need for more research to address this problem, and more resources to assist children of incarcerated parents.

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See Also: Childhood Trauma; Children of Substance Abusers; Families of Prisoners and Ex-Prisoners; Incarceration and Sentencing, Racial Disparities in; Prisoners and Ex-Prisoners.

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Children of Substance Abusers

More than 10 million children under the age of 18 are at risk for both hereditary and environmental effects of parental substance abuse. Genetically, the child of one substance abuser has a 50 percent chance of a biological predisposition to addiction. If addiction is present in both parents, the probability of addiction in their offspring increases to about 80 percent. Substance abusers and their children are high consumers of community resources, accounting for a majority of child welfare cases that cost Americans more than $5 billion yearly.

The children of substance abusers are at risk for physical, social, emotional, cognitive, and behavioral effects of familial substance abuse. The prevalence of substance abuse within any race, ethnicity, or culture determines the prevalence of affected children. Urban areas generally have younger, more ethnically and racially diverse populations than rural areas.

Physical Effects of Parental Substance Abuse

Substance-abusing mothers place children at risk from the time of conception. Alcohol and drug use during pregnancy are associated with miscarriage, premature birth, and low birth weight. Babies who are born addicted to narcotics begin life in need of detoxification. At the time of their birth, these infants may receive specialized medical care, but their needs are ongoing and often require the intervention of the child welfare system for parent education and monitoring to assure that their care continues.

More concerning is the potential for fetal alcohol syndrome (FAS) and other substance-related birth defects. FAS cannot be reversed or remedied and often occurs with secondary conditions that include cognitive disorders, conduct disorders, eating disorders, depression, and psychosis. Implementation of protective factors can reduce the risk of most secondary disorders. Protective factors include early diagnosis, special education, social services, a nurturing environment, and the absence of violence.

During childhood, the children of substance abusers have more hospital admissions for medical problems, which are often related to injuries sustained from physical abuse. Children of substance abusers who are treated for injuries and illnesses should routinely be assessed for mental, emotional, and cognitive disorders. Substance-abusing parents may not follow through with treatment recommendations, so it is important to assess the effects of trauma and begin treatment while service providers have access to these children.

Mental and Emotional Disorders in Children of Substance Abusers

Early in life, erratic and neglectful parenting causes a high rate of attachment disorder in children. Addicted mothers are more likely to abandon their babies or have them removed due to neglect or incarceration. Young children of substance abusers are more likely to be placed in the care of foster parents or grandparents. The ensuing issues are distrust, shame, guilt, anger, and grief. Children who have been removed from their parents need a stable environment with structure and consistency. Most children of substance abusers are at high risk to become substance abusers, so education for foster parents and assistance for grandparents who are raising grandchildren should include an emphasis on recognizing protective factors.

In the households of substance-using parents, children are subject to chaos and deprived of the affordances that assure healthy development. In school, children of substance abusers often have “sloppy Mondays” related to chaotic or violent weekends. Adolescents with substance-abusing parents are more likely to have drug problems and eating disorders. All through childhood, the children of substance abusers have more psychiatric hospital admissions, longer inpatient stays, and greater health care costs than children whose parents do not abuse drugs. A higher rate of exposure to domestic violence increases the probability of post-traumatic stress disorder and other anxiety disorders. Depression and suicide occur more frequently in this vulnerable population. Early diagnosis, treatment, and extended follow-up may decrease the propensity for these conditions to become chronic.

Behavioral Problems in Children of Substance Abusers

Attention deficit disorder and oppositional defiant disorder are more prevalent in the children of substance abusers. In adolescence, the children of substance abusers are more likely to have alcohol and drug problems and the associated problematic behaviors. Anxiety and depression in children often manifest in acting-out behaviors. Although some behavioral problems may occur in children of substance abusers due to neurological problems incurred prenatally, behavioral issues are more likely to be associated with parenting. Parents who abuse alcohol and drugs are poor models for stress management, self-soothing, problem solving, decision making, conflict resolution, and emotional modulation. Much like their substance-abusing parents, children of substance abusers may have poor social skills, poor coping skills, unrealistic expectations of others, and a lack of empathy regarding the effect their behaviors have on others. Often in a substance-abusing household, the children inappropriately assume parental or spousal roles. Concessions of their perceived power and importance cause them difficulty in relationships with peers, partners, teachers, and service providers.

Parental impairment deprives children of normal and normative experiences. Most children look forward to the end of a school day, but children with impaired parents often have increasing anxiety as they near their homes. Many are ashamed of their families, so they do not invite friends to visit and may withdraw from friends who invite them to visit. Extensive research on the resilient children of substance abusers determined that a relationship with a caring adult outside the immediate family system is a protective factor. Extended family members, neighbors, teachers, and coaches frequently fill this role. Children with special talents for the arts, sports, or academics often develop a healthy relationship with a mentor and may be more resilient to family challenges. Human services workers may be the only people who have the opportunity to go above the requirements of their employment and extend themselves to children living in chaos.

Adult Children of Substance Abusers

Addiction and its associated conditions are prone to multigenerational transmission. Children of substance abusers grow up, marry, and have children of their own. In the 1980s, Adult Children of Alcoholics (ACOA) began a movement to define their common issues and provide each other support and encouragement to survive an alcoholic household. Although their self-identified list of ACOA characteristics is controversial for its lack of empirical evidence, it is useful in understanding and addressing the special needs of the children of substance abusers while they are still children. ACOAs claim to guess at what is normal, suggesting the importance of exposure, instruction, and guided participation in social settings in childhood. ACOAs claim fear of criticism, fear of authority, and fear of angry people as core traits, indicating a need for childhood activities that promote mastery and empowerment. The need to provide models for healthy relationships is suggested by the ACOAs' tendencies to confuse pity for love, confuse intensity for intimacy, and love people who need a rescue. A propensity to isolation, self-criticism, and low self-esteem predict depression and suggest that children of substance abusers are more likely to be resilient if they are encouraged to participate, monitored for negative self-talk, and praised for their efforts.

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See Also: At-Risk Youth Services; Child Welfare Services; Childhood Trauma.

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Children of Undocumented Aliens

There are currently 4 million U.S.-born children with at least one undocumented parent in the United States. Over three-fourths of these children are Latino, followed by Asian (10 percent) and Canadian (5 percent), with the remainder being from other (5 percent) groups. The undocumented status of parents impacts the development of their children as well as interactions with institutions such as schools or health care. The undocumented status also impacts experiences with employment, housing, and access to other social services, even when children are U.S. citizens. In addition to a lack of access to resources, children of undocumented parents and their families live with anxiety due to fear of deportation. Some U.S.-citizen children are already living with the consequences of family separation due to deportation. Consequently, the U.S.-citizen children of undocumented immigrants have a vastly different experience than other children—an experience that is virtually unrecognized. Human service professionals should be aware of the risks for children associated with their parents' undocumented status as well as how to support the family's existing resiliency.

Deportation and Family Separation

Deportation has threatened families for years and continues to cause anxiety among many mixed-status families today. Mixed-status families are families that have at least one undocumented parent and at least one child who is a U.S. citizen. In the current climate of anti-immigrant polices enacted at state and federal levels, families express increased fear of deportations. In addition, faced with immigration raids taking place in their communities or workplaces, parents take extreme measures similar to parents living in war zones. Families resort to sequestering themselves in their homes, forgoing income, and keeping their children out of school. The deportation of one parent results in loss of income and inability to meet basic needs for the remaining parent. The undocumented parent who remains is often too fearful to request emergency assistance.

When a parent is detained or deported, leaving the child without parental care, additional consequences occur, as the child welfare system must become involved. It is estimated that for every two deportations of an undocumented immigrant, one child is left behind. The constitutional rights of parents are not confined to citizens, and both the child welfare system and immigration law assume that parents and children should be reunified. However, in too many cases, when a parent is deported or detained, children are separated from parents for extended periods of time, resulting in termination of parental rights. U.S.-citizen children taken from undocumented parents who are deported are often placed in the custody of family members they barely know or in foster homes, causing additional psychological and emotional harm.

Family separations occur because courts have ruled that parents' undocumented status makes them unfit to parent their children, even though the parents have not abused their children. The parent who has been deported is often without recourse in their home country, unable to comply with requirements to be reunited with children or challenge the court ruling.

While the courts would argue that placement in a foster home in the United States and termination of parental rights may be in the best interest of the child, research suggests otherwise. The children who remain behind experience psychological and emotional consequences, such as appetite disturbance, sadness, excessive sleeping, lack of interest in activities that they used to find pleasurable, nightmares, and academic issues. Recommendations for improving this situation include instituting policy changes to protect the rights of undocumented parents and their children; creating positions dedicated to the reunification of these families; training on immigration policy for child welfare workers, lawyers, and judges; and creating partnerships with foreign consulates and the child welfare system to assist in locating parents when deportations or detentions occur.

Service Utilization

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 eliminated legal permanent residents' (i.e., "legal" immigrants) access to means-tested programs, such as Temporary Assistance to Needy Families (also known as "public aid") for a period of five years and denied undocumented immigrants' access to most government programs. Since the law's adoption, there has been continued anti-immigrant sentiment. Human service professionals find it difficult to service undocumented parents because of the lack of services available to them. For example, undocumented individuals may not be eligible for emergency housing or heating assistance.

Furthermore, the anti-immigrant climate has resulted in mixed-status families becoming wary of applying for services out of fear of deportation, even though their U.S.-citizen children are considered eligible for these programs. In particular, parents avoid educational or social resources for their children that require identification, proof of employment, or proof of income. As a result, children of immigrants use public benefits less often than children of U.S. citizens, despite higher rates of economic hardship. Older children continue to experience challenges with access to college. In

2008, for example, the state of Virginia issued a memo stating that children of undocumented parents may be disqualified from in-state tuition rates.

Impact on Child Development

Undocumented parents utilize tremendous survival strategies in order to provide their children with learning opportunities. Undocumented parents also demonstrate resiliency in the face of uncertain and often dire circumstances. For example, the Latino family's emphasis on relationships provides a basis for a sharing of strategies for navigating the complex social service system within their own communities. Despite these efforts and resiliency, the undocumented status of parents has lowered children's cognitive skills due to parents' economic hardships, psychological distress, and a lack of access to social networks. The working conditions of undocumented parents exacerbate the negative impact on children's cognitive skills due to wage theft, long hours, and inflexible work hours. Thus, undocumented status negatively impacts these U.S.-citizen children beyond the impact of poverty and low parental education alone. In addition, as U.S.-citizen children become older, they often express a sense of guilt or conflict because they can access services that parents or noncitizen siblings cannot, creating additional emotional and mental health concerns for these adolescents.

Human Service Professionals

An important key in working with children of undocumented parents is to be familiar with the rapidly changing immigration law and policies. In addition, assisting families in naming and talking about the trauma and discrimination faced as a result of the undocumented status of parents can help parents and their children reframe the challenges they face. Human service professionals should make connections with immigrant and ethnic advocacy groups and associations, which have often developed innovative ways of serving their clients. When undocumented parents have access to service providers and social networks that help them navigate these systems, they access services for their children at comparable rates to documented immigrants. Having access to these networks lessens their sense of fear and increases both resiliency and a sense of efficacy. Specifically, the points of entry for these families are the school and hospital; thus, human service professionals in these settings should be particularly aware of the needs of mixed-status families. It is often through these settings that families are able to access other forms of public assistance and psychosocial support.

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See Also: Cultural Broker; Discrimination and Institutional Racism; DREAM Act, The; Family Reunification; Hispanic Immigrants; ICE Enforcement Detention Centers, Services in.

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Children With Special Needs

"Children with special needs" is an umbrella term that encompasses a wide array of diagnoses and disabilities ranging from mild to severe. Such diagnoses as learning disabilities, attention deficit hyperactivity disorder (ADHD), cerebral palsy, and epilepsy fall under this category. Children with special needs can be identified as those who have medical, neurological, developmental, genetic, behavioral, or emotional conditions that require more health and educational services than their nondisabled peers.

According to the U.S. Census Bureau Report, one out of nine children under the age of 18 receives special education services due to a disability, with a staggering 2.8 million children between the ages of

5 and 15 having some type of disability. Moreover, the families of these children also face many challenges, including the expense and care of the child as well as the emotional impact of dealing with these various difficulties. However, by accessing the appropriate services in the community and school, these families can adjust to the child's condition and educate others through their experiences.

Multiple issues surrounding diversity impact this population. As the number of children under the age of 18 continues to grow, the number of children with special needs will increase. Although the medical, developmental, behavioral, and educational needs of children can affect any racial or ethnic group, it is important for health and educational service providers to be culturally competent in dealing with these children and their families. The assessment and interventions provided to these children should take into account the overall culture in which the child lives as well as their individual needs and functional level.

The World Health Association has developed a model of factors that influence the outcome of children around the globe. In providing services for these children, a health service provider must take into account the physical, medical, and/or psychological conditions and how these factors interact between a dynamic social and cultural environment and with the personal needs of the child and his/her family.

Educational and Behavioral Functioning

Children with special needs typically must be assessed for the condition that impacts their daily life activities. Included in these assessments must be a determination of educational and/or behavioral needs that impact their ability to interact with others and to participate in educational activities. Aspects of a child with special needs that should be included in assessment and intervention can include, but are not limited to, intellectual functioning, learning problems, mobility issues, and poor behavioral adjustment. Not all children with special needs have difficulties in all of these areas; however, good service providers should address the degree of adaptability a child has to navigate through his/her environment.

Family Functioning

Perhaps the most important aspect of working with a child with special needs is to address the multifaceted system of the family. Because various cultures have different values associated with disabilities, it is important to take into account these belief systems and ideas that can impact the family dynamic. Most families must care for their children that have special needs more than families who do not have children with disabilities. Because certain races and ethnicities may have fewer resources, it is important that the services provider is sensitive to these stressors related to caring for a child with special needs.

Diversity Issues

Service providers must be especially sensitive to the idea of able-bodyism when working with children with special needs. Many disabilities that face children tend to be lifelong and founded in medical definitions. However, new research is helping service providers move away from the limitations that these medical definitions and measures of disability indicate. Specifically, by utilizing a model that allows the person with a disability to define the idea him/herself instead of allowing "experts" to do it gives greater empowerment to and emphasis on the individual rather than on the label.

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See Also: Ableism; ADHD, Services for Individuals With; Adolescent/Youth Services: Overview; Autism and Asperger's Syndrome, Services for; Behavioral Health Disparities for Racial and Ethnic Minority Populations; Communication Disorders, Services for; Cultural Competence, Human Service Providers and; Developmental Disabled Individuals; Disabilities, International Variation in Attitudes Toward; Disability Services; Education Support Services; Family Services; Group Homes for Children; Intelligence Testing; Learning Disabilities, Services for Individuals With; Mental Health Services, Children; Psychiatric/Psychological Assessment; Special Education.

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Children's Defense Fund

The Children's Defense Fund (CDF) is a national, nonprofit advocacy organization that was not formally established until 1973 but has historical roots deeply embedded in the civil rights movement of the 1950s and 1960s. Responding to the injustices forced on poor and minority children throughout the history of both the U.S. child welfare and public education systems, Marian Wright Edelman, an attorney and colleague of Rev. Dr. Martin Luther King Jr., began the fund with the goal of challenging the federal government to improve its policies and programs affecting the nation's children.

Philosophy and Methods

CDF has successfully brought the liberal values of its predecessor entities, namely King's Poor People's Campaign and the Washington Research Project, into the post-civil-rights era by broadening the organization's focus to all children and rebranding its cause as one of democratic accountability. Today the organization labels its purpose "the No Child Left Behind" mission and aims to represent nonpartisan interests.

Throughout its history, CDF has maintained that U.S. children do not have a legitimate voice in the policy-making decisions at the local, state, and federal levels that affect them most. Relying heavily on a sunshine advocacy strategy, CDF has strived to be the voice for children by educating legislators on issues that affect children, making legislators' previously closed-door actions public knowledge. The fund also analyzes the impact of legislative decisions, and publishes reports about children's issues that it disseminates to the public.

Milestones and Achievements

CDF's advocacy strategies have resulted in significant milestones and achievements, which have earned the organization a great deal of attention and support. Notable publications by the organization include "Children out of School in America" (1974), the annual Children's Defense Budget (1981–present), Children's Defense Fund's Voting Records for Members of Congress (1982–present, and the "Cradle to Prison Pipeline" report (2007). CDF has also lobbied for the passage of several key pieces of legislation including the Education for All Handicapped Children Act (1975), the Adoption Assistance and Child Welfare Act (1980), and the No Child Left Behind Act (2001). In addition, CDF has been instrumental in gaining federal funding for programs such as Head Start, Medicaid, and the Child Income Tax Credit.

Other Campaigns and Programs

In the late 20th and into the 21st centuries, the Children's Defense Fund began launching a number of public awareness campaigns and supported programs serving children across the country. For example, CDF coordinated the Adolescent Pregnancy Prevention Program, the Vaccines for Children Program, and the CDF Freedom Schools initiative. It also mobilized voters in various campaigns and demonstrations, including the Stand for Children demonstration in Washington, D.C., in 1996, the Children Can't Vote, You Can registration campaign in 2004, and the Health Coverage for All Campaign in 2007.

Noteworthy Supporters

In 2014, Edelman continued to serve as CDF's president. The organization enjoys the support of several well-known celebrities and public figures including actress Reese Witherspoon, basketball star LeBron James, pop music artist Shakira, and former secretary of state and first lady Hillary Clinton. CDF also receives the financial support of major corporate foundation donors such as the Prudential Foundation, the Ford Foundation, and the Kresge Foundation.

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See Also: Administration on Children, Youth and Families; Child Support Agencies and Services; Child Welfare League of America; Child Welfare Services; Children With Special Needs; National Center for Children in Poverty; No Child Left Behind Act; United Nations Convention on the Rights of the Child.

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ChildStats

ChildStats is an accessible resource on the condition of children and their families in the United States. Statistics from 22 government agencies about 41 areas of well-being are compiled by the Federal Interagency Forum on Child and Family Statistics and made available for public use. Each statistic is described as an indicator of one of seven domains of well-being: family and social environment, economic circumstances, health care, physical environment and safety, behavior, education, and health.

The 41 statistical indicators are updated annually and made accessible on the ChildStats Web site: http://childstats.gov. These statistics and others relating to children are mandated by former president Bill Clinton's Executive Order No. 13045 (1997), which required the monitoring of children's well-being. Attention to the needs of children is a long-standing social value in the United States, as analyzed by scholars such as Joel Best. The forum responds to these needs by providing a yearly report, "America's Children: Key National Indicators of Well-Being," available online. In these reports, the 41 well-being indicators are presented, summarized, and monitored for changes over time, with attention paid to changes that are statistically significant or that differ from previous years. These reports are useful resources that summarize massive amounts of government data in a single place.

In addition to the summary statistics presented at the ChildStats Web site, the site provides links to the 22 selected federal agencies that publish statistics related to children's well-being, allowing the user to access each of the hundreds of statistics available in detail. The Federal Interagency Forum on Child and Family Statistics, a division of the Department of Health and Human Services, selects the indicators for each domain of coverage from the various federal agencies in forms that are regularly measured, easy to understand, and serve as useful measures of the state of American children and families. It is important to recognize that the validity of the statistics is uneven, and some areas are covered thoroughly while others are less so. Because the sources for the statistics for each area of well-being are divided among different agencies, each domain has indicator statistics of varying validity.

Analyzing the Statistics

The user should keep in mind that statistics are a social construction, and are no more valid than the processes used to create them. Some are direct counts, as is done by the U.S. Census. These are the gold standard of social measurements. Other than the census, surveys using a random sampling technique may be the most practical way to estimate the characteristics of a population. But surveys have their own characteristic limitations. Social science research has demonstrated how surveys about admissions of behavior do not produce the same results as direct measures of behavior. This research has revealed that reports of behavior based on interviews and surveys systematically underreport deviant and other socially disapproved behaviors. Thus, the domain of behavior, which includes youths' responses to survey questions about smoking, alcohol use, illicit drug use, and sexual activity, must be taken with caution. Declines in some statistics in recent reports may represent behavioral change, but may also represent changes in social norms and willingness to admit socially undesirable behavior.

Some of the statistics include reports of various administrative processes, such as police departments' records of cases involving youth crime. Different procedures are used by the departments to compile these reports, regional and local variations are introduced, and definitions vary from one official and team to another. The results of administrative processes are not comparable and should not be treated as consistent. Neither should the rate of serious youth crimes be taken at face value, for it combines reports of youth about victimization with police records of crimes. The user also should be alert to how greatly the diversity of the population being summarized by the statistics is included and presented.

The work represented among the 22 federal agencies is carefully done and generally can be accepted as the best available information on each of the domains. Nevertheless, a widely recognized concern about children—child abuse and neglect—appears in the domain of family and social environment despite the incomparability of states' data-gathering procedures. Use of National Child Abuse and Neglect Data System (NCANDS) data by the forum fails to recognize the lack of statistical reliability and validity in those measures. A better choice is the forum's omission of the social problem of missing children.

Diversity Statistics

There is much more to be done to gather and report statistics on diversity. The standard categories of age, gender, state and/or region, and race are available from most sources, but the U.S. Census does not gather data on religion and these data are not reported by other federal sources. Education is reported, but not social class. Some income data and categories of poverty are available. But the intersectionality of identities that yield the diversity characteristic of the country and awareness of how race, gender, and class, among other statuses, intersect is not currently available.

The Federal Interagency Forum on Child and Family Statistics also attempts to monitor and coordinate the compilation of child and family statistics by the federal agencies. The agency is particularly helpful in stating areas in which new indicator coverage is needed within its domains and meeting with agencies to promote needed indicators. As the forum is in a position to recommend changes, it would be good to attend to the diversity of the population of children and families. In general, ChildStats is a remarkable resource and is highly recommended to students, researchers, practitioners, and the public.

International Comparative Statistics as Indicators

Other sources of statistics on children's well-being are available from many agencies, including the various census departments of world governments, as well as the United Nations. Such statistics are important, but must be used with caution because they are not developed the same way across nations and even within nations. International comparative statistics for children have been compiled by the World Policy Analysis Center. Other sources on national characteristics include the U.S. Department of State and the Central Intelligence Agency.

One of the most common uses of indicators in the media is the ranking of different countries according to an outcome statistics, such as performance on academic tests or various health indicators. Often the objective of such comparisons is to call attention to an apparently low rating for the United States; then the conclusion seems obvious that more attention to the "social problem" revealed should be given. However, the way the statistics are calculated often differs greatly from one country to another and such comparisons should not be accepted at face value.

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See Also: Abuse and Neglect; Child Abuse Prevention and Treatment Act; Child Welfare Services; National Center for Missing and Exploited Children; National Child Abuse and Neglect Data System; Protective Services for Children.

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Chinese Americans

Historically there has been a scarcity of inquiry into ethnic groups of Asian origin in the United States. Attempts to assess the needs of these groups have been largely restricted to the clustering of several groups under the umbrella terms *Asian Americans* and *Asian American Pacific Islanders*, despite these people's heterogeneity.

Compared to other races, the clustering of Asian Americans has resulted in Asian Americans doing better in terms of education, income, and other factors that have contributed to the model minority myth that all Asian Americans are not in need of human services.

Among Chinese Americans, there are needs in the areas of immigration and acculturation, aging, mental health, and security and safety. These issues were identified as recurring themes in the literature. Chinese Americans have been in the United States since the late 19th century and constitute the largest of the Asian American groups, making up 23 percent of the 17 million Asian Americans. However, even among this group there are numerous individuals who carry with them different languages, customs, and ethnic identities. Those who identify as being of Chinese descent may have lived in Taiwan, Vietnam, mainland China, or any of other places in the world. Chinese Americans may speak many different dialects but the two most common in the United States are Cantonese and Mandarin. As the population of Asian Americans continues to grow at a pace exceeding that of all other racial and ethnic groups, a more precise focus on subgroups may provide a more nuanced, well-tailored approach for addressing challenges and needs present for those falling under this larger term.

Immigration and Acculturation

A number of needs in the Chinese American population are more prevalent within immigrant and refugee populations; these challenges are related to the process of acculturating as individuals adapt to life in a new country. Difficulties associated with adapting can be particularly noteworthy for this population as more than two-thirds of individuals of Chinese descent are first generation. Immigrant populations often bring with them several difficulties that put them at a disadvantage when attempting to join the labor force. Many immigrants lack vocational training appropriate for jobs in the United States and have limited English proficiency; these immigrants tend to be more clustered in urban ethnic enclaves where immigrants from the same country of origin reside in a close geographical area.

Those with higher levels of educational attainment may find themselves employed in positions far below their qualifications. Though some assistance is frequently available for these and other adjustment-related problems, many individuals may not know how to access these resources due to lack of knowledge about available assistance or language barriers. Being able to navigate multiple agencies and formal institutions requires guidance in order for benefits and assistance to be rendered.

Aging of the Population

The Chinese American older adult population is expected to increase faster than the Chinese American population as a whole. Certain needs become present as Chinese Americans grow older. For instance, while normal aging may involve some short-term memory loss, it is important to recognize cognitive deterioration attributable to dementia or Alzheimer's disease. If such problems are not addressed, older adults may be at greater risk of injury or of not being able to meet basic functions associated with daily living. Another concern is that these individuals may be separated from kin or adult children because of geographical distance or lack of transportation.

Family support has been identified as integral to the well-being of elderly Chinese Americans as it has been noted as the most important relationship in their social network. This places older adults at increased risk for being socially isolated, which can exacerbate chronic health conditions or lead to psychological distress. These risk factors are troubling as elderly Chinese Americans are already at heightened risk of depression or suicide, especially among those who are foreign-born. When the family is not available, many older individuals can form relationships of support with neighbors and friends nearby. Finding and promoting methods of bolstering social involvement and support among older adults is a substantial challenge currently and shall only grow over time as the proportion of the elderly increases within this population.

Mental Health Concerns

A number of concerns are present among Chinese Americans related to mental health. One challenge is encountered in terms of dealing with the results of acculturating to the norms of a new country and potential cumulative stressful events. For Chinese people migrating to the United States, there is increased likelihood of having disruptions to social networks and for there to be some alienation after departing their country of origin. A secondary risk that should be considered is that there are likely refugees among those emigrating from overseas; those who arrive in the United States may have fled violence or persecution, creating the possibility of trauma-related symptoms or post-traumatic stress disorder.

Another need associated with Chinese Americans exists in the fact that there tends to be a heightened prevalence for certain mental health conditions. Recognizing these concerns can be difficult, as this population may hold beliefs that attribute different causes for mental illness, including cultural explanations that may be influenced by traditional Chinese beliefs such as karma and failure to honor ancestral spirits. There are also certain cultural syndromes for Chinese Americans. One of these, neuroasthenia, includes fatigue, physical complaints, difficulty sleeping or eating, and dizziness. Another is known as qi-gong psychotic reaction or qi-gong deviance and is marked by dissociative and paranoid symptoms that are acute in duration, which are believed to be caused by incorrect or excessive practice. Chinese Americans may demonstrate mental illness differently through complaints that are bodily in nature such as headaches, chest pain, or digestive problems. Being able to identify mental illness and how it may be manifested represents an important consideration for this population.

Security and Safety

All individuals and groups have a need to feel free from harm in order to feel secure. Among Chinese Americans, a common motif arises regarding being a victim of crime or violence that includes robberies of Chinese businesses and Chinese fast-food delivery personnel; the sense of vulnerability associated with these crimes can be enhanced by a poor relationship with law enforcement or the sense that the criminal justice system will not grant them equal protection.

Past experience and historical precedent can fuel mistrust, result in more frequent confrontations, and complicate efforts to establish a working relationship with formal law enforcement. For Chinese Americans, there has been ample history of injustice that points out differential treatment ranging from the Chinese Exclusion Act to the legal handling of the murder of Vincent Chin. These incidents appeared to demonstrate to the Chinese American community that Chinese Americans were acceptable targets for discrimination and that they could not count on adjudication through legal entities. Efforts by law enforcement and criminal justice agencies to establish a relationship in which community members are valued could diminish these perceptions and increase involvement.

Another representation of a threat to safety found among the Chinese American community may relate to violence within the family. These problems are often demonstrated through physical abuse directed at spouses. A number of factors may be associated with an increased risk for intimate partner violence. There seems to be a pattern of increased prevalence among immigrant populations that can be partially explained through trends from one's country of origin. Looking at spousal abuse in China yields dramatic differences in prevalence based on one's location, with those living in rural areas substantially more likely to be affected by this problem.

Additionally, relationship dissatisfaction has traditionally been an indicator of spousal abuse. Conflicts or dissatisfaction with a spouse's relatives have also been connected with this problem. Experiences of perceived discrimination have been found to be closely correlated with intimate partner violence. Lastly, the stress and hardship of establishing a life in the new country is connected with the risk of spousal violence. Law enforcement and local domestic violence shelter partnerships with the Chinese American community could help establish the trust needed for survivors to seek help in times of need.

Implications for Human Services Professionals

While identifying the needs of Chinese Americans is important, it is equally important to break down the service barriers that prevent Chinese Americans from addressing those needs. Unaddressed needs are detrimental to the physical, mental, and emotional health of this population. When addressing these challenges, it is imperative for human service professionals to consider the cultural connotations associated with problems, as issues such as mental health and domestic violence tend to be stigma-laden topics. Addressing these issues through educational outreach in the community may assist in lessening resistance associated with the topics; such efforts can be augmented through partnering with cultural brokers and leaders within the community to establish a collaborative relationship that can help those in need be directed to and teach practitioners to provide appropriate services.

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See Also: Acculturation; Asian Immigrants; Cultural Broker; Culturally Specific Services; Mental Health Services, Adult.

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Chronic Diseases Common in Developing Countries

This article examines chronic diseases that threaten the health and longevity of individuals living in developing countries, or diseases that are associated with undo health burden. Chronic disease is defined as an illness that is long in duration, is less visible, and progresses gradually. The leading chronic diseases are coronary heart disease, ischemic stroke, diabetes, and particular cancers as well as obesity that tends to be the antecedent to many of these diseases. It is suggested that the rise of incidence in chronic disease in developing countries is a result of increasing age and escalation of overweight and obesity prevalence. In order to obtain a full understanding of the development and maintenance of several chronic diseases, it is necessary to address the crucial function of the obesity epidemic and the risk factors it produces in chronic diseases.

General Risk Factors for Chronic Diseases in Developing Countries

Limited physical activity, consumption of high-density and low-nutrient foods, and having limited access to finances are all risk factors for the development of chronic illness with the exception of obesity. Obesity can be associated with having resources in excess. Tobacco use is another risk factor associated with chronic diseases in developed countries. According to the Centers for Disease Control and Prevention (CDC), it is estimated that 443,000 people die prematurely from smoking or exposure to secondhand smoke. Secondhand smoke has been linked to several chronic diseases, including heart disease, lung cancer, sudden infant death syndrome, acute respiratory infections, ear problems, and severe asthma attacks.

Poor health care is another factor that can contribute to chronic diseases. Lack of access to preventive care, weak primary care systems that are ill-equipped to respond to budding disease symptomatology, and unaffordable treatments are key ingredients in the emergence of epidemics.

It is noted that there is often a convergence of noncommunicable chronic diseases (e.g., diabetes, obesity, or most cancers) and communicable diseases (infections, parasitic diseases, etc.) that produce long-term care needs in developing countries and among vulnerable populations. Low-income countries are disproportionately affected by chronic diseases, often carry the highest disease burdens, and are most susceptible to the negative and positive influences of health behaviors. Over 60 percent of global deaths were produced by preventable chronic diseases and 80 percent of those deaths were located in low- and middle-income countries.

Interventions for Chronic Disease

It is estimated that chronic disease management will cost developing countries $84 billion dollars in 2015, if interventions to decelerate the progression are not implemented. One means of slowing down the advancement is through a population-based approach in which the public is educated (health promotion) on the contributory factors as well as the treatments of chronic disease, to include tobacco use, unhealthy food consumption, and lack of physical activity. Another means of addressing this public crisis is through community-based programs that target high-risk populations and family systems with the purpose of enabling them to become active in their health care while promoting the utilization of community resources and health services. Furthermore, the reduction of saturated fat and the removal of trans fat (unsaturated fat) from manufactured products will also help in the deceleration of chronic diseases in developed and developing countries.

Prevention and Health Promotion

Formal health promotion, or the process by which individuals are empowered to control and increase their health status, has to be an increasingly prevalent component of health care in developing countries where traditional models of treatment once symptoms exist are inefficient, costly, and ineffective, and where prevention is the primary goal. Health promotion focused on nutritional intake (increased fruits and vegetables), aerobic exercise programs (minimum of 30 minutes at moderate intensity multiple times each week), weight management and healthy body weights, smoking cessation, and stress management may prove most effective. These must be culturally tailored in developing countries toward acceptable body image, functional access to resources, and cost. Preventive (health promotion) and interventional efforts are important considerations in the effective management of chronic disease in developing countries.

Obesity

Obesity is a global public health epidemic that affects both underdeveloped and developed countries. Body mass index (BMI) is the universal measurement utilized to calculate body sizes, to include overweight ranging from 25.0 to 29.0 kilograms per square meter (kg/m^2) and obese ranging from 30.0 + kg/m^2. American Heart Association statistics indicate that 154.7 million Americans over the age of 20 are overweight and of these, 78.4 are obese with 33.8 percent being non-Hispanic whites, 37.9 percent being blacks, and 36 percent being Mexican Americans. This health concern also affects 23.9 children, ages 2 to 19, and of these, 12.7 million are obese.

Health disparities and economic, social, and behavioral factors play pivotal roles in the development and maintenance of this public crisis. The BMI is a universally accepted measurement that it is an unrepresentative measure for people of color because it was standardized on white middle-class individuals. This discrepancy can result in inaccurate classifications of body size, particularly since it was determined that blacks have greater body densities than their white counterparts. Several developed countries, particularly the United States, have embraced the "supersize it" mentality, which involves the acquisition of large-capacity products, including food.

This movement is not only socially based but also economically driven. It has been noted that some people of low socioeconomic status will purchase and consume low-nutrient foods because they are accessible and more affordable than high-nutrient foods. The consumption of high-sugar and dense foods drastically reduces energy and motivation

According to the American Heart Association, 12.7 million American children are overweight. Childhood obesity and combating it are issues that are increasingly studied.

required to be physically active. Lack of physical activity impedes caloric expenditure and allows for weight gain. Other contributing factors to lack of or limited physical activities are transportation and media devices. Industrialized and developed countries have implemented sophisticated transportation systems that are conducive to immobility and access to media devices such as television, game consoles, cellular phones, and tablets that greatly promote a sedentary lifestyle.

Diabetes

Approximately 350 million people worldwide have altered glucose metabolism, insulin insensitivity, or pancreatic disease (autoimmunity) that results in the condition of diabetes. In Type 1 diabetes, processes like autoimmune disease render the pancreas unable to produce insulin or to produce insulin in deficit amounts to effectively manage glucose levels in the body. Although chronic with increased disease burden in childhood and adulthood, this condition requiring exogenous insulin is not considered a preventable disease.

In Type 2 diabetes, the body does not effectively use insulin to manage blood glucose levels and a state of hyperglycemia is produced. The disease is the product of genetic predisposition in the context of environmental stimuli like excess macronutrient intake, lack of physical exercise, obesity, and even poor stress management. Representing the vast majority of diabetes cases, many aspects of Type 2 diabetes can be controlled with behavioral management, and the manifestation of the disease is preventable. Similar to Type 2 diabetes in its symptom complex, gestational diabetes is diagnosed only in women and is most often seen as a multifactorial complication associated with pregnancy.

Diabetes can be associated with additional morbidities such as depression, renal dysfunction, peripheral neuropathy, retinopathy, cardiovascular disease, stroke, and death. In advanced stages of untreated or undertreated diabetes, amputation, dialysis, and blindness are common.

Risk factors for the development of Type 2 diabetes include impaired glucose tolerance test (IGT) or impaired fasting glucose (IFG); increasing age; a family history of diabetes (genetics); neuroendocrine dysregulation; high-fat diet; obesity and overweight; hypertension; black, Hispanic, Asian, American Indian, or Alaskan Native race/ ethnicity; restricted or limited physical activity; and gestational diabetes. Prevention and management of Type 2 diabetes includes nutritional management (high fruits and vegetables/low fat), exercise and fitness, stress management, effective management of comorbid diseases, and weight loss.

Lung Cancer

In the United States, smoking-related medical costs account for greater than 8 percent of medical expenditures. In developing countries, such estimates are sometimes difficult to derive from unreliable and unavailable data and cultural differences in the management of disease morbidities—not everyone seeks treatment in formal settings from professionals who document their processes, outcomes, and epidemiology of diseases.

Estimates of the impact of smoking and factors that influence lung cancer include exposure to pathogens in the home (e.g., gas and coal heating sources, open-air flames, secondary tobacco smoke or exposure) and workplace (e.g., industrial pollutants), and generally poor air quality (e.g., smog). Lung cancer incidence, prevalence, and mortality were greater for men than for women and greater in developing countries where health promotion is less prominent than in countries with more economic growth that allow health promotion and cancer control programs to be an effective influence on health behaviors.

Lung cancer is one of the most frequent cancers plaguing world populations, representing an estimated 12 percent of all cancers. It remains the most common cause of death from cancer with one-half of all cases occurring in developing countries. Based on data from the United States, where some of the best-kept population-level data exist on cancer, five-year survival rates from lung cancer cohere at around 15 percent; they are estimated to be about one-half of that rate in developing countries.

Risk factors include exposure to tobacco smoke (primary or secondhand), exposure to polluted air (radon and other toxins), family history of lung cancer (genetics), exposure to asbestos and inhaled toxins, comorbid pulmonary diseases like emphysema, and excessive alcohol consumption. Lung cancer prevention has primarily focused on nutritional management, effectively managing precancerous diseases, smoking cessation, monitoring and remediating air pollution in the home, and limiting exposure to pollution and toxins known to increase the risk of developing lung cancer.

Coronary Heart Disease

Coronary heart disease (CHD) and stroke account for almost one-third of all deaths in the world. Factors associated with CHD are clear and well known, but there is an emerging science of CHD in developing countries. For example, cholesterol and lipoproteins levels, two factors associated with the development of CHD, were found to be lower in developing countries than in industrialized countries. Similarly and proportionally low was the progression and severity of atherosclerotic plaques in the aorta and coronary vessels of samples collected from developing countries, suggesting that an agrarian diet and physical exercise (labor) may be protective.

Risk factors for CHD include age, gender, family history of CHD (genetics), cigarette smoking, hypertension, body fat percentage, body mass index, serum cholesterol, diabetes, lack of physical exercise, stress, and saturated fatty acids in the diet. In addition to the value of each risk factor, risk is increased as the number of risk factors present increases. Prevention includes smoking cessation, increase in physical exercise, stress management, diet control, and weight loss. An emerging science is evaluating the value of a class of medicines known as statins in reducing coronary heart disease risk.

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See Also: Health and Sickness, Differing Attitudes Toward; Health as a Human Right; Health Care, Disparities in; Health Disparities, Role of; Health Promotion Services; Overweight and Obese Adults and Children; Public Health; Racial and Ethnic Approaches to Community Health; Smoking and Smoking Cessation, Cultural Aspects of.

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Cisgender

Cisgender is an identity term that refers to a person whose gender identity matches the sex that was assigned to that person at birth. The term, which serves to distinguish transgender identity from nontransgender, originated in the transgender rights movement and was borrowed from the biochemical sciences. Cisgender privilege is implied in the use of the term. Some activists and scholars critique the use of the term because of its implications for furthering a binary understanding of normative gender identity development (e.g., transgender or cisgender) rather than a fluid and wide-ranging scope of gender identity. Human services workers should become familiar with sources of privilege and oppression that the term *cisgender* represents and their implications for practice.

Definition, Background, and History

First used in 1994 in Web-based conversations about transgender activism and advocacy, the word *cisgender* became known to refer to persons who are nontransgender-identified. Because of the range of gender identities in the world (e.g., man, woman, transgender, genderqueer, intergender, pangender, two-spirit, etc.) there became a need to distinguish one as having a gender identity that coincides with the sex assigned at birth. This is in contrast to a transgender identity—a person whose gender identity is different than the sex assigned at birth. Gender is generally thought to be a socially constructed concept that conveys the distinction between a person's societal role and the biological sex that was assigned at birth. Gender identity refers to the intrinsic sense of being man, woman, or other gender such as trans and is invisible and internally felt.

Originally used in biochemistry applications, the Latin prefix *cis* refers to things that stay the same, and in Latin it literally means "on this side." Therefore, the term *cisgender* was meant to infer that the person's gender identity stayed the same. The term originally circulated in queer and gender studies scholarship and classrooms and only recently has it been used outside of academic settings. Therefore, many lesbian, gay, bisexual, and transgender (LGBT) persons may not be familiar with the term.

Transgender Rights Movement

The term helps distinguish between the often misused and misinterpreted meanings associated with sexual orientation and gender identity. For example, one can be a cisgender lesbian woman, a cisgender heterosexual woman, a transgender lesbian woman, or a transgender heterosexual woman; just because a person is transgender does not mean he/she is also gay. This distinction is important to the transgender rights movement because many of its activists seek to articulate it as separate from the gay rights movement. A transgender liberation movement began in the early 1990s and was organized to combat the oppressions that transgendered people face. This movement has recently attracted more public attention in the media and within political and activist circles. That attention has come as a result of hard-fought battles for recognition as a culture and identity distinct from the lesbian, gay, and bisexual (LGB) community. The use of the term *cisgender* is also thought to be pertinent to the transgender rights movement because it allows the movement to obtain language that is equally usable to what the gay rights movement has—the "other" (heterosexual).

Transgender women have been the subject of debate in feminist scholarship and activism since the 1970s. Feminists disagree as to whether they should include transgender women in theory, scholarship, and activism. Transgender scholars and activists also disagree about whether or not it is important to be included in a feminist movement that does not seem to want them. Feminists who argue for the exclusion of transwomen claim a medical viewpoint and biological influences in their justification for their segregation. Transwomen who argue for inclusion in feminist discourse claim an oppression viewpoint and use social and cultural influences in their justification for their presence.

Cisgender Privilege

Cisgender privilege is thought to encapsulate the freedoms that nontransgendered people enjoy as part of a social world that still operates within a binary understanding of gender. Socially constructed gender roles, and those who operate within them, are often accepted by the majority of people but fail to acknowledge those that they marginalize. Thus, cisgender represents the free and unquestioned access to public and private social institutions to which nontransgendered people are privileged.

Use of the term *cisgender* can usher in self-awareness. To realize that one never had to struggle with feeling like something other than the sex assigned at birth raises awareness about the experience of transgendered people. Recognition of cisgender privilege can help a nontrans human service worker to understand systemic oppressions faced by transgender people such as: most cisgender people did not have to fight a legal battle to be able to use their own names, did not have to face the marginalization of failing to fit into societal gender roles, did not experience violence and hate language for trying to outwardly show the bodies they feel are right on the inside, and the list of transgender oppressions can go on. Awareness and sensitivity to cisgender privilege is part of culturally competent practice with transgendered people.

Anticis

Some scholars and activists denounce the use of the term *cisgender* because it favors a "normative" developmental trajectory, indicating that an identity should match a biological sex. Inferring a normal trajectory serves to further marginalize people who do not fit into the model, and marginalization is part of the discrimination and oppression faced by transgender people. This critique also involves the misunderstanding that one can be "born a woman" rather than "to become a woman." To use the word *cisgender* is to imply the former, whereas the latter is more congruent with a transfeminist point of view. To suggest that there is an inherent gender identity that one is born with because of the sex assigned at birth is to align with a medical view of gender and sex, which many see as oppressive and inaccurate. A transfeminist view represents a resistance to the medical belief that transgender people are pathological and require treatment. Instead, a transfeminist point of view, which incorporates queer, disability, feminist, and transgender scholarship, seeks to liberate transgender people from the structures that restrict, regulate, and control transwomen's bodies. Such structures include medical and social institutions that tell people what gender is and is not and what expressions of gender are and are not acceptable. Transfeminists argue that regulation marginalizes the voice of someone who disagrees with those definitions and strips the free will of humans to determine their own destiny.

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See Also: Cultural Competence, Human Service Providers and; Cultural Competence, Model of; Gender and Clients; Heterosexual Privilege; LGBTQ Clients; Transgender Individuals.

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Coca-Colonization

Globalization, with its multidimensional outcomes, has resulted in significant changes in every aspect of daily life, including human services and diversity. The gap between clusters of social structure and the scope of diversity spread throughout the world in this process. It generated new terms and perceptions like "coca-colonization."

"Coca-colonization" refers to cultural and economic impacts of the Western, particularly the American, way of life through consequences of globalization processes, on local cultures and economies around the world. It is a term formed by combining "Coca-Cola," a soft drink brand of a multinational beverage company with U.S. origin, and the term *colonization*. Although slavery and colonization were prohibited around the world with increased standards of democracy and human rights, the term *coca-colonization* is ironically used to express the existing influence of developed the economies on economic, social, and cultural structure of developing countries.

The term emerged in the post–World War II years to attract attention to the irresistible spread of capitalism around the world. It became popular with the 1994 publication of Reinhold Wagnleitner *Coca-Colonization and the Cold War: The Cultural Mission of the United States in Austria After the Second World War*. The book pointed out how American culture was internalized in other countries, particularly in the Iron Curtain states, with the influence of music, radio, films, newspapers, and magazines rather than the influence of military or diplomatic power.

Coca-Colonization of the World

How has the world been coca-colonized? Has it only been coca-colonized, or are there other versions of colonization, such as "McDonaldization," which is a similar term used to explain the same idea as coca-colonization. In fact, these are simply symbols to express the extent of a change, which generated a new world in terms of economic, social, and cultural aspects. The change, of course, did not come up in an instant but occurred as a result of evolving processes. Roots of the change date back over centuries to the emergence of new actors in the international system. While empires and states were, previously, the unique actors in the system, nonstate entities arose as a challenge to the state. These entities included international and regional alliances, nongovernmental organizations (NGOs), volunteer associations, multinational corporations, etc. Technological progress from the use of steam in industry and transportation to the invention of the Internet and wireless communication techniques played a key role in the emergence of this new order in the world. As an irresistible result of these processes, the world turned into a small village in which people, goods, money, and knowledge could move easily and quickly. Borders between states became less important because of the transboundary communication and trade between people and companies which are located in different parts of the world. All these processes were results of a new era, which is termed globalization.

Beyond Coca-Colonization

The rapid circulation of goods and money resulted in the need for producing as much as possible in order to meet limitless interests of consumers around the world. Consequently, two approaches emerged as a response to this situation. On the one hand, proponents of globalization argued that the existing order helps people around the world reach outcomes of the system. As in the example of Coca-Cola, for instance, it is possible today for almost every single person to get a bottle or can of Coke in the world regardless of his or her distance to the United States, home of Coca-Cola.

On the other hand, opponents of the current globalized world harshly criticized effects of globalization and argued that the poor became poorer, while the rich increased their assets with free trade and such benefits of globalization. Coca-Cola would be a great example to support this assumption. Only nine glasses of Coke per day were sold in 1886, the year Coca-Cola was created. However, today almost 2 billion of bottles of Coke are sold in more than 200 countries around the world in a single day. In Mexico, the southern neighbor of the United States, for example, the per capita consumption of Coke was 745 servings in 2012, with a 50 percent increase since 2002 and 250 percent increase since 1992. In other words, everybody drank more than two bottles of Coke every day in Mexico in 2012. According to official numbers regarding its consumption around the world, it is apparent that Coca-Cola became a global company with a revenue the surpassing economies of many countries.

Focusing on the years when the coca-colonization term emerged, one sees that there were two superpowers, the United States and the Soviet Union, and their satellite countries in the world. World War II had ended with massive casualties on each side in the war. In the years following the war, but there developed a tense atmosphere all around the world because of the Cold War. Leaving weapons aside, both sides in the Cold War acted as though they would attack each other anytime—even with nuclear weapons. Countries in Europe took positions according to their links with the United States and the Soviet Union. Germany was in the middle of the continent both geographically and politically. The term *coca-colonization* emerged in such an environment and symbolized the influence of the West, particularly the United States, on the Eastern bloc. Eventually, the Cold War ended with the fall of the Berlin Wall, collapse of the Soviet Union, and decline of communism.

Today, countries in the world are much more vulnerable to influences of the above-mentioned changes as borders are more transparent and communication is easier and cheaper. If the West achieved its aim to export its values to other countries via its goods such as Coca-Cola, Levi's jeans, fast-food chains, and Hollywood films during the Cold War years, it is much easier today to export popular culture to other countries via the myriad opportunities of the Internet and other communication techniques. If the impact of Coca-Cola was defined as coca-colonization 50 years ago, today there are many more tools to "googlize," "applize," "facebookize," or "twitize" the world. If somebody asked an individual "to google something" 10 years ago, that individual probably would not understand the meaning of the request.

However, today it is common for people to get the order "Just google it!" If one wants to see the impact of the Internet on social movements in North Africa and the Middle East in the last couple of years, the only thing that one has to do is "just google it." Once one does so, one finds the impact of Facebook and Twitter on Arab Spring movements. Large numbers of people came together against oppressive governments via sharing their ideas through Web sites or mobile applications like Facebook and Twitter. Therefore, although these companies were born in Silicon Valley in the United States and became economic giants, they are now in living rooms of millions of people around the world. Similar to the idea of coca-colonization, today's world, particularly developing countries, can be seen as a target of popular Western/American culture export with all its aspects, including language, lifestyle, and social relations.

Consequences of Coca-Colonization

Coca-colonization with its multidimensional new versions has encompassed the world, but is it good or bad? It is difficult to make a clear-cut evaluation of the consequences of coca-colonization for both the former version and the contemporary versions. It is even impossible to argue that the process of coca-colonization is over. As mentioned above, while there had been a single version of coca-colonization during the Cold War years with a beverage, a couple of Hollywood films, and so forth, today the world faces a multidimensional version of coca-colonization. It has been getting deeper with more aspects. However, the situation is not a one-way street from the United States to other countries.

While the Western/American lifestyle is being exported to the other countries, it is also shaped by the influence of immigrants, students, and employees coming out of the United States. American streets today are full of symbols of the Chinese, Indian, and Islamic cultures. Therefore, it is difficult to judge coca-colonization as an extension of globalization processes as good or bad, because it has multiple aspects both in favor of and against the way of life of the West or the United States and other countries.

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See Also: Assimilation; Biculturalism; Colonialism, Lingering Effects of; Coca-Colonization; Global South/Global North; Melting Pot Theory; Monoculturalism; Multiculturalism; Western Communities and Cultural Competence.

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Code of Ethics of the National Association of Social Workers

One of the distinguishing marks of a profession is the presence of an ethical code. The National Association of Social Workers (NASW) *Code of Ethics* was created as a guide of professional conduct for social workers in their day-to-day practice and ethical decision making. Established as an organization in 1955 through the consolidation of many social work entities, NASW developed and adopted the *Code of Ethics* in 1960, as well as other practice standards. Having undergone multiple revisions over the years, the *Code of Ethics* was most recently revised by the 2008 NASW Delegate Assembly, the representative, decision-making body of NASW, composed of 277 elected delegates. This revision emphasized the profession's responsibility to recognize cultural competence and diversity, expanding sections 1, 2, 4, and 6 to include gender identity and expression, as well as immigration status.

The code is organized into four sections. The first section is a preamble, which provides an overview of the social work profession's mission, as well as its core values. The core values identified are: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence.

The second section details the six purposes of the code: (1) identifying core values on which the mission of social work is based; (2) summarizing broad ethical principles that reflect core values and establishing a set of standards that should be used to guide social work practice; (3) identifying relevant considerations when professional obligations conflict or ethical uncertainties arise; (4) providing ethical standards to which the public can hold social work professionals; (5) socializing new practitioners to social work's mission, values, and ethical procedures and standards; and (6) articulating standards that the profession can use to assess unethical conduct. Additionally, the second section discusses the use of the code, as well as containing a concise discussion on its application.

In the third section, Ethical Principles, the code details the ethical principles that follow from the values noted above. For example, for the value of service, the ethical principle identified is, "Social workers' primary goal is to help people in need and to address social problems." These values, in turn, inform the practice of social work by relating a specific principle to the core values defined in section 3.

The fourth section in the code, Ethical Standards, provides specific ethical standards in regard to social workers' ethical responsibilities to clients, to colleagues, in practice settings, as professionals, to the social work profession, and to the broader society. Some areas covered in subsection 1, social workers' ethical responsibilities to clients, include self-determination, informed consent, competence, cultural competence and social diversity, conflicts of interest, privacy and confidentiality, access to records, payment for services, physical contact, sexual relationships, and termination of services.

While the code exists to guide professional practice, it was not designed to specifically address every issue that practitioners will face. The code serves as a social workers' foundation for ethical decision making and must be applied on a case-by-case basis, but social workers are also expected to adhere to the various laws and legal codes specific to their practice. Not surprisingly, these do not always coincide, leading to a tension in practice. If social workers do not adhere to laws, legal penalties are enforced; if they do not adhere to ethical standards, legal difficulties, as well as potential discipline by professional boards, may occur. Failure to abide by the code can result in sanctions by the NASW, loss of licensure, malpractice lawsuits in civil court, and/or being required to make reparations.

Of particular importance in resolving an ethical dilemma is the recognition of the values, worldview, and cultural background of the client. The social worker's own values and unique life experiences can influence how an ethical dilemma is approached and viewed and even how the code is applied and ranked in terms of the importance of various issues. Self-awareness of values, beliefs, and potential biases can help decrease any negative effects that could hinder the resolution of a particular ethical dilemma.

Noted within the section of the code that enumerates its purposes is the premise that the code does not provide a set of rules prescribing how social workers should act in all situations but instead offers a guide to decision making and conduct when ethical issues arise. While reasonable differences of opinion can exist among social workers regarding the application of the code, social workers should consider how their decisions would be viewed in a peer review process in which the professional standards of the code would be applied.

Also noted within the purposes section are the code's limits, specifically that a code of ethics cannot guarantee ethical behavior, nor can it resolve all ethical issues or disputes. The NASW *Code of Ethics* sets forth values, ethical principles, and ethical standards to which social workers should aspire and by which their professional actions can be judged. The code cannot simply be applied in a routine manner, as each client's issue and situation is unique and requires an individualized assessment and ethical resolution.

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See Also: Council on Social Work Education; Ethnic Diversity and Values; Social and Economic Justice; Social Welfare Policy, Cultural Competence in; Social Work, Diversity Practice in; Social Workers.

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College and University Health Services

Whether private or public, institutions of higher education (IHE)—also referred to as colleges and universities—serve diverse populations, including students, faculty, administration, and staff who hail from the United States and from countries abroad. Country of origin is but one example of the diversities found in academe. As with many other human services agencies, colleges and universities experience diversity of ability and disability, age, race, ethnicity, country of origin, gender, religion, sexual orientation, and socioeconomic class and values and, as such, must demonstrate understanding and respond to these diverse constituents.

The American College Health Association (ACHA) in 2011 articulated its cultural competence statement as ". . . the capacity for an individual, an organization, or an institution to respond to the unique needs of populations whose cultures are different from that which might be considered 'dominant.'" Expressed as the recognition of differences between one group and another, ACHA's statement commits to cultural inclusion, cultural respect, equality, and equity. Inclusion, respect, equality, and equity exemplify the functional components of cultural competence. A culturally competent college or university integrates and transforms knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes necessary to deliver high-quality, responsive health services. Facilitating institutions of higher education's delivery of culturally competent health services are knowledge and experience, beliefs and attitudes that meaningfully value feelings, values, attitudes, and beliefs about self and others, and the institutional response. The policies and guidelines of a culturally responsive college or university are intended to affirm that its policies and procedures are just, provide humane and respectful care for students, protect privacy, and, further, assure that services are beneficial and do not harm.

Colleges and universities can be categorized in multiple ways. For purposes of this article, discussion is limited to institutions that serve residential and commuter students and that are located either in urban or rural locales. Typically, the range of health services delivered by a college or university includes some or all of the following: prematriculation immunization status, tuberculosis screening, drug misuse/abuse education, drug testing of student athletes, emergency and hazard protocols, prevention of sexual violence education, assessment and referral in the case of injury or acute illness, a position paper on tobacco use, and counseling and referral services.

Depending upon the state, colleges and universities are mandated by law to require certain vaccinations for matriculating students. Some states and institutions may require fewer or more, and others may only recommend certain vaccinations. According to the Centers for Disease Control and Prevention (CDC), the list of recommended vaccines may include the following: measles, mumps, and rubella (MMR); polio; varicella; tetanus; diphtheria and pertussis; human papillomavirus; hepatitis A; hepatitis B; meningococcal quadrivalent; influenza; and pneumococcal polysaccharide. It is interesting to note the mandate speaks to matriculated students, but is silent on nonmatriculated or adult and continuing education students. Because there exist a variety constructs by which institutions categorize students, students and parents are encouraged to clarify which vaccinations are required or recommended and into which student category they fall.

Commuter campuses typically provide health services during regular business hours (9 A.M. to 5 P.M. Monday through Friday) during the academic semesters and winter and summer sessions. Depending whether the college or university offers evening and weekend classes, a reduced schedule of health services may be available. On the other hand, residential campuses must configure services to meet the needs of students around the clock, seven days per week during academic semesters and winter and summer sessions. Regardless of where the institution is located, the student health service unit can be considered as a point of entry into health care services provided either on campus or contracted with local medical and emergency health care providers.

Embedded in this broad set of institutional categorizations is the intercollegiate athletic program. Most colleges and universities participate in national and regional athletic conferences for selected individual and team sports. The number of teams sponsored by a campus varies according to the institution's National Athletic Collegiate Association (NCAA) division memberships, local support and interests, and, of course, financial constraints. Members of the NCAA, regardless of the division/s in which they participate, must abide by proscriptive guidelines of Title IX (the 1973 federal legislation that paved the way for equity in educational and athletic opportunity). In the words of the NCAA, "We simply must make sure that our athletics programs represent all of the United States and all of our complexity … committed in higher education and intercollegiate athletics to the philosophy of promoting diversity in our work," and [sic] the NCAA views Title IX as the "Magna Carta for women in higher education . . . providing for women what had previously been denied—opportunity."

Any discussion of college and university health services will include student health insurance. The American College Health Association recommends that policy guidelines for student health insurance address both insured and self-funded health plans and those institutions recognize their respective sponsored health plans as the students' primary source of coverage. What constitutes an adequate and appropriate scope of coverage can include, though not be limited to, coverage for immunizations, preventive screenings and services as mandated by the respective state and federal law, illness and injury, prescription medications,

Students relax on campus. According to the American College Health Association's nondiscrimination policy, the association supports all initiatives to create a campus climate guided by the values of cultural inclusion, respect, equality, and equity.

preexisting conditions, continuity of coverage during medically necessary leave of absence, and continuity of coverage for previously insured students. Most important and fundamental to the culturally responsive institution, as mandated by federal and state law, and where appropriate in keeping with the institution's mission, the student health insurance program must be made available to all students regardless of age; gender identity, including transgender; marital status; physical size; psychological/physical/learning disability; race/ethnicity; sexual orientation; religious, spiritual, or cultural identity; sex; sexual orientation; socioeconomic status; and veteran status. Integral to an intercollegiate athletic program is the institution's responsibility to its student athletes, which is extended to the visiting athletic staff and student athletes during practice and competition dates.

Colleges and universities intentionally seeking to achieve and maintain cultural competence and responsiveness are encouraged to familiarize themselves with the Standards of Practice for Health Promotion in Higher Education (SPHPHE). The constructs that inform SPHPHE's standards of practice affirm that health is the capacity of individuals and communities to reach their potential; specifically, that health is not simply the absence of disease but is "a positive concept emphasizing social and personal resources as well as physical capacities," as stated by the World Health Organization (WHO). It can be argued that the breadth of WHO's statement assumes cultural competence and responsiveness.

SPHPHE advocates health promotion initiatives aimed to expand protective factors and campus strengths and to reduce personal, campus, and community health risk factors. This is possible within the alignment with the mission and value statements of institutions of higher education. Because each college or university is a community—possessing components of a community (space, functional units, patterned social interaction, and symbols of collective identity—each institution is thereby positioned to build upon the interrelationships and interdependencies present among its student members. This approach both examines and addresses health issues at the intrapersonal, interpersonal, and institutional levels.

College and university health services articulate the best of higher education's commitment to cultural inclusion, competence, and responsiveness. While striving to deliver preventive education and services, these units promote the acknowledgement, understanding, and valuing of differing systems of beliefs, values, and customs that affect health. Health promotion in higher education advocates healthy environments guided by cultural competence and inclusion and respect, equality, and equity.

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See Also: Community Health, Racial and Ethnic Approaches to; Health Care Delivery, Models of; Health Promotion Services

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Colonialism, Lingering Effects of

Colonialism determined the policy of most European countries for centuries. Since the 15th century, when Spain and Portugal began colonial acquisition in Africa, India, and the Caribbean, European powers including Britain, France, and the Netherlands began to strengthen their ambitions to gain colonies on these continents. Colonialism was not just a European phenomenon; Asian countries like Japan also participated in the colonization process during the 20th century. With regard to the single colonialisms, factors of human diversities were responsible for the single lingering effects of the colonial rules of colonial powers in different colonial environments. Until the end of World Wars I and II, most colonies remained an essential part of the economies of these European powers, but the effects of colonialism were not one-sided. It influenced the colonies in a way that lingering effects of colonial rule are still visible in some nations. The former colonies remained influenced under economic, ethnic, and religious parameters, which are responsible for the standard of living in the non-European world, and immigrants from former colonial countries may have a need for special human services.

History of Colonization

Colonization occurred for different reasons. The desire for expansion, a religious mission, and the acquisition of new markets and raw materials were responsible for Spain and Portugal to begin colonizing regions in the late 15th century. Christopher Columbus and Vasco da Gama are well-known explorers who opened up new areas for Spanish and Portuguese trade and religious missionaries. In later centuries, both of these colonizers were replaced by the French, the British, and the Dutch, which were responsible for the decline of Spanish rule in Asia and the Caribbean. North America became a model colony, securing the British hegemony as a colonial power. Until the end of World War I, when the British dominions Canada, South Africa, and Australia became self-governing colonies, and the first decade after World War II, when the first African and Asian colonies were granted independence, the European Great Powers and Japan were eager to achieve the status of a colonial power. What had been a valuable part of economic success from the 15th to the 19th centuries became an expensive aspect of foreign policy after the late 19th century. From 1945 onward, most colonial powers became willing to abandon their rule on foreign continents. Despite this, until today, one is able to trace the long-term effects of colonial rule, which many experts think ended too quickly for most colonial nations, where a vacuum of power was responsible for many problems in the aftermath of independence.

Economic Effects

One of the most important lingering effects of colonialism is its economic effect. The European powers acquired colonies to strengthen their industry and supply of raw materials. Because of this, existing economic structures were implemented, as in India during the 15th and 16th centuries; but in later years, the colonial powers adopted a more intensive assertion of the colonial field. Industrialization spread from the mother country to the colonies, which could be seen as a positive effect, but at the same time, the raw materials were exploited (e.g., the gold and silver mines in South America) to provide the European countries with a surplus of prosperity. Many former colonies still produce the same products, which had been implemented as an industrial field in the colonial era (e.g., sugar production in Cuba), but suffer from a lack of precious metals, which were used to finance Europe during the early modern times. As a result, formerly luxurious products became cheaper in the postcolonial and more globalized world. The work-intensive productive processes in the colonial nation were also responsible for a growing slave trade, which justifies the ethnic effects of colonialism.

Ethnic Effects

Because of the Atlantic slave trade, many people were sold as slaves in Africa to harvest cotton in South America, though African slaves were not the only people who were forced to leave their homes. Multiethnic societies were established in the Caribbean, the United States, and South America, where blacks were needed to set up and drive large cotton, cocoa, and sugar plantations. Also, Indian people left their homes to serve in South Africa during the period of massive railway construction. Thus, colonialism led to an ethnic uprooting in African and Asian societies, but this was not its only ethnic effects. The process of demarcation in the colonial field was arbitrary because colonial powers drew the borders on a map. Ethnic conflicts or existing tribal organizations were ignored. This ignorance led to civil wars and many ethnic conflicts in Asia and Africa after the beginning of decolonization.

The different groups started to gamble for national power to establish their rule. For example, the Congolese and Sudanese civil wars were lingering long-term effects of colonialism. Different ethnic groups became part of the same nation-state because they had to live inside the same borders, but were unable to live their daily lives by following their needs and beliefs. Because of religious differences, states split up (i.e., India and Pakistan), in the post–World War

II era. There were not only local conflicts, which worsened as a consequence of the colonial period, but still other ethnic conflicts, especially the conflict between the black majority and the white elite—as was the issue of the apartheid system in South Africa. This was a system that was established during the colonial era, but existed until the 1990s as a lingering effect of colonization. The ethnic conflicts were not the only ones resulting from the colonial rule of the European powers.

Religious Effects

Following the colonial ambitions of the different European states, many missionaries started to enter the colonies to spread Christianity on the far-off continents of Africa, Asia, and South America. They were successful in baptizing many people in different countries, which led to very prominent Christian communities in these countries, such as Brazil. As a lingering effect of colonialism, today's Catholic Church has the biggest influence in former colonies. However, local religious beliefs and traditions were destroyed, and many religious conflicts occurred. One example is the Boxer Rebellion, which was led by a Chinese religious group—the Boxers—as a consequence of the increasing missionary work of foreign missionaries, who tried to baptize the Chinese people. Despite the uprisings, the colonial powers were generally able to suppress religiously driven uprisings in the individual nations, but there were not always conflicts. In some cases, a symbiosis of former religious beliefs and Christianity formed and created new forms of spiritual worship. Traditional and new aspects were mixed to create a new religious movement.

Because of the differing effects of colonialism on the individual colonies, most countries were unable to protect their cultural heritage against colonialism and Europeanism. The daily influence was able to systematically infiltrate the existing economic, ethnic, and religious traditions. As a consequence, the colonies changed. The changes lasted for centuries, and one is able to trace these changes through their lingering effects. Even if the situation differs from case to case, and varies in the extent of its lingering effects, colonialism is a global phenomenon, one of high historical importance, and is able to explain the present human diversity in many different nation-states. Each multicultural society has its roots in migration, which is in most cases a direct consequence of European governmental colonial policies. Even if the aim was initially economic, the way that colonialism was implemented changed through the ages and led to the situation. This situation is determined by different ethnic and religious exchanges, which are a direct consequence of the extended colonial era in the states' histories.

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See Also: Assimilation; Cultural Determinism; Global South/Global North; Power, Race/Ethnicity and.

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Communicable Diseases Common in Developing Countries

Disease is a serious threat to the overall well-being of populations across time and borders. The prevalence of diseases spread through communities and populations has plagued civilizations throughout history. From the bubonic plague in the 14th century that killed an estimated 25 million people in Europe to the influenza virus that results in approximately 500,000 deaths per year today, communicable diseases persist as serious threats to the livelihood of societies and the well-being of people in communities. Three out of every 10 deaths worldwide are attributed to communicable diseases. As organizations focus on the transmission of communicable diseases around the world, health monitoring indicates significant disparities in health education, prevention, and treatment among nations. These issues significantly impact communities in developing countries, where health care is limited and facilities lack the means necessary to provide adequate health care to reduce mortality rates associated with communicable diseases.

Mortality Rates

Deaths associated with communicable diseases account for high rates of premature loss of life. While communicable diseases cause 51 percent of deaths globally based on years of life lost (in young populations), only 8 percent of death in high-income countries is based on premature death, compared to 68 percent in low-income countries. Reliability of statistical data varies widely between high-income and low-income countries, with results from high-income countries valid to plus or minus 1 percent, and results in low-income countries at approximately plus or minus 15-20 percent. The reliability of statistical data in low-income countries is a result of underreporting, suggesting that mortality rates for communicable diseases may be much higher than indicated.

Transmission

Communicable diseases are transmitted from person to person, either through direct contact or contact with infected secretions or discharge. While some diseases, such as measles and pertussis, have a short incubation period and easily detectable symptoms, other diseases produce vague, nonspecific symptoms and some show no sign of infection. The diseases that show little to no sign of infection are those most capable of rapid transmission through a population. Influenza, for instance, is a widespread communicable disease that typically presents itself in symptoms subsequent to the person becoming contagious. Children are more likely to transmit influenza than adults, with incubation periods beginning days before symptoms and lasting up to two weeks after infection. Influenza can be transmitted airborne, through direct contact with a host, or from contaminated surfaces. Influenza outbreaks in developing countries can lead to a significant rise in transmission and death due to overpopulation and poor sanitation facilities, as well as a lack of resources to treat the large number of people suffering from the virus.

Other communicable diseases can become serious, lifelong battles. Human immunodeficiency virus (HIV), the virus leading to acquired immunodeficiency syndrome (AIDS), has become a global concern. Since the documentation of Patient Zero in 1980, HIV/AIDS has infected over 70 million people worldwide, with over half of those cases resulting in death. An estimated 34 million people around the world are currently infected with the virus, with half of them being women and 10 percent children. Because of the lack of symptoms during the early stages of HIV/AIDS, its transmission can go undetected and spread through populations. HIV/AIDS is transmitted through blood and other bodily fluids, most commonly through unprotected sexual intercourse and needle-sharing typically associated with illegal drug use. Other modes of transmission, such as mother-to-fetus transmission and blood transfusions, are more prevalent in developing countries where lack of awareness and medical care fail to diagnose infected individuals, resulting in higher rates of transmission.

Awareness

Implementing disease control and prevention requires effective monitoring, community support, and resources to treat outbreaks and endemic infections. Organizations such as the World Health Organization (WHO), Institut Pasteur, and the U.S. Centers for Disease Control and Prevention (CDC) provide outreach support to developing countries in order to bring awareness to populations lacking preventative education, health care facilities, and vaccination access. Global health initiatives (GHIs) such as Stop TB (tuberculosis), Roll Back Malaria, and the Global Alliance for Vaccines and Immunizations provide support systems and health care services to local communities. These GHIs align with the United Nations Millennium Development Goals (MDG) targeted at improving the quality of life in populations in the least-developed countries. MDG 4 and 5 focus on reducing child mortality and improving maternal health, respectively. MDG 6 achieves the preceding goals by combating communicable diseases in vulnerable populations. Through GHIs and other global awareness programs, worldwide efforts promote sustainable and effective procedures to eradicate preventable communicable diseases aligned with MDG and aimed at bridging the widespread health care resource gap throughout the developing world.

Over a decade since the promotion of MDG, progress has been made toward global awareness and reduction of communicable diseases in the least-developed nations. Although smallpox was eradicated in 1979 and rinderpest in 2011, most communicable diseases continue to plague developing countries in varying degrees. Eradicated or low-prevalence diseases in high-income countries continue to have high mortality rates in the developing world. Polioviruses, for instance, were eradicated in the Americas in 1994 but continue to be endemic in Afghanistan, Pakistan, and Nigeria, and there also are outbreaks in developing countries in which there is overcrowding, high birth rates, and poor hygiene and sanitation. The largest public health initiative in history, proposed by the World Health Assembly (WHA) in 1988 to eradicate polioviruses, has shown a 99 percent success rate globally. Public health initiatives such as Stop Transmission of Polio (STOP) continue to provide country-based support to diminish disease outbreaks and work toward global elimination.

National and regional initiatives focused on communicable disease reduction have also shown great success. African countries, especially sub-Saharan nations, face an HIV/AIDS epidemic, accounting for the deaths of nine out of 10 children associated with HIV/AIDS in the worldwide mortality rate. GHIs concerned with HIV/AIDS focus on health education, treatment, and prevention. Through the President's Emergency Plan for Aids Relief (PEPFAR), the United States and other countries pledge to use breakthroughs in scientific research and effective prevention strategies to promote awareness and globally eradicate HIV/AIDS.

Results and Implications

GHIs and other programs provide a platform for developing countries to establish health practices aimed at preventing and treating communicable diseases. The collaboration through global partnerships to improve health care worldwide has proven successful in combating several communicable diseases across populations. Due to increased health monitoring on local, national, and global levels, great strides have been made to decrease the transmission of communicable diseases. Over 20 million people have survived tuberculosis due to GHI treatments, millions of children avert malaria through prevention and education, and increased access to antiretroviral medication has helped treat millions of people infected with HIV around the world. Yet, as shown through the MDG regarding health, the current status of diseases around the world is not diminishing at the rate many hoped for. As of 2011, over 7 million people infected with HIV lack access to antiretroviral medication. Eighty percent of malaria deaths occur in 14 countries, all of which are developing countries. Although progress is seen in many areas, the eradication of communicable diseases in developing countries is a formidable task requiring the dedication of GHIs and worldwide support to provide developing countries with sustainable methods of health education and prevention.

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See Also: Agency for Healthcare Research and Quality; AIDS/HIV Programs; Health Care, Disparities in; Health Disparities, Role of; Pharmaceuticals, Access to.

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Communication Disorders, Services for

Communication disorders occur across the age span, from infancy to the elderly, and encompass the diagnosis and intervention of individuals with difficulty in receiving, sending, processing, and understanding verbal, nonverbal, and graphic symbol systems. Speech disorders are classified as articulation/phonology, fluency (stuttering), and voice disorders. Language disorders reflect difficulties in form (phonology, morphology, and syntax), content (semantics/meaning), and use of language (pragmatics), or any combination of these linguistic components. Speech and language are distinguished from one another because speech mainly deals with the production of sounds and syllables, and language focuses on understanding (receptive) and producing (expressive) language.

There are multiple causes of communication disorders, such as motor speech disorders like apraxia and dysarthria. Aphasia, loss of language resulting from a stroke, tends to occur more often in adults, but children, particularly those with sickle cell anemia, may also experience strokes. Feeding and swallowing disorders also fall under the umbrella of communication disorders. Different types and degrees of hearing loss influence speech intelligibility and receptive and expressive language, which may be associated with individuals who have been diagnosed as deaf or hard of hearing (HOH). Central auditory processing disorders influence the ability to perceptually make sense out of what is heard, according to the American Speech-Language-Hearing Association. Traumatic brain injury (TBI), autism spectrum disorders, cleft lip and palate, developmental difficulties such as Down syndrome, and emotional/behavioral difficulties also contribute to communication disorders.

Neurologically based sensory and structural difficulties are referred to as organic disorders, as contrasted with functional disorders. Functional disorders occur when the onset of the problem occurs in preschool, school-age, and high school students, and is a disorder for which there is no identifiable cause. Speech-language pathologists (SLPs) are required to spend six years in undergraduate and graduate training and one year of supervised full-time paid practice after completing the graduate degree. Concerns about any individual with a suspected communication disorder should be referred to SLPs, who are highly trained and skilled and can work with families and agencies to meet the needs of the individual.

Demographics

Communication disorders may be acquired or developmental, judged by degree of severity, and may be a primary disorder or coexist with other impairments. As contrasted with language disorders, language differences do not constitute a disability and are influenced by social, regional, and cultural practices. Language differences, also called social dialects, regional dialects, and language varieties, are often associated with race, ethnicity, and cultural variables. Although there is evidence that socioeconomic status (SES) may impact a decrease in vocabulary, overall limited resources do not appear to significantly affect acquisition of the rules of speech and language. SLPs are charged with distinguishing language disorders from language differences by determining what is a communication disorder, and what linguistic characteristics mainly reflect the influence of the person's linguistic environment. It is also the role of the SLP to determine when there are disorders in the presence of a language difference, that is, the two sets of linguistic characteristics can co-occur.

SLPs may have difficulty sorting out which grammatical rules, vocabulary, semantics, and speech productions constitute a difference versus a disorder. The inability to do so tends to lead to misdiagnoses and overdiagnoses of language disorders among children from multicultural backgrounds. Therefore, service delivery requests should ask for an evaluation in the first and second dialect or the first and second language. Other demographic data reveal that males have a higher prevalence in select communication disorders. For example, A. Proctor and associates reported that there was a statistically significant difference in gender, with males having a higher prevalence of stuttering (disfluency) than females. This same study revealed no statistically significant difference in stuttering between African American and white preschoolers. Other evidence from D. H. McKinnon and colleagues suggests a higher prevalence of language disorders and speech disorders may be found in males as opposed to females.

Service Delivery

Intervention plans are typically customized for the individual, depending on the specific disorder or the co-occurrence of disorders. For some communication disorders, such as articulation/phonology and childhood language disorders, there are well-designed intervention programs that may be applied to many who are diagnosed with the same disorder. However, there are other disorders for which an individualized intervention plan must be developed. For instance, the effects of TBI do not result in a homogeneous group, requiring unique therapy plans for each individual. Alternatively, those with aphasia can be categorized into homogeneous groupings, and intervention programs can be applied to everyone with a specific type of aphasia.

Evidence suggests that children receive the greater amount of service because they are screened and identified, and intervention can be readily provided in schools nationwide. Prominent among school-based models of service delivery are the pull-out model, the classroom intervention model, the indirect consultative model, and the collaboration model. In the pull-out model, the child leaves the classroom to receive intervention with an SLP in a different setting within the school. After the SLP completes intervention activities, the child is returned to the classroom. Both individualized and group intervention may utilize the pull-out model. In the classroom-based model, the SLP provides intervention to a child or small groups of children within the context of the classroom. There are different modifications to the classroom-based model. For instance, the SLP and the classroom teacher team teach and use scaffolding to integrate language intervention with regular instruction. Another modification requires the SLP to accept primary responsibility in managing a small class of children who have been diagnosed as language impaired.

The indirect consultative model also has modifications. Indirect infers that the SLP does not deliver the services per se. In some cases, the SLP develops appropriate goals for each child and then supervises a speech-language assistant in administering activities so that the child will meet the goals. The clinician-caregiver consultative model requires the SLP to conduct parent training and thereby facilitates parents' abilities to deliver selected intervention to the child. In other cases, the SLP consults with the classroom teacher who integrates language and speech goals into the context of the curriculum. The collaborative model, a transdisciplinary approach, considers that a single person does not hold all of the knowledge needed to make therapeutic decisions. Therefore, a team of professionals who have expertise in different areas of special education work collaboratively to diagnose the problem, plan goals, and deliver intervention. The team usually includes parents, paraprofessionals, and the students. Studies of which model is more efficacious suggest that no one model is superior to another, and that each is clinically useful depending on its application in different settings.

The American Speech-Language-Hearing Association (ASHA) reports 14 variables that influence service delivery in schools. Jayne Brandel and Diane Frome Loebe reorganized the ASHA variables into characteristics associated with the individual with the disorder, characteristics related to the SLP, and the setting in which services are provided. The model, named the school-based intervention decision making (SIDM) model, consists of variables that can be applied in other service delivery settings outside of the elementary school. That is, when services are delivered outside of the elementary school setting, such as acute and subacute hospitals, rehabilitation facilities, or clinics, the individual, the SLP, and the setting will also be considered in decision making about frequency, intensity, and content of therapy.

With the availability of improved technology, services can be delivered via telepractice communication networks, online Web sites, and other alternative technological mechanisms. Finally, early intervention models have also emerged for infants, toddlers, preschoolers, and their families. Early intervention models mainly focus on family-centered approaches and service delivery in naturalistic environments, such as intervention and parent training during home visits and different types of coaching models.

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See Also: Communication Styles, Ethnic and Cultural Differences in; Disability Services; Disabled Clients; Educational Support Services; Special Education.

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Communication Styles, Ethnic and Cultural Differences in

Because of a growing global economy, the population has become increasingly more diverse. In order to make accurate assessments and plan effectively, communication between human services professionals and their clients must be clear, precise, and complete. For counselors, social workers, case managers, psychologists, nurses, and psychiatrists who depend on the nuances of language to understand their clients at a deeper psychological level, an understanding of the communication styles of many cultures and ethnicities is essential, a task complicated by the countless variations within any ethnic group. The intermingling of races and ethnicities suggests that communication styles will continue to emerge, rendering descriptions of communication styles relative to context and individual differences. Verbal communication includes the spoken word, tone of voice, and nonverbal behaviors. Transcending the written or spoken word are proxemics, the perception and use of personal space; kinesics, bodily movements such as facial expressions, posture, characteristics of movement, gestures, and eye contact; and paralanguage, which includes loudness of voice, pauses, silences, hesitations, rate, and inflections.

Patterns in speech, eye contact, listening, responding, and manner define the communication style of a culture. White, black, Hispanic, Asian, Native American, and Arab cultures have general differences in communication style. In all primates, emotions cause physiological reactions that have distinct universal signs. Culture, however, can modify the expression of emotional responses and complicate the assessment process. For example, poor eye contact and minimal feedback that suggest depression in a white client are normal demeanor for a Native American. Communication differences among cultures also reflect cultural differences in history, beliefs, and values.

High-context and low-context communication refer to how much a speaker relies on actual words to communicate. Cultures that have high-context communication use both verbal and nonverbal messages. High-context communication requires a listener to have excellent observational skills and a thorough knowledge of body language and nonverbal cues to understand the message. Persons from the same culture will more accurately read the meaning of nonverbal behaviors. Persons of a different culture must familiarize themselves with the behavioral nuances of different cultures. Asia, the Middle East, Africa, and South America are high-context cultures. Low-context cultures rely more on the literal meaning of words to determine the speaker's intentions. Written communication is sufficient to accomplish the communication goals of low-context cultures. The United States, Germany, Switzerland, and the Scandinavian countries are low-context cultures.

Whites

Communication patterns among whites are congruent with individualistic societies. Americans are future-focused, task-based, and often driven to gain mastery of people, situations, and nature. Their happiness often comes from achievement. White Americans tend to speak louder and faster than other cultures, and to have more eye contact. In public communications, white Americans restrain themselves from emotional expression, often equating it with a lack of control. Maintaining a midrange of volume, tone, and tempo is preferable to passionate expression, which may be associated with being irrational in America. In conversation, the speaker tends to look away from the listener, and the listener looks directly at the speaker. When whites hear and understand a comment, they nod in acknowledgement, and they respond quickly to the comments of others. White Americans have a moderate range of expressive gestures. Because white Americans have diverse origins, among whites different ethnicities interpret communication differently. Italians, for instance, consider loud and animated talk to be the mark of a stimulating conversation. The English may find the same volume of conversation threatening and the mark of impending conflict.

African Americans

African Americans animate communications with frequent, large gestures and speech that is loud and fast. African Americans have a large range of volume and pitch, and their movement within that range changes from situation to situation. With each other, blacks have closer proxemics and are more likely to communicate through touch. Eye contact is direct and sustained when African Americans speak, but when they are listening, eye contact diminishes, which is the opposite of the dominant white culture eye-contact patterns. African Americans are quick to respond, and it is common within the culture to interrupt before another has finished speaking. Passionate communication is more believable to African Americans, and the neutral, objective tone of standard American English often garners suspicion and distrust.

African Americans speak in a dialect of black English, and can easily change from the dialect to mainstream language. Black English has a unique vocabulary, pronunciation, grammar, syntax, and accent. "Ebonics" is a term coined to describe black English as a combination of ebony and phonics. In many contexts, the cultural communication differences between whites and African Americans are perceived as conflicts.

When African Americans call and respond, whites perceive them as loud, aggressive, and impolite. Whites often view animated African American behaviors as childish and unsophisticated. African Americans communicate with their bodies. The young African American's slow, swinging style of walking gives a message of assertion. Slapping the palms of each other's hands indicates agreement or celebration.

Hispanics

Like Asians and Native Americans, Hispanics have much diversity within the culture. Hispanics have a low-key manner in public, they tend to speak more quietly than other cultures, and they are offended by louder-speaking groups. In a group solely composed of Hispanics, their natural emotionality is expressed with more animated speech and larger gestures. Hispanics may avoid eye contact and look away or down when they are addressed, especially by an older person. Although they nod when they have heard or understood another person, they often have a mild delay before they respond.

Native American

Native Americans value cooperation over competition, and maintain a strong belief in living in harmony with nature and others. In communications, they tend to be reserved and nonconfrontational. It is easy to underestimate a Native American's passion for an issue because of their restraint of expression. Native American communication is low key, with a small range of pitch, tone, and volume. In conversations, Native Americans allow each other to complete their thoughts. Direct eye contact may be seen as intrusive. Indirect eye contact is particularly important in communication with elders.

A silent delay before responding to another's comments is typical. A Native American client may be listening intently while they are looking down. Quick responses to the comments made by a Native American might suggest that the speaker is being dismissive. Although Native Americans offer little feedback spontaneously, a "talking circle" is part of Native American tradition. In the circle, every member has an opportunity to express formerly unspoken thoughts. Verbal feedback and interruption are forbidden in the circle, but subtle feedback is given nonverbally through a grunt of agreement or a cough, indicating that the group is ready to move on.

Asians

Asian culture is diverse, but as a whole, it is collectivistic. Asians place value on the family, community, or work team ahead of the individual. Happiness derives from the success of the group, and failing the group incurs shame. The Chinese and Japanese place importance on status, keeping shorter eye contact with persons of higher status, and adjusting their verbiage to reflect status differences. Compared to other cultures, Asians are reserved in conversation, speaking quietly and avoiding eye contact, especially with strangers. Gestures are restrained in comparison to other cultures. Touching strangers is unacceptable, and women do not shake hands. Comments may be acknowledged with a nod, but Asians tend to have a brief delay before they give a verbal response. Asians are very reserved in expressing emotions, believing that emotionality denotes loss of control, so smiling and laughter are commonly used to mask anger, disagreement, or frustration. Asians are nonconfrontational and indirect, and may maintain silence rather than enter into a disagreement.

Arab Americans

The Arab culture values eloquence. Arabs frequently communicate through poetry, beautiful blessings, and colorful curses. The belief that words have power leads Arabs to believe that negative talk leads to negative outcomes, so they sometimes understate difficulties to avoid giving them power. Arabs are highly expressive, using broad hand gestures and loud speech. Men may exaggerate grief or sadness. A polite demeanor is important in the Arab culture. Some nonverbal behaviors that are acceptable in American culture are offensive to Arab Americans. Excessive smiling, for instance, gives Arabs the impression of superficiality. Pointing a finger at someone is threatening in Arab culture, and calling someone with a finger is considered demeaning. Arabs may soften the truth to maintain a congenial relationship, or they may be vague in lieu of saying "no." Gender roles are an important part of Arab culture. Behaviors typical of the American male are not acceptable in the Arab culture. Males do not stare, maintain eye contact, or engage in private conversation with a woman.

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See Also: Cultural and Linguistically Appropriate Services Standards; Ethnic Diversity and Values; Ethnicity and Clients.

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Community Action Agencies

Community action agencies (CAAs), both nonprofit public and private entities, are the local-level agencies designated to fight the War on Poverty declared by President Lyndon B. Johnson in 1964, expanding on the policy ideas initiated during the Kennedy administration. These agencies were regulated by the Office of Economic Opportunity, which was established by the Economic Opportunity Act (EOA) of 1964. CAAs were tasked with fighting poverty at the local level by helping people achieve self-sufficiency.

The EOA also created programs such as Job Corps, the Neighborhood Youth Corps, and Volunteers in Service to America (VISTA). However, CAAs became the most controversial aspect of Johnson's War on Poverty. CAAs serve both the urban and rural poor, providing a direct source of assistance for those living in poverty. Every state (96 percent of U.S. counties), as well as Puerto Rico and the Trust Territories, are served by CAAs, with nearly 1,000 agencies in existence. CAAs incorporate an empowerment and services strategy aimed at giving low-income people and their communities the tools with which to overcome poverty. The majority of clients served by CAAs have incomes at or below 75 percent of the federal poverty line.

A restructuring phase of CAAs occurred from 1967-68 with the passage of the Green and the Quie Amendments. The Green Amendment required that a CAA must be designated by local officials as the official CAA for a particular area in order to operate in that community and receive federal funds. In several larger cities, the CAAs were taken over by the mayor and turned into a public agency. The Quie Amendment required CAA boards of directors to be made up of one-third elected officials, one-third low-income representatives, and the remainder from the private sector. These two amendments had positive effects on most CAA boards, despite the initial concerns of poverty groups that had been operating independently.

CAAs have undergone many challenges at the federal level since their creation, including President Richard Nixon's directive in 1973 to his appointee to the Office of Economic Opportunity, Howard Phillips, to close the office and not spend the money Congress provided for it (which was not requested by Nixon, but allocated by Congress nonetheless). CAAs survived this challenge, attaining a victory from the U.S. District Court in Washington, D.C., which ruled that the president could not refuse to spend funds appropriated by Congress. In 1974, the

In his special message to Congress on March 16, 1964, President Lyndon Johnson stated, "Because it is right, because it is wise, and because, for the first time in our history, it is possible to conquer poverty."

Community Services Amendments were passed and the Office of Economic Opportunity was dismantled and replaced by the Community Services Administration (CSA). Under President Jimmy Carter, CAAs were strengthened, but the enthusiasm for these programs was short-lived as President Ronald Reagan sought to reduce the federal government's support of domestic social programs, of which CAAs were a part. The consolidation of human needs programs into block grants, with a reduction of funds for those programs, as well as the designation of oversight to the states, resulted in abolishment of the Community Services Administration (CSA) and rescission of the Equal Opportunity Act.

The Omnibus Reconciliation Act of 1981 created Community Services Block Grants (CSBG) to provide continued federal funding of CAAs, with administrative authority for these agencies delegated to the states. At present, CAAs continue to be federally funded through CSBGs. The Omnibus Reconciliation Act also mandated the structure of CSAs, laid out goals, and detailed the use of CSBG funds. The act aimed to have a network of CAAs that would work to reduce poverty, revitalize low-income communities, and empower low-income families and individuals in rural and urban settings to become fully self-sufficient.

Funding and Accountability

Funding for CAAs originates in the Office of Community Services (OCS), which forwards a notice of funds available to the states after Congress appropriates money for CSBGs and these funds have been apportioned by the Office of Management and Budget. OCS receives 1.5 percent of the CSBG appropriation for training, assistance, evaluation, and performance measurement. After receiving their share of the money, the states provide funding to CAAs through grants or contracts.

With the reauthorization of CSBGs by the Coates Human Services Reauthorization Act in 1998, CAAs were required to conduct outcome reporting. In order to measure these agencies' performance, the OCS adopted the Results-Oriented Management and Accountability (ROMA) system. Created by the Monitoring and Assessment Task Force, a group of federal, state, and local community officials, and based on principles contained in the Government Performance and Results Act of 1993, ROMA provides a framework for continual growth and improvement for all CAAs.

ROMA created six broad antipoverty goals to guide the work of CAAs, which sought to: (1) enable low-income people to become more self-sufficient; (2) improve the conditions in which low-income people live; (3) enable low-income people to own a stake in their community; (4) achieve partnerships among supporters and providers of service to low-income people; (5) enable CAAs to increase their capacity to achieve results; and (6) enable low-income people, especially vulnerable populations, to achieve their potential by strengthening family and other supportive systems. To achieve these goals, CAAs assess poverty needs and conditions within their local communities. They also must define a clear agency antipoverty mission and strategy to address those needs, both in the short and long term. Further, CAAs must identify specific results to be achieved among low-income people, organizing and implementing services, programs, and activities to attain the results identified. For each goal created by ROMA, the OCS has set direct outcome measures for which the CAAs must report.

This grassroots, community-controlled effort is led by a locally controlled board, whose members included poor people in the community. The board directs and determines the needs of the local community and where funding could best be spent to alleviate poverty. Because each CAA is locally governed, services and programs vary depending on the needs identified at the local level. When created, the CAAs' board structure was important in terms of representing local needs and those living in poverty, who would be served by the agencies. A provision of the Equal Opportunity Act called for the poor to have maximum feasible participation in the identification of problems and their solutions, as they so defined them. Therefore, at least one-third of the boards' members are from the low-income community, exactly one-third are public officials, and up to one-third are from the private sector.

Promise and Services

Each CAA adopts the National Promise of community action which states: "Community Action changes people's lives, embodies the spirit of hope, improves communities, and makes America a better place to live. We care about the entire community, and we are dedicated to helping people help themselves and each other." CAAs conduct annual community-wide needs assessments to identify the concerns of the low-income community and set program priorities. There is no typical CAA, as each develops programs and services in response to local conditions of poverty. Services provided by the agencies span a wide spectrum including, but not limited to: emergency services (food pantries, energy assistance, homeless assistance), education (Head Start, literacy, adult basic education), food and nutrition (food banks, Meals on Wheels), family development (day care, case management, employment support), training/employment (job readiness, job training, job creation), income management (budgeting, financial literacy), transportation (on-demand transportation, rural transportation systems), housing (weatherization, home-ownership, rental assistance), economic development (small business development, business planning and loans), and health care (prescription assistance, health clinics, and the Women, Infants and Children program). CAAs have also provided local support in helping individuals in their communities cope with natural and man-made disasters.

To guide their work, CAAs follow the Community Action Code of Ethics wherein they dedicate themselves to eliminating poverty by opening to everyone the opportunities for education and training, for work, and to live in decency and dignity, respecting cultural diversity. The community action movement strives to address and ease the misery of poverty, replace despair with opportunity and hope, make known the plight of the poor, focus on people (individuals, families, and communities), and facilitate groups working together to solve problems.

CAAs are represented by the National Association of Community Action Agencies (NACAA), the largest national organization representing the interests of CAAs. The NACAA is governed by a democratically elected board of directors that works closely with state and regional associations to respond to the professional needs of the CAAs. Since 1992, CAA staff can become certified community action professionals (CCAP), a recognition of high honor within the organization achieved via completion of an extensive portfolio, study, and examination.

CAAs continue to work as advocates, service providers, and initiators of change on behalf of the poor. They strive to create the conditions by which low-income individuals, families, and communities can be lifted out of poverty, representing a war on the causes and conditions of poverty by utilizing an empowerment strategy designed to provide the tools with which to overcome poverty.

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See Also: Food Insecurity; Head Start and Prekindergarten Programs; Homelessness; Housing Support and Homeless Services; Poverty; War on Poverty Programs.

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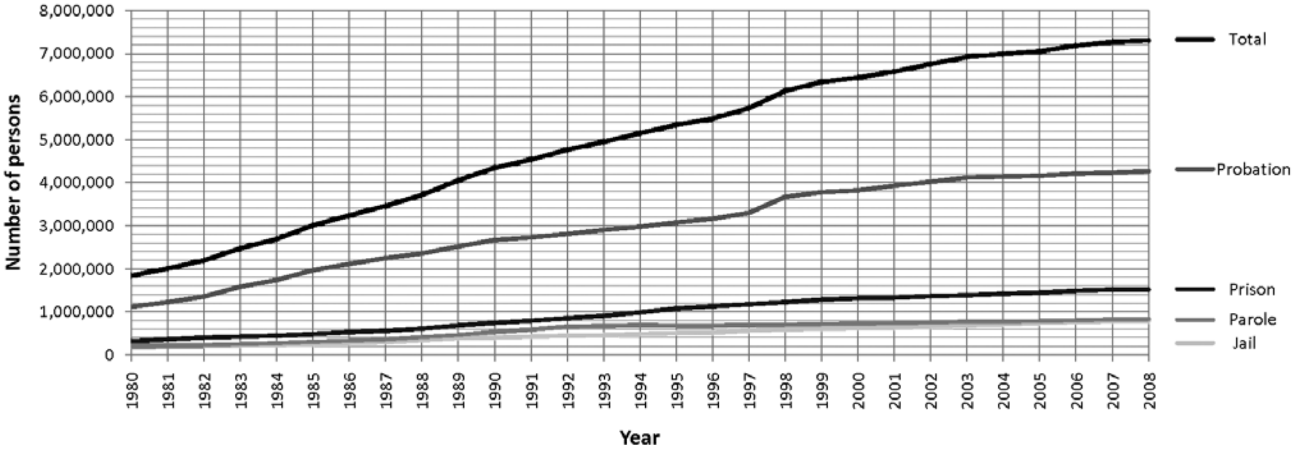
Community Corrections

The United States currently has more incarcerated people than any country in the world. This unprecedented period (1970 to present) of incarceration has resulted in severe prison overcrowding. Prisons in some cases are operating at capacities double or triple their initial design. Prison cells that were initially designed for one person are outfitted with double or triple bunks to accommodate the influx of new prisoners. Prison overcrowding presents serious safety issues for corrections officers and prisoners alike. Escalating prison violence and the high cost of operating prisons, coupled with high levels of recidivism (when people return to prison postrelease), have forced policy makers to examine alternative solutions in response to crime. One example is community corrections. Community corrections is a practice of the criminal justice system that sentences people convicted of crimes to community monitoring, rather than an official prison setting. Community corrections does not restrict an offender to their home, but rather to halfway housing, work, and educational release programs; mental health hospitals; and substance abuse impatient treatment. Some individuals under the auspice of community corrections have yet to be convicted (i.e., are out on bail awaiting trial); however, they are often subjected to many of the same guidelines as those convicted of crimes. City, state, and federal authorities have begun utilizing community corrections as an alternative to sending individuals convicted of crimes to prison. It is estimated that between 5 and 7 million people are under some form of community correctional supervision, such as probation or parole. African Americans and Hispanics represent almost two-thirds of all community corrections convictions. Most are poor, lacking education, and present greater health (physical and mental) disparities than the general public (this also holds true for individuals in prison).

Organization

The length of time that an individual serves while on a community correction sentence varies according to the severity of the crime. A community correction sentence could range from six months to five years. Most individuals sentenced under community corrections are convicted of nonviolent crimes (e.g., drug sale or possession). Many individuals are not sentenced to community corrections, but are rather subject to a period of community corrections after their prison sentence concludes: An

Figure 1 Correctional populations in the United States, 1980 to 2008



Source: Bureau of Justice Statistics Correctional Surveys.

example would be an individual sentenced to five years in prison, but eligible for release from prison after three years. If he or she is released from prison after three years, then he or she is required to serve the remaining two years under community corrections (i.e., parole or probation).

Empirical data has shown that individuals sentenced to community corrections, rather than prison, tend to have a higher ratio of success, meaning that they tend to commit fewer future crimes or to return to prison for violating community correctional guidelines. The relative success of community corrections is partly attributed to its holistic and collaborative approach, utilizing nonprofit organizations, religious institutions, and family/community members in the rehabilitation process. This collaborative approach creates a holistic treatment paradigm that is able to tackle the complexity of challenges often associated with individuals in the criminal justice system, whereas services for offenders in prison settings tend to be minimal and lacking because of budgetary and policy restrictions. Many proponents of alternatives to prison programs, such as community corrections, espouse the importance of partnering with family members and nonprofit organizations. They further denounce a deterministic view of crime (i.e., individual behavior/cognition solely) and the belief that the offender can only be helped, and crime reduced, when a model is established that provides a multidimensional approach to treatment, inclusive of socioeconomic conditions.

Individuals under the auspice of community corrections have restrictions placed on their liberties. They often have stringent guidelines to which they must adhere while serving a community corrections sentence. While the guidelines will vary by state or federal jurisdictions, they often include a restriction on travel, and consumption of alcohol and illegal substances, and mandates to attend substance abuse, educational, and work programs. Restrictions can also include obtaining a driver's license, revocation of the right to vote, inability to reside in public housing, and bans from certain state and federal jobs. Some of these restrictions are lifted once an individual serves the allotted community corrections time, yet research indicates that the stigma of being formerly incarcerated often creates a perverse double jeopardy (i.e., job and housing discrimination because of a criminal conviction) that remains long after the sentence is served.

Management

The local departments of probation and parole typically oversee guideline adherence for individuals in community corrections. A risk assessment scale is utilized to evaluate the likeliness of reoffending, and to thus determine the level of supervision that an individual will require. The risk assessment scale utilizes factors such as the crime accused or convicted, past criminal history, and age of the individual as determinants to calculate risk of the offender committing new crimes. Parole and probation officers arrange meetings with individuals at their respective agencies daily, weekly, and monthly, depending on the determined risk level. The level of risk is typically calculated on a scale from 1 to 10, with 10 being the greatest risk for future criminal behavior. In addition to face-to-face meetings, parole/probation officers can also utilize phone calls and electronic monitoring devices (i.e., an ankle bracelet). An electronic monitoring device conveys an alarm to the parole/probation officer if the individual leaves the agreed catchment area. Catchment areas vary according to crimes committed or accused, but most individuals have the ability to go to work and school or receive treatment while serving a community correction sentence.

During visits with parole and probation officers, individuals in community corrections are often tested for illegal substances, including alcohol. They are also required to give a verbal or physical report (i.e., pay stubs) corroborating their adherence to the guidelines set forward by the terms of their community correction sentence. Parole/probation officers will also conduct both announced and unannounced visits to the home and workplace. If it is deemed that individuals are noncompliant with the terms set out, the respective officer has the power to arrest the individual and confine him or her to jail until a violation of parole/probation hearing occurs. A judge makes a determination at this hearing whether or not a violation occurred. If a violation is deemed not to occur, the individual will be released back to community corrections with the same or updated guidelines. If it is deemed that the individual violated the terms put forward, he or she can be sentenced to a period of incarceration, sometimes for the remainder of the original community correction sentence.

A violation of probation/parole hearing will also take place if an individual commits a new crime and is convicted while on a community correction sentence. In most cases, the new crime conviction is considered a violation of the community corrections guidelines. The judge will most likely recommend that the remaining time be served in prison concurrently or consecutively, with any prison time stemming from the new conviction.

Growth in Usage

Community corrections are of particular importance to policy makers and government officials in light of the current state of incarceration in the United States. State and federal prison populations have risen tenfold from the 1970s to the present. However, the vast majority of people incarcerated are poor people of color, and most are incarcerated for substance abuse violations. However, research indicates that drug usage is in many cases more pervasive among whites. The racial disparity in arrests and convictions has many social justice advocates concerned. They believe that communities, which are already at a social and economic disadvantage, could now be turned into open-air prisons under the auspice of community corrections.

The failure of prisons, coupled with the huge financial cost associated with prison incarceration, has moved community corrections to the forefront of criminal justice. Community corrections are a cheaper alternative to prison incarceration, and have shown greater potential of lowering the likelihood of future crime when compared to individuals sentenced to prison. Greater research and time is necessary to determine if community corrections can truly address issues of crime and punishment in America.

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See Also: Incarceration and Sentencing, Racial Disparities in; Jail Diversion Programs for Children and Adolescents; Juvenile Justice System; Prisoners and Ex-Prisoners; Probation and Parole Officers; Restorative Justice.

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Community Development Block Grants

Created by the Housing and Community Development Act of 1974, the Community Development Block Grant (CDBG) program assists urban, suburban, and rural communities to improve housing and living conditions and expand economic opportunities for low- and moderate-income persons. The CDBG program provides annual grants to 1,209 city and county governments and states. Funding for the CDBG program has been cut 37 percent since 2010, leaving local governments that count on CDBG funds pressuring Congress to restore funds, and critics of the program pointing to what they consider wasteful spending and calling for deeper cuts.

The Department of Housing and Urban Development (HUD) was created in 1965 as part of President Lyndon B. Johnson's Great Society, along with a range of urban grant programs designed to end urban blight and make cities more livable. A decade later, the nation's mayors were disillusioned with the restrictions that these programs placed on how federal funds could be used in their cities, and President Richard Nixon was eager to give cities wider discretion in spending and less government intrusion. The Nixon administration was formulating community development revenue sharing legislation by 1971, and the Senate passed an omnibus housing bill that included community development block grants in 1972. The bill was blocked by the House Rules Committee because of opposition to other provisions in it. Congress passed an omnibus housing and community development bill, including the CDBG, in 1974. It was signed into law by President Gerald Ford a few days after the resignation of Richard Nixon.

Grant Programs

The act combined several categorical grant programs into one block grant. The CDBG program has three major components. First, entitlement grants are distributed by formula to every city that has a population of at least 50,000 or is a county seat. Cities have considerable flexibility in how the funds are spent as long as funded activities meet one of the CDBG objectives: benefitting low-or-moderate-income families, aiding in the prevention or elimination of blight, or meeting a critical community need. Second, grants to small cities provide funds to nonentitlement communities for community development activities in line with the CDBG objectives. In all states except Hawai'i, this program is administered by a state agency. The HUD Honolulu Office directly administers the CDBG program for nonentitlement communities in the state of Hawai'i.

Third, the Section 108 program allows communities to use their CDBG funds as a guarantee to back up federal financing for economic development, housing rehabilitation, public facilities, and large-scale physical development projects. Although there are specific requirements and exceptions, the Section 108 program allows cities access to as much as five times its annual CDBG funding for such projects as the acquisition of real property; the rehabilitation of publicly owned real property; housing rehabilitation eligible under CDBG; construction, reconstruction, or installation of public facilities (including street, sidewalk, and other site improvements); related relocation, clearance, and site improvements; payment of interest on the guaranteed loan and issuance costs of public offerings; debt service reserves; public works and site improvements in colonias; and in limited circumstances, housing construction as part of community economic development, Housing Development Grant, or Nehemiah Housing Opportunity Grant programs.

In addition to these three components, the CDBG program provides grants to insular areas, disaster recovery assistance, and neighborhood stabilization. Insular areas include American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands. CDBG disaster recovery funds are available to states, units of general local governments, Indian tribes, and insular areas designated by the president as disaster areas. Generally, grantees are required to use at least half of disaster recovery funds for activities that principally benefit low-and moderate-income persons. These funds may be used for recovery efforts that include housing, economic development, infrastructure, and prevention of further damage to affected areas, as long as efforts do not duplicate recovery actions funded by the Federal Emergency Management Agency, the Small Business Administration, and the U.S. Army Corps of Engineers.

Congress appropriates these funds in addition to regularly budgeted CDBG funds. The largest appropriations include $3.483 billion in 2001 and 2002 to assist post–September 11th New York City's recovery efforts; $16.7 billion in 2006 to assist the victims of Hurricanes Katrina, Rita, and Wilma; and $15.8 billion in 2013 to assist recovery from Hurricane Sandy. The CDBG Neighborhood Stabilization Program provides grants to communities that have suffered from foreclosures and delinquencies to purchase, rehabilitate, or develop homes and stabilize neighborhoods.

Local entitlement cities and counties receive 70 percent of CDBG funds, and states receive 30 percent. Rural counties and other nonentitlement communities compete for funding from the state formula allocation. The Department of Housing and Urban Development developed the formula that states use to guide allocations. The department must consider such measures of community need as the extent of poverty, population, housing overcrowding, age of housing, and population growth lag in relationship to other metropolitan areas.

Funding Cuts

The 1975 federal budget allocated $2.7 billion to the new CDBG program. Had appropriations kept pace with inflation, the CDGB funding for 2013 would have been more than $11 billion. Instead, for fiscal year 2013, CDBG is funded at $3.07 billion, a 30 percent reduction. Organizations such as the U.S. Conference of Mayors, a nonpartisan organization of cities with populations of 30,000 or more, and the National Association of Counties, the national organization representing the country's 3,069 county governments, utilized their resources to make the public aware of exactly how funding cuts would impact communities. Cities were forced to cut youth programs, assistance to small businesses, support for family rehabilitation and domestic violence shelters, homeless shelters, meals-on-wheels programs, adult literacy classes, and free transportation in poor and rural communities. Individual cities were confronted with cuts ranging from 15 to 50 percent of the CDGB funds that they depended on to keep such programs going. Some media reports noted that most of the services affected by the cuts were to those least able to afford such losses. Others noted that since according to HUD, for every $1 of CDBG funds an estimated $3.55 is leveraged in non-CDBG funds, and that CDBG has created or retained hundreds of thousands of jobs, loss must also be calculated in effects beyond immediate services.

Critics of CDBG, on the other hand, charge that it is a bloated agency filled with waste and abuse. They point to high administrative costs, 17 percent on average according to the Government Accountability Office, and the additional costs of printing manuals to explain government regulations and grant applications, both of which sometimes run to more than 100 pages. They note that the CDBG allocation formula is decades old, and that a phrase such as "housing built before 1940," originally intended to benefit older cities, can now be used to target dollars toward wealthier communities where older homes are restored, rather than poorer communities where older, blighted buildings have been torn down. As examples of waste and distortion of program purpose, they point to such expenditures as $588,000 for a marina in Alexandria, Louisiana; $147,000 for a canopy walk at the Atlanta Botanical Gardens in Georgia; $245,000 for renovations to awnings at a historical market in Roanoke, Virginia; and $294,000 for the development of an educational program at the Houston Zoo in Texas.

Finally, they remind CDBG defenders that the program has a history of fraud, including in San Diego, where $12.9 million was improperly spent for a festival to celebrate a shopping center; in Chicopee, Massachusetts, where $4.3 million went to the affluent neighborhood where the mayor lived; and Utica, New York, where $902,799 was spent on a marina and $255,158 on ski chalet renovations. In 2006, HUD's inspector general reported than in a mere 2.5 years, 159 individuals were indicted, administrative actions were initiated against 143 individuals, five civil actions were in progress, and over $120 million in misappropriated funds were recovered.

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See Also: Housing Services; Housing Support and Homeless Services; Urban Communities and Human Services.

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Community Development Corporations

Community development corporations (CDCs) are nonprofit entities focusing on local development needs. Most often serving low-income, distressed neighborhoods and/or minority/immigrant populations, they provide political capital for underserved communities and people. Their origins can be traced back to the settlement houses of the 1800s, but the modern community development corporation emerged in the 1960s as part of the civil rights and antipoverty movements. Beginning with only a few, the industry has now grown to nearly 5,000. Some have grown into national CDCs (e.g., Enterprise Foundation) or a network of independent CDCs (e.g., NeighborWorks America), but most remain focused on smaller-scale urban and rural geographies. Their work has become more varied over the past few decades but most often involves poverty issues such as housing, environment, workforce training, financial literacy, commercial corridor revitalization, and, increasingly, access to healthy foods and community facility development for charter schools, child care, and health and human services.

Local Action for Government Programs

As government programs targeted for low- and moderate-income communities grew, the need for place-based community action grew as well. Some CDCs formed out of grassroots organizing, while others were created by local governments as an alternative deployment strategy for revitalization and community development funds, such as Community Development Block Grants (CDBGs). Unlike government, CDCs can more readily respond to opportunities, address neighborhood problems from a local standpoint, and coordinate community institutions and grassroots leaders. Through community representatives serving on their governing boards, they also provide a representative voice to underserved communities throughout the political and public participation processes.

One of the hardest challenges of community development work is securing financial capital for development that meets the needs of the people who live in disinvested communities. As advocates for revitalizing neighborhoods, CDCs not only work to attract resources, they also organize against threats that may negatively impact the area (such as an environmentally hazardous industry) or displacement of low-income residents resulting from gentrification. A central theme among CDCs is the construction, protection, and maintenance of affordable housing, and this will vary according to the target area's housing needs. For example, a CDC in rural Texas may work to improve housing conditions for Mexican border workers; comparatively, a Chicago CDC may organize against condominium conversions, advocate for the utilization of tax credits for affordable units, and provide homeownership training and counseling.

Size, Scope, and Role

As with the scope of work, the size of CDCs also runs the gamut. Some national CDCs employ hundreds of people and serve as capital investors in affordable housing and community-oriented real estate development. By comparison, others function as a subsidiary of other organizations, such as churches or nonprofit social service agencies. But ultimately, they all share the same goals: to improve and protect housing options for low-income people, attract capital to disinvested communities, organize stakeholders to maximize limited resources, and represent the interests of the community they serve. Some CDCs have become certified community development financing institutions (CDFIs) in order to provide nontraditional banking services and lending. These services and loans are targeted to communities that are underserved by traditional banks and have populations that do not meet traditional lending requirements.

Because of the broad scope of size and work performed by CDCs, it is challenging to provide a concise description of these organizations. However, they are key players as government agencies, funders, and service providers seek place-based implementation to yield better outcomes. Additionally, government administrators and funders are becoming aware of the need to focus multiple resources across a broad spectrum of social needs. As nongovernmental entities, successful CDCs assemble and coordinate multiple programs and agencies serving low-income persons. During the past few years, the Federal Reserve System has engaged a dialogue between the health care, community development, and banking industries with the goal of using investment to improve health disparities through a more localized approach. As public policy changes with regard to health coverage, financing entities are also becoming more aware of the need for improved interventions. As such, the role of the CDC will continue to shift.

Ultimately, the role of CDCs is to coordinate community development efforts so that they address the problems of their target geography/population. While poverty may not be eliminated, CDCs will continue to mitigate the risks of poverty by building human, social, and physical capital in areas where low-income people are concentrated.

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See Also: Community Development Block Grants; Community Organizing; Environmental Justice; Financial Literacy Programs; Food Desert; Gentrification; Grassroots Leadership; NeighborWorks

America; Poverty; Social and Economic Justice; Social Capital, Role of.

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Community Health, Racial and Ethnic Approaches to

The confluence of changing demographics, the health status of the nation, and the social-political economics of health care has resulted in a re-envisioned approach to assessing the health of the nation, to measuring effective delivery of health and human services, and to developing the health professional's knowledge, skills, and dispositions. Antecedent to a discussion of the numbers of racial and ethnic groups represented in the U.S. population is the understanding that the U.S. Constitution requires a decadal census to ascertain the number of representatives that a state can send to the U.S. House of Representatives. As early as 1790, the Office of Management and Budget (OMB) delineated racial groups for purposes of conducting the census. Census data are used to allocate federal funding for education programs in states and communities; to collect and report national social and health statistics to be used for government agencies' policy purposes; to allocate federal dollars for law enforcement, federal highway projects, aid to farmers, and many other federally financed activities and programs; and to inform a variety of economic statistics that become the basis of the nation's economic policies.

By 1986, the U.S. Department of Health and Human Services issued the Secretary's Task Force Report on Black and Minority Health, which found a disparity in health status of the majority and minority populations in the United States. The minority population was defined as African Americans, Latino/Hispanic Americans, Asian Americans, and Native American Indians, and "despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat and cure disease, Blacks, Hispanics, Native Americans and those of Asian/Pacific Islander heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology."

For the 2010 census, the OMB added language clarifying Hispanics, Arab Americans and Iranian Americans, the Turkish, and West Indians. These changes were made as responses to racial, ethnicity, and heritage concerns. W. B. Du Bois's seminal work, *The Health and Physique of the Negro American* (1906), in which he exposed as myth the prevailing view that blacks suffered higher death rates in the north because of their racial inferiority and vulnerability to cold climates in the north, made unprecedented use of epidemiology. The government recognizes that culture and social identity are intimately linked to behavior, and thus must be reflected in the description of the nation's health status.

The Centers for Disease Control and Prevention (CDC) identified the following racial groups in 2013: African American/Black, American Indian/Alaskan Native, Asian, Hispanic/Latino, and Native Hawaiʻian/Other Pacific Islander. Ethnic identities are complex, reflecting countries of origin and heritages. The 2010 census collected data on the following groups: white, African American or black or negro, American Indian or Alaskan Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiʻian, Guamanian or Chamorro, Samoan, Other Pacific Islander, Other. Further, Question 8 invited respondents to identify as one of the following: not of Hispanic, Latino, or Spanish origin; Mexican, Mexican American, or Chicano; Cuban; another Hispanic, Latino, or Spanish origin. The complexity of these categories underscores the recognition of the need to validly report one's ethnicity.

Definitions

Racial and Ethnic Approaches to Community Health (REACH) is an evidence-based national initiative vital to the Centers for Disease Control and Prevention's (CDC) efforts to eliminate racial and ethnic disparities in health. Recent data report heart disease as the leading cause of death for people of most ethnicities in the United States. Further confirming the reality of health disparities is that non-Hispanic blacks have the highest rates of obesity (44.1 percent), followed by Mexican Americans (39.3 percent); and compared to non-Hispanic whites, the risk of diagnosed diabetes is 18 percent higher among Asian Americans, 66 percent higher among Hispanics/Latinos, and 77 percent higher among non-Hispanic blacks. The Office of Minority Health Disparities has reported health disparities across a wide range of health priority areas, such as cardiovascular disease, diabetes, breast and cervical cancer, infant mortality, asthma, immunization, and obesity. The report argued that persistent health disparities in the country are unacceptable and correctable using dual strategies—universal interventions available to everyone, and targeted interventions for populations with special needs.

Health Disparities and Inequalities

The *CDC Health Disparities and Inequalities Report* of 2011 is the first in a series of periodic, consolidated assessments that highlight health disparities by sex, race, ethnicity, income, education, disability status, and other social characteristics in the United Sates. Data examine health care access, exposure to environmental hazards, mortality, morbidity, behavioral risk factors, disability status, and social determinants for health. The World Health Organization (WHO) reported that the social determinants of health are the circumstances in which people are born, grow, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of economic and social policies and political forces, including gender, racial, and ethnic biases.

Effecting Change

The approaches to effecting change are holistic and seek to support community coalitions that design, implement, evaluate, and disseminate community-driven strategies to eliminate health disparities in chronic disease; provide the infrastructure to implement, coordinate, refine, disseminate, and evaluate successful evidence- or practice-based approaches and programs in local communities; support national and international organizations with local affiliates and chapters to share evidence- and practice-based strategies and culturally based community practices to eliminate racial and ethnic health disparities; increase the evidence around effective strategies to reduce obesity, hypertension, and cardiovascular disease in racial and ethnic communities; and fund community-based organizations to reduce health disparities.

An example of a program evidencing these components are Healthy People 2020, a science-based set of national goals and objectives with 10-year targets, designed to guide national health promotion and disease prevention efforts to improve the health of all people in the United States. The 1979 *Surgeon General's Report on Health Promotion and Disease Prevention*, accepted as the first national report to identify health promotion and disease prevention as national priorities, is the seminal document informing the three-decade national health goal of Healthy People. Healthy Communities Programs, a companion program to Healthy People, seeks to prevent chronic disease, reduce health risk factors, and attain health equity. Reflecting J. Bircher's broader definition of health as "physical, mental, social, environmental and spiritual well-being, not merely the absence of disease," the Designing and Building Healthy Places program promotes educating decision makers on the health impact of community design, building partnerships with community design decision makers and influencers, and conducting studies to identify links between health and community design.

Rewards of Health Equality

Since 2002, the annual Agency for Healthcare Research and Quality (AHRQ) National Health Disparities Reports (NHDR) has documented the status of health care disparities and the quality of care received by racial, ethnic, and socioeconomic groups in the United States. The NHDR documented in 2008 that racial and ethnic minorities often receive poorer quality of care and face more barriers in seeking care, including preventive care, acute treatment, or chronic disease management, than non-Hispanic white patients. Minority groups experience rates of preventable hospitalizations that are, in some cases, almost double that of non-Hispanic whites. African Americans have higher hospitalization rates from influenza than other populations. African American children are twice as likely to be hospitalized and more than four times as likely to die from asthma as non-Hispanic white children. The Joint Center for Political and Economic Studies, in its 2011 report the *Economic Burden of Health Inequalities in the United States*, concluded that between 2003 and 2006, "the combined costs of health inequalities and premature death in the United States were $1.24 trillion." In addition to the potential to reduce the financial burden of health inequalities is the promotion of a quality of life and robustness of a nation that is healthy, able, and productive.

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See Also: Health and Sickness, Differening Attitudes Toward; Health Care, Disparity in; Health Care Delivery, Models of.

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Community Health Centers

Community health centers, also known as federally qualified health centers (FQHCs), are community-controlled health facilities that offer basic medical care in low-income and medically underserved areas. Funded by federal grants and often with sliding-scale fees based on patient income, these centers have provided primary care and preventive services in urban and rural communities across the United States for more than four decades at a cost below the national average for comparable services. In 2013, more than 1,000 community health centers served more than 15 million people in every state and territory, two-thirds of them members of racial or ethnic minorities.

Free dispensaries where part-time volunteer physicians offered medical services to the poor began in the late 18th century. Most of these dispensaries were located in eastern cities and were connected with medical schools. The doctors who provided their services at no cost typically were engaged in research and teaching medical students at the schools. Private practitioners feared that charity services were abused, and that patients who could afford medical care were seeking treatment in the dispensaries. The poor were scarcely less skeptical than the physicians, placing little trust in the dispensaries, where they were often forced to wait for extended periods to receive cursory attention.

More than a century after the controversial dispensaries, health departments in cities established clinics to address the problems of infant mortality and infectious diseases. Baby clinics stressed the importance of hygienic practices, and offered information on topics such as child care and proper nutrition. The clinics that focused on infectious diseases limited their services to diagnosis and advice because private physicians vehemently protested any intrusions into their territory. The New York City Department of Health produced diphtheria antitoxin in its diagnostic bacteriologic laboratory, sold it to drugstores, and offered it free to patients who could not afford it, but accusations of socialism and unfair competition forced it to end the program. Watched carefully by their critics, city and county health departments provided minimal health care for the poor, usually at a level similar to that of the dispensaries, throughout the first half of the 20th century, but it was not until the 1960s that the evolution of community health centers began.

War on Poverty

In the 1960s, a young doctor and civil rights activist, H. Jack Geiger, saw firsthand how effectively community-based health care was serving a Zulu population in South Africa. Impressed with the improvements in the overall health of the community affected by the system, he returned to the United States eager to see such a system implemented in inner-city neighborhoods and rural areas, where poverty was pervasive and health services were often inaccessible. His timing was fortuitous. President Lyndon B. Johnson had declared his War on Poverty, and the community health center was a good fit for the programs that were introduced. Through the efforts of Geiger and others, federal funding was secured for two demonstration projects, one in Boston, Massachusetts, and the other in Mound Bayou, Mississippi.

Legislative changes helped prepare the way for the community health centers. The Kerr-Mills Amendment to the Social Security Act in 1960 made funds available to the states for the medically indigent. In 1962, after the nation's news media made public the living conditions of migrant farm workers, the Migrant Health Act funded rural clinics to provide health care for that population. Congress passed the most significant health care legislation with the Economic Opportunity Act of 1964, which provided for the establishment of community health centers. The first two centers were in operation a year later, the same year that Medicare and Medicaid provided medical benefits to the elderly, the disabled, and families living below the poverty level. A decade later, Congress authorized neighborhood health centers on a permanent basis. Later legislation extended the groups served by neighborhood clinics to include the homeless and public housing residents. The Health Centers Consolidation Act of 1996 identified all health centers programs as community, migrant, public housing, and homeless health centers. The Health Resources and Services Administration, Bureau of Primary Health Care, under the U.S. Department of Health and Human Services, is the federal agency that administers health centers programs.

Organization and Efficacy

In order to receive federal funds, community health centers' patient representatives must make up a majority of each center's governing board and the center must be located in a federally designated medically underserved area; possess nonprofit, public, or tax-exempt status; provide not only comprehensive primary care services and referrals, but also services necessary to access care such as translation and transportation; and provide these services to all residents in their service area, regardless of ability to pay, along with a sliding fee schedule that is adjusted according to family income.

The population served by community health centers in approximately 3,600 communities in the United States is divided almost equally between residents of rural areas and residents of economically depressed inner-city communities. Nearly 70 percent of these patients have family incomes at or below the poverty level. About 36 percent are covered by Medicaid. The number of uninsured patients treated at health centers has steadily increased, growing from around 3.9 million in 1998 to over 5.9 million in 2013. For many of these patients, the community health center is their only source of health care.

Community health centers have been successful at providing quality health care at low costs. They provide comprehensive health care for about $1.30 per day per patient served. A number of studies have shown that community health centers save Medicaid dollars at both the federal and state level because of reductions in specialty care referrals and hospital admissions. Costs for patients with chronic illnesses such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV are also lower at health centers. The lower costs have not affected the quality of care. Both the Institute of Medicine and the General Accounting Office have recognized community health centers as models for screening, diagnosing, and managing chronic health conditions. These centers have also been effective in reducing infant mortality rates between 10 and 40 percent over communities with no health center, and in improving early prenatal care and reducing low birth rates.

Perhaps because of the community representation on their governing boards and the culturally sensitive practices that are in place, community health centers have successfully reduced racial, ethnic, and socioeconomic disparities in infant mortality, prenatal care, tuberculosis case rates, and death rates. One study concluded that even after controlling for sociodemographic factors, there were no disparities in health status among health center patients. The need for the services provided by community health centers is unlikely to decrease in the near future. Even with full implementation of the Affordable Care Act, as many as 26 million people could remain with no access to health insurance.

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See Also: Community Health, Racial and Ethnic Approaches to; Community-Based Services; Health Care, Disparities in.

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Community Organizing

Community organizing is the backbone of social justice activism. It increases community awareness of relevant social service initiatives, holds human services programs accountable to the communities they are expected to serve, and allows communities that participate in these programs to fully participate in policy decisions that affect their lives. While the term *community organization* did not become popular until Christian service organizations began using the phrase in the 1830s, the work is as old as civilization. Archaeologists have uncovered evidence of a workers' strike in 1170 B.C.E. in Deir al-Medina, Egypt, and the praise poem of the Mesopotamian King Urukagina, dated to the 24th century B.C.E., speaks of reforms he instituted on behalf of the poor that would have most likely been preceded by a significant community organizing effort. Every major Western religion was created by community organizers. Judaism was founded by Moses, who organized indentured Jewish-Egyptian laborers against their government; Christianity was founded by a messianic prophet who organized desert Essenes and other poor Judaeans and called for a new social order in the face of his execution; Islam was founded by a prophet-activist who gathered the marginalized around him and intentionally undermined the corrupt Meccan plutocracy. All of these figures used what would later be termed *community organizing* strategies as part of their work.

But while the work of community organizing is not new, its vocabulary and the idea of community organizing as something that one specifically does, separate from other missionary, humanitarian, or social justice work, is new. Chicago labor organizer Saul Alinsky's *Reveille for Radicals* (1946) coined the term *community organizer* and was the first major work to establish a clear strategic and ideological

National Urban League president Whitney Young meets with President Lyndon B. Johnson in 1966. Young pushed for federal aid to cities, a plan that was eventually partially incorporated into President Johnson's War on Poverty.

framework for community organizing. The idea of community organizing as a vocation is still novel enough that when U.S. senator and former Chicago community organizer Barack Obama became the Democratic Party's presidential nominee in 2008, both primary opponent Hillary Rodham Clinton and general-election opponent John McCain openly ridiculed that aspect of his history. By 2013, Republican Senator Rand Paul remarked: "I think we need to have Republican community organizers."

Today, there are many varieties of community organizing, the most basic being grassroots community organizing, in which one listens to the concerns of a community, helps transform those concerns into actionable goals, and then mobilizes members of the community (and allies) around these goals. Doing the work of community organizing as an ally or outsider to the community that is organized is both essential, in that it introduces novel and disruptive elements into existing social structures, and hazardous, in that it can play to a savior complex, an unwarranted sense of entitlement, or more sinister motives. Keeping the community organizing effort centered on the actual needs of the community, and not the projected or anticipated needs of the community, requires a serious and vigilant listening process.

Community organizing has historically been associated with labor, civil rights, immigrants' rights, and other traditionally left-wing movements, and Alinsky's model of community organizing was revolutionary, but many strategic frameworks allow for a great degree of cooperation with historically conservative institutions. The strategy of community development, demonstrated by National Urban League president Whitney Young during the 1960s, centers on organizing community members and corporations to work together on shared strategic interests. Both strategies have been shown to work in some cases. Under the Alinsky framework, community organizing focuses on empowering marginalized people to act in their interests and achieve victories despite the existing power structure, joining with them only on a provisional, case-by-case basis. Community development, on the other hand, works to reconcile the interests of marginalized groups with the existing power structure on a more general and long-term basis. To the extent that the two approaches conflict (and they do not always conflict), disagreement tends to center on the question of whether the existing power structure can be preserved in a way that does not perpetuate existing social injustices—and this disagreement, centering on the nebulous concept of a single "existing power structure," is often semantic.

The idea that community organizing can be reconciled with more conservative community development approaches as parallel elements of the same broader strategy is the implicit ideology of the American progressive left, but it has many critics. INCITE!'s anthology titled *The Revolution Will Not Be Funded: Beyond the Non-Profit Industrial Complex* (2009) suggests that the community development framework often explicitly works against the interests of community organizers and their stakeholders, using direct-service charitable work and inconsequential shifts in policy to pacify efforts to achieve more significant and more lasting change.

Whatever form community organizing takes over the coming century, dramatic changes in communication technology have already fundamentally altered community organizing dynamics. Just as print made the Enlightenment possible, and the telephone made Alinsky-style urban organizing possible, mobile devices and social media have had a dramatic effect on organizing strategies—the full scope of which cannot yet be measured, given organizations' incomplete adaptation to these technologies, and more crucially, given the social inequalities still reflected in the digital divide. As the participation of Americans with mobile and social media presence approaches 100 percent, these technologies will provide increasingly valuable means by which marginalized communities may mobilize and make their voices heard.

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See Also: Community Action Agencies; Environmental Justice; Social and Economic Justice; Subcultures.

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Community Reinvestment Act (1977)

The Community Reinvestment Act (CRA) was passed in 1977 as part of a wider agenda of equity and community redevelopment in the United States. The act is designed to encourage depository institutions to serve the needs of all communities by providing access to services across lending and investment. It provides a framework for financial institutions and other stakeholders to promote banking services to all communities and all members within it. The act dictates that financial institutions must offer equal access to such services for all within their immediate geographic location, "consistent with safe and sound operations." It prohibits "redlining," a process of blocking or restricting access to banking to those in distinct areas. The act was passed in the context of existing limited or discriminatory lending practices for low-income neighborhoods, where banks often excluded those low- or moderate-income neighborhoods from lending and investment services.

This often occurred in a racialized context. Thus, the act was a result of pressure from activists, as well as a wider sense of community decline and economic hardship that plagued many such communities and ultimately damaged the American economy. Subsequently, the act has been subject to a steady stream of legislative and regulatory amendments to tighten up the requirements placed on financial institutions, and further reforms are envisaged in the near future. The act has been the subject of much debate concerning the extent to which it provides a loosening of lending criteria and thus encourages riskier lending practices, the type that influenced the 2008 financial crisis. Opinion on the matter remains deeply polarized.

The CRA was passed as part of a wider process of addressing inequality and discrimination in American society. For example, prior to the CRA, the Fair Housing Act of 1968 and the Equal Credit Act of 1974 sought to tackle discrimination in relation to the characteristics of race and sex. The CRA serves to create equality of access with regard to lending and investment services across America's communities, including mortgages, small business and other credit, and investments. Financial institutions are encouraged to lend to low- and moderate-income groups, in line with sound lending practices. The CRA applies to all institutions that carry Federal Deposit Insurance Corporation (FDIC) deposit insurance. Therefore, it does not apply to all institutions; there are some financial institutions that do not carry FDIC deposit insurance that are able to work outside the act.

CRA compliance is monitored, and banks are subject to scrutiny from a federal banking agency that offers a rating and associated report, which forms part of the supervisory report for that bank. Members of the public can submit comments about institutions, which are also considered. An institution's record is studied by its supervisory agency when it seeks to expand, for example through merger or acquisition. The Office of the Comptroller of the Currency (OCC), part of the Department of the Treasury, has responsibility for assessing banks' records of extending credit to all of the community. The office determines an institution's CRA rating through a four-tiered rating system: substantial noncompliance, needs to improve, satisfactory, or outstanding. The rating is determined by considering an institution's context and the community that it serves.

The act has stimulated debate concerning the extent to which it has been successful in extending credit services to low-income groups. Some economists, for example, have argued that the act has become irrelevant, or at the very least in need of being revisited, despite the various regulatory and legislative amendments to it. However, a study by Drew Dahl and colleagues in 2000 failed to prove that financial institutions respond to regulatory pressures to increase lending to low-income groups, thus arguing that the CRA did not work at that time. Debate has also been sparked concerning whether or not the CRA encourages risky lending. A paper by Sumit Agarwal and colleagues in 2012, for instance, argues that the CRA led to risky lending, which may in turn have contributed to the 2008 financial crisis. Those authors compared the lending behavior of banks undergoing CRA exams with those that were not, and found that compliance with the act led to riskier lending by banks. Yet, this is in contrast to other reports. Ben Bernanke, former chairman of the Federal Reserve, and others have stated on the record that the CRA did not contribute to the subprime crisis in any significant way. However, this view is not accepted by all experts.

A number of commentators insist that the CRA has at least forced banks to engage with those underserved markets—low and moderate income—where this might not otherwise have happened. Groups, including the National Community Reinvestment Coalition, argue that as a result of the CRA, banks have actively promoted housing and economic opportunity for underserved groups by providing affordable mortgage programs, small business loan products, community development financing, and funding for nonprofit housing and economic development programs. Sandra Thompson, director of the Division of Supervision and Consumer Protection at the FDIC, notes that the research evidence overwhelmingly demonstrates that the CRA has resulted in levels of lending to low- and moderate-income groups that have increased at a greater rate than for other income groups. The CRA was passed with seemingly noble intentions, in the context of wider change and the desire to end iniquitous banking practices, which is commended. However, the CRA remains a heated point of discussion, given the recent economic turmoil and staunch opposition from those who disagree with this type of regulation.

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See Also: Community-Based Services; Neighborhood Reinvestment Corporation; Urban Communities and Human Services.

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Community-Based Participatory Research

The National Institutes of Health's Office of Behavioral and Social Science Research defines community-based participatory research (CBPR) as a hands-on, collaborative research approach between research or academic partners and community members, in which both groups have a voice in improving or changing a common community health concern. The ultimate goal is to enhance the community's involvement in applied research. Partnerships draw on the strengths of both participants and provide an opportunity to pool their knowledge and resources in addressing a community health need. CBPR gives community members an opportunity to be actively engaged and consulted during each step of the research process, from the development of research questions to communication of the conclusions and final results, in order to have a positive impact on improving health or reducing health disparities in the local community. Human diversity is important to CBPR because communities comprise persons with different cultural backgrounds, life experiences, and health needs. Interest in using CBPR as a research approach has grown in recent years, and it is used in many fields, including epidemiology, social work, public health, environmental health sciences, and psychology. Numerous examples of CBPR are available on government Web sites, Google Scholar, and professional journals.

Traditional research is a solitary activity. CBPR is more mutual and partnership-based, as both participants learn from each another. Traditional ideas of rigor may not be applicable with real communities where issues are more complex. For example, random assignment of persons to either an experimental or control group may not be possible for ethical reasons, especially when studying life-threatening health diseases. A probability sampling technique may not be possible when studying illegal human behavior, such as the distribution of narcotics.

Advantages of CBPR

CBPR has many advantages. It can improve the provision of care and outcomes for populations defined as at-risk or underserved. It can be applied in diverse communities and in a variety of community settings and across disciplines. It provides an opportunity to build trust between community members and researchers or academic partners, who might otherwise be viewed as "outsiders" to the local community. Ultimately, the trust and joint partnership will allow the pooling of resources, both tangible (e.g., financial) and intangible (e.g., knowledge) resources, to solve complex community health problems and change local policy, practice, and service provision. This trust serves as a foundation for the collaborative process to unfold throughout the research. Working with community partners is key to understanding and learning about community health and health disparities in order to transform current practices. Knowledge of community partners is used by researchers or academic partners to answer complex health questions that are defined as important to the community—not just as the agenda of a researcher. The results of CBPR may influence local or community policy makers to provide more funds for an identified community need or to provide services: this is policy advocacy in action. In some areas of research, particularly those which are grounded in health behaviors that involve moral concerns (e.g., men having sex with men) or illegal behaviors (e.g., substance abuse), this approach may be the only means of gathering data on community health issues that would otherwise not be studied. This is a major advantage of CBPR.

Challenges of CBPR

One of the challenges of CBPR is demonstrating to researchers and academics that this is an appropriate and rigorous research method. Also, as CBPR becomes more accepted among researchers and communities, so must the trust remain between researchers and community members. Noted challenges in the application of CBPR include power issues, true community consent, and the way in which financial incentives may impact the consenting process.

Researchers from various disciplines engage in areas or programs of research to contribute to the knowledge base in a health-related area, such as diabetes or mental health. However, researchers' or academicians' success in their research area (i.e., scholarly publications, grant funding) ultimately catapults them to develop a reputation as "experts" in their field. With respect to the issue of power and egalitarian relationships, the question of who was more responsible for the success of the research project may become an issue. That is, are the researchers invested in the research project in order to meet the community's needs or to advance their individual program of research or reputation?

Whether a community has given true community consent to participate in the research may also become a challenge, especially when the amount of a financial or other resource incentive may influence their decision to participate. Thus, the ethical challenge is how to assess whether true community consent has occurred. For example, a financial incentive to implement new services for an identified health concern can influence participation solely because the services are especially needed in the community when no other resources are available.

Despite the benefits and challenges associated with CBPR, it is a user-friendly and increasingly acceptable applied research methodology to address community health needs that would otherwise go unnoticed.

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See Also: Agency for Healthcare Research and Quality; National Institute of Mental Health; Rural Communities.

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Community-Based Services

Community based services (CBSs) are provided by various types and structures of community-based organizations (CBOs) that serve diverse population segments. CBSs address income, housing, mental health and substance abuse, health, child welfare, child care, criminal justice, disabilities, educational, long-term care, and other similar social welfare needs; these services can be prevention- or intervention-oriented. Some CBOs are specialized in providing services to specific age groups experiencing specific issues, while others provide a range of services to several population segments. For instance, community-based adoption agencies provide adoption services for children under the age of 18; community action agencies may provide a wide range of services (e.g., income maintenance, child care, home-based parental skills training, energy assistance, etc.) to clients of all age groups. Typically, CBSs in nonprofit organizations are supported by mixed funding streams; private fees, philanthropy, grants, contracts with public agencies, and income from the sale of services and/or goods are some of the funding mechanisms. The structure and type of CBO influences the structure and type of services provided by the organization.

Professionals and programs within CBSs implement specific theories of change—assumptions about clients and their behaviors and causal relationships between interventions and outcomes. CBSs attempt to create empowering environments for clients and communities as well as actively engaging community members in designing programs. Notwithstanding the wide range of CBSs, CBOs encounter challenges in delivering high-quality services. Each of these concepts is relevant for human service professionals.

Theory of Change

CBSs and programs are designed to create specific outcomes and provide specific benefits to clients and communities. These services and programs are generally based on theories of change, in which specific activities and steps are expected to produce specific outcomes. Theory of change is a road map for creating the desired change. Ideally, leadership within CBOs explicates each program's and/or intervention's theory of change so that employees implementing the programs are clear about the relationship between their activities and the desired outcomes. Explicating theories of change is more important when organizations are serving diverse population segments because the assumptions about the change process may not be the same for all population segments. Professionals within CBSs attempt to create change in people's lives by changing their knowledge, skills, attitudes, behaviors, and health, or by changing conditions for children, individuals, families, and within communities. By explaining—with a theory of change road map—how a CBS creates desired changes, the program evaluation process can become easier for professionals.

Empowering the Community

Empowerment, a multidimensional concept, can be both personal and social. Professionals within CBSs attempt to create environments for clients to increase their sense of personal, interpersonal, socioeconomic, and political strength and develop a strong sense of self-efficacy. Some strategies for enhancing clients' sense of self-efficacy are: building trusting relationships between program employees and clients, collaborating with clients to design solutions, raising clients' awareness about power and class differences and related issues, teaching specific skills to clients, and promoting activities that will enhance clients' sense of personal power and self-advocacy. Regular in-serving training is essential for promoting and maintaining empowerment-oriented practices within CBSs, especially in light of the diverse population segments that seek assistance from CBOs.

With growing diversity within communities (e.g., immigration patterns, race, ethnicity, sexual orientations, types of family structures, religions, etc.), CBOs are inviting more community participation in effectively assessing needs and designing responsive strategies, interventions, and services to address them. Some legislative mandates also warrant community participation for social program development. The principle of community participation is based on the thesis that population segments experiencing challenges have the best knowledge of their own situations and strengths; they also know how to address these challenges by effectively deploying their strengths and community assets; and, finally, they can easily take ownership of the service or strategy. Hence, inviting their active participation in assessment and program/service design can ensure sustainable service provision and impact.

Challenges in Service Delivery

CBSs encounter several challenges in the areas of delivery systems, sustainability, and privatization. Most communities have several CBOs, so duplication of CBSs and absence of seamless service delivery systems plague the human services field. For instance, several agencies provide home-delivered meals or emergency assistance. Similarly, in the mental health arena or in the child welfare arena, different organizations that may be serving a client may have been unsuccessful in designing a well-coordinated and integrated service delivery system. In the absence of formal interorganizational partnerships or informal interorganizational collaborations, professionals within CBS programs often refer clients to other professionals—in their social or professional network—in related agencies. Hence, coordination of services, especially for addressing complex issues, may occur more through informal relationships and networks than through effectively planned interorganizational alliances, partnerships, and collaborations.

Another issue pertains to sustainability: sustainability of impact, financial sustainability, and sustainability of capacities within CBSs. Increasing focus on accountability is resulting in funders questioning the outcomes created by CBSs. These entities want to ensure that interventions and strategies create a lasting impact on client and community well-being and make a meaningful difference for pressing social, economic, and environmental problems. Program or service sustainability within CBOs is the capacity to continue to deliver intended benefits for an extended period of time after major start-up funds, resources, and technical assistance have been terminated. Maintaining programs within CBOs beyond the end of the start-up grant or funding is a challenge unless early planning has occurred by CBO management and leadership. Similarly, adapting to the changing contexts is very important for program and CBO sustenance.

Related to the issue of sustainability is capacity-building within CBOs. Salaries, work environments, and qualifications of individuals hired by CBOs are factors that contribute to high turnover in some agencies, negatively impacting capacity-building within these organizations and services. Capacity-building focuses on nurturing and building upon the strengths and problem-solving abilities of employees within CBOs. Without sound capacity-building, quality of services delivered through CBSs can be compromised.

Finally, federal and state governments—through a national devolution movement—are subcontracting with private for-profit or nonprofit organizations to provide services that were historically provided by the public sector. Devolution—transfer of power, rights, and responsibilities from one level of government to a government at lower levels—has resulted in privatization of several human services. Government entities are outsourcing the provision of social services to private organizations with the hope of improving efficiency and effectiveness. Privatization is creating ethical dilemmas in CBOs when employees and program directors must balance financial and social impact. Moreover, sometimes in their haste to contract with nonprofit organizations, public organizations may not examine whether CBOs have the capacity to deliver and administer effective CBSs.

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See Also: Case Management Services; Community Organizing; Crisis Services; Day Treatment Centers; Interprofessional and Interdisciplinary Practice; Social Innovation.

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Conflict Resolution and Diversity

Conflict resolution is a relatively young academic field, which has evolved and greatly expanded over the past few decades. There are an array of disputes and conflicts that can be reduced, managed, or resolved. Conflict resolution is a broad term, and when targeting and utilizing diverse conflict-reducing or conflict-ending approaches, collaboration ensures mutually agreed-upon actions. It is also useful in, and applicable to, domains of conflict at interpersonal, familial, communal, organizational, and international levels. Conflict resolution professionals provide a wide range of services for diverse communities. These include mediation, negotiation, workshops facilitation, technical training for staff, organizational conflict resolution skills, and coaching. Because the United States' population is becoming more diverse and multicultural, just as elsewhere, it is essential that conflict resolution professionals and specialists acknowledge, support, and promote diversity in their work, whether in academia, consulting, training, or other professional and organizational settings.

Professional Training

Conflict resolution specialists are trained, impartial, third-party actors who facilitate dialogue processes that oftentimes lead to outcomes that can be beneficial and rewarding for all parties in conflict. It is preferable that conflict resolution specialists have a degree in higher education. This includes those who have acquired training specifically in conflict resolution. Because of conflict resolution's interdisciplinary approach, this degree is valuable because it equips professionals with various models and paradigms/perspectives for addressing disputes and conflicts. Few universities, both public and private, in the United States or overseas, offer Ph.D. programs in conflict resolution. However, master's degrees in this field are growing, both domestically and globally. In these programs, graduate students, working adults, and professionals have more opportunities to acquire knowledge and understand the theoretical aspects of conflict resolution. Conflict resolution professionals are prepared through their training to be well versed or have hands-on practical experience in conflict resolution. For instance, some are required to fulfill requirements through a practicum that incorporates direct experience working with those who need to better manage disputes in different settings.

Despite the requirement and preference for conflict resolution specialists to have a degree in conflict resolution and related fields, it is essential that they are certified. Although there is no national licensing requirement to become a conflict resolution specialist, there are states, such as Florida and California, in which certification is required in order to become, for example, a qualified mediator. If prospective mediators want to practice mediation in Florida, they have a variety of choices and types of mediation from which to choose, depending on their interests and professional needs. Even for those with advanced degrees, such as law, medicine, education, and related fields, in order to practice mediation, they must have at least 40 hours of training to be certified. Among those certifications are: family-divorce mediation, county court mediation, circuit mediation, dependency, appellate mediation, Florida Supreme Court mediation, workplace mediation, and school mediation. Additionally, mention must be made of negotiation, facilitation, conflict coaching, and conflict management training, which are also valuable in resolving various disputes and conflicts.

Services Provided to Schools, Workplaces, Businesses, and Government

Usually, conflict resolution professionals offer services, training, and consultation that are tailored toward a client's specific needs. These services depend on the types of disputes and conflicts encountered, and the context or setting in which they occur. For the purpose of addressing a particular type of conflict or dispute, it is crucial that the service provided align with the objectives and needs of the recipient agency. For instance, there are conflict reduction or prevention professionals who specialize in campus and student-related disputes. Oftentimes, mediation is employed to address an array of student disputes, for example, negotiating living arrangements with roommates, or addressing residential, classroom, team, and student organization diversity. Workplace disputes and conflicts still persist in many organizations and institutions, both public and private. It is essential that conflict resolution specialists/mediators/negotiators create nonjudgmental environments, permitting all the parties to express themselves freely, and enhancing their understanding of the nature of the conflict.

Central to this work is identification of the parties in conflict and their stated issues and concerns. Conflict resolution specialists must have a solid grasp of, and be able to identify as clearly as possible, each party's issues. Furthermore, the mediator must be familiar with any additional underlying concerns that are related to the dispute. Depending on the nature and type of conflict, mediation may be facilitated by one mediator or a comediator over a period of one, two, or more hours. During the mediation process, the mediator may require a private separate meeting, or caucus, with one or the other party. Regardless of who asks for it, the content of these meetings must be kept private and confidential, unless permission is granted to the mediator by one or the other party to disclose such privileged information.

Needs are also valuable for all the parties in conflict. This is true, irrespective of the nature and intensity of their initial incompatible goals and desires. Through the process of mediation or negotiation, conflict resolution specialists (i.e., mediators or negotiators) should be aware of the disputing parties' interests to generate options and alternatives that will best meet everyone's needs. However, the mediator cannot impose solutions on the disputing parties because they have voluntarily entered mediation. The disputing parties must have control of the outcomes, where they can reach agreements that are mutually acceptable. The mediator must also not take sides, regardless of his or her social status and position in a society.

Like mediation, both negotiation and facilitation are valid problem-solving methods. They are useful in, and may be applied to, numerous disputes and conflicts; for example, negotiation is relevant in resolving business disputes, international conflicts, and organizational and family issues. Typically, the professional negotiator guides the dialogue of two or more parties, with the aim of reaching a compromise. Facilitation is another method in which a third party creates an environment conducive for discussion and who leads such conversation. That third party, or facilitator, helps parties to develop ground rules and set the agenda, while allowing the parties to decide the content of their dialogue. The facilitator must not make decisions for the parties. Conflict resolution specialists train frontline employees, supervisors, and managers, so that all may develop and improve skills and competencies necessary to understand and more constructively and collaboratively address conflicts. Communication is key in approaching and reaching common ground on issues that are vital for the growth and sustainability of all types of organizations.

Conflict Specialists Working With Diverse Populations

Conflict resolution specialists work with people of diverse backgrounds. They also bring their personal differences with them to any encounter. They differ in terms of cultural values, views, opinions, social status, positions, interests, and needs. The specialist must first be aware of his or her biases. Second, the responsibility of the conflict resolution specialist in diverse settings is to approach, welcome, and treat everyone from a position of humility and respect. It is essential that the conflict specialist focus on substantive matters that are shared problems of two or more disputing parties, while appreciating their similarities and respecting their cultural differences and individual personalities. Therefore, the conflict specialist's job is to accommodate all those who are seeking professional assistance, regardless of their race, religion, national origin, class, gender, gender identity, sex, ability, or age. The conflict specialist should also be conscious that diversity is an innate aspect of human society. It is important for everyone to understand and celebrate inclusive diversity. One way for conflict specialists to achieve this is to emphasize what people have in common, to bring them together to achieve a common goal.

Last, conflict resolution specialists have a role to play in providing critical wide ranges of human services for diverse populations locally, regionally, nationally, and internationally. They should emphasize and incorporate problem-solving methods in their work that are solutions-oriented. These factors are critical to the masterful use of alternatives to violence, and which can be healthier for, and beneficial to, all those directly or indirectly involved in disputes and conflicts.

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See Also: Conflict Resolution and Diversity Cultural Competence; Ethnic Diversity and Values; Gender and Clients; Multicultural Education; Social Workers.

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Conflict Resolution and Diversity Cultural Competence

Increased diversity creates a rich cultural environment; however, as people from different cultural backgrounds or groups interact, cultural values occasionally conflict. Nonetheless, through a commitment to promote respect and understanding of diverse cultures and social groups, conflicts can be resolved in a culturally competent manner. Cultural competence refers to relevant, effective, and respectful processes by which individuals or organizations respond to all cultures. Diversity cultural competence in conflict resolution entails paying attention to the role of culture in conflict and utilizing strategies to mediate and resolve disputes and misunderstandings that stem from cultural differences.

Culture and Conflict: Linkages

Culture is inextricably linked to conflict. Moreover, culture is a fundamental component of conflict resolution. To better understand diversity cultural competence as it relates to conflict resolution, it is important to consider the meaning of culture. Culture is a complex concept, with various definitions. In a broad sense, culture entails an integrated pattern of learned human behavior that reflects the values, beliefs, attitudes, experiences, artistic expressions, history, traditions, and customs shared and transmitted by a group of people.

Cultural groups can be defined by various characteristics, including: language and nationality, social class, race, gender, religious or spiritual beliefs, ability or disability, sexual identification or orientation, education, employment, and shared history and experience.

Culture is the lens that shapes a group's worldview, what they see and do not see, and how they perceive and understand the world. When the cultural group to which one belongs is in the majority in a given community or nation, the individual is less cognizant of his or her culture because cultures shared by dominant groups are perceived as "normal" or the way things are done. People tend to notice cultures that are different from their culture, perceiving behaviors different from their own as strange or unusual.

When differences arise in cross-cultural encounters and relationships, culture is usually a factor, influencing perspectives, behaviors, and outcomes. In conflict, two different aspects of culture tend to be prevalent: worldview(s) and communication style(s).

Worldviews

Culture provides the lens through which individuals view the world. This means cultures view and interpret phenomena differently. No worldview is superior or more accurate than another; viewpoints are just different. Understanding and accepting the concept of differing worldviews places individuals in a position to learn about other cultures, which is fundamental to conflict resolution and diversity cultural competence.

Communication Styles

Cultures have different rules regarding how individuals should communicate with others. Some cultural groups emphasize listening over speaking. Some cultures use direct styles of communication (i.e., making eye contact, using I statements, speaking loudly), while other cultures use indirect styles of communication (i.e., by means of gestures and other nonverbal cues, showing emotions). Individuals that use direct styles of communication (high assertiveness and low expressiveness) are decisive in their tone and emphasize the bottom line. People who employ the spirited style of communication (high assertiveness and high expressiveness) are animated and can be very persuasive. Those that utilize a systemic style of communication (low assertiveness and low expressiveness) are very precise in their speaking and emphasize facts. Those that make use of considerate styles of communication (low assertiveness and high expressiveness) listen well and use supportive language.

Communication styles are not compatible. Additionally, there are different cultural norms regarding appropriate degrees of assertiveness or levels of tonality in communication. In some cultures raised voices may be perceived as a sign of impending danger or a sign that a fight has started, while in other cultures an increase in the volume of a conversation signifies an exciting exchange among acquaintances.

Essentially, people will interpret the same message or the identical situation in different ways. Moreover, different communication styles reflect different worldviews, which are the foundations of culture. Likewise, behavioral styles reflect worldviews. Acknowledging culture and understanding the various ways that people communicate and behave based on their worldviews can lead to conflict resolution that is culturally competent.

Core Dimensions of Cultural Competence and Conflict Resolution

Culture has a great influence on whether conflict is resolved in a culturally competent manner. Cultural competence has to do with the process by which individuals and organizations respond respectfully and effectively to individuals of all cultural backgrounds.

Individual cultural competence starts with being aware of one's own culture and how culture influences and shapes the conflict resolution process. Additionally, cultural competence requires an acknowledgement of one's own biases and stereotypes. In doing so, individuals have the opportunity to reflect upon how culture is acting upon them. Further, individuals have the opportunity to challenge their assumptions, values, and beliefs, as they attempt to see issues from another's perspective.

Organizational cultural competence involves congruent values, behaviors, practices, skills, policies, and structures that coalesce in a system or organization for individuals to work in the context of cultural differences.

Heterogeneity within cultures is as significant as diversity among cultures. One of the benefits of recognizing that differences do indeed exist within different cultures is that individuals avoid the practice of stereotyping. It is important to view and respect people as unique individuals within their own cultural group(s).

Potential Barriers to Culturally Competent Conflict Resolution

Knowledge and understanding of possible barriers to conflict resolution are primary steps toward eradicating or reducing them. Potential barriers or challenges toward culturally competent conflict resolution include the following:

- Unfamiliarity with other languages, dialects, values, and social norms
- Use of stereotypes to guide interactions with others
- History of negative experiences with individuals from other cultures
- Real or perceived conflict in values among cultures
- Tension and anxiety related to conflict

Guiding Principles for Culturally Competent Conflict Resolution

Through work and education, cultural competence evolves over time. Developing cultural competence results in being able to interact effectively with individuals across cultural differences. Similarly, resolving conflicts constructively requires cross-cultural understandings and awareness. Selected guiding principles for culturally competent conflict resolution require individuals to do the following:

- Learn about other cultures to better understand and appreciate people representing

differences in race, ethnicity, religion, sexual identity, social class, group identity, physical ability, language, beliefs, and behavior patterns.
- Practice cross-cultural communication.
- Challenge their own values, beliefs, and assumptions about the "right way" to communicate.
- Seek methods to be effective in cross-cultural communications when there appears to be a breakdown in communication, rather than blame others for the breakdown.
- Become active and empathetic listeners, attempting to understand other cultural perspectives by putting themselves in other people's shoes.
- Honor other people's opinions and choices regarding whom they want to engage in communication.
- Suspend judgment, making an effort to view the situation from the perspective of an outsider.
- Become familiar with historical events that have caused conflict because of cultural differences. Use this information to develop an understanding of the conflict from the other's point of view.
- Be conscious of power imbalances. Be open to hearing other's perceptions regarding those imbalances
- Keep in mind that cultural norms may not be influencing the behavior of any given individual. Individuals should question their interpretations of the situation and circumstances surrounding the conflict.

In summary, there is no one-size-fits-all approach to conflict resolution. Culture is always a factor in conflict. Cultural competence can help individuals resolve conflicts across differences effectively so as to respect the inherent dignity of all cultural groups.

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See Also: Conflict Resolution and Diversity; Cultural Competence, Human Service Providers and; Cultural Competence, Measuring and Assessing; Cultural Competence, Model of; Cultural Competence, Professional Standards of; Cultural Competence, Training in.

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Continuum of Care

Continuum of care (CoC) is an enabling approach and a concept within social care services (examples could be health care, housing, support to physically and mentally challenged individuals, drug de-addiction services, sexual- and gender-based violence survivor support programs, etc.) that requires the care provider (and other duty bearers, such as state institutions, financial and legal assistance systems, etc.) to develop and implement an integrated, coordinated, and comprehensive system of care, creating a facilitative environment for high-quality support for the beneficiary/client. Central to the CoC concept is the need for all relevant caregivers and other duty bearers to work together in a concerted and coordinated way to provide quality support to the beneficiary or beneficiary group.

The CoC approach can straddle across multiple dimensions. For example, CoC can be explained in terms of time (i.e., through the age gradient for a patient from young to old and the treatment provided over a period of time), space (i.e., provision of treatment in an institution such as a hospital or at the level of the household), service provider (i.e., support to the beneficiary from a family member to that of a social worker to that provided by a specialist), and condition of the client (i.e., from acute, emergency conditions to stages in which the person is recovering).

Key Support Providers

The continuum of care is also explained in terms of the collaboration between the three key support providers. The first level of support is the beneficiary's own home and family, who are key in assisting the person and providing necessary care within their means. This is also the level in which the family could possibly confront and address any behavioral aspects that may be jeopardizing the person's well-being (e.g., substance abuse, sexual behavior, food choices, and other habits). The second level is the wider community where the person lives, which plays an important role in supporting that person through support networks, provision of information, and referrals if necessary. The third level are the public institutions, such as schools, hospitals, social care centers, short-stay homes, transitional shelters, and counseling centers, among other facilities.

In some cases, it is acknowledged that each level assists in solving the care needs for the person, thereby reducing the referral to the next level. For example, in the case of care for persons with substance abuse problems (especially for early addicts), these individuals could be assisted by the immediate family, who could support the person, prevent him or her from accessing the drug, and helping him or her develop a positive lifestyle. The other two levels (community and public institutions) would only be involved should the family be unable to address the issue.

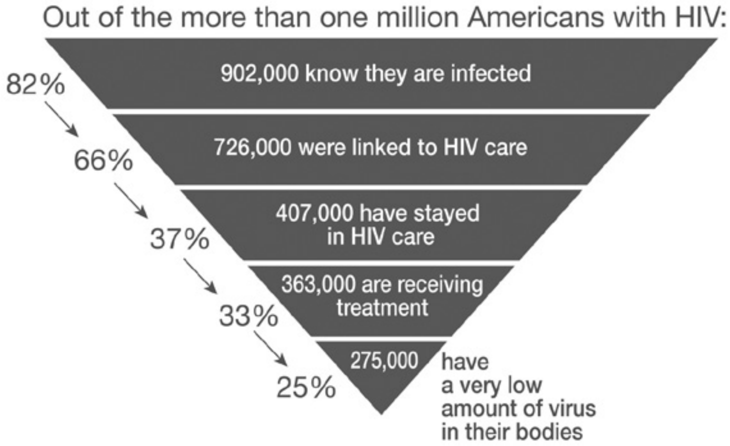

Figure 1 Percentage of HIV-infected individuals engaged in selected stages of the continuum of HIV care in 2010.

Source: Centers for Disease Control and Prevention

Key Success Criteria for Continuum of Care

One criterion for a successful CoC approach is that the care delivered is client-centered and participatory. This can be ensured only if the care providers and duty bearers understand the needs of the beneficiary and design systems that enable and facilitate easy access and usage. The specific realities of the local context are equally important to be considered. Some of the crucial aspects for the beneficiary that need to be kept in mind include: the distance at which service is available, privacy/confidentiality, affordability in terms of cost, continuity and predictability of services, and most important, quality of care.

Other factors may be important depending on the nature of the social service. Participation of the individual beneficiaries, the community at large, and other caregivers and duty bearers within the network is therefore crucial so as to discuss the needs and share their experiences and best practices, which will help in designing the CoC approach.

A second criterion for success is need-based care. Any CoC system must meet the needs of the beneficiary to the extent possible in order to provide quality care. One of the key challenges standardized social service systems face is the fact that these systems over a period of time become extremely rigid and cannot meet the specific needs of an individual or a condition that was not earlier encountered. This could be addressed by making sure any exceptions are carefully dealt with and new protocols and standards are established if needed to provide quality service to the individual.

The need for beneficiary participation in decision making is another key success criterion. A CoC approach ensures that the beneficiary (or family) is equally involved in decisions on the services provided. They are provided all relevant information and necessary advice to facilitate quality decision making. Sharon B. Arnold explains that when consumers are armed with the right information, they will demand high-quality services from their providers, choose treatment options wisely, and become active participants and self-managers of their own health and health care.

A fourth criterion for success is long-term visioning. The strength of the CoC concept is its ability to look at the long term and design and establish a network of providers accordingly. Long-term visioning could be in terms of: anticipated demographic change over a period of time, the dynamics of care needed (e.g., whether HIV prevalence is likely to increase or decrease in an area), cost factors, the need for a trained workforce, shifts in standard practices, and dealing with contingencies (e.g., a sudden increase in homeless people). Such long-term thinking enables caregivers to plan for changes and for integrating systems and approaches, rather than making a complete overhaul every time something in the external context changes.

A successful CoC approach is also collaborative and coordinated. Probably the most important need for an effective CoC is the coordination of services between different actors within the continuum and the positive collaboration among them. An effective CoC is also comprehensive, to the extent that is possible. CoC must include all aspects of care and support the beneficiary needs.

In the case of homeless people, for example, it is important that the CoC system provides for finding temporary housing, locating a permanent (or rental) house, arranging financial services or rent support, providing advice on design, introducing the person to the community, arranging for orientation to the area (if the person is new to the community), providing orientation on safety and security measures, offering vocational training to enable the person to get a job and be self-reliant, and so on. Other aspects need to be added to this continuum depending on the condition of the person. Finally, successful CoC is strategic and proactive to ensure that the services provided achieve the optimum outcome. This outcome could be measured in terms of satisfactory resolution for the beneficiary, good value for the money, synergies established between different service providers achieving maximum output, and so on.

The scope of the CoC system can also expand depending on the perceived needs in the interest of the beneficiary. For example, in an HIV CoC program, prevention aspects may be added to the already existing treatment, counseling, and post-treatment support in order to be effective and reduce the disease prevalence. Similarly, in a program dealing with support to the physically challenged person, the element of advocacy interventions may be included to entitle these individuals to certain rights (such as state support and jobs).

Advantages of CoC Approach

Farzan Bharucha and colleagues provide a compelling case for the use and expansion of the CoC approach in the health care system. Bharucha and colleagues argue that the value of the health care continuum can be best evaluated in terms of the clinical or operational improvements it provides to the overall delivery of care. This implies that a more integrated care continuum offers some combination of better quality, better service, and lower costs per unit of service. The CoC approach is advantageous for the following reasons:

- There is a synergy of action between different service providers, which makes sure that the outcome is more than what they could individually achieve.
- The approach allows specialization owing to participation of numerous providers across the span of care, enabling each provider to specialize in a particular component rather than having to take on a wide range of services that could potentially reduce quality.
- It builds partnership between care providers and other duty bearers leading to greater opportunities to learn from each other, better respond to the beneficiary's needs, and advocate together.
- Beneficiaries have access to a wide range of support services that are easily accessible and within the network.
- A CoC system that is well coordinated is also likely to gain more recognition from state institutions and communities, which could translate to receiving more funding assistance to strengthen the system further and address gaps.

Some of the activities necessary for setting up a CoC include the following:

- Mapping out the service providers. Identifying the various service providers and duty bearers in a certain location or through the expanse of the care continuum is the first stage. This gives a sense of the available providers as well as the absence of specific ones. Any gap in the continuum has to be bridged by setting up new providers or expanding the remit of existing providers to deliver the particular service for which the gap exists.
- Identifying a designated lead within the CoC system. This is crucial in order to ensure that the services are well coordinated. The role of the lead is to organize regular meetings with different providers within the network, sharing lessons and challenges. The lead also identifies any service provision gaps in the continuum and works to address this gap through the inclusion of other providers, changing approaches, or asking an existing provider to take on additional support activities.
- Identifying and communicating the referral pathways once the providers are mapped, designing a referral pathway between them if necessary. Referral systems need to be understood by all providers, including setting up standard protocols and conditions.
- Documenting the case records for individuals is crucial so as to enable the various caregivers to obtain information on the background of the client, past history, support provided, and any specific conditions they need to be aware of. Electronic documentation is probably the most efficient way in which case records are maintained and retrieved, and also ensures confidentiality by limiting access only to those who are authorized. However, given that different support providers rely (or likely rely) on different electronic filing systems, the document transmission system may not be efficient. This challenge has to be addressed. The alternative is paper-based documentation, which is used in many countries/contexts and can serve the purpose if the document management system (and various forms and formats) are standardized, easily understood, and safely stored.
- Training of staff: Given the multitude of actors who are involved in the CoC, it is important that all caregivers have skilled staff that are well versed with the protocols, standards, and approaches used by others. Interorganizational training is sometimes useful to bring together staff from different institutions and departments in order to facilitate discussions and share experiences and expectations.
- Being aware of the community: Existence of a CoC system needs to be well known to the community in which the system is set up so that community members are able to utilize the system. This includes extensive community sensitization regarding the CoC approach, the various actors involved in it, persons who could or could not access these services and preconditions, and the role of the communities themselves in supporting this approach.

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See Also: Home and Community Services; Hospitals; Information and Referral.

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Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) is an international treaty adopted by the United Nations (UN) General Assembly on December 13, 2006. The CRPD is one of several key human rights treaties, including the Universal Declaration of Human Rights (1948), Convention on the Elimination of All Forms of Discrimination against Women (1979), and Convention on the Rights of the Child (1989), among others. These treaties, however, were insufficient to overcome the physical and social barriers that prevented many people with disabilities from receiving an education, becoming employed, obtaining quality health care, moving freely and independently around their communities, and being fully included in society.

There are an estimated 1 billion people with some form of disability in the world, including 182 million children. The CRPD requires nations that ratify the treaty to protect and ensure equal enjoyment of human rights and fundamental freedoms by all persons with disabilities and to promote respect for their dignity. When a nation (called a “State Party” in the treaty) ratifies CRPD, it acknowledges an obligation to make whatever changes may be necessary in its domestic law to fully implement the treaty. In effect, ratification means that a nation consents to be bound by the provisions of the treaty, and to implement the treaty in good faith. As of July 2013, 156 nations signed the treaty and 133 of them ratified it.

Convention Requirements

The CRPD defines people with disabilities to include all individuals who have long-term physical, mental, intellectual, or sensory impairments hindering full and effective participation in society on an equal basis with others. The CRPD specifically requires nations to take all appropriate measures, including passing, modifying, and abolishing legislation, regulations, practices, customs, and other policies to implement the treaty. Fundamental to the CRPD, nations must implement all necessary measures to eliminate discrimination on the basis of disability by any person, organization, or private enterprise. In doing so, the CRPD emphasizes the necessity and importance of closely consulting with and actively involving persons with disabilities (including children) in decision making on issues concerning them.

The CRPD affirms that all persons with disabilities have a right to life, rights to liberty and security, and rights to freedom from torture and inhuman, degrading, violent, abusive, and exploitative treatment. It mandates that all persons with disabilities have recognition before the law and access to justice equal to others. Nations must ensure the accessibility of all public physical environments and facilities (e.g., schools, hospitals, courtrooms) and all public transportation, emergency, and information and communication services in both urban and rural areas.

The CRPD requires nations to promote the research, development, and availability of universally designed goods, services, facilities, equipment, information and communication technologies, mobility aids, and assistive technologies. In addition, nations must collaborate and cooperate in data collection, implementation, and monitoring and reporting progress to the UN.

When a person or group with disabilities claims a nation has violated their CRPD rights, they must use the nation’s available legal mechanisms to redress their grievances. If unsuccessful, they may file a communication with the UN Committee on the Rights of Persons with Disabilities if the alleged violating nation has ratified the CRPD’s optional protocol. This protocol subjects the nation to the jurisdiction of the committee. The committee, however, is empowered to only examine the claim and must submit its findings and recommendations to the nation. The protocol has been signed by 91 and ratified by 77 nations.

Ratification in the United States

There are an estimated 57 million people with disabilities in the United States. They are entitled to civil rights protections under the Americans with Disabilities Act, Individuals with Disabilities Education Act, and other federal laws. The United States to date has not ratified the CRPD. Some critics of ratification argue that current U.S. law is consistent with or more protective than the CRPD, and thus the CRPD need not be ratified. Others have raised concerns that ratification would require costly or invasive changes to U.S. law. The National

Council on Disability (NCD), an independent federal agency responsible for making disability policy recommendations to the president and Congress, supports ratification. In a 2008 report NCD found that the CRPD is largely consistent with federal disability law, although some provisions of U.S. law may require more rigorous implementation by the executive branch or further action by Congress.

NCD also found significant shortcomings in U.S. laws pertaining to people with disabilities. Among the larger concerns were the underenforcement of disability law and voting rights; the inability of federal law to address issues specified by the U.S. Constitution as subject to the authority of state government (e.g., rights of children, legal capacity, family and health law); U.S. Supreme Court precedent that children with disabilities are entitled only to an adequate education rather than to the development of their full potential; issues addressing access to justice, humanitarian emergencies, freedom from exploitation, and the rights of women with disabilities; and nonrecognition under U.S. law of the rights to medical and assistive devices and economic and social protections.

The United States signed the CRPD on July 30, 2009, agreeing in principle with the treaty. Ratification of a treaty requires a two-thirds majority (67 or more votes) of the Senate's 100 members. Notably, the United States has not ratified the conventions regarding persons with disabilities, women, or children. President Barack Obama supports ratification of the CRPD. On December 4, 2012, the Senate failed to pass the CRPD by a vote of 61 to 38.

Conclusion

Studies of the implementation of the CRPD by nations find modest progress in general, widely varying means of implementation under the many different legal systems of nations, and much progress yet to be made in order to see the treaty's full implementation. In the history of international human rights treaties since creation of the United Nations, it has been commonplace for nations to implement treaties over the course of decades. Likewise with the CRPD, each ratifying nation is on its own unique path to full realization of human rights for persons with disabilities.

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See Also: Americans with Disabilities Act; Americans with Disabilities Act of 1990; Individuals with Disabilities Education Act; Universal Access/Universal Design; United Nations Convention on the Rights of the Child.

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Co-Parenting, Cultural Aspects of

Co-parenting is the result of two parents who are no longer in a committed relationship and continue the process of working together to raise and provide for their children. The romantic relationship between the parents may be over, but the parenting relationship remains constant. In a co-parenting relationship, both individuals share the responsibilities of parenting while working to maintain a stable environment for the children. The separation of parents results in changes and inconsistencies that may cause the children to feel a mix of emotions related to confusion, worry, sadness, and guilt. Co-parenting is a holistic process that involves planned and focused activities intended to create a supportive and empowering environment for the child.

This process can be challenging and complex. Families across cultures seek guidance and assistance from services in the community. For a human service professional, it is important to understand the impact that co-parenting has on children. This includes proactively addressing existing barriers that contribute to the conflict between culture and the needs and expectations of the social service agency. Although understanding cultural diversity in the families served in the field of human services is important, the development, delivery, and evaluation of the training of those providing services are also important. Providing continuous love and support during this time of life transition can have a long-term effect on the health and well-being of the family.

Establishing Parenting Arrangements

The arrangement of co-parenting can be established as a result of custody arrangements, mediation, parenting agreements, or by court order. These arrangements may include how frequent and how long a parent spends time with a child. Events related to school, holidays, and family celebrations such as birthdays and/or special events are considered when making these arrangements. The co-parenting arrangement may include a parenting plan, either in the form of legal stipulations or an informal plan created by an agreement made by both parents. The parenting plan typically states procedures to be followed by both parents in relation to decision making, financial obligations, medical issues and expenses, living arrangements, and everyday issues. For a successful co-parenting relationship, both individuals should demonstrate the ability to be somewhat flexible with the parenting plan to also meet the needs of each individual. Being respectful of each parent's time with the children is also a positive characteristic in building and strengthening the relationship of co-parents.

Abiding by the rules and agreed-upon decisions regarding the children can minimize conflict and increase communication regarding the children. Open communication about thoughts and opinions on the children's growth process can lead to mutual support and understanding by both parents. By keeping the best interest of the children as the main priority, both parents can work to reduce conflict through conversation and negotiation when challenges occur.

Focus of Co-Parenting

The goals of a co-parenting alliance can be achieved by maintaining cooperation through communication. In a co-parenting relationship, mutual respect and support for each individual is important for the children to witness and experience. Encouraging children to remain connected to each parent and both sides of the family can be beneficial for the relationship. Observing parents who work together and remain consistent and accountable in their parenting style allows the children to regain stability and familiarity with family lifestyle changes.

Legal and mental health professionals stress the importance of both parents forming a united front in raising their children. By working together, the parents are able to create an environment of respect and mutual support in efforts to strengthen the relationship with their children. Communicating with the other parent does not have to be stressful or include arguments during each contact episode. Many interventions have been developed to assist parents in their co-parenting relationship to reduce stress and conflict, such as attending educational classes that provide skills in shared parenting. By witnessing what other parents have gone through in their co-parenting experiences, parents may be encouraged to focus on the needs of the children and gain insight to better ways of co-parenting. Professionals in the field of human services are encouraged to support parents and help individuals understand that living apart does not mean that they love and support their children any less than before.

Community and mental health services assist families and the new co-parenting alliance with overcoming new challenges in their lives. Children may feel more comfortable sharing personal concerns with someone other than their parents. Assistance can be obtained through schools, community mental health facilities, child and youth service agencies, nonprofit agencies, or private practice.

Risks and Benefits

When parents cannot establish a healthy relationship, the children are at risk and can become entangled in their conflict. If children are constantly exposed to the conflict between their parents, their emotional, mental, and even physical health may suffer. It is important for both parents to not share negative thoughts or opinions about the other parent with the child. Although not always possible, parents should also try not to argue in front of the children. Both parents should seek professional mental health services if they experience frustration, disappointment, hurt, or troubles related to the new co-parenting relationship.

It is important to acknowledge that the children's welfare is the priority in the goal of establishing a healthy co-parenting alliance. Children need both parents to actively participate in their lives. It would benefit the co-parenting alliance to schedule regular meeting times to keep the other parent informed of issues involving the children. Maintaining a strong connection with the children through the parents' separation can be challenging. One of the most valued experiences is helping the children understand what is important. While the children do not have to know all the details surrounding the parents' relationship, telling the truth at an age-appropriate level they can understand is beneficial. Children may feel that they in some way contributed to their parents' relationship ending. Moreover, it is important that both parents stress to the children that they are not responsible for their decision in separating. Reinforcing to the children that they are not at fault for the parents' separation can assist the child in understanding the truth and lessen any feelings of self-blame or guilt.

New Schedule

Children and parents face a new experience of going back and forth between parents and their houses. Neither the parents nor the children have experience with dividing time and frequency of parent visits. Feelings of confusion, worry, and frustration are common at the beginning of the separation adjustment. Following the agreed-upon rules and schedule can minimize feelings of worry and confusion, in some cases, by establishing a regular routine. Children who experience consistency in their schedule experience their environment as much more stable. In working toward the best interests of the children, the parents' priority is creating and maintaining a healthy environment for the children. A co-parenting relationship based on communication and respect tends to offer children an opportunity to grow up in a stable atmosphere that includes both parents.

Finally, creating, understanding, following, and modifying the parenting plan to the best interest of the child is essential in a co-parenting alliance. Working together following the termination of a romantic relationship is not always easy. By being aware of the needs of the children and providing what is needed, co-parents are able to help their children navigate difficult life transitions. This process provides ground for the development of healthy interpersonal relationships in the future.

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See Also: Alloparenting, Cultural Aspects of; Divorce; Parenting Skills Training; Parenting Styles, Cultural Differences in.

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Counseling and Psychotherapy Services

Counseling and psychotherapy are integral services in the diagnosis and treatment of mental and emotional disorders. Either may be delivered as a stand-alone service or in the context of an interdisciplinary approach that includes biological and social interventions. Historically, troubled individuals sought counsel from religious leaders or from elders in their families. In many cultures, this traditional wisdom remains the primary source of help for troubled community members. In Western society, however, the Industrial Revolution created a need for better service delivery to those with mental and emotional disorders. Community mental health centers deliver a large proportion of counseling and psychotherapy services. Currently, to meet a demand from consumers and third-party payers to provide services that are effective and efficient, counselors and psychotherapists are guided by outcome research and are required to use evidence-based practices.

The terms *counseling* and *psychotherapy* are often interchangeably used. Although counselors may conduct psychotherapy and psychotherapists may give counsel, as the profession of counseling has evolved, counseling and psychotherapy have become better defined. Counseling frequently addresses issues of adjustment. A skilled counselor can help ease the strain of normal life transitions by guiding a client through the processes of problem solving, decision making, stress management, or the grief process. Counselors assist clients with interpersonal issues by mediating conflict or teaching social skills. Clients with chronic anxiety or depression often benefit from intermittent counseling to assist them with symptom management. Mental health counselors often practice at a master's level in community mental health agencies. Licensed counselors can also practice privately as generalists or with a specialty. Specialties that require additional certification include vocational counseling, school counseling, substance abuse counseling, employee assistance counseling, hypnotherapy, and marriage and family counseling.

Psychotherapy has evolved to describe services provided by a doctoral-level practitioner who treats mental and emotional disorders as defined in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. Psychotherapy focuses on complex issues that may require exploration of the deeper dynamics of personality, co-occurring medical disorders, and the client's psychosocial profile. Psychotherapy is usually a longer process than counseling.

Practitioners

The core skills of counseling are the staples of all the helping professions. To be effective, social workers, psychologists, psychiatrists, crisis workers, case managers, and psychiatric nurses must be proficient in the active listening skills of attending, reflecting, empathizing, exploring, and planning. Psychotherapy is in the scope of practice of the licensed professions of psychiatry, psychology, clinical social work, clinical counseling, and clinical psychiatric nursing. The licensed professions require specific educational preparation and supervised practice.

The discipline of counseling is self-contained. In the past two decades, counselors have accelerated their efforts to establish and clarify their professional identity and delineate their scope of practice. The American Counseling Association defines and regulates the profession of counseling. The Council for Accreditation of Counseling and Related Education Programs (CACREP) sets the standard for counselor education. In most of the United States, graduation from a CACREP accredited program or its equivalent is a requirement for licensing. With this strengthening of professional identity, education of counselors by psychologists is decreasing, and doctoral programs in counselor education are rapidly growing to meet the needs of CACREP-accredited programs.

Continuum of Care

A continuum of care refers to the frequency and intensity of treatment necessary to be effective. Counseling and psychotherapy services occur at every level of care. An intake counselor conducting an assessment and recommending the appropriate level of care is often the first point of contact for a client. At the lower level on the continuum of care, a patient may attend weekly or biweekly one-hour outpatient counseling sessions. For clients who require more support, structure, or supervision, counselors and/or psychotherapists deliver services in the context of an intensive outpatient program (IOP). An IOP often includes the services of social workers and medical professionals. The

The seminal work for counseling and psychotherapy occurred in the early 1900s, when Sigmund Freud conceptualized the unconscious mind and introduced the psychoanalytic theory.

program participants meet several times per week for individual counseling, group therapy, and medication management. Day hospital programs are a step up from IOPs, and meet daily for the entire day. When inpatient hospitalization is the appropriate level of care, a counselor or psychotherapist may conduct individual counseling or psychotherapy, group therapy, family therapy, creative therapies, or psycho-education. In long-term residential settings, a counselor's duties may include assisting residents in adjusting to residential treatment, conducting community meetings, facilitating resolution of interpersonal issues, and participating in discharge planning.

Community-based counselors and psychotherapists often identify the need for medical intervention, community support, or social services. In the context of wraparound services, counselors work in conjunction with an interdisciplinary team, and may provide services at the client's place of residence to better position them for monitoring safety issues, support systems, and medication compliance. Counselors assist child protective services by working with parents toward reunification with children, and by working with children who are in foster care. In assisted living facilities, nursing homes, and hospice care, counselors assist residents and their families in maintaining their mental health while making difficult decisions, negotiating issues of loss, grief, and making healthy adjustments to critical changes in the family structure. In correctional facilities, counselors provide services to inmates who had mental health or substance abuse issues prior to incarceration, or to those who are pending release.

In community-based correctional halfway houses and three-quarter-way houses, counseling addresses mental health issues, substance related problems, vocational planning, and social support to facilitate successful reentry to the community. In courts and emergency rooms, crisis counselors assist victims of domestic violence and other crimes in establishing immediate safety. Crisis counselors may also debrief victims immediately after a crisis, or assess for and treat post-traumatic stress disorder. School guidance counselors participate in individual education plans, disciplinary actions, and student crises. Some school systems utilize guidance counselors to provide programs for students with problems associated with parental divorce, substance abuse, pregnancy, or other nonacademic problems that interfere with academic performance. Colleges typically have counseling available as a part of student services.

Types of Counseling and Therapy

Psychological theories are the foundation for standard practices of counseling and therapy. The basic theoretical orientations are psychoanalytic, existential, cognitive, and behavioral. The seminal work for counseling and psychotherapy occurred in the early 1900s, when Sigmund Freud conceptualized the unconscious mind and introduced the psychoanalytic theory. Freud's work seeded the emergence of many schools of psychotherapy. Carl Jung's humanistic theory emphasized existential crises and the importance of self. Ivan Pavlov and B. F. Skinner, behavioral theorists, studied how learning serendipitously occurs through classical conditioning, and how rewards and punishments shape behavior. Alfred Adler's theory extended Freud's work by considering clients in the context of their development, emphasizing the importance of family dynamics, birth order, and childhood experiences. Adler's method of reworking the cognitions that stemmed from childhood experiences is a precursor to the current practice of cognitive therapy. Although all of the theoretical orientations drive current practice, most contemporary counseling and psychotherapy is based on cognitive theory, which purports that thinking causes emotions, therefore a change in thinking will bring about a change in emotions.

Freud's psychoanalytic theory is the basis for the contemporary psychodynamic theory. A therapist using a psychodynamic approach helps the client to discover childhood and family-of-origin dynamics that account for the client's current state, and assists the client in releasing the influences of the past. A psychodynamic therapist might also assist a client in identifying and rectifying developmental deficits in social skills, trust, emotional modulation, or conflict resolution. Existentialism, also known as humanism, is a philosophy that explores man's propensity to explore the human condition. Therapies deriving from existentialism include person-centered therapy, gestalt therapy, and logotherapy. Rather than drawing from the past, existential therapists focus on the current state of the client, and whether they are living authentically.

Person-centered therapy relies on a strong therapeutic relationship and the therapists' ability to deliver services with unconditional, positive regard.

Cognitive therapy is founded on the premise that faulty thinking processes cause uncomfortable emotions. Cognitive therapists assist clients in restructuring cognitions that cause emotional discomfort. One method for changing cognitions is to challenge irrational beliefs. Albert Ellis pioneered this approach through rational emotive therapy (RET), in which he identified common irrational beliefs and aggressively disputed the beliefs. Behavioral therapists often treat specific symptoms. Systematic desensitization, for instance, is a type of behavior therapy that incorporates relaxation training, which is indicated for specific phobias. For behavioral issues, behavior modification is treated by developing a system of reinforcement that increases desired behaviors. Rational emotive behavioral therapy (REBT) combines cognitive and behavioral approaches, and cognitions are sometimes changed when prescribed behaviors are carried out.

Most third-party payers require that counselors and psychotherapists have empirical support for the methods they use. Evidence-based practices assure that services are safe, clinically effective, and cost-effective. The brief, specific interventions used in cognitive and behavioral approaches are easier to study than existential and psychodynamic interventions, so their dominance in the field of counseling and psychotherapy may be related to their amenability to the research that drives evidence-based practice.

Alternative Approaches to Counseling and Psychotherapy Services

As advances in medicine and technology have led to a deeper understanding of mental and emotional disorders, counselors and psychotherapists have integrated somatic approaches into their practices. To treat symptoms of post-traumatic stress disorder (PTSD), eye movement desensitization therapy (EMDR) requires a client to recount a traumatic event as they visually follow the continuous back and forth movement of the therapist's fingers or an audible tone. EMDR has proven effective for quickly decreasing symptoms, and is most effective for a single traumatic event. Counselors using emotional freedom therapy (EFT) treat anxious clients by teaching them a technique of tapping specific points on their head, face, and hands. Despite studies that show EFT to be effective, the popular technique remains controversial. Breathwork is a technique of manipulating normal breathing patterns to attain an altered state. Psychotherapists use breathwork in conjunction with drawings, music, and group process to treat anxiety and depression, despite the scarcity of research to support its effectiveness.

Since the wars in Iraq and Afghanistan, the American military has significantly increased its use of mental health counselors for soldiers returning from war, military families, and veterans. They often present with problems of traumatic brain injury, PTSD, domestic violence, and suicide. Similarly, survivors of catastrophic events, acts of terrorism, and natural disasters are at a high risk for severe emotional and functional difficulties. Counselors specializing in crisis and trauma provide immediate services to victims and witnesses to these events. Counselors also work with first responders who experience traumatic stress or compassion fatigue.

Challenges to Counseling and Psychotherapy

Population dynamics present the greatest challenge to counselors and psychotherapists. As 76 million baby boomers pass retirement age, the demand for specialized services will increase. In addition to social, financial, and medical issues of the elderly, baby boomers have a high rate of substance abuse. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 47 percent of older clients seeking mental health services have co-occurring substance-related disorders. It is incumbent upon counselors and psychotherapists to stay abreast of the research on substance abuse diagnosis and treatment for the aging.

Cultural competency may be the greatest challenge to contemporary counselors and psychotherapists. Age, gender, sexual orientation, and disability affect the dynamics of counseling and psychotherapy. With globalization, the cultural mix is rapidly changing. Diversity of race, ethnicity, and religion requires counselors and psychotherapists to understand the beliefs and mores of a group, as well as nuances of communication that, if misunderstood, could undermine the therapeutic relationship that is the foundation of counseling and psychotherapy.

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See Also: Cross-Cultural Service Models; Culturally Diverse Practice, Theories of; Mental Health Services, Adult; Mental Health Services, Ethnic Models and Multiultural.

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Court-Appointed Special Advocate, National Association

The first Court Appointed Special Advocates for Children (CASA) program was founded in 1977 by a juvenile court judge in Seattle, Washington. He recognized an unmet need and realized the benefits of utilizing a group of workers whose sole obligation would be to investigate court cases involving child abuse and neglect and to regularly report objective findings to presiding judges.

The children in these cases have been removed from their homes because of abuse and neglect on the part of their parents and/or guardians. CASA volunteers establish and maintain an ongoing presence in the lives of the children who they serve. These citizen volunteers provide a critical link between the wishes of their young clients and the decisions that judges must make on their behalf. For this reason, CASA workers are often assigned to cases that the judges find the most challenging, complex, and in need of immediate one-on-one attention and reporting.

Factors for CASA volunteer appointments will vary among judges, but they often include cases in which multiple children are a part of one immediate family. There are also frequently times when very young children (usually age 3 and under) are involved. Other common determinants for CASA inclusion are cases in which the children have been sexually abused, have suffered from medical neglect, and/or have been exposed to harmful drugs before birth. Additionally, sometimes the minor females who are involved in abuse and neglect cases are also parents. Juvenile judges will most likely assign CASA volunteers to monitor and advocate for both these young mothers and their children throughout the course of the court cases.

Since its inception, CASA has branched into many state chapters, which provide oversight and support to local agencies within their jurisdictions. Each agency recruits, trains, and supervises a diverse group of volunteers who operate as court officials, and who work with a variety of individuals and organizations throughout the course of each case to which they are assigned. CASA volunteers advocate for the best interests of the children who are directly involved in their cases. Judges support and rely on this service, largely because the information that is provided to them by CASA volunteers is pertinent, fact-based, concise, and solely directed toward the children's needs. CASA's mission is to help abused and neglected children find safe, nurturing, and permanent homes as quickly as possible.

Recruitment and Professional Training of CASA Volunteers

Agency staff members recruit CASA volunteers with the goal of selecting adult individuals from a broad range of ethnic, educational, professional, and cultural backgrounds. However, potential volunteers are not required to possess a certain skill set in order to be considered for service. After applications have been reviewed, each candidate is thoroughly interviewed. Some of the interview questions measure a candidate's cultural competence, along with their willingness to be open-minded and nonjudgmental while working on a court case. Candidates are also examined for their ability to commit to CASA volunteer work, including their availability to attend court proceedings, visit with the children at least one time each month, and remain with a case until it closes. The volunteer screening process includes personal reference checks and criminal background checks.

Once candidates are accepted as potential CASA volunteers, they are equipped with foundational skills and knowledge, which couple with their natural abilities through a research-based and nationally standardized volunteer training curriculum. Recruits receive 30 preservice hours of education, in which case studies and subjects such as child protection systems, abuse and neglect laws, cultural competence, mental illness, and substance abuse are discussed in ways that highlight family strengths. This curriculum encapsulates the roles and responsibilities of CASA volunteers, providing trainees with a greater understanding of how to effectively work on a case, and leaving each worker with a valuable resource manual to draw upon after their advocacy work begins. Annual in-service training is also provided to the volunteers. Following completion of the 30-hour course, candidates are sworn in as official CASA volunteers and "persons of the court" by judges. These qualified individuals are ready to successfully navigate through the social services and judicial systems. They become the voices of the children, and represent their interests. CASA is well-respected by judges and their staff, and volunteers are supported and guided by the CASA staff members.

CASA Volunteer Work

Once a judge appoints CASA to a specific case, its volunteers have legal rights to interview relevant people, and to gather critical information from a number of sources, including court, medical, and school records. Most cases last about one year, and volunteers usually spend about 10 hours per month on each case. This time frame largely depends on the number of children involved and the complexity of the original circumstances that brought a case to court. CASA standards require the volunteers to meet with each child at least monthly. Visits often take place in the foster homes, but could also occur in other locations, such as schools and day care centers.

CASA volunteers strive to ensure that children are thriving in their foster care placements. They also want to know if the parents are following through with the court-directed steps that must be completed before their children can be returned home. In order for CASA to effectively monitor and hold all parties accountable for their actions, volunteers regularly meet with social service providers and anyone else who could affect the cases' outcomes. A typical week could include meeting with the child, observing a parent-child visit, speaking with a caseworker about the family, and following up with a parent's probation officer. CASA volunteers also attend ongoing court proceedings, and when the need arises explain these proceedings to the involved children. CASA volunteers do not offer personal advice to the children, but instead provide steady emotional and moral support through consistent communication and advocacy work. These volunteers must convey respect and courtesy to the children's parents, while clarifying and maintaining their primary role as the minors' legal advocates.

Although CASA represents the best interest of the children involved in each case, the needs of other family members are also recognized, particularly if those needs directly impact the family's ability to successfully reunite. CASA volunteers assess and address such concerns for all immediate family members and foster parents, including any need for mental health, medical, social, and educational supports. Having access to confidential records and multiple service providers affords volunteers with a well-rounded and comprehensive platform to use when determining family needs. Knowledge of these needs is also obtained through direct interviews with external people who are relevant to the case, and through observations during scheduled and unannounced visits to the homes by CASA volunteers.

Concise written reports, which include updates on the children's welfare, along with the parents' compliance with court-ordered requirements, are written by CASA volunteers and filed with the courts for the judges' review. Hearings are scheduled with these judges at least every six months, and decisions are made by those judges regarding where the children will temporarily and permanently live. CASA reports contain such recommendations, and also offer suggestions for making current and future living situations as enriching and as trauma-free as possible for the minors. Each volunteer attempts to stay with the same case until it closes. If this is not possible, then another volunteer is assigned and supervised by CASA staff.

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Court Appointed Special Advocates for Children

See Also: Child Abuse/Neglect, Victims of; Children in Foster Care; Family Services.

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Crisis Services

Crisis services are used by diverse communities and encompass short-term immediate services provided to those experiencing an emergency or crisis situation. A crisis situation or event occurs when an individual is feeling overwhelmed, has difficulty coping, or lacks the resources to cope adequately with emotional, mental, physical, and behavioral distress or problems. Crisis situations or events include the ending of a relationship, death of a family member or friend, or the loss of a job. The definition of a crisis may differ with regard to cultural and linguistic groups. Situations can also be life-threatening, such as natural disasters, sexual assault or domestic violence, physical or mental illness, thoughts of suicide or homicide, and sudden and disparate changes in relationships (such as a death or divorce). At some point, most people experience a crisis. Responses to crises vary, often reflecting cultural and language differences, and most people experience an array of feelings when confronted with a crisis. It is common for individuals to feel emotionally and even physically overwhelmed during a crisis and to experience a loss of effective problem-solving and coping skills.

Crisis services often progress through different phases that are primarily aimed at reducing the intensity of an individual's emotional, mental, physical, and behavioral reactions to a crisis. During the first phase, an assessment is performed, exploring what happened to bring about the crisis and the individual's response to the crisis. An individual's response to a crisis can include emotional aspects (e.g., sadness, fear, anger, grief, or guilt), mental aspects (e.g., difficulties concentrating, loss of focus, or confusion), physical aspects (e.g., headaches, fatigue, or nausea), and behavioral aspects (e.g., loss of appetite, inability to sleep, or restlessness). During the assessment phase, it is also common to screen for potential for suicide and/or homicide. A strengths-based assessment also entails assessing an individual for strengths such as coping skills and social support.

In the next phase, it is critical to assist the individual by decreasing emotional pain, providing emotional support, ensuring safety, and developing a plan for coping with the crisis. This may involve connecting the individual with community resources that they can access to assist in coping with or resolving the crisis. The aim of crisis services is to improve functioning of the individual and assist them in developing new coping skills and avoiding problematic ways of coping such as withdrawal from potential support networks, isolation, and substance abuse. To this end, crisis services assist the individual in recovering from dealing with the crisis and experiencing long-term problematic consequences. Research has supported positive outcomes for crisis services, and has shown that such services lead to decreased distress around a crisis and improved problem-solving skills. Another phase of the crisis service involves informing the individual as to the various responses to crisis, and letting them know that they are having a normal reaction to an abnormal situation. In addition to this normalization of the response to crisis, the individual is also informed that responses are temporary.

The next phase of the crisis service process involves increasing the knowledge of how an individual can avoid or cope with a similar crisis in the future. The individual can be taught how to anticipate a crisis and helped cultivate the skills ahead of time to deal with a crisis. Crisis services largely focus on helping individuals develop the coping skills needed to effectively deal with a crisis. Such services help an individual discover coping skills that they might already have, and to develop new coping skills as necessary. Coping skills might employ relaxation techniques or exercise to address physical and mental stress, as well as journal writing. The goal is to have an individual express their feelings, rather than keeping them inside. Additionally, the individual is guided in discovering their options for social support or spending time with supportive friends and family. In addition to the cultivation of coping skills, cognitive behavioral therapy can be used in crisis services.

In the final phase of crisis services, the professional will assist the individual in helping them realize that they have the resources to cope with difficult crisis situations. The individual is encouraged to use new and previously developed coping strategies, as well as to make realistic plans for dealing with future crises. Usually, the professional will provide appropriate follow-up as necessary. Crisis services are provided by an array of service providers, such as social workers, nurses, doctors, psychologists, and other professionals or paraprofessionals. Services are provided in several different places or settings, including community clinics, hospitals, police stations, social service agencies, schools, and through 24-hour telephone hotlines. With the rise of the Internet, online counseling has also proliferated. Crisis services vary in their duration, ranging from one session to multiple sessions. Such services are not aimed at addressing long-term problems, but rather are aimed at stabilizing an individual experiencing a crisis situation. Peer counseling programs have also established peer counseling centers for specific groups such as seniors, the mentally ill, and adolescents.

Several challenges to providing crisis services have recently arisen. Crisis service providers have had to tackle an ever-growing array of issues and problems faced by clients. Additionally, the diversity of communities, particularly in cultural, ethnic, and linguistic backgrounds, has exponentially grown and has increased the need for more culturally and linguistically competent crisis services. Increased diversity in services, particularly with regard to availability and accessibility to immigrant and refugee communities, is in demand. These communities are often in need of services that are provided in different languages and by responders who are familiar with the cultures and unique needs of the community. As the diversity within communities continues to grow, crisis services will also need to diversify. Communities have also experienced a growth in the elderly and senior populations. Crisis services have also grown with the advent of first response programs. First responders, such as police officers, firemen, and paramedics, have been trained to provide crisis services. Additionally, an increasing number of those who deal extensively with the public have been trained in crisis services and in dealing with irate or violent customers.

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See Also: Behavior Support and Management; Emergency Medical Care; Family Crisis Intervention Planning; Life Skills Training; Mental Health Services, Adult.

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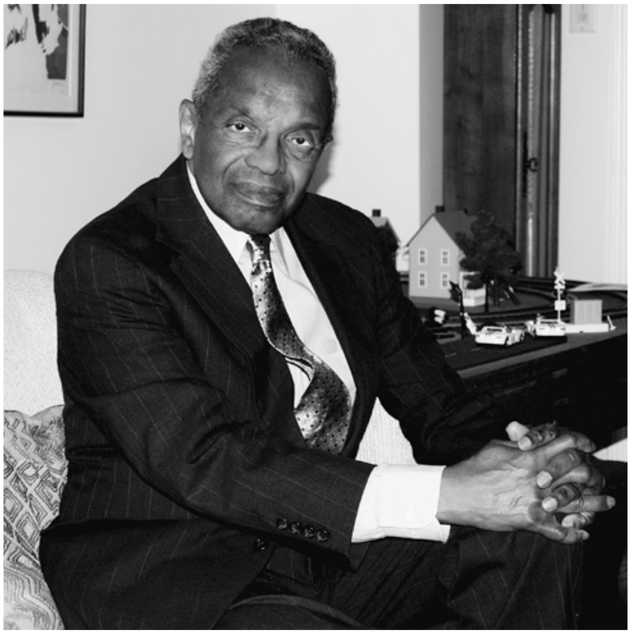
Critical Race Theory

Critical race theory (CRT) is a movement originating in critical legal studies in the mid-1970s, when Derrick Bell and other scholars looking at issues of race, racial subordination, and discrimination were concerned about the slow gains being made by the civil rights movement and began to search for an oppositional voice that reflected a more progressive and politically oriented school of thought. At that time, critical race theorists looked critically at race relations by examining everyday interactions to illuminate the racial component in them rather than promoting the color-blind approach espoused by the law and civil rights activists of the day. By looking carefully at microaggressions and everyday interactions, critical race theorists could help show the true extent of racism in the United States. It was their belief that by critically analyzing race they could begin to alleviate the racism and inequality structurally embedded in society.

Today, theorists reflect on the relationship among power, privilege, and intersectionality. They see power and oppression in a broader context that includes economics, history, education, and politics. The basic tenets of critical race theory include a critique of liberalism, storytelling, revisionist history, structural determinism, cultural nationalism, essentialism, critical pedagogy, and criticism. CRT has produced a number of spin-off movements including critical Latino theory, critical Asian theory, critical feminist theory, critical education theory, critical queer theory, and critical white theory. These schools of thought unite around a social movement that critically analyzes discrimination, oppression, and privilege in broader contexts than race, such as national origin, sexual orientation, class, and gender.

Early Origins

Critical race theory originated in critical legal studies, a field of inquiry that argues that preserving the interests of power, rather than the demands of principle and precedent, is the guiding force behind legal judgments. CRT developed out of a sense of impatience with incremental liberalism, which had failed to eradicate racism and racial subordination, and a growing sense that the early victories of the civil rights movement were being eroded.



One of the first tenured African American professors of law at Harvard Law School, Derrick Bell is largely credited as one of the originators of critical race theory.

Basic Tenets

Critical race theorists believe that acknowledging racism and privilege can help advance the cause of equality, possibly more than any other approach used in law and other contexts. A fundamental method of critique used by critical race theorists has been a critique of liberalism, storytelling/narratives, revisionist history, structural determinism, cultural nationalism, essentialism, critical pedagogy, and criticism.

For example, by attacking law using methods such as storytelling and revisionist history and refusing to take legal doctrines seriously, critical race theorists have shined a light on structural racism and implicit bias in the legal system. Theorists espouse an examination of race relations beyond a simplistic black-and-white paradigm and push forward efforts to understand how race intersects with other forms of oppression. Modern critical race theory includes a migration into and collaboration with other disciplines and scholarly fields and an interest in placing U.S. race relations into a global political and economic context. Although critical race theory began within the legal profession, it has since spread to many other disciplines including education, social work, and counseling.

Critiques of Critical Race Theory

Some critics of critical race theory point toward an inability to apply CRT to real-world situations involving social justice, thus identifying the limited applicability of the theory. Others say critical race theorists are a loose collection of scholars who do not agree on any other standard, manifesto, or set of defining tenets.

Spin-off Movements

Critical race theory has spawned a number of successor movements that critically analyze the interests of those in power in the political mainstream. In the 1990s, Latino scholars began to focus on Latino critical theory. These scholars examine a number of issues such as immigration law and policy, language and accent discrimination, and discrimination based on territorial status. In elementary, secondary, and higher education, scholars have organized around how the histories, experiences, cultures, and languages of students of color have been devalued, misinterpreted, or omitted within formal educational settings. Educators use CRT approaches and theories to help understand hierarchy in schools, tracking, school discipline, and rules and norms in the educational context.

Progressive Asian American scholars, radical LGBTQ (lesbian, gay, bisexual, transgender, and queer) theorists, and critical feminists have organized to focus on the status of people of color under the law, human rights, and the role of the law in responding to the unique challenges affecting groups intersected by race and gender. In social work, the lens of critical race theory examines the experiences of people of color in child welfare, mental health, and health care as well as in the social work education classroom, and discourse centers on the structures, policies, and practices of community-based and government programs and how they influence the experiences of families and individuals of color and others receiving services.

A final spin-off movement is critical white studies in which scholars apply the techniques and approaches of critical race theory to whites. Critical white theorists examine seemingly color-blind laws such as the income tax code, drug statutes, or policing laws in search of provisions that enact a system of privilege to whites or racial subordination to people of color. Critical discourse includes white-collar crimes such as Ponzi schemes versus street crimes, differential drug laws, and immigration laws.

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See Also: Discrimination and Institutional Racism; Race, Social Definition of; Race and Clients; Racism, Long-Term Effects of.

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Cross-Cultural Knowledge

Meaningful discussions of cross-cultural knowledge ideally are holistic and appreciate the essentiality of including the cognitive, psychomotor, and affective learning domains. Benjamin S. Bloom’s seminal work, *Taxonomy of Educational Objectives*, published in 1956, asserts the learner should benefit from development of knowledge and intellect, attitude and beliefs, and the ability to effect physical and bodily skills. Originally created for academic education, Bloom’s taxonomy is relevant to all types of learning.

According to Bloom, the major categories of the cognitive domain are knowledge, comprehension, application, analysis, synthesis, and evaluation. In 1964, Bloom, David R. Krathwohl, and Bertram B. Masia published an updated version of *Taxonomy of Educational Objectives*, which included the major categories of the affective domain, specifically: receiving, responding, valuing, organizing, and characterizing.

The psychomotor domain has been adapted by various educators including R. H. Dave, E. J. Simpson, Anita Harrow, and others. For the purposes of discussing cross-cultural knowledge, the Harrow adaptation of physical and bodily activity into meaningful expression will be referenced. The major categories of the Harrow model include reflex movement, basic movement, perceptual abilities, physical abilities, skilled movements, and nondiscursive meaningful communication. In *Connecting Across Cultures: The Helper’s Toolkit*, published in 2013, Pamela A. Hays affirms a holistic view of cross-cultural knowledge.

Fundamental to an introduction to cross-cultural knowledge is the premise that there are categories of learning domain (ordered in degree of difficulty) and that each category (or level) must be mastered before progressing to the next. With this in mind, consider how the Harrow model adapts Bloom's original categories of imitation, manipulation, practice, integrate (demonstrate), and expert (automate).

Defining Cross-Cultural Knowledge

Cross-cultural competence is the development of knowledge and skill through experience and training that results in a complex schema of competencies that recognize cultural differences, foster perspective-taking skills, and hone interpersonal skills. Elementary school educators sometimes express learning as "ways of," such as ways of knowing (formal, informal, oral traditions, media rich environments), ways of solving problems (culturally determined philosophy, Western and Eastern), ways of communicating nonverbally (eye contact, smiling, hand gestures), ways of learning (individual work, group work, memorization, the question of questions), ways of dealing with conflict (face-to-face, quiet, nonconfrontational), and ways of using symbols (is a swastika always a Nazi swastika?).

Global entrepreneurs posit that intercultural training provides the practical tools to diagnose what is working and what is not working and to propose effective solutions to achieve company goals. While these outcomes are mostly viewed through the lens of a business model, the content domains are similar to those appropriate to health care, human services, education, and human rights. The content ranges from cultural and national heritage to communication patterns, family and community roles, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy, childbearing, death rituals, spirituality, power, respect, religious practices, and ethics. The following drivers offer practical points of reference: How is time perceived, as linear or as flexible? Which has greater value, rules or relationships? How is status derived, from whom you are, or from what you do? Which is most significant, the individual or the group? Are problem solutions direct or indirect?

Supporting Cross-Cultural Knowledge

Sharon Glover advocates a cultural competence continuum that ranges from the destructive or blind to the competent and proficient. Her continuum reiterates the commonly identified core components of ethnocultural empathy, flexibility, interpersonal skill, and communications; and development of mental model/perspective-taking, metacognition/self-monitoring, openness, tolerance for ambiguity, relationship building, and self-efficacy. The I. Papadopoulous, M. Tilki, and G. Taylor model for developing cultural competence articulates four essential cultural stages: (1) awareness: self-awareness, cultural identify, heritage, ethnocentricity, stereotyping, and enthnohistory; (2) knowledge: health belief and behaviors, holistic understanding of the similarities and differences, and health inequalities; (3) sensitivity: empathy, interpersonal skills, trust, acceptance, appropriateness, respect; and (4) competence: acquisition and application of discipline-based professional skills and challenging and addressing prejudice, discrimination, and inequalities.

Larry Purnell's model of cultural competence assumes the need for similar information by (all) professionals. He argued that the metaparadigm concepts of society, community, family, individual, and health are basic to developing cultural competence. It is interesting to note that most researchers' use of the term *competence* implies a set of facts, figures, or "knowledge" of a culture.

While few researchers define what constitutes the "set of knowledge," all assert it necessary. Purnell asserts that the unconsciously incompetent (professional) may become the unconsciously competent (professional).

Michael V. Klein and Robert M. Huff in *Health Promotion in Multicultural Populations: A Handbook for Practitioners and Students* distinguish among demographic, cultural, and health care system barriers, which offer tangible bases for the appreciation of cross-cultural knowledge. For example, gender is not simply being male versus being female. Depending upon the dominant culture, being female is expressed not only as "female" but also as female in a "class" and within the "family." This contextualization of "female-gender" carries objective outcomes realized either as the presence or absence of financial resources.

Geri-Ann Galanti has presented case studies of cross-cultural knowledge from the intersecting perspectives of the caregiver and the client. Examples include possible interpretations that range from the most reasonable to the least acceptable interpretations of a client's (interpreted) noncompliant behavior for medication, what the client's hand and foot gestures communicate, nonverbal cues that do not match the client's verbal responses, and the client's discontinuance of medication that "was working," to name a few. Rudolph Young asserts that the willingness to learn a new language is appreciated as much as actually learning the language; cross-cultural knowledge "lived" contextually expresses respect, humility, and openness.

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See Also: Cross-Cultural Service Models; Cross-Cultural Skills; Cultural Competence, Model of.

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Cross-Cultural Service Models

Historically, there has been a gap between general and cultural practice in the literature. Because of the tension between the separate bodies of thought, clinicians tend to feel overwhelmed and experience high dissonance in the field. In efforts to address this gap, researchers and practitioners have continuously worked to develop culturally appropriate guidelines and practice models in the multicultural literature.

Cross-Cultural Service Models

The purpose of cross-cultural service models is to provide a guide on what to do with clients and to teach clinicians how to accomplish three important tasks: (1) better engage with culturally diverse clients, (2) encourage clients to remain throughout the course of treatment, and (3) foster increased satisfaction with treatment in cross-cultural clinical practice. It is imperative that clinicians understand the critical importance of encouraging open and honest dialogues of cultural difference with their culturally diverse clients. This works to make clients feel more comfortable in session and more willing to share details about difficult experiences that have been affecting their mental, physical, emotional, and spiritual health.

Guidelines

Appropriate timing is essential when considering how and when to engage in these, often uncomfortable, conversations with clients. However, scholars in the field agree on these particular points: (1) cultural difference is not a static construct, but is more dynamic and has individual, subjective meanings; (2) it is vital to work toward creating a balance between differences and similarities within culturally diverse therapeutic dyads; (3) it is the responsibility of the clinician to acknowledge the power dynamics in the dyadic relationship; and (4) a clinician's own knowledge, awareness, and skills in regard to cultural competencies should be considered in the open dialogue. Implementing these points creates a space in which the client can become empowered and can set and achieve appropriate treatment goals.

However, it is important to note that despite encouraging clinicians to actively take responsibility for their own actions and reactions in treatment, the guidelines are lacking in empirical validation for effectiveness in addressing cultural differences in clinical practice. Unfortunately, the guidelines only provide brief, inconclusive suggestions instead of holistic, comprehensive practice models that could strengthen the therapeutic alliance and set the groundwork for therapeutic change to occur.

Specific Practice Approaches

There are three prominent practice approaches in the field: (1) the tridimensional model, (2) the experiential/phenomenological model, and (3) the process model.

The most commonly referred to model is the tridimensional model, which is composed of professionals' attitudes and beliefs, knowledge, and skills in multicultural practice. Two cultural competence constituents are important to note—systematic mindfulness and vigorous sizing. Clinicians with systematic mindfulness are aware of race-specific bias and avoid engaging in stereotyping behaviors and attitudes. These types of clinicians aim to develop hypotheses and follow the appropriate hypotheses testing models in order to better serve their clients. A clinician with vigorous sizing has the ability to separate a person from his or cultural group, but also acknowledge the similarities that the person has with their cultural group(s).

The second common practice approach, the experiential/phenomenological model, urges clinicians to pay particular attention to what the client is sharing, acknowledge their own thoughts, but continue to listen to the client's narratives with openness and receptivity. Accordingly, at this point, the clinician acknowledges and validates the client's lived experience by being respectfully curious and approaching the situation from an "I don't know, please share with me" position. This model has been evidenced to enhance the therapeutic alliance, which ultimately leads to significant therapeutic change over the course of treatment.

The third model, the process model, emphasizes better communication in the dyadic process. One of the core process models proposes eight steps in improving communication that range from knowing thyself to empathizing with persons from other cultures. The other noteworthy process model encourages clinicians to bring issues related to culture, race, ethnicity, and class into the therapy room in order to directly address factors that could be affecting therapeutic change. The ability to engage in the process is crucial to cross-cultural treatment.

Limitations

There are notable limitations with utilizing any of the three models. More specifically, the tridimensional model has been criticized because most of the measures are grounded in clinician self-report rather than objective measures of their actual cultural competence. The experiential/phenomenological model is less focused on treatment rates or outcomes in research, which essentially means that it has less empirical validation. Despite the process model providing a clinically, well-grounded approach to cross-cultural practice, little connection to empirical evidence is available.

Future Models

Moving forward, more empirical research is needed in this area. Moreover, empirical verification will provide a basis for applicability in the human services field. Future studies should require an ongoing assessment, as well as an analysis process.

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See Also: Counseling and Psychotherapy Services; Cross-Cultural Knowledge; Cross-Cultural Skills; Cultural Competence, Human Service Providers and; Cultural Competence, Model of; Cultural Competence, Professional Standards of; Social Work, Diversity Practice in.

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Cross-Cultural Skills

Over the past two decades the United States has experienced major demographic shifts in its population primarily because of the increase in the aged, the birth rate of racial and ethnic minorities, and international migration. This recent phenomenon has created the urgent need for human services providers to acquire cross-cultural skills to address the diverse and complex issues presented by those they serve. In contrast to the "color-blind" practice approaches promoted prior to the 1970s and early 1980s, the social work profession recognized that racial and ethnic differences must be acknowledged to improve the practitioner's professional and competent ability to engage a client with a differing cultural background.

During the late 1980s, clinicians began to embrace the significance of "cultural-sensitive" practice, recognizing that culture presented both strengths on which to build professional client relationships as well as barriers, which unintentionally could result in miscommunication and mistrust. By the turn of the century, numerous guidelines and standards for cultural competency emerged across the human services arena. Specifically, these standards and guidelines targeted cross-cultural practice, research, training, and organizational policies and were promulgated by governmental and professional associations and accrediting bodies such as the: Office of Minority Health (OMH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services, American Psychological Association (APA), Child Welfare League of America (CWLA), Council on Accreditation (COA), Council on Social Work Education (CSWE), and National Association of Social Workers (NASW).

Importance of Cultural Competence

Culture may be viewed simply as one's worldview or as an integrated pattern of living for an individual, a family, an institution, a community, or a society. For both the professional and the client, culture represents values, beliefs, choices, social lifestyle, and other modes of individual and family adaptation to the community and larger society. Cultural perspectives are shared over multiple generations and may persist despite significant opportunities for integration, acculturation, and assimilation. Culture is highly dynamic and evolutionary. Therefore, it is not captured easily due to the intersection of cultural stability and change, change which is created in reaction to exposure to other cultures (frequently through education, cross-marriage, or migration). As a result, complexity and ambiguity may challenge the professional's skill in: (1) forging an alliance or relationship with the client from a different culture; (2) assessing and prioritizing the problem focus for the partnership; (3) identifying culturally appropriate techniques and methodology; (4) facilitating the roles of significant stakeholders, especially the client's natural support system and nontraditional helpers; and (5) accurately and jointly evaluating the efficacy of the intervention.

Individual Cross-Cultural Skill Sets

Culturally competent practitioners must fully embrace a professional code of ethics that genuinely respects and appreciates the diverse cultural identities they may encounter as they serve an increasingly diverse clientele. The framework for individual cross-cultural practice centers on a deeply held conviction and professional desire to enhance the quality of life for others, especially those living with oppression, exploitation, discrimination, violence, poverty, and maltreatment. Cross-cultural skills include the ability to identify the dynamics of cross-cultural interactions, as well as within-group cultural differences and similarities. Acquiring cultural competency is a lifelong process, which requires a comprehensive self-assessment on the part of the professional. Primarily directed by the clients' needs and their responses to the intervention, this self-assessment begins with understanding one's own worldview and biases, underlying factors which inform one's beliefs and attitudes, and awareness of client differences that trigger negative impulses or positive acceptance. It may be necessary for such examination to rely on supervisory or team consultation regarding "blind spots" and the personal impact on daily professional practice with diverse clients.

Practitioners must be educated about culture and how it functions in the everyday life of an individual or a family or during traumatic crisis. Professionals must research and study the implications of varying cultural journeys for their clients, including race, gender, language, sexual orientation, disability, age, religion, social class, ethnicity, national origin, immigrant status, regional upbringing, political beliefs, family composition, and any other difference that is reflected in their unique cultural identity. The goal is not to become expert in all cultures, but rather to foster the ability to engage individuals and families from any culture without generalizing, promoting misconceptions, and stereotyping. It is critical that the professional is emotionally intelligent and willing to invest in ongoing self-examination and be open to both verbal and nonverbal feedback from others regarding biases, cultural assumptions, stereotypes, and offensiveness. "Informed not-knowing" becomes the stance, which ultimately leads to inquiry and advocacy. The client must be allowed to define his or her own cultural identity and describe his or her experiences in the world. In addition to the client, a third-party cultural informant (a member of the respective group or an expert with valuable information) may be useful for gathering additional insights and understanding. The practitioner must learn enough about the norms of the client's culture to be able to reflect on what she or he feels is important to support best practice.

NASW's Standards for Cultural Competence in Social Work Practice indicate that the cross-cultural skill set for a competent social worker includes: (1) learning about the culture of others, as well as cultural strengths and challenges, through open discussion of differences and similarities; (2) comprehensive assessment of client systems that capture cultural strengths; (3) respect for clients' choices in developing goals for service; (4) attunement to clients' cultural and/or marginal experiences in the related environments; (5) effective use of the clients' natural support systems; (6) advocacy within the organization and policy context; and (7) the capacity to actively combat negative systemic and institutional myths and biases.

Organizational Cross-Cultural Capacity

Another important consideration in the application of cross-cultural skills in human services is cross-cultural capacity at the organizational level. Human services agencies provide the environmental context for culturally competent delivery of social, mental health, and health services. These contexts heavily influence the practitioner's ability to collaborate with the client, as well as to drive healthy, desirable case outcomes. From a human resources perspective, the agency staff must reflect the diversity of the clients served and at every level of the organization, from line staff to the executive suite. From a structural perspective, performance quality improvement (PQI) processes must routinely address the organization's personnel recruitment and retention policies and its performance in ensuring a highly qualified, skilled, and diverse workforce. Symbolically, in a culturally competent setting the appropriate organizational culture ("How we are here") reflects a welcoming reception for all, and maintains a physical plant that is attractive and celebrates the diverse cultures present through imagery and art and multilingual/dialect capability.

The culturally competent organization also recognizes diverse holidays through celebrations and social gatherings, which also serve optimally to integrate the diverse workforce. Within a political frame, the culture of a competent organization is safe for the expression of divergent, sometimes conflicting, perspectives and allows for authentic dialogue and appropriate compromise across client and staff lines.

Another important component of organizational cross-cultural capacity is the agency mission. The leadership of the organization should review the agency mission every two years to ensure its alignment with the culturally specific needs of clients that the agency currently serves within its communities. The mission is a major factor in sustaining organizational cultural competence because it guides the hiring and matching process for personnel, including volunteers.

The mission sets the agenda for proactive change and rallies the staff and volunteers. It also frames new employee orientation, in-service training, and ongoing professional development. The mission serves as the foundation for implementing program objectives and measurable outcomes, development and strategic planning, collaboration and partnership activities, marketing, and public policy/advocacy. Organizational leaders with cross-cultural skills practically seek to maintain a responsive, empathic, and sustainable institution that empowers those with the greatest human need to improve their circumstances.

Since the United States is projected to become a majority-minority nation by 2043, human services providers must be prepared to foster relationships within an increasingly multicultural society. The U.S. Census Bureau projects that individuals 65 and over and Asian and Hispanic populations will more than double by 2060. It is imperative that human services providers are committed to mastering cross-cultural skills, evaluating the results of their interventions while remaining actively engaged in lifelong learning.

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See Also: Bias in Service Delivery; Cultural Competence, Human Services Providers and; Cultural Competence, Professional Standards of; Cultural Competence, Training in.

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Cuban Americans

Cuban Americans represent a heterogeneous group whose migration patterns and socioeconomic characteristics vary from other Hispanic groups in the United States. In spite of the diversity among Cuban communities, Cuban Americans display cultural specificities that call for a different treatment of the group.

These specificities stem largely from Cuban Americans’ immigration history. Prior to 1958, the number of Cubans in the United States was limited in spite of the close links between the two countries. It is estimated that at this time there were approximately 221,505 Cubans residing in the United States. However, following the Cuban Revolution of 1959, large numbers of Cubans left the country and immigrated to the United States. As of 2011, 1,889,000 Cubans were living in the United States. This significant immigration consisted of multiple waves of immigration, and each wave has contributed to the diversity of the cultural identity and needs of Cuban Americans.

Cultural Cohesion of the Exile Generation

Cuban immigration can be delineated across several distinct waves, which were characterized by their great demographic diversity. The first waves, which arrived immediately following the Cuban Revolution in 1959 and continued until the 1970s, brought the Cuban elites and Fulgencio Batista sympathizers fleeing from the Communist regime put in place by Fidel Castro. These Cuban immigrants for the most part were educated and had either lost or were at risk of losing their assets to the nationalization programs carried out shortly after the revolution.

Accordingly, they were admitted to the United States as refugees, thus conferring them privileges from which other Latinos did not benefit. The Cuban Refugee Program of 1962 and the Cuban Adjustment Act of 1966, respectively, provided them financial aid and regularized their status, thus integrating these newly arrived immigrants into society from the onset. An estimated 215,000 Cubans made their way to the United States during the first three years following the revolution. The failure of the Bay of Pigs invasion and the subsequent reinforcement of Castro's hold on power further prompted approximately 74,000 Cubans to leave the island and take refuge in the United States.

The next wave began in December 1965 and ended in April 1973. During this period, Cuba and the United States agreed to permit two daily flights to bring approximately 340,000 Cubans to Miami. However, the Cuban government abrogated the agreement in May 1973, which led to a fourth wave of Cuban migration, which this time was clandestine. From the time this wave started to when it ended in 1980, less than 3,000 refugees are estimated to have entered the United States illegally.

From Refugees to Economic Migrants

A fifth wave of immigration, known as the Mariel Boatlift, marked the beginning of a shift to economic migrations. Economic difficulties and internal tensions in Cuba led a group of Cubans to seek refuge in the Peruvian embassy. Shortly after, the Cuban government announced it would permit emigration from the island. An impromptu exodus then occurred between the Cuban port of Mariel and the United States. While there were still some political dissidents among the Cuban migrants arriving in the United States, there was also a large proportion of economic migrants, as well as convicts and psychiatric patients who had been released by the Cuban government for the purpose of emigration. The negative political repercussions from the arrival of these migrants led President Jimmy Carter to halt the exodus, which by this time had nevertheless allowed a total of 124,769 Cubans to depart the island for the United States.

A final wave began following the fall of the Soviet Union in 1989 and the economic and commercial hardship which ensued on the island. A marked policy change occurred; indeed, the favored treatment by the United States from which Cuban immigrants had benefited was tightened with legislation such as the Cuban Migration Agreements of 1994 and 1995, which sought to end the "open-door policy" to Cuban immigration. This is partly due to the differential nature of current Cuban immigrants as economic rather than political migrants.

Current State of Cuban Americans

Although they belong to the same ethnic category, there are major differences between Cuban Americans and other Latinos. Compared to other Hispanic groups, the Cubans are the most geographically concentrated, with 70 percent of the population residing in Florida. Prior to the 1959 revolution, Cuban migration patterns were mainly contingent on work opportunities, and as a consequence Cuban migrants scattered all around the United States, particularly in the northeast and southeast, in states such as New Jersey, New York, and Florida. After the revolution, Cuban settlements became more concentrated, as the majority of Cubans established themselves in Florida and formed enclaves, particularly in Miami, thus providing support and opportunities for fellow Cubans immigrants.

As a whole, Cuban Americans are socioeconomically distinct from other Latino groups or the U.S. population: Their median age is 40, compared to 27 for Hispanics generally; and they are slightly older than the U.S. population, whose median age is 37. Educational attainments of Cuban Americans are similar to that of the U.S population, although slightly lower, but much higher than that of other Hispanic groups. They present lower rates of poverty and have higher median family incomes than other Latinos, but still lag behind the general U.S. population. Cubans also display a deep attachment to their homeland, particularly the political exile generations of migrants, and they usually retain the culture of their homeland as well as the use of Spanish, especially in the Miami enclave. A higher proportion of Cubans are foreign-born (58 percent) than other Latinos (36 percent); however, more than half (55 percent) are U.S. citizens, thereby facilitating their conventional participation in U.S. politics as well as their access to social programs.

Cuban Americans also exhibit great diversity within their group. From the Cuban Revolution until the end of the 1970s, Cuban political migrants were mostly white, older, educated migrants from the upper classes. However, the subsequent economic waves of immigration brought principally darker (mulattos) migrants from the working classes. This racial divide based on skin color is associated to a certain extent with the divide between the different classes and somewhat hampers attempts at unifying the Cuban community. Indeed, these newcomers no longer share the exile identity which unified the first Cuban migrants. Additionally, the rise of second and subsequent generations of Cubans who assimilate quickly into the host society is further eroding the unity of the Cuban community.

Conclusion

The varied waves of immigration resulted in Cuban Americans constituting a socially diverse group whose immigration patterns and socioeconomic characteristics differ from that of most other Latino groups in the United States. Given the heterogeneity of the Cuban Americans as a group and the socioeconomic and cultural distinctions between Cuban Americans and other Latino groups, it becomes necessary to consider Cubans as diverse clients when taking into account their social needs.

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See Also: Caribbean Immigrants; Diaspora; Ethnicity and Clients; Hispanic Immigrants.

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Cultural and Linguistically Appropriate Services Standards

Racial and ethnic minorities bear a disproportionate burden of chronic illnesses, are more likely to be uninsured, face unequal access to quality health care services, and suffer worse health care outcomes than the general population. The provision of cultural and linguistically appropriate services (CLAS) is one strategy to help eliminate these health inequities. By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse communities. The provision of health care services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients can help close the gap in health care outcomes. The pursuit of health equity must remain at the forefront of human service workers' efforts; they must always remember that dignity and quality of care are rights of all and not the privileges of a few.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement CLAS. Adoption of these standards will help advance better health and health care in the United States.

History

In 2000, the U.S. Office of Minority Health (OMH) published the first national CLAS standards, which provided a framework for all health care organizations to best serve the nation's increasingly diverse population. In the fall of 2010, OMH launched the National CLAS Standards Enhancement Initiative in order to revise the standards to reflect the past decade's advancements, expand the standards' scope, and improve their clarity to ensure understanding and implementation. With the enhancement initiative, the national standards will continue into the next decade as the cornerstone for advancing health equity through culturally and linguistically appropriate services.

In 2013, the OMH, an agency within the U.S. Department of Health and Human Services, released the enhanced National Culturally and Linguistically Appropriate Services Standards in Health and Health Care. With implementation of the Affordable Care Act in full swing and growing interest in improving the delivery of care and addressing health care costs, these standards will serve as a critical guide to developing policies and strategies that improve the quality of health and health care services and meet the needs of an increasingly diverse population. The enhanced standards expand the scope of the goals laid out in the standards released in 2000. They broaden the concepts of culture and health, as well as encourage health care organizations to consider not only race and ethnic background, but also beliefs, values, institutions, language, and geographical and sociological characteristics. The new standards also advocate for a broader view of health that encompasses physical, mental, social, and spiritual well-being. In this way, the enhanced national CLAS standards aim to improve overall quality of care, eliminate health care disparities, and achieve health equity.

Beyond a conceptual framework, the enhanced standards provide specific recommendations for addressing inequities at every point of patient contact with the health care system. The end goals of the enhanced CLAS standards are to ensure effective, equitable, understandable, and respectful quality care and services that are responsive to diverse needs. The standards are organized into three themes. The first theme is governance, leadership, and workforce, which provides guidance for developing leadership capacity in health care organizations in order to promote and sustain CLAS. The second theme, communication and language assistance, provides recommendations to health care organizations for addressing language and other communication barriers in order to adequately meet the needs of people with limited English proficiency. The third theme is engagement, continuous improvement, and accountability, which provides a blueprint for establishing community engagement and includes recommendations on conducting community assessments.

National CLAS Standards Opportunities

There are many opportunities to use CLAS standards to effectively enroll populations in health coverage through the new state marketplaces created by the Affordable Care Act. For example, health care organizations that carry out enrollment assistance activities should put the CLAS guidelines into practice. Beyond the Affordable Care Act, the CLAS standards are an important guide for improving quality in the delivery of care. A hospital that is working to enhance patient engagement should look to CLAS standards on data collection and community partnerships. The OMH has launched a new resource center, ThinkCulturalHealth, in order to support health care organizations and stakeholders interested in embarking on CLAS policy and practice. The site includes a cultural competence training curriculum for providers, a clearinghouse of research papers on health disparities, and updates for upcoming CLAS Webinars and events hosted by the OMH. As the United States looks for ways to promote better health and health care, the enhanced CLAS standards provide a useful road map for achieving this goal.

Culturally competent health care systems— those that provide CLAS—have the potential to reduce racial and ethnic health disparities. When clients do not understand what their health care providers are telling them, and providers either do not speak the client's language or are insensitive to cultural differences, the quality of health care can be compromised. Five interventions were reviewed to improve cultural competence in health care systems: (1) programs to recruit and retain staff members who reflect the cultural diversity of the community served; (2) use of interpreter services or bilingual providers for clients with limited English proficiency; (3) cultural competency training for health care providers; (4) use of linguistically and culturally appropriate health education materials; and (5) culturally specific health care settings. A determination could not be made with respect to the effectiveness of any of these interventions. There were either too few comparative studies, or studies did not examine the following outcome measures evaluated in the review: client satisfaction with care, improvements in health status, and inappropriate racial or ethnic differences in use of health services or in received and recommended treatment.

Reasons to Utilize CLAS

CLAS standards were developed to provide guidance on how to improve service delivery to clients who may not have sufficient access to care based on race, ethnicity, linguistic capacity, or cultural background. While the ultimate goal is to benefit the client, there are also great benefits for organizations. CLAS makes sense from a service perspective, a financial perspective, and a legal perspective.

A number of compelling reasons exist for agencies to make CLAS standards a part of their operations. Using these standards makes sense for organizations, employees, and clients. As agencies commit to serving people with different racial, ethnic, and linguistic backgrounds, this commitment will enable health care organizations to: serve healthier, more satisfied clients; increase staff competency and satisfaction; improve business; comply with antidiscrimination laws; protect their organizations from liability; protect federal funding; and improve the ability to secure funding.

Increasing health care access is more complex than simply providing funding to pay for care. Access also requires that health care services be provided in a manner that is culturally and linguistically appropriate and does not discriminate based on race or ethnicity. Such culturally and linguistically appropriate health care is a concern not only of policy makers and health care organization administrators but also of physicians and the educators of future physicians.

While federal enforcement regulations specifically address the standards pertaining to linguistic access, the standards go significantly beyond linguistic criteria in defining guidelines for full access to care. Full access requires that patients receive care that recognizes and responds to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Efforts to implement the CLAS standards are complicated by documented differences in health status and health care access among American cultural/linguistic groups, even after insurance coverage is taken into account. Any consideration of increasing access to care for patient populations that include large numbers of minority ethnicity patients will include an examination of the causes and effects of these disparities. Full access includes the means to pay for care, care that is culturally appropriate, care that is linguistically available, and care that does not discriminate based on the ethnicity of the patient.

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See Also: Chronic Diseases Common in Developing Countries; Cultural Competence, Human Service Providers and; Cultural Competence, Professional Standards of; Cultural Services; Culturally Diverse Practice, Definitions of; Culturally Specific Services.

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Cultural Appropriation

Cultural appropriation is the taking of one culture's artifacts, artistic subject matter, traditional knowledge, rituals, symbols, or technologies by members of another, often dominant, culture. Cultural exchanges are inevitable as cultures interact with one another, and some scholars argue that globalization has ushered in an age of transculturation in which regular contact has eroded cultural boundaries.

When cultural appropriation occurs within the context of a free exchange sanctioned by the culture that produced what is appropriated, or some competent, authoritative representative of that culture, it may be accepted and even celebrated, with no suggestion of immoral or unjust use. But the term as it is most commonly used in the 21st century carries the connotation of exploitation. It is viewed as a kind of theft that is ethically, if not always legally, reprehensible. It occurs in marketing, in classrooms and museums, in all the arts, and in entertainment. From the plays of William Shakespeare to the performances of pop star Miley Cyrus, cultural appropriation manifests itself in observable ways.

Appropriation of the Tangible

James O. Young identifies three forms of cultural appropriation: content appropriation, subject appropriation, and object appropriation. Perhaps the simplest form of cultural appropriation to address is object appropriation, the taking of art, artifacts, and other objects that cultures consider part of their heritage. The archetypal example of this form of appropriation is the Elgin Marbles. The Elgin Marbles are a collection of marble sculptures, inscriptions, and architectural features, most famously from the Parthenon, but also from other buildings on the Acropolis: the Erechtheion, the Propylaia, and the Temple of Athena Nike.

In the early 19th century, Lord Elgin, the British ambassador to the Ottoman Empire, of which Athens had been a part for three and a half centuries at the time, with the knowledge and permission of the Ottoman authorities (as the British are still quick to point out) removed the marbles and shipped them back to Britain. Following a parliamentary investigation as to the legality of Lord Elgin's appropriation, Britain purchased the artifacts from Lord Elgin in 1816 and gave them to the British Museum, where they have been on display for almost two centuries. Even some of Lord Elgin's contemporaries, including the poet Lord Byron, viewed Elgin's removing the artifacts as vandalism, but Britain has resisted all efforts by Greece to reclaim the pieces.

The British argument for refusing to return the Elgin Marbles rested in part on their claim that Greece lacked the proper facility for displaying the historic pieces, but the opening of the $200 million Acropolis Museum in 2009 made that argument invalid. Greece has been more successful with other efforts, acknowledging that artifacts from 25 other

The Elgin Marbles, also known as the Parthenon Marbles, remain on display at the British Museum even after years of dispute regarding returning the sculptures to their place of origin in Greece. Lord Elgin, the British ambassador to the Ottoman Empire, commandeered the marbles and shipped them to Britain, where they have been on display for almost two centuries.

countries have been returned to Greece. Britain has offered to loan the disputed pieces to Greece for display, provided British ownership is recognized, an offer Greece has declined. The cultural appropriation, or misappropriation, of part of Greece's history continues. Meanwhile, museums are filled with similar, if lesser known, examples.

Not all disputed objects are in museums. Friction has developed between South Korea and Japan over cabbage. Kimchi, a spicy, pickled cabbage, is a South Korean national dish now produced and marketed by the Japanese. South Koreans charge that the Japanese producers ignore the time-honored, traditional method of making kimchi, using artificial flavors and a more rapid fermentation process to produce a product that disgraces its name. Japanese kimchi producers insist that the South Koreans have no monopoly on the dish.

Museum curators, archaeologists, lawyers, representatives of various cultures, and others are engaged in ongoing debates over the repatriation of archaeological and ethnographic objects. Native American cultures have been among the most successful in recovering cultural artifacts, sometimes with the voluntary cooperation of museums, or through the Native American Graves Protection and Repatriation Act (1990). Nigeria has sought the repatriation of the Benin bronzes that British troops removed during the 1897 Punitive Expedition. China has argued for the return of bronze animal heads, once part of the zodiac fountain clock in the Yuanming Yuan garden of the Old Summer Palace that French and English troops looted and burned in 1860, and Turkey has made determined efforts to claim antiquities taken before 1970.

Music and Words

The fight against digital piracy may seem unending to composers, musicians, writers, and film producers, but Western copyright laws at least give a weapon to use in the battle. The situation is quite different when the music and the words are owned not by an individual, but by a culture. The debate centered on African American music dates back at least as far as the early part of the 20th century, and a plethora of white American musicians from "King of Swing" Benny Goodman in the 1930s to pop star Miley Cyrus in 2013 have been accused of using, and in some cases abusing, African American music. The line between influence and cultural appropriation is often a thin one. In the case of African American music, a nation's history of racism shapes the argument. No matter how colorblind the fraternity of musicians, for decades in the United States white musicians were hired to play African American music, while black musicians were denied jobs and even entrance to clubs where the music was played. Elvis Presley was the media-proclaimed King of Rock and Roll, with little tribute paid to the African American musicians whose work he had mined.

In 1999, a group of African American organizations and individuals filed suit in Phillips County, Arkansas, charging that the white sponsors of a blues festival had stolen the musical legacy of African American citizens in the county in a "racially conspiratorial process." The class-action lawsuit was eventually thrown out of federal court, by which time several parties to the original complaint, including the local chapter of the National Association for the Advancement of Colored People (NAACP), had withdrawn from the case. However, the charge that African American musical forms are proprietary to their community of origin and the use of those forms by musicians of other races is exploitative and unacceptable is alive, encompassing controversies as varied as Wynton Marsalis's use of his position as artistic director of jazz at Lincoln Center to emphasize his conviction that all jazz must be rooted in black traditional music, and Miley Cyrus's sexualized, racialized performance at the 2013 American Music Awards.

The debate concerning cultural appropriation within literature concerns both the appropriation of cultural materials and the more nebulous use of voice or character that is shaped by a culture other than that of the author. Canadian W. P. Kinsella is the author of a series of novels set on the Hobbema Indian Reserve in Alberta. Kinsella resists the image of himself as a cultural appropriator in such works as *The Fencepost Chronicles*, 13 stories about corrupt tribal leaders, trouble on the reserve, survival schemes, and communal drinking, but critics point out that Kinsella plays to the worst stereotypes of tribal people, and uses a mock patois that is far removed from tribal language. Tony Hillerman, author of two detective fiction series with Navajo protagonists, has also been criticized for appropriating Native American voices, but Hillerman's work has also won praise for his view of Native American life and his accounts of the ethical challenges of living in a multiethnic society.

Even more controversial is Robert Bringhurst, award-winning Canadian poet and cultural historian, who has translated works from classical Greek, Arabic, Navajo, and Haida. The Haida translations of the poems of Ghandl and Skaay, whose works were collected by an American linguist, John Swanton, at the turn of the 20th century, published in a trilogy collectively titled *Masterworks of the Classical Haida Mythtellers*, have brought accusations of cultural appropriation from critics who insist that Bringhurst did not have permission from Haida elders or the Council of the Haida Nation, the governing entity of the Haida Nation, to translate the poems, that he can have no understanding of Haida mythology, and he was merely exploiting it. On the other hand, the literary quality of Bringhurst's work has been acclaimed, as has his presentation of the Haida poetry as art equal to the masterpieces of Western tradition, rather than the folklore of a primitive people. The firestorm that erupted over Bringhurst's translations has largely faded, but the tension between acknowledging collective ownership common among indigenous peoples and the exercise of artistic freedom by the individual artist remains unresolved.

Degradation of Culture

The concern about an outsider profiting from cultural misappropriation is a legitimate concern, whether that profit comes from artifacts, songs and stories, or pharmacological knowledge, but an arguably greater concern is that cultural appropriation can move beyond exploiting a culture to degrading it. That which is valued or even deemed sacred within one culture can be trivialized, diluted, or destroyed by those who appropriate elements of the culture for their purposes. Misrepresentation of a culture by outsiders can create harmful stereotypes. It can even compromise the integrity of a culture.

On January 21, 1984, Michael Heller, a staff photographer from the *Santa Fe New Mexican*, flew over the Pueblo of Santo Domingo and photographed a ceremonial dance. The dance was sacred to the Pueblo. The photographs were published twice, once described as a "pow-wow." The Pueblo filed suit, charging trespass, violation of the Pueblo ban on photography, and invasion of privacy. From the Pueblo point of view, the aerial photography disrupted a community-binding ceremony, and the photographs transformed a sacred ritual in the culture of origin to entertainment for outsiders.

The Hindmarsh Island Bridge in Australia evoked a national debate that garnered international attention. Plans were announced in 1989 to build a bridge across the Murray River, Australia's largest river, in order to connect the mainland with Hindmarsh Island. When construction began in 1993, environmentalists and Ngarrindjeri residents protested, the latter because of the presence of aboriginal archaeological sites. The Australian government announced in 1994 that it would proceed with the bridge. However, a group of Ngarrindjeri women claimed that the bridge posed a threat to a secret woman's tradition. After an investigation concluded that the bridge would desecrate Ngarrindjeri traditions and destroy the culture, the government placed a 25-year ban on building the bridge. In May 1995, another group of Ngarrindjeri women declared the women's secret tradition claim a fabrication. A second investigation ruled in favor of the dissenting women, the ban was lifted in 1997, and the bridge was built in 2001. Findings in a civil case in 2001 rekindled the debate, which continues in books and heated exchanges nearly two decades after the first claim of a secret tradition was made. The longevity of the argument is a prime example of how strongly people on all sides of the debate feel about cultural appropriation.

The second decade of the 21st century sees Atlanta Braves fans enthusiastically doing the Tomahawk chop; Aunt Jemima, based on a minstrel show character, is into her second century of selling products for the Quaker Oats Company; and Victoria's Secret model Karlie Kloss struts a runway in leopard-print underwear, high heels, turquoise jewelry, and a floor-length feathered headdress derived from the war bonnets that are a mark of respect and achievement when worn by Native American chiefs and warriors. A lawsuit filed by the Navajo Nation against Urban Outfitters is ongoing. The retailer ignored a 2012 cease-and-desist letter requiring the company to stop selling a group of "Navajo" items, including Navajo hipster panties and a Navajo liquor flask. Urban Outfitters claims that the word *Navajo* belongs to everyone; the Navajo Nation claims trademark violations and violations of the federal Indian Arts and Crafts Act and cultural appropriation that ends in degradation.

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See Also: African Americans; Cultural Capital, Role of; Native Americans.

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Cultural Broker

A cultural broker is someone who acts as an intermediary between two groups with different sets of values. Anthropologists were the first to come up with this term to define the actions associated with people using middlemen to negotiate or conduct trades between differing cultural groups. Similarly, in the human service field, the term *culture broker* is used when referring to an individual who helps people from different cultural groups navigate the human service system.

The broker is bicultural, meaning that they belong to, and/or possess knowledge of the values and norms of, two (or more) cultural groups. For example, the disability advocate who is not disabled, but possesses extensive knowledge about disabilities and how they affect the individual, can be considered bicultural. Their knowledge, when paired with their unique ability to understand complex interpersonal dynamics, allows the broker to effectively maneuver and transfer information and resources from one culture to another.

The use of a cultural broker is necessary in the human service profession because it supports the practitioner in understanding the culture of their client so that they may better help them. The brokering process also allows the client to learn more about the values of the human service system. This insight may help the client learn ways that they can better access services within this system. Cultural brokering creates a safe place for resources and information to be exchanged, where both groups' values are understood and respected. This unique characteristic of cultural brokering may lead to equitable and accessible services to a variety of cultural groups who may not have had this access otherwise.

Culture and Cultural Brokering

Culture is roughly defined as a shared system of values, rituals, customs, communication, language, rules, and beliefs. This system is used as a lens that shapes and affects how the individual within that culture views and interacts with others and with their environment. These values and beliefs are learned from others and shared by all of the individuals within that system. Often, when one thinks of the term *culture*, they think of ethnicity (a large group of people who are united geographically) or race (a social construct usually referring to the physical differences between individuals). However, the concept of culture goes much further than this. For example, disability groups, political groups, socioeconomic/income brackets, and a number of other groups all have a unique culture affecting how they view the world around them. Some disability groups are proponents of a way of viewing individuals with disabilities that sees them as a person first, rather than their disability first. This group strongly feels that in order to shift this view of people with disabilities that the disability culture (and cultures that exist outside the disability community) must employ the use of person-first language. An example of person-first language is saying a woman who is blind, versus a blind woman. This is just one example of a culture that exists within the disability community.

Cultural brokering involves the cultural broker linking persons with different cultural backgrounds for the purpose of understanding, information, or idea sharing. The exchange of information in the brokering process can occur through various forms of communication, including verbal (with the broker acting as a translator), written, and signed (such as American Sign Language). The brokering process does not involve the literal translation of cultural values; rather, this is subtly done through the brokering process. Possessing knowledge of values of the groups involved in the brokering process allows the broker to effectively communicate information, while remaining sensitive to both groups during the process. In most cases, the broker belongs to the culture that needs to access resources, yet they have the knowledge of the culture of the human service system, which allows them to engage in cultural brokering without losing their cultural identity.

Roles of the Cultural Broker

The broker takes on a variety of roles. Cultural brokers can act as a liaison between the cultures. In the human services perspective, the liaison possesses knowledge of the human service system and how to navigate that system, while also having knowledge about the culture of the group that needs help. The brokering process involves skill and sensitivity to the individual, as well as the groups of people with which the broker is working. Serving as a cultural guide or ambassador, the broker is an expert on their culture, and informs human service providers about the values, beliefs, and unique needs of their community. This often occurs when human service systems are striving to provide culturally sensitive practices, and they use this cultural expert's guidance to ensure appropriate services.

Yet another role that a cultural broker may hold is that of a problem solver in order to resolve conflicts. In this capacity, the cultural broker understands the intervening conditions and outside factors that may have an impact on the cultural brokering process. Acting as mediators, cultural brokers can help ease tension between systems by helping parties learn about one another and be sensitive to one another's perspectives. In the human service system, this involves establishing trust and rapport between the cultural broker, the practitioner, and the client while interacting with one another.

In addition to the roles the cultural broker may assume, they are also a catalyst for change. By communicating between two groups and sharing information that may not have been otherwise shared, the use of a cultural broker may influence new perspectives on how people view certain situations. For example, in the case of a cultural broker who is brokering between an immigration rights group and legislators, vital information sharing may occur that influences a policy-making decision, which in turn advances the immigration-rights group's purpose. While acting in this role, the broker must be sensitive to the interpersonal and larger organizational dynamics that affect the brokering process. From an organizational standpoint, cultural brokers can help the organization and its workers assess their awareness of and openness to other cultures. For example, a nonprofit providing domestic violence services may notice that there are a growing number of Asian Americans in their community. They may seek out a cultural broker in order to develop a specialized and culturally sensitive service for this population of individuals.

Cultural Brokering in the United States

Cultural brokers navigate between systems with different values. Values are often linked to and reinforced by the cultural group to which an individual belongs. Often, cultural groups develop because a number of people have a similar set of values, and have a common need for a particular resource. In the United States, the systems that have access to and control over the vast majority of resources are referred to as the dominant cultural group. These systems that have resources are developed and maintained through dominant cultural values and beliefs. Dominant values in the United States generally reflect democracy, individualism, privacy, change, progress, optimal health, achieving, working, materialism, cleanliness, time, directness, and assertiveness. These values are embedded into many different systems with which clients interact, and human service professionals must recognize these values and reflect on the impact they have on clients. Dominant values also impact the brokering process.

Challenges and Potential Solutions

Challenges arise in cultural brokering when one system is resistant to change, or is resistant to information that does not align with its values. In this situation, the cultural broker may take on a problem-solver role, and strategize ways in which the system can become more open to change. A suggestion to address this includes developing a team within that system (if it has the resources and interest in doing so) to address the value conflict. The broker can assist this team through the process and help them strategize ways in which they can be more open to different cultures. At times, there may be an individual (rather than a group of people) who develops an interest in exploring and confronting the values conflict.

The broker would want to work with that individual to help them explore the value conflict from both groups' perspectives, and possibly strategize ways to involve others in their organization. If this resistance to change starts to cause unnecessary tension, the brokering process between the teams may need to end. The broker may work individually with the systems to assess their needs and find alternate ways they can both receive the resources they need.

It may be difficult for human service organizations to find a cultural broker for a variety of reasons (e.g., being in a rural location, or not knowing where or how to access a broker). To overcome this challenge, organizations can first examine their staff and volunteers to determine if there is someone who may be fit to serve as a cultural broker for the situation. If unsuccessful, the organization can reach out to the community of the nondominant group to determine if there are individuals who may be able to serve the role. A third option is to attend community events or functions in which potential cultural brokers may be present. From a geographic standpoint, finding and using a cultural broker for face-to-face interactions may be difficult in certain areas. In this case, the use of technology such as a Skype or Google hangout may be appropriate.

Implications for Human Services Practice

Human service professionals strive to meet the needs of clients by empowering them and connecting them to services in order to improve their well-being. When it comes to clients who are of a different culture, services may need to be adjusted to be culturally appropriate so that it is equitable to all individuals. When human service providers encounter clients who are of a culture they do not understand, and believe there may be aspects of the clients' background that may affect the helping process, they can use cultural brokers in their service provision. In order to provide effective services and increase clients' positive outcomes, it is the responsibility of the human service provider to seek out and gain knowledge about the various systems that clients need help navigating.

As the country and communities become increasingly diversified, human service professionals will work with a variety of individuals from many different cultural groups. Using a cultural broker will help service providers become aware of the differences among cultures. While one can make generalizations about cultural groups, it is important to be aware that individuals have values that are unique and do not necessarily fit within a certain cultural group. It is important to be aware of differences in others, and how the use of a cultural broker can help one understand more about these differences and increase communication across groups. By acting as the bridge between cultures, brokers can cultivate communication of information and resources, and thus have the power to increase the accessibility of services to diverse groups.

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See Also: Biculturalism; Cross-Cultural Knowledge; Cross-Cultural Service Models; Cross-Cultural Skills; Cultural Competence, Human Service Providers and; Cultural Competence, Model of.

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Cultural Capital, Role of

Pierre Bourdieu, a prominent French sociologist, asserted that social relations are determined by capital acts within networks of exchange to attain power and higher social status. Examples of cultural capital are education, intellectual capacity, skills, attitudes, knowledge, tastes, and preferences that value practices and shape social actions in daily life. Cultural capital is a significant concept in human services and diversification because it explains the reasons of diversification. More importantly, cultural capital devises responses to the questions that emerge from this diversification that affect one's life, from education to social welfare services, through a set of social dynamics and relations that are encountered every day.

Bourdieu states that, apart from economic capital, there are three forms of capital. These are social capital, human capital, and cultural capital. Economic capital is related to economic resources, such as the assets that one has, bank checks, cash, and other financial assets. Social capital is a set of social networks that are established through group membership or club association, which becomes more durable through mutual acquaintance. Human capital refers to a process in which expertise can be attained on a technical subject by training and instruction. A mechanical engineer who uses a complicated robot is an example of human capital. What distinguishes cultural capital from all other capital forms lies in discourses of speech, behaviors, attitudes, and preferences that are transmitted from one's parents and conflated with education and knowledge. Thus, the role of cultural capital has influence on the other capital forms because education level, practices, and knowledge, which are learned from previous encounters, affect social stratification, marital selection, social inclusion or social exclusion, and occupational status. All these variables and outcomes turn to a path of social relations that determine the type of acts between social agencies.

There are three types of cultural capital that shape one's life from different perspectives. These are embodied cultural capital, objectified cultural capital, and institutionalized cultural capital. Embodied cultural capital mainly signifies practices. Attitudes, formal knowledge, behavior, and preference are the main instruments of embodied cultural capital. For example, knowing the importance of good musicals (attitude), having information about the location and type of the musicals (formal knowledge), tendency not only to go to the most popular musicals but also to other amateur performances (preference and attitude), and having a ability to evaluate the quality of a musical with enough confidence to do a critical evaluation (behavior and preference) are concrete examples of this process. Second, objectified cultural capital includes transmittable goods that are reverberated by deploying practices, in other words embodied culture. Examples of embodied cultural capital are books, music, dance, computers, high-tech devices, and paintings. Finally, institutionalized cultural capital turns to value-based appreciation of the practices in embodied cultural capital. The degree that one earns in school is one of these examples. Therefore, institutionalized cultural capital serves to determine resource power and drives one to the related social class according to embodied and objectified cultural capital.

Cultural capital primarily has an influence on social selection because it gives an impetus to the cultural attitudes and behaviors while determining socioeconomic class. In doing so, on one hand, cultural capital allows the accumulation of more economic resources in circles of related social class. On the other hand, cultural practices are associated with the social character of the related group or club in which similar attitudes or behaviors can be practiced by other group or club members. Yet, social class identity and cultural class identity should not be interchangeably used. For example, a student who works hard can attain a high academic degree, even though he or she comes from a lower social class.

From another point of view, a person who has a high social class family background may not pass the exam. This means that the accumulation of cultural capital does not guarantee achievement, but it decreases opportunities for social exclusion. Yet, a high social class background offers other alternatives to socially advantaged people. Creating new opportunities for those with a lower social background is more challenging because the cultural capital of these people does not offer the same alternatives as those who are socially advantaged. This is the reason that cultural capital is a resource of power because it limits or increases opportunities in line with the accumulated cultural capital for each person. Accordingly, people who have similar accumulated cultural capital are more prone to marry or share the same social habitus. However, criticisms are raised about the limits of cultural capital. For instance, the ability of the students can be more important than cultural capital, or gender differences may have a more determinative force in decisions.

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See Also: Cultural Appropriation; Cultural Determinism; Cultural Literacy; Cultural Paradigms; Human Capital Development Initiative.

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Cultural Competence, Human Service Providers and

Cultural expressions are foundational to human service. Understanding the nuances of culture is critical to developing effective human service interventions. This service foundation is informed by knowing oneself, the organizational landscape, and the social context. Culture entails the shared set of values, beliefs, and social norms and the dynamic context in which they are expressed. Culture shapes health, mental health, and social well-being; how people express symptoms, find meaning in life's challenges, understand the causes of difficulties, and cope with difficulties; and how care providers fit within these schemas. Interventions can be prejudicial, discriminatory, mistrustful, and stigmatizing experiences, or they can be empowering journeys. Social structures enforce inequality and disparities, delivering disparate outcomes, which is historically evidenced in how burdens are distributed. Cultural competence matters because culture matters.

Laws, regulations, accreditation standards, professional organizations, community stakeholders, and various organized interests contribute to the demand for cultural competency. Early conceptualizations of cultural competency saw it as the acceptance and respect for differences, attention to differences, ongoing self-assessment, the development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations. The cultural competence continuum ranges from cultural destructiveness, cultural incapacity, cultural blindness, cultural precompetence, and cultural competence to cultural proficiency. The standards for cultural competence developed for social workers, for example, refer to the process by which individuals and systems respectfully and effectively respond to people of all cultures, languages, classes, races, ethnic backgrounds, religions, sexual orientations, gender, physical and mental abilities, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities, and protects and preserves the dignity of each.

Cultural competency is the integration and transformation of knowledge of diversity into policies, practices, and attitudes to improve human service outcomes by learning new behaviors and effectively applying them. The standards identify five essential elements: diversity valuation, capacity for self-assessment, awareness of the dynamics inherent in cultural interactions, institutionalized cultural knowledge, and programs and services that reflect understandings of diversity. Because of the importance of communication in cultural competency, the National Center for Cultural Competence defines linguistic competence as the capacity of an organization and its personnel to effectively communicate and convey information in a manner that is easily understood by diverse groups, including those with limited English proficiency, low literacy skills, or ability challenges. The Office of Minority Health also provides national standards for cultural and linguistic competency by broadening the markers for diversity so that new avenues open in care quality and delivery by responding to demographic

A great example of cultural competence in action would be the Medical Readiness Training Exercise conducted between Ghana and U.S. Army medical professionals as part of the U.S. Army Africa mission. The exercise, as well as the mission, brought these two groups together to promote cooperation and cultural interactions between Ghanaians and U.S. Army personnel.

and social changes, disparities, care quality concerns, legal climates, marketplace competition, and charges of wrongdoing. These types of standards speak of the integration of attitudes, knowledge, and practice competencies.

Attitudes

Broad demographic and social changes reflect a growing diversity, in which racial and ethnic minorities become the majority, immigration and globalization change residency, same-sex civil rights gain recognition, historical religious differences clash, gender equity ebbs and flows, and poverty persists for many disabled people. There is a compelling need to address demographic and social changes to promote well-being (not in the absence of conflict, but in the presence of social justice). Programs, policies, and services manage change and diversity by ending harmful disparities and improving service outcomes. Cultural competency enhances the ability to compete, avoid conflict, and mitigate harm. Effective, efficient, and cost-effective services impact access, utilization, and service outcomes in ways that are enhanced by cultural competency. Attitudes support and can be barriers. The human service provider may have attitudes of warmth, empathy, and genuineness, or they may further stigmatize or prejudice interactions with others. Discussions of privilege may support competencies, or animosities. Attitudes verbally and nonverbally communicated shape individual behaviors and organizational climates. The road to attitudinal change is a journey that encounters barriers, but also reflects values and professionalism. Prejudicial attitudes may be rooted in the intuitive emotional heart, moral judgments, and reasoned thoughts. The pathways that can lead to “cultural wars” can also lead to cultural competence.

Knowledge

Cultural competency requires building knowledge across a wide array of information. It is not focused on knowledge of each area of diversity, but on cumulative knowledge of diversity, and an institutional holding of this reservoir of information. This favors participatory approaches for securing information, and then building on this participation to integrate the knowledge into the helping process (e.g., engaging, assessing, intervening, and evaluating). This includes understanding cultural patterns, historical trauma, social structures, and the intersectionalities where differing identities merge. These are manifested, for example, by the immigrant experience or the cradle-to-prison pipeline of incarceration, changing some communities. The social structures (e.g., historic, economic, political, geographic, religious, and linguistic) shape the experiences that impact help-seeking behaviors, access, utilization, or other practices. Cultural knowledge includes mores, values, traditions, beliefs, customs, communication styles, familial customs, risks, and resiliencies.

Competencies

Human service providers practice competently to improve service outcomes. Engaging the helping process starts with forming alliances characterized by trust, warmth, empathy, genuineness, and shared communications. Competency includes awareness, sensitivity, trust, communication of cultural understanding, the ability to work with and in diverse communities, the establishment of support networks, the ability to empower and confront oppression, and the power to help from a place of strength. Interventions build on strengths, resiliency, and partnerships. Competent assessments include knowing historical trauma, social settings, causes and consequences, who to turn to for help, and how to ask the difficult questions about diversity. The human service worker practices in organizational contexts and an organizational climate (sociocultural dimensions and administrative structures). Cultural competency plans support goal achievement, regulatory needs, and evaluative processes. Cultural competency plans include basic demographic data, sustainability, managerial support, goals and objectives, and outcomes. They are integrated into the mission, strategic plan, implementation plans, structural supports for the plan, training, human resources, and ongoing training. Organizations build on performance goals, strategies to achieve these goals, diversity in staffing, accountability, and consumer leadership.

Beyond Cultural Competence

Cultural competency values diversity and equity, showing it in policies and programs, being self-reflective, implementing and sustaining competencies, supporting staff in their journey toward cultural competency, targeting goals to achieve it, and monitoring and evaluating progress within a participatory framework. One cannot be fully human by preventing others from being fully human. One journeys on the path to cultural competency. It is not good will alone that leads one further down the path, but challenges to structural inequality and institutional racism. The journey welcomes service providers.

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See Also: Cultural Competence, Model of; Cultural Paradigms; Cultural Services.

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Cultural Competence, Measuring and Assessing

There are compelling social and professional reasons why human service workers need to enhance their cultural competency skills. The changing demographics of the population, disparities and inequality, the rapid globalization brought on by economic and technological change, the need for competencies to compete in changing marketplaces, and the legal and regulatory demands of a changing society create demand for cultural competency skills. Ethical standards of practice, accreditation standards for professional training, and regulatory practices require attitudes, knowledge, and skills for culturally competent practice. Despite barriers to cultural competence skill development, there is a growing consensus in professional literature and program practices of the importance of cultural competence. Cultural competency may lead to difficult conversations about diversities, to sensitivities inherent in the conversations, to new practices, and to strategies for advocacy.

The growing demands for practice accountability moves human services professionals to evidence-based practices in order to improve service access and outcomes, reduce disparities, and build quality in transformed service delivery networks. Questions remain about the evidence base for cultural competency in the human services. A disconnect exists between "evidence-based" and "cultural competency" as described by M. R. Isaacs and colleagues. There are knowledge gaps in both cultural competence, and evidence-based practices, a lack of policy and research integrating the two, and a lack of practice-based evidence to support the integration. The evidence-based and cultural competency frameworks may not come together but rather may collide. Integrating an evidence-based approach to the assessment and measurement of cultural competency is vital to understanding and supporting the scientific basis of professional practice integrated with the values and standards of quality practice.

Measuring Cultural Competence

Culturally competent practice is a means to improve human service outcomes. There is a need for an evidence base showing how these competencies improve the quality of service outcomes. This requires an integrative approach addressing the opportunities and barriers as well as the resources to support evidence-based, culturally competent practices and their impact on service quality and the expansion of practice-based evidence. Measuring community needs for cultural and linguistic competence provides a framework for ongoing organizational supports for cultural competency measurements.

A key to integration of culturally competent, evidence-based practice is having the reliable and valid assessment instruments to measure the domains of cultural competence and the evaluation studies to know the impact on service quality and outcomes. Instruments are available for measuring multiple domains of cultural competency. The New York State Psychiatric Institute reviewed a variety of assessment tools for measuring cultural competence at various levels. Multiple instruments are identified at various practice levels, such as agency, provider, consumer/client, and training instruments. Instrument information is provided including citations, purposes, descriptions, assessment levels, administration, scoring, reliability, validity, and developer contact information. Standardized instruments that systematically evaluate practice outcomes offer the potential for the development of practice-based (and evidence-based) application opportunities. It is necessary to have the measurement tools available to support a body of research on cultural competency.

The National Center for Cultural Competence also has resources essential for self-assessment in measuring cultural and linguistic competency. The resources on measuring tools, for example, cover agency, program, provider, client, and training instruments. The center develops tools that target special populations such as measures focused on early childhood, children, families, youth, and sexual minorities. The center also provides support and information on planning for and implantation of culturally competent self-assessments, including information on checklists that support engaging in systematic self-assessments.

The Research and Training Center for Children's Mental Health reviews available instruments to measure organizational cultural competence. The center reports little empirical data on organizational cultural competency. Its review identified studies on the measurement tools available and the domains of the organizational cultural competence measures (values, governance, evaluation, communications, human resources, participation, service arrays, and resources). Cultural competence is a basic part of practice in the human services, and measuring it in practice is requisite to understanding the programs and agencies in which competency is found. Competency development requires support at all levels of the organization.

Assessing Cultural Competence

Assessments in the human services rely on participatory data collection informing practice in the embedded service context. For example, in mental health-related cultural formulations, focus might be on cultural identity, cultural explanations of illness, environments, interactions, or care impact. Clinical assessments address how the person is experiencing difficulties, his or her views on etiology and help-seeking, and conveyance of trust in planned interventions. Organizational assessments might focus on communication, resources, personnel, capacities, or organization climate. Assessments cross over divergent areas of focus, but are contingent upon measurement tools capturing the domains critical to the measures. In a pluralistic society, multilingual (or literacy) competencies may need to be assessed in one context, and trust may be a core competency in another. In some contexts, measuring levels of cultural fit (or acculturation) may tap into a dimension of needed cultural competency.

Exposure to discrimination, violence, or trauma produce biopsychosocial consequences, and assessments require engaging and relationship-building as a means of developing quality assessments. Human services workers build bridges via participation with their clients, whether they are at individual, group, family, organizational, or community levels. Culturally competent practice is the bridge to quality outcomes. Assessments require data (qualitative and quantitative) in order to get to data-driven results. Assessment foci may be at various levels (e.g., care quality, equity, organizational, provider, client, resources, unmet needs, service processes, assets, communications, or even basic demographic profiles). What is critical is that assessments include the key elements thought to be necessary for achieving quality standards of care. Policies and procedures guiding assessments would include nondiscrimination, though reaching this is a journey reflected in taking affirmative approaches to quality.

Cultural competence is the pillar on which human services are built and are supported in practice. However, measuring and assessing cultural competence is not well integrated into practice. Being rich in discussions is not the same as being substantively supported by theoretical or empirical foundations. Some empirical support is described (perhaps more so in the medical literature than in other areas of human services), but little research has been done to know if culturally competent practice leads to improved service outcomes. There is little evidence to support culturally competent practice, though such practice is widely affirmed in practice standards and literature. Valuing cultural competence is not the same as knowing it is achieved. Knowledge of achievement requires measuring, assessing, and methods to provide the data necessary to make judgments on quality outcomes. To integrate evidence-based and culturally competent practices, culture, power, and privilege merge with outcomes in quality care measurement.

To reach evidence-based and culturally competent care integration, planning and implementation are required. Organizational supports for the planning and implantation are essential. The efforts require support for sustainability. Training is often seen as crucial to sustainability efforts, but supports require more than training opportunities. Examples of supports include organizational supports, such as implementation of a cultural competence framework reflected in mission, strategic plan, service implantation plan, policies, procedures, and an organizational structure (an office of cultural competence/staffing, leadership, human resources, budget, microclimate, and training are support examples). It is necessary to have basic demographic data (targets, populations, unmet needs, etc.) available for planning and implementation. Evaluation data that informs cultural competence and effectiveness in service outcomes are key. The attributes of community and context capacity as vital, as are other asset profiles such as staffing resources and improvement goals. The evaluation to support quality includes needs and targets, and processes that lead to outcomes. Assessing for cultural competency requires clinically and methodologically valid tools and assessing organizational and administrative supports, as well as assessing service delivery. Tools have been developed in each area and need applications to build best practices and evidence-based structures.

Evidence-based practice and culturally competent practice are both complementary and challenging. Measuring cultural competence in an evidence-based approach and developing practice-based evidence furthers the integration of the two themes' guiding practice. Participatory approaches with human service partners strengthen the pathways to quality care outcomes in the human services.

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See Also: Cultural Competence, Human Service Providers and; Cultural Competence, Model of; Cultural Competence, Professional Standards of; Cultural Competence, Training.

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Cultural Competence, Model of

Cultural competence refers to integrated patterns of human behavior (e.g., language, thought, communication, action, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups) and implies having the capacity to effectively function as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. The human and social dimensions of cultural competence holistically affect individuals, groups, communities, and organizations. The helping professions (e.g., counselors, doctors, crime scene investigators, home health aides, emergency medical technicians, nurses, police, psychologists, social workers, and teachers) play pivotal roles in delivering culturally competent services across a full spectrum of professions. The interactions between and among individuals and communities (client) and helping professionals (staff) and the respective agency (organization) occur at the levels of prevention, treatment or services, and promotion of well-being and independence.

Operational Definition

Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. Facilitating this transformation is a challenge. The rationale underpinning the goals of cultural competence are expressed as the mastery of specific knowledge and skills that increase the provision of competent care, service, or treatment care to diverse individuals, groups, and communities; and the dispositional objective to meaningfully value feelings, values, attitudes, and beliefs about the self and others. There are several working definitions of cultural competence.

Terry Cross views cultural competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables them to effectively work in cross-cultural situations. The National Association of Social Workers refers to cultural competence as the process by which individuals and systems respectfully and effectively respond to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each. The Western Interstate Commission for Higher Education's (WICHE) mental health standards state that cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, and values in determining an individual's mental wellness/illness, and incorporates those variables into assessment and treatment. For the Child Welfare League of America, cultural competence means an ability to provide services that are perceived as legitimate for problems experienced by culturally diverse persons.

There is congruence among these theoretical and operational definitions. However, one views cultural competence through multiple lenses. One must consider the "bedrock" of cultural competence: self-cultural competence. One is reminded of this initial and crucial aspect of development when revisiting R. Michael Paige and Steven Fraiberg's explanations of meaning making and social development. Extending one's vision of the world to include the "other" is the basis of this model for cultural competence.

Components of a Cultural Competence Model

Whether one views cultural competence as a stage, set constructs, dimensions, domains, or as characteristics, the common components of these categories are significant and serve as the basis of the methodology and approach to or assessment of cultural competence. I. Papadopoulos, M. Tilki, and G. Taylor posited that cultural competence is the fourth stage of four stages. Competence (competent assessment of need, and the ability to challenge and address prejudice, discrimination, and disparity) develops from awareness (of self, identify, heritage, and ethnohistory), knowledge (of health beliefs and behaviors, holistic understandings, similarities and differences, and disparities), and sensitivity (empathy, effective intrapersonal communication skills, acceptance, appropriateness, and respect). The "community tool box" enumerates five essential active principles: valuing diversity, conducting cultural self-assessment, understanding the dynamics of difference, institutionalizing cultural knowledge, and adapting to diversity.

The present participle form of these verbs underscores a key element in the process: that of things still happening. Sharon Glover's adaption of the community tool box articulates a continuum that at its least effective is culturally destructive, and at its best is culturally proficient. Glover's continuum ranges from cultural destructiveness to cultural incapacity, cultural blindness, cultural precompetence, cultural competence, and cultural proficiency. Larry Purnell developed a model for cultural competence that crosses practice disciplines and environmental contexts. The major assumptions informing the Purnell model embrace that all health (helping) professions need similar information; the metaparadigm of health and well-being as global, communal, family, and individual; and recognition that all cultures share core similarities.

Why Cultural Competence?

Diversity is reality: People are all connected through the increasing globalization of communications, trade, and labor practices. Change in one part of the world affects people everywhere. Described as the "butterfly effect," a small occurrence can change the course of the universe. Considering increasing diversity and interconnected problems, working together is the best strategy for accomplishing goals. Because social and economic changes are coming faster and faster, organizations understand the need for cultural competence. If one does not improve one's skills, one is inviting organizational and cultural gridlock. Studies show that new entrants to the workforce and communities will increasingly be people of color, immigrants, and white women because of differential birth rates and immigration patterns. The benefits to diversity are many, such as the rich resource of alternative ideas for how to do things, the opportunity for contact with people from all cultures and nationalities that are living in a community, the aid in strategizing quick response to environmental change, and a source for hope and success in managing shared survival.

The benefits of building an organization's cultural competence include increased respect and mutual understanding among all shareholders; increased creativity in problem-solving through new perspectives, ideas, and strategies; decreased unwanted surprises that might slow institutional progress; increased participation and involvement of other cultural groups; and increased trust and cooperation. While these benefits can be either tangible or intangible, the reduction in fear of mistakes, unhelpful competition, and conflict between staff and leadership is highly desirable, and the promotion of inclusion and equality is essential to fostering organizational cohesion and productivity.

The constructs of cultural competence include the knowledge of, skill in applying, and the open dispositions that embrace languages other than English (LOTE). The anthropological concept of "emic and etic" are at play in the dyad between the English speaker and the speaker of a LOTE. Embedded in the dyad between the participant and observer are beliefs regarding health, healing and wellness, how illness and disease and their causes are perceived, and the behaviors of those seeking health care and their attitudes toward the caregiver. The range of models describing cultural competence embraces global, communal, family, and individual perspectives. At each level, the various models acknowledge that all cultures share core similarities: awareness and acceptance of self and others, and the commitment to embrace shared human and social rights.

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See Also: Cultural Competence, Human Service Providers and; Cultural Paradigms; Cultural Services.

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Cultural Competence, Professional Standards of

The concepts of cultural, multicultural, intercultural, and global competence all share a common focus on the need to appreciate perspective—the value that individuals, organizations, and groups assign to the ways that others evaluate the world relative to their own viewpoints. Cultural competence can be prescriptively seen as a developmental model in which entities are encouraged to progress along a continuum toward knowledge of oneself in relation to one's culture, knowledge of others in relation to their cultures, a core assumption of interdependence, a commitment to cultural differences as potential assets, and a repertoire of applied skills, according to Darla K. Deardorff.

Building upon the notion of cultural competence as making sense of a relatively benign world, standpoint theory presents a world in which one's perspective is socially constructed from the images, story lines, metaphors, and concepts associated with a "subject position," a subjectively negotiated identity within a dynamic cultural system in which power and privilege are unevenly distributed. For example, racial profiling can be said to generate story lines that persistently situate young black and Latino men in subject positions as threats to the established order, providing license to civil authorities to devalue their lives in relation to those of young white men. Standpoint theory anticipates certain social problems because of the limits and conditions placed on the perspectives of those associated with certain subject positions: "What one knows is affected by where one stands in society." Cultural competence can be analytically seen as a political model in which entities can creatively respond to a power system that subjectively restricts or expands choices, as per Julia T. Wood.

When the civil rights movement challenged the overt and covert system of race-based segregation in the United States during the 1950s, 1960s, and 1970s, pathways to higher education opened that enabled diverse populations to negotiate space for discourse about the existing inequities of power in society. During the presidency of Lyndon B. Johnson, the movement accomplished successes for African American agency by mobilizing the federal government as the monitor and enforcer of the educational equity agenda for social change, diversifying representation in the educational workforce and student body, and incentivizing cultural competence, especially through the policies of the U.S. Department of Education and the Department of Health and Human Services. These successes helped to ignite similar campaigns for equity and cultural competence among other marginalized identity groups, including women, immigrants, the economically poor, Latinos, Native Americans, Asian Americans, the lesbian, gay, bisexual, transgendered, and queer community, the disabled community, and the spiritually disenfranchised.

In higher education, scholars of race and ethnicity have elevated the role of cultural perspective and exposed Eurocentric perspectives in academic curricula. Feminist and sexuality scholars have centralized gender and sexuality perspectives and have recognized the contributions of reflexivity, subjectivity, and intersectionality in providing alternatives to the myth of objectivity. Disability scholars have emphasized neurodiversity as a perspective, addressing the influence of differences in the functioning of the brain and nervous system on consciousness, perception, movement, and learning. Through the power of entrenched and institutionalized precedent, these master narratives have worked to normalize and validate the collective perspectives of the West about what is true, right, good, and beautiful—while delegitimizing and disempowering the values and accomplishments of the remainder of the world.

During the presidency of Ronald Reagan, a backlash erupted against the relative prominence of the unfinished equity and cultural competence agenda. Once the world's leader in education, America's schools had entered a period of decline relative to the world's highest-performing schools. The publication of *A Nation At Risk* in 1983 dramatically altered the discourse around public education in the United States, shifting the focus of the national educational agenda from cultural competence to professional standards, from equity to accountability, and from the federal government to the states and business. *A Nation At Risk* concluded that "The educational foundations of our society are presently being eroded by a rising tide of mediocrity that threatens our very future as a nation and as a people." Intervention by the federal government was designated as the central problem facing U.S. education. Intervention had created a national crisis in the public schools that had lowered standards, undermined the nation's sense of a common identity, and threatened the nation's role as world leader. Establishing and applying standards and demanding accountability was the panacea for improving the quality of national education in the international arena. Market forces would be the guarantor of the individual's responsibility for achieving educational excellence. Public education was viewed as the primary channel for transmitting the nation's dominant myths and values and reproducing the culture and power hierarchies of the dominant group.

Over the last quarter century, the trajectory of U.S. education policy has remained tilted toward the centrist side of the accountability paradigm. While no president has veered as far to the right as Reagan, President George H. W. Bush assembled governors to formulate national educational goals. President Bill Clinton encouraged the formulation of learning outcomes to improve measurement of what students should be able to understand, know, and do; promoted standardized testing in schools; and incentivized states to incorporate educational accountability systems. President George W. Bush implemented state curricular standards and encouraged annual assessments of progress toward achieving the standards, but he also advocated for disaggregated testing data for diverse student groups. President Barack Obama has lobbied for the Common Core curricular standards; linked teacher preparation, evaluation, compensation, and retention to student academic achievement; utilized competitive grants to states; and supported accountability for higher education institutions, as well as public charter and rural schools. He has also encouraged innovation in transforming the cultures of struggling schools; supported science, technology, engineering, and mathematics (STEM) education; and built statewide longitudinal data systems for improved assessment.

While government has emphasized accountability, professional organizations and accreditation associations are increasingly becoming the caretakers for cultural competence. In recent years, advocates for cultural competence, particularly in health, health care, nursing, psychology, and social work, have identified barriers to cultural competence, such as the failure to account for the role of culture in diagnosis and treatment, consequent overreliance on a medical model of causation, and omission of the effects of the reflexive bias of the practitioner when confronting cultural difference.

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See Also: Cultural Competence, Human Service Providers and; Cultural Competence, Measuring and Assessing; Cultural Competence, Model of; Cultural Competence, Training in.

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Cultural Competence, Training in

Cultural competence training programs aim to increase cultural awareness, knowledge, and skills leading to changes in staff behavior and patient-staff interactions. Cultural competence training is one method of improving the effectiveness of service providers in meeting the needs of diverse clients and consumers. Evaluation studies looking at the effectiveness of cultural competence training have emerged in many fields, including social work, health care, and counseling. Culture refers to the shared values, traditions, norms, customs, religion, arts, history, folklore, language, and/or institutions of a specific group of people. Competence, in its broadest sense, is having the capacity to effectively provide services cross-culturally. It is achieved by service providers acquiring the ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds and on an organizational/societal level. Cultural competence includes the capability to identify, understand, and respect the values and beliefs of others.

Motivated by a growing body of evidence that the delivery of culturally competent services can improve outcomes and client satisfaction, and by the need to train professionals with the ability to provide quality care for a diverse population, many statutory/accreditation bodies and government agencies worldwide now require cultural competence education and training. However, cultural competence can be perceived as “elementary” by critics because of the lack of a standardized definition and methodology for curricula and research and a limited evidence base documenting the efficacy of cultural training efforts.

Models of Cultural Competence Training

There are a limited number of cultural competence training models, with the majority of models in the fields of nursing, mental health, or social work. These professions have a great deal of client contact and their professionals are likely to encounter people who may be culturally different from them. In all the models, each of the trainings included a cognitive and behavioral component. The cognitive components stress self-awareness and cultural knowledge acquisition. The behavioral components emphasize skill development such as being able to convey respect and genuine regard for others during cultural encounters. A criticism of cultural competency training is that few of the frameworks have developed validated assessment tools with which to evaluate their models. There is also limited information about the associations between patient outcomes and cultural competence training.

One common approach for providing cultural competence training to providers in a number of fields is to include cultural competence training in graduate and postgraduate education. Student counselors, social workers, and nurses are required to learn cultural competence curricula and demonstrate mastery of the learning competencies. Another way of providing cultural competence training is to offer continuing education workshops and training either face to face or online to staff who are already working in health care or mental health agencies as part of their job development, and in some professions as part of the required certification for state licensing. Cultural competence training can focus on the individual clinician-client level, organizational or societal factors, and generally includes a combination of lectures, discussions, group activities, and case studies.

Becoming Culturally Competent

Becoming culturally competent requires self-reflection and an openness and humility that enable the health care or mental health provider to allow the patient to be the expert about his or her experiences. It involves the provider’s willingness to learn from the patient. The process requires using multiple skills such as problem-solving;

understanding the dynamics of oppression and privilege, racism, sexism, classism, homophobia, and other forms of discrimination; understanding the complexity of the service delivery systems; increased awareness of personal biases and stereotypes; having knowledge of the context that influences the behaviors of individuals and families; and utilizing a process of questioning.

Standards, Assessment, and Evaluation of Cultural Competence Training

Standards for cultural competence training have been recommended by a number of organizations and individuals, such as the American Psychological Association, the National Association of Social Workers, and the Association for Multicultural Counseling and Development. In the field of health care, the U.S. Office of Minority Health is promoting national standards for culturally and linguistically appropriate services (CLAS) in all states. The Center for Mental Health Services has also issued guidelines for cultural competency that aim to impact federally funded mental health programs. Many organizations have expanded their guidelines of cultural competence to include organizational processes and policies. In fact, many professional organizations have revised their codes of ethics to include respect for cultural diversity as part of the professional standards for education, training, research, and practice.

The primary method of evaluating cultural competence training has been pre-post comparisons of training participants' cultural knowledge, attitudes, and skills. One of the shortcomings in the current cultural competence training literature is the lack of standardized and validated methods to measure its impact and the limited number of validated conceptual frameworks.

There has not been great variation in cultural competence studies, and there is minimal evidence to evaluate the effectiveness of such training. The majority of evaluations claim success and are self-reported. There is minimal quantitative data, only patient experience or health outcomes. Most of the studies had small sample sizes limiting generalization of the information to other settings. There has been little in the way of serious attempts to evaluate the effectiveness of cultural competence training.

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See Also: Cultural Competence, Human Service Providers and; Cultural Competence, Measuring and Assessing; Cultural Competence, Model of; Cultural Competence, Professional Standards of; Multiculturalism.

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Cultural Determinism

Cultural determinism is the notion that culture determines and defines one's personality, rather than biologically inherited traits. It studies the interactions, relations, and effects between human beings and their cultural environment. Because human service professionals aim at ameliorating human problems, knowledge of cultural determinism can help them improve policies and programs to make them more acceptable, efficient, and dynamic. Its knowledge helps them design their human services strategies in a diversified human environment.

The influence of different factors responsible for making the personality of a human being are recorded using the concepts of cultural determinism, environmental determinism, and probabilism, or cultural ecology. There are a number of theories of social development. The concept of cultural determinism is similar to that of possibilism; it rejects the environment as a controlling influence, and claims that culture is everything for the molding and grooming of an individual. Culture is the collective system of knowledge and behavior that evolves through mutual interaction and collective endeavors, shared beliefs, and mutually agreed-upon values and thoughts. These develop through the course of generations, and are treasured through the ages through many layers of communication. Cultural determinism establishes its proposition on the fact that the ideas, values, beliefs, and behavioral patterns that a human being learns in a culture determine their personality and nature.

Cultural determinism follows the idea that a person is known by his society and company because his personality becomes a bundle of habits that he learns in the surrounding culture. Culture is an important aspect of human development and takes its members into a sustainable society. It contributes to the framing of an identity and healthy self-esteem. Cultural determinism understands that human behavioral patterns, attitudes, and values are the result of cultural indicators and paradigms, rather than biological and technological factors. One can find it as a debate of nurture versus nature. Culture nurtures the being of an individual. A child is born as a plain slate (tabula rasa): his mind is unaffected and clear. Many social, cultural, and political factors make him into a "type" of person and brand his personality. Human development varies according to the stage of a society. The physical stage, vital stage, and mental stage come in a sequence. In a cultural environment, a human being develops from an unconscious to a conscious state. A culture develops over centuries and records the experiences of many known and unknown individuals.

Cultural determinism is found branching into optimistic and pessimistic versions. The optimistic version of the theory of cultural determinism suggests that human nature is highly acquiescent and impressionable in its ideal form, and therefore one can choose the way of life that one prefers for oneself. The negative and the pessimistic aspect of cultural determinism holds that an individual becomes what he or she is conditioned to be. An individual has no control over this phenomenon. A human being is a proactive person and becomes involved in the same course that the culture takes him into. A person within the same culture observes several layers of impression programming within the culture, especially at the level of nation, region, gender, generation, social class, and occupation. Cultural determinism stands against the concept of economic determinism and technological determinism as given in Marxism and a technological stance. Marxist theory asserts that an individual transforms himself into certain ideologies that are motivated by economic and technological factors. Cultural determinism may also be pitted against the technological concept of man and media determinism as sole deterministic factors, but these can stand as a segment of culture.

Cultural determinism thus keeps human beings and culture in a continuous cycle of growth and development. Its ingredients include traits and determining factors that help an individual to carry cultural determinants, through which he or she takes a behavioral stand in society and communicates his or her mind through the structures of the political and economic environment of which he or she is a part, and takes recourse to the future structure of society as a whole. Inculcation of a positive attitude, constructive reception, and response toward organized patterning of anything that contributes to the political and economic setup of the society and nation at large makes a role for cultural determinism. This superstructure also, in the life of a human being, depends upon cultural determinism. Because the process affects how an individual grows and is conditioned, and depends upon their culture, cultural determinism takes many shades and forms.

Consenting or opposing for the better or the worse cause has much to do with cultural determinism. Prioritizing choices that regulate the rules or norms of social behavior is an implication that determines the behavioral stand of an individual on any matter of meaningful concern in society, and how he or she is conditioned in the background knowledge and culture to understand and interpret the gravity of that matter or subject in relation to it. It also determines an overall personality of an individual or face of the group or society that he or she joins, or to which he or she belongs. Cultural determinism becomes an indicator that measures differences in the development of human personality. It regulates various discourses in the society concerned. It can be a potent base of psychological, sociological, political, and economic rendering of human society.

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See Also: Biculturalism; Ethnicity, Definition of; Subcultures.

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Cultural Humility, Model of

The increasing cultural diversity of the United States has challenged professionals to acknowledge the ideological, psychological, interpersonal, structural (both physical and organizational), historical, and socioenvironmental experiences that differentiate culturally diverse groups. A compelling call for culturally responsive practice has emerged as part of a widespread help-giving ethos reflecting a high level of professional commitment to cultural differences and equitable treatment. Critical practice principles have become organized around culturally shared attributes, primarily of racial and ethnic groups, from which to initiate and engage in culturally competent practice. A cultural competence focus has evolved within nearly every human service profession and is most evident in ethical standards and professional codes of conduct.

Trends in human service outcomes in research and from clinical observations illuminate disproportionate and disparate access and outcomes in service delivery associated with cultural differences. Concerns about cultural biases are raised in reporting, assessing, diagnosing, responding to, and evaluating practice outcomes. Service underutilization and premature termination of services have become alarmingly disconcerting as service availability, accessibility, acceptability, adaptability, and affordability are common attributes in the failure of human service professionals to effectively address the needs of culturally different help-seekers.

Cultural competence practice traditionally encompasses four components. A knowledge component draws attention to culturally shared socialization experiences and the intergenerational transmission of values, beliefs, and so on, recognized as distinct within cultural communities. An awareness component requires consciously engaging in and incorporating knowledge about the unique cultural experiences of service recipients.

This component requires help-giving that recognizes challenges and issues from within a cultural lens or worldview specific to the service recipients and their situation. An affective or sensitivity component more closely aligns with cultural empathy and necessitates a sensorial appreciation of a recipient's affective responses to his or her challenges and issues. The fourth component is the place for cultural accountability and an evaluation of the cultural appropriateness, adaptiveness, effectiveness, or relevance of help-giving decision making or actions made in collaboration with or on behalf of service recipients. Cultural action as the fourth component elicits an integration of professional and cultural knowledge and skills.

Impediments to Cultural Competence and Cultural Diversity

Most recently, culturally responsive approaches have been called upon to represent culture more as a complex set of relationships, responses, and interpretations that differentiate individuals and families beyond a list of cultural categories or traits. In the nation's multicultural society and history of immigration, migration, and historically differential experiences of privilege and oppression, individuals have either acquired or been relegated to different levels of social integration. This complexity becomes pronounced when one considers cultural experiences of minority cultures juxtaposed onto more dominant cultural forces, often necessitating unique adaptive practices to navigate cultural differences. From this perspective, multiple dimensions of cultural diversity include power differentials, privilege and oppression, and other social justice-related aspects hardly inconsequential in understanding cultural diversity.

From a basic social science perspective, cultural experiences vary in such profound ways within and across cultures that ascertaining common or core sets of cultural meanings or shared practices minimizes this complexity in ways that misrepresent cultural variation. The multiple and intersecting meanings of culture in terms of their social constructions, contextual adaptiveness, -intergenerational and social transmission, and variations across time, generations, and sociopolitical contexts illustrate the complex dynamics of cultural difference and offer a backdrop from which competence is unlikely to emerge. Producing incontrovertible, observable, and measurable cultural traits, failure to differentiate cultural diversity from its cumulative integration of race and ethnicity, class, gender, religion, and issues of power, privilege, oppression, and so on remains an impediment to cultural competence.

Efforts to bound or generalize cultural differences and experiences as a consequence of cultural differences undermine efforts to more fully recognize U.S. cultural diversity. A common critique of cultural competence perspective is the potential for discriminating against or ignoring various components of diversity by overemphasizing some aspects while underemphasizing more critical aspects as defined by the help-seeker. From a social justice perspective, a cultural competence approach does not reach far enough in addressing systemic and institutionalized oppression nor does it hold professionals accountable for the role they play in exercising professional privilege without sufficiently taking into account the cultural diversity of others.

The most serious barrier to culturally appropriate care is not necessarily a lack of knowledge of the details of any given cultural orientation, but the provider's failure to develop self-awareness and a respectful attitude toward culturally diverse points of view. Rather than learning to identify and respond to sets of culturally specific traits about the help-seeker, the culturally responsive provider must be taught to develop cultural humility.

Cultural Humility Perspective

A cultural humility perspective draws attention to two important concepts, intersectionality and multiculturalism, as important threads that support perhaps the most critical aspect of initiating help-giving: engaging help-seekers as active participants in the helping process.

Intersectionality speaks to the fact that both clients and human services professionals possess multiple identities that are reinforced and reshaped as they interact with their social and physical environments. These interactions are encapsulated in and guided by their multiple identities, which extend beyond race and ethnicity to include gender, socioeconomic class, age, sexual orientation, occupation, family roles, and so on. It is this complex interaction of identities within each individual that makes a person complex and adds to diversity.

Multiculturalism recognizes culture as having both stable and ever-changing aspects that are revised as a consequence of experiences that suppress, reaffirm, or promote adaptive or alternative responses. It connotes a pooling of influences of the many forms of cultural identity imperfectly represented in people's minds, suggesting there is more within-culture variation than between-culture variation.

A cultural humility perspective draws upon three dimensions essential to individuals' connectedness with others and with themselves. First, cultural humility promotes self-awareness to the extent that individuals must appreciate who they are from a cultural perspective and critically assess how this shapes the lens through which they view the world. The concept of "epistemic privilege" draws attention to individuals' unique experiences and the ways they affect and are affected by individuals' internal processing of experiences. Each individual is different, unique, and claims privileged ownership of the lens through which he or she views the world based on both positive and negative experiences.

Through this self-awareness, individuals appreciate the fact that others can claim equal importance to their knowledge of self, relative to their own cultural experiences. Cultural humility in the broadest sense requires more realistic views about one's talents, skills, or capacities. Culturally humble practitioners do not simply acknowledge their limitations or resist overestimating their qualities but find value in the knowledge and experiences shaped by the realities of others outside of themselves.

Cultural humility cautions the worker against viewing culture as fixed and narrowly perceived. Engaging in a process of self-awareness and self-reflection is suggested to awaken the worker to the power imbalance in the helping relationship that may influence her or his perspective on cultural relevance. Critical self-awareness guards the worker from complicity, complacency, premature assessment, and psychological and physical retreat from perspectives that privilege the worker's perspective while ignoring the lived experiences of the help-seeker.

A second cultural humility dimension focuses on differentiation and openness. Workers are encouraged to consider an individual's multiple identities and the way in which their social experiences impact their cultural worldviews. In human services, cultural humility is an essential helping virtue to the extent that it requires a worker to learn from the help-seeker so that helping is relevant in its assumptions and applications.

The third dimension of cultural humility motivates human services workers to consider the fact that in their efforts to know themselves as well as others personally and professionally, in the helping context, they must embrace the reality that the world is far more complex and dynamic then perhaps they can imagine. Cultural humility as transcendence cultivates a disposition that encourages individuals to envision the multiple possibilities of difference that exist beyond one's self in every meaningful helping encounter. Workers lend their expertise on the basis of what they know, draw on the expertise of the help-seekers with whom they work, and even then must recognize that the vastness of experience likely exceeds all that is to be known.

Cultural Humility and Human Services Workers

In sum, demonstrating cultural humility frees workers from having to possess expert knowledge about an array of cultures. This perspective has the benefit of placing the worker in a learning mode as opposed to maintaining power, control, and authority in the working relationship, especially over cultural experiences about which the client is far more knowledgeable. Workers become liberated from the constraints of cultural stereotypes and bounded knowledge about specific cultures, and are encouraged to learn from the people they serve.

From a cultural humility perspective, workers are challenged to learn to identify and build on the assets and adaptive strengths of help-seekers and perhaps engage in efforts to change the kind of social forces that so often act to disempower them as members of society.

Cultural humility is fundamentally geared toward acknowledging rather than resisting or ignoring differences in power, privilege, and oppression. It also relates to an individual's ability to seek an appreciation of and hold regard for others that may generate mutual attentiveness, active listening, and greater possibilities for reciprocal enrichment, particularly when cultural humility is identified as ethically attuned and actively responsive to individuals' boundedness as cultural and temporal beings.

Engagement in culturally responsive practice inclusive of cultural humility offers help that furthers the goals of serving the communities of help-seekers by recognizing their unique contributions to the helping process. Contemporary cultural competence practices alone may be complicit in their own forms of repression, especially when the voices of the culturally diverse help-seekers are silenced. In this sense, conceptions of social justice and inclusion are incomplete without the cultivation of an ethical sensibility like cultural humility.

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See Also: Cultural Competence, Human Service Providers and; Cultural Competence, Model of; Cultural Competence, Professional Standards of; Cultural Literacy; Cultural Services; Culturally Diverse Practice, Definitions of; Culturally Diverse Practice, Theories of; Education for Diversity in Human Services.

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Cultural Literacy

Cultural literacy is a concept that individuals with an awareness of and the capacity to comprehend the history, slang, symbols, and customs that construct and organize a dominant culture will be better able to communicate with one another. This form of literacy asks that individuals have a body of shared knowledge, have an understanding of the historical context of a text or an image, know common symbols, can identify the meaning of common words or phrases, and can grasp common literary or cultural references. To be culturally literate and understand the history, biography, references, and symbols, one must interact with the culture.

Knowledge of a prescribed canon of facts and ideas is not adequate; rather, an individual becomes more culturally literate when engaging with others in the culture and reflecting upon ideas of expression, experience, and connections that many in the culture share. To be culturally literate necessitates familiarity with foundational general knowledge and assumes the use of that information in the creation of a common language and collective awareness of the world. When people know about and appreciate culture and history, their own and others, this cultural literacy impacts behaviors and beliefs in a multicultural world.

E. D. Hirsch Jr. wrote that Americans needed a body of common knowledge to understand and communicate with each other. This common knowledge would allow them to perform as fully formed citizens in a democracy. His writing on critical literacy is founded on the idea that a literate society depends upon shared information, and that schooling students to have a common core of information would ultimately create a more informed and active society. The contextualization of a shared history gives students a place to learn facts about a common culture. Hirsh thought that knowing words depends on knowing cultural realities and the experiences to which the words refer. By having a common core of knowledge, people can understand the symbols, references, and contexts as they try to communicate with one another.

Why Care About Cultural Literacy?

Having a core of information to refer to helps people think, reason, and problem-solve in real time. Instead of having to try to understand the nuances of an example, the individual can work on creating a solution to the problem. It is hard to solve problems, whether they are posed on a test or experienced in daily life, if one does not have some information that one can draw on to understand the issue. Having some baseline information about the dominant culture in which one lives, whether one is part of that culture or not, is useful to navigating society. A person's comprehension of information, whether written, visual, or auditory, directly depends on whether or not the individual has relevant knowledge of the subject at their direct disposal.

For example, if one is having a conversation with coworkers about last night's major televised sporting event, even if one does not follow the teams or even the sport discussed, having basic knowledge of the rules of the game and the interest level of the coworkers would help one to navigate the shared conversation. Similarly, if one is reading an article and someone is described as "quixotic," one would benefit from having some knowledge of the 1605 novel by Miguel de Cervantes, *Don Quixote*. Knowing something of the main character of that novel will help one contextualize the description of another person as "quixotic." In this way, cultural literacy assumes a common reader. A common reader is someone who is literate and shares a common set of knowledge and relevant associations with the writer. In this way, the person who describes a character as "quixotic" assumes that whoever is reading their work will have some connection to the novel *Don Quixote*, even if they have not read the book. If the reader and writer do not share the common link of *Don Quixote*, some of the nuance and context of the writing may be lost.

What Does Cultural Literacy Do?

Cultural literacy provides a foundation for common knowledge. When interacting with others, writing for an unseen audience, or meeting new people, having a common base of knowledge provides shortcuts to mutual understanding. Being culturally literate offers a way for individuals to deal with technological society. People must know how to interact with each other in person, but also online, through e-mail, and when videoconferencing. Mores, customs, and values often do not change as fast as technology, so one must employ cultural literacy to adapt to change. Cultural literacy is important in communication. Whether in person or using technology to communicate, one must be aware that people use more than words to express themselves and understand others. Being able to connect to common history, symbols, and ideas can enhance communication with others. Being culturally literate, in the most basic sense, allows one to more fully participate in public life. When people try to understand each other, they can come together to know the world much better.

Criticisms of Cultural Literacy

There are criticisms of Hirsh's view of cultural literacy. The foundation of his writings on cultural literacy relies on everyone learning discreet facts out of context. There are some that call this indoctrination, instead of literacy. Literacy is not achieved by listing facts. Rather, people need to be able to place ideas and facts in the context of their lived experiences. Learning is also about more than learning facts, but people learn as they experience the world and reflect on it. When cultural literacy is determined or evaluated more on what facts people know, rather than how they integrate facts into their lives, then the decontexualization of knowledge is centered, as opposed to really making connections with the people.

There are also questions about what decisions are made for inclusion into common core knowledge. One must ask questions about who decides what form of knowledge, culture, history, authority, and point of view is deemed normative. One must understand who will compile and teach this information, and be wary of a canon that tries to speak for all, but in reality merely replicates ideas of those in power. When one is not critical of where information comes from, one tends to obscure the ways that the power of making something normal hides the ways that it perpetuates racism and sexism. By forcing knowledge to comply to a seemingly value-neutral idea of common knowledge, the information is laden with what the dominant culture values, to the detriment of the diversity, creativity, and different ways of knowing that those who are different from oneself offer.

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See Also: Cross-Cultural Knowledge; Cultural Competence, Human Service Providers and; Cultural Humility, Model of; Cultural Paradigms; Ethnic Diversity and Values.

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Cultural Paradigms

Cultural paradigms are the all-embracing ways of life whereby communities are given shape. At the same time, these paradigms remain fluid enough to allow for diffusion and penetration of the "other," and even pollination by the other, or affinity to relate. Thus, individuals can experience the collective validation of living and thinking within a paradigm that is also embraced as truth by others, while contributing to the evolution and expansion of this description of truth. Once one understands how the other defines truth, and why the other defines it that way (e.g., what are their underlying cultural values), then one can communicate in a way that is understood by the other and understand the communication of the other, so that the communication loop is completed. At this point, true cross-disciplinary communication between diverse paradigms of defining truth (e.g., scientific and religious) can be initiated. Then one can dialogue from a place of building bridges, rather than walls, and grow in a mutually interactive expansion of understanding of truth. Through interdisciplinary education and research-based knowledge, with a focus on critical thinking, students learn about the history of human services, unique characteristics of human service populations, the diverse needs of clients, and ethical considerations for providing services. Skill development centers on unconditional positive regard, genuineness, reflection, perseverance, compassion, and empathic understanding.

Understanding Cultural Paradigms in Human Services

As a result of the diversity issues within human services, human service educators develop and demonstrate culturally sensitive knowledge, awareness, and teaching methodology; and human service professionals advocate for the rights of all members of society, particularly those who are members of minorities and groups and have experienced discriminatory practices. Furthermore, human service professionals are expected to provide services without discrimination or preference based on age, ethnicity, culture, race, disability, gender, religion, sexual orientation, or socioeconomic status; human service professionals are knowledgeable about the cultures and communities within which they practice. They are aware of multiculturalism in society, and its impact on the community, as well as individuals within the community. They respect individuals and groups, their cultures and beliefs. In addition, human service professionals are expected to be aware of their personal cultural backgrounds, beliefs, and values, recognizing the potential for impact on their relationships with others. Last, human service professionals are aware of sociopolitical issues that differentially affect clients from diverse backgrounds, and they seek the training, experience, education, and supervision necessary to ensure their effectiveness in working with culturally diverse clients.

The field in health care of human services encourages its practitioners to know the cultures of the multicultural client population that they are serving in the United States. The premise behind this injunction is that the use of culturally sensitive techniques that are tailored to the cultural background of the client will result in effective therapy and produce positive outcomes. However, as reflected in the plethora of terms used to describe the application of this knowledge, it is not made explicit why culture would make a difference in therapy, or how it makes a difference in the ultimate outcome. Humans have three basic needs: safety and security, integrity, and a sense of belonging. Yet, each culture uniquely frames each of these needs, and prescribes the sanctioned means to achieve them. In the struggle to define culturally competent or culturally based care, this fundamental aspect is often overlooked. Instead, the Western worldview, structure, and definitions are used as the template to assess dysfunction, diagnose a disorder, and prescribe appropriate care. The theoretical underpinnings of indigenous concepts of self and symbolic interactionism are needed to clarify these cultural misconceptions and construct a new paradigm for providing effective and acceptable care.

Cultural Paradigm Shifts

Max Weber argued that ideas and values are crucial to shaping human action, and thereby bring about change. In contrast, Émile Durkheim argued that changing ideas and values are the product of social change. In other words, make a social change happen, and eventually ideas and values will change to match. Both of these are true. To purposefully hasten the kind of upheaval shift required both approaches. Constructive programs primarily work by processes of education and making gradual changes in existing institutions. They engage in endeavors that teach, apply, and spread new ideas and values suitable to creating and sustaining the new future that these activists are working to create. Obstructive programs aggressively work to directly change behavior, usually through changing laws, and once the behavior is changed, society at large eventually comes to accept and embrace the values lying behind the laws until a worldview that reflects those values becomes the working paradigm, accepted by virtually everyone without thought.

Tactics of the former activists are thought of as “good works” (constructive programs), and the tactics of the latter as “nonviolent persuasion” (obstructive programs). The bigger the evil to be rooted out, the greater the difficulty in shifting the underlying paradigm. For example, in the case of segregation by race or class, at some point the paradigm that some people are inferior to others must be replaced by the paradigm that says that all men and women are created equal. Laws can be made that require equal treatment because at least a few people have decided that the old paradigm is no longer valid or acceptable. It may be, however, a very long time before the majority of people accept as truth the new paradigm, that all are of equal worth. Nevertheless, a great many people who may still be a minority believe, and act on their belief, that working for a change they desire is a worthy and worthwhile goal.

Cultural Paradigm Shifts Take Time

For example, to end the practice of foot-binding in China, a deeply embedded practice of nearly 1,000 years, it was necessary to outlaw it, and then work to change the underlying Chinese concept of what makes a woman beautiful. In 1911, the New Republic of China government outlawed foot binding. Although practiced in secret for a time, it is now defunct. The behavior of 1,000 years changed in less than 100 years. In another example, if women are granted equality to men, it is necessary to change the underlying paradigm of belief that women are created as a second thought or to be the helpers of men, not creatures different from but of value equal to men. In many countries, laws were made that grant rights to women, and as women achieve education and take places as equals in various spheres of achievement, the underlying paradigm of female inferiority is slowly shifting, from a global perspective unevenly, but with increasing speed. For example, it was only roughly 100 years ago that women began to secure the right to vote, and women are now heads of nongovernmental organizations, corporations, and governments.

One of the most impressive cultural change projects was the Christianization, by the Catholic Church and others, of most of Latin America, often in less than one generation. Although many elements of traditional beliefs have persisted in some places to the present day, many long-practiced behaviors changed. For instance, clothing that was more modest was adopted. Taking multiple wives was eliminated. Where it had been practiced before, head-hunting ceased as the new value system spread. In short, people are not passive victims of culture and circumstance, unable to plan and guide a social upheaval great enough to move history toward something grand as opposed to brutal. Likewise, one cannot claim to be too busy, or that change would take many centuries, too much time to merit investment in the effort when there are so many pressing problems.

Under the right conditions, cultural transformation can be stunningly swift. The process of relatively rapid, purposeful change (as opposed to change by the slow, hidden hand described by Adam Smith, or from blind, long-term, underlying social trends) typically has two phases: First, change the behavior itself, usually through changed or new laws, although sometimes in the past it has been at the tip of a sword; and then if conditions (social, economic, ecological) are favorable and all goes well, continued education and experience of the new way of living results, over time, in a shift in paradigm.

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See Also: Cultural Competence, Human Service Providers and; Cultural Competence, Professional Standards of; Cultural Services; Culturally Diverse Practice, Definitions of; Culturally Specific Services.

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Cultural Services

Cultural services consist of a wide range of activities that offer benefits through practicing or reflecting on way-of-life and historical traditions that contribute to the building, sustainability, improvement, and positive growth of people and civilization. The nonmaterial individual, personal, and collective benefits associated with cultural services include enjoyment, pleasure, satisfaction, renewal, regeneration, social cohesion, increased social capital, and a heightened sense of belonging and well-being. The nonmaterial nature of the benefits derived from cultural services creates challenges in quantifying their value and consequently difficulties in measuring their real value. Cultural services are designed to promote, share, and integrate the music, art and design, dance, spiritual practices, religious ceremonies, history, and clothing of ancient civilizations into personal lives through ecosystems, educational experiences, spirituality, rituals, social interactions, art, and entertainment. For example, when one visits a mountainous region and stops to gaze at the boundless beauty of the landscape and contemplate the mightiness and majesty of the height of the mountaintops, one derives and enjoys a sense of the awesomeness of the environment.

Cultural services increase the growth of knowledge and distribution of ideas. The benefits associated with practicing and experiencing traditional activities directly flow from the values, beliefs, and practices of traditional civilizations as they interact with nature. This interaction with nature generates creative reproductions and re-creations of the experience replayed throughout life in various forms including art, architecture, spiritual practices, and ritualized ceremonies. The impact of social participation in cultural activities by individuals spurs the emergence of intended and unintended gains.

Historical, Conceptual, and Organizational Origin of Cultural Services

For centuries, cultural services have been an essential and elemental part of the lives of the people who live in close relationship with nature. Many first nation or aboriginal groups connected their concepts of religion, spirituality, and cosmogony directly to Earth and nature. Ceremonial and worship practices evolved along with the designation of sacred ritual locations. The act of creating and maintaining sacred space represents mankind's oldest form of conservation. Tribes and nations consciously and collectively decided to create and dedicate sacred spaces to worship, praise, contemplate, meditate, sacrifice, dance, sing, chant, heal, and commune. The decision to select and set aside particular spaces, sites, and locations as sacred came with the responsibility to honor, preserve, and protect not only the sites, but also the rituals, spiritual practices, and other cultural behaviors such as dancing, dress, recitations, and music.

Historically, cultural services have been important to people who live in distant places, away from intact natural locations. Additional interest has heightened as groups of people have developed at different paces and in different ways. Some ethnic groups have managed to maintain their cultural practices for hundreds of years, whereas other groups have culturally transformed and assimilated into more modern and integrated cultures. Similarly, some groups have maintained their sacred spaces, whereas others have transformed their ancient spaces into urban or suburban spaces in response to the movement of people across the world, industrialization, and subsequent urbanization.

Curiosity, enjoyment, adventure, and appreciation of diversity motivate hundreds of thousands of individuals to travel the world as explorers, tourists, historians, educators, artists, and scientists. This is the origin and cause for the development of cultural tourism. As local communities realized the economic viability and market value of their natural resources, sacred locations, ritual practices, and arts to outsiders, they developed policies, practices, and programs to preserve, present, and share the benefits of their cultural services.

Education and Training in the Cultural Services Industry

Cultural services professionals are educated and trained both formally in colleges and universities, and informally in community settings. Community settings can be containers, reflecting their cultural heritage. Mainstream educational programs focus on preparing cultural services professionals for the world of work. Higher education institutions have designed and developed curricula to prepare professionals for successful employment in numerous segments of the cultural services industry, including ecosystems, ecotourism, tourism, political science, environmental sciences, chemistry, medicine, physics, biology, theater arts, visual arts, performance arts, museum administration, and docent professions. Cultural services education and training varies by program focus and specialization. While some programs promote a tightly focused topical curriculum, others insist on the importance of an eclectic knowledge base to insure well-rounded practitioners. On the other hand, programs that teach the usefulness of the application of individual elements from a variety of fields emphasize the systems approach to understanding the interconnectedness and interrelatedness of the environment in cultural services.

Educational and training programs with sharply focused areas of specialization produce cultural services professionals with much knowledge and skill, who are capable of providing in-depth knowledge on particular topics and performing specific tasks related to cultural services. Educational specialization in cultural services allows a student to become very good at a particular work task. An advantage of specialization is that a selective task or a small group of selective small group tasks can be done very well and quickly. A disadvantage of specialization is that workers end up with very specific skills that cannot be applied to other aspects of the cultural services.

The education and training of cultural services leaders in communities begins in the homes of families and expands to the larger setting of the community through age-old rituals, ceremonies, and practices. Community settings often reflect the rich cultural heritage of their inhabitants. These settings are natural learning centers and provide fertile ground for learning the details of cultural processes, structures, experiences, and cultural practices. Artifacts, art, jewelry, and ordinary implements such as furniture and utensils serve not only as usable instruments, but they also represent symbols with special meanings and significance. In the community, music, dances, and ceremonies are vehicles to carry the messages, lessons, beliefs, and values shared by all community members.

Cultural services are rendered by the individuals designated by group authorities, usually descending from a family recognized and respected by the community as having a long history specializing in cultural services knowledge.

Cultural Services and Ecosystems

The concept of cultural services is designed to provide a structure for grasping human benefits from complex exchanges between nature and the subsequent social, economic, and environmental changes that occur. One of several broad categories of ecosystems, cultural services results in both spiritual and recreational benefits through inspiration, discovery, mental growth, and artistic experience. Cultural ecosystems services contribute to the broader needs and wishes of society, and therefore to people's willingness to financially support conservation. This includes the spiritual significance and importance connected to specific ecosystems, such as sacred grounds, as well as the inherent beauty of panoramic countryside or coastal formations that attract visitors. In addition, nature directly contributes to improving the quality of life through cultural services and ecotourism.

Cultural Services Recreation, Entertainment, and Education

Cultural services are provided by the cultural services industry, consisting of public and private institutions (e.g., government agencies, nonprofits, community-based organizations, faith-based institutions, corporations, and international groups). Cultural services in the context of recreation, entertainment, and education take many different forms, such as visits to museums, historical sites, attendance at concerts, and festivals (e.g., dance, music, crafts, pottery, graphic arts, media arts, and food). Examples of cultural services recreation, entertainment, and education include the New Orleans Jazz & Heritage Festival and jazz festivals in other cities; Lollapalooza; World Championship BBQ contest; DanceAfrica, Choctaw Annual Pow Wow, blues Festivals, Puerto Rican, Italian, Polish, and other national and ethnic festivals; dude ranches and cowboy ranch camps, farm camps, Kingdom of Oyotunji African Village; and film and video arts.

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See Also: Cultural Broker; Cultural Capital, Role of; Cultural Literacy; Cultural Paradigms.

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Culturally Diverse Practice, Definitions of

Culturally diverse practices are all encompassing, and include cultural awareness, cultural responsiveness, and the respect for cultural differences. With varied diversity becoming a norm in U.S. society and the workplace, an understanding of how to practice with intentionality is imperative. It is necessary to understand cultural proficiency when considering culturally diverse practice. Cultural competence is the ability to function within, or for a culture or cultural practice to effectively meet, the needs of those in the workplace and social environment. In doing so, the culturally diverse practices are delivered with regard to equity and respect for cultural beliefs, behaviors, and practices. Working toward cultural competence into cultural proficiency, the latter provides an organization with behaviors that are not only identified and implemented in practice, but also leads to positive experiences for the diverse population involved.

As part of the critical research surrounding cultural responsiveness, Geneva Gay and Gloria Ladson-Billings identify key components of culturally responsive practice in the educational setting. Culturally responsive teachers have an intentional focus on the learning needs of students, and in that intentionality also include and maintain a cultural consciousness. Geneva Gay also asserts that teachers in a culturally responsive setting work to engage students in a diverse curriculum with a breadth and depth of knowledge of the students' culture within the classroom. Similar modifications could positively impact the work or service setting by implementing culturally relevant client standards throughout individual care, organization branding, and communication.

Culturally and Linguistically Diverse Practice

Reaching optimal cultural proficiency is not possible without a component of linguistically diverse practice. Linguistic diversity is ever-changing and reliant on the population of clients, customers, or individuals served within the organization. The United States has recently experienced a 140 percent increase in the nation's linguistic diversity over a 30-year period, according to the U.S. Census Bureau's 2010 report. The 2007 U.S. Census reported that "of 281 million people over 5 years old, 20 percent (55.4 million) speak another language than English in the home." Understanding the population and creating measures of communication is one of the most important steps in reaching linguistically diverse populations.

In one study, researchers reported on cross-cultural communication and culturally competent care and shared the story regarding practices at a hospital where a linguistically diverse patient checked into the hospital to be treated for stomach pain. Because the hospital did not understand the patient's language, and the patient chanted ritualistic sayings, the hospital admitted her to the mental health ward.

This kind of practice is also quite typical in urban school settings, where there are large migrant populations that the school districts are not ready to service. Often, students from linguistically diverse backgrounds are placed in classes that are below their level of academic understanding because the districts do not know how to identify the students' academic ability with regard to their language ability. Noting the reality of the differences in these backgrounds within the educational setting can help transcend thinking and practice in other work settings.

Organizations can put efforts in place to adopt communication strategies that help remove some of the barriers associated with linguistic diversity. They can create visual aids using symbols and pictures, employ a translator for the most prevalent linguistically diverse group, use culturally proficient body language and appropriate nonverbal cues, provide written materials for the linguistically diverse group, seek community support through volunteerism utilizing religious organizations and cultural entities, and employ service staff who understand cultural sensitivity and create a welcoming environment for those served.

Existing Barriers in Achieving Culturally Diverse Practice

Because the U.S. population has become so diverse and has experienced monumental gains in history based on racial and ethnic diversity, more people are in denial about bias and prejudice. By understanding that racism still exists within organizations and the workplace, the first barrier to overcome is denial. The ability to systemically or incrementally overcome resistance to changes can be daunting. To truly overcome barriers to achieve cultural proficiency, the organization has to recognize the internal and external barriers. When these barriers are in place, the individuals are not recognized within their culture, employees or supervisors may create an environment of superiority, and a negative culture within the organization could be prevalent.

The realities of such barriers are felt by those who are, in most cases, the minority within the organization. The National Institute of Mental Health, Child and Adolescent Service System funded a monograph to address the needs of a culturally competent system of care. One of the recommendations was when attempting to reach cultural proficiency, the ideal set of practices would encompass analogous "behaviors, attitudes, and policies that come together in a system, agency, or among professionals" to impact positive change. By ensuring a practice that delivers these beliefs with buy-in from constituents, those previously listed barriers can be overcome.

Understanding the dynamics of cultural differences can be daunting to some. However, when the organization, institution, or individual moves to a more culturally proficient environment, all parties feel recognized and appreciated for those differences. In order to ideally reach this level of proficiency, organizations should maintain a work environment employing individuals who understand their self-identity and seek out ways to enhance the community with a commitment to meeting the needs of a multicultural environment.

It is important to work within the organization to determine the cultural understanding of staff members. Organizations should identify areas of cultural misunderstanding and bias through staff-wide professional development; seek to understand and incorporate the voices of the community that the organization serves; involve community members through intentional regard to cultural beliefs, practices, and needs; implement a culturally relevant system of operations; develop a task force or small group within the organization to help assess the needs of the prevalent cultures served; involve all stakeholders in developing a shared vision, which is inclusive and respectful of all cultures; and finally, monitor and evaluate best practices and work to strengthen areas for improvement.

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See Also: Cross-Cultural Knowledge; Cultural and Linguistically Appropriate Services; Cultural Competence, Human Service Providers and.

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Culturally Diverse Practice, Theories of

Theories of culturally diverse practice purport that behavior patterns of differing peoples are regulated and impacted by different cultural values, beliefs, and practices. Generally, a practice is a patterned or routinized way in which problems are handled, things are described, objects or bodies are moved, subjects are treated, and the world is understood. The theoretical framework of practice is contingent on the notion of cultural diversity, indicating the variety of human societies or cultures in a specific region, and the world as a whole. Cultural diversity refers to the differences that make each person or group unique when compared with other persons or groups. Cultural diversity has also been defined as the representation of people with distinctly different group affiliations of cultural significance. Cultural diversity is an expanding social phenomenon in an unprecedented era of globalization, migration, population transfer, and the increasing diversification of population and identity patterns within traditionally homogeneous groups. The challenges of the globalizing and globalized world necessitate viewing cultural diversity as essential to theoretical and clinical formulations.

According to theories of cultural diversity, diversity can be classified into two dimensions, primary and secondary. The primary dimension of diversity includes age, gender, ethnicity, physical features, race, and sexual orientation. These primary dimensions are unchangeable and play a crucial role in shaping individuals' basic self-images and worldviews. They also exert an important impact, not only on individuals' early socialization, but also on the other stages of their lives. Secondary dimensions of diversity, viewed as changeable, include educational background, income or socioeconomic status, marital status, parental status, and religious beliefs.

For example, factors such as socioeconomic status, familial interdependence, level of education or acculturation, language, immigration status, and fear of stigma in response to a disease or physical disability may influence clients' experiences and practitioners' practices related to human services. Another factor, and one that can result in a gap between the ideal and the real in human services, is the fear of the differences of others. Likewise, human service professionals are challenged by human fears of differences, and if not well trained in culturally diverse practices, are susceptible to operating from a model of exclusion, rather than inclusion.

Diversity

Within this context, diversity can be viewed as that which distinguishes one group of people from another along primary and secondary dimensions. Although practitioners mainly think of human diversity in terms of the primary dimensions of age, gender, race, sex, and ethnicity, in scholarly literature, heterogeneity and diversity often embrace a very broad spectrum of individual differences. Many scholars advocating theories of culturally diverse practice have used the broad secondary dimensions of diversity to demonstrate the effects of cultural diversity and human heterogeneity on work-group and organizational performance. Further, many core assumptions about diversity in the workplace are drawn from research in which diversity is very broadly defined. When a new idea or practice is experienced by members of a cultural group, people tend to interpret it in the context of their common worldviews. The client's perceptions of a health issue or condition, for instance, may differ from those practicing Western medicine.

The term *diversity* is considered practical shorthand within the practice approach for dealing with a demographic mix of people. A culturally diverse practice is regulated within a system approach, indicating the process for considering how different parts of the whole structure influence and integrate with each other in such a way that problems in a system are viewed as affecting the system as a whole. The system approach relies on an interprofessional or multidisciplinary team, which is considered critical to all models of systematically organized practice in social services, emphasizing that the whole is enriched by the differences of its component parts.

Within the context of human services, cultural diversity is viewed as encompassing both clients and practitioners. Diversity fosters a milieu where all employees, each with specialized professional skills, have the opportunity to recognize their full potential through collaborating with each other. Culturally diverse practices bring together persons of many backgrounds and cultures, whose perspectives on work relations and client-provider relations may significantly differ. Although there is ideological diversity within an agency or profession, good practitioners continue to be guided by a belief in the dignity and worth of all persons. Despite the importance of agencies in managing human services, the genuine service delivered by a social practitioner is a professional social work service, rather than the service of a particular agency. A practitioner or clinician is held accountable for his ethical code of conduct, which states that he undertakes his professional practice in dealing with clients without prejudice or use of stereotypes. Such stereotypes may lead to errors in judgment about clients or cultural groups. Institutions dealing with human services are keen to provide experiences that highlight differences in clients or populations served, as well as differences in practitioners or team members.

Effective Management

There are some misconceptions in dealing with certain problems related to human services. Inadequate social measures and arrangements may be responsible for many of the problematic situations that are understood or defined as products of those who suffer from them. For example, racism is not created by people of color. Although the United States is proud of being a nation of immigrants, not all races, ethnicities, and nationalities are accepted with equally open arms. The highest-risk groups are members of ethnic or minority groups, older adults, and those with limited education. It is unfortunate that some providers treat all older adults the same way. Another example is that because families of color are often stereotyped in the United States as being close-knit and supportive of their kin, social service agencies may not take the time to assess the actual needs of this population. This assumption may lead to less allocation of resources, manpower, and finances for outreach to those communities. In addition, providers may not be knowledgeable about or sensitive to internal variation between different ethnic sub-groups or differences in belief systems of clients. Therefore, professionals' disregard for client heterogeneity is not considered a professional practice.

In terms of the professional practice of practitioners, cultural diversity requires that organizations have a defined set of values and principles and demonstrate behaviors, attitudes, and structures that enable them to effectively work cross-culturally. This means that they must have the capacity to appreciate diversity, conduct self-assessment, manage the dynamics of difference, institutionalize and implement cultural knowledge, and adapt to diversity and the cultural contexts of the clients or communities they serve. They should incorporate these factors in all domains of practice, policy making, administration, and service delivery, and systematically engage clients or consumers, key stakeholders, and communities.

The most important advice offered to practitioners dealing with culturally diverse practices is to manage diversity. Culturally diverse practices effectively operate in the context of strong antidiscrimination environments. The idea is that encouraging an environment of cultural diversity, where peoples' differences are valued, enables practitioners to work to their full potential in a richer and more productive work environment. An advantage of diversity management is said to be its more positive approach. For instance, practitioners with expertise in the care practice of culturally diverse clients can raise awareness and educate other human service providers and staff of community organizations about factors that may interfere with the delivery of mental and behavioral health services to diverse groups of caregivers.

Skills for effective practice in culturally diverse communities include understanding other disciplines' domains of expertise and principles; recognizing and accepting clients' cultural styles; identifying common ground among diverse groups to unite team members; acquiring basic group collaboration skills including communication, negotiation, and time management; learning to communicate in a common language; defining individual roles and processes; applying conflict-resolution techniques; and creating and maintaining shared principles.

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See Also: Cultural Services; Culturally Diverse Practice, Definitions of; Culturally Specific Services.

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Culturally Specific Services

To help overcome the barriers that immigrants and refugees face in utilizing mainstream human services, ethnic populations have developed culturally specific services within their communities to meet the needs of their members. Also known as ethnic-specific services, culturally specific services are human services supported and provided for and by a specific ethnic group within its community, integrating ethnic content and ideology, with a focus on strengthening the family. The formation of culturally specific services in ethnic communities is based on geographic and ethnic identity boundaries. The communities tend to have high concentrations of first-generation, non-English-speaking, working-class immigrants within a small geographical area, known as an ethnic enclave. Living in close geographic proximity has traditionally facilitated the development and maintenance of social networks among immigrants in urban areas. Differences in culture and language between country of origin and host country may constitute initial barriers for new immigrants to participate in mainstream society.

Historically, immigrant ethnic groups have created mutual aid societies to provide service interventions that are not accessible through mainstream agencies. Factors related to immigrant-oriented services formation include (1) a large and growing immigrant population, (2) an immigrant population develops needs not adequately addressed by existing services, (3) a community member with social service experience founds an organization, (4) connections to a larger social service delivery systems exist, and (5) the resources and capacity-building exist to sustain the organization. Historically, organizations providing culturally specific services grew incrementally by adding components when resources became available. Culturally specific services currently exist alongside mainstream traditional agencies as parallel service delivery systems.

Structure and Services

Culturally specific services are delivered through various types of structures, including stand-alone 501(c)(3) nonprofits, 501(c)(3) nonprofits supported by a mainstream agency, programs within a mainstream 501(c)(3) nonprofit specifically targeting an ethnic group, government programs that specifically target an ethnic group, and faith-based entities. The type of services offered by culturally oriented organizations depends on the ethnic community's need, but is also influenced by the founders' experiences and motivation. This need is often determined by talking with community members to understand their needs, as well as through research, such as census data or a formal needs assessment. The services offered are intended to enable the social and economic integration of immigrants. The entities may also engage in organizing and participating in advocacy activities directed toward addressing policy issues, gaining or improving access to political institutions, and developing new discourses for understanding the unique conditions faced by immigrants. At the same time, these entities work to retain the customs and service delivery styles of the countries of origin. Specific services include educational programs, health care, housing assistance, job training, arts and cultural programming, recreational activities, and emergency services.

A characteristic unique to culturally specific service providers is that they often hold an insider doctrine belief that, "You have to be one to understand one." This belief encompasses not only individuals who staff ethnic agencies, but also extends to those who found them. Employing bicultural and bilingual staff helps the agency relate to clients, advocate on clients' behalf, promote trust, enhance participation and cooperation, and recruit volunteers. However, because of a lack of ethnic human service personnel and/or funding to hire bicultural/bilingual human services professionals, culturally specific programs/agencies may need to rely on paraprofessionals for service delivery. The use of paraprofessionals has been criticized because they may be minimally trained, they may be former clients who still need services themselves, they may overidentify with clients, and they may not hold to professional confidentiality standards.

Efficacy

Research on culturally specific services is fairly recent, with the majority focused on Asian Americans and mental health. Initial research indicates that benefits exist for ethnic groups in human service access and use. The presence of culturally specific services can increase an ethnic community's ability to respond to the needs of the community. Many immigrant-oriented organizations provide comprehensive human services and fill an important gap within the service delivery system for ethnic minority communities. For Asian Americans, culturally specific services have generally been better received than mainstream services. When both are available, Asian Americans have been found to use culturally specific over mainstream public-sector services. The social aspects of culturally specific services increase likelihood of participation. Studies have found that culturally specific services in a counseling center reduced service inequities for Asian Americans. In comparison studies with mainstream services on mental health, Asian American clients using culturally specific services reflect an increase in service use, higher return rates, and shorter delays in seeking treatment. The research on outcome measures related to culturally specific mental health programs has been mixed. Common concerns are that several studies use a common database, cross-cultural validity may be compromised, and they may be insensitive to ethnic differences. Additionally, many of the programs and interventions on which they were built do not appear to have been rigorously evaluated.

The use of culturally specific interventions has been suggested in order to address human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) in the African American community. There also exists a general need for culturally specific addiction recovery programs; specifically, substance abuse prevention programs relevant to the African American community. Research with African American clients has focused on the variable of ethnic matching within ethnic-specific mental health services, wherein results have been inconsistent. Preliminary research also indicates that ethnic-specific alternative medicine modalities exist among diverse populations.

The recent development of the culturally sensitive approach has the goal of creating or re-creating programs and organizations that will be more culturally responsive to minority groups. As the population of the United States continues to diversify and the immigrant population continues to increase, the need for culturally sensitive social service interventions will continue to grow. As a result, mainstream entities and ethnic community members may strive to develop a pluralistic model of service delivery. To work with culturally specific programs and agencies, human services professionals may need to consider the important role that these programs/agencies play in providing effective services to local ethnic communities. Practitioners may also examine how to partner with culturally specific programs/agencies to better serve the growing ethnic and racial minority populations.

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See Also: Culturally Diverse Practice, Definitions of; Help-Seeking Behavior, Cultural Differences in; Service Providers and Diversity.

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D

Daniel Memorial Institute Independent Living Skills System

The Daniel Memorial Institute Independent Living Skills System (DMA) is a measure of independent living skills and one of the most widely used instruments in the United States foster care system. Independent living programs across many states and Canada use this measure as their main strategy for assessing and teaching independent living skills to youth. This easy-to-use and practical instrument measures and tracks progress across time. However, despite its frequent use in foster care and youth correctional facilities, no presently available published data demonstrate its reliability and validity across various populations.

Development of the DMA

The Independent Living Skills (ILS) system was originally developed in the 1980s by Daniel Memorial's Independent Living Program staff for use with the youth in their program. Previously, staff would informally assess living skills by observation. However, when attempting to assess hundreds of skills, this task would become burdensome, often taking weeks for assessment. In addition, examiners often would simply ask the youth whether they were competent in a particular skill, which could result in inaccurate assessments when the youth overestimated their abilities. The initial DMA (a list of 231 skills) was developed to assist staff in creating a structured manner of assessing and identifying strengths in independent living skills. Through a grant from the Jessie Ball DuPont Foundation, the ILS software was developed in 1987 and was available nationally. Although the measure was initially developed to primarily target youth in the foster care system, it can also be used with young adults of any age.

Description of the DMA

The DMA is currently in its eighth version. Two different types of assessments were developed: an interview assessment and an objective assessment. The interview has long-form and short-form versions. The long-form interview consists of 231 questions rated as pass or fail by the examiner across 16 categories of independent living, including money management/consumer awareness, food management, personal appearance, health, housekeeping, housing, transportation, educational planning, job-seeking, job maintenance, emergency and safety skills, knowledge of community resources, interpersonal skills, legal skills, religion, and leisure activities. Administration time is approximately one and a half hours for experienced examiners. The short-form interview contains 90 questions in 14 categories (the leisure activities and religion categories are omitted). Administration time for the short-form interview is approximately 30 minutes; the difference between the forms is the level of comprehensiveness.

The objective assessment was developed following patient and professional recommendations. It is a self-administered, multiple-choice measure with four answer options, and ten true/false statements. The objective assessment also has long and short forms, consisting of 231 question and 90 questions, respectively. One of the main benefits of the objective assessment form is that the test can be administered to youth in a group setting, it can be administered over several sessions, and it does not require an examiner to recite the items.

The test developers found the interview format to be more valid than the objective assessment; however, the objective assessment is more reliable than the interview test due to better test-retest reliability of youth's scores across time. It is recommended that, when possible, examiners use the long form of the interview test for a valid and comprehensive assessment. Developers also caution that when using the objective test, youth reading ability and comprehension problems can directly affect the test results, as a sixth-grade reading level is necessary for administration. Both versions of the measure can be scored manually through the use of an answer key or by computer software provided by the developer. When computer scored, the program creates a skill plan, ranging from 15 to 40 pages, recommending goals and strategies for a care provider to address any skill deficits.

Strengths and Weaknesses

As previously stated, the DMA has become one of the most widely used measures of independent living skills. The DMA is easy to use, contains multiple-choice items, and can be completed relatively quickly. The DMA can be used as a pre- and post-intervention assessment tool for program evaluation or effectiveness. However, later literature evaluating the psychometric properties of the DMA revealed that the measure demonstrates weak reliability and validity. Critics have also noted that the measure fails to address other important skills that at-risk populations face, such as mental and physical health, sexual risk-taking and disease prevention, parenting ability, and criminal involvement. An additional criticism is that the measure is not standardized and does not contain a comparison normative group because it was developed to determine knowledge of skills leading to an individualized plan for each youth. The results of this psychometric study suggest that further evaluation and revision of the DMA is needed for it to be considered a valid and reliable measure of a youth's preparedness for successful transition into independent living.

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See Also: Ansell-Casey Life Skills Assessment; Foster Care Agencies; Life Skills Training.

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Day Care for Children

The first day care facility in the United States was established in Boston in the 1840s. First known as day nurseries, child care began as a by-product of the Industrial Revolution. As American cities experienced rapid population growth through an influx of immigrants as well as laborers from around the country, social reformers became increasingly concerned with the problems associated with the overcrowding of urban areas. Social reformers tackled a variety of welfare issues, many of which pertained to the safety and care of children. As a result of their efforts, child labor laws were passed, settlement houses were founded, playgrounds were built, and day nurseries were established.

During the Progressive era, middle-class and wealthy women spent much of their time in social clubs. These organizations often began with the purpose of attending to social and cultural agendas, but as the problems of the time period became more apparent, many clubs embraced new missions and shifted their focus to service and social change. The plight of unsupervised children on city streets became an issue of grave concern to many women reformers, and they responded by creating day nurseries. The ideological foundation for this early form of day care was one of benevolence. Social reformers saw women's work in the paid labor force as an unfortunate situation and were concerned with the safety of the children mothers left at home. Day nurseries were designed to provide a homelike environment and were focused on improving the lives of needy children and their mothers. This included helping immigrants to assimilate to American culture and educating children and mothers on topics such as nutrition and hygiene. In general, the end of the Progressive era marked the end of day nurseries, which came to be negatively regarded as charity projects and sometimes took on orphanage-like qualities.

Beginning in the early 20th century, as the popularity of day nurseries diminished, nursery schools emerged as a new form of day care for children. Nursery schools were modeled after existing schools with an emphasis on early childhood development. However, nursery schools were neither designed to meet the needs of poor families because parents paid to enroll their children in these programs, nor were they designed to meet the needs of full-time working mothers because the school day was typically only a couple of hours long. Instead, the objective of nursery schools was to help foster the social and emotional development of children through interaction with others in a group care setting. As a result, mothers enjoyed the benefits of a few hours of day care. With the focus on educating children, nursery schools helped destigmatize the practice of enrolling children in group day care programs.

Changes in women's participation in the workplace began in the 1930s, then dramatically increased during World War II, and then continued throughout the women's movement and beyond. These changes have resulted in related changes in the structure and assumptions surrounding day care for children in the United States. During times of crisis, the federal government has also validated the need for day care by subsidizing temporary child care programs.

During the Depression, for example, the federal government established emergency nursery schools. The primary intent of these schools was to provide work opportunities for unemployed teachers, but the service provided by these jobs was child care. Throughout World War II, the Lanham Act helped fund day care for children whose mothers were working in wartime industries. While assisting in legitimizing the value of nonmaternal child care, these efforts offered only short-term solutions. It was not until the Comprehensive Child Development Act of 1971 that the federal government laid out a plan for long-term subsidized child care. However, the plan never came to fruition, as President Richard Nixon unexpectedly vetoed the legislation. Although many may argue that a negative stigma continues to surround the institution of day care, attitudes have shifted from seeing day care as a charitable service for extraordinary circumstances to a normative solution for working parents.

Day Care Today

According to census data, in 2011 more than 60 percent of all children in the United States under the age of 5 years (more than 12 million children) participated in some form of day care. On average, these young children spent 33 hours per week in the care of others, and their parents spent more than $9,000 a year on child care expenses. Today, day care for children takes a variety of forms including care by relatives, in-home babysitters, home day care centers, child care facilities, nursery schools, preschools, Head Start programs, and before-school and after-school enrichment activities (e.g., sports and clubs). One of the newest types of day care to emerge are 24-hour day care centers. These facilities are designed to meet the needs of parents who work nontraditional hours and are in need of evening or overnight child care.

Care by a relative is the most common practice, but approximately one-third of children younger than 5 years of age are cared for during the day by a nonrelative, often in formal day care centers and preschools. Because the majority of the day for children aged 5 to 14 years is spent in school, they are less likely to be enrolled in an organized day care situation; they are most likely to be cared for by a relative such as a grandparent or older sibling. However, 15 percent of school-age children are enrolled in before- and/or after-school enrichment programs, which can serve as day care. Older children increasingly take care of themselves; estimates suggest that more than 4 million school-age children are responsible for self-care.

Research indicates that children who spend time in a high-quality day care setting benefit from a positive impact on cognitive abilities and academic success; they do better in math, language, reading, and other subjects than children who do not attend high-quality day care. However, there is also evidence to suggest a relationship between time spent in day care and behavioral problems in school. Studies indicate that day care effects, both positive and negative, can have long-lasting implications on children's success in school, even in the teen years.

The Future

The future of day care in the United States needs to account for the inequities associated with the current child-care structure. Not all parents have access to affordable, reliable, quality day care for their children. Even though low-income workers may be eligible for financial assistance, many find long wait lists or even a depletion of funds when they apply for child care subsidies. Some low-income parents enroll their children in Head Start and universal prekindergarten programs, but not all programs extend into the summer, and parents with irregular work schedules may face additional obstacles. Moreover, day care, like most care work, is a female-dominated occupation that employs many women of color. It is well documented that these workers, many of whom may need day care for their own children, are among the lowest paid workers in the labor force.

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See Also: After-School Services; Department of Education, U.S.; Early Childhood Development; Early Childhood Literacy; Head Start and Prekindergarten Programs.

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Day Treatment Centers

Day treatment centers provide nonresidential services to clients. There is a great need for day treatment centers because they provide educational and support services for many of the youths who become involved in the criminal justice system. The services also address the needs of at-risk youth and juvenile and adult offenders to provide support and follow-up services. Because the services are community-based and nonresidential, clients have easy access to the services at a relatively lower cost compared to residential services.

Day treatment centers are facilities that provide structured, comprehensive, holistic services to clients. These services reduce deinstitutionalization among at-risk youths and juvenile offenders. Day treatment centers are classified as alternate or community corrections. The center provides intensive supervision for clients in that they are required to report on a daily basis. The services are somewhat similar to correctional treatment methods offered by some halfway houses. Program staff at these community-based centers will also address issues related to both the home and neighborhood of the clients. These may include home visits, comprehensive counseling, individualized cognitive-behavioral treatment services, and family integration and drug testing. Historically, day treatment centers originated in Great Britain in the 1970s, however to date several treatment centers are in operation in several cities across the United Kingdom, Canada, and the United States.

Role of Day Treatment Centers

The center provides intensive supervision and supervised placement in order to fulfill the court-appointed requirement of mandatory school attendance as part of probation. The center is also a good alternative for clients who have experienced some degree of failure within the regular school setting. Students with positive outcomes may be redirected to their original educational institution, whereas those with negative outcomes may be directed to a residential facility such as foster care or a juvenile facility.

Day treatment centers seek to provide a comprehensive program of academic training, behavior modification, and close supervision and monitoring of its clients. Day treatment programs provide specialized services designed to meet the unique needs of each client and his or her family. Programs seek to provide an effective balance between treatment, education, and sanctions in order to redirect troubled youth and address the special needs of groups such as at-risk youths, ex-offenders, or current offenders. The ultimate goal of a day treatment program is to provide the type of supervision and monitoring that will improve community safety and reduce or prevent future delinquent behavior.

Day treatment programs are usually small and community based. Hours of operation are generally 9 A.M. to 5 P.M., Mondays through Fridays; however, evening and weekend programs are sometimes provided. The average length of stay in the program varies. However, the duration of a treatment program is based on consideration of a number of factors, including the existence of underlying conditions such as mental health illness and/or drug abuse. Treatment during a typical day may include evaluations and testing, physical activity, group therapy, psychoeducational sessions, skill building, individual therapy, and psychopharmacological assessments.

Services Provided by Day Treatment Centers

The services at the day treatment centers are diverse and embrace different conceptual approaches. Some of these approaches include cognitive-behavioral therapy, which addresses anger, mental health, behavior, and substance use treatment needs; motivational enhancement therapy, which addresses substance use treatment needs; aggression replacement training to address anger, skills deficits, and moral reasoning; and motivational interviewing for rapport-building and developing and reinforcing positive change. The different approaches are used to address the differing needs of the clients. The programs may include educational, behavioral, counseling, and recreational services. The program is organized to provide a typical classroom schedule and setting with highly individualized instruction.

The programs may also include individual and group counseling, recreation, education, vocational training, employment counseling, life skills and skills training, substance abuse treatment, and resource referrals. Provision of specialized programs are also available for the treatment of selected conditions such as alcoholism and substance abuse, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

The Substance Abuse and Mental Health Services Administration reported in 2007 that approximately 23.2 million Americans, or 9.4 percent of the U.S population, are in need of substance abuse treatment. It also suggested that approximately 7 percent of the clients are juveniles, based on previous treatment records. There are large numbers of treatment facilities in all 50 states and the District of Columbia; these range from private to public nonprofit service agencies. An estimate of the number of treatment facilities based on the National Survey of Substance Abuse Treatment Services facilities in 2011 indicated that approximately 12 percent of facilities offered outpatient day treatment or partial hospitalization services

Although many centers may focus on postadjudicated juvenile delinquents and youths who are at risk for involvement in the criminal justice system, the day treatment centers also accommodate adult ex-offenders. Most of the day treatment centers are similar, but they may also differ based on the target population, entry requirements, services offered, goals of treatment, caseload, and requirements of completion. For example, eligibility may be determined by a number of factors such as seriousness of the current offense, criminal history, and the treatment needs of at-risk and delinquent youth.

Evaluation of Day Treatment Programs

Research reports suggest that although day treatment centers have operated for over 30 years, there is little evidence of adequate program evaluation. The reports that exist primarily address evaluations for adult offenders. Some of the program evaluations show inconsistent results because the reports do not always confirm a consistent contribution to the reduction of recidivism rates for offenders.

Because day treatment centers are primarily used by juveniles, there is a need for more extensive and systematic evaluation of the program impact on juveniles. However, current reports suggest that youths who completed the nonresidential program were less likely to be rearrested, adjudicated, or convicted within 12 months of release compared to youth who completed a residential program. The day treatment center seeks to reduce recidivism and improve prosocial behavior outcomes, particularly among youths.

Day treatment centers are cost-effective because they allow program participants to return home at night; therefore, they do not have the costs associated with residential facilities. Ultimately, a day program will seek to improve community safety and provide a wide range of services to reduce future delinquent behavior, as well as provide intensive supervision and support. Day treatment centers also provide a least restrictive environment program that satisfies both the individual's treatment needs and the needs of the family or community.

Day treatment centers provide interventions for individuals who have been involved in, or who are at risk of, future involvement in the justice system. One of the strengths of the day treatment program is that it reintegrates and supports family life, which can significantly contribute to reducing recidivism. It is important that clients be engaged in the program for an adequate amount of time in order to achieve effective service that will reduce the likelihood of recidivism. It is also important that there be systematic and structured program evaluation so that best practices can be identified. Additionally, day treatment centers have a great potential to be successful because they are multidimensional, and different aspects of the program can be modified in order to address the specific needs of a client.

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See Also: At-Risk Youth Services; Community-Based Services; Juvenile Delinquents; Rehabilitation Centers; Youth Risk Behavior Surveillance System.

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Deaf/Hard of Hearing

Deafness is one of the most commonly occurring disabilities. Though there is a relatively low incidence in children, its incidence rapidly increases with age. National statistics for the adult U.S. population indicate that approximately 17 percent has some degree of hearing loss, from mild to profound. A population of this size makes it likely that a human service agency, clinic, or program would encounter someone who is deaf or hard of hearing as a client. Additionally, with the overall population aging, there are increasing numbers of individuals who fall into these categories. Given this growing incidence of deafness and hearing loss, it is concerning that current therapeutic approaches in mental health and other areas remain inadequate in serving the needs of deaf and hard of hearing clients, even after decades of activism and demands for change. There is thus a need for a reframing of services that consider both the uniqueness of the needs of this population and the ways that these clients' needs are the same as those of all clients. This reframing can be informed by a service model based on a social justice orientation that assumes that all deaf and hard of hearing clients have a fundamental right to appropriate and informed care. This model can be viewed as an extension of the current emphasis on the need for service providers to be trained in cultural competency.

Cultural competency is a requisite set of beliefs, knowledge, and skills that practitioners should abide by in working with clients of any background (including backgrounds that differ dramatically from their own). Consideration of culturally competent service provision typically focuses on meeting the needs of members of various racial and ethnic groups. However, by extending this model into the realm of services for deaf and hard of hearing people, it is possible to develop a set of guidelines that improve such services in meaningful and transformative ways. This extension is predicated on the view that: members of deaf culture represent a legitimate cultural and linguistic minority group, and disability status represents an individual's membership in an underserved (and often misserved) group.

People who are deaf or hard of hearing vary on dimensions of age of onset of the hearing loss, degree of hearing loss, educational experiences, language skills (both in English and in American Sign Language [ASL]), and cultural identity. Members of deaf culture use ASL as their primary language. Their view of deafness is based not on a lost ability, but instead on a shared language, common experiences in interacting with the hearing majority, and a visual orientation to the world. Deaf culture has norms that are distinctive to the deaf community. Significantly, many do not long to become hearing, but instead prefer their deaf way of being in the world. In contrast, people who are hard of hearing or who become deaf later in life tend to experience their deafness from the perspective of disability. That is, they interpret their status as a deviation from the norm of hearing, and thus as a loss. They move through a dynamic process of adjustment to their "impaired" status. Regardless of whether individuals identify as members of deaf culture or as people with impaired hearing, they experience the prejudice and discrimination of the hearing majority. Because of the pervasiveness of this discrimination, it is necessary to construe the provision of social services for deaf and hard of hearing individuals within the context of human rights.

Two laws, the Americans with Disabilities Act (1990) and the Rehabilitation Act of 1973, were designed to address discrimination against people with disabilities and to promote their full participation in society. These laws require accommodations (e.g., interpreters and telecommunication access) for people with disabilities in both private and

A deaf, hard of hearing (HOH) or speech-impaired person communicating via a Video Relay Service video interpreter. There are a variety of agencies, organizations, and associations in the United States that advocate for individuals who are deaf and hard of hearing. Services are delivered in a variety of ways, including access through multimedia Web sites.

public settings. As public settings, mental health and other human services must be prepared to provide culturally appropriate and effective communication access to permit meaningful participation. In accordance with these requirements, regardless of whether an individual identifies as a member of deaf culture, or instead identifies as hard of hearing or late deafened, there is a need to invoke a social justice perspective that construes the receipt of appropriate services as a fundamental human right.

The current state of service provision in mainstream therapeutic settings privileges oral and auditory forms of communication. Implicit in this privileging is the assumption that the client has typical speech and hearing. From the moment that this assumption is not fulfilled, practitioners become de-skilled because the skills upon which they typically rely (e.g., the skills of traditional talk therapy) cannot be implemented. In order for practitioners to acquire the requisite skills to provide deaf and hard of hearing clients with the services to which they are entitled, it is necessary to follow a set of guidelines for competent care.

Providing competent care for individuals who are deaf or hard of hearing is complicated by the diversity that exists in the population (e.g., those who identify with deaf culture, and those who identify as impaired). Nonetheless, minimum guidelines include (1) providing in-service training in deaf culture and hearing loss; (2) learning culturally appropriate and effective strategies for sign language, such as oral and written communication with deaf or hard of hearing people; (3) developing a protocol for assessing the communication preferences of deaf or hard of hearing clients at the outset of services; (4) establishing relationships with local interpreter referral services; (5) hiring at least some deafness-skilled practitioners; (6) adapting written materials (such as confidentiality notices) into simpler English; and (7) establishing collaborative relationships with local deafness service providers.

Following guidelines such as these provides not only an opportunity to ensure that deaf and hard of hearing clients receive the highest quality services possible, but also allows practitioners to become better trained. The integration of basic preparation for working with deaf and hard of hearing clients into mainstream training should become standardized within and across training programs for those who will be working in social services. Additionally, following such recommendations can assist service-providing agencies and organizations in enacting a socially just framework of care that recognizes the fundamental rights of all clients, regardless of culture or ability status.

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See Also: Communication Disorders, Services for; Communication Styles, Ethnic and Cultural Differences in; Language Assistance.

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Death and Dying, Cultural Attitudes Toward

While death and dying are important themes across cultures, attitudes toward preparation for dying, funeral rites and customs, and discussion of the subject vary by culture. Human service professionals often work with clients from wide-ranging ethnicities, cultures, and backgrounds. It is imperative that human service professionals recognize different ways of acknowledging and honoring death and dying throughout the world in order to provide culturally competent care. Often, the cultural attitudes of a group are informed by their religious beliefs, so there may be consistency across otherwise very diverse groups of people. For instance, Catholics across North America and most of the world share similar funeral rites for the dead, and believe that death is a natural part of life.

Almost 98 percent of those in Greece are members of the Eastern Greek Orthodox Church. Within this context, a physician will communicate the diagnosis of a terminal illness to family members of the patient, and the family decides if the person is strong enough to withstand hearing the news. At times, the person with the illness may attempt to comfort his or her family members, while for others the subject may be completely avoided. Neighbors and family are supportive of each other, and may provide plentiful food as a caretaking gesture. After a person's death, the family does not eat meat for 40 days, and music is avoided for two years. Burial tombs face the east, and families are buried together. Cemeteries have pine trees planted along the inside wall to ward off evil spirits. After the funeral service, a meal of fish is served to relatives.

While some assume attitudes regarding death and dying are constant across the African continent, there is a wide variety of practices and beliefs related to death. Even among South Africans, there exists a diversity of opinion on the subject. For instance, indigenous South Africans believe that death merely separates a person from physical and spiritual realms. Regardless of religious beliefs, for many in South Africa, death is inevitable. For Islamic Muslims living in South Africa, death is considered one's fate, and to challenge this fate is considered disrespectful. Those of Tswana indigenous background are careful to practice certain funeral rites and activities, such that death does not negatively affect the survivors of the dead. In this way, death is not an ending. The afterlife is a consistent belief, with some specific ideas regarding a gathering place called Aalamé burzakh.

African Americans often wish to care for a dying family member at home. This is not universally accepted because some people believe that this practice is linked to bad luck. Although advance directives (i.e., a do not resuscitate order) may not always exist, some reports have shown that African Americans will favor life-sustaining treatment.

Around 80 percent of those living in India are Hindu, while 12 percent are Muslim. Approximately 2 percent are Sikh. For those who are dying, most are likely to accept their fate as the will of God. Hindus believe in reincarnation, a continuous cycle in which the soul is reborn. They also believe in karma, the idea that one's actions will result in consequences that are carried over into the next life. Neighbors and friends are often considered family, and will bring food to a family and comfort them. It is often believed that life should not be extended by extraordinary means, though pain medication and herbs would be accepted. Death is often celebrated as liberation. A woman would be prepared for the funeral wearing a sari, gold jewelry, and sandals, while a man would be dressed in traditional clothing. Mourners would wear white to signify peace and calm. Wood would be stacked into a funeral pyre and the unembalmed body placed at the top. Family and friends form a circle around the pyre and offer prayers. Once cremated, ashes are taken to the nearest body of water, or the Ganges River if possible.

Among traditional Chinese, a "good death" is wished for, meaning a peaceful, natural death at home, in the absence of life-sustaining interventions. The presence of family and the fulfillment of obligations would be important. Suicide and euthanasia are accepted by many as possible routes to ensure a "good death." Dying with a full stomach is important, and is tied to beliefs about reincarnation. Discussing death and dying is thought to bring bad luck, and such a discussion in front of a person who is dying is considered rude and disrespectful. Advance directives are an uncommon practice among the Chinese. Upon dying, money, food, and other items are placed around a person's coffin. Those who are grieving wear black armbands and white strips of cloth around their heads. The Chinese government requires the body to be cremated, and the ashes are generally buried in a grave with other family members.

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See Also: Chinese Americans; Culturally Specific Services; Do Not Resuscitate Order.

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Deinstitutionalization

Historically, the lack of knowledge about effective care and treatment of the mentally ill, as well as fear and stigma, led to large numbers of patients being housed in institutions. Patients were held for extended periods in these psychiatric institutions, where they received care, but interventions often were unsuccessful and, at times, abusive. These abusive conditions were made public through documents distributed by reformers.

Concern about neglect in mental hospitals led to an interest in developing options for the care of patients within the community. The movement was called "deinstitutionalization." However, this effort at improving mental health care was fraught with problems because it lacked coordinated public planning. In addition, a lack of cultural sensitivity led to an even greater impact on the poor as well as ethnic and racial minorities. The term *deinstitutionalization* is now used most frequently in regard to mental health treatment, but it was used originally to classify a large-scale social reform movement devoted to several human service areas, including mental retardation, criminal justice, and juvenile delinquency.

History

As early as the 1860s, Dorothea Dix began to write about overcrowded and inhumane conditions in psychiatric hospitals. In 1908, Clifford Beers, after being released from a state institution, published *A Mind That Found Itself*, an exposé of conditions inside state and private mental institutions. In the United States, interest in programs to improve mental health grew during World War II when some draftees were found unfit for service due to mental illness.

In 1946, the National Mental Health Foundation was founded by conscientious objectors who had served as attendants at state mental institutions during World War II. They worked to expose the abusive conditions at these facilities, and this became an early impetus in the push for deinstitutionalization. At the same time, the U.S. government began to fund research into treatment and prevention of mental illness with various initiatives; one was the formation of the National Institute of Mental Health (NIMH). The NIMH refers to deinstitutionalization as a process put in place to prevent inappropriate admission and confinement of the mentally ill in institutions and to provide community support systems for mental health services.

During a congressional address in the early 1960s, President John F. Kennedy discussed the need for reforms in mental health. Around that time, the Joint Commission on Mental Illness and Health, a federal agency, released a report titled *Action for Mental Health.* This report cited the extreme costs of institutional care, the lack of therapeutic effectiveness of long-term care, and the deplorable conditions in many large public institutions. Simultaneously, reformers and mental health advocates determined that the care in these institutions was often worse than the effects of mental illness. They began to lobby for the release of these patients into community settings, or deinstitutionalization.

The federal government provided funding to support the release of patients with the passage of the Community Mental Health Centers Act of 1963 and its amendment in 1965. This act appropriated federal funds for the construction of community mental health centers with a goal of diminishing the state mental hospital's role as a major resource for the mentally ill. The plan was to establish a program of federal, state, and local services in the community. The services were to provide prevention, early detection, treatment, and rehabilitation for the mentally ill with case management, counseling, and a clinic to distribute antipsychotic medications.

The discovery of psychotropic drugs in the 1950s is commonly believed to be the start of massive deinstitutionalization. However, from 1955 to 1965, public hospitals decreased in size only about 1.75 percent on average because of a lack of places to send patients. The late 1960s and early 1970s were years of increasing community discharges, with the addition of many federal social service programs, such as Medicare and Medicaid. There was also a great increase in nursing home beds for elderly psychiatric patients and those with dementia. Inpatient hospital beds were being reduced at an average of 8.75 percent per year from 1965 to 1975. Between 1970 and 1973, 14 state hospitals were closed and others significantly reduced their bed capacity. This was a financial relief for the state governments that had been putting massive resources into maintaining these large institutions. States were able to shift the costs for mental health care to the federal government.

Important Factors Affecting Deinstitutionalization

The 1970s saw several judicial decisions regarding the civil rights of psychiatric patients. States were required by the courts to provide treatment, but many states failed to comply with the court mandate. The U.S. Supreme Court, in the case of *Donaldson v. O'Connor*, determined that mentally ill persons could not be confined if those individuals were not a danger to themselves or others and had the ability to survive outside the hospital. In addition, the Third Circuit U.S. Court of Appeals, in *Halderman v. Pennhurst State School & Hospital*, determined that inpatients should be treated in the least restrictive environment. In 1971, the U.S. District Court in Alabama, in *Wyatt v. Stickney*, ruled that all patients confined to institutions or residential schools had the constitutional right to individualized treatment to give them an opportunity to improve their mental conditions. That decision no longer allowed institutions or residential state schools to provide only custodial care, and this was a huge victory in the fight for community reintegration and deinstitutionalization.

Throughout the 1970s, the deinstitutionalization movement was progressing, and inpatient settings were downsizing at a fast pace. Initially, the federal government made a plan for 1,500 community mental health centers to be opened to provide inpatient, outpatient, partial hospitalization, 24-hour emergency services, and education to patients and their families. Unfortunately, a lack of funds available from the federal and state governments led to only 800 of these centers being built, with limited funding for staff. Throughout the 1970s, legislative revisions by Presidents Richard Nixon, Gerald Ford, Jimmy Carter, and Ronald Reagan resulted in further limiting the resources being provided to establish and maintain these centers. By 1981, no more federal funds were available.

The result was that patients were discharged into communities that were unprepared for their release. By the late 1970s, approximately 40,000 chronically ill psychiatric patients were released into New York City. The Upper West Side of Manhattan contained the largest concentration of deinstitutionalized patients in the United States, at 7,000. By the end of the 1990s, 93 percent of the state beds that were filled in 1955 were closed. States were motivated to participate in deinstitutionalization for financial reasons, whether alternative forms of care for the mentally ill were in place or not.

Community Response

In general, public information regarding abuse and lack of treatment in many institutions led to most community members supporting deinstitutionalization. However, communities were not receptive to large facilities for the mentally ill being built in their neighborhoods. Neighborhoods were more receptive to group homes for the elderly and developmentally disabled than the group homes for the mentally ill because the other groups were less stigmatized.

Successful community integration of the mentally ill was affected by a lack of knowledge and by fear, which created negative responses to these patients living in the community. Community boards often opposed housing for discharged patients in middle-class areas, resulting in housing options being available only in working-class or lower socioeconomic neighborhoods, where housing was less expensive. Therefore, high concentrations of discharged patients were being housed in areas that did not offer opposition. This situation forced many patients to be exposed to a hostile environment, deteriorated living conditions, and a lack of access to health and mental health facilities. In addition, some of these areas were riddled with drugs and other illegal activities, leading patients into vulnerable situations they could not manage or into becoming victims of crime or abuse.

The absence of planning for community living of the mentally ill caused discharged patients to be placed in settings with inadequate supervision. Discharged patients were sent to settings such as boarding homes, single-room occupancy hotels, or private homes. The lack of coordinated and essential services led patients back into the hospital, and cases of multiple admissions became known as revolving door cases. In addition, because of the lack of available services in the local communities, many discharged patients became homeless, turned to substance abuse, and/or turned to petty crime to support themselves. These individuals ultimately were housed in jails, shelters, or alternative care facilities such as nursing homes. The return of patients to locked settings is known as transinstitutionalization.

Studies indicate that mentally ill individuals are sensitive to social cues regarding their illness, and this has great bearing on their lives outside of institutions. Negative attitudes are often prevalent in working-class and ethnic neighborhoods. It is reported that social rejection is an enduring force in the lives of people with mental illness. Stigma has been found to be a persistent source of social stress, which leads to increased feelings of self-deprecation. This ultimately impacts the individuals' sense of mastery and ability to function in the community.

Factors in the Successful Return to the Community

The understanding of mental illness is culturally and socially defined. Some ethnic groups somatize mental illness through physical pain or with body and mood changes. Other groups may not express outward signs of struggle. If a community provider is not culturally competent, the care offered may not be adequate and may ultimately be rejected. Many minority groups have been found to lack involvement with community care, and have more unmet needs than their nonminority counterparts. Research has indicated that this difference is significant for African Americans and the lesbian, gay, bisexual, and transgender (LGBT) population.

Severely mentally ill individuals who have spent a significant amount of time in an institution often have lost ties with people in the community and therefore may have fewer resources to draw from when released. Those from lower socioeconomic groups often cannot count on housing or financial support from relatives or friends, making obtaining services more difficult for them than for those who have a more solid base in the community. In addition, the lack of financial means and referrals for social service benefits has an impact on the physical health status of these individuals as well, which furthers their distress and/or depression.

Although there is evidence that family involvement positively affects relapse rates and helps with managing symptoms, financial constraints do not always allow for the family to be involved in the treatment process. Access to mental health treatment for individuals and their families may be denied or limited based on insurance coverage. Often those who have health insurance incur the high cost of a deductible, or copay, for mental health services. Ultimately, those without insurance coverage for mental health interventions will not gain the benefit of the most effective recovery-based treatments and medications. Compounding the costs for effective care are issues related to transportation, family obligations, time constraints, and legal issues. These factors impede the uninsured, the undocumented, and many people living in rural areas from getting essential treatment in their communities.

Returning individuals to the community has been a priority for the mental health, prison, and juvenile social service systems. Education for providers on culturally sensitive and accessible care is essential in this process. Community education is also essential for these individuals to return to the community without stigma and oppression. With adequate resources, the mentally ill can live productive lives in the community.

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See Also: Long-Term Residential Care; Mental Health Service Delivery, Cultural Characteristics of; National Institute of Mental Health.

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Dental Services

Kyle Willis, an unemployed African American man without dental insurance but with a painful, abscessed third molar (wisdom tooth), went in desperation to an emergency room. He was prescribed pain medication and an antibiotic to treat the infection. Lacking sufficient funds, he opted to fill only the pain medication prescription for $3 but not the antibiotic for $27. The infection eventually spread to his brain, tragically killing Willis. This story serves as a stark reminder of the vital and potentially deadly issues regarding access to care and diversity in dentistry. What dental health disparities exist among members of the U.S. population that cause patients to seek dental care in an emergency room? What steps can providers take to meet the oral health needs of at-risk populations?

Dental Health Disparities

Dental disease does not affect all people equally. Latino preschoolers experience 2.5 times more cavities than white children, and African American children experience 1.5 times more cavities than white children. Approximately 34 percent of African American seniors are edentulous (have no teeth) compared to 20 percent of white seniors. Racial and ethnic minorities as well as other at-risk populations not only experience more dental disease, they also are less likely to access services and have poorer oral health outcomes. Dental conditions remain among the most common health problems for low-income, disadvantaged, disabled, and institutionalized individuals. This means increased tooth loss, dental caries (cavities), periodontal (gum) disease, as well as a lower quality of life due to overall systemic health implications. Diseases such as diabetes, cancer, HIV/AIDS, and heart disease can be significantly impacted by oral health.

To address these disparities, providers first should be aware of the inequalities experienced by at-risk populations and target their efforts to the greatest areas of need. In addition, providers should become culturally aware and realize that the greater the social and cultural distance between them and the patients they serve, the greater the potential for suboptimal encounters. The guidelines to accomplish these goals follow:

- Providers should utilize interventions based upon the best available scientific evidence.
- Providers should work to improve patient–provider communication, building trust, and enhancing shared decision making.
- Providers should tailor patient-level interventions to enhance self-management, self-efficacy, and patient empowerment.

Although disparities in oral health and access to care are multifactorial, a common link can be found in the separation of the medical and dental systems. This separation includes professional training, clinical care, continuing education, scholarly journals, research agendas, and financing, as well as health delivery systems. Therefore, if oral health disparities are to be addressed, interprofessional education and collaborative care models must be incorporated into the current training and delivery systems.

Cultural and Literacy Concerns

Cultural competence is required for all dental care providers. Cultural competence is having the ability to provide care to patients with diverse backgrounds, values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs. Cultural competence is more likely to be achieved by increasing the diversity among dental health providers themselves and providing linguistically appropriate services for patients.

Health literacy should also be considered when addressing oral health disparities. Health literacy is the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment. The National Adult Literacy Survey (NALS) estimates that approximately 23 percent of adults have difficulty using reading, writing, and computational skills for everyday tasks. Research also indicates that 41.6 percent of U.S. patients cannot comprehend directions for taking medication on an empty stomach. Therefore, providing oral health materials that are more understandable and are written at the appropriate reading level is vitally important. To better serve the oral health literacy needs of their patient's, providers can (1) use plain, not medical, language; (2) show or draw pictures; (3) limit the amount of information provided; and (4) encourage questions.

Human service workers can partner with dentists and health professionals to address the oral health needs of patients by developing partnerships for referral and care. These partnerships would assure that patients keep their dental appointments, take medication as prescribed, and follow up with care as directed. Likewise, human service workers can reinforce the importance of proper oral hygiene and regular dental care.

Medicaid Coverage

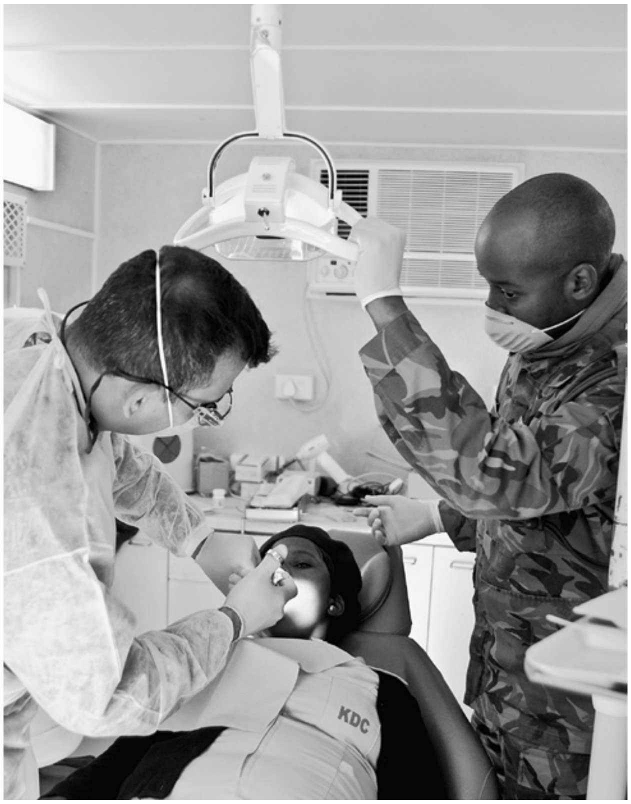
All states in the United States provide Medicaid dental programs for children from low-income families and for adults with special needs. Some states also provide limited Medicaid coverage for other adults. Historically, a low percentage of dentists participate in Medicaid because reimbursement levels tend to fall 10 to 20 percent or more below the breakeven overhead point. In other words, dentists tend to operate at a business loss when providing dental care for most Medicaid patients, whether children or adults. States vary in terms of requirements to participate in Medicaid.

In some states, dentists have the freedom to limit the number of Medicaid patients to children only or to patients within a geographic area such as a county. As an alternative to participating in Medicaid, some providers provide a significant amount of free care for some patients, although the extent of this charitable dentistry is not tracked. One of the areas of focus in the Affordable Care Act (ACA) is to increase access to dental services for children.

Other Options for Accessing and Providing Dental Care for the Underserved

Many state dental organizations organize yearly two-day events, called Missions of Mercy, in which volunteer dentists, dental students, and dental staff provide free dental services. (See, for example, http://www.adcfmom.org/Schedule.) Across many states and years, millions of dollars of dental treatment have been provided. Federally Qualified Health Centers (FQHC) and county or regional dental clinics often offer sliding fees or discounted dental services, making dental care more affordable, especially for those without dental insurance. A map of the FQHC locations in the United States is available at http://www.raconline.org/racmaps/mapfiles/fqhc.png.

Dental schools may also offer special dental treatment programs for community service or service learning opportunities for students. Some dentists and dental students may also volunteer to provide free or significantly discounted dental services through mission clinics (often faith-related) and school-based outreach clinics. A listing of U.S. dental schools can be accessed at http://www.ada.org/267.aspx.



Dentists serving in the U.S. Air Force work with the Botswana Defense Force to provide free dental services to underpriviledged civilians in Botswana.

Finally, a strong movement is currently underway to develop alternative models of dental delivery through midlevel providers such as dental therapists. Midlevel providers provide routine care such as restorations and simple extractions. These models are particularly, although not exclusively, focused on rural or remote areas that lack dentists. The long-term viability and effectiveness of these alternative models are being studied. Success in the future will ultimately depend on the ability of oral health professionals to provide quality and affordable care in order to meet the diverse oral health needs of the public.

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See Also: Health as a Human Right; Medicaid Service Providers and Diversity; Public Health.

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Department of Education, U.S.

The primary mission of the U.S. Department of Education (DOE) is to provide equal access, promote competitiveness, and make quality education accessible for all of its citizens. It also provides curriculum development and facilities improvement grants to schools, as well as financial aid (e.g., loans, scholarships, and grants) to students. In addition, the DOE fights discrimination based on gender, disability, race, and language, among others, which can harm and discourage the disadvantaged and minorities who seek to have access to education. The DOE offers services to diverse populations and supports and promotes inclusion of all citizens with regard to learning and teaching that is intended to prepare students for the 21st century globalized world.

Historical Background

The DOE has a long history that dates back to its establishment in 1867 by the U.S. Congress. Its purpose was to support educational improvements as well as collect information and statistics about the nation's schools. However, because of the fear that an education department would have too much control over state and local schools, the department was reduced to an Office of Education in 1868. Then that small office operated under other federal agencies, including the U.S. Department of Health, Education and Welfare, and the U.S. Department of Interior.

As a result of social and political changes in the 1950s and 1960s, federal funding for education increased. Thus, the role of the federal government in education expanded gradually, with the main purpose being to pass funds from the national level to states, districts, and higher education institutions. Also, the creation in the 1960s of federal programs to reduce poverty and protect civil rights resulted in a dramatic increase in federal funding for education at all levels. Furthermore, in the 1970s, in order to fight issues of discrimination of minorities under the civil rights laws, the functions expanded to cover discrimination based on gender, disability, and language.

The U.S. Department of Education was created as a federal Cabinet-level entity in 1979. President Jimmy Carter was not only instrumental but was also a strong advocate of a department that would serve and provide various functions and services to students and educators alike. But pundits and Republicans argued that this type of department was unnecessary and deemed it to be unconstitutional. They argued that education was not mentioned in the U.S. Constitution and this was another federal bureaucratic intrusion on state and local affairs. However, both liberals and Democrats supported the DOE, recognizing its value and necessity. They believed it to be constitutional under the commerce clause, and argued that the funding role of the department was constitutional under the taxing and spending clause. In addition, among many supporters of this department was the National Education Association.

In 1981, President Ronald Reagan publically announced his intention to abolish the DOE, but his efforts were unsuccessful. He abandoned the plan and focused on the need for school reform that intensified during the 1980s. At that time, issues were paramount with regard to declines in student achievement and standardized test scores. There was concern about the effect these issues could have on U.S. educational competiveness compared to other nations. It was also believed that education was linked to the economy of the United States and may have played a role in strengthening the economy of the United States in relation to other countries.

To address the crisis in education, various states initiated reforms that were aimed at improving the nation's educational system and student achievement. These state-level reforms were encouraged and supported by the DOE's National Commission on Excellence in Education. In 1983, the influential book *A Nation at Risk* was published, and it became an important study for educators and school reformist alike in their efforts to make positive changes in education. In addition, throughout the 1990s, the DOE played a pivotal role in making sure that assessment standards would hold students, teachers, and schools accountable for a higher level of academic attainment.

President Bill Clinton tried to tackle the problem of the student achievement gap in education by enacting goals in 2000 aimed at helping states set high standards for schools and students alike. Clinton also offered and expanded public school choice and supported public charter schools. In addition, the gap was noted in grades by policy makers and educators, among others, in terms of standardized test scores, dropout rates, college completion, and other success measures. For instance, African American and Hispanic students had a lower academic performance when compared to white students. Disparities were also noted among students with regard to family income, gender, learning disabilities, and English-language proficiency. This spurred government action to make positive changes by creating new programs and investing in school reforms.

Later, President George W. Bush signed the federal No Child Left Behind Act of 2002, which focused on standardized tests, school accountability, student assessment, and achievement proficiency in reading and math. Despite the fact that, based on data from the National Assessment of Educational Progress, Hispanic and black students had made great strides in improving performance in reading and math, these students still remained behind their white peers, and the student achievement gap still existed.

The Obama administration has initiated the Race to the Top (RTTT) program, which provides financial incentives to states that provide scholarships and other financial aid mainly to African American and Hispanic students, as well as to others. The aim of these initiatives and programs are to narrow or eliminate the achievement gaps of various student groups, improve student academic performance, and increase school graduation rates. In addition, RTTT focuses on giving grants to help schools to become competitive and assist in closing the gap between low- and high-performing schools.

Functions of the U.S. Department of Education

The main functions of the Department of Education are to establish policies on federal financial aid for education, and to administer, distribute, as well as monitor funds that are given to qualified recipients. The DOE also collects data on trends of education, oversees research in U.S. schools, and disseminates this information to Congress, educators, parents, and the general public. It also identifies the major issues and problems in education and tries to address them through school reform and other avenues. The DOE makes sure that federal educational laws are enforced, which includes prohibiting discrimination in programs and activities receiving federal funds, addressing and resolving complaints of discrimination, and ensuring equal access to education for every citizen. In addition, it monitors and enforces laws regarding privacy.

It is critical to note that education in the United States is decentralized, meaning the DOE does not design curricula, establish schools and colleges, develop or implement testing, or set requirements for school enrollment and graduation. These are the responsibilities of state and local school districts.

The DOE serves diverse populations in various capacities. This includes supporting and promoting inclusion in educational settings, activities, and training, and providing financial assistance to multiracial, multicultural, and other groups. This has been particularly true with regard to supporting and advancing diversity in various levels of education, including higher education.

By giving financial assistance, such as scholarships, loans, and grants, to diverse student populations regardless of race, color, national origin, gender, disability, or age, more educational opportunities will be accessed by students, which will better prepare them for the 21st century. In addition, the DOE has created programs and funds that are allocated for educational purposes for children with disabilities, tribal and Native Americans, as well as other disadvantaged populations, such as families with low incomes, immigrants, women and girls in athletic programs, people in need of vocational rehabilitation, among others.

It is important to understand that federal programs are intended to benefit all students from all walks of life. As the challenges to diversity in academia persist, some scholars speak about the need to expand the circle of diversity in higher education. As a result of the continued increase in the multiracial and multicultural U.S. population, there is more likely a need to take a new look at diversity and inclusion, as well as providing new and various services for a diverse population that would assist in their educational and training needs. It is essential that the DOE continue to tackle challenges of inclusion and diversity of its citizens by creating educational opportunities for all students and educators alike so that they can prosper in the competitive and globalized world.

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See Also: Adult Education Programs and Services; Educational Services; Educational Support Services; Ethnic Diversity and Values; Multicultural Education; No Child Left Behind Act.

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Department of Health and Human Services, U.S.

The concept of social welfare in which the government is responsible for providing a basic standard of living for all Americans was introduced by President Franklin D. Roosevelt as an essential element of his New Deal in the 1930s. Governmental responsibility for providing human services expanded still further with subsequent revolutions in education, civil rights, and consumer rights. The U.S. Department of Health and Human Services (originally the U.S. Department of Health, Education, and Welfare, or

HEW) has traditionally been responsible for dispensing services such as Medicare and food and medical assistance. Designed to provide a safety net for the needy, the disabled, and the elderly, the passage of the Social Security Act in 1935 and the establishment of the Medicare and Medicaid programs in the 1960s set the stage for significant federal government commitment to providing health and human services. Until 1979, HEW oversaw education in the United States and was responsible for the Head Start program created in the 1960s to provide school readiness for underprivileged children, thereby increasing their overall well-being.

In the 1990s, considerable criticism was leveled at the concept of welfare, and political conservatives were insistent that it should be a stopgap measure rather than a way of life. The result was a complete overhaul of the program, and a shift in the Department of Health and Human Services' (HHS) responsibilities to the American people. The success of programs overseen by HHS has been demonstrated by reductions in infant mortality, teen births, deaths from sudden infant death syndrome (SIDS), and the increased number of elderly people who manage to live on their own with only limited outside assistance. Nevertheless, there are still large gaps in the health status of whites and racial and ethnic minorities in the United States, as well as between those with socioeconomic advantages and those who lack them. Experts continue to implore HHS to dedicate more resources to reducing the rate of low-birth-weight and special-needs infants and the number of women having caesarean sections. In addition to providing access to health and human services, HHS conducts research on related issues, including the fields of food and drug safety and biomedicine.

Background

The Department of Health and Human Services was established in 1953 as the Department of Health, Education, and Welfare. When the Department of Education became a separate Cabinet-level department in 1979, HEW became HHS. From the beginning, the department served as a link between individual citizens and the government to which they looked for health and human service assistance. HEW grew rapidly, and changes were common as the department responded to the needs of a dynamic population. Within two decades of its founding, HEW was responsible for 200 federal government programs and was overseeing 13 agencies and 10 regional offices.

As part of the effort to overhaul the existing welfare program, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) replaced Aid to Families with Dependent Children (AFDC) with the Temporary Assistance for Needy Families program (TANF). Welfare reforms placed new emphasis on putting the poor to work. Since the largest segment of this group included single mothers and their dependent children, that effort involved providing extensive child-care assistance through HHS. The reforms also focused on reducing the rate of infants born outside of marriage and stepping up governmental involvement in collecting child support payments from noncustodial parents.

By 2008, HHS employed more than 67,000 people assigned to oversee the dispensation of the nation's health care and provide human services. One in every four dollars in the federal budget was dedicated to serving these needs. The 2012 budget for HHS, in millions, was $873,872, and that figure had grown to $974,594 by 2014. The largest shares of HHS financial resources are dedicated to Medicare (54 percent) and Medicaid (31 percent).

Organization

The Department of Health and Human Services is a Cabinet-level agency, and the secretary of HHS is responsible for carrying out its mission of helping "provide the building blocks that Americans need to live healthy, successful lives." The federal government's commitment to health-related services has evolved considerably since its first effort in 1798, when the government provided assistance to sick and disabled seamen. The divisions that operate under the HHS umbrella include the Administration for Children and Families (ACF), which was established in 1991. AFC has 1,287 employees and operated under a $47.73 billion budget in 2013. The Administration for Community Living (ACL), which was established in 2012 by merging the Administration on Aging and the Administration on Intellectual and Developmental Disabilities, has a staff of 148 and a 2013 budget of $2.07 billion.

Established in 1989, the Agency for Healthcare Research and Quality (AHRQ) is the research arm of the American Public Health Service. AHRQ has a staff of 314 and a 2013 budget of $0.43 billion.

Another arm of the Public Health Service is the Atlanta-based Agency for Toxic Substances and Disease Registry (ATSDR). The Centers for Disease Control and Prevention (CDC) is also based in Atlanta, and CDC is charged not only with disease control and prevention but also with dealing with national health emergencies and working with similar agencies around the world to deal with global health aspects. CDC was established in 1946 as the Communicable Disease Center; it employs 11,086 people and operated with a budget of $10.24 billion in 2013. The Centers for Medicare and Medicaid Services (CMS) oversee the Medicare program and work with states on health programs for the most vulnerable segments of the American population. Established in 1977 as the Health Care Financing Administration, CMS has a staff of 5,591 and a 2013 budget of $763.14 billion. The National Institutes of Health (NIH), which originated as the Hygienic Laboratory on Staten Island, New York, in 1887, is the oldest division within HHS. NIH is responsible for biomedical and behavioral research, and a large component of its role is training researchers and dispensing medical knowledge. NIH has a staff of 18,984 and a 2013 budget of $29.15 billion.

The Food and Drug Administration (FDA) was established in 1906 in response to passage of the Pure Food and Drug Act. FDA has a staff of 14,829 and a 2013 budget of $4.03 billion. Created in 1982, the Health Resources and Services Administration (HRSA) seeks to improve health care for Americans who are uninsured, isolated, or medically vulnerable. With a staff of 1,965, HRSA operated with an $8.10 billion budget in 2013. In 1992, the Alcohol, Drug Abuse and Mental Health Administration, which had been created in 1974, became the Substance Abuse and Mental Health Services Administration (SAMSHA). This agency has 627 employees and a 2013 budget of $3.35 billion. Until 1955, overseeing federal aspects of health services to American Indians and Alaska Natives was the responsibility of the Department of the Interior. Now operating under HHS, the Indian Health Service has a staff of 15,429 and a 2013 budget of $5.30 billion.

Health and Nutrition

The Department of Health and Human Services is commonly known as the federal health department because of its role in dispensing health care to targeted populations. Human service professionals as well as medical professionals acknowledge the importance of preventive health care and nutritional assistance in maintaining good health, and significant HHS resources are devoted to these aspects. In 2011, there were almost 74 million Americans between the ages of birth and 17, and some 22 percent of that population lived in poverty. Of those living in poverty, 39 percent were African American and another 34 percent were Hispanic.

Approximately 96 percent of the eligible poor receive nutritional assistance. In a study conducted by Children's HealthWatch, researchers found that programs such as the Supplemental Nutrition Assistance Program (SNAP) lead to reduced hospitalizations, improved academic performance, and long-term economic success for recipients. A second study conducted by the National Bureau of Economic Research revealed that the benefits of nutritional assistance for children lead to significant reductions in obesity, high blood pressure, and diabetes that continue into adulthood. Through increased spending on maternal and child health, HHS has played a major role in reducing the infant mortality rate in the United States, slashing it from 12.6 per 1,000 live infants in 1980 to an estimated 5.9 per 1,000 in 2013. The number of infants born to teenage mothers has also declined, decreasing from 61.8 per 1,000 in 1991 to 41.9 per 1,000 in 2006. Incidences of SIDS have also fallen, declining from 1.3 in 1990 to 0.6 in 2006.

As the baby boom generation continues to age, the number of elderly is expected to rise, doubling between 2005 and 2035. Thus, the demands on HHS will continue to increase. Studies on the use of preventive health care measures and prescription drug assistance for the elderly have proved that these measures reduce hospitalizations and delay the need for long-term care, resulting in benefits to the greater society as well as to individuals involved. The passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003 has proved successful in significantly improving the health of the elderly who no longer have to choose between medicine and food.

The three most important elements in keeping the elderly healthy is providing access to both physical and mental health care and keeping them involved in life. The trend toward assisted living and away from nursing home care is considered a major step in enabling seniors to retain this involvement.

HHS is involved in all three elements of providing health and human services to the elderly and in decreasing the number of seniors who are placed in long-term care facilities.

In all segments of the population, preventive care benefits such as those dispensed by HHS help identify diseases such as cancer in early stages, saving both lives and reducing medical costs. Assistance with prescription drugs helps keep diseases such as high blood pressure and diabetes under control and helps recipients when health crises do occur.

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See Also: Child and Adolescent Needs and Strengths; Child Welfare Services; Department of Education, U.S.; Disability Services; Group Homes for Adults: Head Start and Prekindergarten Programs; Medicaid; Medicare; Poverty; Race and Clients; Welfare Reform, Role of.

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Developmental Disabilities, Attitudes and Myths in Services for

A number of myths exist about people with intellectual/developmental disabilities. Some of these myths have been sustained over time and have become so ingrained in society that people take them as truths. It is important to recognize that these myths, which affect societal and personal attitudes, also impact the services that people receive and how they receive them.

A myth is a popular idea or belief that is connected to somebody or something, but is exaggerated or untrue. Sometimes a myth is used to justify the perpetuation of a certain state of affairs. Similarly, myths may reflect stereotypical attitudes toward something or someone, although they may also be challenged as unfair representations.

When people talk about attitudes, they are discussing the ways someone thinks or feels about something or somebody. These ideas or feelings are often evaluative in nature. However, people may not be explicitly aware of their attitudes toward certain ideas, objects, or people. People's attitudes may affect or influence their behavior.

Myths and attitudes can operate in tandem. For example, a myth may serve to perpetuate a certain set of attitudes, which may then further perpetuate the myth itself. Because attitudes are evaluative, it is helpful to understand (as Wolf Wolfensberger, who has written extensively about the devaluation of marginalized groups, and Hanoch Livneh suggest) that people do not evaluate or judge something or someone in a vacuum. Many factors can be at play, such as a person's direct or indirect experiences with the subject, childhood influences, the social environment in which they live, or their sociocultural conditioning, such as values, norms, and societal beliefs. Thus, both attitudes and myths can very much affect how people perceive and act toward issues and other people.

Intellectual/Developmental Disabilities

The terms *intellectual* and *developmental* disability are sometimes used interchangeably and have a long history behind them. Words such as idiot, imbecile, moron, and mental retardate were used as bona fide medical terms to describe certain classes of disabled individuals, but these words have become highly pejorative over time.

Today, the American Association on Intellectual and Developmental Disabilities provides a different definition: An intellectual disability is a disability that is characterized by limitations in intellectual functioning and adaptive behavior. Intellectual functioning refers to mental capacity, and adaptive behavior is the ability to perform conceptual, social, and practical skills. Usually these limitations are significant and manifest themselves before 18 years of age.

Historical and Contemporary Devalued Roles

People labeled as having intellectual/developmental disabilities have endured a difficult history. Many myths about these individuals have been created and sustained over time. Often these myths were built around a number of demeaning roles into which people with intellectual/developmental disabilities have been cast. According to Wolf Wolfensberger, some of these roles include (1) a menace to society or being evil in some way, (2) the subject of pity and charity, (3) the child who is never expected to mature into an adult, (4) the patient who is always sick and diseased, and (5) someone less than or not quite human.

Many of these mythical roles are deeply woven into the fabric of society and have negatively impacted public attitudes toward people with intellectual/developmental disabilities. It is helpful to look at some examples to better understand the power these roles have on society. These illustrations will help shed light on how myths have impacted and continue to impact human services and human service professionals.

The menace. From the late 1800s to well into the 20th century, residential institutions were seen as the answer to keeping society safe from people with intellectual/developmental disabilities, who were thought to be a menace to society on several levels. First, a commonly held belief was that their disabilities were linked to many of society's most pressing social ills—alcoholism, laziness, sexual promiscuity, and criminal activity. Second, it was thought that these behaviors were transmitted through their genes to subsequent generations. This link between moral behavior and genetics, coupled with the assumption of promiscuity, led to the passage of numerous laws prohibiting people with intellectual/developmental disabilities from marrying. When these laws proved ineffective, some states and provinces enacted sexual sterilization laws, allowing these individuals to be sterilized against their will and without their consent. The last of these laws was not repealed until the 1970s. The myth of the menace continues to live on today. For example, battles are still fought over whether group homes for people with intellectual/developmental disabilities ought to be allowed into certain neighborhoods, based on unfounded fears that the residents are sexual deviants or other kinds of menaces.

The object of pity and charity. There is a long-standing connection between people with intellectual/developmental disabilities and the ideas of pity and charity. This connection can be traced back to biblical times. Some of the earliest institutional facilities for affected individuals were started and run by various religious orders. However, to be seen as objects of pity disempowers people with intellectual/developmental disabilities and tends to elicit a paternalistic attitude from nondisabled people. Attitudes of pity and charity have not yet disappeared. Many disability organizations continue to be based on charity models, tugging at people's heartstrings for donations. Charity can be a problematic concept for those who receive it, as they are often portrayed as burdens on the goodwill of others. When donors no longer feel compelled to give, recipients are left unsupported. This mind-set becomes especially dangerous when it seeps into the provision of services. When the charity model becomes embedded in human service provision, basic supports become tied to unreliable sources of funding and the will of a government. This means that essential supports may be withdrawn at any time.

The child. As previously stated, people with intellectual/developmental disabilities have difficulties in intellectual functioning. This fact has often been interpreted as a declaration that these individuals are childlike and cannot do things for themselves, thus reflecting on a perceived incompetence. This idea of incompetence began circulating as early as classical

Greek and Roman times, when laws were enacted to provide for guardians to manage the affairs of people with intellectual/developmental disabilities. These laws became the basis for many of today's guardianship laws. Although laws have begun to change in favor of presumptions of competence, in practice the belief remains that people with intellectual/developmental disabilities cannot make certain decisions. For example, doctors, lawyers, and bank employees often require additional signatures on formal documents, even when an individual with an intellectual/developmental disability has the legal authority to sign on his or her own behalf. Organizations delivering services to people with intellectual/developmental disabilities may institute similar rules, thereby further reflecting the childlike role and downplaying their competence and ability to learn.

The patient. Ever since scientists and physicians began their quest to gain a better understanding of intellectual/developmental disabilities in the 18th and 19th centuries, people so diagnosed took on the role of the patient, notwithstanding the actual state of their health or well-being. In addition to seeing people with intellectual/developmental disabilities as perpetual patients, another related issue arose: the proliferation of professionals in various allied fields. Thus, people with intellectual/developmental disabilities became victims of the professional gaze. Many aspects of their lives came under the domain of professionals and were subject to official approval. The prominence of professionals acting as gatekeepers to services and supports is a practice that continues today. For example, access to certain tax credits; to educational, residential, and workplace supports; and to transportation options are all strictly regulated by professional testing, labeling, and assessment.

The not quite human. Unfortunately, the history of people with intellectual/developmental disabilities is replete with examples of inhumane treatment. Their institutional confinement in human warehouses, forced sterilization, and use as human guinea pigs in scientific and medical experimentation are all 20th-century examples of their treatment as less than human beings. The belief that these people are not quite human continues today. With the advent of genetic screening and prenatal testing, physicians routinely suggest selectively aborting fetuses with the markers of Down syndrome. In addition, the argument of medical futility has been used to withhold or withdraw medical care in cases where people with intellectual/developmental disabilities are not deemed worth keeping alive.

Fairfax County Board of Directors in Virginia designated March as Intellectual and Developmental Disabilities Inclusion Month in 2011, with a goal of enhancing understanding of the issues affecting developmentally disabaled citizens. Funding is one key to ensuring that people with intellectual/developmental disabilities receive the services and support they need.

Implications of Attitudes and Myths on Human Service Professionals

As members of society, human service professionals hold certain attitudes and beliefs. However, because of the work these professionals do, it is important that they are explicitly aware of these attitudes, beliefs, and perceptions so that they can provide the most effective support possible with the least amount of negative bias. This awareness is also crucial because attitudes toward people with intellectual/developmental disabilities play a key role in deciding which conceptualizations of disability will be relied upon as models of service provision. These models in turn help (1) define the kinds of services people receive, (2) outline the requirements for education and training for service providers, (3) identify which individuals are deserving of or entitled to receive which services, (4) delineate who is responsible to provide the services, (5) describe where services are to be received, and (6) articulate the circumstances under which services will be provided.

Funding is one key to ensuring that people with intellectual/developmental disabilities receive the services and support they need. However, it must be recognized that the mechanisms in place that either permit or deny funding are based on a professionalized process that is concerned with attaching labels to people and focusing on their deficiencies. This reality encourages the myth that people with intellectual/developmental disabilities are patients and/or incompetent children and should be subject to the gatekeeping authority that society vests in certain professionals, particularly in the medical and allied fields. Reconceptualizing how society sees and values people with intellectual/developmental disabilities can change attitudes, challenge stereotypical myths, and alter the models behind service provision. For example, when supports are accorded to people who are recognized as citizens, another safeguard is in place to encourage and protect services for people with intellectual/developmental disabilities. The role of the citizen provides society with a very different perspective about who people are and what they deserve.

Sometimes it can be difficult to analyze these issues in the field, particularly in situations where the service system is operating largely in a reactive or crisis-driven mode. It is also difficult to take a systemwide perspective when human service professionals are intimately involved in providing intensive support to a smaller group of individuals. People should evaluate the work they do in the context of myths and attitudes. Understanding roles and the implications of holding these roles is crucial to deconstructing the myths about people with intellectual/developmental disabilities. This understanding, in turn, will help challenge and change societal attitudes that have been perpetuated over time and have had significant impacts on all aspects of these people's lives, including the social service industry upon which they rely.

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See Also: Disability, International Variation in Attitudes Toward; Disability Services; Disability Studies.

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Developmental Disabled Individuals

As defined in Public Law 98-527, the Developmental Disabilities and Bill of Rights Act, a developmental disability is a severe chronic disability in an individual 5 years of age or older that is attributable to a mental or physical impairment or a combination of such impairments. Developmental disabilities are manifested before the age of 22 years and are likely to continue indefinitely.

These disabilities result in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. These limitations are reflective of the individual's need for special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

Persons classified as developmentally disabled may include those with mental retardation, Down syndrome, autism, cerebral palsy, and traumatic brain injury as well as some individuals with hearing impairment, vision impairment, and attention deficit disorders. Other terms included in the condition are "learning disability" as defined in the United Kingdom and international definitions of "intellectual disability" (ID).

People with mental retardation are the majority group, and it is toward this group that services have traditionally been targeted. The historic focus on this group has also driven attention to the labels used to describe such individuals. Terms have moved from feeblemindedness, to mental deficiency and retardation, and then to a growing emphasis on the so-called people-first language, such as "person with a developmental disability." This is the term used in this article. (Persons with Down syndrome are considered a subgroup of persons with mental retardation.)

There are no precise prevalence figures for developmental disabilities. The American Psychiatric Association (APA) cited a rate of 2–3 percent of the population in 2000, but more recently researchers C. A. Boyle and colleagues estimate that one in six children has a developmental disability, an increase of almost 14 percent since 1997 figures. Also, the life span of people with developmental disabilities has increased. Scholars A. Factor, T. Heller, and M. Janicki, using 2010 census data, estimate that there were 850,600 people with developmental disabilities age 60 and older in the United States, and that this would increase to 1.4 million by 2030.

History of Services

Throughout history, service delivery for the developmentally disabled has included the following:

- The development of protective residential facilities with educational and self-sufficiency programs in the 19th century (Villages of Happiness).
- Early-20th-century concerns that such disabilities were a manifestation of deviance, encouraging warehousing and sterilization.
- Mid-20th-century scandals over the mistreatment and dehumanization of people with developmental disabilities in large institutions.
- Major movement of services into the community and in support of independent living and family care.

There has also been movement from segregated special education services to inclusion in mainstream classrooms, reduction of reliance on sheltered employment services and development of competitive job opportunities, and greater utilization of mainstream health services. Drivers of these changes have been advocacy, legislation, court action, and Medicaid waiver–driven change processes.

Trends for movement to the community have been supported by reports that people with developmental disabilities living in community settings display (1) increased adaptive behavior, (2) better health compared to those living in nursing homes, and (3) improved quality of life. However, other reports state that community presence is easier to achieve than true community integration.

Of note is the continuing impact of the U.S. Supreme Court's Olmstead decision (*Olmstead v. L.C.*, 527 U.S. 581, 119 S.Ct. 2176, 1999), which observed that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life"; and

> confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.

Related litigation has established the concept of the most integrated setting expressed as where people live, spend their days, work, and participate in their communities.

Health Care and Aging Concerns

Individuals with ID appear to have a greater variety of health care needs compared to those of the same age and gender in the general population. Researcher H. M. van Schrojenstein Lantaman-De Valk and colleagues found that people with developmental disabilities served in mainstream health services had 2.5 times the health problems of those without such lifelong disabilities. Health conditions are reported to be highly influenced by lack of information, lack of exercise, poor mobility, poor eating habits, and medication use. People with developmental disabilities are more likely to lead unhealthy lifestyles, and their health problems go unrecognized even when they attend health clinics. Controversial evidence shows that the experience of poor health and early mortality among people with developmental disabilities may be related to the types and quality of health care services they receive.

Rates of mental health concerns also appear higher. Social, cultural, environmental, and developmental factors and the consequences of polypharmacy and inadequate medication review have also been reported to increase rates of physical, psychiatric, and behavioral disorders. People with developmental disabilities, particularly those with Down syndrome, are reported to be at higher risk for onset of dementia and of premature aging.

Despite these risks and health care delivery concerns, there have been marked increases overall in the longevity of persons with developmental disabilities.

Service Provision

A range of service options are available for people with developmental disabilities, including residential care, family support, and day programming, although access varies across the United States.

Residential care. A range of residential options are available privately, but most residential care for the developmentally disabled is publicly funded. Some large institutions remain, but residential services are generally delivered through group homes, ranging from four to 16 beds, located in community neighborhoods, and supported by a paid staff; apartments and other independent living programs with some staff support; and paid adult foster care. On a more limited basis, homes have been bought and managed by people with developmental disabilities themselves or their families, again with some staff or volunteer support.

Family support. Family support programs are designed to help parents or other family members continue to support an individual with a developmental disability in the home where they have always lived. Supportive services, such as time-limited assistance from professionals, are targeted at the individual with a developmental disability but there may be offerings such as respite care, transportation, educational programs, and support groups that also benefit the caregiver. A core intent is that these services help reduce the need to access out-of-home care.

Day programming. There is recognition that everyone benefits socially as well as economically from opportunities to engage in work, so vocational options are available that include sheltered workshops, job coaching, competitive employment placement, and job training. Not everyone is able to access and benefit from employment programs, however, and there is also recognition of the need for postretirement activities, which means there are often staffed day programs available.

Service Approaches

Four major concepts now influence services provision: self-determination, person-centered planning, participant direction, and permanency and futures planning.

Self-determination. Self-determination refers to an individual having control over all aspects of his or her life and exercising basic rights such as citizenship, liberty, and the pursuit of happiness. For persons with developmental disabilities who have impaired decision making and difficulties in managing their day-to-day life, there must therefore be processes to discover their desires for their lives and to utilize planning and service delivery processes that fulfill self-determination and the realization of the person's wishes. Person-centered planning is a mechanism for realizing self-determination.

Person-centered planning. Person-centered planning is a "process of continual listening and learning; focused on what is important to someone now and for the future; and acting upon this in alliance with their family and friends." Originating in ideas such as normalization, social role valorization, and the promotion of positive approaches to disability, person-centered planning is designed to offer a planning process by which individuals are able to harness services of their own choosing to engage positively in everyday relationships, participate in the community, and exercise choice in their own lives.

Participant direction. Participant direction is a facet of the larger self-determination philosophy in which participants with developmental disabilities actively direct their own chosen services by working with a care coordinator, a financial manager, and service providers. Participants may also designate another person as a consumer representative to carry out all or some of these tasks on their behalf.

Permanency and futures planning. As persons with developmental disabilities age, future living arrangements and the associated legal and financial concerns become major issues. This circumstance can occur because older caregiving parents are no longer able or available to provide care, or because prior out-of-home placements no longer seem suitable for age-related needs. Residential living permanency planning considers best options among independent living; shared households with siblings, other relatives, or family friends; and transitions into supervised apartment, adult foster care, and group home programs. Legal protection issues include legal guardianship, trusteeship, and conservatorship of person and property issues, including the drafting of wills and other documents. Financial issues address arrangements that will ensure continued financial eligibility for needed services for the person with a developmental disability.

Diversity

People with developmental disabilities represent a diverse population in their own right, and there is also growing diversity in terms of race, ethnicity, and socioeconomic status among those seeking and receiving services. Growing numbers of people with developmental disabilities accessing general services rather than those specific to developmental disability also mean that this is a population with whom all human services organizations must engage.

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See Also: Disabilities, International Variation in Attitudes Toward; Disability Services; Disability Studies.

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Diagnostic and Statistical Manual of Mental Disorders, Cultural Responsiveness of

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a reference guide that provides standardized criteria for evaluating mental disorders. The DSM is used by many professionals, including health care providers, social workers, clinicians, legal representatives, and researchers. The objective of the DSM is to create a common language for members of diverse professions to coordinate meanings across professional boundaries. The DSM closely resembles the World Health Organization's (WHO) International Classification of Diseases (ICD) in terms of function. Both reference systems are used by those working in human services for medical coding and insurance billing purposes. First published in 1952 by the American Psychiatric Association (APA), the DSM is currently in its fifth edition.

By the end of World War II, several branches of the armed forces and military affairs had each developed their own criteria and terminology for diagnosing military personnel. That, along with the diagnostic criteria put forth by the ICD, made for widespread disagreement and misunderstanding within the field of mental health. In an effort to allow for cross-contextual communication, the APA commissioned its first task force to develop a uniform way of evaluating, identifying, and diagnosing mental conditions.

The first and second editions of the DSM primarily reflected psychodynamic approaches to psychiatry that were dominant at the time. Psychoanalysis represented the most notable psychodynamic approach, and thus the first authors of the DSM were heavily influenced by the work of Sigmund Freud and Carl Jung. In line with psychoanalytic principles, the DSM founders believed that human behavior could be explained by basic drives and motivations, both conscious and unconscious. As a result, disorders and the symptoms of disorders were interpreted in relation to an individual's experiences, not in terms of a predefined classificatory system.

It was not until the release of the third edition (DSM-3) a few decades later that the manual assumed the form by which it is recognized today. Due to the perceived arbitrariness of psychiatry as represented by psychoanalysis, the 1960s and 1970s were characterized by a great mistrust and skepticism toward the mental health field as a whole. In 1961, sociologist Erving Goffman published his treatise *Asylums*, which read much like an exposé of the current mental health system. Goffman reflected on the ways in which mental health institutions dehumanized patients.

A decade later, within psychology, David Rosenhan conducted his infamous Rosenhan Experiment. The experiment entailed Rosenhan and his colleagues claiming to hear voices in order to be admitted into a psychiatric facility. Once admitted, Rosenhan and colleagues engaged in what would otherwise be considered sane behavior, yet because of the initial diagnosis of mental illness, this behavior was nonetheless interpreted as evidence of a mental disorder. Following the experiment, Rosenhan published his study's findings in an article, "On Being Sane in Insane Places," wherein he discussed the enduring quality of diagnostic labels, such as those featured in the DSM, and how once assigned a diagnosis, a patient bears that stigma throughout his or her life.

Recognizing the antagonism toward psychiatry at the time, the task force for the DSM-3 sought to legitimize psychiatry by grounding diagnostic criteria in evidence-based research. Researchers initiated extensive clinical studies to measure the validity of diagnostic proposals. As part of the movement to make psychiatry an objective science, revisions to the DSM included a five-part axis scheme for comprehensively assessing patients. Axis one comprised mental disorders; axis two, personality disorders; axis three, medical conditions; axis four, environmental factors; and axis five represented a global assessment of functioning (GAF).

Robert Spitzer was a key figure in the production of the DSM-3. As chairperson for the DSM-3 task force, he not only redirected the tone of the DSM from theoretical to empirical, he revolutionized how society conceived of difference. Particularly in the case of homosexuality, certain behaviors that deviated from the norm (heterosexuality) were pathologized and regarded as abnormal by psychiatrists as well as by the general public. Under Spitzer's leadership, the APA struck homosexuality from the pages of the DSM, making it no longer a mental disorder.

Criticism

Two editions followed the DSM-3. Like the editions preceding them, the DSM-4 and the DSM-V were not without criticism. Some of the most vocal criticism came from two social workers, Herb Kutchins and Stuart Kirk, who wrote *Making Us Crazy*. In their text, the authors issued what is now a somewhat common criticism of the DSM; they asserted that the DSM pathologizes otherwise normal behavior. To illustrate, the authors provided the example of the Anita Hill–Clarence Thomas court case. During the hearings, a psychiatrist for the defense speculated that Hill may have been a victim of erotomania, a mental disorder in which the individual subscribes to delusions of another person's love. From this perspective, Hill's behavior was a symptomatic expression of a mental disorder, not evidence of sexual harassment.

The DSM has received further criticism because of its perceived cultural bias. Some argue that the diagnostic criteria featured in the DSM privilege a Western perspective, and pathologize culturally specific behavior. An example is *taijin kyofusho*, which refers to a deep fear of social interaction. Because this specific syndrome is largely associated with individuals of Japanese heritage, many question whether it is an idiosyncrasy of that culture or a social anxiety disorder, as the DSM-V currently classifies it.

Complaints concerning the DSM's pathologization of normal behavior have also been issued by the DSM-4 former task force chairperson, Allen Frances. In his book, *Saving Normal*, Frances raises suspicions about the correlation between the rise in disorders featured in the DSM, diagnoses, and pharmaceutical profits. Critics, including Frances, question whether a child's temper tantrum, for instance, is indicative of oppositional defiant disorder, or whether it is typical child behavior. In light of his objections to the DSM, Frances offers a reminder to practitioners who use it. He advises that individuals consulting the DSM treat it not as an absolute authority with respect to diagnoses, but simply as a guide.

When consulting the Diagnostic and Statistical Manual of Mental Disorders, *Allen Frances, former task force chairperson of DSM-4, advises using the DSM as a guide rather than an absolute authority on the mental health diagnosis.*

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See Also: Children With Special Needs; Counseling and Psychiatry Services; Deinstutionalization; Mental Health Services, Adult; Psychiatric and Psychological Assessment.

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Diaspora

The term *diaspora* refers to individuals who live outside of their countries of origin. The word diaspora is Greek in origin and is literally translated as scattering or dispersion (*dia*, meaning over, and *speiro*, meaning to sow). The term has ancient roots, having been originally used in reference to the historic Jewish exile chronicled in the Old Testament. The term *diaspora* has since been used not only to describe ancient groups of migrants, such as Jewish and Greek populations, but also to describe other migrant groups, such as the Armenians, who have persisted in a desire to return home after centuries of forced exile from their historic homelands.

Human services professionals have a long history of working with migrant populations, and the likelihood of having increased exposure to this often vulnerable and marginalized population is significant due to the ongoing internationalization of the human services profession. Currently, many human services professionals work with refugee and exile populations on micro- and macrolevels, including providing such direct services as assisting in resettlement efforts, providing case management and trauma counseling, to engaging on a macrolevel in policy work and advocacy efforts on behalf of displaced populations. As such, it is imperative that those in the human services fields become aware of the global dynamics that often result in the migration of large groups of people to other countries, particularly when such migrations are forced due to conflict and natural disasters. Gaining greater understanding of diaspora populations, including the unique nature of their exile status, the reasons for their migration (e.g., forced or voluntary, historic or recent), the cultural context of different diaspora groupings, and their orientation toward their respective homelands, is important for human services professionals, particularly those working with diverse populations.

Diaspora groups fall into three timeline categories: (1) historical diaspora, which existed in premodern times (including the Jewish diaspora after the Babylonian exile); (2) new diaspora, which existed in the post–Industrial Age (this includes the Turkish-Armenians in the early 1920s); and (3) incipient ethnonationalist diaspora, which is the most recent group of diaspora that exists in modern times. Thus, according to most diaspora scholars, contemporary diaspora are often considered ethnonationalist by definition since most are members of groups that were dispersed due to ethnic conflict in their home countries.

Some debate exists about what groups of migrants should be considered diaspora. For instance, sometimes definitions of diaspora are based on historic models of Jewish and Greek diaspora, whereas others are narrower, including only those migrations generated from the conflict of people who retain a wish to return home. The latter definitions often include a set of criteria relating to forced dispersion: a collective identity, an ongoing relationship with the home country, a desire to return home, and some level of alienation from the host country. Diasporas are not a homogeneous group, even if they migrate from the same region, but they often do display similar attitudes, beliefs, and behaviors related to their homelands, as well as relating to their homelands in similar ways.

Relations With Homelands

In addition to being members of an ethnic group and their forced migration to a foreign region being generated from ethnic conflict, diasporas differ from other migrant groups because they never really assimilate to their host countries—they remain committed to returning home. Their desire to keep memories of their homelands alive and to eventually return to their homelands often manifests in the development of a so-called imagined homeland, in which homeland becomes almost a mythical place represented symbolically. The desire of diaspora to keep collective memories of their original homelands alive is often rooted in the conflict that caused their violent, forced migration.

The forced migration experiences of many diaspora were marked by violence, trauma, suffering, pain, and loss. Diaspora also often feel alienated from their host countries, even if they live in a country that is open to different cultures, such as the United States. Even when diaspora do successfully adjust and assimilate into their host country, they tend not to let go of their desire to return to their home country. To keep alive memories of their original homelands and their migration experiences, many diasporas maintain themselves as a distinct community that reflects their ethnic and/or religious traditions and practices. Operating as a collective serves many purposes—chief among them is the way in which collective interactions solidify and reinforce their memories and perspectives of their homelands. Despite an enduring desire to return to their respective homelands, most diaspora members remain in their host countries permanently, but they remain transnational in the sense that they have a foot in each world—their original homeland (and its culture) and their new host country.

Diaspora relate to their original homelands in many of the same ways that other migrant groups do, including financially by sending remittances to their family and friends still living in the original country. They also relate to their original homelands socially by remaining connected to friends and family, in the home country as well as throughout the world, and in a humanitarian manner by establishing charities in the home country that benefit various social causes, such as poverty alleviation, women's issues, education, and child welfare. What is different about many diaspora is that they also relate to their homelands politically. Political engagement may be on behalf of the homeland government and can involve lobbying the host government for causes that benefit the diaspora and/or their home country government. Diaspora who are generated from conflict and are opposed to their homeland's government may engage politically in homeland conflict by lobbying their host country for causes against their homeland's government.

Diaspora increasingly use the Internet to engage in various politically related activities. In fact, many diaspora communities, particularly those in the West, are increasingly referred to as digital diaspora, reflecting their prolific use of the Internet, particularly social media for political purposes. Diaspora communities can make conflict in their home countries worse by having uncompromising attitudes and by taking the side of their coethnics, thus exacerbating conflict. But diaspora are often in the unique position to contribute positively to their homelands, particularly in situations of conflict. For instance, diaspora can serve as liaisons between warring parties, serving as mediators in conflict resolution processes. Diaspora can also contribute positively to their homelands by returning home, even temporarily, to build up social capital that has been depleted through years of war.

Diaspora can contribute positively to their host countries as well, by introducing new ideas and perspectives to their host country societies. With increasing acceptance of multiculturalism in many host countries, diaspora members can retain their transnational identity while successfully acclimating and integrating into their host countries and becoming valuable members of society.

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See Also: African Immigrants; Displaced Persons; Refugee Assistance.

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Directly Observed Therapy

Directly observed therapy is defined as a treatment method in which patients are under direct observation when they take their medication or receive their treatment. This method is designed to reduce risks and ensure patient compliance. The significance of directly observed therapy is great, and more dialogue must be continued to promote yet sustain this treatment option. The method by which individuals receive treatment is paramount to the proper delivery of medical services by medical professionals and the receptiveness of treatment by patients. The strategy proves cost-effective yet it seeks to protect the patient's dignity and autonomy. Current research of directly observed therapy indicates positive, negative, and mixed reviews of directly observed therapy approaches in a large proportion of clients who are afflicted with malaria, tuberculosis, and HIV/AIDS. Most important, research has shed light with regard to cost-effectiveness, patients' adherence to medical treatment, and the ability to provide this therapy to indigent patients (e.g., persons who are homeless and underinsured) in dire need of treatment. Therefore, the scope of directly observed treatment seeks to promote wellness and sustain life not just at a given cost but at all costs.

Patient adherence to medical treatment increases the likelihood of improving the health of the patient while significantly decreasing the costs associated with medical care. Directly observed therapy is a treatment strategy modality related to improving a patient's adherence to medical professionals' directives pertaining to regimens. A multimethod approach relieves any transparencies related to treatment. Medical practitioners can alleviate the issues of nonadherence (i.e., reviewing patient's health reports and monitoring pill counts). L. Martin and colleagues reported that 40 percent of all patients have either ignored the advice of health care professionals or had inadequately followed the advice of health care professionals with regard to the proper regimen needed to improve health in cases of debilitating illnesses. Such nonadherence becomes costly, as hundreds of billions of dollars are spent by the health care industry due to noncompliance.

Recent scholarly reviews regarding the directly observed treatment modality have explored various regimens of patients diagnosed with life-threatening ailments. Global medical research, specifically in countries such as Ethiopia, which has a high mortality rate, have adopted the direct observation strategy because it assures that medical professionals have adequately diagnosed the illness and that patients comply with the processes involved to control endemic diseases. Consequently, it has been revealed that patient autonomy, dignity, and integrity pose a threat, particularly with regard to the effectiveness of the delivery of observed treatment to patients.

Justifications

Five justifications must be assessed properly when public health interventions conflict with ethical behavior outlined by the health care community: (1) effectiveness, (2) proportionality, (3) necessity, (4) least infringement, and (5) public justification. These justifications are essential to protect the patient and the general public from unwarranted harm. Burdens that lay with the patient at the request of public health officials should be reciprocated with the community at large. Health care professionals are obligated to identify and remove any program that unjustifiably infringes on the rights of the patient or proves to be ineffective.

The most notable of such unfair programs involves directly observed treatment that works well for individuals with few financial burdens but creates extra financial burdens for indigent individuals, who lack the economic resources needed to successfully comply with specific treatment. John Rawls concurs by stating simply, "All lives have equal value." Therefore, the allocation of resources must be readily available for those who desperately need medical treatment for survival. Thus, some form of moral justification based upon the greater good for humanity and reflected in policies are at times revisited or implemented based on what is deemed to be the most efficient and cost-effective.

Practitioners often must rely upon directly observed therapy as a mode of medical delivery services for proper diagnosis and effective medical practices rendered to the patient. Commonly this involves seeing to proper dosage and other medicinal services needed to combat endemic diseases. Patient adherence is complex and contains multiple concepts with the intent to integrate the data that identifies factors that affect patient adherence with regard to medication management. Studies have shown that exogenous factors relate to patient adherence, not excluding changes in lifestyle. If physicians assume that patients are taking the proper dosage as prescribed, failures may be improperly assessed, leading to the risk of other illnesses that are not related to the principal illness. Most important, it is of paramount importance that patients communicate with health care professionals in earnest with regard to any risks associated with receiving any type of treatment to properly address the patient's medical needs. Complications occur if and when there are additional side affects compounded by the presence of other lingering illnesses. Multiple illnesses will increase the likelihood of a patient interrupting one specific treatment plan in order to give more attention to other health needs that are of equal or greater importance.

With regard to nonadherence of individuals participating in programs that promote directly observed therapy, common problems are closely related to the side effects linked to ingesting additional medicines that are prescribed for patients during the proposed treatment cycle. Research has shown that patients receiving treatment for HIV/AIDS are more apt to be consistent with taking the proper dosage of medicines required to slow down the effects of the illness. For example, patients receiving treatment for HIV/AIDS are required to ingest multiple pills or "cocktails" to combat illnesses that could develop. However, taking various medicines during specific regimen schedules can possibly create side effects that are not related to the prescriptions.

Patients whose immune systems and/or patients who incur low tolerance for pain and illness may discontinue taking certain medicines with the assumption that more powerful prescriptions would offset the prescriptions that are less potent with fewer side effects. Also, the physical effects of more powerful drugs might not be desired by the patient. This would pose a problem for medical care professionals in diagnosing the patient's health, further putting the patient at risk of incurring other illnesses. Directly observed therapy is an effective approach, depending upon the patient's adherence to treatment, affordability, and proper diagnosis of illness.

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See Also: Home and Community Services; Home Care Services; Homelessness.

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Disabilities, International Variation in Attitudes Toward

Research has shown that attitudes toward people with disabilities vary among countries and even within various subsets of people within countries. At variance also is the definition of disability, as consensus of this definition has not been achieved due to factors of ethnicity, religion, and race, which add variables of cultural bias onto attitudes. Distinctions between physical disability and neural-cognitive disability and among rural, suburban, and urban environments also play roles in disability perceptions. Ultimately, perceptions of disability, in the general sense, tend to be negative.

This article focuses on international variations in attitudes toward disabilities in Europe, North America, Central and South America, the Middle East, Africa, and East Asia and the Pacific Islands as well as Australia. Not all citizens of the countries and municipalities discussed share the same views; for instance, people in the United States have been shown to react less favorably to those with physical impairments than their Chinese counterparts. Also, oftentimes people's empathic feelings toward those with disabilities vary, depending on the type of disability. In addition to the individual-level attitudes displayed by citizens, this article touches on government-level macropolicies concerning those with disabilities. At times, the micro- and macrolevel attitudes and policies converge and have a mezzo-level effect on the individual with disabilities.

Historical Notes

The history of attitudes toward people with disabilities has been well documented over hundreds of years, with odd bits of information that predate that time frame. Trends in these attitudes have changed as society has changed from agrarian to manufacturing to service. During the 1500s, Martin Luther perceived the disabled child as evil and worthless. As far back as the 1600s, John Locke distinguished mental illness from intellectual disability. The most positive attitudes toward disabilities were held by practitioners of Islam who held people with disabilities as equals to all other human beings because every human being was equally special to Allah.

European and North American Attitudes

Many European and early North American settlers perceived people with disabilities as evil, a reflection on the devil's works. Perhaps as a result of the agrarian society in which many lived, it was incumbent that all people contribute to their own subsistence as well as that of their families and their communities. In those circumstances, attitudes toward the disabled were pragmatic, and those who could not hold their own were shunned.

During the late 1700s and early 1800s, advances in education in Europe gave hope to training and ability to learn for people with disabilities. With education reform, people with disabilities began to be viewed more positively. This filtered its way to the United States in the mid-1800s. However, these positive gains were short lived with the advent of social Darwinism and mechanisms to measure intelligence (e.g., Alfred Binet's Intelligence Quotient test). By the early 20th century, attitudes moved to distrust, fear of perpetuating inferior human beings, and congregate isolation—the advent of large self-sustaining institutions.

Ties to thinking about and responding to people with disabilities were closely intertwined into the 20th century between European culture and that in the United States. From the 1930s forward, however, a distinct change in attitudes and services began to take place. From that point forward the United States and Canada began to bring their own imprint and advances on thought and policy.

Wolf Wolfensberger proposes that clear patterns of attitude toward disability were evident in history. He advanced the idea that disability was a social problem as opposed to a problem of personhood. That is, communities create in their identity what constitutes normal and deviant, and furthermore, communities identify what is important to them. Once that identity is firmly established, people and groups on the fringes who are perceived as negatively disabled are increasingly treated by lowered social status. Status can change over time, or once communities reassess how they perceive a group or class of people.

To justify lowered status, communities cast people into roles. These roles clearly place the individual and group outside the positive parameters of the community identity. For example, as Wolfensberger argues, people with disabilities are perceived as menacing or dangerous, piteous, a burden of charity, childlike or eternal children, sick, or nonhuman/subhuman. Once cast into these roles, society takes wounding action, including, for example, rejection, segregation, involuntary material poverty, impoverishment of experience, and relationship incongruity. In other words, attitudes proceed from perception, to feeling, to typecast, to isolation/extinction.

One cultural anthropologic theory proposed that attitudes about disability are framed by the codes and laws that govern people. In contemporary Western discourse, particularly in the United States, a primary construct is that of equality, often understood as sameness or similarity. The problem arises in which attitudes toward disability are affected by the tension arising when sameness converges on intolerance. That is, equality is innately opposed to diversity and individualism. People with disabilities can be neither equal nor individual.

Where personhood is equated with being human in valued and meaningful ways, then individuals can achieve personhood to a greater or lesser extent. Characteristics that drive perceptions on personhood are divergent: autonomy and independent versus membership and inclusion. The thought was that people with disabilities often rely on others to accommodate their development; they are rarely able to achieve full personhood, and thus they never can become fully human.

Conceptually, positive attitudes toward disability are found in higher-educated people and in children in North America and Europe. Children have had the advantage of growing up in an era of inclusion such that the mystery of disability is removed. Since attitudes are changing, concepts about inclusion are incorporated into policy and programming. However, as disabled people age, inclusion becomes less successful. Attitudes that hinder opportunities speak to a feeling of disability making the person less competent to participate in meaningful ways, therefore providing less social programming that focuses on inclusion.

Latin America (South America, Central America, and Mexico)

A wide variance in attitude pervades Latin American thinking on disability. Tolerance and treatment are most well established among college-educated persons, particularly women. However, the dominant cultural perspectives on disability are drawn from a focus on family as a linchpin from which attitudes are derived.

In Latin American culture, families take care of their own. Consequently, disability becomes a family matter for help and support. The reason for the presence of disability is varied (i.e., from divine will or as the result of some heretical or physical insult). One of the overriding features, however, is that families manage the disability. This leads to the notion that people with disabilities need to be taken care of. That notion of protection, or overprotection, inherently stymies independence and independent growth for the affected person. Since families take care of their loved ones, disability can be stigmatizing from a community standard, even within extended families.

Mental health challenges are further ostracized within Latino cultures. Attitudes that people are crazy (*loco*) marginalize individuals and discourage open discussion about the disease. Because of the taboos associated with mental illness, services are underutilized. Frequently, treatment efforts go toward encouraging the individual to try spiritual rituals or traditional lore to cure themselves of their affliction.

A dominant attitude in Mexico is said to be pity. It is not a pity of compassion but of negative feelings. Charity becomes the predominant way people with disabilities are supported. Particularly in rural settings, disability is often managed by hiding people within the nucleus of family, with little opportunity for inclusion in groups. In urban settings, a common attitude is that disability prevents development as a whole person. There are no expectations regarding capabilities; thus, the community will provide support through charity.

Frequently, a distinction arises between a physical disability and a neurodevelopmental disability in that people with physical handicaps can overcome their burden and be productive citizens in many ways. People with neurodevelopmental or intellectual disabilities are perceived in different ways, including that they are cursed or thought of as beautiful. These conceptions are derived from cultural variances.

Africa

Attitudes toward people with disabilities vary throughout the disparate societies within the African continent, with the most pervasive attitude one of feeling helpless and lacking hope. The etiology of disabilities may be attributed to sorcery, paranormal forces, interventions by a deity, and/or sexual causes.

Perceptions and treatment of individuals with disabilities in Africa vary widely. For instance, the Chagga in East Africa perceive those with physical disabilities as pacifiers of spirits of an evil nature. This serves a protective function for those with these disabilities within this group. Similarly, in West Africa law enforcement officials are chosen from those with noticeable physical impairments among the Benin. Within this same community children with physical impairments are thought to be protected by paranormal forces and to bring good luck to those around them.

In contrast, to the Chagga and Benin, the Ashanti of central Ghana exclude men with physical defects or impairments from becoming chiefs in the community. If a chief were to develop an impairment, he would be removed from the position. Traditionally, children with obvious physical disabilities are rejected. Children with severe developmental disabilities, believed to be animal-like, are often abandoned at the edge of a water source to facilitate a return to their so-called own kind. Within Ghana, however, there are variations in attitudes. Those with developmental disabilities are often revered and thought to be a reincarnation of a divine being among the Ga.

Within Kenya and Zimbabwe, a child with a disability may be thought of as a curse to an entire family. This brings shame to the family and often results in rejection. Rejection comes with medical, social, and educational costs, including comparatively little food and medical care compared to other children, less attention and nurturing from parents, and fewer educational opportunities. While social perceptions may influence academic chances, the Kenyan constitution calls for inclusive education, as does the Kenyan Persons with Disabilities Act of 2003. This inclusion was further updated in 2010 in a policy regarding special needs education adopted by the Ministry of Education.

In some communities, those with physical disabilities are looked upon favorably, but these perceptions can vary within a singular community, as is the case with the Ibo of Nigeria who may look upon those with disabilities with a range of attitudes from favoritism to disdain.

East Asia

The World Health Organization (WHO) has stated that the Asian and Pacific areas are home to more than 400 million people with disabilities, which constitutes two-thirds of the world's disabled population. After realizing the dearth of resources available and provided to this population, WHO designated the period from 1993 to 2002 as the Asian and Pacific Decade of Disabilities. The year 2007 marked only the second time that the Special Olympics was held in east China. The Special Olympics is the world's largest sports organization for people of all ages with intellectual disabilities. The Chinese showed the largest delegation, despite a perception, at times, that questioned the abilities or the extent of ability in those designated as having disabilities. China has made progress in creating a national focus on accepting and supporting those with disabilities.

The Special Olympic games at Fort Gordon, Georgia, on March 24, 2010. Conceptually, positive attitudes toward disability are found in higher-educated people and in children in North America and Europe. With attitudes changing in this way, more frequently concepts about inclusion are incorporated into policy and programming.

Like others, Asian governments have also made educational provisions for students with disabilities. In China, education is required for all children, including those with disabilities, through the Law on Compulsory Education and the Law of the Protection of the Rights of the Disabled. In 2003, a cluster of "sunshine homes" were created in China that provide supported employment for teenagers and young adults with intellectual disabilities. In the mid-1990s, the Lao People's Democratic Republic also required compulsory education for all children, including those with disabilities.

Even given the advances in education reform for those with disabilities, East Asian disabled children continue to have the lowest access to education. When the person with a disability is also a female, the rate of educational access is even lower. The concept of karma may play a role in the perception of the disabled child as punishment for an individual's or family's wrongs or misconduct. As a result of these feelings, a family member may be hidden from public view and subsequently miss opportunities for community activities as well as educational opportunities. This phenomenon has been confirmed in almost all developing East Asian countries, as well as in Cambodia and Thailand.

The 1997 Fiji Poverty Report confirmed that those with disabilities are often treated as though they have no value, and therefore they are not provided with the necessary resources to capitalize on their abilities. Those with disabilities were confirmed to be the most disadvantaged in the country.

Middle East and North Africa

Within the Middle East, variations in perceptions of disabilities exist as they do in other areas. Throughout many countries in the Middle East and North Africa, amputations are a common cause of disability. Afghanistan, for instance, has one of the largest populations of disabled people in the world, due mainly to encounters with land mines. Discrimination continues to impact the disabled of Afghanistan, despite interventions and aid from numerous international organizations. Physical and verbal abuse are common, and deficits in access to health care and education are frequent.

Social stigma as well as lack of access to transportation, buildings, and services continue to exist throughout the Middle East and north Africa. The stigma and environment of exclusion encountered are not just outside the home—many families also stigmatize family members with disabilities. As is the case in many areas, women are further burdened in this regional context. Women are the main caretakers of those with disabilities. Disabled women are stigmatized or denied access to services, education, or opportunities only because they are female and disabled.

In Saudi Arabia, a plethora of programs for the disabled exist in urban and metropolitan areas, but programs are lacking in rural areas, where over half the population resides. Statistics regarding disability prevalence are underreported, but it is known that the cause of many disabilities arises from consanguineous marriages of closely related relatives. The issue of disability is a sensitive one, although Islamic Sharia stresses human rights for everyone, including those with disabilities. Provision of health care services is emphasized over providing educational and vocational opportunities.

In Egypt, about 3.5 percent of the population has a disability. Egypt has developed programs to assist those with disabilities, and the Ministry of Education has implemented special education services in more than 160 specialized schools and at least one special education classroom in more than 200 schools. Despite this, these services reach only about 10 percent of those with disabilities.

The Jordanian Law for the Welfare of Disabled Persons states that an education must be made available for those with disabilities, specified as students with special needs (including medical conditions and intellectual disabilities), learning disabilities, behavior problems, and speech and language issues. Laws such as this one exist in some areas, but laws creating an inclusive environment are nonexistent in other areas and lack systematic application in still others.

Australia

In contrast to other nations, issues around treatment of those with disabilities as well as provisions of services are similar throughout Australia. The Australian perceptions of those with disabilities within their own borders is unique, however, given their extremely diverse population, including indigenous Aboriginal and Torres Strait Islander populations with their own history of discrimination and strife. Within this indigenous population, those with disabilities are reported to require services at twice the rate of nonindigenous people with disabilities. This is attributed in part due to general socioeconomic disparities and histories of discrimination, but also increased risks such as high body mass index, smoking or exposure to smoke, substance abuse, and poor nutrition, among others. The National Disability Insurance Scheme (now known as Disability Care Australia) has created a specific focus on supporting indigenous populations, and has also refocused the goals to an early intervention and prevention model for both indigenous and nonindigenous populations.

Recent reform efforts in Australia have highlighted the fact that the population is aging in increasing numbers with trends similar to different countries around the world. This growth also is seen in those with disabilities, who are living longer as opposed to the quite shortened life spans that were predominant among this group 30 to 50 years ago. While discrimination, social exclusion, and a lack of understanding of the ways in which those with disabilities can be integrated into the common social culture may still exist, government reforms are attempting to remove the gap between services for the aged and services for those with disabilities. The government initiatives are also focusing on person-centered and self-directed services for those with disabilities, as well as encouraging choice and participation through the process of obtaining and executing those services.

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See Also: Cross-Cultural Knowledge; Cultural Paradigms; Developmental Disabilities, Attitudes and Myths in Services for; Developmental Disabled Individuals; Disability Services; Education, International Variations in Attitudes Toward; Ethnic Diversity and Values Institutional Oppression.

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Disability Services

Service delivery to persons with disabilities, their families, and their communities occurs at multiple levels and through many funding streams. Understanding this delivery requires a clear understanding of (1) the frequent presence of coexisting intellectual and developmental, sensory, communication, or cognitive disabilities; (2) multiple funding streams; and (3) types of disabilities. This article reflects general trends in service delivery. Services for persons with disabilities tend to be relatively advanced compared to human services for other populations because this group has many family members and other advocates seeking reliable and effective programs.

Across the different types of disabilities, individuals and their advocates increasingly focus on concerns to improve environmental accessibility and inclusion in their communities. Recent decades have seen the shift from services being provided based on a diagnosis to a functional approach. Under this functional approach, individuals receive services based on what is required to improve quality of life, increase their own decision making, and support community inclusion. Vital issues include conceptualizing new perspectives arising from the field of disability studies in which the traditional medical model is rejected in favor of full inclusion and the assumption that people with disabilities are best served if their lives

At a U.S. Department of Agriculture (USDA) National Disability Employment Awareness Month event in Washington, D.C., hiring and employing individuals with disabilities pose questions to panel members. Agriculture Secretary Tom Vilsack is dedicated to establishing the USDA as the lead federal agency in employing individuals with disabilities.

are interconnected through their peers, who may or may not have disabilities. In this shift from a traditional medical model (that assumed a deficit in the individual) to a social model of disability (focused on inclusion), relevant employment issues and services lead to increased community participation (e.g., supported employment); housing services; and a community in which approaches such as person-centeredness, peer support, consumer-driven, and independent-living movements are provided to increase a disabled person's likelihood of becoming a fully participating citizen.

Systems of Delivery

Delivery schemes for persons with disabilities are provided both publically and privately. In the public realm, this may include special education services for children with disabilities through the public education system in either a regular classroom or through segregated settings, disability services offices at colleges to support students by discerning and recommending reasonable accommodations, and rehabilitation services for veterans through the U.S. Veterans Administration. The federal government also funds three core functions provided in each of the 50 states and territories. These core functions include advocacy and protection; funding for disability councils so these political jurisdictions can support local initiatives; and University Centers for Excellence in Disabilities, which provide research, technical support, preprofessional training, and other services within a state or territory.

In the private realm, services are provided by not-for-profit and for-profit organizations. The not-for-profit organizations include those that primarily receive funding through a combination of fees, insurance payments, and governmental contracts from local, state, and federal sources. These organizations typically serve those persons with intellectual and developmental, communication, sensory, or psychiatric disabilities. Often persons receiving services are referred and funded by local (e.g., county) governments. In the for-profit sector, persons receiving services frequently have a disabling condition that may be temporary or long term, such as traumatic brain injury, with third-party insurance or first-party fees covering the cost of providing the services.

Types of Services Provided

Service types range from income support and maintenance to direct services. Services include those operating under a medical model (which assumes a deficit in the individual), to a psychosocial model, to a full community inclusion model. Similarly, this range reflects services being provided in varied settings, from segregated settings (e.g., special education schools) to those reflecting full inclusion. In the inclusion model, natural supports—in the form of peers without disabilities, friends, employers, and others—help to attain the inclusion of the individual, often through providing assistive technology and reasonable accommodations.

Two programs dominate the provision of income support and maintenance, Supplemental Security Income (SSI) and Social Security Disability Income (SSDI). Those who receive SSI typically have no or little work history and therefore do not quality for SSDI. Those on SSI often include persons with a lifelong or congenital disability (e.g., Down syndrome), whereas those receiving SSDI more likely acquired disability during their adulthood as a result of injury. SSDI is funded through the Social Security Administration, whereas the costs of SSI are provided by the federal government and matching funds from the states. Similarly, Medicare pays the health care costs of persons with disabilities who have had a significant employment history, whereas Medicaid covers the costs of persons without a significant employment history. Community support services provide advocacy, housing services, and other programs so that individuals can live and thrive in their communities.

Employment services cover a broad range of options. Current best practice reflects an inclusive approach over the more traditional approaches such as sheltered workshops and enclaves. Current practices include competitive supported employment, in which a person with a disability works in a competitive position and receives job-coaching supports. These supports are delivered according to the need of the individual and typically are reduced over time.

Education services in the United States have evolved from segregated education services, in which students attended separate schools, had special education instructors, and rode separate transport systems, to education settings in which students have become included in classrooms and schools with their peers who do not have disabilities. Services are provided to students who may have learning disabilities, sensory and communication disabilities, and intellectual or developmental disabilities. Housing services for persons with intellectual and developmental disabilities have shifted predominately from the traditional institutional scheme to apartments and other community-based options.

Funding of Disability Services

Disability services are funded through a variety of mechanisms. For example, within the private sector of the economy, employers and public spaces are required to make reasonable accommodations under the Americans with Disabilities Act, in order to make their job sites and locales accessible. The majority of funding, however, comes from federal, state, and local governments, with federal sources dominating services affecting quality of life, functioning most often by not-for-profit organizations. The majority of public funding originates from the federal government in the form of block grants to the states. The states then allocate funding to their counties or other local entities. These public local entities then subcontract with private not-for-profit and for-profit entities to provide an array of services at the local level.

Models of Service Delivery

Since the 1970s, disability services have increasingly reflected an inclusion model in which the disabled person participates fully as a citizen within the community. This scheme differs radically from previous ones in which the person with a disability typically resided in institutions, training centers, or other segregated environments. This new wave of services is further reflected in programs such as employment services via supported employment versus the traditional sheltered workshops, travel training in order to learn to use fixed route public transit versus paratransit systems, and planning of services where person-centered planning has replaced multidisciplinary teams.

Acquired Versus Congenital Disability

Disabilities can be either acquired or congenital. An intellectual or developmental disability either develops in the fetus, results from genetic factors, or occurs at the time of birth. People who acquire a disability will access the various delivery systems differently than those with congenital disabilities.

The most common types of acquired disabilities involve veterans who have lost a limb or those who have post-traumatic stress disorder. If determined eligible, these individuals typically receive services through the Veterans Administration. Other acquired disabilities are through accident or injury. These may include spinal cord injury and traumatic brain injury. Another and growing group are people who have acquired a disability because of the aging process.

Services provided to people with congenital disabilities tend to be lifelong and include screening and assessment, education, employment, housing, income assistance, health, and other services to support individuals who have conditions that limit their functioning.

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See Also: Accommodation; Americans with Disabilities Act; Assistive Technology; Autism and Asperger's Syndrome, Services for; Behavior Support and Management; Children With Special Needs; Deaf/Hard of Hearing; Developmental Disabled Individuals; Disability Studies; Life Skills Training; Reasonable Accommodations.

Future Readings

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Disability Studies

Disability studies, as an academic discipline or critical field of inquiry, arose from a desire to challenge the ways in which the idea of disability and society's response to it have been understood over time. The field was not created in a vacuum. It has strong ties with the disability movements and disability rights movements in Great Britain, the Nordic countries, and North America. As people with disabilities began to protest the ways in which they were being treated and the inequalities they faced on a daily basis, so, too, did academics (particularity those living with disabilities) begin to take a critical look at the ideas defining and shaping disability. The goal of those in disability studies is not simply to critique or to theorize. Rather, the ultimate goal is to effect positive change in the lives of people with disabilities. The first step in this process is to recognize the lived experience of disability as authentic, valued, and valuable.

This article provides some general context of how disability was conceptualized historically; explores the responses in Great Britain, the Nordic countries, and North America that have led to some of the foundational formulations of disability studies; examines some of the new approaches to disability; and concludes with a brief discussion of how these new understandings of disability affect practices in human services.

Historical Approaches to Disability

In the Western world, disability has traditionally and historically been seen not only as something different, but as something negative. Disability has been seen as a moral stain or punishment, as a problem in need of fixing, and as an illness or something wrong with a person. This approach has had several major consequences for people with disabilities and how they have been seen by nondisabled people, the effects of which are still evident today. For many people with disabilities, having their disability framed as something "bad" has often meant social stigmatization and societal rejection.

Not only were people with disabilities stigmatized, many were institutionalized. Facilities were built to take care of people who were seen as being incapable of caring for themselves. Children and adults were removed from their families and friends and sent to live in these institutions, which were often located outside urban areas, thus creating a physical distance between the disabled and the nondisabled. Sometimes the rationale for this process was defended as being in the best interests of those with disabilities. Although these centers initially were seen as places to educate and train people, they eventually became places in which to house anyone who was seen as a problem for society. Severe overcrowding meant people lived in extremely inhumane conditions, which further emphasized their role as less than or not quite human beings.

As scientific knowledge began to progress, the idea of disability as a deficit or deficiency took on new meaning. Scientists sought to better understand different disabilities, and were concerned with origins, classifications, and treatment. This approach cemented the notion that disability was an unacceptable condition that science should address through cure, or if that failed, through amelioration, making the individual as close to so-called normal as possible. Scientists and physicians were soon joined by other professionals, such as psychologists, nurses, and therapists, each claiming to have unique knowledge to deal with disability. This resulted in the creation of professionalized and medicalized lenses through which disability was viewed, and resulted in people with disabilities being cast into the role of the patient, notwithstanding their actual state of health.

Over time, charitable groups began to form around these disabilities. For example, organizations to further the interests of people with visual impairments, Down syndrome, and cerebral palsy were established. One of the major goals of these kinds of organizations was to raise funds, often to cure the disability or rehabilitate the disabled. This mind-set reinforced the idea that people with disabilities were to be pitied because of their disability and led many nondisabled people to think of disability as some kind of personal tragedy of others and their families. People with disabilities became the recipients of the charity of the nondisabled.

New Approaches to Disability

The cumulative effects of these approaches to disability and people with disabilities meant that nondisabled people often had little, if any, contact with people with disabilities. This served to reinforce the notion of difference, defect, and deficiency. Able-bodied society was not used to having people with disabilities as contributing members. As a consequence, nondisabled people became suspicious and intolerant of difference, and as a result, disabled people became further stigmatized and devalued. When people with disabilities finally began to take their places within their communities, these communities were ill equipped to accommodate the diversity that came with the movement toward full inclusion. People with disabilities were seen as a problem because they simply did not fit.

The result of this disconnection prompted people with disabilities, their families, and their allies to begin to respond to physical and social exclusion and discrimination in more systematic ways. These responses had different foci in different countries. However, the common theme across these various regions was a demand for inclusion and the development of new approaches to how to understand and respond to disability. The following sections highlight only some of the nuances of the constantly evolving field of disability studies:

The British Focus. In the early 1970s, disabled people began to organize in an effort to effect change in their lives. Their original focus was to eliminate the segregated facilities in which they lived, worked, and went to school. Their goal was to be integrated into society. This was accomplished by shifting the focus from disability as a personal tragedy to disability as a form of social oppression. This idea of moving from the individual to the social is sometimes referred to as the social model of disability. A critical gaze was directed at society itself and how it was actually organized to exclude people with disabilities.

This movement originated with and was promoted by and on behalf of people with physical disabilities, both activists and academics, such as Michael Oliver. Thus, it developed more specifically around issues facing people with physical disabilities. One hallmark of this approach is the distinction made between the two terms *impairment* and *disability*. The former term is used to explain the limitation actually experienced by the individual, be it sensory, physical, or mental. The latter term is used to describe the lack of participation and/or loss of opportunities experienced by the disabled person as a consequence of the social and political ways in which society is organized.

For example, traditional responses to people who are unable to walk likely focus on rehabilitative strategies to gain some ability to walk and/or medical research into spinal cord regeneration, with the ultimate goal of enabling these individuals to walk. Little attention is paid to the social exclusion when disabled people simply aren't able to gain access to places and spaces within their communities. Essentially, they are not expected to be in those places and spaces.

However, the social model approach began to ask why the built environment was so hostile to people with physical disabilities. If, for example, stairs were eliminated and replaced with ramps, many people would benefit from the removal of this structural barrier. In addition to wheelchair users, people with walkers, strollers, luggage, and those using canes or crutches would all be able to avoid awkward negotiations with steps.

The Nordic Focus. Nordic countries have established a very strong social welfare consciousness that has led to the development of robust social welfare policies. In the context of people with disabilities, this has put a focus on best practice in the area of community-based services and supports. The origins of this focus lie within the principle of normalization, first envisioned in the 1960s in Denmark and Sweden. Normalization stresses the importance of community inclusion and participation rather than segregation for people with disabilities. It promotes the idea that the "rhythms" in which people with disabilities live their lives should be as close as possible to the rhythms of nondisabled people. This way of thinking challenges traditional notions that people with disabilities are best served in institutional settings, which in no way mirror the ways in which nondisabled people live. Normalization also considers people with intellectual disabilities, a group that was largely ignored in the formulation and theorization of the British social model.

The relational model of disability, developed in the Nordic countries largely by academics, is heavily influenced by normalization. This approach contains the following three key aspects:

- Like the social model, it acknowledges that there is a need to adapt the environment to people with disabilities to correct the mismatch between the existing environment and people with disabilities.
- In addition, the relational model suggests that disability is situational. This means that, depending on the context, a person may not be disabled. For example, in a power outage at night, a person with a visual disability is not disadvantaged by a lack of light, whereas a sighted person likely is. Similarly, if a community were fluent in both English and a sign language, a person who could not hear would experience no communication disadvantage because of deafness.
- Finally, proponents of this approach reject the view that people are either able-bodied or disabled, instead recognizing that disability is one part of a continuum of different ways of being.

The North American Focus. In the North American context, several complementary influences were at work in the 1960s and 1970s that advanced the cause of people with disabilities. The first was the rise of the minority model approach to disability, which was based on the U.S. civil rights movement. This approach focused on people with disabilities as another minority group who have been discriminated against and denied their rights.

Demands were made for access to spaces, places, and services that were equal to what was available to nondisabled people. For example, the independent living movement called for support for people with disabilities to live independent and self-directed lives. Such support, offered through a variety of services, enables people with disabilities the opportunities to be actively engaged within their communities.

The advent of the minority model, originally led by disability rights activists, expanded to a concerted effort by parents of children with intellectual disabilities to deinstitutionalize their children and provide support for them within the public school systems, communities, and general workforces. This resulted in the formation of the community living movement. People with intellectual disabilities themselves also began to mobilize, forming a self-advocacy organization called People First. Disabled members of this organization, reacting to the derogatory and often hateful references to which they have been subjected, insist on being seen as people first.

Another influence in North America was the importation and adaptation of normalization, which was ultimately reframed as social role valorization (SRV). At its heart, SRV focuses on identifying the ways in which the devaluation of marginalized groups occurs and provides strategies for human service professionals to help develop valued social roles for people with disabilities to combat this devaluation.

A third influence is an academic response to the prejudice endured by people with disabilities, arising from the field of sociology, which emphasizes the fundamental nature of disability as socially constructed rather than inherent in the individual. Such thinking challenges the assumption that disability is a real, objective, and uncontested category. It stresses the importance of accepting and valuing the lived experiences of people with disabilities. There continues to be an ongoing discussion of new ways of conceptualizing disability using a social construction framework to critique established views and practices.

The inclusion and full participation of people with disabilities as equal citizens links these various approaches to a common goal, although the path to achieving it may differ. Reaching this goal has been aided by laws such as the Americans with Disabilities Act, the Canadian Charter of Rights and Freedoms, and the United Nations Convention on the Rights of Persons with Disabilities.

Implication for Human Services Practice

The field of disability studies offers human service professionals as well as those interested in and affected by disability a framework in which to broaden their understanding of disability and challenge more traditional responses and ways of thinking. The analyses from disability studies encourage people to think about and react to disability and people with disabilities in new and more positive ways. Disability studies offer a multifaceted lens for understanding the experiences of people with disabilities. Despite the differences of the various approaches within the field, disability studies suggest that disability should be problematized for society and not for the individual.

Two major implications exist for professionals and nonprofessionals alike. The first is one of perception and attitude. The ways in which many people think about disability often go unnoticed. In forcing society to reexamine some of its deeply held beliefs about what it means to be disabled, disability studies provide a clear articulation of the ways in which traditional approaches to and understandings of disability have served to create a highly marginalized and devalued group of people.

The second implication is more practical but no less important. Society must consider how it might organize, or reorganize, the physical and social worlds so as to incorporate people with disabilities in more genuine and authentic ways. In the end, it is insufficient to guarantee equality without directly addressing the ways in which policies, practices, and service systems act as barriers to the full and equal participation of people with disabilities. It is vital that human service professionals provide services and supports in ways that do not promote, or at least minimize, the stigma associated with disability.

Conclusion

The field of disability studies offers the tools to reimagine disability as simply another of many human conditions. It forces society to open its eyes and allows people to challenge their own misperceptions and unchallenged misconceptions about people with disabilities. Above all, it encourages society to see the person beyond the disability and provide valued, respectful support to a group of people who deserve to be viewed in this light because they are fellow human beings.

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See Also: Accommodation; Americans with Disabilities Act; Assistive Technology; Developmental Disabled Individuals.

Further Readings

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Disabled Clients

Disability issues have increasingly become a subject for discussion in the last few decades. In this article, the term *disabled clients* refers to people who access services within a variety of health and social care organizations and come into contact with a diverse range of staff at different points in their lives.

Critical to this discussion of disabled clients are a definition of disability and an understanding of the three key models of disability, namely the medical model, the social model, and the International Classification of Functioning Disability and Health (ICF). Further, a discussion of the potential impact of having a disability is explored, and key developments such as technological changes, media coverage of disability, and development of equality legislation and health promotion are examined in relation to their impact on disabled clients. The discussion concludes with some suggestions for the future to improve the lives of disabled clients. At this point, however, it is critically important to examine the complex and diverse nature of disability, as any narrow understanding of the issue may be limiting at best and may overlook the diversity within disability.

The Complexity and Diversity of Disability

Disability is complex and this has led to much debate without any consensus regarding definitions. The World Health Organization (WHO) and World Bank jointly published the *World Report on Disability*, which suggests that more than a billion people in the world live with a disability of some kind, and estimates that among those affected, 200 million people have problems in being able to function. Disability is multifaceted, and it would be very simplistic to view and diagnose disabled clients as a homogenous group.

In some cases, disability can be temporary, as for an older person sustaining a hip fracture and being unable to walk for six weeks, resulting in a temporary disruption in usual activities. Disability can also be long term and life changing, as in the case of a young person being diagnosed with multiple sclerosis, a neurological condition with fluctuating symptoms and abilities that may require long-term management. In addition, some forms of disabilities may be life limiting and progressive, such as a diagnosis of terminal cancer. In some cases, disability is attributed to people who have cognitive difficulties and problems with reasoning, learning, and understanding. Examples include individuals with learning disabilities, or those who experience difficulties with social functioning and empathy, as seen in some forms of autism. It is critical to underline that disabilities may not always be outwardly obvious or visible (e.g., some mental health conditions such as depression or sensory disabilities involving hearing loss).

Disability and impairment may be a result of an event or encounter that will have happened at different points in time in a disabled client's life story. For instance, an event may have occurred in the period leading to birth or during birth, such as cerebral palsy. This condition may lead to weakness or paralysis in the upper limb, thereby having a significant adverse impact on a person's ability to wash and dress. Or the disability may be a result of something that occurred later in life, such as a cerebral vascular accident resulting in paralysis and mobility problems.

Given the diverse range, nature, severity, and context within which disabilities may be understood, it is critical to consider how disabilities may impact the affected groups and individuals. Crucially, the impact of disability on disabled clients may differ from person to person, depending on factors internal to the person. Example factors include the severity of the disability, gender, personal coping strategies, financial factors, spirituality, levels of personal capacity, personality, self-esteem, age, and culture. As a matter of caution, though, it would be simplistic to conclude that any of these factors in isolation or combined articulate the impact on affected individuals without appropriate and targeted assessment.

In addition to such internal factors, external factors impact significantly on disability. The cultural, social, political, and physical environment surrounding the disabled client and support systems are critically important to address issues around disability and its diverse nature and needs. For example, the *World Report on Disability* acknowledges that there is a link between poverty and disability in developing countries in that high rates of untreated illnesses may lead to disabilities. Importantly, individuals' economic and social environments may play a significant part in their risk of becoming disabled.

These diverse factors surrounding disability present many challenges for people working with disabled clients. Disabled clients are not a homogenous group and should therefore not be subjected to one-size-fits-all solutions and diagnostic yardstick approaches. Disability has been recognized and understood in different ways over time, and several models have been proposed that consider disability in different ways, each having an impact on how a disabled client is understood by others, including people who provide services.

Models of Disability

Medical model of disability. Under the medical model of disability, disability is generally associated with a particular medical diagnosis and prognosis and focuses on signs and symptoms. The model suggests that disability is situated entirely within the disabled person. The medical model of disability essentially highlights what disabled clients cannot do due to whatever impairment or dysfunction they possess. The aim of the medical model is to treat symptoms and problems arising from the disability. Commonly, this model assumes that people working with the disabled client are the experts.

Some proponents of the medical model argue the importance of identifying and addressing signs and symptoms and what a disabled person cannot do because of their diagnosis as a means of getting appropriate support and treatment. Critics argue that this approach to disability is too narrow and that the focus should be on the environment around the disabled client rather than considering only the disability itself. Further, the medical model is sometimes criticized as potentially leading to clients being treated as passive recipients of care as opposed to them being the experts on their own disability and able to work collaboratively to find solutions to any problems they experience.

Social model of disability. The main thrust of the social model of disability is the emphasis on considering a disabled client from a more holistic perspective. The social model suggests that the disability is predominantly not the diagnosis, signs, and symptoms, but the disabling and inaccessible environment surrounding the affected people. An example of this is a full-time wheelchair user who would like to utilize the local gym facilities, but the bus to the gym does not have enough space for a wheelchair, and several steps leading up to the gym make it inaccessible. This leads to the disabled being excluded from an activity that may be meaningful and purposeful to them and being denied an opportunity to access leisure activities that may enhance their overall health and well-being. Indeed, the *World Report on Disability* argues that disability is a human rights issue, as disabled people face many barriers affecting multiple areas of their lives that nondisabled people do not necessarily face.

The disabling environment goes beyond consideration of the physical environment within this model and includes the attitudinal barriers and stigma associated with disability and disabled clients. Stigma is defined in this context as people making negative stereotypical assumptions about people with a disability. This can translate into some people with disabilities being excluded from groups or communities because they do not feel welcome. It may also lead to clients with disabilities not being recognized for their talents and what they can potentially contribute toward society because emphasis tends to be placed on incapacities and deficits rather than strengths and capabilities.

Negative attitudes toward people with mental health issues have been highlighted frequently; in particular, tabloids have been criticized for their sensationalist portrayal of schizophrenics commonly linked with violent crimes, stirring up fear among the general public. Inequalities in job opportunities due to stigma and discrimination have been highlighted frequently by service users with mental health problems. The social model of disability would attribute some of these inequalities as being the result of employers' lack of understanding. A number of programs have been developed to try to demystify mental health problems and raise awareness in the workplace.

Overtly identifiable disability may in some cases be recognized and perhaps dealt with differently from disabilities not blatantly obvious, such as those related to mental health. People with mental health problems have stated that they commonly experience stigma, and many service user groups have described how this impacts negatively on their lives and opportunities. Such issues sometimes arise in the process of people with mental health problems applying for jobs and disclosing their diagnoses. This disclosure seems to have the likelihood of putting them at a disadvantage in getting jobs, even though with relevant support in place they would potentially be productive in the job. These experiences may impact negatively on self-esteem and self-belief.

Proponents of the social model perspective would argue that if some changes—in some cases very minor—are made within the work environment, people with mental health problems would be able to do the job successfully. As can be seen, the social model underscores the importance of

The Opportunities Fair and Beyond Art Exhibition, held in Hockley, United Kingdom, was a free event focused on people with learning disabilities, physical disabilities, mental health difficulties, autism, visual and hearing impairments, adults 65 and over, and all carergivers. The event allowed these groups to find out what services, support, and opportunities are available to them.

working in collaboration with the disabled clients by way of assessing the clients' perspectives in capturing both the barriers they face as well as aspects that would enable them to function and participate in a given environment.

Examined from another angle, it could be argued that the social model of disability is a less hierarchical approach compared to the medical model of disability. Of course, the medical model of disability at times has a place within the client-support interaction, considering that different clients have differing needs. What is appropriate to one client may not necessarily be beneficial or appropriate to another. Thus, each of these models has its advantages and strengths. Some critics argue, however, that the medical and social models are often presented as occupying opposing ends of a continuum when they should both be recognized as offering different perspectives on disability.

International Classification of Functioning Disability and Health

Fragmented perspectives to understanding disability can be problematic in addressing the genuine and diverse needs of disabled clients. Thus, the need to appreciate the complexity and diversity of disability and the context surrounding it have been encapsulated in another framework, the International Classification of Functioning Disability and Health. The ICF was collaboratively developed by a team of people from clinical practice, academic institutions, and the disabled population. It aims to offer a universal approach toward defining and understanding the impact of disability through the use of comprehensive and neutral language.

The ICF represents a dynamic and interactive perspective on understanding individual disabled clients and the impact of disability across populations. Three main interconnected areas are proposed:

- Impairments emphasize the person's specific disability (e.g., left-sided upper limb weakness).
- Activity limitations focus on challenges faced by the disabled person in carrying out activities (e.g., dressing, cleaning teeth).
- Participation restrictions are centered around difficulties the disabled person may experience in any area of life (e.g., access to leisure facilities or inaccessible university buildings impacting access to education and progression).

The ICF considers disability to be the result of any difficulties within these three domains and considers positive areas within them that may lessen the impact of the disability. The ICF proposes that disability is a dynamic concept that can change rather than a static and fixed concept that is easily categorized. How the environment (positively or negatively) impacts the disabled client is a key part of the model, emphasizing some of the aspects of the social model of disability highlighted earlier. Indeed, the environment and its impact on disabled clients are viewed broadly to encompass many dimensions, including attitudinal, institutional, social, physical, and political factors.

Personal factors of disabled clients constitute an important part of addressing issues around disability. Personal factors can have a significant impact on participation in desired activities and life, and as such they form some of the key features of the ICF, including self-efficacy and personal drive. Both the taking part in activities and the degree of potential to participate are critical starting points for informed engagement.

Within the ICF is a strong emphasis on the interaction among personal factors, such as health, impairment, and capacity, and the environmental context and barriers. Indeed, this is important because people with disabilities worldwide have historically lived, worked, and socialized in segregated settings. However, awareness, lobbying, and sensitization of these needs have contributed to significant shifts in Western countries and progressively so internationally. Political shifts and the ability to appreciate the issues brought about by the disability movement have resulted in significant changes in the way disability is viewed. Such changes have led to more inclusive legal, economic, social, and financial approaches, as well as a more prominent and effective platform for discussions with and about disabled people.

Advocates of the ICF argue that it offers a less concrete simplistic perspective on disability, which can enhance the understanding of disabled clients. The framework acknowledges strengths and also recognizes barriers in the environment that could be changed to facilitate and enable participation of people with disabilities. This recognition and acknowledgment may promote disabled clients' involvement in valued activities, potentially leading to a more socially inclusive society where disability is viewed across a continuum of abilities and difficulties. This perspective is rather different from situations whereby disabled clients are categorized and potentially labeled by their diagnoses. The above discussion thus naturally leads to how clients' disabilities affect them.

The Impact of Disability

Although it has been acknowledged that disability experiences are diverse, disability is commonly associated with disadvantage, stigma, and discrimination. The *World Report on Disability* highlights that people with disabilities are often more likely to experience health inequalities and difficulties in accessing the services they need and to have problems gaining work and participating in community activities. In addition, they are not always able to live independently, and they experience poverty and reduced access to education.

The impact of stigma and discrimination can be significant and potentially lead to people with disabilities experiencing low self-esteem and loss of belief in their capacities and self-efficacy, potentially leading to a negative cycle of loss of motivation and withdrawal. For various reasons—cultural, social, economic, and political, among others—people with disabilities in parts of the developing countries are sometimes shunned and excluded from communities; the impact may be more severe than in more developed countries. Some of the experiences and attitudes toward disabled clients may not necessarily be worse in developing countries, but the political, legal, and economic environments alongside awareness frameworks in developed countries have brought this issue to popular discussion.

The impact of disability could be a result of an interaction between the person with disabilities and the barriers within their context as outlined above in the social model of disability and the ICF. However, although the impact is significant, a number of developments have made a positive difference in the experiences of some clients with a disability; these will be explored next.

Positive portrayals of disability encouraging attitude change. Advances in technology have had a noticeable impact on the lives of disabled persons in terms of enabling them to overcome some of the physical barriers that exist. The 2012 Paralympics in the United Kingdom demonstrated that the use of technology combined with natural ability and determination can lead to positive results and highlight the strengths of disabled persons. An example is the U.S. paralympian Jerome Singleton, whose lower leg was amputated at the age of 18 months, and who uses a carbon blade prosthesis to run. Another is South African double amputee Oscar Pistorius, who became known as the blade runner. These prostheses have played roles in overcoming physical limitations for amputees, and such positive achievements may also have impacted social attitudes toward persons with disabilities.

Health promotion. As the *World Report on Disability* highlights, the rates of disability are forecast to rise, predominantly because of the increase in diseases that can cause disabilities (e.g., diabetes, cardiovascular disease, cancer, and mental health problems). Health promotion has been developed as a means of preventing diseases and taking a proactive stance in addressing health needs across individuals, communities, and societies. Health promotion approaches seek to address three main areas:

- Primary prevention seeks to prevent the disease/illness from happening in the first place through education (e.g., dietary education to prevent cardiovascular disease).
- Secondary prevention focuses on identifying and responding to disease in its earliest stages (e.g., breast cancer screening and early intervention to minimize the impact of the disease).
- Tertiary prevention targets individuals and populations who already have an established disease and attempts to successfully manage it to prevent further disease and disability and promote quality of life (e.g., stroke rehabilitation programs).

Health promotion approaches translate across physical and mental health, are cost-effective, and can be delivered in many settings outside of traditional care settings. Individuals and communities should be actively engaged and motivated to take responsibility for their health within these approaches, which may present challenges if people are unwilling to engage.

Assistive technology creating more accessible environments. Technology in some countries has also had a positive impact on clients with disabilities, particularly in enabling them to be able to live safely and independently for as long as possible in their own homes. Assistive technology is a broad-based term that encompasses products, devices, and any equipment that aims to enhance or maintain safety and independence for disabled clients in a range of settings. Telecare, for example, is an advanced alarm system with sensors placed around a disabled client's home so that if the client falls, the sensors pick up on this and set off an alarm without the person needing to be near an alarm button.

In addition, advancements made in the areas of assistive technology and dementia have been beneficial not only to the clients but also their caregivers. For example, reminder messages can be recorded and then activated to remind a person with dementia to lock the door or pick up keys.

Sensors placed around disabled clients' homes can trigger alarms if they leave water running or forget to turn off the gas. More controversial forms of telecare used with people with dementia are tracking devices—the person wears a tag, and satellite devices alert caregivers as to their whereabouts. Some critics have called the use of tagging devices inhumane and have warned that use of such devices may lead to staff not giving the care and supervision needed to people with dementia. Other critics have suggested that overuse of any equipment emphasizes a person's disability and may have a detrimental impact.

Indeed, advocates of telecare have suggested that consent must be gained for any equipment and the person with a disability needs to be proactively involved in the whole process of choosing which equipment will be important for them and their circumstances. Although this is deemed good practice, challenges emerge when disabled clients may not have the capacity to consent to equipment even though it may be beneficial to them and their health and safety.

Celebrity culture and its portrayal of disability. Popular culture has played a significant role in bringing issues about disability to the forefront and has encouraged people to talk more openly about disability and appreciate the human face of disability. Films such as *A Beautiful Mind* have illustrated some of the complexities around having a mental health diagnosis. This film illustrates the narrative of a gifted mathematician and his coming to terms with having a diagnosis of schizophrenia and then going on to win the Nobel Prize.

The comedienne Ruby Wax has talked openly about her own experiences of depression. She wrote a play, *Losing It*, that has successfully toured the West End in London in which she uses personal examples to illustrate the complexities around mental illness and tries to raise awareness of it as a hidden disability that is part of the human condition.

Art and culture have also played roles in promoting disabled people and in encouraging debate and discussion around disability issues. For example, in 2007, Alison Lapper, an artist who was born without arms and with shortened legs, was made famous by a marble sculpture of her while pregnant placed on a plinth in Trafalgar Square in London. The motivation behind the sculpture, according to the sculptor, Marc Quinn, is that disabled people are underrepresented in art.

Well-known and highly respected theoretical physicist Stephen Hawking is another example of a high-profile person with a disability who has overcome many barriers and challenges. Diagnosed with motor neuron disease in 1963, he is a positive example of what can be achieved.

Legislation Promoting Equality

Despite best intentions, if calls for good practice, physical adaptations, pronounced declarations of appreciation, and understanding of issues around disability are not underpinned by legislation efforts, they can prove futile. Although most people working with disabled clients will endeavor to work in their best interests, a legal framework is always an important part of understanding and addressing disability issues. In the United Kingdom (UK), for example, as a direct result of legislation such as the 1995 Disability Discrimination Act, most buildings currently being constructed will ensure access and usability by disabled employees and clients likely to use the building. Within this legislation, employers are required to make reasonable adjustments to a job if a person discloses a disability. In addition, the 2010 UK Equality Act consolidated and developed equality legislation further by bringing together all antidiscrimination legislation. The United Nations Convention on the Rights of Persons with Disabilities entered into force in May 2008, explicitly highlighting disability as a human rights issue. It aims to protect the rights of disabled people to live and participate as fully engaged citizens and identifies where changes need to be made to enable this to happen.

Conclusion

The developments discussed above relating to disability may contribute toward the vision and realization of disabled clients being able to feel socially included in each sphere of their lives and to live fulfilling lives that enhance their health and well-being.

Some evidence suggests that negative and stereotypical attitudes are changing, but there are still some developments to be made in this area. Indeed, although positive portrayal of disability in the media as well as equality legislation may have had an impact, there are challenges in measuring attitude change and the impact of policy developments and whether they translate across all areas of the world. Further, disabled clients themselves need to be encouraged to play key roles in terms of policy development and identifying structural inequalities that exist as well as identifying the best solutions for these issues.

Technological developments have enhanced opportunities for disabled clients to live safely and independently. It is crucial, however, that disabled clients be enabled to play active roles in consenting to equipment and that their capacity to consent is assessed. Also, equipment should not replace excellent humane care; rather, it should enhance good practice. It is also questionable whether such technological advances have translated into developing countries where the financial and legislative infrastructure may not always be in place to support such developments.

Although positive changes have occurred, more proactive approaches will need to be harnessed to address the barriers facing people with disabilities (e.g., education), preventive approaches such as health promotion, and redesign of towns and cities to enable accessibility. Most important, the inclusion of people with disabilities in the development of policy, organizational, and cultural modifications has proved crucial in realizing real and sustained change.

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See Also: Accommodation; Americans with Disabilities Act; Assistive Technology; Developmental Disabled Individuals.

Further Readings

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Discrimination and Institutional Racism

In his writings in the 1900s about race relations, W. E. B. Du Bois often asserted that the problem of the 20th century was the color line (i.e., barriers between white and nonwhite people). This idea rings true today, even as the overt racism that characterized that period has transformed to more covert but no less destructive forms. Institutional racism, in which the values, beliefs, and principles underlying organizations' policies and procedures affect racialized groups, provides a powerful mechanism to exclude stigmatized populations, marked as not white. Both public and private institutions are extensions of larger society and are not immune to racist attitudes and values of the white dominant group, in which the need to exercise power and control over others is preeminent.

Racism is always harmful, but discrimination perpetrated by service-oriented organizations is particularly vexing because it can deny help and support to the very people who come to these organizations for assistance. The disadvantages caused by lack of access to such services can have consequences in all areas of life, including, among others, social, economic, educational, and legal. For human services in particular, the issue must be faced and a solution sought.

Today, many people of privilege feel that they live in a color-blind society, and that racism is a problem of the past. Such thinking was likely behind the

June 2013, U.S. Supreme Court decision in striking down section 4 of the 1965 Voting Rights Act, a key piece of U.S. civil rights legislation. Historically, however, racism has been an accepted—and legal—aspect of North American culture. For example, in Canadian residential schools in the 1940s and 1950s, aboriginal peoples were used as test subjects for government-sponsored malnutrition studies, perfectly legally, and without their knowledge or consent. They were selectively studied for these experiments simply because of their status as a minority group. In the southern United States, the legacy of Jim Crow segregationist and racist laws has persisted unabated; racist sentiments that have devalued African American lives allowed the murder of Trayvon Martin to go unpunished. George Zimmerman, of mixed Hispanic and white racial heritage, fatally shot Martin, an unarmed 17-year-old black male youth, in February 2012. Zimmerman was acquitted in July 2013 by a mostly white jury, but debates continued to rage as to whether this was a racially motivated crime. Although Zimmerman's act was adjudged to be legal under Florida's Stand Your Ground statute, his acquittal served to reduce black people's confidence in the criminal justice system and sent a message that violence perpetrated by those in power against black people was acceptable in society.

Institutional racism is more a question of organizational policies and practices, not laws. Racial discrimination by institutions is a particularly insidious and concerning type of cruelty, and it may lead to more damaging outcomes than other forms of racism. Racist attitudes and beliefs are embedded within institutions, including schools, governments, religious or faith-based organizations, and law enforcement. But institutional racism is often ignored or denied, so that nothing is done to correct the oppressive situation. An example within law enforcement is the New York Police Department's controversial stop-and-frisk policy, under which officers can stop and search citizens with no need for reasonable suspicion of any criminal activity. Racialized people, most of them African American and Latino men, have been selectively targeted for stop-and-frisk. From an economic perspective, moreover, labor market outcomes for racial and ethnic minorities are strikingly disadvantaged. Consistent with findings in the United States regarding job applicants with African American–sounding names, academic studies show that Canadian immigrants with Indian-, Pakistani-, or Chinese-sounding names were significantly less likely to receive a job callback than equally qualified applicants with English-sounding names. These experiments demonstrated evidence of implicit bias on the part of employers against prospective job applicants on the basis of race or ethnicity; such violation may have discriminatory effects, including sustaining caste-based economic inequality, in which racialized groups are denied full participation and inclusion in society.

Historical Overview

Racism has been prevalent in North America since colonial days. Some of the first instances of institutional racism to take place in Canada and the United States were governmental policies of assimilation that discriminated against and denied rights to aboriginal peoples and Native Americans. Slavery of African Americans and black Canadians is another prominent example of state-sponsored federal ordinance. In addition, early immigration policies discriminated against several groups, including Chinese, Jewish, and non-Protestant European immigrants. At the start of the 21st century, when populations were becoming more ethnically diverse, racism was deemed unacceptable, and new legislation was put in place with the goal of preventing discrimination. Although these attempts to prevent discrimination served to make racism more subtle, it still remained.

The concept of institutional racism emerged in 1967 in the work of Black Power activists Stokely Carmichael and Charles Hamilton. In their book *Black Power,* they discussed the pervasiveness of racism in the United States. They wrote of a type of racism linked to unjust bureaucratic policies. Their analysis divided racism embedded within organizations into individual racism and cultural racism. Although connected, these forms of racism can be seen as separate phenomena. Individual racism comprises the racist attitudes, beliefs, and actions of a single person. Cultural racism is racism embedded in a society's collective beliefs and values. Cultural racism leads to institutional racism, which in turn can cause individual racism.

In the 1970s and 1980s, some of the first North American antidiscrimination legislation appeared. In Canada, laws such as the 1986 Employment

Stokely Carmichael, pictured in the 1967 Michigan State yearbook. Carmichael and Charles Hamilton wrote Black Power, *which discussed racism in the United States.*

Equity Act and the 1988 Multiculturalism Act were created with the purpose of ensuring equal opportunities in employment as well as promoting social diversity. Similar legislation appeared in the United States in the form of affirmative action policies. These new policies and laws, designed and meant to regulate discrimination by organizations, took into account the idea of institutional racism as suggested by the 1981 Scarman Report, which defined institutional racism as something that must be conscious within an organization. However, because institutional racism can operate without the conscious knowledge of institutional actors, it is often overlooked, and, unfortunately, the new laws and policies did little to fix the problem.

Effects

Institutional racism operates in many different settings, but regardless of its professional context, the outcome is the same—it denies legal rights and limits life opportunities for racialized groups. A cycle of oppression, it creates disadvantages in one area that lead to further disadvantages in others. For instance, unequal distributions of educational resources create disparities in the quality of schooling available to white and nonwhite children. Minority residential communities are also more frequently located near highways, factories, and industrial plants, which can pose various health problems. Low employment contributes to crime levels in already suffering communities, and policing in these areas tends to be generally strained and impelled by racial animus. Racialized groups in any neighborhood are more likely to be singled out or harassed by police. Once arrested, they are more likely to be charged with an offense. They also represent a higher proportion of the prison population. This is particularly true for young black men, and increasingly for men of Arab and Middle Eastern descent. Since the terrorist attacks of September 11, 2001, Muslim men have increasingly and dramatically been stigmatized throughout North America. They are at high risk for experiencing Islamophobic discrimination and violence.

This cycle of oppression can have serious consequences on individuals' well-being. Some people who suffer from the effects of racism may go on to develop physical and mental health complications such as anxiety, depression, and heart disease. Exposure to traumatic events, in the case of aboriginal peoples, may precipitate experiences of posttraumatic stress disorder (PTSD), often referred to as residential school syndrome. Human services providers may not be aware of the cultural differences of the clients they serve, as their practices are based on majority (i.e., white) norms, so that when people suffering from racism turn to human services organizations for assistance, they may face the same racist policies and discrimination that led them to seek help in the first place.

Those who seek services from such institutions may face barriers, such as discriminatory eligibility criteria for services, or policies that interfere with cultural practices. Many individuals who become aware of institutional racism within agencies that operate under racist policies may take offense and cease to use those organizations. Fearing a loss of clients and decreased service utilization, such organizations may deny and cover up their racist tendencies. Agencies operating under racist policies are not fulfilling their mandate to serve the public when they serve only a portion of the populace. In a recent example, a young boy in Québec was denied a place on a soccer team because he was not allowed to wear his turban during games. This uniform policy selectively discriminated against Sikhs and other minorities. The premier of Québec initially supported the decision to ban turbans.

However, after a backlash of criticism from the general public, the Québec Soccer Federation decision was reversed, and a formal apology was given. New controversy has since emerged in Québec regarding the prohibition of overt display of religious symbols and articles of faith by civil servants, under the guise of a separation of religion and state. The proposed secularism charter targets racial, ethnic, and religious minorities, who may feel pressure to choose between their religious convictions and their livelihood. Such a policy can severely curtail employment opportunities for certain segments of the population, further reducing public access to trained employees, especially those with sociocultural backgrounds different from the dominant (i.e., white francophone) social group.

Employees of agencies operating under racist policies are themselves not free from harm. Working in a racist environment, they may develop individually racist attitudes that will carry over into their social environment. Today, people do not wish to admit to racist attitudes and may not be fully aware that they are participating in racist practices. Institutions cannot solve these inherent problems by denying or ignoring them; that would serve only to allow their racist practices to continue. The Québec Soccer Federation's apology made no acknowledgment of institutional or structural racism; rather, it denied that racism had been a factor in the decision making. This contrasted with the Canadian government's apology for institutionally racist practices related to the Chinese head tax and Indian residential schools. These actions followed the example of the Mulroney government, which issued a formal apology for the internment of Japanese Canadians. In each case, redress was offered in the form of monetary compensation, but only if survivors could prove, through substantial and intrusive assessments, that they suffered under federal policies of racial segregation and legal discrimination.

The legacy of institutional racism in North America is such that standard practice is to discriminate as long as an apology eventually follows, along with a denial of racism designed to protect the image of racist institutions.

Solutions and Strategies

Many laws, regulations, and organizational policies have been put in place, but applying them in everyday practice has proved difficult. Institutions have attempted various policy changes, including changes in regard to hiring, promotion, evaluation, and compensation. Two methods in particular have been used: cultural awareness training and racism awareness training. Cultural awareness training aims to give frontline workers and management an understanding of different cultural backgrounds; for example, how a person's background may influence the way that person sees the world and relates to others. Essentially, cultural awareness training explores the nature of differing perspectives. When it comes to tackling racism, it is more of a preventive approach. Racism awareness training, in contrast, confronts racism more directly. This type of training focuses on how racism manifests in societies and organizations and teaches strategies for how to address it.

These methods have each been shown to be effective at the individual level, but very little has changed at the institutional level. Training programs that are designed and intended for individuals need to be combined with changes to policy and power structures within organizations. Ideally, institutions should encourage people to challenge the conventions and foundations of their own organization. Human service organizations especially need to critically analyze who they are, who they serve, and how those services are offered. Many individuals who are able to recognize discrimination and wish to report it are denied the opportunity to do so as a result of institutions that are bent on denying their claims of discrimination. They can be denied the ability to report through the lack of an established complaint system within their organization or through fear of being penalized as a result of a complaint. Often, those who make complaints receive fewer opportunities for advancement or may be transferred to less desirable work within institutions. Those who have been marginalized need to be empowered and come together in collective action.

A major problem is that a primarily white management has difficulty in determining what constitutes racism and recognizing it within their own organization. A racist environment within an organization will affect how procedures are carried out and how further policies are created, including the policies designed to prevent discrimination. Operating inside a culturally racist society, even the most well-meaning organizations have failed to eliminate racism embedded in their workplaces. The results of some strategies that may have proved effective are difficult to replicate because institutions vary in the ways racism is perpetrated.

The first step toward a solution is to understand the meaning of institutional racism and what constitutes it as such. The next step is to learn to recognize it within one's own organization. Only when these two criteria are met can organizations implement and monitor strategies to prevent institutional racism from happening. Additionally, what is needed is an understanding of cultural racism and how this contributes to the racism within institutions, to get at the root cause of discrimination and institutional racism, so that structural changes can be carried out for the betterment of the institutions and of society.

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See Also: Institutional Oppression; Prejudice, Theories of; Racial Microaggression; Racism, Long-Term Effects of; Social Work Practice and People of Color.

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Displaced Persons

The term *displaced persons* refers to individuals who are forced to flee from their homes, often suddenly, due to some type of crisis, such as conflict or a natural disaster. This type of crisis is also commonly referred to as forced migration. Mass forced migration that results in large numbers of people fleeing their homes is a relatively new phenomenon; it is often the result of violent armed civil conflict that causes thousands, sometimes millions, of people to leave their communities, often across international borders.

Even though people become displaced for a range of reasons, the primary cause of displacement is conflict. The pattern of world conflict has changed considerably in the last few decades, with a shift away from interstate conflict over territory and toward a pattern of intrastate conflict involving one or more rebel groups fighting against government forces. Most of these conflicts are in sub-Saharan Africa and southern Asia, where violent civil wars have cost the lives of millions, with millions more being displaced from their homes.

Typically with a natural disaster, the displaced populations can return home as soon as their communities become safe again, and life goes back to normal. But when people are forced to flee their homes and communities due to conflict, their situations and the response from the international community become far more complicated.

International law stipulates different categories of displacement based upon the circumstances surrounding the forced migration. Thus, different terms are used to describe displaced populations. It is important to understand the various legal designations of displacement since it is often the designation that determines the level of protection and services provided to the displaced population. Essentially, there are three legal designations, or legal statuses, for individuals who are forced to flee their homes: (1) refugee status, (2) internally displaced person (IDP) status, and (3) stateless person status.

- According to international law, individuals may be granted refugee status by the United Nations (UN) if they meet the criteria set forth by the 1951 Convention Relating to the Status of Refugees, which states that refugees are those individuals who have a reasonable fear of persecution based upon their race, religious beliefs, nationality, or membership in a particularly social and/or political group. One of the most significant requirements for gaining refugee status is that the individual must have fled across international borders.
- When people are forcibly displaced from their homes and communities but do not cross international borders, they are referred to as internally displaced persons. IDPs may also include situations involving cycles of violence (not rising to the level of civil war), natural disasters, or mass human rights violations.
- Stateless persons are defined as people who have no nationality. People become stateless for a variety of reasons, including situations in which a country no longer exists, such as Palestinians living in Jordan, or the Roma people, who have migrated throughout Europe for more than a century.

Nyanzale, in the Masisi, a small town where the population has more than doubled with the arrival of 20,000 people displaced from villages up to a day's walk away. The people fled out of fear because of fighting between rebel forces and the Democratic Republic of the Congo armed forces. Most of the world's displaced populations come from Africa and Asia.

The number of displaced people that the UN High Commissioner for Refugees (UNHCR) is responsible for has increased dramatically in the last decade because of the dramatic increase in worldwide conflict. Among the more than 42 million refugees worldwide, the UNHCR is responsible for just over 10 million. Most of the world's displaced populations emanate from Africa and Asia and remain within their general area of displacement. For instance, of all refugees from the continent of Africa, 80 percent remain in the region and only 20 percent are relocated outside the region. This situation can be good when many such individuals return home once conditions allow, but it can be bad when individuals who are forced from their homes but remain in the region continue to engage in the conflict.

The goal of the UNHCR is to find durable solutions for displaced situations with the best option always being a resolution of the conflict so that displaced populations can return home. In fact, most refugees and IDPs are able to return home once the civil unrest in their communities subsides, but sometimes people are not able to return home quickly because their homelands are experiencing multiple cycles of violence and civil unrest. Often, even if groups of individuals can return home, this does not always mean resuming life as it once was because many countries recovering from conflict are at high risk of renewed conflict and are often struggling with destroyed infrastructure and a lack of human capital. Thus, many displaced individuals often experience a cycle of repeated displacements in which they are forced to reside in UNHCR refugee camps, sometimes for extended periods of time, before they can return home, only to be displaced again when the violence resumes. These repeated disruptions in personal and community stability are often devastating for individuals and families, as well as the community as a whole. A cycle of repeated violent forced migration, resettlement, and reintegration into the home county (or a host country) is devastating and can affect every domain of the lives of those impacted—everything from individual and family psychosocial functioning to the ability to earn an education, build a career, or even build a family.

Unfortunately, for most of the world's refugees, conflict-generated IDPs, and stateless persons, a durable solution to their displacement is not easily found, leading to millions of displaced groups residing in refugee camps for extended periods of time. This dynamic is often referred to as protracted refugee situations (PRSs). In PRSs, large groups of individuals (hundreds of thousands to millions) are forced to flee their homes due to violence, and may be forced to live in UNHCR refugee camps for decades if conditions in their homelands remain dangerous and no other long-term solutions, such as permanent resettlement in a third host country, can be secured. Individuals in PRSs are often filled with hopelessness and are often forced to endure violence, including gender-based violence similar to that which forced them from their communities. They are also forced to endure a state of perpetual limbo as they wait for the international community to make determinations about their futures.

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See Also: African Immigrants; Asian Immigrants; Diaspora; Refugee Assistance.

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Disposition of Juvenile Records

Traditionally, the names of juveniles who commit crimes have not been publicly released because keeping them private has been considered a major step in the rehabilitation process. It has been considered a given that juveniles who commit minor crimes may still become contributing members of society. As such, they should not have to be labeled as criminals for their entire lives. As a rule, juvenile justice records have tended to remain sealed or be expunged when former offenders reach adulthood if they have committed no further crimes. Because criminal laws come under the province of state governments, each state is responsible for determining the dispensation of juvenile justice records. Consequently, laws vary significantly among the states. The privacy right of juvenile offenders has become a heated issue since the final decade of the 20th century because the offenses juveniles commit have become increasingly violent. Many states are now charging juveniles as adults in extreme cases, and adults have no right to privacy in criminal courts. Educational institutions from elementary to college are also demanding access to records of violent juveniles in order to provide protection on school grounds.

By the mid-1990s, 27 states had passed amendments stipulating a bill of rights for victims of crimes, and victims' rights advocates began demanding that victims and their families be given the right to testify in court during the trials of violent juvenile offenders. Members of the public are also insisting that they have a right to know what crimes are being committed in their own neighborhoods, regardless of the age of the perpetrator.

Background

Until the end of the 19th century, there were no separate courts for juvenile offenders. In 1899, Chicago established the first juvenile court as a way of providing rehabilitation for juvenile offenders and keeping them away from hardened criminals. The practice of limiting access to juvenile justice records was completely voluntary on the part of the courts and the media, and both entities cooperated in protecting the records of juvenile offenders from public scrutiny.

As the crimes committed by juveniles became more serious in nature, positions on privacy rights shifted. In 1980, only six states provided public access to juvenile justice records. By the mid-1990s, 21 states had begun opening up trials of violent and repeat juvenile offenders. In 1995, 26 states mandated public access to juvenile court proceedings. Maryland began publishing both the names and photographs of juvenile offenders, insisting that the practice added as a deterrent. That same year, the U.S. Supreme Court refused to hear a hate crime case, *United States v. Three Juveniles* (61 F. 3486). That refusal allowed to stand a lower court decision permitting individual judges to exercise responsibility for determining whether juveniles were entitled to privacy.

Access to Records

All states have recognized the need to allow certain individuals and groups access to the criminal records of juveniles. Those with access include attorneys; federal, state, and local law enforcement officials; court officials; parents or guardians; agencies that supervise juveniles who are incarcerated; probation officials; victims and potential victims; and school officials. Criminal justice researchers are allowed access in almost all states.

New York allows access only to the juvenile and his/her parents and to the judge with jurisdiction over the juvenile's trial. In West Virginia, a court order is needed to obtain access to juvenile records. Alabama, Mississippi, North Dakota, and South Carolina recognize the public's right to know that a violent crime has occurred, but the name of a juvenile offender cannot be released to the public. Alaska allows identities to be made public only when the safety of a school or the public is at issue. California, Louisiana, and Pennsylvania permit public release of a juvenile's name only if the juvenile was older than 14 years of age when committing a serious felony. In Utah and Virginia, the names of individuals older than age 12 and 13, respectively, are released if that juvenile is accused of murder, manslaughter, aggravated assault, arson, or a sex crime. Tennessee and Wisconsin release names when it is deemed to be in the best interests of the juvenile. Maryland releases names for good cause, and Illinois attempts to balance the rights of juvenile offenders with those of individuals or groups requesting access.

The Current Situation

States retain the right to control if, when, and how juvenile records are permanently sealed or expunged. In general, sealing or expunging occurs when a juvenile offender reaches a certain age without committing additional serious crimes. Oklahoma and New Jersey also seal records of juvenile offenders who enlist in the military. Twenty-two states treat juvenile justice records that have been sealed as if they never existed. In Florida, records are sealed unless a former juvenile offender applies for employment in a criminal justice agency, a school, a seaport, or a venue that would allow the former offender access to children or vulnerable adults. Juveniles whose records have been sealed or expunged may truthfully answer that they have no criminal history.

As juveniles continue to engage in increasingly violent crimes, many of which take place on school grounds, states continue to pass laws that require authorities to notify schools of criminal records of violent juveniles. By 2006, 44 states had enacted such laws. At the college and university level, prospective students are usually asked about any criminal history, and some schools ask specifically about juvenile offenses. By 2009, 66 percent of U.S. colleges were routinely requesting access to juvenile records of students and prospective students.

Victims' rights are a significant factor in the battle to open up criminal records of violent juvenile offenders. Members of the public have also entered the fray, demanding the right to be told about violent juveniles. The demands of victims and the public are particularly insistent in the case of sex crimes, deeming it important for entire communities to know about the presence of sexual predators living nearby. In such cases, the right to protect the privacy of juvenile sex offenders is considered less important than the public's right to be made aware of the danger their presence presents. Bills dealing with the subject have failed to pass Congress, and in the absence of federal laws, state laws continue to range from those of Kansas, where judges have the right to decide whether to release the name of a juvenile sex offender to the public, to Missouri, where the names of juvenile offenders are not included in public registries. Since courts at both the federal and state levels have held that juvenile offenders have no constitutional right to privacy, the dispensation of juvenile justice records continues to be hotly debated.

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See Also: Counseling and Psychotherapy Services; Juvenile Delinquents; Juvenile Justice System.

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Diversities

Diversities, formerly the *International Journal on Multicultural Societies* (*IJMS*), is a scholarly and professional journal established in 1998 by the social sciences research and policy division of the United Nations Educational, Scientific and Cultural Organization (UNESCO). The journal is now jointly published by UNESCO and the Max Planck Institute for the Study of Religious and Ethnic Diversity at Göttingen, Germany. Its objective is to improve the linkages between academic communities in various regions and across different social science disciplines. In May 2010, *IJMS* changed its name to *Diversities.* The new International Standard Serial Number (ISSN) for *Diversities* (2079-6595) has been linked to the ISSN for *IJMS* (1817-4574) for bibliographic reference and records. Its editorial office is located at the Max Planck Institute for the Study of Religious and Ethnic Diversity. *Diversities* is a peer-reviewed, open-access, online-only publication, available on the Web site, www.unesco.org/shs/diversities and on the directory of open access journals at www.doaj.org.

Diversities provides a platform for international, interdisciplinary, and policy-related social science research in the fields of migration, multicultural policies, and human rights. One of its particular features is to promote policy-relevant social science research. Each issue is devoted to a coherent, thematic debate on a key issue in the field of migration and multicultural society. Topics and contributors represent the full range of global regions. Examples of the themes include exploring religious pluralism (1999), the human rights of linguistic minorities and language policies (2001), national identity and attitudes toward migrants (2005), depicting diversities (2010), and skilled migration and the brain drain (2012). *Diversities* publishes two issues per year, each issue generally including five to eight thematic publications in addition to unsolicited manuscripts in the open forum section (i.e., any topic within the domain of the journal) and book reviews.

The *IJMS* published policy-relevant social science research on multiculturalism, and established itself as a successful electronic journal with a broad audience worldwide. Following the traditions of *IJMS*, *Diversities* explores a wide range of topics related to social differences, including ethnicity, religion, language, gender, sexuality, disability, social status, and age. It focuses on how these notions are socially constructed, how they unfold in different contexts, and how they are addressed in policy and practice. The journal provides a forum for discussion, debate, refinement of social theory, and development of key ideas at the nexus of research and policy.

Editorial Board

As of 2013, the journal's publication director is Golda El-Khoury, team leader at UNESCO, Sector for Social and Human Sciences. Its editor is Gabriele Alex, professor at the Department of Social and Cultural Anthropology, Eberhard Karls Universität Tübingen, who first served as the editor-in-chief for *Diversities* in 2010 when working as a research fellow at the Max Planck Institute for the Study of Religious and Ethnic Diversity. She assumed the editorship from Matthias Koenig, who was the founding editor of *IJMS.* The journal's editorial board includes professionals and experts drawn from various fields. The editorial board members include Rainer Bauböck (Austria), Matthias Koenig (Germany), Lily Kong (Singapore), Peter van der Veer (Netherlands), Yinong Zhang (China), Brenda Yeoh (Singapore), and Patricia Mohammed (Jamaica). These editorial board members are from diverse disciplines, including anthropology, geography, sociology, religious studies, linguistics, and feminism, among others.

Submission, Review, and Publication Processes

Diversities makes announcements and open invitations for future publications. Articles are normally commissioned by the editorial office with the assistance of an external guest editor for the issue. The UNESCO Web site provides information about the requirements and time lines for manuscript submission. The publication guidelines include information about word limits, citation style, quality of language, and formatting style.

All articles are peer reviewed to ensure that they meet the desired quality. Published studies generally are clearly understood and easily accessible to all, including nonexperts. Authors are encouraged to formulate clear and direct arguments and to avoid excessive technicality, jargon, and methodological protocol.

Diversities emphasizes the importance of respecting differences in beliefs and backgrounds of diverse groups. Authors are encouraged to discuss controversial ideas and doctrines in a positive manner to avoid others attributing ulterior motives. Further, the articles should not be offensive to member states of UNESCO or jeopardize the spirit of international understanding and cooperation. The journal makes explicit claims, noting, "The opinions expressed in *Diversities* are those of the authors and do not necessarily reflect the views of UNESCO." UNESCO also reserves the right to editorial revision and abbreviation of the text, although any revision involving substantial change will be forwarded to the author for accord before publication.

As of 2013, abstracts of articles published in *Diversities* appear in the following indexes: Cambridge Scientific Abstract (CSA), Sociological Abstracts and Worldwide Political Science Abstracts, Elektronische Zeitschriftenbibliothek (EZB), International Bibliography of the Social Sciences (IBSS), Public Affairs Information Service (PAIS), Social Science Information Gateway (SOSIG), and Zeitschriftdatenbank (ZDB). All articles can be accessed in portable document format (PDF) through an open access channel known as the directory of open access journals (DOAJ).

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See Also: *Journal of Immigrant and Minority Health*; *Journal of Ethnic and Cultural Diversity in Social Work*; Multiculturalism; Spirituality/Religion and Diversity; Values and Ethics, Ethnic Diversity of.

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Diversity and Equality in Health and Care

The international journal *Diversity and Equality in Health and Care* (http://www.ingentaconnect.com/content/rmp/dehc) can trace its origins to a pilot 2004 special fifth issue of the well-known journal *Health and Social Care in the Community*, coedited by professors Paula McGee and Mark Johnson. British publisher Radcliffe Medical of Abingdon offered these editors the opportunity to create their own journal, which would join the publisher's stable of world-class medical journals, including *Education for Primary Care*, *The London Journal of Primary Care*, *Mental Health in Family Medicine*, and *Quality in Primary Care*. The journal adheres to the standards of the International Committee of Medical Journal Editors (ICMJE) and the Committee on Publication Ethics (COPE), and all papers are peer-reviewed.

Originally published as *Diversity in Health and Social Care* (ISSN 1743-1913, e-ISSN 1743-4904), the first volume of this journal appeared in late 2004, with a major focus on migration, ethnicity, and health, as well as health inequality in general. Over time, the journal increasingly attracted papers that also examined issues of gender, disability, and sexual orientation. Starting in January 2009, the title was revised to *Diversity in Health and Care* (ISSN 1759-1422, e-ISSN 1759-1430), following a refocusing of the publisher's interest on health service delivery. In 2012, after the purchase of the publisher by Electric Word, the title was finally revised to reflect the increased focus on inequality and diversity, including attention to intersecting inequalities across more than one strand of disadvantage, to the present *Diversity and Equality in Health and Care* (ISSN 2049-5471, e-ISSN 2049-548X). Earlier issues are indexed in the same sequence but may be identified using older International Standard Serial Number (ISSNs) numbers.

Diversity and Equality in Health and Care dedicates space for the publication of research and debate papers that address issues relating to the equitable provision of health care and services for members of diverse social groups and settings in all countries worldwide. The journal recognizes that many such papers may not gain acceptance in mainstream discipline-led journals, which view such issues as marginal or contentious and therefore not always acceptable to conventional reviewers. *Diversity and Equality in Health and Care* welcomes papers relating to all aspects of diversity in health and care and the inequalities experienced as a result of ill health, marginalization, prejudice, stigma, and issues in service provision. Published papers report on qualitative or quantitative research, describe and evaluate good practice, put forward arguments for debate, or discuss educational matters. The journal particularly encourages papers that present multiprofessional perspectives, that give attention to the views of service users and caregivers, and that explore the international dimensions of diversity and equality across and within cultures.

Diversity and equality are seen as very broad concepts, embracing areas that include, but are not limited to, race, culture, and ethnicity; sexual orientation; gender; migrants; caregivers; physical, communication, and learning disabilities; spirituality; and underserved or marginalized populations. Diversity also extends to the wide variety of settings in which care takes place as well as the multidisciplinary nature of professional practice. *Diversity and Equality in Health and Care* carries theoretical papers but also insists that materials published should contribute to the improvement of practice and professional development.

All issues include a section titled Knowledge-share, which carries a mixture of good practice studies, book reviews, and reports of meetings. A regular feature on continuing professional development in each issue highlights new knowledge in a specific field of practice. Selected papers may be offered on open-access terms. The journal is hosted online by IngentaConnect, and enjoys worldwide readership.

The editorial board of *Diversity and Equality in Health and Care* includes individuals representing the United Kingdom, South Africa, Switzerland, Jordan, the United States, Saudi Arabia, and New Zealand. The editors welcome the following:

- Research papers that address any aspect of diversity, including evaluative studies and methodological debates
- Practice papers that provide examples of culturally competent practice, or address the practicalities, policy, or managerial aspects of delivering services to members of diverse groups
- Debate papers that address key issues in diversity or focus on underresearched topics
- Knowledge-sharing reports, which may include book, Web site, video, and other resource reviews and papers about specific initiatives to improve practice

Submissions to the journal come from all around the world. Nearly all submissions undergo two independent, blind reviews, and are then returned to the authors with the reviewers' comments. Approximately one-third of the submissions are subsequently accepted for publication following revision. *Diversity and Equality in Health and Care* is indexed in:

- CINAHL
- Health Policy Reference Centre
- SocIndex (FT)
- Family and Society Studies Worldwide
- Gender Studies Database
- Race Relations Abstracts
- Social Care Online
- British Nursing Index
- Health and Social Care Abstracts
- CSA Sociological Abstracts
- CSA Social Services Abstracts
- DH-Data
- Ulrich's International Periodicals Directory
- SCOPUS (SciVerse)
- NHS Evidence

Subscriptions to *Diversity and Equality in Health and Care* include printed issues, access to online current content, the full text archive, Internet reference linking with search facilities, and an e-mail contents alert service. Individuals can also purchase online-only access to the journal, which excludes only the printed issues, for a reduced rate.

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See Also: Behavioral Health Disparities for Racial and Ethnic Minority Populations; Disabilities, International Variation in Attitudes Toward; Discrimination and Institutional Racism; Ethnic Diversity and Values; Health Care, Disparities in; *Journal of Ethnic and Cultural Diversity in Social Work*.

Further Readings

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Diversity in the Workplace

Workplace diversity refers to the similarities and differences among workers within organizations. Workplace diversity initiatives emerged from two divergent forces that exerted separate but significant influences on workplace diversity policies and practices. Protections found in equal employment legislation and penalties enacted to protect workers from discriminatory hiring and dismissal practices developed first as a result of the civil rights movement during the 1960s and 1970s. The business case for diversity emerged later as a result of increased competition for talent and a desire to improve organizational bottom lines through greater retention, engagement, and organizational commitment of employees from diverse backgrounds. Workplace diversity programs initially focused exclusively on the recruitment of workers based on race and gender characteristics. As more women and minorities entered the workforce, workplace diversity programs expanded to address concerns of retaining and promoting women and minorities through mandated diversity and sensitivity training for all employees. Dimensions of diversity now include age, ethnicity, gender, physical abilities, sexual orientation, educational background, geographic location, income, marital status, parental status, caregiving responsibilities, religious beliefs, work experience, work preferences, and job classification. Current diversity practices have expanded to focus on the climate of the organization as a means to promote inclusion.

The term *diversity* typically refers to organizational focus on the personal and interpersonal, whereas the term *inclusion* refers to a focus on the systemic. Inclusion focuses on how workplaces create opportunity, interaction, communication, information, and decision making as means to leverage diversity. Inclusive organizations employ a holistic approach to create structures, policies, and practices that reflect an understanding of the multiplicity of views and an appreciation for differences through better interactions among employees, clients, and vendors. Organizations that practice inclusion are thought to create cultures that invite collaboration; support problem solving; and promote creativity, flexibility, and responsiveness to change. Organizations can be diverse but not inclusive in the sense that they might have recruitment and retention policies and practices to promote diversity among employees but not change the way that these interactions are structured. Conversely, an organization might have internal policies and practices that are inclusive but may not be diverse. Diversity and inclusion practices within organizations are viewed today as a means to promote workplace fairness and organizational effectiveness.

Workplace diversity is intrinsic to human services because the workplace represents a community in which a significant proportion of a variety of adults participate for most of their lives. Engagement in paid work has financial, emotional, cognitive, and social benefits for individuals and provides a benefit system that includes wages as well as benefits and services directed at the social, financial, and health needs for which individual workers and their families are eligible. These benefits provide individuals and families with security against the privatization of human services through access to low-cost health care, health care savings, retirement and income savings, disability and death benefits, and education and child care credits. Systemic bias and discrimination against individuals based on gender, race or ethnicity, disability, religion, sexual orientation, sexual identity, and caregiving responsibility limits participation in work, which in turn limits human potential.

Discrimination in the Workplace

Diversity and inclusion practices within organizations are meant to reduce discrimination and exclusion of particular groups from full participation in the workforce. Discrimination in the workplace occurs when individuals, institutions, or governments treat an employee differently because of personal characteristics, such as race, age, gender, sexual orientation, disability, and caregiving responsibilities, instead of how well they can carry out their work. This treatment results in a negative outcome, such as limited access to jobs, denial of a promotion, unfair dismissal, or reduced compensation. Discrimination within the workplace has a number of distinct facets: it can be overt or covert, and it can be enacted intentionally or unintentionally. Overt acts of discrimination refer to explicit policies or laws that generate unequal treatment among groups. Covert discrimination refers to the implicit effects of overt laws or policies governing the workplace. Discrimination is labeled "individual" when it refers to a single act carried out by a worker within an organization. It is labeled "institutional" when it occurs as part of organizational policy or practice.

Workplace discrimination is a significant social and economic problem today. According to the Center for American Progress, discrimination is estimated to cost businesses $64 billion a year in lost productivity, poor job performance, and turnover, and it exposes organizations to costly litigation. A recent study conducted in California by the UCLA-RAND Center for Law and Public Policy found the average individual discrimination lawsuit costs employers $550,000 in court fees and compensation. Class action discrimination lawsuits can cost organizations millions of dollars in sanctions. The social costs associated with workplace discrimination are also high, seen through untapped human potential, loss of self-esteem, lost productivity, and organizational commitment.

The U.S. Equal Employment Opportunity Commission (EEOC) is responsible for enforcing all federal laws related to protecting workers from discrimination. Most employer organizations are covered under the EEOC (minimum of 15 employees; organizations with labor unions and employment agencies also are included). The EEOC receives, investigates, and resolves complaints of employment discrimination and may in certain cases pursue litigation if discrimination is found. The EEOC also conducts outreach, education, technical assistance, and evaluation programs related to diversity practices and policies. Organizations work with EEOC guidelines to ensure that they are meeting federal requirements on recruitment, hiring, and compensation, training, and firing of employees. According to the EEOC, employment discrimination charges have increased over the past 15 years by 23 percent, from 80,680 in 1997 to 99,412 in 2012. Of the cases filed with the EEOC in 2012, approximately 34 percent were related to discrimination based on race, 31 percent on sex, 23 percent on age, and 21 percent on disability.

Laws Protecting Workers From Discrimination and Bias in the Workplace

Workplace diversity practices originated with legal protections and strategies aimed at protecting certain classes of workers from discrimination through the use of nondiscriminatory hiring practices. Two responses characterize these protections against discrimination. Laws prohibiting discrimination based on personal characteristics are considered negative actions and were originally meant to promote equity and fairness in employment practices for women and minority groups. The Equal Pay Act of 1963 and Title VII of the Civil Rights Act of 1964 exemplify this type of action by prohibiting wage discrimination based on gender, age, or race; mandating equal wages for performing the same job; and prohibiting discrimination in hiring based on race, color, religion, sex, or national origin.

Subsequent legislation attempted to redress sustained and systemic discrimination through the creation of positive actions, designed to right past wrongs by providing disadvantaged groups with better opportunities. An example of a discrimination law meant to embody a positive action is found in Executive Order 11246 of 1965, which stipulates that organizations must ensure equality in hiring employees through the creation of action plans meant to increase the presence of women and minorities in workplaces and participation in managerial and leadership positions. Affirmative action policies in general are thought to increase organizational diversity in two ways, through (1) mandating requirements on the composition of the public workforce by specifying recruitment and promotion strategies aimed at designated groups, and (2) incentivizing private businesses to actively recruit and promote employees from key demographic groups by granting preferential access to government contracts to businesses engaging in equal opportunity employment practices. Businesses awarded government contracts are required to report their organizations' affirmative action plans and organizational demographics annually to the EEOC.

The successes of earlier legislative efforts to increase the participation of women and racial minorities into the workforce led other marginalized groups to fight for and win protections to the right to work. For example, the Age Discrimination in Employment Act of 1963 protects older workers by prohibiting discrimination in hiring, promotion, or dismissal due to age. The Pregnancy Discrimination Act of 1971 expanded protections to pregnant workers by prohibiting employers from not hiring, retaining, or promoting women who are pregnant. Workers with disabilities were extended specific protections from workplace discriminations in Title I of the 1990 Americans with Disabilities Act (ADA). The Family Medical Leave Act of 1993 secures unpaid job protections for workers with family care responsibilities, and the association provision within the ADA protects this group of workers with family care responsibilities from discrimination in hiring, promotion, compensation, and termination due to their caregiving responsibilities. Workers who identify as gay, lesbian, bisexual, or transgendered have protections under Title VII of the Civil Rights Act. Twenty-one states and the District of Columbia have specifically outlawed employment discrimination on the basis of gender identity. Federal employees have further protections against this bias through Executive Order 11478 (Section 1).

Legislation protecting key groups from discrimination in the workplace also serves to defend protected employee groups from employer retaliation. Employer retaliation complaints represent 38 percent of all discrimination complaints filed with the EEOC. Employer retaliation refers to any adverse action by an employer, employment agency, or labor organization against a covered individual when that individual is engaged in a protected activity. Adverse actions are categorized as an action that attempts to keep someone from opposing a discriminatory practice such as termination, denial of promotion, threats, unjustified negative evaluations, or increased surveillance. Covered individuals are people who have opposed unlawful employment practices, participated in legal proceedings, or asked for accommodations based on the legal protections afforded individuals based on race, color, sex, religion, national origin, age, or disability. Protected activities include opposition to activities believed to be unlawful, such as complaining to anyone about alleged discrimination against oneself or others, threatening to file a charge of discrimination, picketing, filing a charge of employment discrimination, or cooperating with an internal investigation of alleged discriminatory practices.

Demographic Trends Influencing Workplace Diversity Needs

A number of economic and demographic factors impact the current workforce and make workplace diversity a priority for organizations. First, the global economy predicates a need for organizations to work across national boundaries with their different languages, customs, and expectations. Most large companies have offices in multiple countries with customers as well as employees who most likely speak a variety of languages, and have customs and practices that may be very different from those of the parent organization. Failure to understand cultural customs and expectations can negatively affect organizational bottom lines through high turnover rates and decreases in employee commitment and productivity. As technology improves, access to more diverse populations is expected, as companies will expand to foreign locations in an effort to remain profitable and competitive.

The demographics of the workforce are also changing in several significant ways that require workplaces to attend to the diversity of the workforce. A key demographic shift is in the number of women who are entering and remaining in the labor force. U.S. census data show the participation rates of women in the workforce have increased significantly, from 37 percent in 1965 to 63 percent in 2011. Women compose nearly half (47 percent) of

The U.S. Army defines diversity as "the different attributes, experiences, and backgrounds of our soldiers, civilians, and family members that further enhance our global capabilities and contribute to an adaptive, culturally astute Army."

the labor force in the United States, and they are the primary wage earners in approximately 40 percent of households with children under the age of 18 years. The entry of large numbers of women into the workforce has created tensions in the workplace because, prior to this shift, women historically had acted as family caregivers while men worked outside the home as breadwinners. This gendered division of labor has allowed employers to structure the type, duration, and benefits associated with paid work on the assumption that men did not have child care responsibilities within the home. With more women in the workforce, workplaces have had to address the dual roles occupied by women by reexamining the structure, duration, and positive aspects of work through enhanced benefits packages and work-life initiatives as a means to recruit and retain women.

The aging of the workforce is a second demographic trend influencing diversity of the workforce. U.S. Department of Labor estimates suggest that by the year 2020, 25.2 percent of the workforce will be 55 years of age or older. Between 1977 and 2007, the employment of workers age 65 years and older increased by 101 percent compared to 59 percent for all workers in the population (age 16 years and older) during the same period. The rate of people age 75 years and older in the workforce has increased by 172 percent from 1977 to 2007.

The aging of the workforce is thought to be due to three occurrences: the aging of the baby boomer generation, the fact that older adults are staying in the workforce beyond traditional retirement age, and the economic crisis of 2008. Labor force participation rates for older adults (those age 65 years and older) have been steadily increasing since the mid-1990s, a complete reversal from previous trends in the 1970s and 1980s. Older workers are also much more likely to be employed in full-time rather than part-time work, which represents another reversal. This trend, coupled with low birthrates across most industrialized countries, means that fewer workers will be entering the workforce, older workers will hold onto jobs for longer periods of time, and, as they exit, labor shortages across all employment sectors are expected to occur.

Fertility rates, in contrast, are expected to remain at replacement levels. This means that any growth in the labor force will increase the need to pull workers from untapped parts of the labor pool (e.g., more women with children, people with disabilities, and immigrants). Immigration currently contributes 40 percent to the growth of the U.S. population overall and represents 16 percent of the labor force. Both these numbers are expected to grow over the next decade, which will increase the need for organizations to attend to workplace diversity and inclusion needs in order to attract and retain workers from these key demographic groups.

Diversity and Inclusion Practices

Human resource professionals enact the human service functions of organizations. They are responsible for recruiting, selecting, training, motivating, and rewarding employees. Human services professionals create training programs aimed at promoting diversity initiatives within organizations. They are also key influencers of organizational climate and culture through their strategic business relationships with top executives and managers. Within organizations, human resource managers are often the creators and disseminators of key policies meant to promote diversity within the workplace. In larger organizations, human resource professionals whose function is to manage diversity within the organization may hold specialized titles and training in diversity and inclusion practices.

The type and scope of diversity practices enacted by organizations are determined by a number of factors, including organizational size as well as commitment to and belief in the business case for diversity. The seven most common diversity and inclusion practices found in organizations are defined as follows:

- Affirmative action plans are action-oriented strategies carried out on an annual basis as a means to identify, evaluate, and achieve fair representation of women and minorities within organizations.
- Diversity committees and task forces are formed for the purpose of bringing people from disparate parts of an organization together to oversee diversity initiatives through brainstorming needs, identifying solutions, and monitoring progress.
- Affirmative action and diversity managers are dedicated positions that manage affirmative action and diversity initiatives

within organizations through the tracking and reporting of recruitment, retention, training, compensation, and promotion of women and minority employees.

- Diversity training is the most common diversity practice found in organizations. It developed as a means to educate managers on antidiscrimination legislation, suggest behavioral changes to address bias, and raise cultural awareness and cross-cultural communication. Diversity training has evolved further to focus on the need to create inclusive culture and climate through the creation of opportunities for women and minorities. This training is often offered to management or to all employees as part of an overall training plan.
- Diversity evaluations for managers refer to organizational assessments of attitudes and behaviors meant to provide managers with feedback on how their day-to-day decisions impact employee diversity.
- Diversity network programs are meant to build inclusion by creating networks for employees to facilitate the sharing of career information, advice, and opportunities for advancement through the development of professional networks. Diversity network programs vary in form from informal brown bag lunches on selected diversity topics to structured national conferences.
- Mentoring programs operate in a more deliberate fashion than do networking programs by matching junior employees on the management track to senior counterparts, with the goal of providing opportunities to meet and discuss career opportunities and seek informal career advice.

Impact of Diversity Practices Within Organizations

Organizations spend between $200 million and $300 million per year on diversity management alone. Yet very few comprehensive studies on the impact of diversity practices have occurred. Studies that have looked at whether diversity practices create and sustain a diverse workplace found some practices to be more helpful to women than to minorities and identified others as harmful to team processes by promoting feelings of difference instead of similarities. One consistent finding is that organizations who adopt diversity and inclusion practices for structural rather than symbolic reasons are more likely to attract and retain a more diverse workplace. This is because these organizations create institutional supports for diversity and inclusion, which are effective at changing the culture of the organization. The allocation of authority, accountability, and expertise (seen through affirmative action plans, diversity committees and task forces, and diversity managers and departments) to responsible stakeholders within organizations ensures that someone bears responsibility for insuring that diversity goals are developed, monitored, and met.

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See Also: Americans with Disabilities Act of 1990; Discrimination and Institutional Racism; Education for Diversity in Human Services; Equal Opportunity and Civil Rights; Equal Pay Act of 1963; Fair Labor Standards Act; Medicine, Workplace Diversity in.

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DiversityRx

The entity known today as DiversityRx evolved from an amalgamation of organizations and associations that came together with a central objective—to provide information, and in that process, offer education as it relates to the provision of health care services that meet the needs of culturally and linguistically diverse members of society. Cultural and linguistic differences historically had placed groups at a strong disadvantage for receiving health care. The DiversityRx alliance includes, among others, Resources for Cross Cultural Health Care (RCCHC) and the U.S. Department of Health and Human Services (HHS) Office of Minority Health. Support also came from, among other organizations, the Henry J. Kaiser Family Foundation, the California Endowment, the National Conference of State Legislatures, and Drexel University School of Public Health's Center for Health Equality. The 1995 launch of RCCHC soon produced the first DiversityRx Web site (funded by the Henry J. Kaiser Foundation) and the CLAS-talk listserv, as well as the National Conference on Quality Health Care for Culturally Diverse Populations.

Much of the strength of DiversityRx is attributed to its many alliances. In conjunction with a number of partners, DiversityRx supports the Your Voice initiative of the Tides Center, which operates as a nonprofit management service and does work in a vast array of areas, including health, community development, and social justice. In addition, research and policy projects of DiversityRx and RCCHC have received funds and support from a number of agencies related to HHS, such as the Office of Minority Health and the Agency for Healthcare Research and Quality.

The Target

Understanding the cultural and linguistic concerns that serve to insulate and often isolate diverse members of society is central to the focus of DiversityRx and its many partners to provide services for impacted groups. These groups include minority members of society, immigrants, and indigenous communities. In its mission to serve this group, DiversityRx has embraced partnerships with a wide spectrum of health care providers, policy makers, researchers, and other public and private entities. These committed providers strive to address the disparity created in both accessing and thus ultimately receiving health care comparable to other segments of the population. With its strong focus on promoting education, DiversityRx's role, in addition to providing information to its partners that can be used to effect changes that will ultimately result in the identified group accessing needed health care, is one of support. This has been the mission of DiversityRx since 1997.

Tools

To address the objective of providing information, DiversityRx and its partners have elected to utilize the forum that speaks loudest today—technology. Much of their information sharing utilizes virtual learning events in the form of Webinars and mini-conferences, and the provision of resource databases, by which distance issues and other institutional obstacles are tackled. The objective is to identify topical issues and, through these and other media, to give members access to relevant information and facts that will guide their actions. The learning has been described as bottom-up peer learning, by which each member and participant contributes to the education of the others via the open medium provided by the constructed network mechanism. A big part of the success hinges on participation and the learning and problem solving that is accessible and anticipated through the "virtual" learning approach. No limit or boundaries are set on the collaborations because the open nature of the forum fosters current information as well as unfolding problem solving. The plan is to continue to implement peer-learning networks. This approach has received favorable reviews from member organizations and individuals. With more community involvement and a more direct approach to raising and sharing issues and the responses to these issues, the vision is that more interaction will result in a wider dissemination of appropriate information, techniques, and best practices, which will ultimately filter down to the population at the heart of this project.

Structure: The Your Voice Project

DiversityRx has identified a three-prong approach to achieving participation and information sharing: (1) the establishment of peer-learning communities, (2) virtual learning opportunities, and (3) improvements to the Web site.

With peer-learning groups, professionals hold regular monthly forums to address the practices and challenges they face. Group size is between 12 and 20 members, who are required to communicate for a year. To safeguard against attrition, which has the potential to derail potential inroads and creativity and in general simply be disruptive to progress, participants are formally screened for fit and commitment. Further, participant guidelines stipulate involvement in a number of ways—for example, monthly online meetings, each member's possible lead on a topic at one of these forums, participation in blogs and the listserv, other levels of involvement that are more likely to result in a cohesive group, and continued participation. The objective is to

The purpose of DiversityRx is to improve the accessibility and quality of health care for minority, immigrant, and indigenous communities, as it is clear that significant disparities exist in health care to minority groups across the United States. In its mission to serve these groups, the organization has embraced a wide spectrum of partnerships.

share what works and what does not. Forums don't end after the formal scheduled meetings; there is opportunity to continue discussion beyond the meetings via listserv. Further, information is available in a clearinghouse of sorts, and thus is always available for referral.

The second forum type amounts to miniconferences—again, structured around very relevant issues impacting culturally and linguistically diverse groups and the need to have service delivered in a way that they can both access and understand. These conferences tackle issues of practice, research, and policy. Participants have an active part to play—they are solicited to direct the topics of these forums. As with the peer-learning group, DiversityRx chronicles and archives the forums for reciprocity. Typical working communities may be between 50 and 100 individuals. Here, commitment for at least one year is desired to foster cohesiveness. Some of the methods seen in peer-learning groups are employed, as well as others, such as invited guest speakers and participants with special expertise and collaboration(s) on specific problems.

The third approach is maintenance of a relevant Web site by which users can obtain what they need and not have technology itself become an obstacle. Updates of the site allow for full use as well as obtaining information on other useful sites. Learning events are scheduled; these may take the form of guest speakers with question and answer sessions (all via the Internet). Some conference forums may have several guest speakers and participants.

The public is able to access the Web site. They may use the listserv, get involved in seminars, and share information and resources at their disposal. To maintain the integrity of the Web site, guests are screened.

As stated earlier, a number of partners share the initiative of providing information on health care for diverse groups. Some have a more specific charge, such as Migrant Health Promotion, Inc. (MHP), which focuses on migrants, farm workers, and border communities with the overall objective of promoting sustained healthier lifestyles to these groups.

Conclusion

The literature is clear on the disparity that exists in health care to minority groups across the United States. One factor contributing to this disparity revolves around access to available services; yet another factor is the divide resulting from cultural insulations on the one hand and cultural biases on the other. Underserved populations must be reached, and the best way to achieve this is by equipping those on the front line—those who come face-to-face with clients. The difficulties they encounter because of their own inadequacies and that of the institutional structures can only begin to be countered by providing a bridge—one that understands the factors that prevent available service entities from getting to those who need it, and provides clear avenues by which providers and clients can meet in an atmosphere in which linguistic and cultural divides are overcome. DiversityRx and its many partners seek to provide that bridge through technology and education.

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See Also: Diversities; Diversity and Quality in Health Care; Diversity in the Workplace.

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Divorce

Although American divorce rates are not climbing as rapidly as they did in the 1970s and 1980s, divorce remains common in modern American life. There is an abundance of data on marriage, divorce, and cohabitation in the United States; most estimates indicate that half of all first marriages end in divorce. However, accurate divorce rates are tricky to ascertain because of many variables, including a decrease in the rate of marriages, lack of reporting, small sample sizes, total population versus adults, and inability to differentiate between the number of first marriages and subsequent marriages that end in divorce. In working in human services fields in the 21st century, it is imperative to have an understanding of the trends of this data, the deficiencies in the available data and studies, and the implications of divorce in a diverse population.

Divorce Statistics

According to U.S. census data, there were 877,000 divorces in 2011—3.6 per 1,000 of the total population (of 44 reporting states and Washington, D.C.). This was a decrease from the 1990 data, which indicated that 4.7 people out of every 1,000 were getting a divorce (1,182,000 divorces). However, the decrease in divorces does not necessarily indicate a decrease in the divorce rate because the marriage rate also decreased. In 2009, there were 2,118,000 marriages in America (6.8 per 1,000 of the total population), a marked decrease from 2,443,000 marriages (9.8 per 1,000) just two decades before.

The National Health Statistics Report in 2012 reports marriage and divorce data on first marriages in the United States using the 2006–2010 National Survey of Family Growth (NSFG). These statistics use national samples of both women and men aged 15–44. The 2006–2010 NSFG was based on 22,682 face-to-face interviews— 12,279 with women and 10,403 with men, aged 15–44 years in the household population of the United States. Out of the sample of women surveyed, there were 5,534 first marriages and 1,574 first marriages that ended in divorce. Out of the men surveyed, there were 3,734 first marriages and 1,236 first marriages that ended in divorce. Even though these statistics show a higher marriage and divorce rate for women than men, the research also used a sample that consisted of more women than men. Although the divorce rate in women is still slightly higher than men in the 2009 U.S. Census data, a more equal picture of the divorce rate between men and women is portrayed—9.2 percent of men and 9.7 percent of women (per 1,000) were divorced in 2009.

The Impact of Diversity on Divorce

According to the NSFG, diversity impacts the incidence of divorce in many ways. In looking at the probability of a marriage lasting 20 years, race has an impact on the findings. The highest probability is for foreign-born Hispanic men (70 percent) followed by Asian women (69 percent). Approximately 54 percent of Caucasian women, however, will have a first marriage that lasts 20 years, followed by only 37 percent of African American women; there is no difference in the rates between Caucasian and African American men.

Socioeconomic status also has a significant impact on the divorce rate in the United States. Although Americans with a higher socioeconomic status are more likely to get married, the divorce rate is still higher in those with lower socioeconomic status. Lower-income couples experience stressors including a lack of resources to meet basic needs, difficulty in obtaining employment and housing, and the inability to achieve personal goals. They may be less likely or able to seek help or intervention in their marriage because of reduced access to psychological or social support. A higher divorce rate also maintains and/or contributes to the poverty rate: the poverty rate in children of married parents is 10 percent, whereas the poverty rate in children of female-headed families is almost 50 percent.

Religion also affects the probability of a first marriage lasting at least 20 years. Women who indicated they were raised in “other religions” had a 65 percent probability of their first marriage lasting 20 years. Women who reported being raised in a household without religion had a 43 percent probability of their marriage lasting 20 years. Educational status also impacts divorce. People with a high school diploma have a much lower probability of staying married for at least 20 years than people with bachelor’s degree (49 percent compared with 78 percent for women, and 47 percent compared with 65 percent for men).

Same-sex marriage is recent in the United States, and as such there is little data on either incidence or legal precedents regarding same-sex divorce. Same-sex divorce is an important issue, however, because having legal safeguards in place at the dissolution of a relationship is one of the benefits of having the relationship legally recognized. Divorce laws protect spouses from unequal treatment, consider the rights and needs of children involved, and ensure financial support for the lower-earning spouse. If the heterosexual divorce rate is a reliable indicator, as more states continue to adopt same-sex marriage legislation, the incidence of same-sex divorces may also increase.

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See Also: Families, Nontraditional; Family Structure, Diversity of; Marriage Counseling.

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Do Not Resuscitate Order

In health care settings, a do not resuscitate order (also called a DNR or no code, referring to the medical shorthand for no code blue) is an advanced directive or legal order stating that the patient wishes not to receive cardiopulmonary resuscitation (CPR) or advanced cardiac life support (ACLS) in the event of cardiac or respiratory arrest. This order takes effect when the patient is no longer able to communicate his or her wishes.

A DNR order does not restrict treatments such as chemotherapy, radiation, antibiotics, dialysis, or nutrition/hydration for the patient. Patients will continue to get medical attention, including pain medications for comfort, but if cardiac or respiratory arrest occurs, CPR will not be started, nor will the patient be intubated. Otherwise, the medical team will continue to care for and support the patient.

More recently, some health care providers are using the term *allow natural death* (AND) because this term focuses on the care being provided and not what is being avoided. This shift in terminology, although not universally used, allows patients, families, and health care providers to make decisions about end-of-life care without fear that something is being withheld from the patient. This shift in terminology is seen as a way to get more patients, families, and health care professionals involved in end-of-life conversations with less trepidation about what will not be done for the patient and a focus on how the patient wants death to occur. This does not mean the end of DNR orders, as they are instructive for the health care team, but it allows for patients and families to make better-informed health decisions.

Health care professionals can follow a DNR order only if they know it exists. When in doubt, caregivers will perform CPR on a patient experiencing cardiac and/or respiratory arrest. It is important to inform doctors, nurses, caregivers, and other family members of the patient's wishes for the DNR order. If the patient is transferred to another facility or health care team, regulations from the Health Insurance Portability and Accountability Act (HIPAA) require the patient (or health care power of attorney) to restate that this issue has been addressed and the DNR order is still what the patient wants. It is helpful for family members and the health care team to be fully informed of the patient's wishes so they can provide the patient's requested care when the patient is unable to communicate it. In short, DNR orders exist so the patient can receive the desired care.

Do Not Resuscitate Orders and Advanced Directives

As part of advanced directives and living wills, patients can state their wishes for end-of-life care, including DNR orders, if the time comes when they are no longer able to speak for themselves. A DNR order can also be written by a physician or health care provider as a doctor's order in the medical chart. Many states have specific forms or guidelines about DNR orders. The wishes outlined in advanced directives and living wills are not binding, so the addition of the DNR order in the medical chart is important. Some states do not recognize DNR orders in advanced directives or living wills outside of the hospital setting. For example, first responders or emergency medical services may be required to start resuscitation procedures unless a specific state form is properly filled out and cosigned by a physician or health care professional. DNR forms and rules differ from state to state, so it is important to make sure the specific state's rules are followed to assure adherence to the patient's wishes.

Making the Do Not Resuscitate Decision

Decisions about end-of-life care should be made before they are needed. If a health crisis occurs, it could be too late to communicate a patient's wishes for a DNR order. Also, starting the discussion about patient wishes early allows for family members and the health care team to effectively coordinate care and do what is best for the patient. Talking about dying is often both difficult and sad, but it allows everyone involved to honor the patient's vision for the end of life. Communication between the patient, family members, and health care professionals will let everyone involved with the patient provide care and support while respecting the patient's wishes. A DNR order, like any advanced directive, can be changed as needed, based on the patient's health care changes or preferences.

Implications for Diversity in Human Services

Professionals working with families who have or are creating DNR orders should bear in mind that not all patients and families make this decision in the same way. Health care workers need to be aware that factors such as the patient's age, health level, family structure, and culture are important influences in the decision-making process. When working with patients, personal cultural competence can help encourage and support patient advocacy and identify potential barriers in the process of honoring the DNR order. DNR orders are recognized as ethically and medically appropriate, but staff, family, and patient education are important to assist in making the best decision for that patient

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See Also: Adult Day Care; Aging and Adult Services; Case Management; Death and Dying, Cultural Attitudes Toward; Department of Health and Human Services, U.S.; Elder Care/Geriatric Services; Emergency Medical Care; Health Insurance Portability and Accountability Act of 1996; Hospice Services; Medical Transportation; National Institute on Aging; Palliative Care; Respite Care; Respite Services; Senior Services.

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Domestic Violence, International Variations in Attitudes Toward

The World Health Organization (WHO) noted in 2013 that 35 percent of women worldwide have experienced either physical and/or sexual intimate partner violence or nonpartner sexual violence. Most of the violence is intimate partner violence, with 30 percent of all women who have been in a relationship having experienced physical and/or sexual violence by their sexual partner. The highest prevalence was found in central sub-Saharan Africa, with a prevalence of 65.6 percent of ever-partnered women having experienced intimate partner violence. All regions of sub-Saharan Africa were found to be above the global average of 26.4 percent. The lowest prevalence was in east Asia (with 16.3 percent); other regions below the global average are high-income regions, such as western Europe (19.3 percent), North America (21.3 percent), central Asia (22.9 percent), and southern Latin America (23.7 percent). WHO notes that even in regions where the preponderance for violence falls below the average, between one-quarter and one-fifth of ever-partnered women have experienced partner violence.

Key determinants of the existence and/or acceptance or toleration of domestic violence include the attitudes and beliefs held at the individual, community, and societal levels. These can be influenced or exacerbated by less specific but relevant stereotypes held and perpetuated about women and violence, gender, and equality, and are arguably equally influenced by matters of religion, class, education, and race. Rachael Pierotti notes, “The definition of violence against women is a cultural product; it is based on fundamental principles of world society, including universalism, liberal individualism and equality.” However, she continues, “Global inequalities affect the construction of violence against women, but the current influence of global cultural norms cannot be reduced to the unilateral imposition of Western values.” In an Australian study, respondents argued that domestic violence could be excused, for example, if it resulted from people getting so angry that they temporarily lost control or if the violent person genuinely regretted the violence.

Michael Flood and Bob Pease of Australia argue that the literature on community attitudes regarding violence against women concludes that attitudes are influenced by dominant social norms. In relation to the formation of such attitudes, they maintain that

Anti–domestic violence sign located outside Entebbe, Uganda. The highest prevalence of domestic violence is in central sub-Saharan Africa, with a prevalence of 65.6 percent of ever-partnered women having experienced intimate partner violence. All regions of sub-Saharan Africa have been found to be above the global average of 26.4 percent.

people who support traditional gender roles are more likely to express attitudes that support the use of violence. In this context, men are more likely than women to hold both traditional views about gender role and violence-supportive attitudes. Those attitudes that justify violence against women are reflected in day-to-day social and familial relationships and are arguably constantly reinforced. Children who witness violence or are direct victims of that violence are more likely to develop attitudes that support the use of violence as a means of conflict resolution. This, of course, will manifest itself in the perpetuation of violence and in the preservation and advancement of accepting attitudes toward violence. Flood and Pease found that violence against women is highest in societies in which masculinity equates to dominance, toughness, and honor; where there are rigid gender roles; and where violence is routinely drawn upon to settle disputes.

Cultural Attitudes

The Innocenti Research Centre of the United Nations Children's Fund (UNICEF) noted in 2000 the influence of traditional and cultural practices upon the propensity for violence against women. Examples of such influence include female genital mutilation (with 130 million women globally reputed to have undergone this procedure, at a rate of 2 million annually); dowry-related violence (with more than 5,000 women killed annually if the conditions laid down by their husbands for the dowry are not met); with so-called accidental kitchen fires constituting a key mode of killing; and so-called honor killings for reasons including alleged adultery, premarital relations, and falling in love with someone of whom the family disapproves. Beyond these examples, UNICEF cites a range of cultural, economic, legal, and political factors through which domestic violence is perpetuated. Thus, for example, UNICEF notes the impact of cultural definitions of appropriate sex roles and values that provide men proprietary rights over women. It notes the impact of economic factors such as limited access to employment, limited access to education and training, and women's economic dependence on men. UNICEF notes further factors such as legal definitions of rape and domestic abuse and insensitive treatment of women by the police and judiciary. In addition, UNICEF notes factors such as domestic violence not being regarded seriously by politicians, perceived dangers of challenging the status quo, and limited participation of women in the organized political system.

The attitudes alluded to are important not only in terms of providing precursors to and supposed justification of violence, but also in terms of the manner in which they assist in developing the language utilized to describe and comprehend violence against women, societal response to violence, and responses of female victims. Community norms are crucial for determining whether violence is sanctioned, condoned, or condemned, and if so to what extent and why.

Possessing violence-supportive attitudes does not necessarily lead to the perpetration of violence against women. In a research review relating masculine ideology to sexual aggression, Sarah Murnen, Carrie Wright, and Gretchen Kaluzny suggest that men are more likely to have engaged in sexual assault or to profess a likelihood for committing rape in the future if they identify with traditional images of masculinity and male privilege and they hold hostile and/or negative sexual attitudes toward women. Flood and Pease note, for example, a connection between exposure to pornography—especially if frequent—and violence-supportive attitudes. Men who hold traditional, rigid, and misogynistic gender-role attitudes are more likely to be violent toward female partners. However, J. Basili and R. Brown argue that there is an important distinction to consider between implicit and explicit attitudes. Implicit attitudes are deemed to reflect one's inner feelings more accurately than explicit ones. Thus, one might express an explicit support for gender equality while harboring an implicit bias against such equality. Or one might hold an explicit attitude condemning discrimination or violence against women but implicitly approve of the social norms and gender attitudes that may perpetuate that discrimination or violence.

Global Attention

Within the European Union (EU), a recent survey indicated that the majority (84 percent) of EU respondents thought that violence against women was unacceptable and should always be punishable by law. A lesser percentage (12 percent) maintained that, although unacceptable, violence against women should not always be punishable by law. Smaller percentages thought domestic violence to be acceptable in certain circumstances (2 percent) or in all circumstances (1 percent). Within EU member states, the picture varies. Thus, 93 percent of respondents in Greece argue that violence against women is unacceptable and should always be punishable by law, but only 66 percent of people in Latvia are of the same view. Furthermore, 5 percent of respondents in Belgium argue that domestic violence is acceptable in certain circumstances, and 3 percent of respondents in Italy argue that domestic violence is acceptable in all circumstances.

Pierotti argues that in global terms, "the consensus is that a husband's physical abuse of his wife is part of a broader social system that reinforces gender inequality." In her study of attitudes toward violence against women in 26 low- and middle-income countries ranging from Armenia and Colombia to Rwanda, Turkey, and Zambia, an increasing rejection of intimate partner violence occurred in 23 of those countries, with a robust change in attitudes toward such violence in 12. Thus, for example, in Nigeria, the percentage of women rejecting intimate partner violence increased from 33 percent in 2003 to 52 percent in 2008. This increase was deemed by Pierotti to have coincided with increasing global attention raised in relation to it. Pierotti discovered that women with greater access to education and access to the media were more likely to reject intimate partner violence.

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See Also: Domestic Violence, Victims of; Family Violence Prevention and Services; Women, Battered.

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Domestic Violence, Victims of

Given that an estimated one-third of the world's women will endure an abusive relationship in their lifetimes, it is essential that communities provide services to victims of domestic violence. More than just shelter for those fleeing abusers, victims may need legal and medical help, therapy and counseling, workforce training, transportation, child care, and more. Many domestic violence shelters or centers either provide these services or make referrals to community organizations that can provide them.

History

Prior to the Battered Women's Movement of the 1970s, no organized services were available for victims of domestic violence. Victims had to rely on their families and friends for shelter and support. Women's Advocates, established in 1974 in St. Paul, Minnesota, is considered to be the first emergency shelter for domestic violence victims. By 1982, the United States had more than 300 shelters. They were

A domestic violence awareness mural, titled "A Survivor's Journey" was created in 2010 by Joel Bergner in Washington, D.C. An estimated one-third of the world's women will endure an abusive relationship in their lifetimes. Research has shown that in the United States, immigrants are at 40 percent greater risk for victimization.

generally organized around radical feminist principles, as they were modeled after homes and operated with an egalitarian, communal structure.

As the number of women seeking shelter continued to grow, advocates realized that they needed to collaborate with other agencies to meet the demand for assistance. Shelters reached out to form alliances with other groups and organizations, including local, state, and federal government entities. These coalitions helped fund the work, but, according to numerous scholars, resulted in a gradual shift away from the founding feminist principles. Some have criticized domestic violence shelters because of this change in philosophy.

Domestic Violence Centers

Today, many shelters or centers operate under a philosophy that seeks to empower victims to take control of their lives, enacted through services and support toward that goal. This assistance might include emergency shelters as well as safety planning, therapy, support groups, referrals to and collaborations with area agencies, efforts to help children who have witnessed abuse, and legal assistance, among other forms of support. However, most domestic violence victims do not stay in a shelter; thus, the support offered by these outreach services are critical. Most domestic violence shelters operate 24-hour crisis lines to counsel victims. Increasingly, domestic violence services also include an educational component.

While domestic violence shelters offer an important lifeline for victims, they struggle to meet the demand for help. Every year since 2005, the National Network to End Domestic Violence (NNEDV) has coordinated a one-day census of domestic violence centers to assess the scope of services provided and to identify areas in need of improvement. In 2012, 86 percent of the 1,924 certified centers participated in the 24-hour census. The survey found that 64,324 victims were served in one day. Three-quarters of the responding centers provided emergency shelter, and some 35,323 victims stayed in shelters or transitional housing during the 24-hour census. Of these, 24,783 were children. A total of 29,001 adults and children received nonresidential assistance and services, including counseling, legal advocacy, and children's support groups. More than 50 percent of the responding centers provided court accompaniment and/or advocacy for survivors, half provided transportation, 45 percent provided some form of group support, and 44 percent offered advocacy related to public benefits. Local and state hotlines answered 20,119 calls and the National Domestic Violence Hotline answered 702 calls, averaging more than 14 hotline calls every minute. In communities across the United States and its territories, 25,182 individuals attended 1,162 training sessions provided by local domestic violence programs.

Unfortunately, more than 10,000 requests for help went unmet during the 24-hour census. Of these unmet requests, 65 percent, or 6,818, were for emergency shelter or transitional housing. Often, all shelter beds are full, and victims in need must be referred to other services. Only 41 percent of the responding centers have transitional housing for victims. Counseling and legal assistance ranked second and third in terms of unmet requests. More than half of the centers were able to provide advocates to support victims in court, but only 11 percent could offer actual legal assistance. Centers cited numerous reasons for their inability to meet all of the requests, including lack of funding for needed programs and services (42 percent); not enough staff (30 percent); lack of available beds and/or funding for hotels (26 percent); too few specialized services (23 percent); and limited funding for translators, staff who are bilingual, or accessible equipment (10 percent).

Special Populations

Most shelters are designed for women and may not be open to male victims. Although women make up the majority of domestic violence victims, it is imperative that males who fear for their lives also have access to safe spaces. Across the United States, only a few shelters are specifically for men; thus, men must remain in dangerous situations, seek help from family or friends, or end up at homeless shelters where abusers can find them. Teen victims may find it difficult to access the support of domestic violence centers, as many are not knowledgeable about where to go, do not have the support of an adult to help them get there, or believe that the services are only for adults. Domestic violence centers can also improve on their capacity to serve elder victims.

Similarly, many shelters are not well equipped to serve victims with unique cultural, physical, or mental needs. Research has shown that immigrants on the whole (not necessarily from a specific nation or region of origin) are at 40 percent greater risk for victimization. Immigrants from other cultures may not be familiar with the laws and type of assistance offered to victims in the United States, and they may not know how to contact service providers. Language barriers may also leave some immigrant victims without help. Domestic violence centers must work to offer culturally competent services. Additionally, Native American women endure abuse at twice the rate of non-Native women, yet many living on reservation land have limited access to shelters or other services.

Domestic violence centers also must work to ensure that services are accessible to those with physical or mental disabilities. This includes, but is not limited to, special phone services or sign language interpreters for those with hearing challenges; braille for persons with visual impairments; and ramps, modified bathrooms, and other accommodations for those with mobility problems. Center staff should be trained on how to deal with specific mental or emotional disabilities, including when it is appropriate to refer a victim elsewhere for more extensive assistance. Further, crisis line and shelter staff must understand how to work with victims who may express suicidal tendencies.

Referrals

Domestic violence centers can also assist victims by referring them to other community agencies. That is, centers can and should partner with housing authorities, workforce training programs, local legal aid entities, medical doctors, and others to ensure that victims receive the help that the center cannot provide. Domestic violence centers can provide these referrals and help train professionals in these fields to understand domestic violence and to support victims. Medical professionals are encouraged to screen patients using specific questions or surveys. Well-trained medical professionals can help victims once abuse is disclosed or identified by taking careful documentation that can be used in legal proceedings or to access other services and by providing support and information about other services. Although not all victims call police, some do. Many police agencies now have victim advocates who assist in cases of domestic and sexual violence.

Middle- and upper-class victims often do not seek the assistance of domestic violence shelters due to the stigma they perceive to be attached to this form of help. Instead, these victims often seek the assistance of private therapists or counselors. Thus, therapists and counselors provide an important first line of help for many victims of domestic violence, and they must ensure that they are adequately trained on how to support and empower these victims.

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See Also: Cultural Competence, Human Service Providers and; Information and Referral; Interpersonal Violence; Women, Battered.

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Dominican Americans

The Hispanic population in the United States is expected to continue to expand and become the largest identified minority group. Dominican Americans are typically defined as individuals born in the Dominican Republic or of Dominican descent living in the United States. Currently, it is estimated that 1.5 million Dominicans live in the United States. They are the fourth-largest Hispanic group, although projections foresee continued and exponential growth over the next decades. There is a need to understand Hispanics as a cultural group; however, there is increased need to further comprehend the cultural differences that define Hispanic subgroups in order to provide adequate health care.

Records of immigration from the Dominican Republic date back to 1930, and a massive exodus of Dominicans arrived in the United States during the 1960s after years of political instability and economic downfall. The U.S. military occupation of the Dominican Republic in 1965 ensued after democratic elections and a military coup d'etat triggered street revolts, further deteriorating social, political, and economic stability. However, the greatest influx of migration from the Dominican Republic to the United States occurred after 1990.

Demographic Factors

General demographic factors make Dominican Americans similar to the rest of Hispanic Americans, but some aspects are idiosyncratic to this population. Understanding both aspects, especially the latter, allows for a more accurate appraisal of the cultural uniqueness of this group and facilitates identification of needs for appropriate care.

Initially, a major concentration of Dominican Americans resided in New York. Over many years, Dominicans have moved all across the United States, but with higher concentrations in cities in the northeast. The three states with the largest populations of Dominican Americans are New York, New Jersey, and Florida. Their native language is Spanish, and the majority have Roman Catholic religious affiliation. Most Dominican Americans self-identify as mixed race, with European, African, and/or Tainos Indian ancestry. Two-thirds of Dominican Americans are foreign born; thus, they experience different levels of acculturation. More than half speak fluent English.

The educational attainment of Dominican Americans is higher than comparable groups of Hispanics living in the United States; at least one-third have some college education or an associate's degree.

Many Dominicans obtained legal status through the Family Reunification Act, but a percentage remain undocumented. Most Dominicans share a commitment to send periodic remittances back to family in the Dominican Republic and express a desire to remain in contact with the native land. Some also foresee saving money and returning to live in their country of origin.

Cultural Aspects Relevant for Health Care

Traditionally, Dominican Americans have shown respect toward the medical community, but may have reservations about mental health utilization due to stigma and lack of access to culturally sensitive and informed care. Many Dominicans defer to family, friends, and community stakeholders (e.g., priests) for mental health and emotional support. The extended family also plays an important role in the lives of Dominican Americans, providing instrumental support, financial safety nets, and emotional guidance. When professionals from the medical and psychiatric communities interface with Dominicans, it is relevant to inquire about their definition of who is considered their extended family, as some friends may be closer than biological family and sources of support may include godparents, priests, and community stakeholders.

The Dominican culture promotes *familismo,* which refers to developing strong family ties, as well as *respeto* (respect) toward spouses, parents, and the elderly. When followed for physical or mental health care, it is often important to make provision to include the extended family in important decision making and for passive consent, which may be instrumental in the follow-up, management, and compliance with medical directives.

Strong variations and intracultural differences exist among social classes. Dominican Americans from a higher socioeconomic status in the native country may have had access to U.S. culture through education, music, travel, and technology, and many may have spoken English before migrating due to access to multiple entry visas. In contrast, Dominicans from a lower economic stratus and/or from rural areas in the native land may have had more limited access to education, technology, and U.S. acculturation, and potentially fewer opportunities to gain lawful entry into the United States. There is great variability in exposure and acclimation to U.S. culture as a function of sociodemographic factors among Dominicans, and there is often a need for inquiry to replace assumption in the development of estimates of opinions, perspectives, and experience within health care.

Although the majority of the population from the Dominican Republic is of mixed race, patterns of intracultural differences still exist—the majority of the population of a higher economic level is of European descent, and the majority of the population of a lower economic level is of African ancestry. These intracultural patterns are intricately intertwined with geographic region and a range of other sociodemographic factors that make conclusive statements difficult. Covert and overt racism continues to influence Dominican society and needs to be considered as an important influence for Dominican Americans.

The different levels of acculturation of Dominican Americans may be more obvious when treating families. Foreign-born parents may be more likely to believe that their younger family members are suffering with anxiety, depression, or other psychiatric disorders because they are deemed to be oppositional to parental norms rather than that they are simply responding to the values and expectations of the host culture. Clinicians who are familiar with these patterns can often address the expectations of worried parents and normalize the experience for younger members of the family structure.

In summary, Dominican Americans living in the United States represent a wide spectrum of demographic, socioeconomic, and background experiences. Awareness of such cultural diversity will facilitate appropriate health care.

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See Also: Central American Immigrants; Hispanic Immigrants; Undocumented Immigrants.

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DREAM Act, The

The Development, Relief and Education for Alien Minors Act, popularly known as the DREAM Act, was first introduced in Congress in 1995 and was modernized in 2001. Building on the Deferred Action Childhood Arrivals Program of the Obama administration, the 21st century DREAM Act was intended to open up educational and citizenship opportunities for a group that ranges in number from 800,000 to 2 million. Individuals within that group arrived in the United States as the children of illegal immigrants with no control over their destination. Yet, they constantly face the threat of being deported to countries of which many have no memories. Known as Dreamers, those who qualify for the program could enter an expedited path to citizenship by pursuing degrees in higher education or by serving in the U.S. military. Various versions of the DREAM Act have included such stipulations as requiring the individual to have graduated from an American high school and having lived in the United States continuously for a specified period. Even though the bill has received bipartisan support, most detractors are Republicans who have managed to prevent passage of the DREAM Act for more than a decade. Opponents of the DREAM Act generally oppose passage because they consider that it amounts to amnesty for individuals who entered the United States illegally as children, because it presents obstacles to enforcing other immigration laws, and because it fails to adequately address border security issues. The fact that immigration reform continues to be a contentious and divisive issue has contributed to the difficulties surrounding passage of the DREAM Act. It has been suggested that President

DREAM Act protesters appear for President Barack Obama's visit to Austin, Texas. The Development, Relief and Education for Alien Minors Act, popularly known as the DREAM Act, was first introduced in Congress in 1995 and was modernized in 2001. One study estimated that if Dreamers were allowed to become citizens via the DREAM Act, they could potentially generate from $1.4 to $3.7 trillion in taxable income over a four-decade period.

Barack Obama has managed to bypass congressional action by exercising his right of prosecutorial discretion, which has allowed his administration to refuse to enforce the deportation of Dreamers.

In 2013, existing immigration laws stipulated that minors could obtain permanent citizenship status only if their parents become citizens. An estimated 11.5 million undocumented aliens were living in the United States at the time. Children who entered the United States illegally with their parents had the right to obtain a free public education. Beyond secondary school, however, states retained the right to refuse admittance to state schools to undocumented aliens, regardless of the age at which those aliens entered the United States. Also, because Dreamers have no documentation, they may be denied the right to obtain drivers' licenses. Since they may be unable to obtain Social Security cards, they may also run into major obstacles when looking for employment. Dreamers have found their voices as they lobby, protest, and fight for their rights to become U.S. citizens.

Congressional Action

In 1995, Senator Dick Durbin (D-IL) brought the issue of the rights of illegal immigrants who had come to the United States as children to public attention by introducing the DREAM Act for the first time. At the same time, Lincoln Diaz Balart (D-FL) introduced the bill in the House of Representatives. The purpose of these bills was to pave the way for permanent residency for Dreamers and prevent their being deported as a result of the Illegal Immigrant Reform and Immigrant Responsibility Act (IIRIRA) of 1996. In 2001, the modern version of the DREAM Act (S. 1291) was introduced in Congress for the first time. Subsequent versions of the bill have repeatedly made their way through congressional channels, only to be ultimately defeated.

In 2006 and 2007, the DREAM Act was introduced as part of the Comprehensive Immigration Reform Act. With bipartisan support under the leadership of Senators Ted Kennedy (D-MA) and Arlen Specter (R-PA), the bill won significant support. However, invoking cloture and ending debate failed to win sufficient votes. Thus, its opponents managed to prevent its passage. The 2009 version of the DREAM Act was one of the more liberal versions to be introduced in Congress. It would have allowed Dreamers to obtain permanent residency over a six-year period if they earned a two-year college degree or if they served in the U.S. military for at least two years. Any individual who failed to complete these requirements became subject to deportation from the United States.

In 2010, the DREAM Act received its strongest support and came within five votes of passage before it was defeated by a vote of 55 to 41 in the Senate, falling short of the 60 votes needed for passage. The 2010 version had already passed the House by a vote of 216 to 198. The next year, Senate Majority Leader Harry Reid (D-NV), who has repeatedly demonstrated a strong commitment to helping Dreamers, Durbin and Robert Menendez (D-NJ) reintroduced the DREAM Act in the Senate. In the 2011 version, Dreamers could qualify for benefits if they were between the ages of 12 and 30 at the time the DREAM Act became law, had arrived in the United States before their 16th birthdays, were of good moral character, had lived in the United States continuously for five years before passage of the act, and had received either a high school diploma or a General Educational Development (GED) diploma while living in the United States.

Current Status

In a 2013 article for the *Texas Law Review,* Robert J. Delahunty and John C. Yoo argued that the Obama administration had found its own way to protect Dreamers from deportation despite the failure of Congress to pass the DREAM Act. In 2012, for instance, when the Immigration and Nationality Act (INA) mandated the deportation of Dreamers, the president used prosecutorial discretion and ordered immigration officials not to enforce the law.

The 2013 version of the DREAM Act required that all applicants for benefits have arrived in the United States before the age of 16 and have lived in this country continuously for at least five years before the date that the bill became law. In June, the Republican-controlled House voted 224 to 201 along strict party lines to resume deporting Dreamers by adding the stipulation to a routine spending bill for the Department of Homeland Security. The action was a symbolic move that allowed Republican opponents of the bill to express their lack of support for the issue of immigration reform. A study conducted at the University of California, Los Angeles, estimates that if Dreamers were allowed to become citizens via the DREAM Act, they could potentially generate from $1.4 to $3.7 trillion in taxable income over a four-decade period. That potential is one of the strongest arguments in favor of the passage of the DREAM Act.

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See Also: Children of Undocumented Aliens; Immigration Law, History of U.S.

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Drug and Alcohol Screening

The purpose of screening for drug and alcohol misuse is to identify the possibility of a problem, which warrants a more in-depth substance abuse evaluation. Hallmarks of effective screening are that it is short, diverse, and sensitive enough to capture most cases of misuse. By design, screening is meant to be overinclusive, detecting a person who may not have a problem with drugs and alcohol so as not to miss capturing anyone who actually does have a problem. Screening for drug and alcohol abuse is a vital function for those working in human service organizations, from hospitals to child protective agencies to elder care to criminal justice facilities.

Given the goal of screening to capture all those with drug and alcohol use problems, the process of screening must be sensitive to the unique presentation of these issues among various groups of people. For example, patterns of alcohol use among adolescent boys, where binge use at parties is more common, differs significantly from the use of alcohol by older women, whose symptoms mimic signs of aging and often complicate screening. As a result, screening for substance misuse among these two groups would need to be sufficiently sensitive to capture the unique drug and alcohol use problems within each group. Not only do the characteristics of age and gender impact substance misuse screening, but also numerous factors, such as race/ethnicity, sexual orientation, the presence of co-occurring mental health disorders, and varying abilities and/or disabilities, as well as socioeconomic status, impact the ability to effectively screen for drug and alcohol use issues.

Gender

Substance abuse screening tools have been found to be less effective in capturing a woman's substance misuse as compared to a man's. This results partly from the increased stigma experienced by women who misuse substances, which causes them to often underestimate or conceal their substance use. An additional concern is that women experience more significant health and social consequences, such as organ damage, cancer, and losing custody of children, from consuming less alcohol and other drugs than their male counterparts. Both of these factors contribute to making screening for substance misuse among women more challenging. Accommodations that can be made to reduce these challenges include allowing women to self-administer screening tools to reduce the effects of stigma. Also, reducing the threshold of screening tools for women may capture risky substance use earlier, which would result in earlier intervention for substance use disorders among women.

Alcohol screening tools that have been recommended for women's use are the CAGE, TWEAK, and AUDIT. Suggested scoring thresholds for women are one point for the CAGE, two points for the TWEAK, and four points for the AUDIT. The CAGE also has a modification, the CAGE-AID, to successfully capture drug use among women.

Furthermore, specific screening tools have been shown to be preferential for use with pregnant women, including the T-ACE, TWEAK, and the 5P's. Tailoring substance use screening to reflect the unique substance use patterns and experiences of women make achieving the goal of screening to capture all women misusing substances more likely.

Age

Most screening instruments are developed on adults and therefore do an adequate job in capturing substance misuse in populations in their 20s through midlife. Groups that have significantly different use patterns reflective of their developmental stage are adolescents and college students as well as older adults.

Adolescents and college students. Adolescence is a time of considerable risk for beginning substance use as well as the further development of a substance use disorder in adulthood. Researchers have found that of the adults who currently struggle with a substance use disorder, 90 percent began using substances prior to age 18, and 50 percent of them began using prior to age 15. Hence, the importance of delaying the onset of substance use as well as identifying and treating those who already have begun misusing is imperative. Addressing substance use among adolescents is centered on risk factors. Most instruments have a narrow focus on particular risk factors, and the National Institute on Drug Abuse developed the Problem-Oriented Screening Instrument for Teenagers (POSIT), which covers many of the identified risk factor domains.

In regard to college students, binge-style drinking has long been a concern. A specific tool has been created to detect heavy and risky drinking among students aged 18 to 25. The Brief Alcohol Screening and Intervention of College Students (BASICS) was created to assist college students in making less destructive decisions regarding alcohol use.

*Older adult*s. Drug and alcohol use among older adults is often underidentified not only by human service workers but also by various professionals and family members alike. This oversight is due in part to the bias that older people don't have problems with substances. Screening for substance misuse in the aged is complicated because many of the signs of substance use problems mimic the common signs of aging, including memory loss, impaired balance and gait, neglect of hygiene, and sleep disruption. With the obvious parallel to the usual signs of aging, screening older adults for substance misuse requires further scrutiny. Furthermore, given the loss of lean muscle mass, which results in less water in the body, it is recommended that older adults drink less alcohol as they age. Thus, the quantity of alcohol cutoffs for screening tools must be reduced for older adults.

Race, Ethnicity, and Culture

Issues of consideration around race, ethnicity, and culture require human service workers to be mindful of several factors that may impact drug and alcohol screening. Paramount among them are issues of language, acculturation, bias, and norming of screening instruments. Although it is obvious that individuals should be screened for substance misuse in a language in which they are fluent, other concerns related to acculturation are less straightforward. For example, often related to the level of acculturation, individuals may be skeptical of the medical system in the United States, and given the stigma often associated with drug and alcohol use, people may find screening questions intrusive and threatening. This may more often be the case if the substance is illegal or if the person is undocumented in this country.

Another influencing factor is screener bias. Health services workers, like anyone else, have biases that stem from their experience in the world. These biases can impact effective screening. For example, a worker may be less likely to screen an Asian American than a Native American for substance misuse, given their knowledge of prevalence rates of alcohol and drug usage, thus resulting in underidentifying substance use among Asian Americans.

When using a screening tool, consideration needs to be paid to whether that tool was normed on the racial or ethnic group of the person a worker is screening. It can also be difficult to locate such information on translated screening tools. Furthermore, evaluation studies concerning screening instruments among various racial or ethnic groups suggest that the level of sensitivity of the screening tool varies not only by race or ethnicity, but by gender as well.

Socioeconomic Status

Health professionals have demonstrated certain expectations toward people of varying socioeconomic status, which have resulted in people perceived as upper class or with wealth not being screened for substance misuse as often as people perceived as poor. In no group is this demonstrated more clearly than in the case of pregnant women. Pregnant women who are perceived as middle or upper class, and who often visit private physicians, are less likely to be screened for substance misuse than pregnant women perceived to be of lower socioeconomic status, particularly if the woman receives her prenatal care in a clinic setting. Unfortunately, this results in women of means being less likely to receive substance abuse interventions, which have negative consequences for their babies.

Sexual Orientation

The Institute of Medicine has found that lesbian and bisexual women are at greater risk of developing a substance use disorder than heterosexual women, making screening among sexual minority women all the more important. Although few screening instruments have been validated on lesbian and bisexual women, the CAGE has demonstrated comparable reliability and validity among heterosexual, homosexual, and bisexual women.

Co-Occurring Substance Abuse and Mental Health Disorders

Given the high prevalence rates of people who have both mental health and substance use disorders, it is imperative that human service workers are knowledgeable in screening for co-occurring disorders. Not only is it more common for individuals with co-occurring disorders to seek treatment than those with only one disorder, but also having two disorders complicates the screening, treatment, and recovery of each disorder. When screening for both substance use and mental health disorders, the goal of screening is twofold: to capture the possibility of substance misuse as well as the possibility of any array of mental health disorders, such as anxiety, depression, post-traumatic stress disorder, bipolar disorder, and schizophrenia. Also noteworthy is that as the severity of the mental health disorder worsens, the likelihood of an accompanied substance use disorder increases. In essence, the only question that a screener needs to answer is whether this person possibly has both substance use and mental health disorders. If that possibility exists, then further evaluation and assessment are warranted.

An instrument commonly used to screen for mental health disorders is the Mental Health Screening Form-III. Although this form has demonstrated limited validation, professionals have found that it more than adequately serves the purpose of capturing the possibility of mental health disorders. In addition, a screening instrument commonly used to capture substance misuse among individuals suspected of having co-occurring disorders is the Simple Screening Instrument for Substance Abuse (SSI-SA). The SSI-SA has been found to be sufficiently sensitive and reliable in capturing substance misuse in co-occurring populations, particularly those at high risk of dual disorders, such as prison inmates. Furthermore, both the Mental Health Screening Form-III and the SSI-SA have been recommended to capture co-occurring disorders among homeless adults, a group with exceptionally high rates of co-occurring disorders.

Developmental Disabilities

Advocates purport that the incidence of substance use problems is increasing among individuals with developmental disabilities such as mental retardation, cerebral palsy, and autism. People with developmental disabilities have been found to use substances not only to deal with uncomfortable feelings, but also as a normalizing activity in an effort to be like everyone else. Given the significant variation in functioning levels among individuals with developmental disabilities, human service workers must have a clear sense of the individual's ability to cognitively understand and accurately respond to screening questions, resulting in providing varying degrees of assistance to individuals during the screening process. A few drug and alcohol screening instruments are recommended for use with individuals with developmental disabilities, including the Alcohol Use Disorders Identification Test (AUDIT), the Drug Abuse Screening Test (DAST), and the Alcohol, Smoking and Substance Involvement Test (ASSIST).

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See Also: Alcohol Consumption, International Variations in Attitudes Toward; Substance Abuse and Mental Health Services Administration; Substance Abuse Treatment for Children and Adolescents.

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Dual Income, No Kids

Dual (or Double) Income, No Kids, commonly referred to as DINK, describes couples who both work and have not yet had children. They are therefore able to afford a lifestyle without some of the responsibilities that come with having children. These couples also are credited with fueling retail business because they have a comparatively higher income to spend on consumer goods, although this may not be the case depending on the income level of the couple.

The DINK status is not necessarily permanent; couples who later have children may move from being labeled DINK to DIWK (Double Income With Kids). Miriam N. Kotzin points out that the term DINK as it is traditionally constructed is related to age and place in the life cycle of a couple. Contemporary usage of the term DINK applies to a couple only during the decades when they otherwise might be financially responsible for children. DINK refers to both gay and straight couples, but is not commonly used in connection with older, preretirement couples who are at the age that any children would be presumed to have become independent, or even, generally, to describe very young couples just starting their lives together.

DINK populations are believed to be increasing in overall percentage globally due to the rapid urbanization in the world coupled with such factors as increasing outside home employment opportunities for women, as well as the challenges and opportunities of modern life and the choices and independence it provides. This increased percentage of DINK couples is seen especially in the developed countries as well as big cities in the middle-income and developing countries. It is important to understand this growing demographic group and some of the factors and perceptions regarding them. This article provides a summary of some of the reasons why couples choose to stay without children, perceptions of such couples by others, and some of the wider issues with DINK couples.

Why Do Couples Choose Not to Have Children?

The following reasons can explain the desire to remain without a child:

- *Work pressures*. Many working couples are concerned that their busy working lives will not allow the support that a child would need. They may also worry that the attention a child would require and the various responsibilities that come with parenthood will lead to a loss of professional attention and focus and will affect career progression. Therefore, couples avoid or delay having a child until they achieve the level of career growth to which they aspire or until they feel confident to juggle the responsibilities of both work and parenting successfully.
- *The cost factor*. Having and supporting a child in some cities (or countries) can be expensive. Couples many times are conscious of the fact that their income (even though both are earning) may not be enough to adequately cover the expense of raising a family without affecting the lifestyle they want to maintain.
- *Desire to spend time with each other*. Many couples believe having a child will take away the attention that each of them bestows on the other.
- *Uncertainty with partner*. It is widely believed that having a child (biological or

adopted) bestows a higher permanency on the need for the couple to stay together or presents more challenges in the case of separation (e.g., the cost of divorce and alimony support). In situations where either or both of the partners are not sure about the other (whether they make a compatible couple for long term), the plan of having a child is postponed until they develop the trust necessary between them.

- *Biological factors*. DINK status may also include couples who are unable to have their own child because of biological reasons such as infertility. Adoption is an option, although it may not be their preference and they may choose to remain childless.

The Social Consequences of Being a DINK Couple

Whatever the reasons, DINK couples may be envied or ostracized, depending on the perceptions of friends, family members, and society in general. In many societies, having children, especially within a marriage, is seen as a responsibility. Couples who do not have a child after a long marriage (the length of time being a variable depending on the social values and acceptable practices) are seen as careless, selfish, and interested only in their own well-being and pleasures. They may also be perceived as free riders, not contributing to society as those couples with children do (i.e., by supporting the economic and social support infrastructure, such as schools and various jobs that come with child care). Seen from this perspective, the term *DINK* can be perceived as derogatory or hurtful for the couple. Some common questions and remarks from families, friends, and colleagues are: "When are you planning on having a baby?" "If everything is fine between you, why are you not having a child?" or "You know you are not getting any younger [especially to women]." DINK couples are also constantly subjected to descriptions of how happy friends and family members who have kids are. Such close scrutiny of their lives and questioning may lead DINK couples to avoid social events or to bond with other DINK couples.

Conversely, these couples may be seen by many as having made the right decision (especially by others who have one or more children and are feeling pressured with the responsibility). These couples are seen as pursuing career growth, retaining options for mobility, and having more freedom and independence. That is, DINK couples can easily take new jobs in different locations or take the risk of switching careers if need be without worrying about children and their needs, such as schools and other support systems.

In many countries (e.g., Singapore, Russia, Germany), falling birth rates are sometimes attributed to increasingly more couples remaining without children. In Japan, these couples are called NOKS (No Kids Couples), and various types of incentives and financial support are presented to motivate them to have children. Research from Israel by Alma Cohen indicates that financial incentives have had "a significant positive effect on fertility, with the mean level of child subsidies producing a 7.8 percent increase in fertility."

The choice to be a DINK couple rests with individual preferences and what works for them. It is therefore not fair to term it as right or wrong or to use a social or moral compass to judge them.

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See Also: Families, Nontraditional; Same-Sex Couples/Marriage.

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Early Childhood Development

The literature of developmental psychology, sociology, neurobiology, cultural anthropology, social work, education, and related fields is replete with discussions of early childhood development. In an effort to avoid duplication of the readily available literature on early childhood development, this article focuses on some of the major themes and ideas inherent in early child development studies from an intersectional perspective. Intersectionality is grounded in a critical analysis of race, class, gender, and other aspects of social location through which power is constituted. This framework is utilized to increase understanding of the broad concept of early childhood development within the field of human services, with a goal of speaking directly to the issues of social determinants and power on a subject that is often held to be universal within its respective multidisciplinary contexts. Major areas of discussion include theories grounding the study of early childhood development, relational and ecosystems approaches to early childhood development theory and practice, and major areas of research and praxis, with a focus on multisystemic levels of intervention.

Early childhood development is a broad term within the human services professions. It refers to the individual processes of biopsychosocial maturation of children aged roughly 3 to 5 years, as well as the theories, literature, and interventions that drive practice, services, policy, and praxis for and about children in this age group. This article looks at the major areas of development, and discusses the theories and practices shaping current understandings of development.

Early Childhood Development in Mainstream U.S. Culture

The FrameWorks Institute, a nonprofit think tank dedicated to "changing the public conversation about social problems" through informed discourse, has identified early childhood development as a target area requiring an increasingly nuanced picture within mainstream U.S. culture. Literature from this project describes a typical understanding of the complex processes of early childhood development in the United States as a so-called black box. This discomfort leads to increased reductionist thinking, relying on what is familiar, observable, and tangible, rather than grappling with the complexity of the topic. Therefore, the default model of early childhood development in mainstream culture equates successful or healthy development with a self-reliant, autonomous individual, with physical safety, cognitive development, and socialization being the key determinants of a seemingly innate and mysterious process.

However, the vast literature on early childhood development makes it clear that the process of development is achieved in a relational context, inextricably dependent on the multiple, overlapping (and often invisible) environments in which development occurs. Fully understanding child development means also understanding an ecological or person-in-environment perspective in which individuals and their environment have active, multidirectional influences on each other. Individuals cannot be separated from the factors or influences of their immediate environments. This calls for a more precise understanding of the environmental and social contexts in which families raise children. A comprehensive understanding of early childhood development must incorporate an awareness of the dynamic interactions between individuals and their environments, particularly in defining and shaping risk and protective factors for individuals and their communities.

The Separate Self Model

Ideas that become part of a culture's dominant narrative are inherently shaped by that culture's institutions. In early childhood development, the disciplines of psychology and sociology in the United States are key players in the idealization of a separate, self-reliant individual as the desired outcome of traditional models of development.

Traditional models and theories of development (as advanced by Sigmund Freud, Margaret Mahler, Erik Erickson, and Jean Piaget, among others) conclude that self-reliance and autonomy are obtained through the mastery of a series of increasingly complex and "essential" crises, largely involving separation of oneself from others. Therefore, the individual is defined as someone whose primary identification is in his or her separation from or nonreliance on others. Within separate self models, development occurs within a vacuum, in which the relationships of the growing child to caregivers, community, and environmental context are de-emphasized, leading to an appearance of universal applicability.

Traditional models of development are the frameworks that create benchmarks for healthy or normative development in the early years. The following brief overview of three major developmental theorists who have historically emphasized a separate self model focuses on descriptions of development during ages 3 to 5 years:

- Freud (1856–1939). In Freud's three-stage psychosexual model of development, infants and children become self-actualized through increasing mastery over unconscious drives. The anal stage is the second stage of development, and occurs from ages 1 to 3 years. The goal of this stage is to increase control over one's bowel and bladder, frequently identified in the contemporary developmental goal of toilet training.
- Erikson (1902–94). In Erikson's eight-stage psychosocial framework of development, an individual resolves basic psychosocial conflicts along a continuum of positive and negative outcomes in each stage. Each stage also lays the ground for the stage above it. In early childhood, the psychosocial conflict is termed "autonomy versus shame and self-doubt," in which children are guided toward independence and individuation through exercise of free will. In this stage, Erikson notes that if children do not receive these critical opportunities in free choice, they will have a "lasting propensity for doubt and shame."
- Piaget (1896–1980). Piaget's four-stage developmental model focuses on a child's ability to make meaning of the world through physical and cognitive experiences. Motor skills, language, and abstract cognition are viewed as dependent, sequentially acquired phenomena that develop completely through the individual's isolated experience. Early childhood is described in the preoperational stage, in which children use symbols to represent and communicate about their environment. In this stage, language and imaginative play are developed.

Critiques of the Separate Self Model

The relational movement in feminist psychology, most notably the work of the Jean Baker Miller Training Institute and the Harvard Project on the Development of Women and Girls (spearheaded by Carol Gilligan), offers critiques of the universality of the separate self models. The work coming out of the Harvard Project is notable for its emphasis on the role of voice, authenticity, and power in the course of development, particularly the ways in which dominant power structures work to silence the voices and experiences of women and girls.

Gilligan was one of the first scholars to explicate the essential problems in separate self models of development—mainly, that the theories were developed based only on the experiences of (and research with) white men and boys, and that all diversity or difference in these models (and therefore experiences that may appear different) was identified by the models themselves as a deficit. This did not adequately capture experiences outside of a narrow range defined as normal, and immediately defined alternate expressions as deviant, leading to increased labeling and stigmatization along the lines of race, class, and gender. Gilligan and colleagues argued that defining a single group's experience as normative reinforced preexisting structures of social power and did not adequately capture the experiences of marginalized groups.

Gilligan's colleagues at the Jean Baker Miller Training Institute developed the relational cultural theory, which included revised models of development. Relational cultural theories of development are built on the essential premise that individuals grow in, through, and toward relationships throughout their life spans. The model notes that strength occurs in relationship, and development moves toward ever-increasing relational complexity rather than toward isolation. The goal of relational models of development emphasizes the self in relation to the world, positing that human beings are hardwired for relational connection and are inevitably shaped by their relationships to others and their environment. The concepts of relational cultural theory become particularly important in people's understanding of the importance of attachment for prosocial development and the complex web of environmental factors that form the most recent advances in early childhood development.

From Theory to Practice

Current practice in early childhood development revolves around understanding and enhancing the growth and maturation of children from ages 3 to 5 years, their families, and their communities. This area is identified as a critical period of growth for children, laying a foundation for intellectual, physical, and emotional well-being throughout their lifespans. Research and interventions focus on differences in developmental outcomes and ways of strengthening various levels of the environment to increase the likelihood of fostering ongoing growth for children and their communities. Areas for environmental interventions include (1) the microenvironment of the family, (2) the mezzoenvironment of the neighborhood or community, and (3) the macroenvironment of the wider society.

Scholar Judith Bernhardt traces the understanding of diversity in the field of early childhood development and identifies the following four phases from the discipline's formative years through the present: (1) diversity as deficit, (2) diversity as disadvantage, (3) diversity as noncore difference, and (4) diversity as fundamental heterogeneity. She notes that the stages are broad sweeping but have real impact in policy design (particularly in the definitions of need over time), implementation, and efficacy.

Major Domains in Early Childhood Development

Practitioners in early childhood development have identified the following domains as major, interconnected areas of development:

- *Cognitive and neuro-development.* The development of the architecture of a child's brain, leading to the capacity to make meaning of one's experiences, to engage in the world, and to regulate affect and behavior.
- *Affective and social development.* A child's capacity to identify, regulate, and express emotional responses, and then to utilize these experiences in relationships with family, peers, and institutions.
- *Physical development.* A child's internal and external biological maturation, leading to increased capacity to act in the world, locomotion, and the so-called hardwired circuitry developed in the child's body.
- *Identity and relational development.* A child's sense of self in the world, particularly as related to issues of social location, power, and ability to affect change in the world, achieved through relationships.

The concepts of attachment theory (a child's sense of security and stability in relationships) are included in this domain and have significant impact on affective regulation and social development.

Significant Trends in Policy and Praxis

Much of the literature and interventions in early childhood development focus on identifying differences in developmental outcomes in the four domains listed above and determining effective strategies for increasing the likelihood of optimal development. This is largely done through the identification of risk and protective factors, including stress and relationships.

Stress. The presence or absence of stress plays a significant role in the development of a child's neural circuitry, which lays the foundation for affect and behavior regulation, and later capacity to engage in educational opportunities. Children who are exposed to prolonged stress are shown to have decreased skills in executive functioning, caused by chronic activation of the flight-or-fright response in the face of pervasive stress. Children who are exposed to prolonged stress have increased difficulty with working memory, attention, and impulse control, leading to difficulties in responding accurately to actual or perceived stressors throughout their life spans. However, if children possess or develop the capacity to regulate stress effectively, they are able to manage adverse situations more effectively throughout their life spans.

The neurobiology of stress is compounded by overlapping factors of chronic poverty, exposure to racism and societal devaluation, and witnessing or surviving interpersonal and/or community violence. Thus, children in communities where

Current practice in early childhood development revolves around understanding and enhancing the growth and maturation of children from ages 3 to 5 years, their families, and their communities. This area is identified as a critical period of growth for children, laying a foundation for intellectual, physical, and emotional well-being throughout their life spans.

there is more stress are significantly more likely than those in lower-stress communities to experience the adverse developmental effects associated with stress.

Relationships. The presence of caring, strong relationships with caregivers or caring adults significantly increases developmental outcomes, particularly the ability to regulate affect and behavior. Growth-fostering, mutually empathic relationships are the operative ingredient in secure attachment, increasing a child's sense of safety and mitigating the impact of stress in a child's life. When these relationships are compromised (e.g., through trauma, loss, or increased stress on the part of caregivers), children are less likely to internalize a sense of safety or expectation that their needs will be met. This sense of uncertainty can amplify the impact of stressors.

Intervention

Early childhood is the preferred time for interventions because it provides opportunities for change before patterns of neural activity and behavioral trajectories are firmly established.

The double and triple jeopardy of being a poor child of color exposed to trauma increases risk for individuals as well as communities. Thus, multiple levels of ongoing intervention are indicated. These include interventions specifically aimed at increasing individual and family capacities for managing stress simultaneously with policy and social justice interventions focused on eliminating the root causes of increased stress and adversity in disadvantaged communities. Best practices literature also stresses the efficacy of interventions developed with individual and community ownership and participation across all levels of the intervention process.

Conclusions

Early childhood development identifies major milestones and normative growth trajectories from the ages of 3 to 5 years in U.S. culture. These areas include physical development, cognitive development, and social development. Early childhood development is a broad field with implications for human services professionals in a number of fields, including education, childhood mental health, pediatrics, clinical case management, advocacy, and research across the social sciences. A comprehensive, multidisciplinary approach to this complex subject is critical to collaboration across disciplines, leading to more effective outcomes.

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See Also: Behavioral Health Disparities for Racial and Ethnic Minority Populations; Changing the Client Versus Changing the Environment; Childhood Trauma; Discrimination and Institutional Racism; Head Start/Prekindergarten Programs; Poverty.

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Early Childhood Literacy

While literacy has been a focus of primary school education for centuries, interest in identifying effective practices to promote literacy in the early childhood years is a fairly recent phenomenon. In addition, the scope of activities and competencies included within literacy has considerably broadened over the last 50 years or so. However, over the last two decades, a number of educational practices have been identified in both individual classrooms and entire schools that are associated with helping young children become literate.

The earliest focus on childhood literacy, in the first decades of the 20th century, was on determining when a child was ready to learn to read (several key theorists agreed that children were not ready to begin learning to read until the age of 6 or 7). These early approaches were heavily influenced by behaviorist psychology and used a narrow definition of literacy as decoding text. Following World War II, the scope of literacy research broadened to include social concerns (e.g., what is literacy for, and what do people do with it?) to understand literacy as including a number of complex processes, and to consider the importance of writing as well as reading in literacy.

By the 1970s, researchers realized that preschool children brought individual strategies to literacy based on printed language in their environment, and literacy was thus defined as a much broader set of behaviors than had previously been used. Many researchers also began looking at how home-based practice affected children's literacy, a substantial shift from studies of 50 or 60 years earlier that considered literacy as something taught to children in school. In 1986, George Wells published *The Meaning Makers*, which summarized many beliefs that still guide early childhood literacy programs. These include the fact that from a young age, children can take the initiative in literacy programs, that reading to children and engaging them in conversation about books is a key early literacy activity, and that literacy activities should be authentic and meaningful to the children taking part.

Kathy Hall reviews research into effective ways to improve student literacy while noting that this field of inquiry is fairly young, and that interest has shifted over the years from the teacher to the school as the unit of analysis. Multiple researchers noted in the 1990s that little research had been done to identify effective literacy teaching strategies, a gap remedied by a number of studies based on extensive observation of instructors in their classrooms.

The conclusion of this research was that effective literacy teachers balance and integrate learning the codes of written language (e.g., the correspondence between sound and symbol, word recognition, vocabulary, and grammar) with authentic uses of language (e.g., by having students write for authentic purposes and read and respond to a variety of literature). Excellent literacy teachers also use a variety of techniques in their classroom, including shared reading, partner reading, independent reading, lessons in the mechanics of writing, and free writing in journals, and teach students how to use a variety of cues for successful reading within ongoing reading and writing activities. Finally, they use techniques such as scaffolding and modeling, and create classrooms that are rich in print materials while being welcoming and homelike for students.

Many of these early literacy effectiveness studies were carried out with children in middle- and low-middle-income communities, with low-income children less well represented. In the early 2000s, several studies looked at literacy practices that were effective with lower-income children, looking primarily at schools in the inner cities, where students were achieving high degrees of literacy while schools with pupils from similar backgrounds were largely failing. These studies found that five characteristics separated the most effective schools from the less effective. First, effective schools made literacy a priority and devoted more time to literacy, including both reading and writing, than less effective schools. Second, effective schools emphasized small-group instruction and teacher-directed activities that allowed instruction to be customized for different levels of students, rather than primarily engaging in whole-group instruction. Third, teachers in effective schools involved parents and built on the cultural backgrounds of their students. Fourth, teachers in effective schools taught word recognition skills as strategies to immediately apply, and coached students in applying these recognition strategies in their daily reading practices. Fifth, in effective schools, teachers gave timely and effective feedback to students while understanding that the students were learners with personal interests and agendas.

Several other commonalities have been found in the most effective early childhood literacy teachers. Effective teachers are committed to helping their students make sense of authentic texts and to write for a variety of purposes. Second, effective teachers devote time to helping children understand the reasons for the different tasks that they are asked to perform, rather than simply teaching the technical aspects of literacy. Third, effective teachers believe that all of their students can become effective readers and writers, and expect them to do so.

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See Also: Adult Literacy Programs; Educational Services; Educational Support Services; Multicultural Education.

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Eating Disorders, Cultural Aspects of

Diagnosable eating disorders share in common the presence of a persistent pattern of dysfunctional eating or eating-related behavior that results in altered food consumption or weight management approaches and significantly impairs psychosocial functioning, psychoemotional adjustment, or physical health. Diagnosable eating disorders differ from everyday problems associated with eating, weight and weight management, or body image in that they are syndromes that cause clinically significant distress and/or impairment in functioning in social, occupational, or other important life roles or areas.

In many settings, human services professionals require competencies in identifying, assessing, and intervening or referring for intervention those consumers, clients, or patients who experience eating disorders. These competencies include understanding the gender-related and other cultural aspects of these mental health needs.

Clinical Aspects: Defining Four Major Eating Disorders

The American Psychiatric Association (APA) includes in *Diagnostic and Statistical Manual of Mental Disorders* (fifth ed.), known as DSM-5, at least four major eating disorders important to practitioners in the human services: (1) anorexia nervosa (anorexia), (2) bulimia nervosa (bulimia), (3) binge eating disorder, and (4) other specified eating disorders.

Anorexia. Individuals experiencing anorexia present three primary features:

- Persistent severe restrictions in their food intake.
- Intense fear of gaining weight or becoming fat, or severe weight management to avoid gaining weight (e.g., self-induced vomiting, misuse of laxatives).
- Disturbances in self-perceptions of weight or body shape.

Dieting and an intense focus on weight loss is common in U.S. populations. However, normally expected weight loss attempts differ from anorexia in that eating and weight management behaviors for anorexics lead to severe, significantly low weight, which falls below what is considered minimally normal according to health standards.

Bulimia. Individuals experiencing bulimia present three characteristic features:

- Recurrent episodes of binge eating.
- Recurrent inappropriate or unhealthy compensatory behavior to prevent weight gain.
- Self-evaluation that is overly influenced by weight, body size, or body shape.

Certainly, individuals without a diagnosable eating disorder might binge eat on occasion, may periodically use unhealthy weight loss strategies, and sometimes may overly associate self-esteem with body image. Diagnosis of bulimia, however, requires all of the following for a period of three months or longer: (1) at least weekly, recurrent episodes of binging during which the person feels genuinely out of control; (2) an entrenched pattern of at least weekly unhealthy compensations for binging through recurrent self-induced vomiting, misuse of dieting medications, or overexercise; and (3) self-evaluation that is significantly influenced by body image.

Binge eating disorder. Individuals experiencing binge eating disorder present recurrent episodes of binge eating for at least three months without the compensatory behaviors of bulimia. These episodes differ from normally expected occasional overeating in that these individuals (1) feel their eating is out of control during a binge; (2) eat too rapidly, become overly full, or binge when not hungry; and (3) feel a clinically significant level of self-disgust, embarrassment, or depressed mood.

Other specified eating disorders. Individuals experiencing other specified eating disorders present clinically significant distress or impairment in role functioning due to eating-related behaviors that do not meet the full criteria for any of the other disorders described above. This behavior might include, for example, (1) experiencing all of the features of anorexia except that extreme weight loss has not produced subnormal body weight; (2) presenting all of the behaviors of bulimia or binge eating disorder, but with lower frequencies of the relevant behaviors than required (for example, less than once a week) or for a shorter duration than required (for example, for less than three months); or (3) other combinations of problematic eating-related thoughts, affect, behavior, and physiology that cause clinically significant distress or impairment. Prior to the publication of DSM-5, these were referred to as eating disorders not otherwise specified (NOS).

Gender Aspects: Prevalence and Importance in Human Services Populations

Understanding the basics of these four major eating disorders is important. Human services professionals must recognize these concerns when they occur in their consumer or client populations. As Laura Choate and others have emphasized, professionals have been responding increasingly to gender-related counseling needs. Females greatly outnumber males with eating-related problems, and the population most likely to experience eating disorders is that of late adolescent girls and young adult women. In fact, internationally, eating disorders are among the 10 most common causes of psychological distress in young adult women. A. M. Schwitzer and colleagues report that on college campuses with large concentrations of female students, “the high incidence of eating disorders is especially well-documented.” But males certainly experience eating disorders as well; for instance, as many as 30 percent of adolescent boys report body dissatisfaction and unhealthy weight management. Binge eating disorder, in particular, seems less skewed by gender than the other disorders. The APA reports that in clinical populations, the ratio of females to males with eating disorders is 10 to 1.

Further, as Schwitzer and his colleagues discuss, by far the most commonly observed eating-related disorders among females are the heterogeneous group of moderate problems characterized as other specified eating disorders. Occurrences of anorexia, bulimia, and binge eating disorder are relatively low. The authors found that in community populations, the prevalence of anorexia was less than 1 percent, the prevalence of bulimia was about 1–1.5 percent, and the prevalence of binge eating disorder was 1.6 percent. By comparison, in a variety of studies with college populations, only 6 percent of females reported anorexia or bulimia concerns, whereas 25 to 40 percent reported moderate concerns falling under the category of other specified eating disorders. These include the symptoms of body image worries, weight management problems, and out-of-control eating. Professionals must understand that other specified eating disorders are very commonly associated with a constellation of additional problems, including moderate depression, moderate stress and anxiety symptoms, low self-esteem, interpersonal dependency, and problematic perfectionism, as well as' difficulties in seeking and maintaining professional helping relationships.

Family Aspects: Genetic and Behavioral Influences

Developing an eating disorder is multidetermined. Besides gender, family of origin has an impact. There is increased risk of developing an eating disorder among individuals with family members with eating disorders. The heightened risk likely combines some increased genetic or physiological vulnerability and predisposing family psychosocial factors. Anorexia and bulimia risks are higher for those with first-degree relatives with these disorders, according to the APA. Females with other specified eating disorders are likely to have a family member with an eating disorder, highly likely to have communication and relationship difficulties with parents, and highly likely to have enacted the so-called perfect role in their families. They may be emotionally dependent in their young adult relationships with parents.

Societal Aspects: Cultural Influence of the Thin Ideal

By far, the most widely recognized societal-level cultural influence on the development of eating disorders is the so-called thin ideal. This ideal refers to the importance of extreme thinness and physical attractiveness for girls and women. The ideal is communicated directly and indirectly via interpersonal relationships, group dynamics, and media portrayals, among other societal-level messages.

Most authors agree that essentially all females in the United States and elsewhere where the thin ideal predominates are pressured to some extent to achieve these standards. Although many are able to resist these cultural pressures, about half of all young adult women develop some combination of negative cognitions and negative affective symptoms associated with body image dissatisfaction. As C. Rhodes cites, illustrations of these faulty cognitions triggered by cultural-level thin idea pressures include: "Thin equals control equals power!" "Sex equals power" "The mirror is my enemy" and "I need to look young to attract a mate." Consequently, women with body image dissatisfaction often engage in maladaptive eating practices and excessive dieting. In turn, a portion of women who experience these initial characteristics stemming from the thin ideal then go on to develop diagnosable eating disorders. This chain of effects is especially salient for practitioners—because the thin ideal is such a critical aspect of eating disorder formation, prevention and treatment almost always includes some psychoeducational and cognitive-behavioral or schema-based components aimed at reducing the impact of the cognitive distortions it produces.

Sociocultural Aspects: African American, Asian American, and Latina Women

Historically, eating disorders primarily have been associated with European American females. In the past, researchers such as R. M. Talleyrand consistently reported low prevalence rates of eating disorders among women of color; these findings were explained by these populations being seen as "less likely to be exposed to key risk factors such as a thin ideal or societal pressures to be thin." Today, however, eating-related concerns are recognized among various racial, cultural, and ethnic groups and populations. Documented eating disorder prevalence rates among girls and women of color appear similar to those for European Americans. In part, because recent eating disorder research more appropriately includes individuals of color, more accurate knowledge of this population is available.

Additionally, as Talleyrand points out, newer research suggests that the increased presence of culturally diverse celebrities and media personalities may be yielding greater body image and eating problems among girls and women of color. At least three populations deserve special attention regarding eating disorders from the human services professionals who work with them: African American, Asian American, and Latina women.

African American women often are seen as having some resilience to the major eating disorders because they are less culturally susceptible to the thin ideal. Research by Talleyrand suggests that African American women often are “less likely to have concerns about their size and body shape, less likely to view themselves as overweight, and less reliant on dieting behaviors allegedly due to African American cultural norms that support heavier body ideals,” so body satisfaction levels may be higher for African American females. At the same time, prevalence rates for eating disorder symptoms still appear high; most notably the presence of binge eating disorder symptoms is of special concern, as are high prevalence rates of excess weight and obesity.

Asian American women are underrepresented in the eating disorder literature. This may reflect bias—this population might be overlooked, according to Talleyrand, due to the “stereotypical belief that Asian Americans’ . . . smaller body sizes protect them from experiencing body dissatisfaction.” Further, there may be methodological problems with much of the research. More recent studies suggest overall rates of eating disorder symptoms in Asian American women are about the same as with other ethnicities, and may be higher for binge eating symptoms. Further, it appears Asian American women may tend to adopt Eurocentric mainstream body image ideals and therefore have similar rates of body dissatisfaction. Asian American females also may have unique negative self-attributions connected to facial features and specific body parts.

Latina females also are underrepresented in the eating disorder literature—here again, perhaps due to a biased perception that, according to Talleyrand, “Latina women are protected from being dissatisfied with their bodies because larger women are considered healthy and wealthy among Latina cultures.” A competing view is that Latina adherence to more traditional gender roles leads to an intensified focus on physical appearance and, in turn, greater susceptibility to body dissatisfaction and therefore to eating disorders. In fact, Neumark-Sztainer and colleagues report high rates of dieting and body dissatisfaction, so while this population conventionally has been seen as protected from internalizing the thin ideal, they still appear to experience eating and body image behaviors characteristic of the major eating disorders.

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See Also: Help-Seeking Behavior, Cultural Differences in; Mental Health Services, Adult; Overweight and Obese Adults and Children.

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Economic Support and Services

The U.S. government provides aid to its citizens through economic support and services in a variety of ways. Government spending on the poor is the primary example, with cash aid as economic support (e.g., Temporary Assistance to Needy Families, or TANF) and skilled assistance as services (e.g., casework). Public spending on social insurance programs also assists workers who meet expected challenges in the life cycle (e.g., Social Security) and larger economic cycles (e.g., unemployment insurance). In comparison to these more visible forms of economic support and services, government spending on tax deductions that mostly assist high-income individuals build wealth (e.g., the mortgage tax rate deduction) is rarely acknowledged as a form of government aid. The government provides economic support and services to people in all economic classes, but these differ in social acceptability and visibility. Knowledge of each is important for social workers to promote policies that pursue social and economic justice.

Public Aid

Pilgrims that settled land that would eventually become the United States transplanted a system of aid developed in England, most prominently the Poor Laws of the 1600s. The principles of this system were concerned with ensuring the maintenance of the social order based on the extraction of labor and acceptance of hierarchical relations in a feudal system. Whether recipients were deemed worthy of charity depended on perceptions of their ability to work to support themselves. Typically, the elderly and infirm were considered unable to work, and were thus worthy of outdoor relief. The able-bodied, on the other hand, were undeserving and were put to work in workhouses. The principle of least eligibility further dictated that the aid provided could not exceed the least amount that could be earned by the typical worker of the time so as not to create a disincentive to work. Public aid is meant to provide a minimal form of support, after all other resources such as family have been exhausted.

This system is still present today in the present-day assistance programs for TANF and General Aid (GA), a system of economic support and services that stigmatizes recipients through exhaustive questioning of their motives for applying for assistance. By focusing on individual characteristics related to deservingness, it does not promote questioning of the larger systemic reasons for poverty (e.g., high costs of housing relative to wages). The unintentional consequence of asset testing pushes families into spending down all resources to be eligible, and conversely, to discourage saving because doing so could jeopardize aid.

Social Insurance

The capitalist system is based on the idea of free exchange between the owner of labor (the worker) and the owner of accumulated wealth that can purchase labor (the capitalist). The communist critique of this libertarian ideal is that the exchange is inherently exploitative because the labor that is purchased serves to create more wealth for the capitalist. Between the two ideological extremes is the idea that the nature of the relations between the worker and employee can be regulated to bring economic gain and social good.

This system is the most widely used form of economic support and services. Far from the stigma tied to the receipt of public aid, social insurance is seen as an entitlement and reward for the years of work provided by those who are now elderly. Although there is strong public support for public insurance for the elderly, the mandatory spending on Social Security and Medicare is questioned by politicians by reframing it as a form of public aid that can no longer be supported by tax revenue. The system was not designed to adjust to demographic shifts like the aging of the large baby boomer population and advances in technology that have increased life spans. Yet, adjustments to the formula used for contributions could be considered an extension of the same fundamental principle of the government regulating economic exchange in order to serve the larger goal of providing economic support and services to those who need it most.

Support for Asset Building

The third system of government assistance provides supports for individuals to build wealth. While intimately intertwined with notions of the United States' exceptionalism, the system of federal supports that assist individuals to achieve the American dream is largely invisible. Social workers, trained to gravitate toward problems like poverty, typically stop paying attention when discussions of wealth-building activities arise. This is despite the fact that it takes wealth to truly escape the economic insecurity of poverty. However, asset building as a form of economic support and service is important for social workers to track because it is in the allocation of resources to stimulate wealth building that the economic disadvantage that results from institutional oppression can be seen most clearly.

Assets (also known as capital or wealth) such as homes and private pension plans possess economic value. Because they can be spent in times of crisis or used to generate additional income flows, measuring both assets and income presents a more accurate picture of the economic stability of a household. High-income individuals can acquire even higher consumer debt, which may quickly lead to financial ruin if their income flow is disrupted. Conversely, a low-income family may inherit a home with a mortgage that is fully paid off; such a family saves on housing costs, lowering their spending on the biggest single expenditure most families must pay, and has ownership of a very valuable commodity (e.g., they can borrow against the equity to start a small business or send children to college).

Promotion of wealth building has long been a part of federal policy, with examples ranging from the Homestead Act to favorable terms for home financing with the G.I. Bill, to the plethora of tax deductions for retirement savings, home acquisition, and other forms of wealth building.

How closely does the current arrangement of the asset-building system meet the goals of social or economic justice? A simple calculation suggests that the current direction of expenditures only compounds traditional inequities in access to mechanisms for wealth accrual. Nonwhite families were generally excluded from the Homestead Act and from home purchase through the G.I. Bill, which means that the massive wealth generated for lower-income families at that time was passed down through the generations along racial lines. For example, the Pew Center estimated in 2011 that Hispanic and African American families had 18 to 20 times less wealth after the economic crash than white families.

Analyses by the Center for Economic Development and Annie E. Casey Foundation show that currently more than half of the nearly $400 billion spent for asset building is captured by the families making the top 5 percent of earnings, while those with the lowest incomes receive nearly nothing. The key to both the invisibility and the inequity of the asset-building system is its mechanism for distribution of the funding. Only a small portion of the funding is specifically directed toward those with lower incomes, and the overwhelming majority ($35.2 billion of the $36.5 billion) of this spending is used on postsecondary education (e.g., Pell grants). As with public aid, this funding comes from the general revenue part of the federal budget, with allocations debated vigorously every year as Congress deliberates authorizing the president's proposed budget. The vast majority of the funding ($347.8 billion) is spent as tax exclusions and deductions. Although owed money uncollected is worth the same as money spent, this form of expenditure is not debated in annual budget appropriation talks because the money never appears in the pool of revenue collected in taxes. These funds are largely collected by individuals earning the highest incomes because only they itemize the deductions to their spending.

Conclusion

The economic support and services provided by the U.S. government to its population is considerably more complex than it seems when people debate the value of providing welfare to the poor. It ranges from (1) the highly contested system of public aid meant to provide the population with a minimum standard of living, to (2) the social engineering that enables entitlement programs that anticipate ebbs and stops in earning potential during cyclical economic downturns and parts in the life cycle of most workers, to (3) the largely invisible investments in the asset building of the population that mostly benefit the more wealthy minority. It turns out that they are focusing on just one ring of what turns out to be a three-ring circus.

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See Also: Education and Training Vouchers; Equal Pay Act of 1963; Fair Lending Practices; Financial Literacy Programs; Social Security, Services Funded by; Social Welfare Policy, Cultural Competence in; Welfare Reform, Role of.

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Education and Training Vouchers

The U.S. education and training voucher (ETV) is the first federal program specifically created to address the postsecondary educational needs of current and former foster youth. The population of ETV-eligible youth (those who have been in foster care on or after their 14th birthday and those who have not been adopted before their 16th birthday) is considerable. According to the U.S. Adoption and Foster Care Analysis and Reporting System (AFCARS), in September 2011, more than 26,000 young people aged out of foster care, 11 percent of the total foster care population. (Aging out means the youth is no longer in the foster care system and is solely responsible for his or her own well-being.) Despite the economic advantages of completing high school and obtaining a postsecondary education credential, foster care youth lag far behind the national trends. This is concerning because foster care youth with limited educational attainment are at very high risk for unemployment, homelessness, incarceration, and dependence on public assistance.

Foster Youth Needs

A significant gap exists between students who were in foster care and their peers who were not with regard to college readiness, enrollment, retention, and graduation. According to a study conducted by the National Association of Student Financial Aid Administrators, at age 19, only 18 percent of foster care alumni versus 62 percent of their 19-year-old peers are pursuing a four-year degree. This study also suggests that even when foster youth do attend college, they are less likely than their nonfoster care counterparts to earn a degree. At age 25, less than 3 percent of foster care alumni compared to 24 percent of their counterparts completed a bachelor's degree or higher. Regarding pursuit of any type of postsecondary credential, only 26 percent of foster care alumni who enroll in college compared to 56 percent of their peers have earned a degree or certificate within six years of enrollment.

Not completing postsecondary education limits prospects for employment, which has significant implications on lifetime earning potential. According to a study conducted by MPR Associates, a nonprofit consulting agency for the U.S. Department of Education, persons 25 to 34 years of age who had at least a bachelor's degree earned, on average, 61 percent more than those with only a high school diploma or General Educational Development (GED).

Federal Policy

Over the past decade, federal policy makers have responded to the many educational challenges faced by young people aging out of foster care. In 2001, under Title II of the Promoting Safe and Stable Families Amendments (P.L. 107–133), Congress authorized educational and vocational training programs for older youth, leaving foster care under the John H. Chafee Foster Care Independence Program (CFCIP). CFCIP is a capped state entitlement program, with an initial appropriation in fiscal year 2003 of $182 million, of which $42 million is dedicated to funding ETVs. Since 2003, this appropriation has fluctuated between $44 million and $46 million. States receive an annual allocation based on their percentage of children and youth placed in foster care; they have two years to spend each year's allocation. States are required to provide 20 percent of their annual allocation through an in-kind or cash match. States can use their ETV funds to provide current and former foster youth with up to $5,000 per year for postsecondary training and education. These ETV funds can be used to defray the costs of tuition and fees, books and supplies, room and board, and miscellaneous personal expenses, including purchase of a personal computer, transportation, and child care.

Youth already participating in the program on their 21st birthday remain eligible until age 23, as long as they are making satisfactory progress toward completion of their postsecondary training program. Satisfactory progress has been defined by the federal government as the maintenance of at least a 2.0 grade point average (GPA) and no more than one incomplete or course withdrawal per semester. The most recent major federal child welfare legislation, the Fostering Connections to Success and Increasing Adoptions Act of 2008, also contains provisions that promote educational stability, and expands eligibility for the ETV program to youth who exit foster care through adoption or relative guardianship when they are at least 16 years of age. It is estimated that around 150,000 youth nationally meet the criteria to receive ETV funds.

Conclusion

Although ETV legislation was enacted in 2001, it was not operative in most states until 2003–04, making it a relatively new federal initiative with little longitudinal research as to its effectiveness. There is need for increased investment on the part of the federal government, the states, and communities to effectively monitor the quality and quantity of services provided as well as the outcomes experienced by young people who have enrolled in the program.

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See Also: Children in Foster Care; Fostering Connections to Success and Increasing Adoptions Act of 2008; John H. Chafee Foster Care Independence Program.

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Education for Diversity in Human Services

Education for diversity in human services encompasses three interrelated themes. The first is educating human services staff to deal with diverse populations. The second is ensuring that governmental and agency programs and policies do not foster or maintain discrimination and are sensitive to diverse cultural differences. The last requires increasing diversity among human services providers. Education appears to be the key to these three themes. As the makeup of the populations receiving human services changes, staff must appreciate and understand how to work with diverse groups, and organizations must comprise a diverse staff.

What Is Human Services?

According to the National Organization for Human Services (NOHS):

> The field of Human Services is broadly defined, uniquely approaching the objective of meeting human needs through an interdisciplinary knowledge base, focusing on prevention as well as remediation of problems, and maintaining a commitment to improving the overall quality of life of service populations. The Human Services profession is one which promotes improved service delivery systems by addressing not only the quality of direct services, but also by seeking to improve accessibility, accountability, and coordination among professionals and agencies in service delivery.

According to this definition, many professionals holding specialized degrees are human services professionals. In fact, most educational programs in human services include faculty with degrees in a diverse range of academic and professional disciplines.

Human services is a generic term that covers the broad range of services that are provided to people in modern society. Many human services workers are employed and supervised by professionals in social work, education, public health, mental health, and corrections as well as myriad other civil service settings. They are often part of an interdisciplinary team. Job responsibilities and titles vary, depending on the setting within which these professionals work and the client population served. The NOHS Web site (www.nationalhumanservices.org) lists 40 examples of occupational titles that human services workers may be known by in the fields of health care, social services, education, health, mental health, addiction treatment, criminal justice, and education.

The U.S. Department of Labor, Bureau of Labor Statistics indicates that human services workers serve diverse populations with a range of problems. The primary purpose of the human services worker is to assist individuals and communities to function as effectively as possible in the major areas of living. Clients may include children and families; the elderly; people with disabilities, addictions, medical problems, and mental illness; veterans; immigrants; those under court supervision, on probation, and on parole; and homeless individuals. Thus, human services workers may work with any individual, family, or group that has a problem and needs to access the formal service delivery system.

NOHS describes the generic knowledge and skills necessary for all human services professionals. Human services workers must understand the nature of human systems ranging from individuals to communities as well as the conditions that promote or limit functioning. They must have the ability to identify, implement, and evaluate interventions that promote growth and goal attainment. These interventions need to be congruent with the values of clients, organizations, and the human services profession. This last set of generic abilities becomes the basis for competency in working with diverse client populations and in both understanding and respecting differences.

History of Human Services

Prior to the 1960s civil rights movement and the War on Poverty, what is now known as human services was hosted within many different professions, including social work, mental health, medicine, education, rehabilitation, social services, and nursing. These professions required both undergraduate and graduate college degrees and specialized professional education. These professions have their own education accrediting bodies and codes of ethics to address standards of diversity in professional practice and education. Some paraprofessional staff participated in these settings and were often responsible for work that did not require professional training.

The War on Poverty led to the development of human services as a discipline based on a need for paraprofessional and community-based workers. The expansion of education, health, and social services programs was accompanied by demands for increasing numbers of qualified staff. Much of the new legislation supported local projects that employed community members in new fields and sometimes in fields traditionally reserved for credentialed professionals. Federally financed community action programs created new roles, tasks, and fields of employment for people regardless of their credentials.

Head Start and day-care programs required nonprofessional child care staff such as teacher aides and day-care providers. The Head Start program started in 1965 as an eight-week summer program for children from low-income communities who would be attending public school in the fall. As the program developed, so did the demand for child care workers, assistant teachers, and dietary staff. The number of home-based day-care programs also multiplied. Some women who were receiving Aid to Families with Dependent Children (AFDC) received training as day-care providers; their homes were certified as home day-care settings and they received supervision from social services agencies. These women were paid to watch the children of other AFDC recipients, who could then go to school and end their welfare dependence. Many of these day-care providers were also able to continue their education to earn certificates as teacher assistants, two-year college degrees as kindergarten and preschool teachers, and bachelor's degrees.

At the time of the War on Poverty, there was a separation of services program within governmental departments of social services, which separated the functions of services programs from the determination of eligibility for those programs. In the past, a social worker with a bachelor's or master's degree determined eligibility and also provided case management and other social services. With the advent of separation of services, a new level of worker was implemented. Such individuals were eligibility specialists who collected documents to determine whether an individual or family was qualified to receive benefits from these programs. In many cases, these positions required only high school degrees and offered job opportunities for good-paying civil service jobs with benefits and opportunities for job advancement and education.

These programs also created another level of paraprofessional staff that worked under the supervision of professionals. They became known by a

President Lyndon B. Johnson signs the Medicare Bill at the Harry S. Truman Library in Independence, Missouri. The implementation of Medicare was a key part of the War on Poverty. The War on Poverty led to the development of human services as a discipline based on a need for paraprofessional and community-based workers.

variety of job titles, including case aides, nursing aides, and mental health aides, among others. These individuals might have received in-service training or earned certificates or degrees from community colleges and vocational training programs. Unlike clerks, they worked with clients to provide services, such as a recreation aide in a senior center or a mental health program; a nursing aide in a hospital, nursing home, or community setting; a dietary aide working with welfare clients to improve their food choices; or a case aide in a drug treatment program helping clients remain in contact with their children or helping them find housing with which to return to the community. Such workers required skills in working with people and negotiating various aspects of the service delivery system. These jobs often offered benefits and opportunities for continuing education.

The Civil Rights Act of 1964 opened up access for minority populations to many governmental programs such as AFDC, food stamps, Medicare, and Medicaid as part of the War on Poverty. At the same time, unemployment in the United States was approximately 19 percent and many of the unemployed belonged to minority groups. The various War on Poverty job-training programs increased the opportunity for minority individuals to earn academic credentials, which provided them with opportunities for jobs in health care, government services, and education. Work incentive programs were specifically designed to help individuals on AFDC and welfare get training. The civil rights and welfare rights movements resulted in the inclusion of many who had been previously excluded from federal programs.

The Older Americans Act of 1965 created a number of programs to meet the needs of the aging population, which necessitated the need for staffing. Not only did this legislation provide funding for programs, it also provided "training of special personnel needed to carry out such programs and activities." Many community-based programs, including multipurpose senior centers and senior meals programs (e.g., Meals-on-Wheels), were funded to meet the mandate of this legislation, which offered additional job and training opportunities for individuals to work with seniors.

The Community Mental Health Centers Act of 1965 was designed to increase the services provided to mental health patients who needed support in returning to their communities. Paraprofessional staffing was needed to help supervise and support individuals who were released from in-patient psychiatric care to community settings. It was believed then that the use of psychotropic drugs would allow individuals to function within their communities. This did not happen, however, because adequate funding was never available to fully implement the needed numbers of community mental health settings, and the psychotropic medications either did not work for all mental illnesses, and/or once released from in-patient facilities many patients failed to take their medications. Homelessness and substance abuse became serious problems for the community-based mentally ill. The end of the Vietnam War increased the numbers of individuals needing care for mental illness and substance abuse. While the need increased, the funding for programs and staff decreased. Programs serving these populations currently continue to use many human services staff to provide outreach, intake functions, and case management services.

Education for Human Services

Educating this generic worker, who may work with different types of clients, with different types of problems, and in different types of settings, presented a challenge. Traditional education had focused on specializations within the professions, which had long used paraprofessional staff under supervision. Recognizing the need for this new professional, some colleges developed generic human services programs that used courses from other academic disciplines and added some specialty courses focused on human services. Others added courses or minor concentrations to already existing programs in psychology or sociology. Many were in two-year community colleges with a focus on career opportunities or transfer to four-year colleges. As was common in many professional programs, students were often required to do internships in community settings.

Funded by the War on Poverty legislation, various demonstration projects arose throughout the country. In 1964, Audrey Cohen had a new vision for education for human service workers. She developed the Women's Talent Corp as a demonstration project funded by the Office of Economic Opportunity (OEO). The goal was to train women who were interested in improving their communities. Program participants were placed in funded (paid) internships in community-based health clinics, day-care programs, housing projects, and legal services. In 1967, the Women's Talent Corp became the College for Human Services, which was later known as Audrey Cohen College and now is the Metropolitan College of New York (http://www.mcny.edu). The founder's name remains on the Audrey Cohen College for Human Services and Education, which offers a certificate in substance abuse counseling (CASAC), associate's and bachelor's degrees in human services and urban studies, and master's degrees in education. This college continues to serve an older, nontraditional, mostly minority student population.

To educate individuals in this new profession, Cohen and her colleagues also developed a new model of education that was designed to meet the needs of adult students, who would be working in a variety of settings with diverse clients. This model is known as Purpose-Centered Education®, which does not look like a traditional college education. The program of study has changed in the last 50 years, but many of the original elements remain the same. Currently, the program in human services remains transdisciplinary (not multidisciplinary) and incorporates knowledge from psychology, sociology, philosophy, political science, economics, education, law, history, anthropology, and social work. There are no disciplinary departments as found in traditional colleges, and students take a structured series of courses each semester. Each semester organizes all of the transdisciplinary courses around a purpose. Each purpose has five dimensions: values and ethics, self and others, systems, skills, and purpose (which incorporates field and constructive action). Therefore, students do not take, for example, Psychology 101, but rather have this course content throughout their self and others courses, which may also incorporate content from psychology, sociology, philosophy, anthropology, and philosophy.

Each semester the purpose seminar helps students integrate material from their coursework with professional performance in their field setting. Historically, field work was paid internships in community settings funded by federal programs, but now students use either their work settings or unpaid internships. Some internship settings are able to offer students stipends or, in some cases, jobs. Similar to traditional internships, students go to field settings and perform various tasks under supervision. The difference is that within their field settings, students are required to carry out constructive action projects that demonstrate integration of their learning in the purpose and their mastery of the abilities/skills necessary for professional practice. Students are asked to produce a document each semester that demonstrates their abilities to plan, implement, and assess their projects.

This purpose-centered approach, which links the classroom to the field, has been adopted in various forms by other colleges. The new Stella and Charles Guttman Community College of the City of New York college system (http://www.guttmen.cuny.edu/index.html) incorporates this approach into its human services program. Each semester's classroom learning is linked by a theme that is connected to field experiences. In addition to some specialized human services courses, the curriculum includes traditional departmental courses.

Diversity in Educational Programs

From their earliest start, many of the human services programs had diverse student bodies due to their focus on developing staffing to meet the needs of War on Poverty programs. Many of these new students had been on welfare themselves, were unemployed, and/or had been the beneficiaries of other public programs. The Civil Rights Act of 1964 opened educational opportunities to many who had been previously denied such options. Both the women's liberation and civil rights movements resulted in increasing numbers of women and African Americans attending college and training programs. Affirmative action legislation forced educational institutions to review their admission policies to redress past discrimination.

Over time, traditional college students entered the field of human services rather than the professional programs. In some cases, this was related to their idealism and interest in working to improve their communities; in other situations, they either did not wish to or could not meet the standards of professional or preprofessional programs. Human services careers offered students the option of working with people outside of the business sector and traditional accredited and credentialed service models.

Standards

Codes of ethics are one way that professions set standards of behavior for practitioners. While not law, such standards are often used by courts in making determinations of unethical behaviors or malpractice. An individual practitioner does not have to be a member of a professional organization for the courts to apply a code of ethics they consider to be the acceptable standard of care. Such professional codes are also linked to education programs, accreditation, licensure, and professional certifications. A review of the codes of ethics of the professions within the human services fields shows that they support inclusion and nondiscrimination standards. Some also suggest the importance of social justice to eliminate discriminatory actions and practices.

In 1996, the Council for Standards in Human Service Education (CSHSE) adopted Ethical Standards for Human Services Professionals. The preamble acknowledges that human services professionals have an appreciation of human beings in all of their diversity. Two specific standards relate to the role of human services in advocating for the rights of individuals who have been historically oppressed (Statement 16) and providing services without discrimination based on age, ethnicity, culture, race, disability, gender, religion, sexual orientation, or socioeconomic status (Statement 17). Statement 18 focuses on respecting cultures and beliefs. Human services professionals are expected to be aware of sociopolitical issues that differentially affect clients from diverse backgrounds (Statement 20) and to seek the training, experience, education, and supervision necessary to ensure their effectiveness in working with culturally diverse clients (Statement 21).

The Human Services-Board Certified Practitioner (HS-BCP) certification has been developed by the Center for Credentialing and Education (CCE), NOHS, and CSHSE. Compliance is voluntary and verifies educational requirements and practice knowledge for those with human services degrees. Individuals who wish to earn this credential have to comply with the HS-BCP Code of Ethics, which states that human service practitioners will:

> Refrain from unlawful discrimination in occupational activities, including but not limited to discrimination based on age, race, gender, ethnicity, sexual orientation, gender orientation, religion, national origin or disability. Occupational activities include relationships with employers, clients, and colleagues (Standard 4).

Accreditation of human services education programs is done through CSHSE, and is in the process to secure recognition by the Council for Higher Education Accreditation (CHEA). Human services programs, like other college programs, are currently accredited through their regional accrediting body, rather than the professional accrediting body.

Colleges that wish to become accredited by CSHSE must meet the established curricula standards. CSHSE has educational requirements for associate's, bachelor's, and master's degrees in human services. The standards contained in the CSHSE Member Handbook may be numbered differently for the three levels of education, but all three require the following:

> Emphasis on context and the role of diversity (including, but not limited to ethnicity, culture, gender, sexual orientation, learning styles, ability, and socioeconomic status) in determining and meeting human needs.

At both the associate's and bachelor's levels, students are required to appreciate the "worth and uniqueness of the individual including culture, ethnicity, race, class, gender, religion, ability, sexual orientation, and other expressions of diversity." All three levels of students are required to develop awareness of their own diversity and to develop practice competencies to work with culturally diverse client populations. Thus, it becomes necessary for all human services programs to include content on diversity in their educational programs and to develop practitioners who are culturally competent and dedicated to safeguard that program's function without discrimination in the delivery of services.

Conclusion

Since its inception, the development of education for human services professionals has focused on providing career pathways for individuals who are interested in working with people. The students themselves are often drawn from and represent the diverse populations they serve. Some may continue on to professional graduate programs in different fields, and others will work in agencies providing a range of services to varied clients. Beyond just the provision of services, human services workers must engage in social justice activities and empower marginalized groups to ensure the development of programs and services to meet the needs of a diverse and multicultural society.

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See Also: Equal Opportunity and Civil Rights; Social Welfare Policy, Cultural Competence in; Social Work, Diversity Practice in; War on Poverty Programs.

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Educational Services

Everything a school system does, including providing classroom instruction, can be considered an educational service. However, other educational services are offered outside the traditional classroom setting and/or for other than average students, including special education, education for gifted students, guidance counseling, and testing. Awareness and understanding of cultural diversity is key to providing optimal services for a wide range of clients.

Special Education

Special education is provided to students who have needs beyond those of the typical or average student in a school or district. Examples of students who may be placed in special education include those with an identified physical or mental disability (e.g., blindness or mental retardation), and those with emotional disturbances or behavior problems that make them unable to function in a traditional classroom. Although theoretically special education is meant to provide a student with the most appropriate educational services for their particular needs and capabilities, critics charge that special education programs are sometimes used as a "dumping ground" for children from low-income or racial and ethnic minority homes, and that children from racial majority, middle- or upper-income homes exhibiting similar behavior would not have been placed in special education. In addition, some see special education as operating as a "holding tank" for children deemed troublesome or low achieving, and this label becomes self-fulfilling because students in special education do not receive challenging academic instruction, are not held to high standards of achievement and behavior, and fall further and further behind their peers.

Although some types of special education (e.g., for the deaf) date back to the 18th century, special education within school systems became much more common after compulsory education became the norm (every U.S. state had some sort of compulsory education law by 1918). However, some children with disabilities remained excluded from ordinary school classrooms until the 1980s, when mainstreaming (placing children in the least restrictive educational environment) became popular. Today, students with disabilities are entitled to appropriate free public education that is provided by their school district, must be provided appropriate services and an individualized education program (IEP), and must be mainstreamed as much as possible (e.g., included in ordinary classrooms as feasible, possibly with some additional instruction specific to their needs outside the mainstream classrooms).

Gifted Students

Interest in identifying gifted and talented students dates back at least to the early 20th century, although sustained interest in providing specific educational programs appropriate for gifted and talented students is a more recent phenomenon. Gifted and talented students can be seen as the reverse of students in special education: Whereas for the latter, the standard educational program may be too challenging, for gifted and talented students, it may be too easy.

Interest in developing the abilities of gifted and talented students, particularly in mathematics and the sciences, was given a large boost by increased educational funding following the launch of the Sputnik satellite by the Soviet Union in 1957—nurturing gifted students became seen as one aspect of enabling America to stay competitive with the Soviet Union. Another boost was provided by the 1983 report *A Nation at Risk*, produced by the National Commission on Excellence in Education, which noted that American students were falling behind the students in many nations that were considered economic competitors of the United States.

School systems have adopted two different approaches to gifted students: acceleration, in which students progress through the regular school curriculum more quickly than average students, and enrichment, in which students are provided with extra educational experiences and challenges, but remain otherwise on track with other students of the same age. Although it is difficult to design studies to demonstrate the effectiveness of gifted and talented programs (finding an appropriate control group is a particular problem), there is evidence that they benefit students. However, gifted and talented programs are not universally available, and are more prone to cancellation in tough economic times because it is assumed that the students will do well enough without special help.

Gifted and talented programs are also controversial because some see them as elitist and contrary to the spirit of public schools, whereas others argue that the methods used to choose students for the programs are biased and based on economic status and/or racial and ethnic background, rather than merit. In addition, students can be coached for entrance testing to gifted and talented programs, and this type of coaching may be available to some students, but not to others. One often-cited example is that of the "examination schools" in New York City, public schools that admit students wholly on the basis of a competitive exam.

Asian students are disproportionately accepted to the top schools (e.g., 14 percent of students in the New York City school system are Asian, but over two-thirds of the students at the most competitive school, Stuyvesant High School, are Asian), whereas African American and Hispanic students are accepted at a rate far below their representation in the student body. Many attribute this discrepancy to the fact that many Asian students attend after-school coaching for the entrance test, paid for by their parents, whereas African American and Hispanic students do not have access to similar coaching.

Vocational Services

Vocational education refers to education aimed at producing skills needed for employment in a wide variety of fields, including agriculture, business, technology, trades, and health care. Vocational education may be seen as an outgrowth of the apprenticeship system used in the United States from the colonial days onward, and which is still in place in some professions. A wide variety of vocational services can be provided to students and community members, both within the framework of educational institutions (including K–12 schools, vocational schools, community colleges, colleges, and universities) and in the community (e.g., public libraries and employment offices). One distinctive aspect of vocational education is that classroom instruction and practice often includes practical skills (e.g., working on automobile engines) as well as less specific, book-based skills (e.g., learning algebra and geometry).

One controversy in vocational education is whether vocational education should be provided in consolidated high schools that also offer academic preparation for students intending to enroll in college, or whether vocational education should be provided in separate vocational schools. A related question is whether students should elect or be sorted into a vocational or academic track before they begin high school, or at some point during high school, or if they should be free to take both academic and vocational courses throughout their high school career. While the separate-track approach used to be common in the United States, and is still in use in some countries (often in conjunction with industry-sponsored apprenticeships), separate vocational education has been seen as a means to prevent some students (often those with lower socioeconomic backgrounds and/or from minority racial or ethnic groups) from entering higher education in the United States.

Although many agree that high school students who do not wish to attend college should still be educated to qualify for a career that will be satisfying to them as well as economically rewarding, the development of high-quality vocational classes and the creation of strong ties with the industries that could employ vocational graduates has lagged behind other developed countries. While a variety of factors have contributed to this situation, the historical perception of vocational education as "less than" academic education, or as a means to segregate students based on economic or demographic characteristics, plays a role in hindering the development of vocational education in the United States.

Guidance Counseling

Guidance counseling as an expected service of schools began developing in the United States in the late 19th century, in conjunction with several reforms including compulsory education, restrictions on child labor, and the development of vocational education. The development of assessment methods to determine aptitude was given a boost during World War I because the military needed to assign large numbers of young men to different jobs and to select those believed to have leadership capability. This led to the rapid development of guidance counseling in American high schools, with over 900 schools offering vocational guidance by 1918. The types of counseling expanded in the next two decades to include social, personal, and educational counseling, although some programs were cut back during the Great Depression.

Guidance counseling received another boost in 1958, with passage of the National Defense Education Act, which provided funding for guidance counseling and improved educational programs in many fields, including math, science, and foreign languages. Guidance counseling developed further as a professional field in the 1970s and 1980s, and currently all the states and Washington, D.C., require guidance counselors to have a graduate-level education, with most requiring at least a master's degree in counseling or a related field;

Deaf interpreters are an example of educational services that may be offered outside the traditional classroom setting and/or for other than average students, including special education, education for gifted students, guidance counseling, and testing. Awareness and understanding of cultural diversity is key to providing optimal services for a wide range of clients.

many also require a number of practicum hours in a school setting.

The types of services provided by guidance counselors vary according to the state, individual school system, and grade level of the school, but some commonalities exist. At the elementary school level, guidance counselors often provide individual and group counseling, do classroom presentations, act as liaisons between the school and the families of individual students, and develop behavior and educational plans for students who display negative behaviors or have special needs. At the middle school and high school level, counselors typically deal with an even wider variety of issues, including vocational and academic preparation as well as personal and social issues of individual students. Among the many issues that guidance counselors must confront at the middle school and high school level are academic failure and dropping out, gang membership, teen pregnancy and fatherhood, abusive homes, substance abuse, and bullying and school violence.

One area in which the workload of guidance counselors has substantially increased is counseling for college preparation and applications: As the process has become more complex and competitive, high school counselors are a key resource for students in terms of choosing what schools to apply to, preparing their applications, and making sure that they take the appropriate tests and meet all deadlines. This role is particularly important for students in large public schools, and for those from minority and low-socioeconomic status families, who are unlikely to have as much knowledge about how the applications process works as students from middle- and upper-income families. Highly qualified students from low-income backgrounds are less likely to apply to highly competitive universities when compared to students from richer families who may have lower qualifications, and high-quality guidance counseling can play a role in reversing this trend.

Testing Services

School systems may also be responsible for administering and interpreting various kinds of tests. This service may be handled by in-school guidance counselors or school psychologists, or it may be handled by specialized assessment psychologists who travel from school to school. Although intelligence testing is controversial because there is no agreed-upon definition of intelligence, and many common intelligence tests are culturally biased, intelligence testing as part of an overall evaluation intended to provide the best educational services to a student may be warranted in some cases. The first general test of intelligence was developed in France by Alfred Binet in the early 20th century, in part to help identify poor children with high intelligence who might otherwise be neglected by the school system. A number of other intelligence tests have since been developed, including the Stanford-Binet and the Wechsler Intelligence Scale for Children (and a corresponding Wechsler Scale for adults); these and many other intelligence tests produce results in terms of an intelligence quotient, or IQ score, which can be used to compare the results for a student with the national average for his or her age group.

Vocational interest and aptitude testing dates back to World War I, when Arthur Otis developed two tests that could be administered to large groups of recruits and used to screen and sort them into jobs: the Army Alpha A, for those who could read and write; and the Army Beta, for illiterates. The continuing influence of the military on vocational testing is seen today in the Armed Forces Vocational Aptitude Battery (ASVAB), a test intended to evaluate future success in a number of occupations, and that is taken by many high schools students, even if they do not intend a military career. Vocational interest tests such as the Myers-Briggs Type Indicator (MBTI) are also sometimes administered as part of high school guidance counseling. The MBTI, which is based in part on the theories of Carl Jung, sorts individuals on four personality dimensions (extraversion or introversion, sensing or intuition, and thinking or feeling, and judging or perceiving) and suggests careers according to how an individual is evaluated on those dimensions. As with intelligence testing, vocational aptitude and interest tests are controversial and should be used as part of a plan to help students explore their interest in and suitability for different careers, rather than the final word on any student's future career choice.

Scores on college admissions tests such as the Scholastic Aptitude Test (SAT) and American College Test (ACT) are required as part of the application process for many colleges and universities, and many high schools offer test preparation services to help their students do their best on these exams. Test preparation may be offered by school personnel or by an outside agency contracted for that purpose, such as the Princeton Review. Although test preparation services are somewhat controversial, and their efficacy has been questioned, many students from middle- and upper-income families pay for private testing services, and thus schools sometimes offer them in order to put their students on an even footing with more privileged students.

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See Also: Adult Education Programs and Services; Cross-Cultural Knowledge; Cultural Competence, Human Service Providers and; Educational Support Services; Multicultural Education; Special Education.

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Educational Status and Service Delivery

The U.S. education system is required to provide a free and appropriate formal education to over 54 million students, with at least 17 million additional students engaged in postsecondary education at colleges and universities. From early childhood through adulthood, students served by the U.S. education system range in ability, race/ethnicity, socioeconomic status, native language, religion, and school location (urban/suburban/rural), among other sociodemographic characteristics. In the context of this increasingly diverse population, meeting the educational needs of students in the United States is an exciting and challenging prospect. In an effort to support all students, and particularly students who have been traditionally underserved by or excluded from the education system, policy makers and educators have implemented a wide range of legislation, initiatives, and services.

Student Diversity in the U.S. Education System

In the United States, children can begin formal education in the public school system as early as 3 years of age, and continue education well into their adult years. A typical sequence of schooling includes early childhood education (e.g., preschool and kindergarten), elementary and secondary education (grades 1–12), postsecondary education (e.g., community college, undergraduate programs, and graduate programs), and adult/continuing education. Vocational/technical training programs span secondary and postsecondary education. In the United States, only elementary and secondary education are required by law. The age limit for compulsory attendance varies by state, and ranges from 16–18 years old.

The U.S. education system serves a diverse population. For example, recent estimates suggest that 40 percent of public elementary and secondary school students are racial/ethnic minorities. Historically, access to education in the United States was often limited and in some cases denied based on membership in a marginalized group. Today, the right to education is granted to everyone; however, large differences still exist in both the quality of education and the educational outcomes experienced by many groups.

For example, the most recent National Assessment of Educational Progress indicated large gaps in achievement by race and socioeconomic status. These differences in achievement are also reflected in the underperformance of many limited English proficiency (LEP) students, who are held to the same standards as native-English-speaking students, even though they often fail to receive the academic and language support necessary to achieve at the same levels.

Individuals with Disabilities Education Improvement Act

The U.S. education system is responsible for serving students with a range of learning needs, including over 6 million children with disabilities. The Individuals with Disabilities Education Act (IDEA) is federal legislation that requires states to provide a free appropriate public education in the least restrictive environment for all children with special educational needs up to the age of 18 or 21. IDEA also requires early intervention services for infants and toddlers (ages 0–2). Determination of eligibility for specialized services involves a variety of evaluation procedures, such as interviews with teachers and parents, classroom observations, and the use of appropriate assessment tools. Additionally, cultural and contextual factors should be taken into consideration during evaluations to avoid mislabeling and/or overrepresentation of specific groups in special education programming. The use of multiple assessment methods is designed to safeguard against this, and other methods such as testing in the child's native language and testing by a bilingual service provider can further prevent misunderstanding children's needs.

Once a child is classified as having a disability, an individualized education program (IEP) is developed and continually reviewed. The IEP specifies an individualized plan to meet the child's specific learning needs. All services identified in the plan must be provided in the least restrictive environment, which often means that children should remain in the general education classroom with their peers as much as possible.

Response to Intervention

Response to Intervention (RtI) is a three-tiered approach that many states have adopted as a key component of identification for special education and related services. Specifically, the first tier of this approach is the promotion of high-quality, evidence-based instruction for all students. Progress monitoring is utilized to identify students who are in need of additional support beyond instruction provided in the general education classroom. These children are moved to the second tier, in which they receive evidence-based intervention and instruction, usually in small groups. Finally, intervention methods for children who are not responsive to universal or targeted small-group interventions receive intensive interventions in the third tier.

In RtI, students must progress through all levels before a referral for a special education evaluation can be made. As a result, RtI reduces the likelihood that children are mislabeled or inappropriately placed in special education services because of inadequate instruction in the general education classroom. Because this issue affects ethnic/minority and socioeconomically disadvantaged students most frequently, RtI is protective against sociodemographic disproportionality in special education. In recent years, a second form of RtI, which mirrors academic RtI, has been developed and implemented to address students' social emotional learning.

No Child Left Behind Act

The No Child Left Behind (NCLB) Act, passed by Congress in 2001, is a sweeping attempt at educational reform that seeks to repair the damages of the past, close the achievement gap, and improve the U.S. education system by providing additional funding and support to schools that are underperforming, many of which serve racial/ethnic minority children and children from low socioeconomic backgrounds. NCLB provides federal funding to states that establish annual assessments to ensure that schools are making adequate yearly progress (AYP) toward state-determined academic benchmarks. The intention behind NCLB is to provide quality education for all children through adequate, evidence-based instruction by high-quality teachers in the classroom, but the law has been surrounded by controversy. For example, NCLB requires detailed reports on school performance that are frequently seen as demeaning; it is viewed as placing sanctions on already struggling schools, making it even more difficult for them to achieve AYP; it de-emphasizes science, art, and electives; it disincentivizes programs focused on gifted, talented, or other high-performing students; and it is thought to drive administrators and teachers to narrowly focus on subjects covered by yearly assessments (e.g., "teaching to the test").

In addition, NCLB's goal to support the English fluency of LEP students has not been supported by the quality of English-language instruction for nonnative English speakers available at schools. In 2010, President Barack Obama responded to calls to reform NCLB by proposing a plan called the Blueprint for Reform of the Elementary and Secondary Education Act. This blueprint included a broader range of standardized assessments that evaluate more advanced academic skills and appropriately assess all children; a focus on rewarding progress, rather than penalizing failures to achieve goals; and an emphasis on a wider range of academic subjects. The reformed law was not authorized by Congress, leading the Obama administration to grant waivers from NCLB requirements to most of the states.

Waivers provide flexibility to states within the law as long as the states have a plan to implement high academic standards, enhance teacher and principal development, and improve accountability through comprehensive assessments that reward those schools making progress toward goals. Because of its discriminatory and exclusionary past, the U.S. education system is now actively taking steps to provide equal educational opportunities and promote equivalent educational outcomes for all American children and youth.

Early Childhood Education

Nearly two-thirds of all 3- to 5-year-old children in the United States are enrolled in early childhood education programs. Common early education settings are nursery school, day care, preschool, prekindergarten, and kindergarten. Children enrolled in early education programs typically range from 3 to 5 years old. Though prekindergarten is less common, most public elementary schools offer kindergarten for 5-year-old children.

Although not required by law, many families choose to enroll their children in early childhood education programs in order to begin developing the skills necessary for school readiness and set the stage for later academic achievement. Typical activities in early childhood education focus on the development of preliteracy and language and prenumeracy skills, along with arts and crafts, music, gross motor activities like running and jumping, and free play.

Federally funded programs, such as the Head Start program, provide children from low-income families the opportunity to begin developing their preacademic skills. In addition, Head Start also provides services to promote social and emotional development and physical health and nutrition, with the goal of promoting positive academic, behavioral, and health outcomes in this traditionally underserved population.

Current estimates suggest that 29 percent of families who participate in the Head Start program are African American, and 37 percent are Hispanic/Latino. Additionally, 12 percent of Head Start students have disabilities. Other federally funded initiatives like Early Reading First focus specifically on the development of language and preliteracy skills in early childhood education settings. Early Reading First was created in response to the growing realization that many children, particularly those from low-income families, were entering formal education settings without the basic school readiness skills prerequisite for short- and long-term academic success.

Elementary and Secondary Education

In the United States, children are required by law to attend elementary and secondary school, at minimum, until age 16, but some states require attendance until 18 years of age. Therefore, 98 percent of children and youth aged 6 to 17 are enrolled in school. The majority of these students attend one of over 96,000 public elementary or secondary schools. Elementary education typically consists of grades 1 to 5, while secondary education includes middle school (grades 6–8) and high school (grades 9–12). Students typically attend schools according to the neighborhood in which they live. In accordance with IDEA, students with disabilities are entitled to an education appropriate to their needs in the least restrictive environment. Accommodations such as untimed tests or the utilization of a teacher's aide within the general education setting are a few ways in which these needs can be met.

Children in elementary school typically spend their day in one classroom with one teacher who covers a variety of subjects such as reading, language arts, spelling, math, history, social studies, and science. Length of time spent on each subject is flexible and based on classroom needs. Children may also participate in gym, art, music, and recess. During elementary school, federally funded programs such as Reading First help support the development of reading, with the goal of teaching all children to read prior to completion of third grade. To encourage the use of evidence-based instructional methods and assessments, financial support is given to states and districts that demonstrate commitment to these efforts. In line with compulsory attendance laws, recent estimates suggest that 98 percent of adults have completed elementary school.

In middle school, children typically switch classrooms throughout the day based on a set schedule. Middle school teachers generally teach a few subjects, in contrast to elementary school teachers who are responsible for teaching the entire core curriculum. In addition to topics covered in elementary school, most middle schools integrate a health class into their curriculum. In high school, students' days are typically broken up into periods. Students have a course schedule, developed with assistance by a guidance counselor and based on the students' interests, abilities, and desired career paths. Core subjects covered are English, science, social studies, and math. Students may also take elective courses such as foreign language studies or culinary arts. Honors or advanced placement classes may be made available for enrollment by high-achieving students or students trying to better prepare themselves for postsecondary education.

Vocational training may also be offered as part of, or in addition to, core coursework and electives, and provides an opportunity for specialized training in a vocational field, sometimes without the need for further education postgraduation. Providing a vocational education in American high schools has a long history, but it has recently come to light that minority students are overrepresented in vocational/career tracks as opposed to college tracks. This concept, called "tracking," has brought additional attention to the disproportionality associated with race/ethnicity and socioeconomic status endemic in U.S. schools.

A total of 85 percent of U.S. adults over the age of 25 have completed high school. The graduation rate for certain groups is notably lower. As reported by the National Center for Education Statistics, 2009–10 high school graduation rates were 66 percent for African Americans and 71 percent for Hispanics/Latinos, as compared to 83 percent for whites.

Postsecondary Education

Postsecondary education includes vocational/technical institutions, junior/community colleges, undergraduate programs, graduate programs, and postdoctoral study. Vocational/technical institutions provide job-skill specific training (beyond vocational training offered in secondary school) in areas such as business, finance, agriculture, and technology. Degree and nondegree programs are available. Junior/community colleges offer two-year associate's degree programs, and are often used to transition from high school to a university setting. They also provide education to a growing number of adult students. Colleges and universities offer the opportunity to pursue a four-year bachelor's degree, which can include advanced study in a wide range of areas including the liberal arts, sciences, architecture, and business.

These institutions also offer advanced degrees, including master's and doctoral degrees, which typically include highly focused study in a particular field, including law and medicine. Though approximately 25 percent of adults over 25 have completed a four-year degree, the graduation rates for ethnic minorities are notably lower, with the National Center of Education Statistics reporting six-year graduation rates for African Americans, Latinos, and whites as 39.9, 51, and 62.1 percent, respectively, in 2011. Targeted recruiting of ethnic minority students, financial assistance/support (e.g., loans, grants, and scholarships), and cooperative student groups (e.g., the Hispanic Student Union, Black Student Union, and the Multicultural Student Coalition) exist with the goal of bolstering the enrollment and retention of underrepresented groups in higher education.

Adult Education (Basic, Secondary, and Continuing)

The opportunity to pursue education in adulthood is not exclusive to postsecondary institutions. In contrast to colleges and universities, adult education often specifically targets groups that had reduced access to or ability to take advantage of the U.S. education system. Additional instruction in basic skills, such as reading and writing, along with the opportunity to receive an equivalent high school diploma are available for individuals who failed to complete high school. In addition, community-based organizations often offer listening,

An adult education computer lab. Adult education often specifically targets groups that had reduced access or ability to take advantage of the U.S. education system. Continuing education opportunities such as the completion of a certificate or taking individual courses for professional development, personal enrichment, or work-related skills are also available.

speaking, reading, and writing instruction to nonnative English speakers who have recently immigrated to the United States. Continuing education opportunities such as the completion of a certificate or taking individual courses for professional development, personal enrichment, or work-related skills are also available. There is a considerable amount of human difference reflected within the U.S. education system, and a variety of initiatives and services are available to meet the needs of the increasingly diverse student population. Careful consideration of the culture, context, and background of all students, especially those who have been traditionally underserved by or excluded from the education system, is critical to ensure equal educational opportunities and outcomes for all.

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See Also: Department of Education, U.S.; Educational Services; Educational Support Services; Individuals with Disabilities Education Act; No Child Left Behind Act; Office of Special Education and Rehabilitative Services; Special Education.

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Educational Support Services

Even though the general education programs of public schools strive to provide the best possible education to children, some students' needs are not met. Schools provide educational support services to assist these students in receiving a free and appropriate public education in the least restrictive environment.

Students qualifying for educational support services may have a variety of needs. Educational support services are provided for the developmentally and physically disabled, the gifted and talented, those for whom English is not their primary language, children from low socioeconomic status (SES) backgrounds, and others. Educational support services are often run separately from the general education program; these offerings are intended to supplement, not supplant, that curriculum. Funding for educational support services often comes from income streams different from that for the general education program. The consistency of that funding greatly influences the success or failure of educational support services offered.

Background

All 50 states and the District of Columbia provide public education for children from kindergarten through grade 12. Additionally, many states also fund preschool programs that permit some children as young as 3 years of age to attend classes. Historically, schools provided instruction that was directed at same-age grades. Children who struggled with material at their grade level were expected to master this curriculum without special assistance, resulting in many children leaving school. Those students who were advanced also were afforded no special treatment, although sometimes they were allowed to skip a grade to put them with children working at the same cognitive level. Children with mental or physical disabilities were often excluded from school altogether and were either kept at home or sent to asylums.

This scenario began to change in 1975, when Congress passed the Education for All Handicapped Children Act (later the Individuals with Disabilities Education Act, or IDEA). This act required all schools accepting federal funds to provide children with cognitive or physical disabilities equal access to education. To this end, school districts were required to assess children who might have a disability. If a child was found to have a cognitive or physical disability, the school was required to form an individualized education plan for that child and to monitor the child's progress over time. This change in law created many new opportunities for children with disabilities. About this time, many states also began gifted education programs, intended to provide cognitively advanced children with additional opportunities in their academic work. During the last 50 years, interest also grew in assisting preschool through college students from low-SES backgrounds, and a variety of programs were developed to do so.

Types of Services

Educational support services are provided to students in a variety of ways. Some services are available to students as separate programs, offered before or after school. Other services are offered distinct from the general education program, either in the years before most children enroll in school, over the summer, or at some other time. Additional services, such as pull-out instruction or resource specialists, supplement the general education program. Which educational support services are available depends upon adequate funding, and decisions must often be made among viable alternatives. To ensure equity, many school districts provide open forums to elicit comments and input from teachers, parents, students, and other concerned individuals regarding which options to offer.

Educational support services are offered to address perceived needs among various groups of students and to address certain mental and physical disabilities that affect individual children. Schools have long noticed that children from low-SES backgrounds perform less well than their more affluent peers. To address this problem, the federal government has established a variety of programs that are separate from, although sometimes affiliated with, the general education programs offered by K–12 schools.

Head Start. The Head Start program is a program developed by the U.S. Department of Health and Human Services (HHS) that attempts to provide educational, health, and nutritional support to low-SES children and their families. Head Start works to establish a learning environment that develops children's cognitive skills, enhances their physical and emotional health, and fosters stable family relationships. To ensure a successful transition from preschool to kindergarten, Head Start assists children in engaging with peers outside of their families, adjusting to the space of the classroom, and meeting school expectations regarding behavior and other interactions.

Originally launched in 1965, Head Start has now served over 30 million children. An Early Head Start program, serving students from birth until age 3 years, was added because development that takes place during these early years is believed to be imperative to children's development. The perceived success of Head Start led to the formation of similar programs to augment the educational experiences of older children.

Upward Bound. Upward Bound works with high school students from rural areas or from low-SES households whose parents did not attend college. Working to enhance these children's chances of going to college or university, Upward Bound programs participate in a competitive grant process for funding that permits students to take college preparatory classes during the summer on a college campus and then to engage in weekly follow-ups and tutoring during the academic year. Usually run by colleges or universities, Upward Bound programs work with K–12 school districts to coordinate efforts with children and their families.

Educational support services. A variety of educational support services are also offered by K–12 school districts to children who exhibit programming needs that are not provided by the general education program. Students who struggle with reading, for example, may be offered a variety of educational support services to improve their performance. School-based, short-term intervention programs are offered to struggling readers in an effort to help them become proficient. Such reading intervention programs are not designed to replace good classroom instruction, but instead are intended to supplement that instruction so that children are able to engage in classroom activities. Specially trained teachers work with the struggling readers, sometimes in the general education classroom and sometimes outside the classroom. Reading intervention programs feature individually designed instruction that addresses an individual learner's needs. Special equipment (e.g., sandpaper letters, magnetic words, and other tools), is used for sorting, to assist visual discrimination, and to engage in word study, a careful analysis of how words work. Successful reading intervention programs assist children in becoming proficient readers and reduce the need for special education services.

Individual educational programs. For children with more serious needs, such as mental or physical disabilities, referrals from their classroom teachers often lead to screening by a student study team (SST). If the SST assesses a child and discovers a learning disability, the child is eligible for an individualized education program (IEP). The IEP states which educational support services that student will receive, ranging, for example, from sessions with a speech pathologist, time with a resource specialist teacher, or placement in a special education classroom. For children with severe needs, an option is full-time placement in a special school, such as a school for the blind or deaf. The efforts of most special education programs are designed to mainstream children whenever possible, so that they spend as much time as practicable in the general education classroom. For older students, the IEP also considers transitions to full-time care and vocational training, if appropriate.

Gifted and talented programs. Advanced students sometimes qualify for gifted and talented programming. These educational support services are intended to enhance highly able students' general education experience, and may involve differentiated instruction from the general education teacher, enrichment programs that take place outside of the classroom, special classes, or special schools. Some gifted and talented students are also permitted to skip grades for a single subject or even for an entire academic year in all subjects.

Although this type of acceleration has been shown to be highly effective, many classroom teachers do not favor it. By the time gifted and talented students reach high school, special programming options are sometimes offered to them. These options may include dual enrollment at a local college or university, where the high school student is able to earn college credit while still enrolled in high school. Advanced placement (AP) and international baccalaureate (IB) programs are also offered by many school districts as a way of offering special programming while keeping the students at their high school campus.

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See Also: After-School Services; Assistive Technology; Department of Education, U.S.; Developmental Disabled Individuals; Early Childhood Literacy; Head Start and Prekindergarten Programs; No Child Left Behind Act; School Health Services

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Elder Care/ Geriatric Services

Elder care services comprise health and human services geared to those in late life. In the United States, individuals aged 65 years and older are generally defined as elderly. These individuals in late life also are referred to as older persons, aged, or elders. A growing percentage of the U.S. population is in this age group. Many services and public programs are specifically available for elders, and a growing number of health and human services professionals are specifically trained to work with this population.

Gerontology and Geriatrics

Gerontologists are trained to work with elders and study aging and late life. Generally, gerontologists are first trained in a primary discipline, such as psychology, sociology, biology, or economics. In addition, graduates of professional programs such as social work, nursing, medicine, occupational therapy, and physical therapy can specialize in gerontology, according to the Gerontological Society of America (www.geron.org). The specialty for a professional who works mainly in medicine or health care is termed geriatrics.

A gerontology or geriatrics specialist encounters three age groups: the young-old (65–74 years of age), the middle-old (75–84 years of age), and the old-old (85 years of age and older). Compared to the younger elderly, a higher percentage of the old-old need and use support services.

Many individuals incorrectly believe that most elders are lonely and sad and that many live in a nursing home. In fact, most elders live independently in the community and have positive interactions with extensive social support. Although most of the old-old have at least one chronic disease or disability, the majority do not experience any major loss of function for most of their late lives.

Demographics

In the United States, the proportion of the population aged 65 years and older is rapidly rising. According to the U.S. Census Bureau, in 2010 about 13 percent of the population were age 65 and older. This percentage is expected to rise to nearly 20 percent in 2030, when most of the youngest of the post–World War II baby boom generation will have turned 65. This rising proportion of older individuals is important because many more will need elder care services and public programs, while there will be fewer younger, working individuals to provide care or pay into the tax system to support programs for the elderly.

Life expectancy is defined as the average number of years an individual will live after birth. In the United States, people live an average of 78 years. This average is influenced by rates of infant mortality as well as late-life diseases. On average, women live longer than men, and white individuals live longer than black individuals in the United States.

During the next several decades, the older population will become more racially and ethnically diverse. In 2010, about 80 percent of those 65 years of age and older were non−Hispanic whites. The percentage of the U.S. population in this group is expected to decrease to about 58 percent by 2050. Between 2010 and 2050, the older black population is estimated to grow from 9 percent to 12 percent, the Hispanic population from 7 percent to 20 percent, and the Asian population from 3 percent to 9 percent.

Currently, race and ethnicity are correlated to educational attainment of those age 65 years and older, with non-Hispanic whites and Asians most likely to have completed high school and college. Living arrangements vary greatly for older individuals, with older black men more likely than other men to live alone, and non-Hispanic white women and black women more likely than older Hispanic or Asian women to live alone. Due to Social Security and Medicare, overall poverty rates among the elderly are lower than in younger populations. However, income disparities from younger ages continue into late life.

Health and Human Services

A variety of community-based services are available to support elders. Some services, such as skilled home health care, homemaking services, chore services, and home-delivered meals, are provided in the home. Other services (e.g., congregate meal sites and senior centers for low-cost meals and socialization opportunities, senior employment programs; adult day services, subsidized housing, and low-cost transportation), are community based. The rights of elders are protected by laws against age discrimination in employment, as well as laws against elder abuse, neglect, and exploitation. Many lawyers who specialize in elder law have expertise in wills, estate planning, and legal protections for elders unable to make their own decisions.

Long-term care involves a disease or disability that requires months of care and services. Long-term care can occur in a person's home, adult foster care, assisted living, or in a skilled nursing facility. Increasingly, individuals spend weeks in a skilled nursing facility for rehabilitation and then return home for continuing care. Patients expected to live less than six months are eligible for hospice care, which focuses on comfort and support for the individual and his or her family rather than on treatment or cure.

Geriatric medical care can be very complicated because older individuals often have multiple chronic conditions and take many medications. The complexity of the person's health condition can make diagnosis and treatment challenging. Some physician offices, medical assessment centers, and hospitals provide specialized services for older patients. Assessment, diagnosis, and treatment are often delivered and determined by a team of medical professionals.

U.S. Policies

In the United States, specific policies, social services, and health care services support elders. Social Security and Medicare are entitlement programs available to all elderly who have been employed in the United States or are married to someone employed in the United States. Social Security provides a monthly income for eligible elders, and Medicare provides health insurance for elders. Since these programs were established in 1935 and 1965 respectively, the percentage of elders in poverty has dropped significantly.

Another important government program affecting the lives of elders is Medicaid. This means-tested program pays for health and long-term care for low-income individuals of any age. Medicaid is a major funder of long-term care services for elders because a person needing skilled nursing services for many months or years will likely spend their assets and then become eligible for Medicaid.

Many community-based services are developed and funded throughout the United States through the Older Americans Act (OAA). The OAA supports area agencies on aging, which are referred to as the aging network, which links individuals with information and referral services.

Elder Care Careers and Training

The Association for Gerontology in Higher Education lists seven categories of roles for gerontological specialists: advocacy, direct service provision, education and training, management and administration, marketing and product development, program planning and evaluation, and research. In addition, many professionals specialize in gerontology, including architects, clinical psychologists, counselors, educators and researchers, lawyers, long-term care administrators, nurses, physicians, recreation therapists, rehabilitation therapists, and social workers.

Training

Some gerontology or geriatrics careers require specialized training or testing. Many universities offer coursework in gerontology, through which students can earn certificates, undergraduate minors, majors, or even graduate degrees in gerontology. Physical therapists take an exam to specialize in geriatric care, and occupational therapists submit a portfolio for peer review. Physicians complete an additional year of training and pass an exam to become a geriatrician. Nurses at all levels of certification can obtain a geriatric specialization through coursework and exams.

Coursework on aging covers biology, psychology, and social aspects of aging. Throughout their training, students learn to consider the needs of families and caregivers in addition to the needs of older individuals. Geriatric specialists learn to diagnosis and treat geriatric syndromes, which often have multiple causes and multiple symptoms. According to the American Geriatrics Society (www.americangeriatrics.org), some of these syndromes are malnutrition, sleep problems, delirium, dementia, dizziness, falls, and pressure ulcers.

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See Also: Adult Day Care; Age and Clients; Aging and Adult Services; Case Management Services; Home and Community Services; Longitudinal Studies of Aging; Medicare, Medicaid, Nursing Home Care, National Institute on Aging, Senior Services; Protective Services for Adults.

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Emergency Fuel Services

The disruption of power impacts humans in enormous ways, particularly during a natural or human-caused disaster which can leave thousands of people without medical services, potable water, sanitation, critical communications systems, and electrical services for up to several weeks. This is certainly the case for emergency medical services (EMS) systems, a central component of a health care system, and even more acutely so for older patients, those in critical care, and populations that tend to be underserved.

Emergency fuel services refers to the logistical process of petroleum fuel delivered to propane- and diesel-powered backup generators in order to restore and maintain functionality of the infrastructure of emergency medical services, hospital services, and related needs during a large commercial power failure. Logistics include the deployment of backup generators during a power outage or natural or human-caused disaster, as well as the necessary activities to prepare for a disaster, such as routine and emergency fueling, maintenance, inspection, and repairs of emergency fuel delivery and operation systems.

Emergency fuel services are particularly critical in health care because emergency medical operations, hospitals, and other health care facilities cannot operate without power. In a natural or human-caused disaster, resources are needed to provide emergency medical care. The absence of electricity can cause life-threatening loss of oxygen; refrigeration for organ transplant procedures; and critical transportation, including ground transportation of emergency vehicles and air transportation, most notably life-flight procedures.

The Critical Need for Fuel in Medical Services

Health care and medical services, particularly emergency medical transport, are fundamentally petroleum dependent. Hospitals and other health care facilities pose the greatest need for unfailing power delivery ensured by well-maintained standby power systems. The Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), and Federal Emergency Management Agency (FEMA) guidelines and mandates specify that backup power is required to guarantee the viability of medical or laboratory equipment for critical applications. Often, however, these guidelines and mandates fall short of specifying the full scope of the backup systems necessary for the applications.

Some studies have analyzed the critical need for fuel in health care, but far more research is needed to assess the use of fuel for EMS, the potential impacts of fuel scarcity on operations, or the strategies to minimize these impacts. One study analyzed the energy needs specifically to describe the location and timing of unmet disaster needs collected in real time through the disaster phases immediately following Hurricanes Katrina and Rita. Researchers analyzed 635,983 recorded telephone calls placed from August to December 2005 to the Texas Health and Human Services Commission's Texas 2–1–1 program, which provides assistance in connecting citizens with critical services. Types of unmet needs were studied for specific time periods and locations. Results of the study revealed that of the total 2-1-1 calls placed, 65 percent arose from needs unmet after the hurricanes. The category of transportation and fuel appears to be the lowest subsection of unmet needs (at 4 percent), but it is important to understand the integral fuel needs for nearly all of the remaining, more substantial unmet needs reported in the study: housing and shelter (28 percent), health and safety (18 percent), and food and water (15 percent).

As with the above Texas 2–1–1 study, it is important to not overlook the myriad health care and emergency needs requiring electricity and, in the event of a power outage, fuel to operate emergency backup generators. For example, a specific case study in health care delivery, reported by a team of heating, ventilation, and air conditioning (HVAC) engineers, focused on vaccine implementation. In this case study, a state agency purchased one large refrigerator for central storage of vaccines and three smaller, more mobile refrigerator units in which to store vaccines at remote vaccination centers for its implementation of the CDC Vaccines for Children (VFC) program. Vaccines must be stored in refrigeration below temperatures mandated by the CDC to maintain their potency and viability. The study therefore analyzed the need to deliver emergency fuel and backup generators in the event of a full power outage and proposed a logistics plan.

Petroleum is used widely in health care—primarily it is a transport fuel, but it is also a feedstock for pharmaceuticals, plastics, and medical supplies; few substitutes for it are available. This dependence theoretically makes health care vulnerable to petroleum supply shifts, but this vulnerability has not been empirically assessed. An analysis to quantify key aspects of petroleum use in health care and explore historical associations between petroleum supply stocks and health care prices confirms that petroleum products are intrinsic to modern health care and that petroleum supply shifts can affect health care prices. In anticipation of future supply contractions lasting longer than previous shifts and potentially disrupting health care delivery, the study proposes an adaptive management approach and outlines its application to the example of emergency medical services and petroleum-intensive activities such as home health services and emergency medical transport of patients. (Staff transport is actually health care's largest category of petroleum use, but there are no published data on health care personnel transport.)

There is no doubt that modern medicine worldwide relies on petroleum, particularly to transport patients, staff, and supplies, and to manufacture supplies and pharmaceuticals. This reliance is particularly heavy in the United States, which consumes petroleum disproportionately on a per capita basis compared with other nations. There is increasing consensus that petroleum production has already declined or will soon begin to decline and that constrained supplies will adversely affect most sectors, including health care.

Several authors have highlighted health care's exposure to declines in petroleum production, but the issue has received little attention from economists or policy makers, and little has been done to further assess and manage the potential risk. Renewable power sources that do not depend on utility power are needed to help raise the level of comfort and keep critical loads and business equipment operating. Renewable resources, such as photovoltaic, biomass, geothermal, small hydro, solar thermal, and wind, have attractive security attributes and reduce the risk of pipeline interruptions and central station outages. They are an environmentally benign and inexhaustible source of energy.

Best Practices in Energy-Efficient Health Care

Dell Children's Medical Center in Austin, Texas, has implemented an integrated hybrid energy plant providing the 35,000-square-foot facility with power, chilled water, and steam. The system is connected to the itKal grid, giving it flexibility during normal operations and the ability to switch to what is known as island-mode operation, functioning completely separately from the power grid, in the event of a power grid outage.

The Dell Children's Medical Center energy system is central to the medical center's award of the Leadership in Energy and Environmental Design (LEED) EAl efficiency credit, the first hospital in the nation to earn this highest award of energy efficiency by the U.S. Green Building Council (USGBC), a nonprofit organization committed to a prosperous and sustainable future for the United States through cost-efficient and energy-saving green buildings.

Public health researchers and practitioners argue that the need for sustainable practices and independence from nonrenewable energy sources will avoid what they deem to be an inevitable crisis of petroleum scarcity. Researchers, practitioners, policy makers, and energy companies must all be actively involved in finding sustainable solutions. They note the need to clearly identify the explicit and often overlooked connections among all aspects of dependence on power as these connections relate to health and medical care, most notably but certainly not limited to emergency medical services.

Researchers have focused specifically on the critical response needs that would emerge in a future influenza or other pandemic in an energy-challenged situation. Connections among global economic conditions, energy availability, and public health are far more extensive than nearly anyone can comprehend, and health researchers and practitioners, particularly those in public health, need to be central in the consideration of energy sustainability.

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See Also: Emergency Medical Care; Natural Disasters, Service for; Pandemics; Policing and Safety; Public Health; Refugee Assistance; Rural Communities; Senior Services; Social and Economic Justice; Transportation Services; Trauma-Focused Services; Urban Communities and Human Services; Victim Services.

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Emergency Medical Care

Emergency medical care within the United States and most Western societies is a medical specialty that provides treatment for individuals who suffer from acute conditions or injuries that need immediate attention. Such conditions threaten patients' lives, eyesight, limbs, or mobility. These ailments can be physical and can include harms related to maternity and psychiatry. Other emergency situations require the alleviation of severe pain that could be symptomatic of a life-threatening condition, such as cardiac arrest.

In most facilities in the United States, the primary purpose of emergency care is to stabilize, manage, or diagnose patients in distress. A patient might receive a diagnosis after being admitted for one or more symptoms, such as chest pains, trauma or injury, obstructed breathing, poisoning, assault, or any other serious event requiring medical attention. Emergency care is often confused with urgent care, which attends to medical conditions that require serious attention, but do not pose a threat to life, limb, or eyesight. Examples of urgent care conditions are a physical symptom that signals an early stage of cancer or a physical injury to the mouth that requires dental care.

Emergency medical care is intended to be short term, and patients may be referred for long-term care or receive treatment that alleviates the medical condition. Following treatment during emergency medical care, patients often need to follow up with their primary care physicians or with a clinic. This is especially true if the acute condition is symptomatic of a chronic or ongoing problem. Despite the importance of seeking emergency medical care to address critical issues, disparities exist among populations who seek and receive care. In particular, racial and income-related disparities may exist due to lack of access to care, or there may be prejudice and discrimination on the part of providers.

Emergency medical care requires extensive knowledge of many skills, such as clearing blocked airways, relocating fractured or dislocated bones, suturing lacerations, stopping bleeding, treating or stopping heart attacks, combating drug and substance overdoses, and delivering babies, among many other procedures often performed in emergency situations. Emergency care providers not only serve patients for acute and urgent conditions; they also function to protect public health and safety as well as to prevent disease and injury. Through the interventions and treatments they provide, emergency medical care professionals often address conditions, disasters, or epidemics that potentially threaten the health and safety of others. Such behaviors and illnesses include substance abuse, human immunodeficiency virus (HIV) infection, undiagnosed mental disorders, and domestic and interpersonal violence, among other medical and safety issues.

Locations of Emergency Medical Care

Emergency medical care can be found in local hospitals, short-term emergency facilities, intensive-care units, and other locations where acute treatment is available. Not all locations are easily accessible by disenfranchised populations, especially by people who live in rural or underserved areas, which often are occupied by ethnic or cultural minorities. In addition to static locations, emergency care is required in the wake of disasters, crises, and terrorist attacks—cases in which medical professionals (e.g., emergency physicians, first responders, emergency medical services staff) would be required to go to the location of the disaster.

Emergency Medical Care Providers

Medical schools across the United States have a total of 76 emergency medicine care departments, and more than 120 emergency medicine residency programs are offered throughout North America. Emergency care fellows and interns can receive training in a subspecialty, such as hyperbaric medicine, palliative medicine, research, toxicology, pediatrics, sports medicine, or critical care, among others. The board that certifies the emergency care specialty is the American Board of Emergency Medicine, which conferred its first certification in 1980.

Physicians and registered nurses typically are traditional emergency medical care providers. In many cases, however, these professionals are not the first people patients see in an emergency. In addition to those who work in hospital emergency departments, first responders might arrive first on the scene, such as the home of a patient suffering a heart attack or the scene of a traffic accident. First responders often work with emergency medical

Emergency medical technicians in New York City transport a woman to the hospital as the woman's mother and son stand nearby hugging. Emergency medical care within the United States and most Western societies is a specialty that provides treatment for individuals who suffer from acute conditions or injuries that need immediate attention.

services (EMS), including ambulance drivers, emergency medical technicians, medical dispatchers, paramedics, ambulance care assistants, and other professionals who provide basic life support at the primary scene of the emergency.

Physicians and other staff who work in emergency medical care are often overworked because their department is likely understaffed. Understaffing and the hectic atmosphere often associated with emergency medical care can leave many providers stressed and anxious. Because of the high volume of patients seeking emergency care, physicians and staff might experience a sense of helplessness when they are too busy or hassled to feel or show compassion and caring for their patients. Furthermore, perceived cultural differences between staff and patients can add to the stress, especially when language barriers make it difficult for patients to understand information and physician recommendations.

To show compliance or deference to their physicians, patients of a different cultural background or language might be passive or remain silent, even if they have questions or might have reservations about following the doctor's advice after leaving the emergency department. Cultural awareness and training of medical personnel in diversity, in addition to hiring diverse emergency care providers, can help close the gap in unequal access to emergency medical care.

As with other health care professionals, emergency care providers would benefit from communication skills to build rapport with their patients as well as assess medical situations. Unfortunately, evaluating the emergency situation often yields a limited view of the problem, and emergency care providers typically are unable to build and maintain patient relationships in order to better understand their patients' conditions in the same way other specialists can. In addition, emergency care providers often don't have access to patients' medical records, which can make evaluation and diagnosis difficult.

Public Use of Emergency Medical Care

For many individuals in the United States, the emergency room is the primary or only means of receiving basic health care, partly due to the lack of insurance or the inability to pay for traditional doctor visits. This situation was especially true prior to the implementation of the Affordable Care Act (known as Obamacare). Emergency care departments are typically understaffed and overcrowded, partly because laws require them to treat anyone who seeks care regardless of their ability to pay. In addition, emergency departments tend to be understaffed because they are often viewed by hospital administrators as a financial burden rather than a major source of income.

Providers who work in emergency medical care often encounter depressed, anxious, or even difficult patients. These difficulties might result from the trauma experienced by the patient, such as a heart attack or an accident, or stem from psychological issues, such as anxiety, post-traumatic stress disorder (PTSD), or other clinical conditions. The PTSD might even stem from an issue that is more physical in nature. For instance, patients seen in the emergency room for gunshot wounds, suicide attempts, sexual assault, cardiac arrest, or any other stressful event might already be exhibiting signs of PTSD, which can range from exhibiting fear or terror to feeling numb. Emergency room providers and staff are typically aware of and prepared for such patients, and physicians can prescribe medications that can sedate and treat patients whose symptoms do not subside.

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See Also: Alcohol and Substance Abuse Services; Community-Based Services; Crisis Services; Dental Services; Domestic Violence; Health Insurance; Hospitals; Information and Referral; Interpersonal Violence; Medical Necessity; Natural Disasters, Service for; Palliative Care; Pandemics; Public Health; Suicide Prevention Services; Uninsured Clients; Women, Battered.

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Emic and Etic

The words *emic* and *etic* describe standpoints or strategies for the study of human behavior. These terms distinguish approaches that seek to understand the meaning of an event within the specific cultural frame of the people observed (emic approaches) from those that assess human behavior within social scientific or professional frames of understanding (etic approaches).

In the context of human services, an emic approach seeks to understand what it is that actors in a social group perceive as problems or possibilities and how they may seek to explain, imagine, and influence the world. An etic approach instead shifts the perspective to that of the observer; the categories of assessment or inquiry that become important from an etic perspective are those that the researcher or professional applies across diverse contexts.

Origin

Linguist Kenneth Pike coined these two terms in 1954. Pike's proposed difference between emic and etic studies came from an analogy with the linguistic terms phonemic and phonetic. Phonemes are the sets of sounds produced in a particular language that are distinguishable by native speakers from other sets of sounds. Phonetics, on the other hand, is the field of study concerned with speech sounds, classified in categories devised by linguists, and presumed by some scholars to be universal. Pike distinguished emic and etic approaches as different standpoints from which an observer can describe human behavior. Emic approaches are attempts to discover and describe the pattern of a particular language or culture from the point of view of its speakers or actors. Etic approaches describe newly found data in reference to existing classificatory systems devised prior to the study. For Pike, emic standpoints are internally focused on the relationship of behaviors and events within a larger pattern, whereas etic studies require that analysts stand outside of the behavior and events they observe in order to compare them to behavior and events in other cultures and groups.

By the 1970s, these terms were in widespread use in anthropology, introduced by the influential anthropologist Marvin Harris, who applied the terms somewhat differently than did Pike. For Harris, emic and etic approaches are different strategies of research, distinguished by the operations of the observers. Emic descriptions are those that elicited accounts of values, intentions, meanings, groups, and practices. Etic accounts, in contrast, are accounts of human behavior described without attempting to infer or elicit choices or dispositions. Harris argued that an etic behavioral record was required to identify unexpected outcomes or aggregate consequences of individual behavior.

Human Services

Since the 1980s, the terms have found widespread use in human services. In this literature, the distinctions between emic and etic are often used in ways that overlap other opposite terms to which they are related but not synonymous with the usages as defined by Pike and Harris. Examples include insider versus outsider perspectives, mentalist versus behaviorist, or subjective knowledge versus scientific knowledge.

Within human services, these terms are particularly prevalent in literature that addresses cross-cultural encounters in professional contexts, such as medicine, psychology, counseling, education, and social work. Some scholars in these arenas encourage human services professionals to strive to understand the knowledge and meaning of problems from the perspective of those whom they seek to help as well as from the professional perspectives of the helper.

For example, it is possible to study child abuse from an etic perspective by assessing the distribution of the problem and its statistical correlates, including the characteristics of people who are involved in it and the interventions that have been applied and evaluated elsewhere to address the problem. Some scholars of cross-cultural practice, however, encourage professionals to also seek an emic perspective, prompting them to seek to understand why those accused of child abuse are behaving as they do, what meaning they assign to the events, and what help they may seek.

To use another example, an etic approach to the effects of welfare reform might measure the results in terms of predetermined criteria such as the size of welfare caseloads, or the level of labor force participation by adult recipients of assistance. An emic approach to this same subject might explore women who are seeking welfare benefits for their families, or strive to understand the meaning of welfare reform to children whose parents strive to meet the demands of revised welfare regulation.

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See Also: Cross-Cultural Knowledge; Ethnocentrism and Ethnorelativism; Help-Seeking Behavior, Cultural Differences in; Values and Ethics, Ethnic Diversity and.

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Eminent Domain

Eminent domain allows governments (federal, state, or local) to take privately owned property for public use. The right to take privately owned property by eminent domain is an exceptional right of the government that must be balanced between the rights of the private property owner and the benefits to the public. In some cases, the property taken is in an area with a diverse population of citizens. Even though the owner of the private property must receive just compensation from the government for the property, these owners may not be able to recreate the unique aspects of their diverse community, including their businesses, community centers, services, and familial relationships. Human services practitioners should be aware that the use of eminent domain might irreparably change the nature of diverse communities. Thus, they should educate citizens regarding both the opportunities and pitfalls of the government's use of eminent domain to take private property. A summary of eminent domain is provided in this article, along with issues that may arise when faced with the prospect of property being taken by eminent domain.

The Fifth Amendment of the U.S. Constitution gives the power to the government to take private property; however, this same amendment also provides the private property owner with rights under the due process clause. Specific guidelines govern taking property under eminent domain: (1) private property must be involved, (2) the private property must be taken, (3) the private property must be taken for a public use, and (4) the owner of the private property must receive just compensation.

Use of Eminent Domain

The government owns lands used for roads, utilities, and other government functions. However, expansion may require that the government acquire adjacent privately owned property. The government can take for public purposes all or a portion of the private property. Historically, the government would take privately owned lands for infrastructure expansion, such as for roads or additional utilities. However, the government has also taken private land for purposes such as to improve blighted areas or for economic development. Blight has not been universally defined, but it typically refers to an area that has properties that appear deteriorated or run down, have unpaid taxes that exceed the value of the properties, or are currently in such condition that they impact the vibrancy and safety of the neighborhood. In many cases, individuals living in blighted areas are people of color or those with a lower income or socioeconomic class. The government, in utilizing its power of eminent domain to take private property in blighted areas, may disproportionately affect these individuals. In these areas, owners of private property or renters living in privately owned property might be displaced simply based on where they live. The compensation provided by the government may be considered just, but it may not fully compensate property owners for reestablishing their lives, schools, communities, and connections to their neighbors.

In addition, although the government can utilize eminent domain to take land for public purposes, communities and private property owners must remain vigilant to ensure that the land is not turned over to private developers to redevelop the land for private purposes. The definition of public purposes has expanded to include economic development to revitalize an area. Economic development can include a number of land uses including commercial, residential, and recreational uses.

Challenges to Eminent Domain

Even though the government can legally use eminent domain for economic development purposes, private property owners recently have challenged this use of eminent domain. In 2005, the U.S. Supreme Court heard the case of *Kelo v. City of New London* (Connecticut), in which private property owners challenged the need of the government to take their property for economic development purposes. In this case, the private property owners owned land where the city of New London planned economic development. The plan for economic development included the construction of a waterfront hotel, retail stores, office space, restaurants, residences, marina, and support services. The proposed new development was expected to add approximately 1,000 new jobs, increase tax revenues, and revitalize the waterfront areas. The land needed by the city was planned to be taken by eminent domain.

Of the 15 private property owners in the area targeted for development, all but nine of them sold their land to the city. The nine property owners who refused to sell did not believe their property was in a blighted area or in poor condition. Essentially, the nine property owners argued that this public domain-taking was not for public purposes. The case was heard by the lower courts and ultimately was heard by the U.S. Supreme Court, which held that economic development would benefit the public by generating tax revenues and was a public purpose. The court determined that eminent domain could be used to take privately owned land in this case. Therefore, the nine private property owners lost their case.

As a result of this Supreme Court case, at least 44 states have implemented laws to limit or suspend the use of eminent domain for economic development purposes. However, at this time economic development is considered a public purpose and thus the government can still take private property for economic development purposes using eminent domain.

Compensation

As stated, the government must pay the private property owner just compensation if the property is taken for public uses. Therefore, the value of the property must be determined. The government utilizes an appraisal process to determine the value of the property. An appraiser determines the current value of the property considering, for example, the value of the land and any improvements on the property, access to roads, how the property is used, zoning of the property, nearby businesses, whether the property is rented and the value of the rents, and any recent sales of similar property. Based on the appraisal and any other factors relevant to the property, the government determines the value of the property and the price it wants to offer the property owner. If the property owner agrees with the appraised value of the property and accepts the offer from the government, then the government buys the property. If the property owner does not agree to the price offered by the government, then the matter proceeds to a condemnation proceeding. Condemnation proceedings vary by state, but generally the process formalizes taking by eminent domain and involves a proceeding and notice to the private property owner that the government is taking the property. The property owner has due process rights and an opportunity also to offer an appraised valuation of the property. The property owner presents this appraised value in an effort to gain agreement with the government on a price for the property.

The private property owner may also assert that the government is taking a larger portion of the property than is required for public use. If the private property owner is successful in making a case against taking the entire property for public use, then the government will pay the owner just compensation for the portion of the property taken. In this case, the land will be divided to include both private and public use. For example, the private owner may sell the government a portion of land to build a road, and the remaining land owned by the private owner may contain the family home located in close proximity to the road. Private property owners should consider the impact of sharing their remaining privately owned property with the nearby public use. Over time, the value of the privately owned property could be impacted either positively or negatively. These concerns should be factored into the value of the property when private property owners consider what price to accept when selling their private property to the government.

Conclusion

Eminent domain provides the government a mechanism to take private property for public use if it justly compensates private property owners. Over time, however, the government has begun declaring areas as blighted in order to take private property for economic development. In response, private citizens are keeping a watchful eye on government officials' use of blight to take private property by eminent domain in an effort to limit taking private property for for-profit ventures.

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See Also: Housing Services; Primacy of Place; Rural Communities.

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Employee Assistance Programs

Employee assistance programs (EAPs) are workplace human services that make up part of the fringe benefits system found in employment. EAPs constitute an important facet of diversity in human services because they are an important point of access to behavioral health services for U.S. workers who would otherwise not have access to prevention and treatment services for mental health and substance abuse issues.

Approximately 65 percent of U.S. employers offer EAP services to their employees and their families. EAPs were designed to identify and address issues related to employees whose personal problems impacted their performance at work. The core functions of EAPs later broadened to helping workplaces improve the health and productivity of the overall organization by providing consultation, training, and evaluation to strategic business groups within organizations as a way to promote the organizations’ investment in human capital, address the costs of doing business, and minimize business risk. At the individual employee level, EAPs address issues encountered by troubled employees through the use of professional human service skills to identify, assess, refer, and/or treat employees and their families. Key health and wellness concerns addressed by EAPs are mental health, substance abuse, and marital, financial, legal, and stress-related issues that affect job performance.

EAP professionals come from a variety of health professions (psychologists, marriage and family therapists, substance abuse specialists, occupational nurses, and occupational social workers) and work in a range of settings (hospitals, mental health clinics, unions, EAP companies, managed care organizations, and employer organizations). EAP counselors typically have a master’s degree in one of the human services fields; some hold a designation as a Certified Employee Assistance Counselor (CEAC).

Employees can access EAP services under a voluntary or mandatory referral process. Voluntary referrals are made through a self-referral process (or at the suggestion of a supervisor, colleague, or friend). Mandatory referrals are usually the outcome of a corrective strategy made by supervisors when an employee is not meeting performance standards. Employees can access services by telephone, in person, or over the Internet, typically depending on the location of the services themselves. Onsite programs provide services to employees at the workplace. Off-site programs provide services to employees in the community. Many employers offer their employees a combination of on-site, off-site, and Web-based services.

The Business Case for EAPs

The business case for EAPs operates from the premise that EAP services can help reduce the cost of employee absences, presenteeism, workplace injuries, and turnover by working within the organization to address the health and wellness of all employees. Presenteeism—the practice of coming to work when ill, injured, or distracted by other concerns—is the leading cause behind the total cost of worker illness and lost productivity at work.

The costs of employee absences are estimated to represent 36 percent of total payroll costs. Employee injury costs are an estimated $250 billion per year. Turnover costs associated with replacing employees can cost organizations as much as $60,000 per employee. EAPs reduce these costs by working with supervisors and other key business partners to address these risk areas through targeted (individual) or broad (organization-level) approaches.

The prevalence of mental health and substance abuse in the United States, coupled with the fact that the majority of people with these issues receive little to no treatment, make the need for EAPs imperative. Prevalence rates from the 2009 National Survey on Drug Use and Health estimate 45.1 million adults had a mental illness during the past year and 8.9 million had a substance use disorder. Among the 11.4 million U.S. adults aged 18 years or older with a serious mental illness in the past year, 11.1 percent were also employed. Mental illness impacts work productivity through increased absences, presenteeism, and turnover. Research has found that employees who suffer from depression, compared to their coworkers without this condition, are twice as likely to miss work for health reasons and seven times more likely to be ineffective at work. The National Institutes of Health reports serious mental illness to cost $193.2 billion per year in lost earnings.

Substance abuse rates similarly impact employer bottom lines through increased absences, presenteeism, accidents, and turnover. Prevalence rates for alcohol consumption among working adults suggest that the majority of working adults consume alcohol regularly. The 2009 National Survey on Drug Use and Health (NSDUH) reported that 64 percent of full-time employed adults reported drinking alcohol. Among the 56.5 million adult binge drinkers, 42.1 million (74.4 percent) were employed either full- or part-time. Of the 15.5 million heavy drinkers, 11.6 million (74.9 percent) were employed. Substance abuse costs workplaces an estimated $120 billion per year due to lost productivity at work.

Stress due to work is also a major concern for employers because it continues to be a leading cause of illness and lost productivity for most employers. A survey on work stress conducted by the Bureau of Labor Statistics found that the median number of work absences was 23 days per year, four times the incidence of nonfatal workplace injuries and illnesses. Stress has also been linked to presenteeism, a leading cause of lost productivity at work. Other issues of concern thought to impact work performance are financial issues, marital distress, and poor financial planning. These issues are often made more complex because they tend to appear in conjunction with both mental health and substance abuse concerns.

History of Employee Assistance Programs

Modern-day EAPs grew from welfare capitalism, which developed in response to increasing worker

Employee assistance programs (EAPs) constitute a critical facet of diversity in human services. Employees can access these services under a voluntary or mandatory referral process. EAPs are an important point of access to behavioral health services for U.S. workers who would otherwise not have access to prevention and treatment services for mental health and substance abuse issues.

dissatisfaction during the late stages of the Industrial Revolution. Welfare capitalism describes services provided by early industries for the benefit of workers. Often, companies would provide their workers with housing, education, medical services, recreation, and social activities. These benefits were a means to counter growing unionism as well as a belief that these services increased productivity and profits by signaling to workers that employers cared about their well-being.

Two features within welfare capitalism led to the later development of EAPs: (1) employers began to address employee problem drinking, and (2) the growth of the use of social secretaries to address other personnel issues. Problem drinking had long been recognized as an issue that costs organizations money through increased employee absenteeism, illness, accidents, and turnover. The development of effective treatment approaches to alcoholism resulted in the growth of early occupational alcoholism programs that were then placed within employer organizations. Social secretaries emerged later, during the 1920s; their function was to improve communication between the employers and their workers and help manage personal problems impacting work performance.

EAPs began as internal programs within large organizations and were part of human resource departments. Once managed behavioral health organizations (MBHOs) began to take over behavioral health services during the 1990s, EAPs became associated with benefit services. The entry of MBHOs into the EAP market changed the structure, function, and scope of services. Organizations began to contract out EAP services to third-party providers as a way to manage behavioral health care costs. This model of service became known as an external model. Modern EAPs are managed as internal and/or external units. Their form and function is often contingent on the resources and requirements of the organization. The commodification and quality of services provided by these external providers has been criticized for being uneven, fragmented, uncoordinated, and duplicative in terms of both costs and benefits. The Mental Health Parity Act of 2009 was meant to counter the use of caps and limits imposed on behavioral health services by MBHOs.

EAPs have recently begun to expand their service and focus to realign with the diverse needs of organizations. This reorganization has involved expansion of services into consulting and legal/financial management; new populations such as disaster victims and refugees; integration with work/life services; and focusing more programming on prevention, early intervention, and health and wellness services. This shift is partly due to an increased emphasis within organizations on workplace diversity, work/family issues, and health promotion as cost-saving strategies that can enhance the health of organizations.

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See Also: Health Care Delivery, Models of Care; Mental Health Services, Adult; Workplace Health Services.

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Employment/Career Assistance Services

The field of employment and career assistance services encompasses a broad range of activities, including vocational guidance within educational and social service institutions; governmental job training and job placement programs; and special services for population segments, such as veterans, the disabled, ex-prisoners, and individuals reentering the labor market after a long hiatus (e.g., former stay-at-home mothers seeking work after their children are grown). Because the world of work is constantly changing, those providing employment and career assistance services must be aware not only of the current and projected demand for particular skills and occupations, but also of the changing social context of work and patterns of employment.

Although they are often equated, it is useful to think of the terms *job*, *career*, and *vocation* as referring to separate entities. The most specific term is job, which refers to a particular instance of employment. Career refers to a more general pattern of employment—for instance, one could have a career in engineering that would include many separate jobs within the general field of engineering. Finally, vocation refers to a strong feeling, based on intuition or emotion as well as reason, that a person may have that they were meant to work in a particular field or at a particular job. Historically, the term *vocation* was used for the calling some people felt to enter the priesthood, or to become a monk or a nun, but the term is also used today to refer to secular occupations, so someone may feel they have a vocation to teach or to become a writer or a physician. Ironically, vocational education often means something quite different—to prepare an individual for a particular job, sometimes at the expense of their general or academic education—but it is rare that the two disparate meanings of vocation are confused.

These distinctions are important because the individual seeking employment and career assistance may have different priorities and motivations than the person providing the assistance or the governmental or other organization funding the assistance. For instance, employment services provided by the state to unemployed individuals may be focused primarily on placing them in any job that seems a reasonable fit, whereas the individuals may feel more strongly about what type of work they want to do. Similarly, a vocational guidance counselor in an educational institution may be most concerned with providing practical advice to students based on the expected demand for particular skills or occupations, whereas the students may feel they have a vocation to enter a field where steady employment is rare.

The number of people who persist in artistic careers (e.g., acting or writing), despite the well-known facts about how difficult it is to make a living in those fields, provides strong evidence that there is more to career choice than calculating the expected monetary rewards. Conversely, some people have criticized guidance counselors for urging students to "do what you love" and incurring large amounts of student debt with few prospects of earning enough to pay back the loans. It has been proposed that students at state universities in Florida who choose to study less practical or vocationally oriented subjects (such as the arts) should pay higher tuition than those in fields such as engineering or the hard sciences.

Attitudes toward employment and career assistance have also changed over the years. Today, it is rare for individuals to hold a single job over their lifetimes, and thus, for most people, greater emphasis should be placed on acquiring general skills and a flexible attitude toward employment rather than preparing for a single, highly specialized job. According to the U.S. Bureau of Labor Statistics, people born between 1957 and 1964 held an average of 11.7 jobs between the ages of 18 and 46 years, with only 10 percent holding four or fewer jobs.

Attitudes have also changed concerning who is suitable for what type of career—for instance, women composed 4 percent of physicians in the United States in 1905, 7.6 percent in 1970, and 25 percent in 2004; in 2003, for the first time, half of new medical school students were female.

Various types of tests are available to assist in the employment and career assistance process, although the results of any test should be considered in the context of other information, including an individual's interests, experience, and academic background. Some tests are based on determining an individual's personality type and then matching that type with jobs. The Myers-Briggs Type Indicator (MBTI), based on the theory of Carl Jung, assigned individuals into psychological types based on four dimensions: extraversion or introversion, sensing or intuition, thinking or feeing, and judging or perceiving. The belief is that an individual's psychological type, determined by the MBTI, can then be used to suggest occupations that might suit him or her.

The Keirsey Temperament Sorter assigns individuals to one of four types: artisans, guardians, idealists, or rationals. Each of the four types has two roles, and each role has two variants. For instance, guardians are divided into administrators (further divided into inspectors and supervisors) or conservators (further divided into protectors and providers). As with the MBTI, certain jobs and careers are believed to be associated with certain temperaments.

In contrast, some tests used in employment and career assistance aim to evaluate concrete aptitudes and achievements. One of the best known tests of this type is the Armed Services Vocational Aptitude Battery (ASVAB), introduced in 1968, which is used both by the armed services and in many U.S. schools. In its current form, the ASVAB consists of 225 questions in nine subfields: general science, arithmetic reasoning, word knowledge, paragraph comprehension, mathematics knowledge, electronics information, auto and shop information, mechanical comprehension, and assembling objects. ASVAB scores are reported in percentiles, ranging from 1 to 99, and specific aptitude areas are associated with specific occupations. For instance, scores on the verbal, arithmetic reasoning, and mathematics knowledge would be considered particularly relevant for someone interested in entering a clerical profession.

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See Also: Cultural Competence, Human Service Providers and; Cultural Literacy; Disability Services; Discrimination and Institutional Racism; Diversity in the Workplace; Hispanic Immigrants; Military Veterans; Prisoner Reentry Programs; Veterans Services.

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Empowerment Research

Empowerment research is an essential component in the emerging role of science in informing the delivery of culturally and socially competent human services. Empowerment research differs from traditional approaches to research in the health and social sciences in that it aims to invert the typical top-down research process in which research participants' own knowledge and expertise are subjugated and viewed as less valuable than the knowledge and expertise of the scientist.

The empowerment stance in social science research has been informed by a number of ongoing trends, including multicultural psychology, social justice research, participatory research, and positive psychology. The impact of researchers adopting an empowerment approach in social science research has been considerable, particularly with regard to the reporting of research findings that represent the lived experience of members of marginalized groups.

The Need for Empowerment Research

Traditional research in the health and social sciences has been criticized for employing research methods that disempower research participants. Critics of the traditional research approach challenge the pervasive assumption that it is possible to create a bias-free science in which objective observation derives neutral information on which all rational individuals can agree. The claim of neutrality has been criticized for denying power differentials between researchers and participants, hence not fully acknowledging the risk of exploitative and damaging research practices to vulnerable populations, however unintentionally. This is true especially as it pertains to marginalized and oppressed groups that have little access to resources and power, such as women, indigenous people, people of color, refugees, and those living in poverty. Furthermore, social sciences have been criticized as being dominated by Western psychological perspectives and theories. Much research has been said to resemble a colonialist approach in which researchers enter communities uninvited and exploit existing resources and structures in order to gather data that are of no benefit to the communities under study. Empowerment research addresses this issue by assuring that researchers must follow the needs and wishes of the communities with which they work, thereby shaping methods, data, and theory that are decidedly community-driven.

Empowerment Research in Action

Empowerment research invites researchers to ally themselves with members of marginalized communities to collaboratively identify critical issues, design studies to illuminate these issues, and ultimately create action for social change. Much of this work has taken the form of participatory action research (PAR), an approach characterized by anti-oppressive, power-sharing projects. In PAR, university (or other professional) researchers do not conduct studies on community members, they conduct studies with community members on issues of local relevance and interest. Joining together in PAR teams, professional and community researchers have tackled many different kinds of local concerns around the world, including issues related to wellness, education, and environmental conditions, and have contributed new knowledge, services, and policy initiatives in the process.

An example of empowerment research includes a 2007 project by Lisa Goodman and colleagues. Their ROAD (Reaching Out About Depression) project was organized by a network of counseling and law school faculty and students in collaboration with a group of low-income women in Boston. ROAD's goal was the discovery of alternative solutions for depression for women in the community, and the project group met with community members in their homes to conduct collaborative meetings and workshops and to support community members in carrying out project functions of direct benefit to them.

A second example involves the development of Anti-Oppression Advocacy (AOA), as reported by Alisha Ali and Kristin Lees in 2013. AOA was developed to address economic justice and promote emotional well-being. The authors described an example of AOA that used photovoice, an image-based technique for storytelling and meaning-making that was created by Caroline Wang and her colleagues for use by PAR teams. The community members who participated in the AOA project used their photographic images documenting unsafe building conditions to partner with local homelessness groups to advocate for safer low-income housing. As evidenced in these examples, empowerment research fulfills the researcher's goals of unearthing new research findings as well as community goals for positive change and social action.

Future Directions

Empowerment research is a relatively new approach to conducting investigations in the social and human service sciences. As such, the types of projects described here are often considered to be outside of the mainstream of scientific research. However, with growing recognition of the need for more socially relevant science, acceptance of empowerment research is expanding. Challenges still remain for researchers who adopt an empowerment approach, including the need for researchers who are not trained in an entirely Western model of science.

Global research outside of North America and Europe is thus essential to the growth of empowerment research. Similarly, conventional methods for the dissemination of research findings need to be expanded to include dissemination and engagement with the broader communities in which researchers conduct their work.

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See Also: Culturally Diverse Practice, Definitions of; Culturally Diverse Practice, Theories of; Service Providers and Diversity.

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Enterprise Community Partners

Enterprise Community Partners (hereinafter referred to as Enterprise) is based in Columbia, Maryland, and is a national nonprofit dedicated to creating housing opportunities for low- and moderate-income people in the United States. In 1982, legendary developer Jim Rouse and his wife Patty Rouse founded Enterprise (originally the Enterprise Foundation), with the ambitious goal that every person should live in a decent and affordable home and be able to move out of poverty. Today, 30 years later, Enterprise provides both funding and technical expertise to achieve this goal. Enterprise comprises a network of related entities to address the issues of housing access as well as community-based solutions. Enterprise is guided by the belief that for housing to be a platform for success, it must exist in an environment with jobs, quality schools, child care, transportation, health care, and support for seniors, with access to parks, community spaces, and food and retail services that support a healthy lifestyle.

The History of Enterprise

In 1972, members of a Washington, D.C., church were working to create low-income housing in the Adams Morgan neighborhood of Washington. These women had no development, financial, or construction experience whatsoever; despite that, and based on their commitment, they made a nonrefundable deposit to purchase two apartment buildings. This commitment impressed James Rouse (1914–96), then chief executive officer of the Rouse Company, a successful and well-known developer in the Washington area. Rouse had focused in the 1960s on the development of Columbia, the planned community in Maryland, and in the 1970s on the development of festival marketplaces, such as Faneuil Hall in Boston and Harborplace in Baltimore. Rouse helped the women secure $625,000 to complete the purchase of the two buildings and $125,000 toward the cost of rehabilitation. Jubilee Housing was born in 1973, with Rouse as a founding member. Jubilee served as the launchpad for The Enterprise Foundation, which Jim and Patty Rouse founded in 1982. In 2005, it was renamed Enterprise Community Partners.

Since its inception, Enterprise has raised and invested nearly $14 billion in equity, grants, and loans to help build or preserve 300,000 affordable rental and for-sale homes as well as to create more than a half million jobs nationwide. Its award-winning Enterprise Green Communities initiative offers the first national framework for green affordable housing, and more than half of the homes it finances meet the Enterprise Green Communities criteria.

The Structure of the Enterprise Companies

Enterprise is headquartered in Columbia, Maryland, and has offices across the United States. In 2013 it had projects in 14 states (California, Colorado, Georgia, Illinois, Louisiana, Maryland, Massachusetts, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, and Washington), and the District of Columbia.

Through a network of companies, Enterprise, the parent company, offers a range of financial products and programs to improve and increase the supply of affordable housing as well as to revitalize communities. Enterprise provides technical expertise to local development partners, leads policy advocacy work and initiatives, operates national programs such as Enterprise Green Communities, and makes grants to partners to help them strengthen operations or plan projects. These grants come from funds raised from individual donors, corporations, foundations, and the government.

Enterprise Community Investment helps bring necessary capital into Enterprise projects. This includes the Low Income Housing Tax Credit (LIHTC), an indirect federal subsidy used to finance the development of affordable rental housing for low-income households; and the New Markets Tax Credit, which allows a tax credit for those making equity investments in specialized financial institutions serving low-income communities. Enterprise Community Investment also provides multifamily and commercial real estate lending through Bellwether Enterprise Real Estate Capital, a national commercial real estate and multifamily mortgage banking company. In addition, Enterprise Community Loan Fund brings early-stage debt capital to support community development lending, and Enterprise Community Asset Management oversees a portfolio of homes from project construction, to leasing, to completion.

Enterprise's Current Challenges

Current economic, energy, and environmental challenges demand greater investment in affordable housing and healthy communities. Enterprise has introduced solutions through public−private partnerships with financial institutions, governments, community organizations, and other partners to address these issues. According to Enterprise officials, politics and economic pressures at the federal, state, and local levels mean that needed federal dollars will continue to wane, and Enterprise must diversify its funding by expanding access to capital that is targeted not just for low-income projects, and by encouraging systems that make the most of every public subsidy and philanthropic dollar.

Recognizing this need, Enterprise conducted a thorough search of market opportunities across the country to enable it to expand geographic reach, product offerings, and ability to serve multifamily and commercial real estate borrowers. In addition, the merger of Enterprise's Multifamily Mortgage Finance business with Bellwether Real Estate Capital in 2012 moved Enterprise beyond affordable multifamily and community building finance into the commercial real estate sector. This merger strengthened Enterprise's ability to expand financing for its projects. In 2011, before the merger with Bellwether, Enterprise's multifamily mortgage finance business closed $157 million in loans. After the merger, Bellwether Enterprise provided $1.2 billion in financing.

Enterprise's Advocacy Efforts

Enterprise plays a key role in several important advocacy campaigns. First, it is involved in efforts to increase affordable rental housing through a coalition named "A Call to Invest in Our Neighborhoods," which is focused on protecting and preserving the federal Low Income Housing Tax Credit. Second, Enterprise works with the Green Affordable Housing Coalition to advocate for green affordable housing at the federal, state, and local levels. Third, Enterprise works to mitigate the impact of foreclosures on low- and moderate-income communities through the National Foreclosure Prevention and Neighborhood Stabilization Task Force, with an eye to develop appropriate policy, legislative, and programmatic initiatives in this area.

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See Also: Community Development Block Grants; Housing Services; Low-Income Housing Tax Credits

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Enterprise Zone

Enterprise zones (EZs) relate to a special policy meant to attract investment and to encourage economic growth in distressed areas. Grounded in a free-market economic principle, this policy consists of mainly fiscal incentives for companies operating within a designated area. EZs are located in declining urban and rural regions with high unemployment, poverty, vacant land, and deteriorated infrastructure. In the United Kingdom (UK), EZs are linked with the regeneration of former industrial sites, whereas in the United States, enterprise zones are often linked to inner-city economic downturns. EZs marked the shift from the Keynesian economic model, which favors an active government and controlled growth, to the need for economic revitalization by any means. The concept has seen resurgance during the recent economic crisis, despite evaluative research questioning the effectiveness of enterprise zones.

The concept of enterprise zones is attributed to British urban planning professor Peter Hall, who, inspired by Asian freeports, saw in EZs an "extremely last-ditch solution" to be tried "only on a very small scale" following the collapse of the UK manufacturing industry. Margaret Thatcher's administration initiated many EZs as a quick fix for abandoned industrial areas. In the United States, Stuart Butler, the director of a conservative think tank, is credited for the concept. During the Ronald Reagan and George H. W. Bush administrations, more than 40 states developed EZs according to their own legislation. However, not until 1993 was the first federal program legislation enacted. Initially, the liberal and Democrat members of Congress were skeptical about the feasibility of private-sector growth tackling poverty and complex social issues. There was also a concern that the policy would provide rationale for eliminating other urban aid programs. Evaluations, such as a 2005 review of EZs by the Minnesota House of Representatives, validated this concern.

The rationale behind the EZ program is that a free market is a solution for overcoming concentrated poverty or for reviving the local economy in abandoned industrial areas. The underlying assumption is that high costs are the main barrier to economic activity in disadvantaged areas. Declining areas pose transportation problems; have poor capital, low-skilled workers, and high criminality; and raise safety concerns and costly environmental problems. Research such as that by Wilton Hyman shows that small enterprises provide the highest economic advantage because, unlike larger companies, they are more likely to (1) find existing infrastructure sufficient, (2) create the largest number of new jobs, (3) hire local unskilled labor, and (4) risk operating in marginal neighborhoods.

Across the United States, the enterprise zone program provides a large variety of incentives and eligibility criteria. Generally, companies benefit from cost-saving mechanisms (e.g., hiring-tax credits, loans at below-market interest rates, and reduced sales taxes) and, in some cases, less government regulation. Companies (and individuals) are eligible if they have an office location or manufacturing facility within the boundaries of an EZ, and if they hire employees from an EZ or have equipment operating there. In California, for instance, the hiring-tax credit can amount to 50 percent of the entire salary of an employee.

Controversies and Critiques

Despite being studied extensively, there is no clear evidence that EZs are effective in the sense of (1) bringing new (and not relocated) business to the region, (2) producing sustained growth rather than short-term booms, (3) subsidizing companies that would otherwise fail, and (4) causing job or income growth that otherwise would not have occurred. Evaluations, however, led to mixed and inconclusive results because of the paucity of data, methodological limitations in inferring causality, different economic conditions among cities, the absence of control groups, and ultimately difficulties in balancing the costs of the subsidies with the social benefits. Evaluations also need to account for the various subterfuges for meeting eligibility criteria among beneficiaries (e.g., reverse commuting for employees, rapid turnover of firms, and opportunistic relocation from neighboring areas).

Mounting data demonstrate that EZs generate low-wage jobs, rapid turnover of firms, and little investment in the disadvantaged areas. Whether the EZs make the transition to unsubsidized and sustainable economic areas or they remain dependent on external state support is still uncertain. Data from the United Kingdom indicate that up to 80 percent of the jobs created are taken from other places, and EZs generate a short-term boom followed by a long-term falling off into depression. In the United States, the conclusion of an evaluation of 75 EZs located in 13 states was that most EZs failed to meet the expectations of sustainable economic growth and community revival. The 2005 Minnesota House of Representatives study indicated that "some zones in occasional situations may be at least temporarily successful."

The program is being criticized for favoring corporate interest at the expense of small entrepreneurs, who end up competing with highly subsidized companies that relocate in their area. The level of disadvantage in several EZs has been questioned. For example, EZs include such affluent zones as the Los Angeles downtown office area and San Francisco's financial district and Fisherman's Wharf. Other concerns refer to the program being applied uniformly across many regions with different economic and social profiles.

EZs are expensive programs, with as much as £23,000 (US$37,800) per new job they created in the United Kingdom during the 1980s. The Minnesota review uncovered situations in which provisions have led to cuts in public spending inside the EZ or increasing taxes outside the zones. Concerns over unbalanced industrial development, the so-called suburbanization of investment at the expense of inner-city minorities, and prioritization of capital over labor add up, according to an assessment of the program by Alan H. Peters and Peter S. Fisher. Allegations in the United Kingdom state that selection of EZs is linked to political party consideration. Following calls for transparency, the U.S. Senate is considering requiring the creation of a public database of companies that receive the fiscal incentives and the number of jobs they created.

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See Also: Community Development Block Grants; Poverty; Urban Communities and Human Services.

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Environmental Justice

One of the gifts of globalization to humankind is environmental awareness. In fact, globalization has affected ecology in both positive and negative ways. On the one hand, globalization promotes neoliberalism, which offers freedom of markets and trade without intervention of states. On the other hand, it raises awareness of environmental problems, such as climate change, environmental degradation, pollution, and waste disposal. To deal with these problems, the concept of environmental justice emerged in the early 1980s. In today's world, environmental justice has been understood with broader scope and is more globalized, thereby focusing on fair distribution of justice and raising concerns on social issues.

In the last two decades, scientific research has clearly indicated that disparities in the location of environmental hazards related to race and class have gradually increased. Thus, environmental justice emerged mainly as a result of the disparity in locating polluting industries and facilities such as landfills and power plants. In the United States, these environmental pollutants are often located near low-income communities as well as African American, Hispanic, and indigenous communities. The main idea is that certain communities, particularly low-income societies, are disproportionately burdened by pollution and are having insufficient access to environmental resources. Increasing public concerns about the negative impact that human activity could cause to the environment has led the U.S. government to take action against this issue by ratifying the National Environmental Policy Act, which later ensured the creation of the Environmental Protection Agency (EPA) in 1970.

The term *environmental justice* is defined by the EPA as being about the protection of human health and the environment, highlighting fair treatment to all people and their involvement regardless of race, color, ethnicity, or income, thus prioritizing the development, implementation, and enforcement of environmental laws, regulations, and policies. In this sense, fair treatment means that any group of people, including racial, ethnic, or socioeconomic entities, should not be exposed to disproportionately negative environmental consequences resulting from industrial, municipal, and commercial operations or the execution of federal, state, local, and tribal programs and policies. Much empirical evidence has also corroborated the existence of environmental injustice, particularly in low-income and minority communities.

Regarding the definition of environmental justice, David Schlosberg has suggested that the term has two different aspects. Whereas the first aspect refers to a social movement focusing on fair distribution of environmental burdens (e.g., pollution,

A photo of New Orleans after Hurricane Katrina in 2005. The flood event affected the city's poor, black neighborhoods disproportionately in comparison to the city's wealthier, white neighborhoods. Considering disproportionate environmental burdens, it is clear that low-income and minority communities are vulnerable in many ways regarding the equal distribution of justice.

industrial facilities, and crime), the second aspect refers to theories of environment, theories of justice, environmental law and governance, environmental policy, political ecology, development, and sustainability. In addition to cited definitions of environmental justice, the South African Environmental Justice Networking Forum, a nationwide umbrella organization coordinating the activities of environmental activists and organizations that are interested in social and environmental justice, defined the term *environmental justice* as a social transformation directed toward meeting basic human needs and improving the quality of life, health care, housing, human rights, environmental protection, and democracy.

Forms of Environmental Justice

Many countries agree that environmental justice provides a better life and more inhabitable world for future generations, but safeguarding of environmental justice is still a controversial issue. In this respect, in order to achieve environmental justice across the world, distributive, procedural, and structural forms of injustice should be considered together.

Distributive forms of environmental injustice. Considering disproportionate environmental burdens, it is clear that low-income and minority communities are vulnerable in many ways regarding the problems of the distribution of justice. According to fair share principles, everyone gets an equal share of environmental benefits (goods) and burdens (bads) regardless of race and class. To achieve this, states, policy makers, and international communities have tried to focus on sanctions for the overall reduction or prevention of harm rather than applying a simple redistribution of environmental burdens. Therefore, the distribution of equity requires institutional structures that aim to raise awareness of issues of justice. In this respect, participatory practices are claimed to be most likely distributive ones. Thus, the distribution of inequities in environmental justice communities is interdependently related to procedural and structural injustices.

Procedural forms of environmental injustice. Environmental justice can also be defined as fairness in decision-making processes, and it asks for righteous participation in any level of decision-making processes, including the levels of need assessment, planning, implementation, enforcement, and evaluation. As observed in democratic societies, more participation enhances fairness over decision-making processes. In this sense, public participation plays a key role in issues of environmental justice. Currently, though, environmental justice policies aim to improve public participation, particularly in disadvantaged communities; implementation of this policy, however, raises concerns over how and to what extent public participation will be carried out. This is still a contentious issue among state officials. In this regard, John Forester provides participatory practices for environmental justice program coordinators to deal with structural and procedural forms of injustice:

- Cultivate community networks of liaisons and contacts, rather than depending on the power of documents to provide and disseminate information.
- Listen carefully to gauge the concerns and interests of all participants in the planning process in order to anticipate probable political obstacles, struggles, and opportunities.
- Notify less organized interests early in the policy-making process.
- Educate citizens and community organizations about the policy-making process.
- Supply technical and political information to citizens to ensure informed and effective political participation.
- Make sure that community as well as neighborhood nonprofessional organizations have access to public planning/policy-making information, plans, notices, laws, relevant meetings, and consultations with agency contacts.
- Encourage community-based groups to express open and full information about proposed projects and policy-making possibilities.
- Develop skills aimed at working with groups and to dealing with problematic situations.

Structural forms of environmental injustice. When environmental injustices are structurally examined, the focus mainly concentrates on environmental racism. In this context, David Pellow has attempted to explain the complexity of the structural forms of environmental injustice by creating the environmental inequality formation that integrates the notions of environmental racism and structural forms of environmental inequality. Pellow suggests that the term *environmental racism* focuses on disparities of environmental hazards, and environmental justice is centered on making people's ordinary lives better and improved.

The Environmental Justice Movement

The environmental justice movement is a relatively new social phenomenon that emerged as a result of protests by African Americans in the south against hazardous waste facilities in predominantly low-income communities. These environmental justice cases increased awareness and interest in low-income and minority communities dealing with disproportionate environmental burdens by arguing that everybody has a right to access clean water and clean air, and that nobody has the right to destroy the environment. Environmental justice, as a powerful sense of justice directed against inequities and social conflicts over polluting factories, toxic waste facilities, and road construction, has contributed to the emergence of the environmental justice movement. For example, the process of institutional improvement united large groups such as Friends of the Earth and Greenpeace, and contributed to the resurgence of grassroots environmental groups during the 1990s (e.g., the United Kingdom's antiroads protesters and the U.S. environmental justice movement).

The environmental justice movement emerged in the United States during the 1980s with the mushrooming of networks of grassroots groups such as the Clearing House for Hazardous Waste. The main idea of the environmental justice movement is the recognition that environmental hazards are closely interlinked with race and poverty, which can be seen in the large numbers of African Americans and Hispanics who live close to hazardous and toxic waste sites. The other principle of the environmental justice movement is that environmental justice requires a public policy that should be based on mutual respect and justice for all people. To reach a degree of intragenerational equity as a condition for intergenerational equity, no group should be asked to bear a disproportionate share of environmental burdens, which is a referred principle within the context of environmental justice.

Having considered the history of environmental justice, it is obvious that there are many lessons to be learned. For example, the protection and preservation of the natural environment should be noted as an important and crucial issue before involving in a debate about ensuring justice in environmental issues. Thus, environmental justice requires universal protection from nuclear testing, as well as extraction, production, and disposal of toxic/hazardous wastes and poisons that threaten the fundamental right to access clean air, land, water, and food. In this respect, the establishment of environmental justice and its sustainability will contribute to the achievement of peace and prosperity worldwide.

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See Also: Discrimination and Institutional Racism; Environmental Racism; Public Health; Racism, Long-Term Effects of.

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Environmental Racism

Environmental racism is a combination of environmental practices and policies aimed at directing unpopular industrial businesses to locate disproportionately in communities of color. The problem of environmental racism gained traction in U.S. politics in the early 1980s, when local officials in Warren County, North Carolina, a predominately poor, black area, decided to locate a polychlorinated biphenyl (PCB) landfill there.

This resulted in mass protests and led to an investigation by the U.S. General Accounting Office (GAO) to determine whether the phenomenon of "siting," or placement of hazardous industrial sites, were indiscriminately located in areas with high concentrations of minority and poor residents. The concept of "environmental racism" is often coupled with the term *environmental justice*, a movement aimed at fairly distributing the burdens of environmental hazards across individuals and groups. Issues of NIMBY (not in my backyard), uneven political power, and lack of access to decision makers, as well as economic development policies of local and state governments, also complicate the issue of environmental racism.

Americans have traditionally viewed environmental degradation as something that affects individuals equally, regardless of location. Following the protests in Warren County, however, the GAO report, which looked at hazardous waste landfill locations across the south at that time, found that three out of four were located in communities that had high concentrations of African Americans. Later research also found that these decisions are not driven primarily by racial factors alone, but have both race- and class-biased components to placement choices along with other factors such as the percentage of the population employed in manufacturing.

Environmental Racism and Public Policy

A description of the general dangers of hazardous waste is warranted before considering the issue of environmental racism. The U.S. Environmental Protection Agency (EPA) describes hazardous waste as any by-products of industrial production that present significant health and/or environmental problems. These types of by-products can be corrosive, toxic, reactive, or ignitable. Until the late 1970s, many hazardous waste products were discarded without much consideration for the potential dangers they posed. Over time, lax regulation of industrial waste produced large waste sites, and environmental damage was approaching a tipping point.

When the EPA began an inventory of these hazardous sites across the country in the mid 1980s, they found nearly 20,000 uncontrolled sites that had the potential to cause severe harm to the environment through seepage into groundwater stores, affecting both livestock and citizens. In response, Congress passed the Resource, Conservation and Recovery Act (RCRA), and the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), in 1976 and 1980, respectively, to curb abuses of industrial producers. These acts stipulated that new waste must be managed at approved facilities (i.e., landfills, incinerators, or impoundment facilities). The main differences between the two laws are that RCRA is focused on the management of storage, treatment, and disposal of hazardous waste in facilities that are currently in operation, whereas CERCLA handles the administration of remediating abandoned sites.

Among the provisions of RCRA, the federal government, along with states and localities, shares the burden assuring the responsible generation, storage, transportation, and disposal of newly created waste by-products. RCRA directs states to grant siting, or approval, of new locations for waste sites. The public is granted some rights under RCRA, namely, the ability to sue companies found to be in violation of RCRA or even sue the EPA for lax oversight.

Under CERCLA, Congress authorized the federal government to provide financing and assistance to clean up abandoned waste sites. The financing comes from a trust fund established with revenues from taxes levied on certain products, such as petrochemicals, crude oil, and imported petroleum products. It also permits the federal government to require parties who are found to be creating uncontrolled hazardous waste sites to finance cleanup. Additionally, CERCLA requires states to monitor and participate in cleanup activities within their borders. Finally, CERCLA identified a number of so-called Superfund sites that are prioritized for long-term cleanup efforts through either removal of hazardous materials at the site or remediation.

At the local level, government officials are responsible for providing avenues for public comment on decisions to locate waste sites in communities. Additionally, local governments are highly regulated in providing adequate zoning and easements between residents and incompatible land uses. Local governments can also be held financially responsible for violations of either act.

Environmental Racism and Politics

Community decision making is an important component to understanding the prevalence of environmental racism. The absence of minorities or the economically disadvantaged from the policymaking process at the local level often results in their communities being targeted for placement of these sites. Lack of representation on city councils, in government positions, or at hearings related to these types of issues negatively impact minorities and the poor. Lax enforcement of the various federal and state statutes and regulations can also have disproportionate effects.

Segregated housing patterns and low home values in areas with high concentrations of minorities have been linked with environmental racism. In many cities and towns across the United States, African Americans, Hispanics, Asians, and other minority groups tend to live in homogenous neighborhoods, unlike their economically disadvantaged white counterparts. Those in the middle class tend to be more engaged with local politics; it is assumed that poor whites who live in neighborhoods that are more heterogeneous by income are able to avoid adverse political decisions due to strong middle-class opposition to locally unwanted land uses (LULUs). Being voiceless in the political process is detrimental not only in regard to health outcomes but also in depressing home values further. Low housing values also increase the likelihood of siting hazardous waste sites, thus creating a vicious cycle that minorities and the poor have trouble breaking, as many are limited in their ability to “move with their feet” to neighborhoods or communities where these issues are not as prevalent.

Mitigating Environmental Racism

Public officials have some tools at their disposal for reducing the disparate effects of environmental racism, namely, through the use of administrative or bureaucratic discretion. First, implementing a comprehensive strategy to notify affected residents of location decisions should occur early and often. Representation on boards and other decision-making bodies are also critical in these types of situations. The right to accurate and complete information for industries wishing to locate in communities is also something local officials should require from corporations. Additional soil and monitoring procedures may need to be utilized in order to correctly estimate levels of toxicity in communities.

City officials and corporate partners should also be aware of the proximity of citizens to sites and be cognizant that discriminatory effects may occur; therefore, leaders should take care to ensure segments of the population are not bearing a disproportionate burden of the risks associated with toxic chemicals in the local environment.

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See Also: Discrimination and Institutional Racism; Environmental Justice; Racism, Long-Term Effects of

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Equal Opportunity and Civil Rights

Human society is very diverse, with sociopolitical and economic differences in addition to cultural and other differences. Many modern societies are multicultural in nature. To ensure equality in the distribution of human needs and services, the principles of equal opportunity and civil rights must be enshrined in the rules and regulations that govern human interactions. Socioeconomic inequality pervades human relationships; issues underpinning inequality have been subjected to constitutional provision under local, national, and international laws. Equal opportunity principles have provided an explicit understanding that human services and their delivery be devoid of inequality, oppression, segregation, prejudice, exclusion, and stereotypes, and allow application of equality in the distribution of society's goods and services. Civil rights encompass equal opportunity. Civil rights are described as natural or constitutional law bestowed on an individual simply by right of being a human being. The inclusion of civil rights in how people deal with one another ensures equal opportunity and efficient human services delivery based on recognition of individuals' backgrounds and diversity.

Equal opportunity provides positive steps toward ending discrimination, preventing its occurrence, and creating opportunities that were previously denied to qualified minorities and women. A need for equal opportunity comes with enormous implications for the positions of women and people of color because such programs provide opportunities that were previously gender- and color-based. In spite of equal opportunity law, however, many women and minorities are in vastly lower-paying jobs and still face active discrimination in some sectors. Equal opportunity and civil rights laws provide increased opportunities for women and people of color in the workplace. Equal opportunity in employment ensures that a fair chance at job opportunity is created irrespective of class, age, gender, and background.

Equal opportunity also removes barriers such as biased testing and hiring practices. It also reaches out to underrepresented women and minorities through institutions such as colleges, minority organizations, and ethnic media. Equal opportunity is created to remove biases in recruitment, hiring, promotion, and compensation practices, such as unnecessary job requirements. Many employers now design equal opportunity and diversity forms to be filled out by work supervisors and managers so that workplaces comply with equal opportunity laws. Managers and supervisors are required to take appropriate corrective or disciplinary steps in cases of discovery of discrimination, reprisal, civil rights violations, and related misconduct in employment and are held accountable for failure to do so. Annual performance appraisals for managers and supervisors include an evaluation of their compliance with the commitment to civil rights and equal opportunity.

Equal opportunity in education in the United States has been described as successful as a result of the increase in the number of women and people of color in schools, colleges, law schools, and elsewhere. For example, in 1978, in the case *Regents of the University of California v. Bakke*, the Supreme Court ruled that diversity could be a compelling governmental interest that permits the use of race as a factor in a narrowly tailored admission program.

Human Diversity in the Context of Equal Opportunity

Society is changing and developing—globalization has brought the whole world together as a family. Individuals' social identities may impact their experiences in life. Discrimination works in different ways, including making assumptions and hasty generalizations, stereotyping, patronizing, humiliating, ignoring some people, and disrespecting people.

The following principles demonstrate how an individual's identity and diversity can be valued appropriately: treating everyone as an individual; responding to an individual and his or her social identity in an individual manner; recognizing differences and responding appropriately; respecting everybody's sociocultural, economic, and political characteristics or social situations; increasing the knowledge and understanding of aspects of social identity that may be different; avoiding stereotyping or making assumptions about people based on social identity; recognizing that some interactions may impact on someone in a negative or difficult way because of an aspect of the person's social identity; recognizing that life experience may impact on some people more than others; recognizing that one's own social identity may create cultural conflict in different ways; and avoiding the use of inappropriate and disrespectful language relating to social identity or social situation.

Equal Opportunity in the Context of Civil Rights

Civil rights include protection from discrimination based on race, gender, sexual orientation, gender identity, national origin, color, ethnicity, religion, and disability, as well as individual rights such as privacy and the freedoms of thought and conscience, speech and expression, the press, assembly, and movement. Civil rights are constitutional rights or international human rights tools to prevent discrimination against individuals at both the domestic and international levels (e.g., the 1948 Universal Declaration of Human Rights and the 1969 International Convention on Civil and Political Rights).

Civil rights movements began as early as 1848 in the United States with such documents as the Declaration of Sentiment. Other examples of civil rights movements are the U.S. civil rights struggle in the 1960s, when the rights of black citizens had been violated; the Northern Ireland Civil Rights Association; and civil rights movements in many countries (e.g., Charter 77 in Czechoslovakia, the Civil Liberty Organization in Nigeria, and a host of others). The techniques of civil rights movements to achieve equal rights include civil disobedience, strikes, demonstrations, lobby campaigns, civil unrest, armed rebellion, civil resistance, and nonviolent methods. Civil rights promote and ensure that people have equal access and opportunity to participate in certain human services programs without facing unlawful discrimination.

Civil rights for women and minorities encompass the following aspects of human values: women's rights, which include equal pay for equal work; the Fair Pay Act of 1999, which provides equal wages and benefits for work of equivalent value; breaking the glass ceiling, which is defined as the hidden barriers that women and people of color face as they move up the social strata; and the U.S. Domestic Violence Act of 1995. Minority rights provide protection orders for hate crimes, which could be defined as intentional selection of a victim because of that individual's actual or perceived race, color, national origin, ethnicity, gender, disability, or sexual orientation. Minority rights also support affirmative action to ensure that minority applicants are preferentially treated to make up for past discrimination. To ensure equal opportunity in the United States, special language programs are required of all schools that accept federal funding.

Civil rights also encompass health rights for ill and disabled persons to protect victims against discrimination and denial. Examples include the Americans with Disability Act (ADA), AIDS/HIV Act, handicapped access, and laws against mental illness discrimination. Other civil rights include religious rights, which include school prayer, posting the Ten Commandments in public places, and recognition of hours of prayer.

Equal Opportunity and Civil Rights Work

To ensure equal opportunity and civil rights, some countries created government entities to oversee equal opportunity and civil rights, such as the U.S. Office of Civil Rights and Equal Opportunity, which has responsibility for a wide range of equal opportunity and diversity activities. Examples of these responsiblities include the following:

- Planning, implementing, and directing programs designed to ensure equality of employment opportunity for all regardless of gender, race, color, ethnicity, religion, age, disability status, or sexual orientation
- Managing the system for processing, adjudicating, and resolving complaints of discrimination in compliance with all applicable laws
- Developing and directing a program of reasonable accommodation for employees with disabilities
- Developing and maintaining all necessary information systems to manage equal opportunity programs
- Developing reliable statistical analyses and tracking equal opportunity workloads.

Coverage of Equal Opportunity

Equal opportunity ensures that all persons shall have the opportunity to be considered for employment without regard to their race, color, religion, national origin, ancestry, alien or citizenship status, age, disability, gender, sexual orientation, veteran status, or any other characteristic protected by applicable federal, state, or local laws. In sum, it covers all forms of discrimination. Discrimination, including treating some employees less favorably or harassing employees on any of the grounds stipulated above, can happen as a result of negative attitudes or prejudice. Even if it is unintentional, such actions can still be considered as discrimination.

Discrimination could also be described as barriers or stringent requirements that make it impossible for some class of people to access opportunities or services available to others. For example, work experience may put a recent graduate at a disadvantage when applying for a job. Likewise, stringent work requirements, such as overtime or full-time employment, may put women at a disadvantage as a result of gender roles performed by women. Some of these stringent requirements may be justified, however, in certain employment situations; but if the justifications are not lawful, a court or tribunal may decide that unlawful discrimination has taken place.

Ideally, equal opportunity covers the right to enjoy equal treatment and a life free from discrimination. Equality legislation is designed to protect people from unfair treatment, covering many areas of daily life such as employment, training, education, housing, the policies of public authority, and the provision of goods, facilities, and services. Equality law applies to a wide variety of situations, including getting a job, finding accommodation, accessing education and health care, and services such as those provided by banks, insurance companies, shops, pubs, restaurants, and leisure facilities. This is the case whether the services are paid for or free of charge.

In relation to employment, services, and functions, equal opportunity covers the following areas: disability, gender reassignment (undergone or proposing a change in gender form), pregnancy and maternity, identity (race, color, nationality, ethnic origin), religion or belief, gender, and sexual orientation (gay or lesbian, heterosexual, bisexual, or transgender). In relation to employment only, equal opportunity covers age (exemption, attainment of retirement age), marriage, and civil partnership. To ensure an organization is in compliance with equal opportunity policy, the organization must put policies in place to deal with complaints about discrimination on any grounds, discuss equality with employees' unions or those representing labor, ensure that employees know where to go if they have concerns about discrimination, ensure that there are adequate procedures in place for assessing and managing the needs of employees with disabilities, deal with complaints adequately and promptly, keep adequate records, freely discuss issues related to equality within the institution, and provide timely feedback to the individual.

Case Study

Understanding how inequality can impact an individual's course of life is essential to preventing potential discrimination. People can encounter unfair treatment in many aspects of their everyday lives because of their individuality, such as personal appearance, size, personal preferences, or social situation (e.g., being an ex-offender, being homeless, being a single parent); misuse of drugs or alcohol; citizen status; or health. Inequality also occurs with respect to some protected features, including being refused a job because of sexual orientation, or limited access to health care because of disability. In a practical sense, inequality can surface in the following ways: a female clerk discovers she is earning less than a male colleague doing similar work, a foreign student is teased and harassed by fellow students because she cannot speak the English language fluently, a house owner advertising a rental house indicates that blacks need not apply, a woman is fired from her job because she wants maternity leave, a man is not treated by a doctor because his religion is different from the others in his locality, a staff member is refused promotion because he is of a different ethnic background than the other workers; a student applicant is denied college admission because he is indigent, or a person is denied work because she changed her sexual orientation. People who experience inequality need services that restore their dignity and freedom.

Human services needed by the persons facing unequal treatment include psychological support, education, and legal assistance. Government departments and institutions and nongovernmental organizations provide support for people facing inequality and unfair treatment. An equality and human rights legal framework covers employment practices and service delivery, and employees need to work within this framework to avoid discrimination. For example, the Equality Commission in

Northern Ireland offers free, confidential information and protection for people who are victimized because they have been involved in a discrimination complaint. As human society becomes increasingly diverse and multicultural, there is a growing need to be able to respond appropriately and sensitively to diversities. Employers should enable their workfoces to reflect this diversity around gender, race and ethnicity, disability, religion, sexuality, class, and age to promote equal opportunities. Successful implementation of equality and diversity in all aspects of work and education will ensure that human beings are highly valued, motivated, and treated fairly.

It is instructive to note that equal opportunity legislation and civil rights law play complimentary roles. They ensure that fair play, equality, and justice dominate the way human beings organize themselves in this diversified modern world. They are also implemented at both the public and private sectors to promote affirmative action that serves women, people of color, and people with disabilities.

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See Also: Education for Diversity in Human Services; Ethnic Diversity and Values; Office for Civil Rights; Service Providers and Diversity; Social and Economic Justice.

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Equal Pay Act of 1963

The U.S. Equal Pay Act (EPA) is a federal law that seeks to equalize the salaries and wages paid to employed women with the levels paid to men for work of an equal nature and quantity. The act amended the Fair Labor Standard Act of 1938 and was a key element of President John F. Kennedy’s New Frontier program. The year 2013 marked the 50th anniversary of the passing of the EPA.

History and Development

At the turn of the 20th century, women composed around 18 percent of the U.S. labor force, increasing to just 25 percent in 1940. The entry of the United States into World War II in 1941 precipitated a massive influx of women into paid employment, and many of these women remained in the workforce following the conclusion of the war. Consequently, by 1960, some 23.3 million women were part of the U.S. workforce, a figure equivalent to almost 40 percent of all women of working age. Although the majority of women workers in 1940 were single, those joining the labor force after that time were predominately married, and a large proportion of those were from low-income families. This suggests that a key driver of the uptick of paid work among wives was family need.

These changes in the composition of the labor force did not, however, precipitate much change in occupational sex segregation or wage disparities. The entry of women into occupations traditionally dominated by men was in many cases prevented by collective bargaining agreements, employer resistance, or even the law. Women who were able to take up male-dominated roles typically received much lower wages for performing the same work as men did. For instance, U.S. Department of Labor survey data from 1960 show that the median salary of a woman in a sales job was just 40.9 percent of her male counterpart, and male bank tellers received up to $31 per week more than women in the same job. Evidence also suggested that these wage differentials could not be accounted for by differences in age or education. Data presented to the Labor Subcommittee of the Senate Committee on Labor and Public Welfare in 1962 revealed, for example, that women pharmacists who had received a degree two years prior were paid $1,560 per year less than a male pharmacist who had received the same qualification at the same time. Overall, the gender pay gap of full-time workers in 1960 was 39.2 percent.

Several actions to rectify this situation were presented to Congress from 1945 to 1960, but it was not until 1961 that the President's Commission on the Status of Women, set up by John F. Kennedy, proposed real policy action on the subject of equal pay for comparable work. During the hearings that followed under the auspices of the House Committee on Education and Labor, an amendment to the general order was presented that replaced the notion of comparable work with equal work. The change bolstered public and partisan support for the policy, and the concept was enshrined in law in the Equal Pay Act on June 10, 1963.

In endorsing the new law, President Kennedy stated the following:

> The lower the family income, the higher the probability that the mother must work. Today one out of five of these working mothers has children under three. Two out of five have children of school age. Among the remainder, about 50 percent have husbands who earn less than $5,000 a year—many of them much less. I believe they bear the heaviest burden of any group in our nation. Where the mother is the sole support of the family, she often must face the hard choice of either accepting public assistance or taking a position at a pay rate which averages less then two-thirds of the pay rate for men.

Provisions of the Act

Under the terms of the EPA, women and men performing jobs that demand "equal skill, effort, and responsibility, and which are performed under similar working conditions" must be paid the same. The EPA protects the rights of both sexes. An individual who seeks to establish a case under the act must demonstrate that (1) an employer pays one sex more than another; (2) both sexes perform an equal amount of work that demands equal levels of skill, effort, and responsibility; and (3) working conditions for both sexes are equivalent. An employer who is accused of discrimination under the EPA can present one of four defenses, known as affirmative defenses. An employer may legally pay employees of one sex more than another sex if wages are based on a system of seniority, a system of merit, a system that distinguishes payment on the basis of quality and quantity of production (e.g., certain piece rates), or if payment is differentiated on any factor other than sex. Of these four defenses, the "factor other than sex" defense has been invoked most frequently and has been the subject of intense debate and controversy. Critics have argued that this defense enables employers to fabricate other reasons for the wage gap.

Consequences of the EPA

In the 50 years since the Equal Pay Act was passed, wage disparities between men and women have slimmed, but a gender pay gap remains. In 1963, the average woman was paid 59 cents for every dollar earned by a man; in 2013, Census Bureau data showed that women are paid on average 77 cents for every male dollar earned. Critics have argued that there are too many loopholes in the legal framework of EPA for wage equalization to be achieved. Enforcement is complainant driven, but many wage policies are not transparent, so individuals may not know whether they are being discriminated against. It is argued that the reference to equal work does not allow comparable worth policies to be established; that is, the idea that sex-segregated jobs that require different, but equally valuable, skills (e.g., office secretaries and construction workers) should be paid similarly. Given the pervasiveness of occupational segregation by sex, many believe that legislation based on the principle of comparable worth would do more to equalize wages than legislation based on the principle of equal work. The Paycheck Fairness Act was a bill designed to tackle the vagueness of the fourth affirmative defense and eliminate salary secrecy, but it was filibustered in the Senate in June 2012. In 2013, Senator Tom Harkin, with co-sponsor Delegate Eleanor Holmes Norton, introduced the Fair Pay Act, a bill based on comparable worth, which they argued would address the undervaluing and underpaying of work in which women predominate, which includes much of human services employment, such as child care, nursing, and social work.

Implications of the EPA for Human Services

The Equal Pay Act applies equally to all sectors and occupations, but it has had a substantially positive effect on human services occupations, which tend to be dominated by women and are generally found in the public sector. The disproportionate effect of the EPA on female-dominated public sector jobs means that the wage gap is much slimmer among human services workers than among men and women in many other occupations. In some states, such as Minnesota, the wage gap in human services is said to have been eliminated completely. Data from 2010 suggests that the average female social and human services assistant earned $33,543, compared to $35,748 for her male counterpart. This contrasts favorably with, for example, the average female aircraft mechanic, who, at $40,884, earned almost $16,000 less than her male counterpart.

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See Also: Americans with Disabilities Act; Discrimination and Institutional Racism; Diversity in the Workplace; Equal Opportunity and Civil Rights; Fair Labor Standards Act.

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Ethnic Diversity and Values

"Ethnic diversity," "ethno diversity," or "multiculturalism" are all terms used to describe nations, communities, and/or societies that comprise multiple cultures. Typically, ethnic diversity describes the degree of variety of ethnic groups living together on a common territory. In a descriptive fashion, it applies to the demographic makeup of the culture; generally from an administrative standpoint these can include nations, states, cities, local neighborhoods, communities, businesses, schools, institutions of higher learning, and the like. In its normative manner, ethnic diversity refers to ideologies and/or political and societal policies put into place to promote diversity as an institutional norm. In this implication, ethnic diversity or multiculturalism is a social order that is completely accepting of the full mosaic of differences human beings embody as well as their aspirations of self-expression, through whatever means they deem most appropriate in relation to a specific ethnic culture.

Presently, social sciences has a very substantial literature on what constitutes ethnic groups and what binds them together. Ethnic groups may live together in a plural society (a society comprising different ethnic groups or cultural customs), or in the supporting structure of which ethnic or cultural differences are reflected, or may form cultural enclaves or dispersion of a different culture within a host society. In the past, issues around ethnic diversity were the domain of social anthropologists. These issues now frequently are also taken up by the mass media and politicians and are established with a suggestive normative mode, being mostly seen as a burden or a challenge rather than a benefit, especially in nation-building efforts. Similarly, the aspects of culture lead to value systems, which shape behavior, and can be the forerunner to unfair or different treatment of ethnic groups other than one's own, especially in some areas of human services. As a result, principles and policies that affect ethnic diversity values show wide discrepancies, particularly on a national level. As a consequence, the espoused ethnic diversity (multiculturalism) values are inseparable from human services and diversity issues. Overwhelmingly, the focus of human services professionals and scholars has changed in the past few decades as they face a progressively more diverse service population in the United States.

Although diversity itself covers a wide-ranging collection of human differences, included in these diverse collections, along with ethnic diversity and values, are differences in ability and disability, age, ethnic background, gender and gender role, geographic origin, level of education, religion, sexual orientation, and socioeconomic class. Accordingly, the major elements of an ethic group's culture orient it to activities, social relations, self, the world, and the passage of time. For that reason, the valuation of ethnic diversity is strictly related to cultural patterns. All the same, diversity in the population necessitates a shift in diversity focus in education, training, and information for the human services labor force to perform in their professions as interculturally competent service providers. Consequently, it is extraordinarily important that human services professionals understand diversity in cultural patterns (beliefs, norms, values, and social practices) if their desire is to become competent in intercultural communication in the effective and efficient delivery of professional human services.

Thus, the scope of these ideologies and policies correlate with human services and diversity through the cultural underpinning of the ethnic diversity values, norms, and belief systems in place. This scope may vary from support of equal respect for the various cultures in a society, to a policy of promotion of the maintenance of ethnic diversity, to policies focusing on whether people of diverse ethnic and religious groups are attended to by the authorities as characterized by the category of which they are members. Conversely, two main dissimilar and ostensibly conflicting strategies have developed through different government policies and approaches. One main approach focuses on competent intercultural communication that transverses cultures and interpersonal communication and interaction linking different cultures. This approach makes available junctures for cultural dissimilarities to interconnect and interact to conceive multicultural values and belief systems and norms. Simply put, it advocates support for cross-cultural channels of communication and challenges the tendencies for a culture to separate itself from a societal unit, commonly giving rise to interculturalism. The focal point of the second approach is diversity and cultural distinctiveness. In this approach, cultural isolation is viewed as a way to safeguard the uniqueness of an indigenous culture of a nation or area and also play a major role in universal cultural diversity. One common aspect of many policies following the second approach is that it avoids the presentation of any specific ethnic, religious, or cultural community's values, norms, and belief systems as most important. Thus, values being a component of cultural patterns, the relationships between values and human services in this overview would be best represented within the cultural pattern framework of intercultural communication and interaction.

Diversity is defined in terms of religious beliefs, ethnic backgrounds, gender and gender roles, age, and cultural values; increasingly, though, diversity is being defined in terms of the physical environment and technology, over and above terms of social organization, imaginative thoughts, and constructions of reality. As a consequence, an intricate collection of theories and concepts has arisen to take account of these changes in the real world. These theories differ greatly as to whether diversity is a valuable good or disadvantageous to progress and social structure. Nonetheless, according to sociological systems theory, to regard solely one influential tradition is to assume that increasing differentiation of social systems enhances their adaptive capacity to challenges ahead. The result is a multiplicity of social structures—organizations and schools of thought that are, to a greater extent, particular to solving specific problems, leading to a general advancement of research and development. Increasing social diversity, however, also creates growing problems of governance. Managing multifaceted systems requires additional social devices of control and management of resource distribution and conflict arbitration resolution. At any rate, one particular empirical studies model has proven useful because it describes a broad range of cultural patterns in comparison to which a particular culture's values can be understood through its five major elements: activity, social relations, self, world, and time orientations. The comparison and contrast of the elements of cultural patterns reveal strong links among these elements and the evolution of valuation of ethic diversity.

Values and Cultural Patterns

Values are unambiguous or implied, idiosyncratic of an individual or an attribute of a group, shaping choices from available ways, means, and outcomes. Nevertheless, diversity and cultural values also differ throughout ethnic groups as well, as is evident in their beliefs (what people assume to be true about the world), norms (socially shared expectations of appropriate behavior), and social practices (typical, predictable behavior patterns followed by a culture). Accordingly, values are the desired characteristics or objectives to which a collective aspires, and are therefore a component of cultural patterns. A particular group's cultural values are not, however, typically an interpretation of that group's actual behaviors and characteristics and what they illustrate. Nevertheless, how ethnic diversity is valued in a society and the influence of these values define the basic understanding of what a group of people regard as important or unimportant, good or bad, fair or unfair, appropriate or inappropriate. Also, from culture to culture, the intensity (importance of the value) differs. Thus, application of this intensity reveals itself as the foundation upon which human services are built, from the perspectives of competent and professional human services providers as well as those who receive the services.

Activity Orientation

Activity orientation is a culture's view of human actions and the activity of expression of oneself. It also provides answers to questions such as the following:

- Is engaging in "good" activities important to being a member of one's culture?
- Is the capability to change one's life circumstances important?
- Are work and play different, and which is more important?
- Is life a series of solvable problems or a collection of event experiences?

A culture's activity orientation is typically defined by choosing a place, on the range of being, doing, and becoming.

- Being cultures value inaction and acceptance of the condition or state of affairs that currently exists. African American and Greek cultures as well as Hindus from India are described as espousing this view. These ethnic groups also tend to adopt the view that all events are predetermined and thus will inevitably occur.
- In contrast, European Americans' dominant characterization is an orientation toward doing (assuming that it is important to get things done, but work is done only at work, and social and personal relationships are totally separate from the working environment). The evaluation of activity comes from scrutinizing a tangible product or observable action directed at others. The values of striving and seeking to change and control one's circumstances, as well as encouragement to work hard, be tenacious, and not give up are embodied in a doing culture. Doing cultures find problem solution a preferable course in dealing with challenges, rather than acceptance of the world's present characteristics.
- Ethnic groups such as Native Americans and South Americans value the activity of becoming; humans are evolving, changing, and are predisposed to reason ways in which to change themselves as a means to effect change in the world.

As a consequence, when being and becoming cultures work and/or interact in an environment of doing cultures, their behavior is often misinterpreted because activity is not typically associated with external products or actions, and interpersonal communication is differently shaped. As a result, interpersonal communication relationship values of being and becoming cultures are ostensibly differentiated from that of doing cultural groups, in which social and personal relationships are totally separate from the working environment. This may lead to reprimands of employees who mix working and socializing.

Social Relations Orientation

Social relations is a description of how a culture of people organize themselves and form relationships with each other. These relations can vary from emphasizing differences and a societal class structure to striving for equality and the absence of a societal class structure. What a culture values in social relationships affects interpersonal communication style. Some cultures may emphasize implicitness, subtlety, and indistinctness. An example of this would be eastern Europeans, African Americans, and Mexican Americans. However, for example, African Americans prefer not to use mediators in communication with fellow culture members. Conversely, the European American preferred value of interpersonal communication is to be specific, explicit, and direct in personal reactions and ideas. They also value, ideally, the belief that people should depend on self to achieve professional business goals. Likewise, some cultures value interdependence and a minimum number of obligations, whereas others encourage acceptance of obligation and independence.

For example, many European Americans underscore equal opportunity and uniformity in their interpersonal relationships, even though certain groups have been treated in discriminatory and unequal ways, especially in regard to human welfare and the organized welfare services that a community provides. Nonetheless, equality as a value and belief is frequently expressed and is a justification of one's actions. In contrast, cultures such as Korean emphasize status differences, while Mexican Americans draw on cultural roots in traditional Mexican values and formalize diverse ways of communicating depending on one's social characteristics, even though a noticeable difference exists in the degree of importance on formality.

Conversely, many people from other cultures have difficulty with cultures such as the United States that stress equality and thus informality in interpersonal relationships

Insomuch as groups are concerned, cultures such as those of Japan, Korea, and China identify with only a few distinct groups, and they value the ties that bind them to these groups; thus, membership may endure a lifetime. In contrast, European Americans typically value membership in many groups, but these alliances may be easily discarded when there is no perceived value, so they are transitory in nature and important for only brief periods of time (e.g., changing jobs, best friends for short intervals of time).

Both African Americans and European Americans value the belief that socioeconomic class should not be a precursor to opportunities and choices that define one's social role. They believe that people should not be restricted by conditions of their origin. Nevertheless, values in cultural patterns can also prescribe different and or appropriate behaviors for men and women, some being strict and specific whereas others allow for more ambiguous interpretation.

Self-Orientation

A culture's self-orientation involves how members of the culture value and describe their identities, the kinds of people who are valued and respected, whether the self is viewed as changeable, and what motivates individuals to actions. For most European Americans the emphasis on the individual self is so intense and omnipresent that it is nearly unfeasible to grasp an opposing outlook. This, too, is the motivation for the value of self-orientation among European Americans as well as African Americans. This belief, combined with the doing culture, helps create a set of beliefs and values that puts individuals in control of their own destinies. Consequently, failure is viewed as a lack of determination and not being inclined toward giving a full effort.

Another point of diversity value distinction as it relates to self is the perception of whether a culture believes people are inherently bad, good, or a combination of the two. For example, the Chinese culture believes people are inherently good and therefore valued, and they must be protected from exposure to corruption. Other cultures, however, rely on religious doctrine and see humans as inherently bad. Related to the emphasis on duties or rights, for instance, the Japanese culture expects its members to act fairly to others because it is their duty. The concept of duties and obligations to others, however, is not a strong motivator for other cultures, such as European Americans.

The allegiance to the old or the young and how these individuals are valued varies across cultures. For example, many Asians and Asian Americans base decisions on the preferences and desires of the senior. In contrast, European Americans place greater value on youth; new ideas and innovation are more important than the wisdom of the past in that culture.

World Orientation

The value placed on whether humans are intrinsically evil, whether humans are different from other animals and plants, and whether they are subjugated or living in harmony with nature, the spiritual world, and other living things defines a culture's world orientation. For instance, in the African and African American worldview, humans exist interactively in a hierarchal unity with God, man, and the natural world. One is to be aligned with the forces of nature and to be an integral part of nature and strive to live in harmony with the universe. Native Americans likewise espouse this value.

The Latino culture places tremendous value on spirituality and sees humans as being subjugated to nature. In contrast, European Americans see humans as separate and distinct from nature and other forms of life. Nature is regarded as something to be manipulated, conquered, and controlled in order to improve life. This is a result of the value placed on the accepted primacy and individuality of each person. Because humans are viewed as distinct from nature, disease, poverty, and hardship can be overcome to accomplish wealth and health. Also, European Americans generally believe and understand that the physical world and spiritual world are separate.

Time Orientation

Time is conceptualized and valued differently among cultures. Some cultures express the future as most important; others, the present; and yet others, the past. Japanese and Chinese cultures place value on the past. Most European Americans view time as valuable and scarce; thus, they strive to save time, daily events are dictated to schedule, and punctuality is defined. For cultures such as Indian, Kenyan, and Argentinian as well as among African Americans, time is less hectic, more relaxed, and more comfortably paced. For African Americans, time is less driven by a need to accomplish tasks than it is to participate in events that create their own cadence.

Benefits of Ethnic Diversity

Nevertheless, management theory's contrast of diversity valuation to politics has in the interim taken a constructive direction. Ethnic diversity values management is being used to transform ethnic diversity into a commerce benefit. Ethnically diverse teams are consciously created to augment innovations and improve output. For example, empirical studies in Europe and the United States show that areas and organizations with a highly diverse work force are innovative and productive. Ethnic diversity, specifically, is seen as a positive feature for development of a knowledge-based economy.

Economists have now started to propound whether ethnic diversity is good or bad from an economic point of view, and why. The common assumption looks to be that ethnic diversity is good for innovations; however, it is troublesome if social consistency is nonexistent. Similarly, business studies literature is even more concrete in stressing the positive aspects of workforce diversity in terms of ethnicity along with gender and age. For instance, one of the world's largest banks refers to the positive aspects of diversity. In addition to ethnic diversity, other individual differences are recognized and appreciated, as well as how diverse perspectives generate creativity, productivity, and performance that would lead organizations to progress.

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See Also: Cultural Competence, Model of; Cultural Services; Diversity in the Workplace; Ethnicity and Clients.

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Ethnic Groups and Drug and Alcohol Use

Historically, substances such as drugs and alcohol have been utilized throughout the ages. Drugs and alcohol have been used for ceremonial, religious, social, and recreational as well as abusive purposes. That is, drugs and alcohol may be viewed to serve a prosocial or antisocial function for the varying ethnic groupings and persons who imbibe. Societal, political, and moralistic values also contribute to the determination of whether a certain drug or behavior (e.g., alcohol use) is condoned rather than condemned. For example, in the era of Prohibition in the United States, some believed alcohol to be a moral evil, whereas others believed its usage, although illegal, was an inherent right.

A more recent example involves state laws permitting marijuana for medical and/or personal usage. Although this issue has opponents as well as proponents, what appears to have taken place is a general societal shift condoning the use of marijuana for medicinal purposes. In fact, the U.S. Justice Department recently indicated that where state law(s) conflict with, and perhaps contradict, federal law(s), governmental emphasis will be placed upon prosecuting dealers and traffickers rather than individual users themselves. For some, this is seen as a dramatic policy change, particularly since persons of nonmajority groupings who were previously found guilty of nonviolent drug offenses were given what may be considered harsh and long sentences for similar behavior. Although societal, political, and religious values may wax and wane—as well as change—altogether over time there remains a belief that certain minority groupings are predisposed genetically, prone behaviorally or personality-wise, and/or structurally different from the larger majority group.

Biopsychosocial Model

Although biological, psychological, and sociological factors and related theories to explain drug and alcohol use were often seen as contradictory, the overarching biospychosocial model put forth by George Engel is widely held today to better explain the complex nature and interaction of factors that play a role in drug or alcohol use and abuse. Although no one theory is universal, the biospychosocial model allows multiple influences to be accounted for in terms of the development of use and abuse (i.e., alcoholism and addiction).

The biospychosocial model examines a continuum in terms of contributions toward subsequent use and abuse of substances, including such variables as genetics and neurobiology, expectancies for and behaviors prone to use and abuse, as well as familial and peer influences. Furthermore, the biopsychosocial model in effect provides a multifaceted lens from which to view ethnic minority (as well as majority) group drug and alcohol use to provide a comprehensive approach to treatment via human and social services.

What Constitutes a Drug and Drugs of Choice

Many consider a drug to be an illicit or illegal substance that has no medicinal value. Others use a broader interpretation and consider all psychoactive substances, such as caffeine and nicotine, as drugs. Further, many Americans do not perceive alcohol to be a drug per se, notwithstanding the myriad negative consequences (e.g., breakdown of relationships, accidental deaths) associated with drug and alcohol misuse and abuse. Just as societal, political, and moral values shape whether a certain drug or alcohol is considered harmful or inappropriate, there is also disagreement and debate about just what substance(s) rise to the level of being considered drugs. Thus, drugs of choice, such as alcohol, may be perceived as less detrimental than, say, cocaine, even though it is equally damaging physically, psychologically, and socially. Therefore, an ethnic minority user's drug of choice may be seen to be less (or more) self and other impactful, dependent upon a range of issues.

For example, crack cocaine use and its negative effects upon the African American population have been widely viewed as much more damaging to society at large than cocaine usage among the majority Anglo population. What seemingly is agreed, in general, is that a drug's accessibility in combination with the user's monetary means often impacts the choice of substance. Notwithstanding that alcohol is the most widely used drug in America, so-called gateway drugs such as cigarettes or inhalants are often seen to lead to later harder drug usage. For example, a Hispanic individual may initiate drug use by inhaling gasoline, which may lead to alcohol and then marijuana use, which may later lead to cocaine use. What is almost a certainty is that the negative consequences and effects of drugs themselves do not discriminate, yet they are seen to disproportionately impact ethnic minority groupings.

Ethnicity and Risk Factors

Risk factors for ethnic groups are considered to be aspects that influence and increase the likelihood of using drugs or alcohol, and may include heightened socioeconomic difficulty, lack of resources, financial strain, familial unemployment, abuse or violence within the home leading to or resulting in child welfare and department of human services involvement, parental and/or peer substance use, risk-taking personality, positive attitudes and beliefs toward substances, accessibility to alcohol and drugs, neighborhood poverty, community disorganization, targeted enforcement and incarceration, disease, and potential for premature death.

According to the Annie E. Casey Foundation report "Faith Matters: Race/Ethnicity, Religion, and Substance Use," the poor as well as African and Hispanic Americans disproportionately experience negative health and social costs of substance abuse, even though they use substances at similar or lower levels than white Americans. The 2011 National Survey on Drug Use and Health (NSDUH) *Summary of National Findings* reported that among persons aged 12 years or older, the current rate of illicit drug usage was highest for persons reporting two or more races, followed in order by American Indians or Alaskan Natives, Native Hawai'ians or Pacific Islanders, blacks, whites, Hispanics, and Asian Americans. In contrast, that same NSDUH survey reported that among persons aged 12 years or older, the current rate of alcohol usage was highest for whites, followed in order by persons reporting two or more races, American Indians or Alaskan Natives, Hispanics, blacks, and Asian Americans. Put another way, although substance use does not discriminate by ethnicity, drug and alcohol use is widespread across racial and ethnic groupings.

Which individual, family, peer, and community factor(s) might engender the initiation of substance use? One such community risk factor includes target marketing of alcohol and tobacco products. Focused marketing to ethnic groups has taken place for decades and has been criticized over the years for the disproportionate number of billboard advertisements seen in ethnic neighborhoods. For example, research has shown that marketers advertise billboards containing products with higher alcohol by volume (e.g., malt liquors known as 40s) within ethnic neighborhoods. Not only are larger sizes and brands advertised on billboards, the Annie E. Casey Foundation report indicated that black-oriented magazines contain more alcohol and tobacco advertisements than magazines targeted at the general population. In fact, the U.S. Food and Drug Administration (FDA) issued an advanced notice of public rule-making as of July 2013 to obtain information related to the potential regulation of menthol in cigarettes, in part due to concerns that the impact of the advertising, sale, and distribution of menthol cigarettes may negatively and disproportionately impact the health of specific ethnic and racial subpopulations. The 2010 NSDUH summary reported that African Americans and other ethnic minority groups were more likely than whites to smoke menthol cigarettes (i.e., African American 86 percent, Hispanic 38 percent, Asian 33 percent, white 27 percent). Thus, disproportionate marketing to ethnic minorities may be viewed to increase risk, particularly so in black and Hispanic communities, in part due to media exposure and alcohol accessibility at neighborhood convenience stores as well as a level of disorganization. Notwithstanding, risk factors may be seen to influence certain ethnic groups' drug and alcohol use, as well as factors believed to delimit one's initiation and harmful use of substances and related negative consequences.

Ethnicity and Protective Factors

Protective factors for ethnic groups are considered to be aspects that act as buffers or preventive agents that decrease the likelihood of using drugs and alcohol. These factors may include education and school involvement; access to resources; familial

A person smoking a marijuana joint. In the 21st century there has been a general societal shift condoning the use of marijuana for medicinal purposes.

employment; nurturing and supportive homesteads; parental and/or peer nonuse of substances; high self-esteem; religiosity; inaccessibility and difficulty procuring drugs and alcohol; healthy neighborhoods; communities that thrive, due in part to policing, and are organized; access to health and wellness care; and potential for individual, familial, and community growth and development.

A strong community connection and ties to religiosity and spirituality that certain ethnic groupings evidence (e.g., black, Hispanic, and American Indian) may serve to buffer against substance use through social control. According to the Annie E. Casey Foundation report, a review of 150 studies on alcohol and drug abuse found that persons who consider themselves highly religious were less likely to use substances altogether or to experience negative consequences. A person's attachment, commitment, involvement, and belonging to a group often instill positive attitudes, beliefs, and practices, which may ultimately shape and determine individual values, and thus influence prosocial constructive rather than antisocial destructive behaviors.

Treatment Issues for Ethnic Minorities

Just like no two persons are alike, no two individuals from within an ethnic grouping are exactly alike, neither in terms of presentation nor background. That is, although certain factors may predispose or prevent drug and alcohol use, there is both similarity as well as diversity among persons of a particular ethnicity. Although human and social services workers should be well trained and become learned about ethnicity and racial issues, a wholly complete understanding and accurate picture of the nature of substance use and ethnicity as a factor has yet to materialize nor become clear.

Notwithstanding the aforementioned, human and social services practitioners should familiarize themselves with the culture and customs of those persons and groupings with whom they interact. Information should be sought from the client regarding their own values and beliefs as well as experiences, so as not to stereotype, but rather to tailor an individualized treatment plan that both recognizes one's self-determination and is mindful of one's ethnicity.

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See Also: Acculturation; Alcohol Consumption, International Variations in Attitudes Toward; Cultural Competence, Human Service Providers and; Culturally Specific Services; Drug and Alcohol Screening; Ethnicity and Clients.

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Ethnicity, Definitions of

Although the use of the term *ethnicity* is not very old, the concept goes back to antiquity. It was earlier understood as the feeling of clan and kinship, solidarity of a group or community, and the common strands of behavior and culture. In every phase of human history the consciousness of ethnicity has shown a major presence, and it has been a major cause for conflicts in medieval and ancient times, when racial and cultural pride played vital roles.

The word *ethnicity* is commonly used as a synonym for nationality, race, and tribe, and denotes the link and identity of any person with any specific culture, region, race, belief, behavioral group, custom, or dialect. Ethnicity has been defined in multiple ways, including three core elements, namely common descent, a common history, and/or a common homeland. Ethnicity has been variously defined in cultural anthropology but no consensus definition has been reached. It is the cultural and social background of an individual in the broad sense of the term. Some scholars associate ethnicity and ethnic groups with nationalities, such as German, French, British, Arab, and Turk.

Since human services professionals aim at ameliorating human problems, the proper understanding of the term *ethnicity* can help them improve upon the policies and programs for making the term more acceptable, efficient, and dynamic, and will, of course, help these professionals in designing their human services strategies in a diversified human environment.

Etymology

The word *ethnicity* has been derived from the Greek word *ethnos,* which entered into English via the Latin word *ethnicus.* In Homeric Greek, the term had a variant connotation such as swarm, flock, host, or band, which later came to be known as nation or people. Hellenistic Greeks used the term *ethnicity* to define someone as a foreigner or barbarous. From the late Middle English, it came into vogue as an equivalent to folk or people. In early modern English usage, the term *ethnic* has been used to describe a pagan or heathen people—those who were not the believers in Christianity, or participated in the Christianoikumene.

The Hebrew word *goyim*, translated at that time as *ta ethne* (the nations), was generally used to represent being of little worth, showing a sense of contempt and disdain for the attitudinal behavior, values, and practices of non-Jews. Sometimes it was used in a neutral, even positive way to refer to a Christian; however, it suggested a degree of condescension.

In the 19th century, the term *ethnic* meant something peculiar to a race, people, or nation, which is somehow closer to the original Greek meaning. As a term, *ethnic group* was used for the first time in 1935. The *Oxford English Dictionary* placed ethnicity in its vocabulary in 1972. In a broad sense, therefore, the term *ethnic group* describes a group sharing common cultural heritage, ancestry, physical appearance, mythology and history, motherland, ritual, culture, cuisine, dialect, and linguistic patterns.

Modern Definitions of Ethnicity

Different social scientists have used various approaches, such as primordialism, essentialism, perennialism, constructivism, modernism, and instrumentalism, to study and define ethnicity. In pre-Weber intelligentsia, social scientists had blended the concept of race and ethnicity. Max Weber's introduction of ethnicity as a social construct has segregated the study of ethnicity from race. Cultural theorists such as Stuart Hall, Etienne Balibar, and Immanuel Wallerstein hold the view that ethnicity must be viewed as a plastic and malleable social construction that derives its meanings from the particular situations of those who invoke it. They find that "ethnicity has no essence or center, no underlying features or common denominator." John Hutchinson and Anthony D. Smith focus on ethnic group, or ethnie, as the major catalyst of ethnicity, and find the six main features of an ethnic group to be "a proper name, common ancestry, historical memories, elements of common culture, an association with the homeland, and a sense of solidarity." Gerald Berreman finds ethnicity to be a level of social stratification or social inequality that also includes race, class, kinship, age, estate, caste, and gender. He has clearly differentiated ethnicity from race or class.

Sian Jones has summarized the existing definitions and theories of ethnicity, and has suggested her own definition with the help of three terms: "ethnicity, ethnic identity, and ethnic group." To Jones, ethnicity is a "social and psychological phenomena associated with a culturally constructed group identity." She has analyzed the patterns of primordialists and instrumentals, and has suggested her alternative approach, known as practice theory, which includes many aspects of both. Primordialists such as Clifford Geertz, Edward Shils, and Harold Isaacs have found ethnicity to be a natural phenomenon with its foundations in family and kinship ties. Isaacs described ethnic identity as the "basic group identity."

While critiquing primordialists' approaches, Jones finds that they are not balanced, and simply make the ex post facto arguments. Jones finds the instrumentalist theory to be relating ethnicity with the mediation of social relations, "and the negotiation of access to resources, primarily economic and political resources." She finds the instrumentalists to represent two groups—those focusing on the sociostructural and cultural dimensions of ethnicity, and those representing the interpersonal and behavioral aspects of ethnicity with greater subjectivist stance.

Later, Jones offered a balanced definition of ethnicity. To her, ethnicity "is not a passive reflection of similarities and differences in the cultural practices and structural conditions in which people are socialized." It is not created "entirely in the process of social interaction, whereby epiphenomenal cultural symbols are consciously manipulated in the pursuit of economic and political interests."

In summary, ethnicity can be defined as an understanding or allegiance to a specific cultural group on the basis of genetics, mythology, dialectical patterns in language, sociopolitical consciousness, behavior, shared developmental patterns, and cultural manifestations.

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See Also: Biculturalism; Cultural Determinism; Ethnic Diversity and Values; Ethnocentrism; Honor Killings; Subcultures.

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Ethnicity and Clients

This overview of ethnicity highlights some of the problems inherent in its definition as well as its utility in the human services. The current political goals to decrease ethnic health disparities rely heavily upon human services professionals' use of the term *ethnicity*. Ethnicity can be utilized to either clarify or muddle aspects of the client that relate to mental health. Human services professionals who are committed to the well-being of their clients will use ethnicity along with an array of other salient characteristics to best serve their clients. Professionals who are complacent might rely on ethnicity alone for predicting therapeutic outcomes or pathology, ignoring the more relevant statuses or divisions of its meaning, The different components of ethnicity as well as the statuses related to it have been well researched by psychologists and social workers. This information can be used to understand the client and to identify a professional orientation to ethnicity that is practical and beneficial. By understanding the meaning of ethnicity, professionals in human services can help ensure that disparities are reduced, not perpetuated, while serving, evaluating, and generating programs to enhance the well-being of ethnic clients.

The meaning of ethnicity relies most upon its political context followed by its use among professionals, its measurement as either open-ended or a forced choice, and the varying degrees to which individuals identify with the label. Today, ethnicity is defined within a political context that seeks to reduce health disparities. This means that the inclusion of ethnic labels is required for federally funded research so as to reduce ethnic health disparities as part of a sociopolitical agenda. The U.S. Department of Health and Human Services offers the following five categorizations for ethnicity: "No, not of Hispanic, Latino/a, or Spanish origin"; "Yes, Mexican, Mexican American, Chicano/a"; "Yes, Puerto Rican"; "Yes, Cuban"; and "Yes, another Hispanic, Latino or Spanish origin." These standard ethnic group, were derived from the U.S. Office of Management and Budget. This measurement of ethnicity is considered a forced, rather than open-ended choice. It has been adopted by national organizations such as the U.S. National Institutes of Health, Census Bureau, Department of Health and Human Services, and Centers for Disease Control and Prevention. The inclusion of ethnic categories in research and practice is required in accordance with the *Publication Manual of the American Psychological Association* and *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists*.

Professional Orientations to Ethnicity

Professionals in human services are typically concerned with when to use ethnicity appropriately as opposed to reaching consensus on its definition. Paired with modern requirements to capture ethnicity using standards set by the government, the term *ethnicity*, in its essence, is dynamic and interactive. Ethnicity represents a social construct whose use by practitioners demonstrates either their complacency or commitment to achieving a clearer definition. A professional whose orientation to ethnicity is more complacent than committed will use the category to provide insight to appropriate practices, to explore pathologies related to ethnic group membership, or to predict outcomes. An orientation to ethnicity that is committed reflects a consideration of the validity of the term or the heterogeneity of its group members. Individuals with a committed orientation to ethnicity are less likely to use the concept alone as a predictor of outcomes, pathology, or appropriate services, and instead to focus on related factors that are more reliable and well-researched.

Understanding ethnicity as having three components—culture, subjective identity, and shared experiences—has utility in the human services even though orientations to ethnicity are varied between complacent and committed. Professionals in the human services can further understand ethnicity and the client by identifying the characteristics perceived to be shared among Hispanics/Latinos, despite the group's heterogeneity. Some of these characteristics include interdependence, willingness to sacrifice for group welfare, avoidance of conflict, strong attachment, loyalty, connectedness to extended family, adherence to gender roles, obedience to authority, and being flexible about time.

Professional Utility of Ethnicity

Effectively utilizing ethnicity to improve the quality of services requires knowing the individual's orientation to ethnicity (i.e., culture, subjective identity, and shared experiences) simultaneous to understanding the professional's orientation to ethnicity (i.e., complacent or committed) while identifying how it has been assessed (open-ended versus forced choice). An example of complacent practice would be assuming the aforementioned ethnic group characteristics to be true for an individual whose ethnicity is measured via forced-choice categorization. For professionals whose orientation to ethnicity is committed, the assessment of an individual's ethnicity as open-ended helps avoid stereotypes. Assessing ethnicity open-endedly taps into the client's orientation to the social group. Individuals who choose to freely identify with an ethnic label reveal their perceptions about shared experiences. Aspects of an ethnic group that are viewed as homogenous in the eyes of the client generate useful clues about that client's subjective identity. The shared characteristics of an ethnic group, as perceived by the client, are most likely to be assessed by committed professionals open-endedly in order to generate a truer definition. In this capacity, ethnicity may help in understanding clients and the degree to which they identify with their ethnic group.

Ethnic groups in the United States lack the characteristics of a category; therefore, knowing a client's ethnicity alone will not explain outcomes per se. Heterogeneity within an ethnic category (more differences within a group than similarities) is inevitable. This is especially true for forced-choice measures and those who respond to the category "Yes, another Hispanic, Latino, or Spanish origin." The ethnicity of the client relies partially on the practitioner's orientation to the term and the framing of its assessment. Assessing ethnicity open-endedly generates more knowledge about the client's subjective identity, whereas understanding ethnicity via forced choice generates a social address that provides a clinician with an idea of where that client has been placed in and by society.

To utilize ethnicity effectively when providing help or care, the consideration of ethnically salient statuses becomes increasingly important. These salient features are immigrant, generational, and acculturative status—better suited for use in the human services than ethnicity alone. These different statuses have been well researched in terms of the pathology of mental illness, access to mental health services, and outcomes. Ethnic group members are shaped and impacted by these statuses in ways that are important for professionals in the human services to understand.

Immigrant Status and the Client

Immigrant status refers to whether an individual was born within the United States. It further specifies the characteristics of ethnic clients that are perceived as being shared but often are not. Immigrant status is more characteristic of a category than the label of ethnicity. Immigrant status is capable of distinguishing important differences among ethnic group members and is related to the human services in three different ways: accessing mental health services, mental health outcomes, and the pathology of certain mental illnesses.

Ethnic group members born outside of the United States are more likely than ethnic clients born in the country to inhabit immigrant communities. Within these immigrant communities the visibility of mental health services is poor. This environmental barrier to service, combined with individual differences among immigrant clients, is a determinant of underutilizing mental health services. Identifying whether an ethnic individual was born in the United States is valuable toward understanding why and/or how an ethnic client accesses services as it relates to the composition of his or her community.

The immigration statuses of clients can be related to outcomes by way of their environment, similar to accessing care. The degrees to which immigrant ethnic clients access care and rely on familial bonds for support relate to how well a client responds to receiving services in a professional setting. Family as a primary source of support is considered a barrier to accessing services outside of the home. Familial bonds are often anticipated to be stronger for immigrant clients compared to those who were born in the United States. Reasons for this difference include community settings, language, customs, practices, and access to ethnic foods, as well as other factors, including generational status and acculturation. Members of a particular ethnic group vary individually in terms of resiliency, mental health problems, vulnerability, and responses to services as well. These ideas suggest that professionals in the human services need to focus more on environmental factors than ethnic group membership alone. Therefore, in terms of outcomes, immigration status explains factors salient to mental health better than ethnicity alone.

Immigrant status is related to the pathology of mental illness, and this relationship has come to be known as the immigrant paradox. The idea is that immigrant status protects against a variety of psychological disorders. This phenomenon is labeled a paradox because it is often assumed that the stress related to immigration or emigration would be a risk factor for these individuals. Ethnic group members who were born outside of the United States, however, are far less likely to develop anxiety or depression disorders compared to their non-Hispanic white counterparts. Ethnic group members born in the United States are more likely to have psychological issues similar to nonethnic groups. This paradox is not, however, generalizable to all Hispanics and Latinos—it has been found to be most consistent among Mexican Americans, whereas for Cubans and other ethnic groups it holds true only for substance abuse disorders. Again, the strength of the familial bond is an influence on the relationship between immigrant status and mental health pathology. Familial bond relates to acculturation, generational status, and environmental conditions, explaining the way in which immigrant status maintains or enhances well-being.

Acculturation and the Client

Acculturation is known as the process in which a client adapts to the culture of their country of residency. Aspects of this process include language use, behaviors, and subjective identity. The process of acculturation is dynamic. It can be both beneficial and harmful to well-being, and is influenced by generational status, age, and immigrant status. Acculturation and mental health are related in three different ways: (1) the degree to which an individual acculturates to their country of residence, (2) the degree to which the individual retains the culture of their country of origin (enculturation), and (3) the way in which the two interact. The latter, termed *biculturalism*, is anticipated to be the most protective orientation to culture for ethnic group members.

Ethnic group members who were born in the United States or have lived in the country for a long period of time may adopt dominant cultural norms. Specifically, acculturation via language, behaviors, and identity has been found to relate to positive mental health experiences. Language is one of the necessary tools to navigate society. The relationship between language and education, employment, and other adaptive features of society explains why ethnic group members who acculturate typically have better well-being than those who do not.

Ethnic group members who are highly enculturated, or have maintained the culture from their country of origin, have been found to have adverse mental health outcomes as a result. Feelings of not belonging can relate to poor mental health.

Individuals who acculturate minimally to the dominant culture are more likely to experience anxiety as a result. Immigrant communities that do not require the use of dominant cultural behaviors or practices, however, may not relate to negative mental health. Varying degrees of acculturation within the family can generate discourse related to well-being. Children of immigrant parents may not feel as though their parents have the resources to cope with problems specific to the dominant culture norms, which can relate to accessing mental health care.

Ethnic group members can benefit most by acculturating and enculturating: it can increase their resources and maintain well-being. Clients who identify with the dominant culture as well as with their ethnic culture have twice the cultural tools required for interaction and acclimation. This concept of biculturalism is useful in the human services as it identifies more than one source of cultural information for the client. Knowing that the more cultures a client identifies with is beneficial can help achieve positive outcomes.

Generational Status and the Client

“First generation” refers to individuals born outside of the United States being the first members of their family to migrate to the United States. The offspring of first-generation individuals constitute the second generation of a family, and their offspring constitute the third, and so on. Generational status is intertwined with dimensions of ethnic clients that relate to acculturation and mental health; it is specific to family context and immigration status. As previously mentioned, familial bond—the degree to which family members rely on one another for support—is predictive of accessing outside help or care. Families with no more than two generations present in the household would be expected to have greater family cohesion. Third-generation ethnic group members are anticipated to have more familial conflict than first- or second-generation households. As a result, multigenerational family members may seek out services at rates comparable to non-Hispanic whites. In the community, generational status influences which coethnic group members a client chooses to identify (or not identify) with. Differences between generations are often related to acculturation. First-generation ethnic clients are more likely to live in communities highly populated with immigrants and are strongly enculturated to their country of origin. First-generation clients living in nonimmigrant communities, especially those clients who are younger, may be more likely to have adverse mental health issues arise as a result of their otherness. For use in the human services, generational status is relevant to ethnic clients because of its interaction with immigration and acculturation. Ethnicity alone tells little about clients, their environment, or the outcomes in the context of the human services.

Compounding Race and Ethnicity

A portion of clients in the United States are identified as being nonethnic group members. For some of those clients, their racial categorization may make salient some of the topics discussed in this article. Ethnicity is intended to identify only those who have an ancestry of Latin or Hispanic background. Clients from racial groups such as Asian, Pacific Islander, or eastern European may not meet the criteria for ethnic group membership per se, but they are impacted by generational, acculturative, and immigrant status as well. As a result of this, ethnicity and race are often used interchangeably or inclusive of other social groups such as Jewish, Amish, or Mormon.

Ethnicity, however, is defined in the United States to pertain only to individuals who identify through forced-ethnic labels whether their ancestors, or they themselves, came from Spanish-speaking countries. These countries include, but are not limited to, Argentina, Bolivia, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Spain, Uruguay, and Venezuela.

Together, race and ethnicity can generate two subtypes of ethnic group members determined by skin color: white-ethnic and black-ethnic. This intersection of race and ethnicity promotes that non-Hispanic white is the norm and that other racial groupings require further specification, or ethnicity, to describe to what degree they are Hispanic/Latino. Therefore, non-Hispanic whites, by definition, are without ethnicity. The racial groupings within Latin countries (e.g., Mexico, Puerto Rico, or Cuba) are not considered, even when assessing ethnicity within the context of race. For Americans whose ancestry is within one of the aforementioned countries, a label of ethnicity is an option. The label is not universal. For example, a person with markedly dark skin residing in the United States could potentially identify racially as black/African American and ethnically as Hispanic/Cuban. In this sense, the role of identifying ethnicity is simply to determine whether that individual is tied, historically, to a Spanish-speaking country. This same individual may opt not to respond further and identify only in terms of race. The importance of assessing ethnicity open-endedly relates to its effective use in the human services. Understanding individuals and the degree to which they identify with the shared experience of their ethnic group simultaneous to their own orientation to ethnicity is the ideal for professional practices.

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See Also: Acculturation; Biculturalism; Cuban Americans; Department of Health and Human Services, U.S.; Dominican Americans; Ethnic Diversity and Values; Ethnic Groups and Drug and Alcohol Use; Ethnicity, Definitions of; Family Structure, Diversity of; Health Disparities, Role of; Help-Seeking Behavior, Cultural Differences in; Hispanic Americans; Hispanic Immigrants; Immigrant Populations, Human Service Needs of; Immigration: Human Services Issues; Mexican Americans; Puerto Ricans; Racial and Ethnic Categories, U.S. Census; South American Immigrants.

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Ethnocentrism

Ethnocentrism is a term commonly used to describe a group-held belief that one’s group is the center of everything and that all others should be rated with reference to it. The original conceptualization of ethnocentrism was defined as a belief that one’s own group has a style of living and values that were better or superior to those of other groups. By the mid 1900s, ethnocentrism had come to stand for an individual’s unsophisticated reactions to cultural differences. Research by Gordon Allport confirmed this allegiance to in-group norms. Ethnocentrism has been extended to understand in-group/out-group violence, intolerance, and the presence of authoritarianism in particular members of society.

In recent years, the term has been further expanded to apply to acts of discrimination toward new immigrant groups in transitioning democracies or in societies that have, until now, enjoyed a relatively homogenous population. It can also be used to explain judgmental thoughts and actions toward out-groups. Finally, ethnocentrism should be understood as assuming out-groups are threatening in some fashion, typically through misunderstanding or disregard for other ethnicities as well as racial, cultural, or historic traditions.

In the fields of sociology, urban politics, political behavior, and psychology, much research has been conducted to determine the extent of ethnocentric attitudes in society. In the field of human services, caseworkers, personnel, and clients should be aware of all forms of ethnocentrism because it can affect interpersonal communication, evaluation, efficacy of service provision, and overall work conditions.

Ethnocentrism, In-Groups, and Out-Groups

William Sumner held that groups in society are naturally in conflict and that peace between warring factions could be explained by the demands of war by the in-group on an out-group to maintain peace. Ethnocentric behavior is based on boundaries created by the in-group that are usually defined by one or more observable characteristics (such as physical features, religion, or language) regarded as indicators of common descent. An in-group can also be described as a group of individuals with cultural, racial, historic, or ethnic similarities that share an attitude of superiority toward an out-group. In-group members hold that out-group members are alien, foreign, or otherwise by nature—they are different and therefore can be discriminated against.

In-group members often think they have a proprietary claim on privileges, benefits, and power. They also are suspicious that the out-group has designs on in-group benefits. This situation of open and constant warfare produces within the in-group sentiments of loyalty, superiority, and approval of distinct views coupled with disdain, hatred, and contempt for the out-group. This hostility toward any out-group, typically referred to as xenophobia, is exhibited in small forms ranging from preferences of consumer choices (e.g., Ford over Honda) to large-scale conflicts (e.g., the Chechen War, discrimination toward Jews in Nazi Germany, the U.S. civil rights movement), euthanasia, and voting. Extending the definition further, Sumner states that for group cohesion to last, it must be well-disciplined; therefore, discord within the in-group could result in expulsion. Thus, the creation of internal practices that promote solidarity and similar belief structures to hold the group together against outside influences fosters attitudes of ethnocentrism.

Ethnocentrism and Culture

In a multicultural society, the dominant group (in-group) determines the standards for society. Therefore, when the dominant group holds the belief that their standards or beliefs are superior or ideal, then the behaviors of the minority groups are viewed as inferior. This difference can be seen by comparing one's feelings toward the people who live in a neighboring town or city in the United States. In this example, one feels an affinity toward one's friends and local community, as well as the uniqueness of community activities, the local economy, and civic culture.

Thus, the neighborhood affinity, also called in-group consciousness, is superior to that of a nearby neighborhood. But both neighborhoods, as part of one town, are superior to those of another town. Compare this to the way people use knives and forks. Individuals usually do not think of the way knives and forks are used in one town as superior to the way another town or neighborhood uses them, but may consider these implements handier when eating than say, chopsticks or tearing meat directly from the bone. This in-group consciousness is born from familial relationships, territorial interests, or other associative affinities in daily or periodic contact. Through the process of socialization and enculturalization (forks, yes; chopsticks, no) as well as regular reintegration of cultural patterns between and within individuals, feelings of in-group superiority can develop, leading to ethnocentrism.

Present Day Ethnocentrism

In the United States, studies of ethnocentrism have shown that white attitudes toward civil rights issues have shifted over time from outright discrimination to specific grievances with social programs aimed at redressing social inequities. In current discussions on racism and discrimination, ethnocentrism is hidden, or discussed in a language that cloaks actual meaning. Additionally, by eliminating legal discrimination by race, religion, or ethnic background, in-groups have tried to exhibit their dominance by putting into place restrictive employment standards vis-à-vis state immigration laws in Arizona and Mississippi, or using other means to determine in-group membership (e.g., name bias, not in my backyard, or systemic bias in health care).

Ethnocentrism is thought to involve substantial cognitive ability and is based on a variety of social and cultural inputs. Forms of ethnocentrism can be found in most societies and is even thought to be something developed in the preconscious. Individuals exhibiting ethnocentric ideology tend to divide humanity into groups, and then determine whether they identify or counteridentify with them. If a group is counteridentified, individuals react by rejecting the out-group's legitimacy. Ethnocentric persons will express their disdain by criticizing the out-group in moralistic or pseudopatriotic terms.

They also tend to shift in-group/out-group distinction, depending on the issue being discussed. By asking respondents how close or far they feel from other groups or individuals in society, researchers have reliably been able to identify anti-Semitism, racism, and sexism as well as ethnic discrimination in respondents and the traits connected to the formation of ethnocentric attitudes.

Research since the 2000s has focused on the mechanisms by which people incorporate ethnocentric thinking into their evaluations of others. Explorations in subliminal priming, rationalized racism, and the creation of social identity as a psychological phenomenon have been shown to be contributors to decreases in overt racial or ethnic discrimination while simultaneously showing increases in ethnocentrism throughout society as a whole. More recently, ethnocentrism has been correlated to increases in ethnic conflict, consumer decisions in purchases based on marketing strategies, changes in voting behavior, and war across the world. As national boundaries, globalization, and immigration practices take hold throughout the world, it would seem that ethnocentrism as a strategy to self-select into like-minded groups will increase.

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See Also: Ethnicity, Definitions of; Implicit Bias; Power, Race, Ethnicity and; Racism, Long-Term Effects of.

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Ethnocentrism and Ethnorelativism

Human services professionals aim at ameliorating human problems; a knowledge of ethnocentrism and ethnorelativism can help them improve policies and programs and make them more acceptable, efficient, and dynamic. A knowledge of ethnocentrism and ethnorelativism will, of course, help them in designing their human services strategies in a diversified human environment.

Ethnocentrism

Ethnocentrism is defined as having the idea that your own group or culture is better or more important than others. Expression of ethnocentrism may be subtle of overt and generally has a negative connotation. A person with ethnocentrism believes in the superiority of one's own culture. Such individuals or groups do not allow other people or other groups into their category and create barriers in the smooth flow of communication. This tendency in its extreme stage takes the form of xenophobia, phobia of foreigners and strangers, which becomes a deadly barrier in communication.

Ethnocentrism can occur due to the conditioning of the individual. In other words, it has to do with how individuals or groups have developed an understanding toward the socially acquired rules or norms of human behavior. Ethnocentrism may be regional, cultural, or can originate from the manner that an individual adopts to educate himself or herself.

Based on cultural, contextual, psychological, social, and rational factors, ethnocentrism is a development of a kind of tendency in which individuals or groups become judgmental on their own set principles and rules of human behavior. Ethnocentrism can also be correlated to cultural relativism, a concept in anthropology. Cultural nearsightedness is the mild form of ethnocentrism, which is characterized by a person simply neglecting another culture in comparison to the person's own culture.

The term *ethnocentrism*, coined by William G. Sumner, is used in anthropology and cultural studies. It has mixed response among the intelligentsia Franz Boas and Bronislaw Malinowski, who have criticized the concept of ethnocentrism and suggested that any cultural scientist should avoid this practice.

Antiethnocentric ideas have been propounded by Malinowski in *The Sexual Life of Savages in North-Western Melanesia*, by Ruth Benedict in *Patterns of Culture*, and by Margaret Mead in *Coming of Age in Samoa*. Ethnocentrism creates the paradigm of self and other by creating the icon of binary opposition at a later stage, which harbors subconscious discrimination in public spheres and the workplace as well.

Ethnocentric behavior can be seen throughout history in human civilizations across all cultures. Many religious sects and cultures had long been involved in group favoritism and other group condemnation. Belief in ethnocentrism has led to the development of cultural and social barriers. The bush tradition in the settlers' colonies in Canada, cultural chauvinism, and distinction based on creed or sect have emanated from such a belief. In colonial situations, it has been observed as a rampant pattern.

Ethnocentrism has created many constructs leading to cultural chauvinism, such as the names Brahmavart and then Aryavart in ancient India, deprecating the existence of other non-Aryan cultures in the land. Derogatory words such as kafir (nonbeliever) and savage, among others, or addressing any nation or culture by expressions such as "one nation under God," "God's own country," "divine nation," "God's promised land," and "God's chosen people" are typical.

British expansionism in the 17th, 18th, and 19th centuries, expressions such as "white man's burden," the mandate of heaven in China, the concept of Arya and Anarya cultures in ancient Indian history, the concept of Nazi versus others in Nazi Germany, opposition of believers and nonbelievers in the Islamic and non-Islamic world, unwanted cultural colonization in the later decades of the 20th century and in the 21st century, and many more examples coincide with the cult of ethnocentrism.

Examples of ethnocentrism are spread in subcultures, pop cultures, and literature. Television serials and movies in all cultures have shown instances of ethnocentrism. Other examples include William Shakespeare's *The Merchant of Venice*, George Bernard Shaw's *Pygmalion*, Zora Neale Hurston's *Their Eyes Were Watching God*, and George Ryga's *The Ecstasy of Rita Joe*.

Ethnocentrism is a big barrier in intercultural communication and stands as a major factor for the clashes of different cultures, religions, castes, and sects all over the world. It emanates racism and prejudice, pride and vanity, and weakens human bonds and the cult of universal brotherhood. To avoid ethnocentrism, one should avoid simplification and unnecessarily being judgmental, and one should be thorough and objective in idea formation and criticism.

Ethnorelativism

Ethnorelativism, in contrast, is a concept of embracing the values of other cultures. It is prouniversal brotherhood, with a trend of looking at other cultures with a sense of understanding. The trend of liberalization and globalization has made the world a global village in which the bonds of cultures are breaking, giving way to a world culture truly based on cosmopolitanism. The Internet and social media sites have largely contributed to the concept of ethnorelativism. Gone are the days when blind nationalism and cultural chauvinism were the words of pride and superiority. Nationalism is not enough today, and mutual cooperation and understanding have become the current buzzwords.

If ethnocentrism sees a threat in another culture, ethnorelativism sees amity in that culture. A shift from ethnocentrism and ethnorelativism means a diversion from hatred toward love. Whereas ethnocentrism is based on denial, ethnorelativism stands for acceptance. Milton Bennett has presented categorical development of the two concepts, and has sketched the journey from ethnocentrism to ethnorelativism as a movement in six stages: denial, defense, minimization, acceptance, adaptation, and integration. From the first stage to the last, the behavior and attitude of the practitioners of the culture change toward other cultures. A person or culture that journeys from ethnocentrism to ethnorelativism moves from an uncultured vision to a multicultural rainbow of perception. For education and learning, trade and commerce, world peace and sustainable development, ethnorelativism is the need of the hour.

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See Also: Biculturalism; Cultural Determinism; Ethnicity, Definitions of; Honor Killings.

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European Americans

Because U.S. society increasingly sees itself as a "salad bowl" rather than a "melting pot," diversity and multicultural perspectives in human services provision need to extend to clients who are part of the European American majority, not just members of ethnic and racial minority groups. This shift poses several challenges. The European minority is expected to maintain political and economic power, dominance and influence, it is projected to retain a European American majority. In previous times, members of this group thought of themselves as simply Americans. While many European Americans think of themselves as race- and culture-free, social scientists understand European American identity as a socially constructed set of categories to be understood, addressed, and engaged in effective service delivery. Whereas some immigrants from Europe are nonwhite, the term *European American* today typically refers to persons who are racially white—a distinction not always made in the 19th and 20th centuries, when some European immigrant populations were not always considered "white." This is not a neutral issue of terminology; white, European American social identity is charged with subjective meaning and carries economic and social mobility advantages.

Some European Americans are immigrants from western and eastern European countries, each with distinctive cultures and cultural values; others are their children born in the United States; most are descendants of immigrants from generations past. Distinctions relevant to human services provision are drawn between those assimilated and acculturated to the U.S. majority culture, those in the process of acculturating, and those who retain a "hyphenated American" identity. These distinctions, not limited to a generational dimension, have implications for the language of service delivery and for whether services should be provided in culture- or community-specific programs. European Americans are diverse in socioeconomic status, religion, and many other dimensions. Increasingly, they prefer or insist that human service providers respect and address their chosen identity, cultural particularities, and needs. While this can at times assume racist and anti-immigrant overtones, it is important that human services providers recognize that this is not always or exclusively the case, but can reflect positive self-regard and cultural pride.

Intersectionality theory developed as a way to understand that identity is complex, layered, and conflictual, not unidimensional. Thus, the identities and human service needs of European Americans involve considerations of socioeconomic status, gender, sexual orientation, religious, and other categories. Intersectionality theory argues that human service provision program design and service delivery needs to take into account that European Americans fit into multiple, sometimes conflicting categories of identity; a diversity of client preferences, values, and needs have to be taken into account in program design and provider training. This acquires particular salience when serving European American language and religious minorities.

European Americans living in poverty may need service providers to have particular sensitivity to their shame at being a socioeconomic minority within a majority seen as privileged. European American men may feel that human service providers are insensitive to their values and needs, especially if they follow traditional role models and values. European American women receiving human services often need providers to appreciate that they may embrace diverse gender role experiences and values, may or may not have histories of domestic and sexual violence and rape or be open to speaking about them, and may or may not embrace feminism. In programs serving persons with hyphenated white ethnic identities, lesbian, gay, bisexual, or transsexual (LGBT) individuals may feel invisible and inhibited from articulating their needs. Persons with religious orientations may be reluctant to engage in human services, or guarded in their interactions with providers; conversely, religiously identified human services organizations may need to pay particular attention to making their services attuned to diverse groups of European American clients.

White privilege is defined as the unearned advantages that come from being white in a racially stratified society, and is embedded in institutional structures largely unnoticed among European Americans. Whites are carefully taught to ignore this privilege, but to believe that their lives are neutral, normative, and typical—that people of color are marginalized and oppressed through some inherent fault of their own. Public policies, laws, and unspoken practices reflect this oppression in human services systems and society. Racial socialization describes the process, often intergenerational, by which people learn about themselves and others. In a society that advantages whites, most often the belief is that this is the only legitimate worldview. Most European Americans do not self-identify as white. It is often difficult for European Americans to acknowledge whiteness and white privilege.

When European Americans first become aware of their white privilege, feelings of shame, guilt, anger, and considerable pain may surface. Such acknowledgement may come in human services systems, in which European Americans often encounter ways that they are similar to and simultaneously privileged over oppressed populations of color. Human services workers, on the front lines of such charged encounters, can help European American clients understand their emotional reactions to white privilege and understand how they contribute to and are hurt by oppressive practices. Understanding European Americans as a cultural group with both historical and cultural specificities and within-group diversity is an emerging perspective in the human services. By reviewing ways in which European Americans present both legitimate cultural needs and issues of privilege in human services settings, one hopes to offer program developers, administrators, and service providers some conceptual tools for making their work with this population more sensitive, attuned, and effective.

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See Also: Ethnic Diversity and Values; Ethnicity and Clients; Ethnicity, Definitions of; Ethnocentrism; Ethnocentrism and Ethnorelativism.

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Executive Orders

According to the National Organization for Human Services, human services workers need to "have preparation which helps them to understand human development, group dynamics, organizational structure, how communities are organized, how national policy is set, and how social systems interact in producing human problems." A key service performed by human services workers is integrating their clients into the community by helping them obtain a job. Human services workers serve a wide variety of clients, including the elderly,

President Barack Obama signs legislation in the Oval Office on December 22, 2010. Executive orders (EOs) are issued by the president and have the full force of law, even without the approval of Congress. EOs differ in that they cannot create new laws and can only interpret old ones. EOs generally affect only government workers and contractors.

homeless, immigrants, and veterans, as well as people with addictions, criminal records, disabilities, and mental illnesses. Many of these groups may be subject to different types of discrimination and stigma.

As such, it is important for human services workers to advocate for their clients, repudiate potential stereotypes, and remind employers of the legal statutes protecting their clients. To do this, human services workers must be familiar with past employment laws to help protect and advocate for their clients in the employment sphere.

Legislation passed by Congress is not the only way laws are enacted. Executive orders (EOs) are issued by the president and have the full force of law, despite not being approved by Congress. Presidents have the right to issue EOs due to an overarching grant of "executive power" in the Constitution and a clause charging them to "take care that the laws be faithfully executed." However, EOs differ from actual laws in that EOs cannot create new laws, but only interpret old ones. Generally, EOs are used to manage the federal government and affect only government workers and contractors.

In the past, EOs have been used by presidents to protect equality as well as perpetuate inequality. For example, Executive Order 10730, issued by President Dwight Eisenhower, sent troops to protect African American students trying to integrate into a public school in Arkansas. However, Executive Order 9066 issued, by President Franklin D. Roosevelt, allowed Japanese Americans to be put in internment camps during World War II. Although some have contested the president's right to make laws without congressional approval, executive orders continue to be an active part of the legislative process.

EOs started to be numbered under President Abraham Lincoln, and there have been well over 13,000 executive orders enacted. However, only recently have presidents begun to issue executive orders protecting the increasingly diverse populations found in the United States. One of the first executive orders protecting the rights of citizens was Executive Order 8802, issued in 1941 by President Roosevelt, which prohibited discrimination by defense contractors based on race, creed (also known as religion), color, or national origin.

The EO also established the Fair Employment Practices Committee, which did not last long and was terminated in 1945. President Harry S Truman expanded upon this in 1948 when he announced Executive Order 9981, which required equal treatment, regardless of race, color, religion, or national origin, in the armed services. He established a committee called the President's Committee on Equality of Treatment and Opportunity in the Armed Forces, which was abolished two years later in 1950.

President John F. Kennedy was the first to make significant headway when, in 1961, he enacted Executive Order 10925, establishing the President's Committee on Equal Employment Opportunity and requiring all government contractors to take affirmative action in the recruitment, employment, promotion, and training of employees regardless of their race, creed, color, or national origin. This was an especially important EO because it was the first that mandated affirmative action. In 1964, Title VII of the Civil Rights Act (CRA) transformed the President's Committee on Equal Employment and Opportunity into the Equal Employment Opportunity Commission (EEOC). In 1965, President Lyndon B. Johnson extended affirmative action by issuing Executive Order 11246, which added gender to the categories of nondiscrimination and substituted religion for creed. He also furthered Title VII of the CRA by requiring that all government contractors have to take affirmative action, whereas in the original Title VII, affirmative action was required only after an employer had been found guilty of discrimination.

Other executive orders focused on expanding protection to different groups. Executive Order 11141 by President Johnson in 1964 prohibited discrimination on the basis of age unless it was based on a bona fide occupational qualification, retirement plan, or statutory requirement. In 1969, President Richard Nixon issued Executive Order 11478, superseding Executive Order 11246, by requiring equal employment opportunities in the federal government, prohibiting discrimination based on race, color, religion, sex, national origin, handicap, or age, and extending affirmative action programs.

Recently, attempts have been made to add sexual orientation to the list of protected groups in employment. Executive Order 13160 in 2000 was signed by President Bill Clinton to provide limited protection to people in federally conducted education and training programs. It prohibited discrimination based on race, sex, color, national origin, disability, religion, age, sexual orientation, and parental status. Also signed by President Clinton in 2000, Executive Order 13166 successfully protected people with limited English proficiency (LEP) by requiring federal agencies to provide meaningful access to services and programs for people with LEP.

While the issuance of an EO against discrimination is a good first step, violations of EOs have found limited success in litigation. Courts generally dismiss cases based on EOs because EOs do not state that individuals have a right to pursue personal litigation against companies who fail to comply with the EO. The only penalties described in EOs for failure to comply with its statutes are that the Secretary of Labor has the right to publish the names of the contractors, to recommend to the Department of Justice or EEOC to hold legal proceedings, and to terminate or suspend any current and/or future contracts.

Therefore, in *Cohen v. Illinois Institute of Technology* (1975), when a professor attempted to sue for sex discrimination based on Executive Order 11246, she was denied. The court ruled that there was no right to pursue personal legal action in the EO. Thus, EOs are similar to the guidelines published by the EEOC in that they cannot be used as the only ground for a legal action.

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See Also: Employment/Career Assistance Services; Equal Opportunity and Civil Rights; Equal Pay Act of 1963; Hispanic Immigrants; Legal Services; Meaningful Access; Office for Civil Rights.

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Face Blindness (Prosopagnosia)

Prosopagnosia (PA) is a neurological condition of being blind to or having impaired perceptual deficit for recognizing faces (human or animal). Prevalence rates in the population have been reported as high as 2.5 percent. Possible reasons that PA was not identified earlier as a major deficit disorder might be that it comes in degrees of severity and persons living with PA tend to use other sensory cues to compensate, so it is unnoticed, even in some adults. This neurological deficit is not due to a lack of attention, eye anatomical deficits, a learning disability, or memory disturbance. It most probably has existed in humans for thousands of years.

Description

To be blind to recognizing someone an individual knows well (including a spouse, children, or friends) by their facial features alone means one does not identify them by looking at them. Moreover, when looking in a mirror, people with PA do not recognize their own faces in the reflection. The act of facial recognition requires the scanning and encoding of many different aspects and proportions of facial structures into a unified composite of chin and cheek curvatures, slope of the forehead, angularity or broadness of the nose, mouth shape, teeth, eyes, size of eye orbits, eyebrows, thickness of the lips, and ears. Most people take for granted the ease by which their brains holistically synthesize visual sensory stimuli to provide them with a near instant facial recognition of hundreds or thousands of relatives, friends, colleagues, and celebrities. Among the more perplexing aspects of people's brains is that they underlie the production of perceptual events without realizing how they accomplish it.

A description of PA was popularized in 1947 by German neurologist Joachim Bodamer. He published case studies of World War II soldiers, including that of a young man who survived brain damage due to a bullet wound and lost the ability to recognize his own facial reflection and the faces of others. Bodamer coined the term *prosopagnosia* from the Greek *prosopon* for face and *agnosia* for the absence of knowledge about objects, shapes, colors, and so on. PA is characterized as only sensation without perception and observation without realization. People with PA can name specific facial features, even point them out, and yet, cannot synthesize the whole from different facial features to generate a recognition of someone they know.

Persons exhibiting PA are always struggling to find connection and create recognition that a non-afflicted person seems to create effortlessly. People with severe PA find it nearly impossible to distinguish a male face from a female face, process emotions from facial expressions, or to estimate age from facial features alone. Furthermore, television and movie plots could be rendered meaningless, as they require the ability to track the identity of the characters in order to make sense of what happens to them from scene to scene. Without facial recognition, following character development is haphazard at best.

Types of PA

There are two types of PA, developmental and acquired (with two acquired subcategories, associative and apperceptive). Developmental (congenital) PA is described as a lifelong condition wherein facial recognition has never occurred. This type of PA is not attributed to a known incident of brain damage; it has been present since childhood. Some evidence exists that a genetic defect may underlie this type of PA. A heritable hypothesis of PA has been forwarded to explain situations when PA occurs in more than one family member. The prevalence of finding multiple family members displaying PA is consistent with autosomal dominant inheritance.

Acquired PA is correlated with right hemispheric brain damage to the fusiform gyrus, a brain area that is associated with facial feature recognition and memory; however, bilateral damage could be observed as well. The causes of acquired PA include tumor growth (astrocytoma, glioblastoma, or oligodendroglioma), stroke (infarctions), head trauma/injury (resulting in lesions), and forms of neurodegenerative disorders. Brain lesions in the medial occipitotemporal area most often result in PA abnormalities or impairments. Recently, mapping neural networks of the right hemisphere ventromedial (deep-middle) occipital to the temporal cortices are believed to be involved in facial recognition abilities.

Associative PA is characterized as the inability to match a face with an identity, yet some people with PA retain a limited ability to process facial features piecemeal. A major difference between associative and apperceptive PA involves a degree of severity, with associative PA being more frequently observed. Anterior temporal damage can also be seen as well. Apperceptive PA is a more complete form of facial recognition blindness and is reflective of more extensive fusiform damage.

Similarities exist between PA and Capgras syndrome (CS), as well as differences. People with CS believe the delusion upon face-to-face meeting with their real parents or friends that they have been replaced with impostors. The key feature of the Capgras-afflicted is they are unable to believe recognizable persons are authentic, yet a person diagnosed with CS retains the ability to recognize the voice of a parent or friend as authentic. How this can occur remains unexplained. Given some seemly similar identification deficits characteristic of Alzheimer's disease, autism, and nonverbal learning disorders, it is of great importance to find and employ a diagnostic tool specific for PA. A recently developed test for PA, the Cambridge Face Memory Test, has shown promising results. The Prosopagnosia Research Centers provide online testing (www.faceblind.org).

Treatment

Effective treatment for persons with PA involves teaching them strategies to focus on other sensory features and cues to generate recognition. One approach is to help them develop compensatory skills to assist in correct person recognition. Thus, learning to notice nonfacial features (e.g., clothing type and color, hair color and shapes, facial hair shape and distribution, teeth, body/head shape, scars, and gait) provide useful cues to spark recognition. For example, in one case, a patient with PA lost the ability to recognize another person when that person removed eyeglasses.

What is lacking or impaired in PA is the holistic processing of facial features as one facial gestalt as opposed to separate unconnected features. How all-in-one recognition of faces occurs remains to be explicated beyond the descriptive stage. PA manifests in different types and qualitative degrees of impairment, and is thus not believed to be one unified disorder.

Minimally, PA affects personal identity and social interactions, such as schooling difficulties, being considered shy, the inability to read facial emotional signals, or difficulty in making friends, and can easily lead to clinical depression. Thus, providing an improved quality of life for PA-afflicted individuals is critical. Doing so requires finding a way to fix defective brain processes that are rendered unable to synthesize specific facial features and leave faces looking equally unrecognizable. The big challenge for PA remains development of effective treatments in addition to teaching coping strategies. The creation of novel interventions (perhaps combinations of stem cell therapy, gene therapy, or even brain connection restructuring) to establish or recover brain processes underlying the wholeness of feature synthesis for facial recognition is required.

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See Also: Americans with Disabilities Act; Disability Services; Learning Disabilities, Services for Individuals With; Sociology of Disability.

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Factline: Tracking Health in Underserved Communities

Toward the goal of raising public awareness and facilitating distribution of information on health disparities, Factline: Tracking Health in Underserved Communities was a Web-based project focusing on health disparities. Paralleling the structure of Healthy People 2010, as designed by the U.S. Department of Health and Human Services, Factline sought to make information and recources on public health and health disparities widely available to a range of target audiences.

Factline: Tracking Health in Underserved Communities was a project of the Institute on Health Care for the Poor and Underserved, associated with the *Journal of Health Care for the Poor and Underserved* housed at Meharry Medical College in Nashville, Tennessee. The National Library of Medicine supported the Factline project with three years of funding from 2004 to 2007.

The Factline Web site housed information, including statistics, graphics, and research reports, on disparities in health in several underserved groups. These populations include people of color, the elderly, and women. Web site information was accessible in both English and Spanish.

The project objectives included supporting Healthy People 2010 goals by making information easily available. In particular, Factline sought to translate and condense research findings, making this work available to, understandable for, and usable by several diverse audiences. Target audiences included activists, policy makers, educators, students, practitioners, journalists, and researchers.

Information on the Factline Web site was organized into five main areas: Access to Health, Mental Health, Minority Health, Sexually Transmitted Diseases, and Women's Health. Within each focal area were several resources and subtopics with additional depth.

A highly useful function of the Factline Web site was its facilitation of further research. The site was constructed to support research in the medical literature or on media coverage of particular topics. Factline entries also contained references for the individual works featured on the site.

Due to the conclusion of the funding cycle and the staff time necessary to continue the Web-based project, Factline was discontinued. Earlier information and resources are no longer available via Web searches.

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See Also: Agency for Healthcare Research and Quality; Behavioral Health Disparities for Racial and Ethnic Minority Populations; Community Health, Racial and Ethnic Approaches to; Health Care, Disparities in; Health Disparities, Role of; National Center on Minority Health and Health Disparities; National Health Care Disparities Reports; Public Health.

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Fair Labor Standards Act

A major piece of President Franklin D. Roosevelt's protective legislation for workers and the last measure of the New Deal, the Fair Labor Standards Act (FLSA) of 1938, was a federal statute that

- Mandated a maximum workweek and a minimum hourly wage
- Provided for adequate compensation for overtime
- Severely restricted child labor on a national scale.

The FLSA aimed at social justice by preventing workers' exploitation and restrained employers' strategy to compete on the market by reducing salaries. Moreover, it set the general principle that the government could rely on the commerce clause of the U.S. Constitution to regulate labor matters in industries involved in interstate commerce.

Repeatedly amended since the postwar decades, the Fair Labor Standards Act has not only increased the minimum wage several times to help adjust salaries to the inflation rate, it also has expanded its coverage to previously exempted workers and broadened its scope to protect female employees by prohibiting gender pay disparity. Overall, the FLSA has improved the well-being of laborers by sustaining wage rates and has shielded children from dangerous occupations. However, it has revealed little concern for issues of diversity, especially regarding workers with disabilities.

The Precedents

The FLSA supported the right to a living wage as the cornerstone of citizenship in a workers' republic. As such, it was part of Roosevelt's general commitment to uproot the social evil of poverty in the United States and, in particular, to come to the relief of the destitute during the hard times of the 1930s.

The 1916 Keating-Owen Act had already intended to strictly limit child labor. Likewise, the 1933 National Industrial Recovery Act had stipulated that requirements regarding minimum wages and maximum hours should be included in the fair competition code agreements that businesses had been encouraged to create. Yet the Supreme Court invalidated both measures in 1918 and 1935, respectively.

The latter decision also struck a heavy blow against Roosevelt's plans for economic recovery. Actually, the president's humanitarian vision of labor protection intertwined with the means to overcome the Great Depression. On the one hand, preventing the exploitation of wage earners by curbing their workweek would force entrepreneurs to hire more personnel and help relieve the unemployment rate. On the other hand, the increase of workers' purchasing power would ease their access to consumerism, and thereby contribute to reducing overproduction.

A Troubled Legislative Process and its Consequences

In 1937, the Fair Labor Standards Bill reintroduced the provisions that had previously fallen under the ax of the Supreme Court. Specifically, it outlined definite standards to prevent a new ruling of unconstitutionality on the ground of improper delegation of legislative authority to the federal government.

The proposed piece of legislation met with strong opposition, however. Most southern Democratic congressmen, even though they belonged to Roosevelt's political party, feared that the establishment of national standards for wages would further cripple the economy of their region because the competitiveness of industries below the Mason-Dixon

Line relied on the payment of lower salaries than those of businesses in other sections of the country. Unions were unenthusiastic as well. Worried about the defense of their own prerogatives, their leaders thought that the bill would undermine their own authority among workers because government stipulations would replace collective bargaining by labor representatives in securing better wages and hours for the work force. Consequently, Congress tabled the bill. It was only after the unexpected victory of one of its most vocal advocates, Senator Claude Pepper (D-FL), against a conservative opponent in a hotly fought 1938 primary election that the bill was eventually brought out to the floor. However, it also needed Roosevelt's masterful legislative maneuverings to pass.

The Fair Labor Standards Act established a 44-hour workweek, with a further reduction to 40 hours within two years, and a 25-cent minimum wage per hour, to be increased to 40 cents in the same period. It also required that overtime be paid at one and a half times the standard rate. In addition, the FLSA outlawed the labor of children under the age of 16 years, as opposed to age 14 in the 1916 legislation, and raised the minimum age to 18 for hazardous occupations.

The quid pro quo to secure the votes to pass the bill was a number of concessions to appease single congressmen seeking immunity for the main businesses of their respective districts. Consequently, the FSLA was eventually unable to result in a significant reduction of regional differentials in wages. Furthermore, it failed to offer coverage for those categories most in need of protection, such as agricultural and domestic workers, among whom ethnic and racial minorities were overrepresented. In addition, the FLSA had overall a significant exemption rate for female employees, reflecting the paternalistic approach of the New Deal to labor and welfare legislation, with its focus on protecting male breadwinners and marginalizing women in the job market in order to persuade the latter to stay home and raise children. Indeed, upon its initial enforcement, the new legislation covered 39 percent of male and as little as 14 percent of female workers nationwide.

Section 14(c) allowed discrimination against people with disabilities, who could be paid less than the minimum wage, on the alleged ground that they were underproductive workers. This measure was conceived in part to offer enterprises financial incentives to hire disabled individuals and to offer them the basic training to enter the work force. It also encouraged the employment of laborers with disabilities in segregated workplaces, called sheltered workshops, where they performed mainly menial tasks.

Postwar Developments

World War II delayed the full enforcement of the Fair Labor Standards Act. For example, the 40-cent rate became effective as late as October 1945. The postwar decades, however, witnessed a progressive growth of the hourly minimum wage, which rose from 75 cents in 1949 to $7.25 in 2007. Coverage was also extended to new groups, most notably farm workers in 1966 and seasonal and migrant agricultural laborers in 1983, classes with a remarkable concentration of Hispanic immigrants.

Other statutes included provisions that banned a few discriminatory practices that the original Fair Labor Standards Act had not addressed. In 1963, following a significant increase in the number of breadwinning women, the Equal Pay Act forbade lower wages for female workers performing the same tasks as their male colleagues. In 1967, the Age Discrimination in Employment Act outlawed unequal compensation on the basis of age, including the denial of health benefits, that had theretofore usually affected new employees of at least 40 years of age. It applied, however, only to enterprises with more than 20 workers, and it permitted wage differentials on the ground of seniority in any businesses.

Attempts at curbing additional forms of discrimination were to no avail. For instance, amendments to also place workers with disabilities under the protection of the Fair Labor Standards Act—most recently introduced in 2011 and 2013—had not been passed.

The Fair Labor Standards Act eventually concerned itself with health services as well. It required employers to inform employees of coverage options available through an Health Insurance Marketplace in compliance with the 2010 Affordable Care Act.

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See Also: Americans with Disabilities Act; Americans with Disabilities Act of 1990; Diversity in the Workplace; Equal Pay Act of 1963; Poverty.

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Fair Lending Practices

A loan is a debt owed by a borrower to a lender. In the case of a monetary loan, the borrower (customer), who can be an individual person (consumer) or a business, borrows an amount of money from the lender (creditor). The borrower agrees to pay the lender back at least the same amount of money at a later time, which generates an obligation to repay. This repayment is usually done in partial payments. Loans are to be distinguished from acts of charity, and also from a joint investment, in which the investor shares in the risk. In the case of a loan, the lender expects the same amount of money to be repaid regardless of the borrower’s own profit or loss.

The amount of money borrowed in a monetary loan is called the principal. In the case of most monetary loans, the borrower must pay an extra amount of money, called the interest, in addition to paying back the principal. The interest is the cost of the loan to the borrower. In a legal monetary loan, a note specifies the principal, the rate of interest on the principal, and the date of repayment. By agreeing to the loan, the borrower is obligated to repay the lender the principal plus the interest by the date of repayment—that is, when the loan matures. A legal monetary loan is a contract enforced by law.

History of Usury

Historically, charging interest on loans has been controversial. Although the practice was legal among the Mesopotamians, the Hittites, the Phoenicians, and the Egyptians, the Torah prohibited the Israelites from lending at interest to other Israelites—they could lend only to non-Israelites (Deuteronomy 23:19: “Thou shalt not lend upon interest to thy brother”). The Qur’an prohibits lending at interest as well, and as a result specialized codes of banking have been developed for those obeying Qur’anic law.

Saint Anselm of Canterbury (1033–1109) argued that charging interest on loans was not merely a lack of charity but was the same as theft. Saint Thomas Aquinas (1225–74) argued, following Aristotle, that charging the borrower interest was charging the borrower twice: for the money and for the use of the money. Hence, charging interest was deemed unjust. The original meaning of the word *usury* (from the Latin *usura*, meaning interest) was to charge any fee whatsoever for the use of money. Usury consisted of either charging interest on loans or charging a fee for changing money (as is done in a currency exchange)—according to William Blackstone, (1765–69), “When money is lent on a contract to receive not only the principal sum again, but also an increase by way of compensation for the use, the increase is called interest by those who think it lawful, and usury by those who do not.” Pope Clement V (1264–1314) abolished all laws that permitted usury and made the belief in the right to usury a heresy in 1311. It therefore was a sin to charge interest on a monetary loan. Pope Sixtus V (1521–90) condemned usury as “detestable to God and man, damned by the sacred canons and contrary to Christian charity.” The prohibition against usury in Christianity led the Jews to become moneylenders to Christians.

However, in the 16th century, with the passing in 1545 of An Act Against Usurie by King Henry VIII (1491–1547), interest rates on shorter-term loans dropped from around 20 to 30 percent to around 9 to 10 percent, and the practice of charging moderate interest on loans became acceptable. Then usury came to mean the practice of lending money at unreasonably high or excessive rates of interest. As a result, unreasonably high or excessive rates of interest are now described as usurious.

Types of Loans

The interest rate charged on a monetary loan depends on the type of loan. A secured loan (e.g., mortgage loan or automobile loan) is one in which the borrower pledges an asset as collateral in case of defaulting on the loan. An unsecured loan is one not secured with the borrower's asset(s). Unsecured loans include personal loans, lines of credit, bank overdrafts, payday loans, and credit cards.

Interest rates on unsecured loans are nearly always higher than on secured loans because the options for recourse by the lender against the borrower in the event of default are more limited. Since the lender in the case of an unsecured loan has an additional risk that the loan may be uncollectable in the event of the borrower's insolvency, the lender will charge a higher interest rate. This is not considered predatory by lenders.

Prime lending is lending in which the prospective borrower has a good credit history, has demonstrated the ability to properly manage credit, and has sufficient documentation of requisite financial resources. According to James Carr and Lopa Kolluri, subprime lending is lending in which the prospective borrower has a poor credit history, has demonstrated an inability or unwillingness to properly manage credit, has insufficient documentation of requisite financial resources, and often has other application shortcomings as well. Subprime loans carry higher interest rates than prime loans, in part due to the higher risk to the lender.

According to Kenneth Temkin, however, subprime loan rates are also higher because the underwriting guidelines for such loans are not standardized across the industry. Temkin states that subprime loans are "three times more likely in low-income neighborhoods than in high-income neighborhoods, and five times more likely in black neighborhoods than in white neighborhoods. In predominantly black communities, high-cost subprime lending accounted for 51 percent of home loans in 1998, compared with only 9 percent in predominantly white areas," despite the fact that "lower-income status is not synonymous with higher credit risk." Also, according to Temkin, the "level of subprime lending to black households and communities far exceeds the measured level of credit problems experienced by such households." Based on a Freddie Mac study from 1999, however, "black households have roughly twice the credit problems" of white househholds, but "blacks rely on subprime refinance roughly four times as much for their mortgage credit."

Predatory Lending

Predatory lending is a subset of subprime lending that, Carr and Kolluri explain, generally has at least one of the following three further characteristics: (1) "unreasonable and unjustifiable loan terms"; (2) "outright and fraudulent behavior that maximizes the destructive financial impact on consumers of inappropriate marketing strategies and loan provisions"; and (3) "targeted marketings to households on the basis of their race, ethnicity, age or gender or other personal characteristic unrelated to creditworthiness."

Most predatory lending has all three characteristics. First, its abusive lending may involve both the loan itself and the terms of the loan. The loan may be unnecessarily large and in excess of the market value of the home, making it difficult to pay off; it may be structured to extract the greatest possible return for the lender; and it may be designed to preclude the borrower's ability to pay it off, such as with negatively amortizing loans, in which the monthly payment is less than the interest, and the deferred interest is added to the principal, so that the principal increases each month. The loan terms may include excessive closing or appraisal charges, high origination and administrative fees, and exorbitant penalties for prepayment of loans (true of 80 percent of subprime mortgages). Also, the terms may be such that the borrowers are locked into the loan and cannot refinance to take advantage of lower interest rates. The loan may also include single-premium credit life insurance, and have a large so-called balloon payment due when the loan matures, effectively making refinancing unavoidable.

Second, fraudulent behavior by predatory lenders may include refusing to provide modest home equity loans; giving expensive loans to borrowers who could qualify for regular loans; pressuring people to fully refinance their homes; consolidating consumer debts into home equity loans that have a higher rate of interest than the consumer debt; not presenting the interest rate of the loan and other charges on the loan as negotiable; failing to clearly and accurately disclose terms and risks, including hidden fees in the amount borrowed; providing obscure information; using high-pressure tactics to force prospective borrowers to continue through the loan application process; omitting explanations of credit life insurance or balloon payments; discouraging borrowers from exploring lower-cost options; disguising a high annual percentage rate in a lower short-term rate; structuring loans with payments the borrower cannot afford; adding cosigners whom they believe have no intention to contribute to payments; refinancing loans for a lower interest rate when the rate is not lower and/or there are higher processing fees (flipping); refinancing loans with the result that beneficial loan terms are lost; forging loan documents; altering loan documents after they have been signed; and using abusive and high-pressure collection practices such as harassing phone calls and threats.

Finally, predatory lenders typically, although not exclusively, target the poor, the less educated, the financially unsophisticated, racial minorities, women, and the elderly. They especially target households that have limited incomes but significant equity in their homes. These households are often in neighborhoods in which better loans are not readily available. As has been reported by Carr and Kolluri, “a community flush with ‘fringe lenders’—check cashing outlets, pawnshops, rent-to-own stores, title lenders, and similar operations—as well as excessive subprime lending, is the environment in which predatory lending activities often flourish.” People can be lured into taking out such loans by aggressive mailing, phone calls, TV ads, and door-to-door salespersons. They are often told that the loan is a quick way to pay down a credit card, to take a vacation, to pay off expenses, or to have lower monthly mortgage payments. In addition to home loans, predatory lending includes cash advances or payday loans (a short-term loan until the borrower’s next payday), tax refund application

A study found that minorities were much more likely to be charged higher interest rates than whites with similar credit ratings. Such mortgage discrimination played a role in the real estate bubble that burst in 2008, where it was found that minorities had been disproportionately steered into subprime loans and represented a disproportional percentage of foreclosures.

loans (a fee for an advance on an anticipated tax refund), credit card late fees, and checking account overdraft fees, where the fee paid is equivalent to an unreasonably or excessively high interest rate .

Note that if the predatory loan is a secured loan, upon default the lender can obtain the collateral (e.g., property or automobile) and make a profit on the sale of the asset.

Mortgage Discrimination

One form of predatory lending is mortgage discrimination on the basis of race or ethnicity. Earlier in the 20th century, African Americans and other minorities were systematically denied loans, which contributed to urban decay in many cities. The Home Mortgage Disclosure Act of 1975 required banks to disclose their lending practices in the communities they served, and this improved conditions for minorities. However, contemporary mortgage discrimination takes the form of targeting minorities and charging them more than would be charged to a similarly situated majority borrower. According to Michael Powell, a former Wells Fargo loan officer, for the 10 years prior to 2009, "employees had referred to blacks as 'mud people' and to subprime lending as 'ghetto loans.'" The National Association for the Advancement of Colored People (NAACP) has filed class-action lawsuits in a number of cities (e.g., Los Angeles and Salt Lake City) against many lenders such as Wells Fargo, HSBC Bank, JPMorgan Chase, and Washington Mutual, alleging that they systematically offer substandard terms on loans to African American and Hispanic applicants with similar credit, income, and qualifications to white applicants.

A 2007 study by the Furman Center for Real Estate and Urban Policy at New York University held that home buyers in predominantly African American and Hispanic neighborhoods in New York are more likely to get mortgages from subprime lenders than can home buyers in white neighborhoods with similar income levels. Another national study by the Center for Responsible Learning found that African Americans and Hispanics were 30 percent more likely to be charged higher interest rates than whites with similar credit ratings. A report by the Neighborhood Economic Development Advocacy Project and other groups cited by Manny Fernandez found that compared to whites in New York, African Americans were five times more likely and Hispanics were four times more likely to pay higher interest rates on loans. Such mortgage discrimination played a role in the real estate bubble that burst in 2008, where it was found that minorities had been disproportionately steered into subprime loans and represented a disproportional percentage of foreclosures, according to Barbara Ehrenreich and Derek Muhammad.

A further related practice is mortgage discrimination on the basis of sex or gender. As Anita Hill argues, "Across the economic spectrum, women receive less favorable terms than similarly situated men on home purchase, refinance, and home improvement loans," with the result that women are less able to reach economic self-sufficiency. Further, she states, "there is evidence that subprime lenders charge black women and Latinas higher rates and fees than same-race men and white men, again, regardless of income and across all loan types," compounding race and gender discrimination.

It is also the case that elderly women are prime targets of refinance and home improvement subprime lenders, meaning that they are in greater jeopardy of becoming dependent on their families or social services. Indeed, single-parent women, who have difficulty obtaining loans, are often told that "the conventional loans are unavailable to them and that subprime loans are their only recourse," and the cost of an escalating subprime loan payment has seen an increase in homelessness among such women. Hill points out, "A former loan officer testified about how she marketed subprime mortgages: 'If someone appeared uneducated, inarticulate, was a minority, or was particularly old or young, I would try to include all the [additional costs] CitiFinancial offered.'" Mortgage brokers may also check property deeds and other public records and identify homeowners who have substantial equity in their properties and encourage them to refinance with a predatory lender, who then provides the broker with a referral fee. "Elderly, black, widowed women are frequent targets," according to Carr and Kolluri.

States' Laws

Historically, in the United States, usury laws have been states laws that specify the maximum interest rate that can be charged on loans. After 1776, all states in the Union adopted usury laws, and most states capped the interest rate at 6 percent. Loans with unlawfully high interest rates were unenforceable in court. However, in the early 1900s, a number of states eliminated their usury laws, and other states raised their interest limit to 10 or 12 percent. Between 1945 and 1979 all states adopted special loan laws that capped the interest rate at 36 percent. However, in *Marquette National Bank of Minneapolis v. First of Omaha Service Corp.* (1978), the U.S. Supreme Court established that lenders are allowed to charge the legal rate of interest in their home state regardless of the borrower's state of residence.

Some states eliminated their interest rate caps, with the result that several credit institutions relocated to states without interest rate caps, effectively allowing them to operate nationally with no interest rate caps. Furthermore, in 1980, the Depository and Institutions Deregulation and Monetary Control Act exempted certain federally chartered lending institutions from state usury interest caps. In 1994, the Home Ownership and Equity Protection Act identified certain potentially predatory mortgage loans and provided some substantive protections to home mortgage borrowers with interest rates that were extraordinarily high, but set no caps on what interest rates could be charged for these loans.

The 1968 Truth in Lending Act requires disclosures of the annual percentage rate (APR) of charge, either nominal APR (simple interest rate for a whole year), or effective APR (fee plus compound interest rate for a whole year) and terms of the loan, but does not regulate interest rates. The Racketeer Influenced and Corrupt Organizations Act in 1970 made it a federal felony to lend money at an interest rate more than twice the state usury interest rate and to try to collect this unlawful debt. It is also a federal offense to use violence or threats to collect such unlawful debt. These federal criminal laws are aimed at coercive loan sharks.

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See Also: Discrimination and Institutional Racism; Financial Literacy Programs; Microlending Programs.

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Families, Nontraditional

Families have traditionally been defined in terms of a mother and father who are married and have biological children of this union. However, the definition of family has evolved over the last few decades with the changes in American culture and with the migration of various cultures to the United States. Nontraditional families are those families that do not fit the traditional definition of family described above. Susan Stewart notes that nontraditional families do not include two married parents and their biological children. Nontraditional families include adoptive, foster, cohabitating, single parent, grandparent head of household, blended, divorced, and same-sex parents.

In the field of human services, practitioners encounter and service all types of family from traditional to nontraditional. Human services practitioners may take on the role of advocate, case manager, monitor, social service worker, job developer, and aide in their work with nontraditional families. Human services practitioners can be found servicing nontraditional families in a number of environments, including educational settings, nonprofit agencies, and local and federal government agencies. In fact, human services practitioners may develop home studies for adoptive and foster families to predict the outcome of children being placed in these homes. They may work with single parents to remove barriers to social issues that impede family function as well as evaluate or refer these populations for services. They may also offer support services to blended, divorced, and same-sex–parent families. Understanding the characteristics of nontraditional families is important to practice in the field of human services.

Adoptive Families

Many states have a number of children in care who will never return to a biological family member. There is an increased need for adoptive families in the United States, even though infertility issues within families have led to an increased use of adoption to create familial environments for children and meet the needs of these families to parent. Scenarios range from mothers who have given their children up for adoption to provide a better lifestyle for them to mothers whose rights have been terminated, forcing their children into adoption. In all instances, adoption involves the loss and gain of a family. Marta Reinoso, Femmie Juffer, and Wendy Tieman note that adoption implies the building of a family as well as the loss of a birth family.

Children can enter into adoptive homes as early as birth and as late as 18 years of age. Adoptive families can be headed by single parents, same-sex parents, and family members. In fact, when parental rights are terminated, immediate family members are often targeted to adopt. Stepfamilies often turn to adoption so that the children within the family can legally establish a relationship with the stepparent in the family. By adopting their stepchildren, stepparents give their stepchildren the same legal rights within the family unit as the biological children of the marital relationship that binds them. The changes in marital laws that govern the marriage of same-sex couples have increased the prevalence of same-sex family adoptions. International adoption has become more prevalent in today's society as well. Many couples, including celebrities, have traveled to other countries and adopted children who are at risk or in orphanages in those countries. The adoption process is more complex in these situations; however, international adoptions are more visible today than they have been in previous years.

Human services practitioners work with the adoptive population in a variety of ways. They may develop home studies of the families seeking to adopt. As a part of these studies, human services practitioners make suggestions to the court and agencies on whether adoption should be granted to the family. They may provide ongoing monitoring or support to new families as well as parenting training to support positive family functioning to adoptive families. In cases where families decide to rescind their adoption and give the children back to the agency or state, human services practitioners work with the state, family, and children to remediate the issues and provide services to the children. In international adoptions, human services practitioners may work as liaisons between orphanages and private adoption agencies. They can also work for the orphanage in caring for the children within that facility. Advocacy for children is a key role within adoptions, and human services practitioners work with other professionals in order to properly advocate for the children involved.

Foster Families

Families in today's society face many challenges. Many of these challenges result in children being removed from their biological family environments. These removals are thought to be temporary, and the children are placed in temporary familial environments until they can be reunited with their biological family members. Foster families include those families who contract with the state or a private nonprofit agency governed by the state to provide parenting to children in the state's custody as well as biological relatives (also referred to as kinship foster care). Foster families have been defined in terms of children being in out-of-home placements.

The number of children in state custody within the United States is increasing. The characteristics of these families differ from other nontraditional and traditional families because they involve complex relationships among the state-funded foster agency, biological parents, the legal system, and social workers. Foster parents are responsible for the typical day-to-day care and activities of the children as well as for meeting court requirements. Foster families are licensed by the state in which they wish to provide services, and they must attend training to prepare them for fostering children in state custody. Many foster families become adoptive families when biological parents permanently lose their legal parental right to raise their children.

Human services practitioners work with foster families in a number of capacities. Human services practitioners may work for the state or a nonprofit foster care agency that places children in foster homes. Human services practitioners may also license foster homes and train people to be successful in their roles as foster parents. Human services practitioners can also work as liaisons among biological parents, agencies, and foster families in arranging parental visits, making recommendations, and removing barriers to reunification of children with a biological parent.

Cohabiting Families

Cohabiting families may seem on the outside to be traditional families. These families include a mother, a father, and biological children. However, cohabiting families do not include a married mother and father. In the United States, the prevalence of cohabiting families is increasing as marriage within certain cultures declines. Cohabiting families function as traditional family units but have no desire or intention of becoming legally bonded through marriage.

Cohabiting families may have limited resources in regard to health care or the recognition of the union. Human services practitioners may encounter this population in a number of environments, including programs that service low-income families or children of these families such as Head Start. In these roles, human services practitioners may refer families for services to assist them in removing barriers or may work one-on-one with these families to increase healthy family functioning. Human services practitioners may find difficulty working within the confines of the cohabitating relationship in advocating or supporting the needs of the family.

Single-Parent Families

The past few decades have seen a rise in single-parent head-of-household families. Nevertheless, human services practitioners may encounter difficulty in working with this population due to the stigma of single parenting. Ken Lewis historically defined single-father families as including an unmarried male and his minor children living in the same household. This population includes widowers, divorced, separated, never-married, and single adoptive fathers. Single-mother heads of households are much more prevalent than single-father heads of households, with one in five children in the United States living in a single-mother household. William Doherty and Shondam Craft have found that in most cases mothers have custody of the children.

The number of single parents within the United States is growing; it can include those in military service and individuals who utilize surrogates due to the lack of physical presence of the other parent in child rearing. Military families take on many of the characteristics of single-parent families when the military spouse is away for extended periods of time, leaving child rearing to the nonmilitary spouse. Homosexual parents can fall into the single-parent status due to the use of surrogates as well as adoption. Human services practitioners service single parents in a number of environments, including working with families in accessing resources, finding employment, obtaining legal guidance for custody, and locating support networks. Human services practitioners may also work with the children of these families in helping them to cope with the physical absence of the other parent.

Grandparent Heads of Households

Grandparents are increasingly raising their grandchildren when biological parents no longer can. Molly Williams describes grandparent caregivers as those who have primary responsibility for their coresident grandchildren under the age of 18 years. The U.S. census has reported 5.8 million coresident grandparents; of these, 2.4 million are grandparent caregivers. Many of these families fall into the category of kinship foster care families as well. Grandparent heads of households encounter many barriers to parenting in addition to age and health concerns, such as fixed incomes (retirement and Social Security) or the inability to get children to various appointments due to a lack of transportation. Some grandparents return to work in order to provide for their grandchildren. However, these children seem to thrive in familiar family environments.

Human services practitioners often work with this population in providing resources to limit and/

Maryland First Lady Katie O'Malley's foster parent appreciation luncheon, May 19, 2012. Seated are the guests of honor—foster parents and the children they care for. Foster families involve children being in out-of-home placements, and families contract with the state or a private nonprofit agency governed by the state to provide parenting to children in the state's custody as well as biological relatives.

or remove barriers. Human services practitioners offer support and develop grandparent networks to enhance the development of children within these families. Transportation services are often provided to the grandparents by nonprofit agencies. Public transportation is often provided at no cost to these families. Nonprofit agencies that work with grandparents may provide transportation to agency-related appointments. Human services practitioners work to establish these relationships and advocate for the family.

Blended Families

Blended families are often seen in the image of the *Brady Bunch*, a popular television show of the late 1960s that was among the first shows to depict this type of family. Ottilia Brown and Juliet Robinson describe blended families as deriving from second marriages with children from previous marriages all living in the same household. These families can include children on both sides of the marriage, creating a stepfamily. The term *blended families* has also been used to include cohabiting unmarried couples with children who have come from previous relationships. The dynamics of blended families are complex, which creates difficulty among the relationships involved. Researchers have focused on defining these complexities and the characteristics of these families. Tension among family members is a common characteristic due to the reorganization of the family. Blended families are often confused with biracial families; however, the characteristics differ greatly in focus. Biracial families include couples with different ethnic and cultural backgrounds who have biological children. The greatest challenge of biracial families is functioning through the prejudices brought against them. In contrast, the challenges of blended families lie within the family unit, as children in blended families may have difficulty adjusting to the new family functioning.

Human service practitioners may work with the family in increasing homeostasis and family functioning, identifying problem areas, and referring families to support resources. Human services practitioners may work in providing parenting workshops and support groups.

Same-Sex Families

The population of same-sex families within the United States is growing. Laws have changed in many states to recognize the unions of gays and lesbians, allowing them to marry and obtain the same rights as heterosexual married couples. Societal changes have led to changes in the family structure among these populations. Damian McCann and Howard Delmonte note that same-sex families are created through lesbian and gay couples becoming parents through adoption, foster care, in vitro fertilization, and surrogacy. In fact, lesbian couples have used anonymous sperm donors to become pregnant as well. Some lesbian couples have used one spouse's egg and a sperm donor, and had the fertilized egg planted in the other spouse. Society may argue against same-sex couples having parental rights. Despite ridicule, prejudices, and barriers, however, homosexual couples are becoming parents at a growing rate.

Human services practitioners encounter this population in their journey to becoming parents through adoption and foster care. Human services practitioners work with these families in educational settings and in providing support services. In providing services to this population, human services practitioners have to be aware of the barriers this population faces in order to adequately provide support. Advocacy is a major part of the role between same-sex families and human services practitioners.

Divorced Families

Divorce has been on the rise for decades in the United States. The rate of divorce has created a structure of families that are complex in their ability to parent and cope with divorce. The dissolution of the family unit causes a notion of family in which emotion and tension are at the forefront. Children within these families have difficulty coping, articulating, and working within the new confines of the family. These children often have to adjust to two homes, two sets of rules, and two structures. Human services practitioners may encounter divorced family structures in support group, educational, and court-enforced environments. The latter causes the most tension within the families. Human services practitioners work in these environments in roles that offer support, referral services, and homeostasis to the family structure.

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See Also: Aid to Families with Dependent Children, Historical Role of; Family Services; Family Structure, Diversity of; Family Therapy; National Survey of Family Growth.

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Families of Prisoners and Ex-Prisoners

Research indicates that currently more families are impacted by incarceration than at any point in the history of the United States. More than 2 million men and women reportedly are incarcerated in state or federal prisons. Further, more than 5 million men and women are under the jurisdiction of some form of community corrections (i.e., probation or parole). Annually, more than 700,000 people are released from state and federal prisons, and more than 10 million will cycle in and out of city and county jails. Women (often mothers) have the dubious distinction of being the fastest-growing prison population in the United States. It is estimated that more than 2 million children have a parent incarcerated, and more than 5 million have a parent on probation or parole.

This entry highlights a few of the many human services needs of families impacted by incarceration. Families are defined to include children, blood and legal relatives, as well as partners that incarcerated and formerly incarcerated people have lived with or plan to live with once released. Human services examines the financial, social, and emotional needs of families impacted by incarceration.

Financial Needs

Most incarcerated individuals contributed financially to their families prior to incarceration. Thus, incarceration creates an immediate loss of income to the family. The financial loss is further exacerbated as the incarcerated individual looks to the family for assistance with legal fees and court fines or surcharges (if found guilty) as well as other needs not provided by prisons and jails, such as stamps to send letters and money for phone calls. The majority of individuals incarcerated in the United States hail from poor communities, where the loss of income can have a substantial impact on the quality of life of family members left behind. In many studies, grandparents are forced to raise children left behind by an incarcerated parent. This often has the ability to seriously compromise their financial flexibility and quality of life. Unfortunately, the financial situation does not get better after the individual is released.

The stigma of being formerly incarcerated often inhibits newly released prisoners from obtaining jobs. Numerous research studies have shown that formerly incarcerated people face discrimination in the job market at unprecedented levels, thus placing an even greater financial strain on the family to not only continue to take care of themselves, but to now care for the returning family member. In many cases, families have no choice but to turn to the welfare system in an attempt to make ends meet.

Social and Emotional Needs

The loss to more than 2 million children of mothers and fathers who are incarcerated creates serious social and emotional challenges. Incarcerated individuals are severely limited in their ability to provide emotional support for their families. Prisons tend to be in remote locations that often are inaccessible for family member visititation. Studies show that more than half of incarcerated men and women who report to be parents don't receive visits from their children. Families that are able to visit their loved ones while incarcerated report being frustrated by the security and prison requirements, some of which may require the removal of clothing as well as the examination of body cavities. Depending on the level of confinement (minimum, medium, or maximum custody), visiting families may not be able to physically engage with their loved ones, thus exacerbating the confusion and frustration created by the incarceration.

The inability to communicate regularly by telephone (calls are charged at higher-than-market rate and are highly restricted) further inhibits the incarcerated individuals' ability to provide social and emotional support for their family members, who often report feeling scared, lonely, and depressed throughout the incarceration of the loved one. Research in this field is limited, but the few studies that have been carried out show that children with incarcerated parents tend to suffer from various social and emotional inhibitors such as depression, trauma, anxiety, and shame. Their ability to form healthy relationships is severely compromised. These children tend to exhibit greater levels of hostility, engage in illicit drug use, have higher levels of truancy, and are at greater risk for suspensions and expulsions from school.

The trauma present in these families tends to inhibit healthy communication and coping mechanisms. Younger children are often kept in the dark regarding an incarcerated family member; older children who know more may experience shame, frustration, or resentment. Adult family members don't fare much better—the stigma of prison often leaves them to deal with the challenges of incarceration and reentry (release from prison) by themselves. Many families report feeling ashamed to discuss a loved one's incarceration with friends and other family members, often making excuses for their absence.

The transition home for most formerly incarcerated people is not an easy one. Research indicates that within three years, more than half will return to prison for new crimes or a violation of their release stipulations. Their inability to secure employment and adjust to a new role in a family with changing dynamics, coupled with their expectations to return as providers for their families, tend to strain already compromised relationships. Greater research is needed in this area, as it is clear that the needs of families impacted by incarceration are extensive.

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See Also: Community Corrections; Incarceration and Sentencing, Racial Disparities in; Jail Diversion Programs for Children and Adolescents; Juvenile Justice System; Prisoners and Ex-Prisoners; Probation and Parole Officers; Restorative Justice

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Family, International Variations in Definitions of

It is difficult to separate the idea of family from the marriage and postmarital residence rules in different societies. Marriage has been defined by anthropologists as a formalized, essentially universal, culturally accepted relationship between two or more people, usually of opposite sexes, who have mutual rights and obligations. Marriage forms a family of procreation between the marrying parties. The marital household becomes a family of orientation to any children of the marrying parties. Robin Fox has conducted research demonstrating that some people on Tory Island, Ireland, continue to reside with their families of orientation following their weddings. A similar family system is found among the Nayar caste in India. In both of these family types, male individuals live with their mothers, siblings, and female sibling's children, but only women live with their own children.

Monogamy

Monogamy is (usually) marriage between one man and one woman at a time (exception: the Nuer of the southeastern Sudan and the Ibibio of southeastern Nigeria have so-called woman marriages). Monogamy is the cultural ideal in only 25 percent of the world's societies, such as the United States, England, France, and other Westernized countries. Nonetheless, it is the most common real form of marriage in many more societies for a variety of reasons, such as economics or different stages of the life cycle. Although some politicians have claimed in recent years that monogamy is the only biblically approved form of marriage, this is not true; the Bible contains many cases of polygamy.

Polygamy

Polygamy can be any form of multiple-partner marriage, and it creates families that share members with other families to create a superfamily. Usually polygamy refers to polygyny, the most common culturally ideal form of marriage in the world (about two-thirds of the world's cultures favor it).

Polygyny

Polygyny is marriage between one man and two or more women at a time, as in some biblical cases of marriage, such as Joseph, Leah, and Rachel. (Often, the women are sisters; this is called sororal polygyny.) A type of polygyny found among the Nuer is called ghost marriage, in which a woman marries a dead man, and his living brother (who may be married to someone else) acts as proxy for the ghost. This forms a family that consists of a woman, a ghost, and any children that they may have (with help from the ghost's living brother).

Polyandry

Polygamy may also refer to polyandry, which is very rare. It is marriage between two or more men and one woman at a time, as found among some families in Limi, Nepal, where one woman will marry a group of brothers. This form of family is known as fraternal polyandry.

Consensual Unions

Some families do not involve marriage; these may be based on consensual unions, which are are nonmarital sexual and/or economic unions. These unions may be temporary or permanent. Families based in consensual unions are found in many parts of the world, including the modern United States. Judith Gussler found consensual unions among some poorer families on the island of St. Kitt's in the Caribbean, where women did not choose to marry their children's fathers, reasoning that by having their children with several men, they maximize the economic potential of child support. This leaves families consisting of mothers and multiple children who may have only one parent in common.

Nuclear Family

In the United States, the standard definition of a family is what anthropologists refer to as the nuclear family. A nuclear family can be defined as a married couple and any unmarried children that they may have who still are living with them. There can be many variants on this basic form: children who no longer have parents still would be a family, as would one-parent households. Couples who have no children would still constitute a family, as would same-sex households, as well as marriages between women traditionally recognized among the Nuer of the southeastern Sudan and the Ibibio-speaking Anang of southeast Nigeria. But what constitutes a family varies in different societies, and the standard American definition of what constitutes a family is not necessarily the case—even in the United States. Older (and sometimes younger) people who are without immediate biological relatives locally sometimes construct families from nieces, nephews, or a few close friends or neighbors, who all watch out for and perform tasks for each other.

Stem Family

Conrad M. Arensberg and Solon T. Kimball described the stem family in their book, *Family and Community in Ireland*, about County Clare, Ireland. The stem family lies between the nuclear family and the extended family and is made up of grandparents, one married son, his wife, and any children they may have, and the unmarried siblings of the married son. During the time of Arensberg and Kimball's research in the 1930s, County Clare farms were too small to subdivide among all of the possible heirs, so only one member of a family (as a rule a son) would inherit the patrimony. Only one daughter might be able to marry because there might be enough for only one dowry (inheritance at a daughter's matrimony). Some children might enter a seminary or convent, become shop apprentices, emigrate, or they could stay on the farm as unmarried, unpaid farmhands and housemaids, likened to stems off the family tree that never bore fruit.

Extended Family

Extended families may be defined as multiple generations of closely related nuclear families who live conterminously, that is, within the same house or very near to one another. Extended families often are found in agricultural societies that practice patrilocal residence, wherein most farming is done by men, such as the Jats of Haryana State in India. Patrilocal residence is postmarital residence with the husband's family; technically, this is called virilocal residence until the couple have children. Extended family households may also be found in other parts of India, the Arab world, and China. This involves billions of people, making the patrilocal extended family the most common ideal family type in the world, practiced by about two-thirds of human cultures. Other examples of societies with patrilocal families include some traditional Native American societies, such as the Omaha and Shawnee in North America and the Yanomamo in South America.

Matrilocal extended families are more common in horticultural societies in which most farming is done by women, such as the Hopi of the southwestern United States. Matrilocal residence is postmarital residence with the wife's family; technically, this is called uxorilocal residence until the couple have children. Matrilocal extended family households are more rare than patrilocal extended family households, being practiced by only about 15 percent of cultures. The Cherokee, Crow, and Navajo are examples of Native American societies with matrilocal families, as are the Yoruba from Nigeria.

Clans

The word *clan* comes from the Gaelic word *clann*, which means family. A clan is a very large family that believes it shares a common ancestor, who may have existed so far in the past that they cannot trace their genealogies back to that ancestor. Frequently, this is because it may be a totemic ancestor—a plant, animal, or force of nature that they believe took human form and gave birth to the first human clan member. A collection of related clans is called a phratry.

The Universal Incest Taboo

All societies prohibit incest. This is a universal taboo, but what defines incest varies in different societies. In the United States, it is generally considered incestuous to marry anyone closer than a third cousin, but anthropologist Alan Beals reports that in Gopalpur, a village in southern India, a man's parents may arrange a marriage between him and his sister's daughter. However, in all societies, marriage or mating is forbidden between mothers and sons, fathers and daughters, and sisters and brothers. Historically, very few exceptions to this taboo exist, and those are royal families who ruled by divine right; in ancient Egypt, the Inca in Peru, and in Hawai'i, heirs who did not have the requisite divine ancestry would not have the right to rule.

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See Also: Families, Nontraditional; Family Structure, Diversity of; International Adoptions and Families.

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Family Crisis Intervention Planning

Family crisis intervention planning refers to the activities related to the preparation and provision of actions to intercede, assess, and prevent incidents and circumstances that create disruption and destruction in the life of a family member or the family as a whole. Most commonly, family crisis intervention planning is related to families with members who suffer from serious emotional, behavioral, and/or mental disorders. Mental health crises tend to occur in such situations, and these disturbances tend to disrupt or damage the balance, equilibrium, or homeostasis of the family, thereby leading to or resulting in personal or familial harm. Often, family crisis intervention planning entails preparation, forecasting, and provisioning. In addition, families with histories of domestic violence, physical abuse, or sexual abuse can also benefit from family crisis intervention planning. Finally, families with a member or members suffering from alcohol, drug, or chemical dependency and addiction are also candidates for family crisis intervention planning.

When things fall apart as a result of a mental health crisis, individuals quickly learn that this crisis is just as important to address as any other health care crisis or emergency. It can be difficult, or even impossible, to predict just when a crisis event will happen. In fact, a crisis can occur without warning. A mental health crisis can occur even when a family has a crisis intervention plan in place. A crisis also can take place when the family crisis intervention plan has been closely followed and the family used well-practiced techniques taught to them by mental health professionals. Having a family crisis intervention plan does not prevent a mental health crises from occurring. Mental health profesionals do the best they can with the information and resources available at the time of a family crisis. Family crisis intervention planning is an important tool or means to help families cope with a mental health crisis, and can produce proactive and reactive plans. Proactive plans include tangible or intangible supports that are expected to prevent a specific family crisis from happening. Reactive plans are created and designed by the team to prepare for what actions will be taken if and when a crisis actually occurs.

In the context of mental health issues, the first step of family crisis intervention planning is to fully understand what a mental health crisis is. A mental health crises is any situation in which a person's behavior puts that person at risk of harming or hurting themselves or others and/or when the parent or family members are not able to resolve the situation with the skills and resources available. Mental health crises can be caused by a variety of factors, such as increased stress, changes in family situations, stress associated with changes in life situations, or substance use, as well as other factors that may trigger an increase in behaviors that lead to a mental health crisis. Medical illnesses can also impact mental health and subsequently can lead to a crisis. Any of these things can present coping problems to someone, but they can be more difficult for someone with a diagnosis of mental illness. Many people with mental illness don't understand their illness and the symptoms that may suddenly appear. Family crisis intervention planning is critical to the safety and well-being of the individual and to the family as a whole.

Family Diversity and Family Crisis Intervention Planning

Every family has its own unique culture, traditions, history, and values. Family culture includes definitions of success; attitudes about time, money, and personal space; language; food; and concepts of beauty, art, and music. From family to family, there are a wide range of dissimilar beliefs, a variety of communication styles, differing problem-solving techniques, an assortment of individual role and power arrangements, as well as many other diverse characteristics of family structure. These distinctive and diverse features of family culture make every family crisis intervention planning experience uniquely individualized to each client-family. Although culture is important, family diversity extends far beyond the concept of culture and comprises all forms of diversity, such as differences related to disability, ethnicity, marital status, sex and/or gender choice, economic status, age, class, color, and national origin.

Consequently, family diversity factors into intervention planning by requiring human services professionals to possess or acquire and utilize new knowledge and skills in ways to make possible and ultimately ensure the competent delivery of services. For many, the new knowledge begins with self-knowledge or self-awareness of their own values, beliefs, biases, prejudices, and stereotypes. The journey to become a competent diversity service provider can be both exciting and frightening. The acquisition of knowledge and understanding related to family diversity enables human services professionals to interact, build positive and supportive relationships, and more effectively facilitate family intervention crisis intervention planning. Effective interventions require service providers to be sensitive and open to learning, accepting, honoring, and respecting those family structures, roles, values, attitudes, and behaviors that are different from their own. Furthermore, human services agencies and organizations have the responsibility to incorporate responsive services matched to the assets, strengths, and needs of diverse families.

Diverse families perceive and respond to a wide variety of life situations in vastly different, widely varied, and culturally unique ways. In reality, culture influences what type of threat or event is perceived as a crisis, how families interpret the meaning of crisis, and, in turn, how families respond to their perceptions and react to their interpretations of events perceived as family crises. In family crises, culturally diverse families may seek help or sometimes choose not to seek help; they express emotions or remain silent, and/or describe the circumstances surrounding their family crisis in distinctively different ways that are often foreign to the human services provider. In addition to between-group cultural differences, significant diversity exists within racial, ethnic, gender, age, ability (and disability), and class groups. Customs unique to the culture of origin can and often do influence and even determine how the family will deal with crises and whether contact and interactions with human service providers will be managed by the family, and if so, how this will be done.

A family crisis typically occurs when the family is confronted with unexpected change. Sudden events or life changes can be confusing, difficult, and seemingly impossible for the family to successfully adapt or cope. Culturally diverse families seek help from human services professionals as a result of experiencing a wide range of family crises including the loss or death of a loved one or relative, the loss of a job, divorce, and poor school performance or dropping out of school. For example, Asian American students at all levels are generally stereotyped as technology savvy, academically high-achieving students. In reality, Asian American students are a diverse group. Not all are brilliant, exceptional students, or computer geeks. This stereotyping hides the reality of many Asian Americans who find it difficult and sometimes impossible to achieve at high levels in school. Struggling with a new culture and language, some do not reach the heights of the celebrated few who are successful, and they drop out of school. This circumstance brings a great deal of shame to the family, creating a family crisis.

Another example of family crisis concerns a Haitian family in which the husband has been caught cheating on his wife, which precipitates marriage and family counseling. Because of their belief in voodoo, the wife is adamant that the husband is currently under a spell by which he is also possessed by spirits that govern his unfaithful behavior. Voodoo is an ancient West African religion practiced by more than 30 million people. Voodoo is a religion of spirits, and practitioners of voodoo believe that the world of humans is shared by the world of the spirits who can influence, control, and subsequently impact the world of the living. In such cases, human services professionals encounter families with strong beliefs very different from their own.

Human services professionals face a multitude of challenges in understanding and effectively addressing the complex and complicated family crises presented by diverse families. Human services professionals accustomed to a so-called one-size-fits-all model must come to grips that this approach will not suffice. The uniqueness of each culturally diverse family requires flexibility in the type and duration of the treatment experience. To meet these challenges it may be suggestive for human services professionals to remember that families respond to crisis and recover within their cultural context including their traditions, beliefs, and value systems. It may be helpful for human services professionals to enlist the assistance of a cultural broker (someone familiar with the family's culture) to help in the recovery from the family crisis. Although there is no single suggested approach, care should be taken to provide respectful, accessible, equitable, and informed services to families from diverse backgrounds.

Wraparound and Family Crisis Intervention Planning

Using the wraparound approach to plan for family crisis intervention in which mental health issues are present, the family begins by meeting with family members and the people who know the person with the mental health condition and who are familiar with the crisis behavior. Despite the intensity of the crisis behavior and the range of emotions that it can create, the group begins by working to develop a clear picture of the crisis behavior. This review is possible because most crises have happened before. The group continues by prioritizing crisis or safety situations using likeliness of occurrence and severity indicators of importance. The group discusses the crisis setting or environment, events prior to the crisis, and conditions that may be helpful in predicting a potential crisis situation.

This phase is critically important and useful, as in many cases the crisis has occurred many times. The group is looking for keys to understanding the crisis, triggers, and precipitating events. Other discussion topics during the family crisis intervention process include what happens during the crisis and what person or persons are involved. The group seeks to determine whether other activities or events going on in the environment have an impact that influences or worsens the crisis. Next, the discussion focuses on what happens after the crisis to help define the destructive and damaging behavior. This phase of the discussion concludes with a review of what has been attempted in previous crisis situations and how effective or successful previous attempts were at intervening.

The next phase of the wraparound approach to family crisis prevention planning begins with the group identifying the benefits attached to the behavior exhibited or during the crisis situation for the family member, relative, or significant other(s). Next, the group turns its attention to brainstorming possible alternatives for preventing or intervening in the crisis situation. The group develops a set of simple and clearly defined action steps created specifically to respond, intervene, and prevent the crisis from happening. The family crisis intervention plan identifies the signs or behaviors that indicate what is about to happen or happening and the actions necessary to prevent the crisis from happening or to mitigate the crisis once it begins. Each member of the team reveals his or her concerns regarding what could possibly go wrong. The team should identify where its plan seems most vulnerable and what the potential consequences would be if the plan does not function, and should be prepared to make course corrections in the plan as needed. Finally, the family crisis intervention plan lists a thorough and ordered set of steps to be followed by the group if and when the predicted crisis occurs.

Addiction and Family Crisis Intervention Planning

When loved ones are struggling with the self-destructive behaviors associated with addiction or are facing other problems that are negatively impacting them and the people around them, it can be difficult to figure out how to help them to get the help they need. It is especially challenging when family members continue to avoid help or refuse to seek help, or simply do not realize and accept the severity of their problems. Often an intervention is an effective way to persuade loved ones to take the first step toward recovery. This type of family crisis intervention consists of a gathering of family members, partners, close friends, and significant others, who meet to persuade a person to seek help or treatment for a problem. Family crisis interventions of this sort are considered important to address a range of problems, including drug or alcohol addiction or abuse, eating disorders, addictions to behaviors, domestic violence or self-harm, and even the reluctance of an elderly family member to seek the level of care required for their safety and health care needs. These family crisis interventions are a caring, considerate way to guide and motivate someone to get the needed treatment.

Family intervention crisis plans that address addictions are a chance to let loved ones know that people close to them are concerned for their health and well-being. If done properly, family crisis interventions are thoughtful, nonjudgmental, and respectful. They can also be helpful and healing for friends and family because they are opportunities to share their feelings of pain and frustration amid a group of supportive people.

Family crisis intervention planning that addresses addictions begins with someone close to the person experiencing the challenges of making a proposal to utilize an intervention as a tool or mechanism to assist the person in getting the needed help. Next, a planning team is formed, usually consisting of several persons who are willing to take on leadership roles in the intervention process. The entire family crisis intervention planning process is a learning experience for the members. It is not uncommon for a mental health or addictions specialist or professional to take a leadership role in the planning process. In fact, it is recommended that a counselor, social worker, or professional interventionist be consulted when planning an intervention before any action is taken. These interventions are highly charged and may produce violent results. Family crisis interventions of this type will typically produce a wide range of feelings, including anger, shame, resentment, and a sense of betrayal. It is critically important that family members play significant roles in the development and implementation of the crisis intervention plan. To work effectively, a successful family crisis intervention must be planned well. A poorly planned family crisis intervention can worsen the situation and create emotional and psychological wounds that are difficult to heal.

Conclusion

All family crisis intervention plans should include a debriefing. The debriefing occurs as immediately as possible after each crisis occurs. The team should meet to review the crisis to determine whether the plan actually worked and if course corrections are necessary going forward. All plan modifications should be discussed with the entire group and communicated to any absent team members for implementation of the plan in the future.

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See Also: Crisis Services; Domestic Violence; Family Violence Prevention and Services.

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Family Permanency Planning

The establishment of a permanent, safe, and nurturing environment to promote a child's well-being cuts across all human service arenas, no matter the diversity of children across race, ethnicity, gender, age, and socioeconomic background. According to A. Maluccio and E. Fein, permanency planning "involv[es] a mix of family-centered, child-focused, and culturally relevant philosophies, management, and program components and practice strategies designed to help children and youth live in families that offer a continuity of relationships with nurturing parents or caregivers and the opportunity to establish lifetime relationships." Establishing a place of permanency is best done with the inclusion of a child's family members or close family friends who have intimate knowledge of a child's needs and specific life situation. This focus on including those intimately involved in a child's life, most notably family members, embodies a family-centered approach to permanency planning. Family-centered permanency planning assists in a child's transition and adjustment into his or her new placement, as those closest to the youth are consulted about the plan. Possible permanency goals include reunification with the child's biological parent(s), adoption, guardianship, or placement with a relative.

There are four types of permanency planning: reunification with the biological parent(s), foster care, adoption, and kinship care. Reunification of the child with their biological parent(s) is usually the first type of permanency planning pursued. Recently, both the rights of fathers in child custody disputes and the consideration of the father as a "permanent parent' have received more national attention in permanency planning. When circumstances do not warrant reunification of their biological parent for various reasons (e.g., parent struggles with substance abuse or mental health issues, or if a child was sexually abused in parental care), children may be placed with a relative, called kinship care, or placed in a licensed foster home with foster parents who have passed a background check and are trained in addressing the well-being of children in their care.

When practicing culturally sensitive family permanency planning with diverse groups, many child welfare workers have relied on kinship care as a viable option. It is defined by the Child Welfare League of America as the act of caring for and protecting children by their relatives, godparents, stepparents, members of their tribes, or any other capable adult who shares an existing kinship bond with the child. Kinship care is often practiced informally as members of a family or close community may share responsibility in nurturing and protecting their children without any involvement from the child welfare system; however, these informal arrangements are usually temporary. Alternately, formal kinship care involves the child welfare and family court systems, inherently implying legal oversight of the child's care while under the supervision of kin (e.g., kinship homes must be approved according to state law and licensed). Although formal kinship care requires an outside party to assess a kin's suitability to provide care as opposed to more informal arrangements, this continuum of family permanency planning is considered one of the most collaborative and culturally sensitive approaches to child placement.

The 1980 Adoption Assistance and Child Welfare Act (ASFA) (P.L. 96-272) was passed in response to concern about the longer periods of time children remained in foster care. It highlighted family reunification for children in foster care, and as a result, child welfare agencies refocused on this policy goal of reunification. ASFA also focused on the prevention of foster care placement, including the provision of services and supports to families to prevent foster care placement. Adoption is often viewed as the last type of permanency planning to be employed. Even under the best circumstances, the removal of a child from their home is traumatic, with the child experiencing multiple placements and losses prior to their adoption by a "new" family. Approximately 400,000 children are in the foster care system in the United States, with about 25 percent of them eligible to be adopted. The most common form of adoption in the United States is called Stepparent Adoption, "the legal adoption of a child by the spouse of the child's birth or previous adoptive parent." Lesbian, gay, bisexual, transgender, or same-sex couples seeking to adopt a child face additional barriers, as only the District of Columbia and 19 states allow joint adoptions by same-sex couples.

Children from underrepresented and ethnic minority groups are often disproportionately represented in permanency planning programs. Due to the overrepresentation of these youth and their unique needs, it has become increasingly common in social services to employ more targeted efforts when finding placements for these children. One such effort includes engaging families of ethnic minority youth (i.e., family-centered permanency planning) to identify the most culturally appropriate placements. Further, "permanency planners" should utilize more targeted and tailored recruitment strategies when seeking out adoptive families for children from minority groups. Whether youth are being reunified with their biological families or placed in new homes, the goal is to place a child into a safe and lasting home, one in which the child will thrive. Within the context permanency planning for children of ethnic minorities, the Department of Health and Human Services reports that those youth who are matched with families of similar cultural backgrounds and ethnicities are more likely to be well-adjusted and experience less stress as a result of the life change.

Children with clinical mental health and behavioral health needs, those with medical conditions requiring 24-hour care, and those referred to as "medically fragile" are usually placed in a higher level of foster care called therapeutic foster care, where foster parents have received intensive training to help meet the child's mental health, behavioral, and medical needs.

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See Also: Child Abuse/Neglect, Victims of; Child Protective Services; Families, Nontraditional; Foster Care Agencies; Mental Health Services, Children.

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Family Planning Services

Until the early 19th century, no formal system was in place to support women and men with decisions about pregnancy and access to health status information. By the early 20th century, however, family planning advocacy efforts accelerated. Having access to options when making decisions about birth control can have impact on individual, family, and community health. Family planning provides information about sexual and reproductive health and assists with decisions regarding abstinence and preventing, delaying, or achieving pregnancy. Through family planning services, men and women can be helped to make decisions about having children that take into account all aspects of their lives, including financial and health conditions and personal situations.

Family planning services include a range of reproductive health options that offers access to effective, safe, and affordable contraceptive supplies and information, as well as preventive health services. Family planning options include natural, medical, surgical, or chemical contraceptive methods, infertility services, adolescent services, and breast and cervical cancer screening. Family planning services also include access to human immunodeficiency virus (HIV) and sexually transmitted disease (STD) screening, testing, and information. Inherent in family planning is the right of men and women to be informed, make their own reproductive decisions, and obtain medically appropriate services. The World Health Organization (WHO) considers family planning a critical poverty reduction and health improvement method. Similarly, the U.S. Centers for Disease Control and Prevention (CDC) indicates that the systematic provision of family planning services is a significant public health achievement.

History

Birth control and family planning were practiced in early Egyptian and Greek societies. However, in medieval England, family planning and birth control were viewed as a moral issue, and efforts to delay or prevent pregnancy were frowned upon. By the 20th century, lack of access to services and information had become an important public health concern. Margaret Sanger, a public health nurse, was an early advocate of the benefits of family planning, and spurred the early birth control movement.

Family planning services include a range of reproductive health options that offers access to effective, safe, and affordable contraceptive supplies and information.

Sanger, concerned with high miscarriage rates and frequent pregnancies among low-income families, began a campaign to provide information on and access to birth control. Sanger eventually opened the first family planning clinic in 1916 in Brooklyn, New York. She continued to open clinics across the United States while promoting changes in laws that prevented distribution of contraception. Sanger is credited with starting the modern family planning movement and with founding the American Birth Control League, which eventually became Planned Parenthood of America.

Sanger's association with the eugenics movement is viewed with controversy. Eugenicists believe that the human race could be improved through careful breeding. Although she did not agree with all aspects of the eugenics stance, Sanger thought the spread of untreatable disease and mental illness could be ended with population control efforts. Sanger eventually distanced herself from the American eugenics movement.

During the 1960s, the birth control pill and the intrauterine device (IUD) provided accessible and convenient birth control methods and increased their availability to women and families in underserved communities. In 1965, the U.S. Supreme Court struck down laws that prohibited contraception use by married couples. Further government sanctions of family planning services occurred in 1970, when federal funding was authorized under the Family Planning and Research Act, which established Title X of the Public Service Act. Title X provides access to family planning information, contraceptive supplies, and health prevention activities. Authorization for Medicaid payments for family planning services occurred in 1972.

Title X now provides funding for family planning clinics throughout the United States, including state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital, school, and faith-based programs, along with other private nonprofits. Under Title X, abortion is not covered as a method of family planning. Funded services include contraceptive care, screening for HIV and other STDs, as well as for cervical cancer. Title X–funded programs offer these services to men and women in their communities and provide access to care that may otherwise be unavailable. Providers funded under the Title X program must deliver service despite a person's ability to pay. The majority of those served in these programs have incomes that fall below the federal poverty line. One of the primary objectives of Title X is to expand access to health care for low-income communities.

Working in Family Planning

Individuals who work in the family planning field include physicians, nurses, social workers, pharmacists, and community health workers. Most family planning professionals work in community clinics and other community-type organizations. Family planning professionals engage in an array of activities that enable women and men to make informed decisions about their reproductive health. A clinician, who may be a physician, physician's assistant, nurse practitioner, or nurse midwife, provides medical services. Clinical services involve reviewing the client's medical history and conducting a medical exam. Counseling may be provided by any of the family planning professionals and includes offering information to help clients understand contraceptive options, correct use, possible side effects, and safer sex options. Family planning professionals are concerned with promoting family well-being, responsible decision making, and healthy pregnancy outcomes.

Many young people become sexually active during adolescence, and family planning professionals are especially concerned with providing them needed information and services. Several risk factors exist for sexually active adolescents that information and services can prevent. Sexually active adolescents are at high risk of HIV and STD infection, unintended pregnancy, and poor pregnancy outcomes. Family planning professionals seek to increase skills among young people to make choices that have a positive impact on their future development.

Effective strategies used by family planning professionals involve engaging with a variety of community institutions to better support young people. For example, reproductive health education programs are offered in schools, community centers, churches, and other places where young people gather. Positive messages are also promoted in the media. Engaging youth is an important task in family planning services.

Worldwide Concern

Meeting family planning needs in developing countries is a critical concern among family planning advocates. Worldwide, family planning programs have been developed that seek to enable individuals to have control over their sexual and reproductive health. These efforts are designed to overcome obstacles that prevent access to information and services. Family planning in developing countries is also viewed as an effective poverty-reducing effort that has the potential to bring about improvements in women's and children's health.

Evaluating family planning programs is another critical endeavor that determines the overall effectiveness of services. Evaluation determines whether family planning services have met their overall goals and are delivered in the most cost-effective manner. Evaluation of these factors is especially important in light of national and international funding cuts to family planning services. It is clear that in the long run, funding cuts will have a direct impact on the quality and availability of services, and thus the overall health and well-being of families and communities may be impacted as well.

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See Also: AIDS/HIV Programs; Female Genital Mutilation; Gender Issues and Roles in Developing Countries; Gender Issues and Roles in Non-Western Countries; Health Care, Disparities in; Infant Mortality/Sudden Infant Death Syndrome; Infanticide, International Variations in Attitudes Toward; Midwifery; Public Health.

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Family Preservation Services

Although the term *family preservation services* (FPS) did not emerge until the late 1970s and early 1980s, this intensive intervention strategy has been in implementation and revision since the turn of the 20th century. Conceptually, the framework of family preservation has remained the same throughout its history: to provide assistance to low-resource children and families living in poverty through strengths-based interventions. In the mid-20th century, however, the focus shifted from giving resources such as money and food to families to providing therapeutic services for families in crisis in order to stabilize the unit and prevent children from being removed from their homes. Additional interventions included supporting families reunifying after placement and interrupting intergenerational cycles of family violence and separation. This article centers on a brief history of government legislation, diversity, empirical research, and theoretical underpinnings of FPS interventions.

History of Government Legislation

The Adoption Assistance and Child Welfare Act (AACWA) of 1980 was put into place to provide assistance for children at risk for out-of-home placement and to prevent placements within the foster care system. AACWA contained multiple provisions, but as it pertains to FPS, it provided that all participating agencies must provide reunification and prevention programs for children and families involved in the foster care system. Due to this legislation, the decade of the 1980s showed a decline in children placed in foster care. Additional funding for FPS was obtained with the Adoption and Safe Families Act of 1997, which provided support for child placement permanency and family support systems such as crisis stabilization, reunification counseling, and domestic violence assistance. The most recent efforts to clarify and support the needs of children and families was provided in the Child Welfare Policy Manual in 2001, which defined expectations of agencies to provide "reasonable efforts" to prevent out-of-home placement of children.

Diversity

Although FPS is intended to service low-resource families, evidence suggests that there is a gap in services for children and families who fall into categories within special populations. These populations can include, but are not limited to (1) families and children of color—specifically African Americans, Hispanics, and Native Americans; (2) families with older children; and (3) families with children who are severely emotionally disturbed (SED). Although families and children of color (predominantly African American) are disproportionately represented in foster care, evidence suggests that FPS is not targeted toward these groups and treatment modality is not congruent with these clients' needs. Concomitant to this phenomenon is the large number of FPS workers who self-identify as European American and who may have worldviews that are not congruent with minority values regarding family functioning. These issues as well as others must be addressed to increase efficacy of FPS for all families and children.

Empirical Research

Utilizing empirical studies to identify the overall efficacy of FPS has been difficult for a number of reasons. Given the multitude of responsibilities that service agencies have, adhering to a strict research protocol may not always be a top priority of workers due to clients' more emergent needs. Common issues with past FPS efficacy research have included (1) a lack of experimental groups for a true experimental design, (2) inadequate documentation of clients' progress through FPS interventions, (3) issues with data collection, (4) poorly defined research terms, and (5) issues with statistical analysis. Additionally, within research literature, no specific definition exists of what constitutes success in FPS interventions.

Although it may be assumed that children remaining in their own homes is evidence of a successful intervention, this may not necessarily be the case because family crises can vary in length (chronic versus short term) and severity. Therefore, using the measure of custody could be an incorrect sign of success. Moreover, agencies that intervene with children and families may be required to measure variables such as arrest rates, hospitalizations, and/or social services interventions that could prove useful in determining intervention success. This information may be as valuable as prevention of out-of-home placement, but if data are not uniformly collected, it is difficult to compare one agency or intervention program to another. To improve studies regarding FPS outcomes, researchers may need to focus on creating a cohesive definition of success, create a metric to measure FPS success, and develop a metric that can help measure the efficacy of services received.

Theoretical Underpinnings

FPS services have been provided by both public and private agencies with varying treatment modalities and levels of success. The intent of treatment variation is to create tailored interventions that match treatment strategies with families' needs to create the best possible outcomes. Specific factors that could influence the success of families receiving FPS services include highly motivated clients, intensive intervention by clinicians with highly developed family therapy skills, and follow-up services conducted by the same clinicians who performed initial FPS services. Additional factors that may influence success include the cultural competence of clinicians, limited caseloads to allow clinicians to focus more on a few families, and strong clinician/family relationships.

Many clinicians working in FPS will initially utilize crisis intervention strategies for their first interventions. Crises in the life of a family can be developmental and/or environmental in nature. Developmental crises can include incidents such as adolescents engaging in criminal behaviors, parents being unemployed or underemployed, and the death of a family member. Environmental crises include gang violence, riots, and unstable living conditions. When either type of crisis is a chronic part of family life, all members tend to experience emotional side effects such as anger, depression, and anxiety. FPS interventions tend to focus on crisis stabilization techniques to alleviate tension and stress in single events and those families living in chronic crisis. This type of stabilization can take several hours to a few days to complete, depending on the severity of the crisis and the nature of the disruption to family life.

As clinicians develop a working relationship with families and are able to stabilize the initial crisis situation, they may engage in systemic therapy interventions to help conceptualize families' functioning and create a treatment plan. Systemic theorists promote the idea that the family should be conceptualized in terms of a holistic unit whose functioning is unique and at its best helps maintain the overall well-being of the individual members. Ideas of family systems theory that aid in understanding the family as a unit include family dynamics and reciprocal interactions; communication patterns that promote homeostasis within the family; patterns of power and control; and family members' rules, roles, and interaction patterns.

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See Also: Department of Health and Human Services, U.S.; Family Services; Family Therapy; Family Violence Prevention and Services; Mental Health Services, Adult; Mental Health Services, Children.

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Family Reunification

Family reunification has long been a cornerstone of U.S. immigration policy. Many advocates and researchers suggest that families should not be separated by using laws that prohibit family members in the country of origin from joining U.S. naturalized citizens or legal permanent residents (LPRs), also known as green card holders. Not only is reunification socially acceptable, but many studies suggest positive impacts for the family and the receiving economy. A close association exists between family-based and employment-based policies. Supported by family networks, reunited immigrants tend to have increased social and occupational mobility, demonstrate entrepreneurship, and build increasing social capital. Another benefit of reunification is the ability to maintain a single household rather than multiple households in different countries and to contribute to the domestic economy rather than remitting funds to the country of origin. However, some do not see these advantages; they fear a multiplier effect in which each new naturalized citizen or LPR will geometrically increase the number of immigrants that may be allowed into the country as each new immigrant becomes the sponsor of more family members. Immigration policy of the 20th century has prevented the multiplier effect and created long waiting lists and backlogs of visa requests by family members.

History

Immigration policies and acts have been an ongoing concern and continue to be a concern in the United States in the 21st century. Early moves by the federal government to control immigration date back to 1882, when individual states surrendered immigration legislation to the federal government. By 1917, serious efforts were under way to control immigration and to screen individual immigrants, and in 1921 the first ethnic quotas were set. The National Origins Act of 1924 effectively ended the so-called open-door immigration by establishing annual limits and exact ethnic quotas. However, family reunification remained a pillar of immigration policy.

Family reunification appeared as a major concern as early as 1885 with the Foran Act. Although this act was designed to control the import of labor, family reunification presented the most used loophole to allow new immigrants to enter. The original language of the act indicated that no suggestion was intended that would not allow any individual from assisting family members, relatives, or personal friends from migrating to the United States for the purpose of establishing a home. The phrase "personal friend" was removed in 1891. The National Origins Act of 1924 continued the policy of reuniting families by assigning 50 percent of quotas to the fathers and mothers of U.S. citizens (USCs) over 21 years of age or to husbands of USCs. Another large portion of the quotas were reserved for family members of LPRs. LPRs could sponsor minor children under 21 years of age and wives, but husbands were not included. The policy of reunification was continued in the 1945 War Brides Act that allowed spouses and children of U.S. citizens or veterans to enter the country.

The executive branch of the U.S. government was examining immigration policy changes by 1963, and President John F. Kennedy envisioned three criteria for immigration reform: the need for skilled workers, family reunification, and a priority of registration. Two changes were considered for reunification: parents of U.S. citizens would qualify as nonquota numbers, and preference would be extended to parents of LPRs. The Immigration and Nationality Act of 1965 set preference percentages for family members including siblings of U.S. citizens, removed the quota system, established visa categories, and set family reunification as a cornerstone of immigration policy.

The next major changes occurred in 1986 and 2001. The Immigration Reform and Control Act of 1986 (IRCA) offered amnesty to undocumented immigrants, and as immigrants became naturalized citizens and LPRs, the doors opened for the multiplier effect. However, requirements for reunification became more stringent with the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001. Better known as the USA PATRIOT Act, immigration duties were moved to the newly created Department of Homeland Security. Both the 1986 and 2001 acts created backlogs and long waits for visas, and the USA PATRIOT Act criminalized many family members seeking to be reunited with relatives. A strict bureaucratic model and requirements define the current process.

Process of Reunification and Immigration Reform

The current process for reunification establishes two family categories: immediate family (family reunification) and family preference (legislative numerical limits). Immediate family includes parents, spouses, and minor children of USCs, whereas family preference is a tiered category that gives preference to (1) unmarried adult children of USCs, (2) spouses and unmarried children of LPRs, (3) married children of USCs, and (4) siblings of USCs. Other relatives, such as aunts, uncles, and grandparents, are not included in the family reunification process nor are the siblings and parents of LPRs. USCs must be over 21 years of age, establish the relationship through documentation, and demonstrate an ability to support a relative at 125 percent of the poverty line. Sponsors must fill out an I-130 form, which will be approved or denied by the U.S. Citizenship and Immigration Services. Approved relations who are currently in the country may file a Form I-485 and request a status change to LPR, and approved relatives outside the country must report to a U.S. consulate to be processed for a visa. The process can be long and often may take several years, resulting in cases of undocumented immigrants desperate to reunite with family members residing in the United States.

The 21st century has witnessed a new concern and effort for immigration policy reform. Many family members without documentation have been criminalized as they cross the border in an effort to rejoin families. Mothers, fathers, and children have been caught in a time-consuming process and bureaucratic administration of current laws, have been criminalized, and have suffered imprisonment or deportation. A deported relative cannot return to the United States legally for a period of 10 years.

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See Also: Immigration: Human Service Issues; Immigration Law, History of U.S.; U.S. Immigration and Customs Enforcement.

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Family Services

A family is viewed as a cohesive unit; when an individual within the unit has an issue, the entire unit suffers to some degree. Service agencies within the United States take a holistic approach to working with families. In fact, the services offered at most human services agencies are designed to meet individual needs but also address the family unit as a whole. Maeve O'Halloran and Owen Doody contend that an approach with a person-centered care philosophy when servicing families will enable individual family members to receive the help needed while addressing the needs of the family as a unit. Fostering relationships in the family by valuing and promoting the family's strengths is central to providing a supportive environment in family-centered services. Many agencies in the United States are designed to service families by assisting in removing barriers, strengthening bonds, creating familial environments, and supporting the family unit.

Community Services

Community agencies within each state provide the community with mental health, intellectual disability, and substance abuse services. These services assist families by enabling participants to stay near their family and friends while receiving services. Services can be short term or long term and involve treatment planning that includes family members of the clients being serviced. Such services are also provided through local departments of human services.

Departments of Human Services

Agencies of state departments of human services offer a variety of programs to support the family. Programs include adoption, foster care, child protective services (CPS), and many other prevention services to strengthen families and improve child well-being.

Adoption agencies provide children who are unable to be raised by their biological parents the opportunity to be legally united with another family. Family service agencies work to unite children with families as well as families with children. In some instances, children can maintain contact with their biological families, but this is not common practice. Adoption offers positive benefits for the children and families. There are lifelong implications for the adopted individual, the adoptive parents, and the birth parents in navigating the new relationships. Differences in familial environments and in decisions to continue biological relationships can be a challenge to adoptive families.

Foster care is a program that provides services for children who no longer can reside with their families due to abuse, neglect, and abandonment. These children are provided a familial environment in which care is provided on a temporary basis. During this time, a permanency goal is designed to ensure the children will have an appropriate placement. The ultimate goal of foster care is reunification with the biological family. The children will remain in the foster care placement until their families are able to provide for them again or until permanent placement is available for the children.

Child protective services, a federally mandated program, accepts and investigates reports of abuse and neglect of children under the age of 18 years. The goal of CPS is to protect children from physical, mental, and medical neglect and from sexual abuse and exploitation, as well as to prevent and alleviate family crises. Child protective services are available around the clock every day. CPS is also an intervention method to help families who are struggling. The goal is to assist families in getting back on track by intervening if abuse or neglect is present. In some circumstances, children are permanently removed from homes and become a part of the adoption and foster care programs.

Family Preservation and In-Home Service Programs

Kristin Duppong Hurley described family preservation services (FPS) as short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. Jennifer Mullins described FPS as a program designed to prevent out-of-home placement for children who are at risk of child maltreatment. The services are founded on the belief that when parents are provided with services and support, the children can be protected and safe within their own families. The services are provided 24/7 and include a brief but intense four- to six-week program, as well as in-home training to provide families with skills to address real-world situations as they occur.

In-home services are performed in the client's or family's home, and typically are used by low-income families. These services can include counseling, prevention, education, and support for families who are unable to easily access services in their community. Many community programs have an in-home component to service families.

Counseling Services and Family Programs

In many areas, counseling facilities offer individual, couple, and family counseling. These services can be found in hospitals, private clinics, schools, treatment centers, and other service facilities. Many community agencies have a counseling component to assist families that qualify. Depending upon the facility, the services can be short term or long term.

Some communities have facilities that offer programs for families, such as educational workshops, counseling services, and family recreational activities. Services also include parenting support, career development, and food support. These programs focus on removing barriers and strengthening families.

Child Care and After-School Programs

Most communities have child care facilities to support working families. Churches, educational institutions, and the workplace can provide child care services. These services provide families the opportunity to work, attend school, and perform other responsibilities. Children who attend child care facilities are given an opportunity to develop socially. Many facilities are educational facilities and provide an opportunity for educational development for the children who attend. Community-based child care programs are often supported with government funding to assist in servicing families in a holistic manner.

After-school programs provide services for families who need added support during the hours immediately following school. Each program is unique and can be housed within the local school or community agency. These programs typically are offered to elementary school children but may extend to middle school children. The average program provides tutoring services and other activities to learning such as character building.

Hospice and Respite Care

Hospice is end-of-life care for those who have been medically certified with an expected six months or less to live. Typically, hospice teams provide emotional and spiritual care for the patient and the family. Hospice can be provided in hospitals, nursing homes, or the patients' homes. Typically, patients choose to receive care in their homes to provide them more comfort and time with family.

Respite care provides family caregivers additional help with a family member who has development delays, physical disability, and/or intellectual disability. Respite care can be provided by sitter-companions in-home, at a specialized facility, at a therapeutic adult day care center, and for emergency care. Respite care provides families with a break from the day-to-day care of disabled patients. These breaks are typically short term and temporary.

Family Planning Services

Family planning clinics can be found in many communities. The World Health Organization (WHO) describes family planning as services allowing individuals and couples to plan and prepare for their desired number of children and the timing of their births. These services include education about preparing and planning for children; education about and distribution of contraceptive methods is also a part of most family planning programs. Many clinics offer treatment of involuntary infertility. Family planning programs help prevent the transmission of the human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) and infections. Family planning services recognize that a woman's ability to understand the importance of the number and space of her pregnancies has a direct impact on her health and well-being as well as the outcome of each pregnancy. These services have been found to reduce unsafe abortions.

Laura Wherry states that the U.S. government, under the national family planning policy, provides contraceptive and related preventive services for low-income women without health insurance or access to affordable health care. The goal of this policy is to increase access to contraceptive services, supplies, and education to reduce the number of unplanned pregnancies. Other preventive services are provided, such as breast and cervical cancer screenings and STD tests.

Family Peer Advocates

Jennifer Wisdom describes Family Peer Advocates (FPAs) as a service that provides parents with a model, coach, and support to help them understand and cope with various service systems. It is a family-to-family support service that can help reduce barriers families may face when accessing children's services, and it helps the parents become more involved in these children's services. According to the New York State Family Peer Advocate credential, FPAs have lived-experience and receive skills and training to empower and support other families. Advocates typically can be found through government agencies and state programs.

Lesbian, Gay, Bisexual, Transgender, and Queer Families

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) families are gaining more interest, but are marginalized in communities and research. A number of communities offer services and centers for the LGBTQ community, and this number is increasing. The LGBTQ centers across the United States offer services such as care management, housing, administrative support, outreach, resource centers, meals programs, HIV education and testing, case management, children's outreach, individual and family counseling, support groups, adult and youth services, and social and educational events, as well as LGBTQ video educational resources. These centers offer a safe haven for the LGBTQ population.

Families With Severe Physical Disabilities

Families with children who have physical disabilities need a variety of services and support in accordance with the unique needs of each family. P. S. Samuel explains that the traditional model of disability intervention was focused on fixing the family rather than supporting the family. Current services focus on the family and delivering the services needed. Maeve O'Halloran found that when families with children who have intellectual, developmental, or physical disabilities are serviced with a family-centered approach in which families are considered to be the center of society, better outcomes are achieved compared to traditional models. When families are supported and receive effective quality services, they in turn support the society and community in which they live.

Support for families with children who have disabilities includes services that are formal and informal as well as tangible goods that enable the full participation of each member of the family. P. S. Samuel found that minority families, such as families of color and lower socioeconomic status, face barriers in accessing these services. Minorities with disabilities in the United States are considered the most marginalized of the marginalized populations. These support services need to be more readily and easily accessible to minority families.

Community Outpatient Mental Health Services

Community mental health services that provide outpatient care offer counseling services to individuals and families that do not require the person or family to stay at the center. Outpatient care gives patients the opportunity to be a part of a familial environment on a day-to-day basis while receiving treatment. Mary J. Baker-Ericzen reported that there is a need to improve the quality of care in outpatient mental health community service agencies;

this is a national health care priority. These services are needed to provide clinical care for children and adolescents with disruptive behavior problems. Community mental health agencies also provide support for the families of children with disruptive behavior problems. These services are typically found as a part of community health departments.

Financial Services

Families all have financial obligations, and when dealing with financial obligations each family has unique circumstances. Some families are low-income and need added support, which is offered through such government services as food stamps; Temporary Assistance for Needy Families (TANF); Medicaid; Medicare; and the federally funded health and nutrition program for women, infants, and childen (WIC). James Grubman explained that one of the most important decisions a family makes is whom to entrust with their financial resources. He goes on to highlight the need for financial services staff and managers to increase their knowledge of how to help families in these important areas. Socioeconomic status does not solely determine a need for financial support. Financial planning is needed for all families in preparation for the future.

Depending on the type of support a family needs, financial advisors work at local banks and financial centers, and financial educators within the community support families. These advisors provide needed information to individuals and families about managing money, budgeting, saving, loans, trust funds, investments, and other financial information and resources.

The U.S. Department of Agriculture explains that WIC provides federal grants to states for food, health care referrals, and nutrition education for low-income pregnant, breast-feeding, and non-breast-feeding postpartum women, and to infants and children up to the age of 5 years. Typically, the women and families would apply for WIC at their local department of human services.

Military Family Support

Military bases worldwide offer military family support centers. Fleet and Family Support Centers are located on naval bases and provide services such as mental health counseling, financial counseling, family counseling, career counseling, referral services, community information, job-seeking information, volunteer opportunities, homecoming support, seminars, how-to publications, outreach programs, school programs, spouse programs, teen programs, and education/classes. Many communities have Veteran Affairs (VA) facilities that provide veterans with similar services, such as education and training, vocational rehabilitation and employment, loans, life insurance, pensions, compensation, financial counseling, independent living programs, mortgage delinquency assistance, and fiduciary programs. In addition to the military bases and government offices, a few programs support military families in the community. Community agencies are evolving in their support of military families due to the growing recognition of the needs of military families.

Services for At-Risk Families

Services for at-risk families can be provided in communities, schools, and other facilities. At-risk families typically are more prone to having social and economic challenges. These families are often identified by the community in which they belong and the prevalence of challenges they face. Having one or more socioeconomic challenges can make a family prone to having other challenges. Umatilla Morrow Head Start defines at-risk families as having one or more of the following: low-income, substance abuse, child abuse, neglect, domestic violence in the home, recent divorce, loss of family member(s), child development issues, extreme or questionable health, mental health or nutrition issues, changes in typical behavior, and disabilities, among other factors such as family stress and literacy issues. Programs that service at-risk families often provide education, prevention, and methods to remove barriers to positive family development. Family service agencies are designed to address the needs of families in a holistic and comprehensive manner. The issues supported by these agencies vary, but ultimately result in increased family functioning.

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See Also: Adoption, Agencies and Services; At-Risk Youth Services; Child Protective Services; Counseling and Psychotherapy Services; Department of Health and Human Services, U.S.; Family Planning Services; Family Preservation Services; Family Reunification; Foster Care

Agencies; LGBTQ Clients; Medicaid; Medicare; Mental Health Services, Adult; Health Services, Children; Respite Care; Adoption; Foster Care; Counseling; Veteran Services; Temporary Assistance to Needy Families.

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Family Structure, Diversity of

The view of the traditional nuclear family, made up of two biological married parents with children, dominates in most social and health services delivery settings. However, family structure in the 21st century varies considerably and has significant implications for the development and delivery of family policies and human services. A review of current family arrangements reveals many family types, including not only traditional two-parent families but single-parent families, stepfamilies and blended families, cohabiting or civil union partnerships, same-sex couples, foster and adoptive families, and grandparent-headed families. Having a sound understanding of how families are organized and how family composition can influence an individual's day-to-day functioning, development, and outcomes over the life course is central for human service providers as they work to meet the needs of the clients they serve.

Describing family structures and the processes (e.g., marriage, divorce, having children) that generate those structures is rooted in the disciplines of family studies and demography (the study of the characteristics of human populations). However, a wide range of practice, research, and policy fields have had long-standing interest in understanding variation in family structure because of the broad implications such diversity has for providing services to varied populations in society. The purpose of this entry is to describe variation in family structures today with particular attention given to the diversity of family types across different demographic groups and, where applicable, prominent demographic transitions that affect family structure.

Definitions

The term *family* is defined in different ways across settings and disciplines. For example, family demographers use information about household members' sex, age, marital status, the number of people in a household, and the relationships people have to one another to describe the structure of families. The U.S. Census Bureau uses a legal definition of family in its survey research, which is "a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together." The census further defines a stepfamily as "a married-couple family household with at least one child under age 18 who is a stepchild (i.e., a son or daughter through marriage, but not by birth)," a married couple as "a husband and wife," and an unmarried couple as "two unrelated adults of the opposite sex." Numerous family subgroups are not represented by these census definitions and are also missing from other common sources of data and analysis on family structure. This article draws from these various census definitions and expands on them to focus on a variety of family types in the United States in an effort to capture some, but certainly not all, of the significant diversity that represents American families.

Married Two-Parent Biological Families

Marriage has been the bedrock of family life in the United States for years, representing the key structure around which young adults organize their lives. The predominant form of family life today still consists of two married heterosexual adults with children, but since the mid-20th century, the United States has witnessed a significant change in family structure, namely, delayed marriage and, in some groups, postponement of marriage alltogether. The vast majority of people do eventually marry but the proportion of the population who marries has dropped, and the median age at which both men and women first get married is at a historical high point: 28.4 for men and 26.5 for women, according to data from the 2009 American Community Survey (ACS). The percentage of women who were married was highest in 1950 at approximately 65 percent. In 2009, the ACS found that less than half (48.3 percent) of all men and women age 15 years and over were married. Differences in marriage by race suggest that a higher proportion of black men and women never marry compared to white men and women. Blacks represent the group with the lowest proportion married (29 percent), compared to Hispanics (43 percent), whites (52 percent), and Asians (58 percent).

Tied to the delay in marriage appears to be a trend toward the postponement of childbearing, especially among more highly-educated groups in society. That is, individuals are putting off getting married and having children until later in life. In addition, a decoupling of marriage and childbirth altogether is occurring whereby parents have children outside

Single-parent families have long been a part of the U.S. social fabric. Death was once the primary cause of single parenthood, but more recently, divorce and childbirth outside of marriage have become the primary drivers behind this segment of the population. Unmarried individuals adopting or caring for relatives' children also represent single-parent family configurations of marriage and raise them without both biological parents present in the household. In place of the traditional family structure encompassing marriage and childbearing early in life, some individuals are choosing alternative approaches to forming a family that result in delayed or forgone marriage and selection of some other family configuration.

Single-Parent Families

Single-parent families have long been a steady part of the U.S. social fabric. Death was once the primary cause of single parenthood, but now divorce and childbirth outside of marriage have become the primary drivers behind this segment of the population. Mother-headed families, in which the father, while legally or socially tied to the family, is separated for military or employment reasons (e.g., migrant workers), constitute single-parent–like families as well. Children adopted by unmarried individuals or children cared for by relatives represent other types of single-parent family configurations. According to the 2011 Annual Social and Economic Supplement of the U.S. Census, approximately 27 percent of children live with only their mother or father today, and women head up the vast majority of single-parent families. Rates of single parenthood vary considerably by race or ethnicity, education, and age. Approximately 16 percent of white, 27 percent of Hispanic, and 52 percent of black children live in single-mother families. Well-educated people are less likely to divorce or have children outside of marriage compared to those who are poorly educated; older women and those with higher incomes are also less likely to raise children on their own.

Expanded employment opportunities, modest increases in wages, and in many cases public assistance have enabled women to leave problematic marriages or to have children outside of marriage. These labor market and income support changes are potentially advantageous to working mothers, but single parenthood—especially for women—puts families at significant risk of poverty. On average, women earn less than men, tend to face obstacles in collecting child support from fathers, and are pulled out of the labor force more often and for longer periods than men, resulting in fewer wage-earning adults in the household. This combination of factors puts children and their mothers in single-parent families at risk for a host of negative social, economic, and health outcomes.

Stepfamilies or Blended Families

A stepfamily is formed when two adults enter into a cohabiting partnership and at least one of the adult partners has a child from a previous relationship. Today, significant diversity among stepfamilies characterizes this growing group of individuals. Data from the 2009 Survey of Income and Program Participation indicate that of the 50.8 million children who live with two parents, 10 percent (5.3 million) lived with a biological parent and married or cohabiting stepmother or stepfather. Families in which both adults have children from a previous relationship are sometimes known as blended or complex families and are differentiated from simple stepfamily households in which only one of the adults has prior children.

Historically, stepfamilies formed when a spouse died and the other partner remarried. While remarriage rates did not change significantly over the course of the 20th century, it was not until the 1970s, when remarriage following divorce, as opposed to spousal death, became the most common cause for the formation of stepfamily households. Unfortunately, complete data that accurately capture the number and configuration of stepfamilies in the United States are lacking because of the complexity inherent in where children, parents, and partners reside and how they relate to one another. For instance, in a mother-stepfather household in which the mother's biological child lives, the Census Bureau would count the family as a stepfamily household only if the stepfather completed the census form. If the mother participated in the survey, she would report her relationship to the child as biological and thus be precluded from being identified as a stepfamily. Complex family configurations that involve stepfamilies and that may span generations and households have implications for child and adult well-being and should be considered in assessments of individual and family functioning.

Cohabiting Families

Cohabitation is defined as the coresidence of two individuals who are in a romantic or intimate relationship. According to The National Center for Family and Marriage Research, 60 percent of women ages 19 to 44 have cohabited at some point, and an estimated two-thirds who married for the first time in the last decade cohabited prior to marriage. Cohabitation rates rose significantly over the last several decades among all racial/ethnic groups, as well as across education levels. Increases in cohabitation were greatest, however, among individuals with less than a high school diploma and among non-Hispanic whites. Although often short-lived, this nonmarital, coresidential form of partnership has become a normative experience for many American couples. Young men and women today view cohabitation as a trial form of marriage, and they live together in hopes of testing out their compatibility before entering into matrimony. The rapid rise in cohabitation is also linked to another significant demographic transition in society, namely the increase in nonmarital childbearing. The 2002 National Survey of Family Growth indicates that 40 percent of recent nonmarital births were to cohabiting women. Cohabitation has garnered considerable attention because of the relational implications associated with this form of family composition. As cohabitation becomes increasingly common and socially legitimized, years of research suggest that premarital cohabitation has a negative relation with future marriage and relationship stability. As such, cohabitation should be taken into consideration when aiding families in human services settings.

Same-Sex Unions (Lesbian, Gay, and Bisexual Families)

Lesbian, gay, and bisexual families vary extensively in composition, legal recognition, and household membership. The children in these families may be biological, adopted, step, or nonrelated (e.g., child of a partner). Families may also include gay, lesbian, or bisexual children with heterosexual parents. As of August 2014, 13 states legally recognized same-sex marriages. Data from the 2010 ACS indicate that about 1 percent of all couple households nationally (594,000) were same-sex unions, and of these couples, 26 percent reported that they were spouses. Of the same-sex couple households, almost one out of five reported having children. Issues pertinent to gay, lesbian, and bisexual families are complex and vary widely. Factors to consider include policy and social debates on same-sex marriage and domestic partnerships, discrimination in the workplace and other settings, and family relationships and the dynamics related to homosexual disclosure either by parents who are gay or lesbian or by children who disclose to their heterosexual parents.

Conclusion

The diversity of family structures in the 21st century is notable and extends far beyond the traditional nuclear family consisting of two heterosexual adults with children. While the inclusion of more common nontraditional family types, such as cohabiting and same-sex unions, is essential in any discussion of contemporary family structure, so too are other family arrangements. Alternative family types include foster and adoptive families, grandparents raising children, complex or multiple partner fertility families (when adults have children with more than one partner), polygamous families, and nonchildbearing families. Although beyond the scope of this discussion, all family arrangements are important when taking stock of human services and diversity.

The fluidity with which family types develop and function today calls for an expanded conceptualization of family structure and an ongoing review of the complex nature of family arrangements. As the work of human service providers moves away from large institutional contexts to smaller, often community-based settings, having a fuller understanding of the family context in which children, youth, and adults live will be helpful. Extending human service providers' knowledge of family structure, cultural context, and family bonds and networks can be useful in identifying families' strengths and where resources and support are needed. Human services providers, policy makers, and researchers together can continue the important work of examining and embracing the broadening landscape of family arrangements that encompasses family life in the United States in the 21st century.

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See Also: Co-Parenting, Cultural Aspects of; Divorce; Same Sex Marriage/Couples; Single Parents; United States, Demographics of

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Family Therapy

Family therapy emerged from a systems theory of behavior to assess and transform reciprocal patterns of interaction between two or more people. These interactions continually organize and reorganize roles and responsibilities across three or more generations. Conceived in the late 1950s as an alternative to the individual focus of psychodynamic and behaviorist theories, family therapy focuses on the interactions that shape family structure to support development of family members. Based on family composition, these roles and responsibilities reflect ethnic and socioeconomic norms of family members.

Sigmund Freud's psychoanalytic therapy and its progeny, psychodynamic theory, postulate that human behavior is the product of an individual's internalized childhood experience. Behavioral therapy in the mid-20th century saw human behavior as a function of a linear cause-and-effect relationship among an external antecedent, the individual's behavioral response to it, and the subsequent external consequence.

However, in family therapy, why a behavior occurs is not a useful question. Instead, a family therapist perceives and adjusts who does what with whom, when, and in what manner in the reciprocal interactions of family members. Family roles, responsibilities, and organizational structure are manifest in these interactions. Thus, family process and structure rather than the content within or the rationale for these interactions is its primary concern.

Early Pioneers

At its inception, family therapy pioneers split between those who continued to work through intrapsychic constructs of psychodynamic theory and those who fully embraced systems theory. Nathan Ackerman, a psychoanalytically trained child psychiatrist, initially studied unemployment's effects on the mental health of Pennsylvania miners and their families. Later, although he experimented with in-home therapy and with assigning a single therapist to work with a mother and child at the Menninger Clinic, he continued to emphasize the psychological impact on individual family members of family patterns of interaction. With Don Jackson in 1962, he founded the seminal peer-reviewed journal, *Family Process*, with Jay Haley serving as its first editor.

Murray Bowen, another pioneer who worked at the Menninger Clinic, also incorporated psychodynamic constructs and assumptions to an expanded focus on families as systems. Bowen postulated that schizophrenia was the product of an unresolved symbiosis of mother and child, and articulated concepts such as undifferentiated family ego mass, triangulation, differentiation of self, and intergenerational transmission of symptoms.

Through the 1960s, a blending of constructs from Ludwig von Bertalanffy's general systems theory with Gregory Bateson's work on cybernetics and communication theory produced the foundation of a family systems theory. Much of this occurred at the Mental Research Institute (MRI) in Palo Alto, California. There, Jay Haley, Don Jackson, Paul Watzlawick, John Weakland, Virginia Satir, and others, merging perspectives from a variety of disciplines, joined Bateson in examinations of interactions between schizophrenic patients and their families, and then examined the transformation of family interactions around delinquency, school problems, psychosomatic disorders, and marital conflict.

Structural and Strategic Models

From this foundational theory testing at MRI, many family therapy models emerged. Jay Haley joined Salvador Minuchin, Braulio Montalvo, Harry Aponte, Peggy Papp, Charles Fishman, and others at the Philadelphia Child Guidance Clinic, which developed a significant family therapy training program. Minuchin and Fishman published seminal books on structural family therapy, a well-defined, easy-to-learn model. They supported Haley as he explored communication patterns in his book *Problem Solving Therapy*.

By the late 1970s, Haley and his wife Cloe Madannes founded the Family Therapy Institute in Washington, D.C., and published seminal texts on strategic family therapy and reparative therapy in families in which a child was sexually abused. Related to Haley's work, Mara Selvini Palozzoli, Luigi Boscolo, Gianfranco Cecchin, and Guliana Prata, Italian family therapy pioneers at the Milan Institute, developed a contextual and positive reframing of problem behaviors to transform paradoxical processes in family structure. Although Minuchin's work often focused upon lower-class and working middle-class families, these models were tested with a variety of populations and presenting problems. Researchers used videotape review and live supervision from behind one-way mirrors to enhance therapist knowledge, skills, and effectiveness. All of these models focused upon family process and cultural norms that shaped roles, responsibilities, and boundaries within and between family subsystems (couple, parental, child, and extended family). All viewed behaviors of concern as a product of current family process. By changing that process, family structure and beliefs changed as presenting problems diminished.

Rethinking Assumptions and Focus

By 1980, the focus of family systems theory increasingly included the context of family member interactions with schools, youth peer groups, and the community. This gradual shift toward the ecology of human interactions was propelled by Bateson's *Steps to an Ecology of Mind* (1972) and *Mind and Nature* (1979) and especially by Uri Bronfenbrenner's *The Ecology of Human Development* (1979), which applied constructs from more than a decade of development of family systems theory to produce a theory of social ecology called ecological systems theory.

Through the final decades of the 20th century, systems theories of behavior and family therapy models were also reshaped by the critical and constructivist thought influencing most Western social sciences. The Women's Project critically examined male pioneer assumptions about and emphasis upon differentiation, individuation, and mother-child interactions as targets for change. Betty Carter and Monica McGoldrick highlighted the influence of culture and ethnicity. Countering Milton Erickson's psychodynamic, male perspective of individual human development, they produced *The Family Life Cycle*, a stage theory of family development that applied constructs from family and ecological systems theory across three or more generations while acknowledging the influence of gender, race, culture, socioeconomics, and community resources, among other factors in shaping family achievements or problems.

In this same period, the voices of families also emerged to criticize a deficit, medical model focus that characterized much of the language and process of all therapy. Organizations such as the National Alliance on Mental Illness (NAMI) and the Federation of Families for Children's Mental Health noted that an overemphasis on so-called dysfunctional interactions in families ignored real strengths that could be the basis for change. These and other groups insisted on a collaborative role in assessment and treatment that often extended to research.

Multisystemic therapy (MST) also emerged in these decades. Developed through research, it embraced a community-based collaborative assessment and intervention process with families. It is defined, taught, and supervised through nine principles anchored in ecological systems theory.

Constructivist thought shaped the emergence of Tom Anderson and Michael White's narrative family therapy. Similarly influenced, William O'Hanlon, Michele Weiner-Davis, Steve DeShazer, and Kim Insoo-Berg defined and tested solution-focused brief family therapy.

Both approaches have roots in Bateson's communications theory. However, unlike structural, strategic, or multisystemic therapies, or the use of cognitive behavioral therapy as an intervention technique within some of these models, the clinician does not actively intervene in family process. Drawing from the philosophical deconstruction of postmodernist thought, narrative therapy seeks change through neutral conversation that simply reimagines family experience. For these reasons, Minuchin and others continue to question postmodernist narrative approaches with families.

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See Also: Family Structure, Diversity of; Marriage and Family Therapy; Multisystemic Therapy.

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Family Violence Prevention and Services

Family Violence Prevention and Services administers the Family Violence Prevention and Services Act (FVPSA) programs. First authorized in 1984 as part of the Child Abuse Amendments (P.L 98-457), FVPSA is the primary federal government's funding support dedicated to emergency shelter and related assistance for domestic violence victims and their dependent children. Operationally, FVPSA is a part of the Family and Youth Services Bureau, a division of the Administration on Children, Youth and Families within the Administration for Children and Families.

The main allocations of FVPSA funding come from the U.S. Department of Health and Human Services, which funds the essential services for domestic violence and primary and secondary prevention plans. Through FVPSA's funded programs, a network of community-based shelters and nonresidential services provide safe housing, advocacy, legal assistance, counseling and support groups, safety planning, and crisis response to domestic violence victims. The major objective of the FVPSA is to address domestic violence as a widespread social problem with serious health costs and consequences.

Domestic Violence and Abuse and the FVPSA

Domestic violence entails a pattern of abusive behavior in any relationship that is perpetrated by one partner to gain or maintain power and control over another intimate partner. Domestic violence has been referred to as domestic abuse, spousal abuse, battering, family violence, and intimate partner violence.

It can take many forms, including physical, sexual, emotional, economic, or psychological abuse or actions that detrimentally impact another person. Domestic violence and abuse includes any behaviors or actions that blame, coerce, frighten, humiliate, hurt, intimidate, isolate, terrorize, threaten, or wound someone. Domestic violence and abusive behaviors are varied, as follows.

- Physical abuse behaviors include hitting, slapping, grabbing, biting, and punching, among others. They also include such acts as denying medical care to a partner or forcing consumption of drugs and/or alcohol upon another person.
- Sexual abuse behaviors include, among others, coercing or attempting to coerce sexual contact or behavior without consent,

marital rape, and attack on sexual parts of the body.

- Emotional abuse includes constant criticism, name calling, damaging behavior of the other person's relationship with his or her children, and undermining the other's sense of self-worth and/or self-esteem.
- Economic abuse includes behaviors such as attempting to control another person by withholding access to money or causing loss of employment and/or income, as well as actions intended to make an individual financially dependent.
- Psychological violence and abuse include causing trepidation by intimidation, verbal abuse, destruction of pets and property, threatening harm to self, and threating to harm those related to the other (e.g., parents, children, and friends).

Domestic violence can also mean endangerment, criminal coercion, unlawful imprisonment, trespassing, kidnapping, stalking, and harassment. Domestic violence and abuse occur in various cultures across the world, irrespective of socioeconomic background, educational levels, ethnicity, age, sexual orientation, religion, or gender. It occurs in all forms of relationships, including opposite-sex or same-sex married partners, those living together, and those dating. The adverse impact of domestic violence and abuse not only affects those who are directly victimized, but also has a substantial consequence on the community and society at large. The victim's family members, friends, coworkers, and other witnesses are all affected. Approximately 15.5 million children are exposed to domestic violence each year. Those children who witness domestic violence and abuse while growing up are adversely affected by that experience. Exposure of children to frequent domestic violence and abuse experiences in the home predisposes them to multifarious social, health, and behavioral problems. It also teaches them that violence is normal, which increases their likelihood of becoming violent and abusive in their own future relationships.

Prevalence of Domestic Violence and Abuse

Accurate statistics on the scope of domestic violence and abuse are difficult to establish because data may vary depending on the reporting source. Nonetheless, approximately 1 to 5 million women in the United States suffer nonfatal violence each year at the hands of an intimate partner. Every year, one in three women homicide victims is murdered by her former or current partner. Women are five to eight times more likely than men to be victims of domestic violence. One in every four women will experience domestic violence during their lifetimes, with females who are 20 to 24 years of age at the greatest risk of nonfatal intimate partner violence. The Department of Justice reports that between 1998 and 2002 in the United States, 73 percent of family violence victims were female, 84 percent of spouse abuse victims were female, and 86 percent of victims of violence committed by an intimate partner were female.

Annually, more than 4 million women experience domestic violence of physical assaults and rapes, and nearly 3 million men are victims of domestic violence in the form of physical assaults. Although the majority of domestic violence victims are women, abuse and violence against men occur far more often. It is estimated that as many as one in three victims of domestic violence are male; however, men are reluctant to report abuse by women because they feel embarrassed, or they fear that they will not be believed, or worse, that law enforcement will assume that they are the perpetrator of the violence and not the victim, since they are male. Similarly, women who do not report intimate partner violence to the police frequently identify three cardinal reasons for keeping silent: the private nature of the relationship, their fear of retaliation from their abuser, and their feeling that the police would not respond properly to the abuse.

Role of the Family Violence Prevention and Services Act

By far the most extensive legislative response to the problem of domestic violence and abuse—FVPSA's additional funded programs—include the National Domestic Violence Hotline, State Domestic Violence Coalitions, a network of National Resource Centers and Culturally Specific Institutes, and targeted discretionary grants, as well as the Centers for Disease Control and Prevention's DELTA Program. The legislative charge for FVPSA is twofold: (1) to assist states in efforts to increase public awareness about and prevent family violence and to provide shelter and related assistance for victims of family violence and their dependent; and (2) to provide for technical assistance and training relating to states, local public agencies (including law enforcement agencies, courts, legal, social services, and health care professionals), nonprofit private organizations, and other persons seeking assistance. Currently, FVPSA formula grants are awarded to every state and territory and to more than 200 tribes. In addition, subgrant funds are awarded to more than 1,200 community-based domestic violence shelters and 300 nonresidential services programs providing shelters and other domestic violence prevention services.

The outcome evaluation of FVPSA's efforts in accomplishing its objectives concluded that the nation's domestic or family violence shelters are addressing victims' urgent and long-term needs and are helping victims protect themselves and their children. Public awareness of the social problem of family or domestic violence has tremendously increased through FVPSA efforts. After the FVPSA's program expiration in 2008, efforts of domestic violence advocates led to the reauthorization of the legislation as part of the Child Abuse Prevention and Treatment Act, which Congress passed on November 10, 2010. The bill was signed into law by President Barack Obama on December 20, 2013, reauthorizing FVPSA through fiscal year 2015.

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See Also: Domestic Violence; Domestic Violence, International Variations in Attitudes Toward; Domestic Violence, Victims of.

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Family Violence Prevention and Services Act

Domestic violence is a severe problem that affects men, women, and children throughout the United States. The Family Violence Prevention and Services Act (FVPSA) is a U.S. law that provides government funding to aid victims of domestic violence, family violence, and dating violence. Aid exends to the dependent children of these victims. Each type of violence encompasses acts or threats of physical abuse, psychological abuse, sexual abuse, economic abuse, or emotional abuse. Domestic violence and dating violence refer to the perpetration of these abuses from one member of an intimate or dating relationship toward the other, whereas family violence refers to abuse that occurs between any two members of a family or household.

Originally enacted as a component of the Child Abuse Amendments of 1984, the FVPSA currently provides the single largest federal funding source for domestic violence emergency services, which include shelters and counseling services, legal advocacy, victim assistance, and prevention and education programs. The FVPSA allocates funds to each state, including more than 2,000 private nonprofit and public agencies that carry out research, information sharing, and training. The goal is to improve the collaborative efforts of mental health, legal, and medical professionals to better serve the needs of victims of domestic violence. The reach of the FVPSA is extensive, as domestic violence affects men, women, and their dependent children regardless of age, race, socioeconomic status, religion, and sexual orientation..

Scope of Domestic, Dating, and Family Violence

Domestic violence, including dating violence, is a prevalent problem affecting more than 12 million men and women each year. According to a survey conducted in 2010 by the Centers for Disease Control and Prevention (CDC), one in four women and one in seven men reported being victims of physical violence perpetrated by an intimate partner. In 2007, domestic violence accounted for approximately 14 percent of homicides. Domestic and family violence can also have detrimental effects on victims' health and well-being. Victims may suffer minor or serious physical injuries, such as scratches, bruises, head trauma, broken bones, or internal bleeding. Victims may also report psychological effects, including trauma symptoms, panic attacks, difficulty sleeping, difficulty forming new relationships, and low self-esteem. Furthermore, victims of domestic or family violence are at an increased risk for depression, eating disorders, suicidal thoughts or actions, and the use of harmful coping strategies, such as dangerous alcohol consumption or drug abuse.

The monetary costs associated with incidents of domestic violence are high. The cost of medical and mental health expenses, decrease in productivity from time out of work, and law enforcement and legal services subsequent to domestic violence is more than $37 billion annually. Such costs, coupled with the wide-ranging negative effects on men, women, and children, solidify the need for the FVPSA and its funded programs.

Funding and Authorization

After its authorization in 1984, the FVPSA became the sole funding source with the purpose of providing financial support to domestic violence programs and shelters. The FVPSA was amended and reauthorized by Congress in 2010 as an element of the Child Abuse Prevention and Treatment Act and was again reauthorized in 2013 through fiscal year 2015. Changes to the 2010 act include broader definitions of types of violence and of eligible entities to ensure greater access to services as well as a greater focus on preventive programs. The approved funding in the amount of $175 million allows the FVPSA program to provide formula grants to states, territories, and Native American tribes; subgrants to local domestic violence programs; national centers for training and technical assistance; and operation of the National Domestic Violence Hotline.

Appropriation of Funding

The FVPSA is the only source of federal funding dedicated solely to domestic violence victims' assistance, prevention, and emergency services. State formula grants account for 70 percent of the total appropriation of the FVPSA and serve as the main method through which the FVPSA funds are dispersed nationally to U.S. states and territories. Each state, as well as the Commonwealth of Puerto Rico and the District of Columbia, receive a base grant of $600,000 annually. Ten percent of the FVPSA appropriation is set aside each fiscal year for Native American tribes and organizations. The remaining funds are divided and allocated to states based on population. Funding is then granted to local private, public, nonprofit, and faith-based agencies that have verified research-based practices, as mandated by the FVPSA legislation.

States utilize the FVPSA funding for a variety of services for victims of domestic violence and their dependents. Emergency services funded through the FVPSA are perhaps some of the most crucial in that they support more than 1,600 shelters and provide safety and short-term stability. The FVPSA-funded state programs further provide medical care, mental health counseling services, transportation, and legal advocacy to victims and their children. State programs also appropriate funds to execute outreach and prevention programs as well as to raise public awareness to encourage victims to seek assistance and report violent crimes. Goals of the FVPSA program further include increasing access to domestic violence–related services and better serving victims in marginalized communities.

To support these efforts and meet the needs of victims of dating, domestic, and family violence, the FVPSA encourages and funds collaborative efforts among health care professionals, law enforcement, violence prevention and service programs, and state coalitions. The FVPSA funding plays an important role in improving the overall quality of life for men, women, and children affected by domestic violence in the United States.

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See Also: Child Abuse Prevention and Treatment Act; Domestic Violence, International Variations in Attitudes Toward; Domestic Violence, Victims of; Family Violence Prevention and Services

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Female Genital Mutilation

Female genital mutilation (FGM, also called female circumcision or female cutting) involves the practice of removing part or all of a girl's external genitalia for nonmedical purposes. This practice, which dates as far back as the 5th century B.C.E., is believed to have its roots in ancient Rome and Egypt. FGM is considered a rite of passage marking a girl's transition to womanhood. It is often deeply intertwined into the fabric of the societies where it is most frequently practiced, and is often rooted in the cultural and/or religious belief that female circumcision is necessary to ensure a woman's sexual purity and restraint. Additionally, the female sex organs are considered dirty, evil, and even dangerous in many cultures that practice FGM. For instance, men in some tribes in the Sudan believe that if a woman's clitoris is not removed, it will grow to rival the size of a man's penis.

FGM is classified into four categories, each with increasing levels of severity. Type 1 involves the partial and/or full removal of the clitoris (often called clitorectomies), with the labia kept intact. Type 2 involves the removal of the clitoris as well as the labia minora. Type 3, the most extreme form of FGM (often called infibulation), involves the removal of the clitoris and the complete scraping away of the labia minora. In many countries, infibulation also involves the creation of a vaginal seal, involving the stitching together of the labia majora, with only a small opening being left for the passage of urine and menstrual blood. When a woman (or girl) marries, her vaginal seal is broken by her husband (often ceremoniously and quite painfully), which proves she is a virgin. The process of breaking the vaginal seal is often repeated throughout a woman's life, as the ripped pieces of her labia are sewn back together again to ensure ongoing chastity, only to be broken apart again during subsequent sexual intercourse or at childbirth. Clearly, the constant sewing up and breaking apart of the woman's vagina causes significant physical trauma as well as great psychological distress. Type 4 involves all other forms of nonmedial genital mutiliation, such as stretching, scraping, notching, and piercing.

FGM is most often performed by local midwives or tribal healers in nonmedical settings where unsterilized traditional tools, such as razor-like instruments or some type of scalpel, are used on one girl after another in succession. The girls do not receive pain medication and often must be immobile for up to a month at a time due to bleeding and pain. FGM is most frequently performed on girls between the ages of 10 and 16 years, but in some cultures it is performed on girls as young as 4 or 5 years old. FGM ceremonies, which often are attended by the entire community, include several girls laying in rows, with parents or community leaders pinning them down and holding their legs open so that the girls' genitalia can be cut. Physical side effects include profuse blood loss, infection, urinary problems, scar tissue that intereferes with childbirth, recurrent pain, reinjury, and even death.

Female genital mutilation is almost universally considered a serious human rights violation and many advocacy campaigns have been initiated in an attempt to stop it.

Psychological consequences include post-traumatic stress disorder, depression, feelings of powerlessness, and loss of self-esteem.

In many regions, the consequences for girls who do not undergo FGM are harsh. For example, in many societies that practice FGM, if a girl's family refuses to allow her to undergo the genital cutting ritual (or if the girl refuses), she will be ostracized completely from society and will not be allowed to marry. In some societies, the consequences are even harsher and may included complete social shunning. For instance, in many Masai tribes in Kenya, women who are uncircumcised are also excluded from all forms of cultural engagement, including marriage, family events, communal celebrations, and even communal eating. Unfortunately, many girls who have not been circumsized are left with no alternative other than to enter prostitution, which then serves to support the myth that the clitoris leads to promiscuity. This type of social shunning often leads many loving mothers and aunts to force their daughters and nieces to undergo FGM because they fear that is the only way to ensure their daughters' social and physical protection.

FGM is almost universally considered a serious human rights violation, and many advocacy campaigns have been initiated in an attempt to stop this practice on a global basis. In response to international pressure, many at-risk countries have passed legislation making FGM illegal, but enforcement remains a challenge because FGM is deeply ingrained into everyday norms and traditions in these cultures. In many countries, FGM tends to be practiced more frequently in rural areas, far away from urban centers where enforcement is easier and communities tend to be more progressive. International efforts have also focused on campaigns to address FGM and its consequences within a local context. In fact, the United Nations has partnered with several nongovernmental organizations (NGOs) in the development and implementation of awareness campaigns targeting community and tribal leaders, as well as providing services for victims of FGM, focusing on medical, mental health, and residential needs.

Human services professionals can contribute to the fight against FGM on both a micro- and macrolevel in many ways. Human services professionals engaging in counseling and case management with diverse populations, such as refugees, are likely to encounter women who are survivors of FGM. When counselors and case managers are more aware of this historic practice and the impact it has on female survivors, they will be more likely to anticipate the short- and long-term consequences (both psychological and physical), even if their clients do not initially disclose their experiences. Counseling and case management can then focus on a range of issues, including assisting clients in managing these consequences, which are likely to be at least partially seated within a cultural context. On a macrolevel, human services professionals can be most effective when they collaborate with a network of social justice advocates, including advocacy organizations working on an international level. It is vitally important to also engage with members of the local community, since those within the communities that practice FGM are likely to have the best understanding of the cultural forces that are the most resistant to change. Human services professionals can then be partners in the development of so-called home-grown solutions that take into consideration the belief systems, feelings, and needs of the local community, which will increase the likelihood of effecting enduring change.

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See Also: Gender Issues and Roles in Developing Countries; Trauma-Focused Services; United Nations Convention on the Rights of the Child.

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Fetal Alcohol Syndrome and Drug-Exposed Infants

Women's use of alcohol and drugs during pregnancy leads to a continuum of impairments among the infants who were prenatally exposed to these substances. Infants who were exposed to opioids or multiple drugs experience the highest risk for adverse neonatal outcomes compared to infants who were exposed to a single substance. Prenatal exposure to illicit drugs increases the risks for sudden infant death syndrome (SIDS) and can lead to impairments in infants' psychomotor development. Women who engage in frequent bouts of binge drinking when pregnant increase their newborns' risk for adverse neonatal outcomes compared to women who may have had a few alcoholic drinks during pregnancy. Due to the adverse effects for newborns, the best strategy is for women to abstain from using alcohol and drugs when pregnant. It is important to realize that some fetal alcohol effects might occur even before a woman realizes she is pregnant.

Definitions

Fetal alcohol syndrome disorder (FASD) comprises a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. Fetal alcohol syndrome (FAS) is a serious developmental disorder caused by prenatal exposure to alcohol, and it represents the severe end of FASD. The consequences of FAS range from mild intellectual and behavioral issues to profound disabilities or premature death. FASD is among the most commonly known causes of mental retardation and is a major public health problem. Alcohol-related neurodevelopmental disorder (ARND) and alcohol-related birth defects (ARBD) are also part of the spectrum of fetal alcohol disorders. People with ARND might have intellectual disabilities and problems with behavior and learning. Those with ARBD might have heart, kidney, bone, or hearing problems or a mix of these problems.

The lifetime cost for one individual with FAS in 2002 was estimated to be $2 million. This is an average for people with FAS and does not include data on people with other FASDs. People with severe problems, such as profound intellectual disability, incur much higher costs. The cost to the United States for FAS alone is more than an estimated $4 billion annually.

Diagnosing Prenatal Alcohol Exposure

The possible detrimental effects of prenatal alcohol exposure have been known for some time. Although historically it has been recognized that the children of alcoholics had problems, the cause was thought to be the result of poor genetic stock rather than any direct effects of alcohol.

The modern era of recognition of the detrimental effects of prenatal alcohol exposure began when Ken Jones, David Smith, and associates published two papers in 1973 describing a common set of features in 11 children whose mothers were known to be alcoholics or heavy drinkers during their pregnancies. Jones and colleagues named this constellation of features FAS. Subsequently, it was discovered that French physician Philip Lemoine had previously described this common pattern of anomalies in 1967.

The number of people with an FASD is unknown. Scientists believe that there are at least three times as many cases of FASD as FAS. Studies conducted by the Centers for Disease Control and Prevention have shown that 0.2 to 1.5 cases of FAS occur for every 1,000 live births in certain areas of the United States. In 2010, approximately 10 percent of pregnant women reported any alcohol use in the preceding 30 days, and about 2 percent of pregnant women reported binge drinking in the preceding 30 days.

It may be easier to diagnose FAS in young children, whereas the diagnosis in the neonatal period may be more difficult. Furthermore, changes in the face may occur as the individual grows into adulthood and obscure the typical facial appearance of FAS. Of concern is (1) the necessity of documenting the exposure history of the mother, (2) the reluctance of physicians to inquire about the drinking histories of pregnant women or women contemplating pregnancies, and (3) the fact that not all physicians and other health care providers are well trained or confident in their ability to recognize these effects.

There are three criteria for diagnosing FAS: specific pattern of facial features, pre- and/or postnatal growth deficiency, and evidence of central nervous system (CNS) deficiency. The individual must meet all three criteria to be diagnosed with FAS. However, the facial characteristics basically define FAS. The discriminating facial features are short palpebral fissures (the length of the eye opening), a flat midface, an indistinct or flat philtrum (the ridge under the nose), and a thin upper vermilion lip. Although each of these features can occur in a variety of disorders, the combination appears to be consistent with heavy prenatal alcohol exposure. Children with FAS can have other facial features, such as epicanthic folds (tiny folds of tissues along the eye opening), a low nasal bridge, an underdeveloped jaw, and minor ear anomalies. Usually the children are born small (less than 25th percentile) and remain small, at least until puberty. Finally, there must be evidence of CNS dysfunction, which might be physical (e.g., microcephaly, where the head is smaller than normal) or behavioral (e.g., hyperactivity, mental retardation). High levels of prenatal alcohol exposure are related to an increased risk for deficits in intellectual functioning. However, deficits in intellectual functioning can occur in children without all of the physical features required for a diagnosis of FAS. Children with FAS can also have heart defects, skeletal anomalies, altered palmar creases (creases on the hands), and urogenital anomalies.

Only a minority (10–40 percent) of the children of chronic alcoholic women are diagnosed with FAS. This suggests that some individuals are more susceptible than others, and that there are certain factors that increase the risk to the adverse effects of prenatal alcohol. First, the higher the dose of prenatal exposure to alcohol, the more likely it is that the child will exhibit fetal alcohol effects. The pattern of exposure is also important. Binge drinking, which produces high blood alcohol levels, is more damaging to the fetus than chronic alcohol exposure that produces lower blood alcohol levels. Thus, peak blood alcohol level may be an important factor. In addition, the developmental timing of alcohol exposure may influence the outcome. For example, the facial features associated with FAS appear to be related to alcohol exposure during the first trimester. In addition, genetic factors, nutritional factors, parity, and synergistic reaction with other drugs may influence the effects of prenatal alcohol exposure.

Children with FAS experience a range of developmental concerns, such as mental health problems and disrupted school experiences. As they mature, children with FAS also engage in relatively high rates of inappropriate sexual behavior, and a significant number have alcohol and drug abuse problems themselves. The factors that are protective against such developmental concerns include being raised in a stable, nurturing home; diagnosis before 6 years of age; no sexual or physical abuse; not changing households every few years; not living in a poor-quality home; and early intervention services.

Interventions

Given that there is no cure for FAS or FASD, the most appropriate strategy is prevention, such as assuring that all women have access to prenatal care and other services needed to ensure a healthy pregnancy. Women identified as being at high risk of having a child with FAS can be targeted for prevention interventions. These risk factors include being older; American Indian/Alaska Native; black, not Hispanic; unmarried; unemployed; without prenatal care; and a smoker during pregnancy. Mothers of children with FAS have a lower educational level, have more live-born children than mothers of children without FAS, and have been binge drinking and/or drinking heavily (seven days a week) during pregnancy. Other potential risk indicators include being on public assistance, receiving Medicaid at their child's birth, having a history of treatment for alcohol abuse, having been confirmed as an alcoholic, having a history of marijuana or cocaine use during pregnancy, having their infant screen positive for alcohol or drugs at birth, having a history of induced abortion, and having a mental illness.

Very little work has been done to develop interventions and treatment for children with FAS and for infants prenatally exposed to drugs. Data suggest that some children with FAS who also have attention deficit disorder do indeed respond favorably to stimulant medication. Early motor training to address motor deficits, balance problems, and gait anomalies may also be effective. Such services may be available through local early intervention programs. The Individuals with Disabilities Education Act (IDEA) states that children younger than 3 years of age who are at risk of having developmental delays may be eligible for such services. However, prevention is still the best approach.

To summarize, almost 50 percent of pregnancies in the United States are unplanned, stressing the importance of educating all women of childbearing age about the risks of drinking alcoholic beverages and using illicit drugs. Public health campaigns to increase awareness of how to prevent FAS and the risks of women using drugs when pregnant can be beneficial in improving infants' health outcomes.

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See also: Adoption: Infants, International, and Older/Special Needs Children; Alcohol and Substance Abuse Services; Ethnic Groups and Drug and Alcohol Use.

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Filipino Americans

Asian Americans are one of the largest racial groups in the United States. Yet, while studying or discussing Asian Americans, it is critical to understand that the monolithic group called Asian Americans actually comprises many different ethnicities reflecting a diversity of traditions, cultures, and languages. In addition, a dramatic difference in socioeconomic status and immigration status exists among the groups, which needs to be recognized when considering the well-being of Asian American communities.

Filipino Americans are the second-largest Asian American population in the United States. A predominantly immigrant, foreign-born group, Filipino Americans reside primarily in California, Hawai'i, and the U.S. east coast. Close to 2.9 million Filipinos live in the United States, according to the U.S. Census Bureau, and close to 4 million Filipinos will be living in the United States by 2030. Filipinos were one of the earliest groups to immigrate to the United States, and they came in four distinct waves. The first Filipinos, who came to the United States in the mid-1700s as seafarers on the Manila galleons, eventually settled in Louisiana. The second wave arrived during the time that the Philippines was a U.S. colony with a population primarily of laborers from the Ilocano- and Visayan-speaking provinces. The third wave arrived post–World War II and consisted mostly of Filipinos who served with the U.S. Armed Forces and were given the opportunity to become U.S. citizens. The fourth and largest wave of Filipinos came to the United States as part of the passage of the 1965 Immigration Act. Many of these Filipinos came as occupational migrants (e.g., nurses, physicians, accountants, and teachers) and were highly educated and English-speaking.

A diverse group, Filipinos consist of more than 60 cultural minority groups and speak 100 ethnic languages. Filipinos have a long history of colonization, which has greatly impacted their culture and social structure. Filipinos were colonized by Spain for roughly 300 years and were subsequently colonized by the United States. During Spanish colonial times, regionalism was encouraged in order to prevent nationalist revolt, and social policies were enacted that severed the Filipino social structure. The Spaniards also brought the religion of Catholicism, which continues to heavily influence Filipino customs. The differences in language and subculture might explain the divisiveness and lack of unity that persists in the Filipino American community.

Compared to other Asian Americans, Filipino Americans can be characterized as at high risk for mental disorders. Compared to white Americans and the general U.S. population, Filipino American adults have higher rates of depression. Prevalence of depression is also higher compared to Japanese and Chinese Americans, but rates may be underestimated because Filipinos tend to deny, somatize, and endure emotional problems. Filipino adults have lower suicide rates than whites and other minorities, possibly due to the influence of Catholicism as well as available extended family and social support systems. For depression, Filipinos have the tendency to seek spiritual, personal, or social treatments, rather than Western medical treatments, and consider interpersonal factors as important treatments. For example, highly religious Filipino Americans are more likely to seek help from religious clergy, whereas those who are highly spiritual are less likely to seek help for mental health issues. Despite their middle-class status, English proficiency, employment status, educational attainment, acculturation levels, and access to health care, Filipino Americans underutilize mental health services.

Filipino Americans, along with other ethnic communities, face racism, which can adversely impact their mental health. Various studies have shown that Filipino Americans report the highest rates of perceived discrimination, which is significantly associated with depression. Researchers indicate that chronic exposure to racial discrimination is related to chronic diseases (e.g., heart disease, diabetes, blood pressure, and alcohol and substance abuse). Studies of the influence of racism on the psychological health of Filipino Americans are limited. Even though Filipinos are generally family-oriented and rely primarily on family for social support, compared with other Asian Americans, Filipino Americans use mental health services at a much lower rate. Possible explanations for lower rates of help-seeking include loss of face, adherence to Asian cultural values, help-seeking attitudes, low levels of social trust, and cultural mistrust toward seeking professional mental health services.

Researchers have documented mental health differences between U.S.-born and foreign-born immigrants. U.S.-born individuals tend to use specialty mental health care at higher rates than immigrants, yet immigrants have better mental health than their U.S.-born counterparts. Furthermore, other studies indicate that for mental health indicators, U.S.-born and foreign-born adults were equally likely to experience serious psychological distress. Indeed, this distinction between U.S.-born and foreign-born adults holds merit for Filipinos. Foreign-born Filipinos, compared to U.S.-born Filipinos, have significantly lower levels of depressive symptoms. In contrast, U.S.-born Filipino Americans are more likely to use the lay system as their usual source of care, compared to professional or folk systems. Compared to other immigrants, Filipino Americans have high socioeconomic status, yet their mental health does not reflect this social status. The mental health needs and help-seeking behavor of Filipino Americans must be examined within the context of various social factors.

Recent health statistics provided by the President's Commission on Asian Americans and Pacific Islanders in 2001 show that Filipino American adolescents have one of the highest rates of suicide ideations and attempts in the United States. Furthermore, alarmingly high statistics on other health issues, such as rates of HIV/AIDS, unintended pregnancy, eating disorders, sexually transmitted diseases, and drug use, are also reported for Filipino American communities across the United States. Indeed, increased research and clinical attention on the Filipino American population are needed. Second-generation Filipino youth also face heightened risk for health concerns.

Young Filipino men and women experience contradictory messages and pressures to succeed with the standards of their families, gender differences, and specifically the intense messaging around academic majors or career choices and expectations of being a family (e.g., not to get pregnant out of wedlock). As a result, some second-generation Filipinos experience suicidal ideation and severe stress from pressures to succeed, combined with little to no outlets for support or encouragement to seek help from outside the family. This suggests that although not all Filipino children of immigrants suffer from alienation from their parents, the model minority picture of Filipino immigrants being able to assimilate with little cost may have detrimental effects.

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See also: Arab Americans; Asian Americans; Vietnamese Americans.

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Financial Literacy Programs

Contemporary interest in financial literacy has been traced to a 1992 report prepared for the National Westminster Bank in London that focused on adolescents and their need for financial education in light of the financial deregulation in the 1980s. Growing concern about the state of financial illiteracy in Great Britain led to the creation in 2000 of the first national agency in the world charged with elevating consumer levels of financial literacy, the Financial Services Authority (FSA). In short order, the FSA was followed by the Financial Consumer Agency of Canada (2001), the European Clearinghouse for Financial Literacy in the Directorate General for the Internal Market (2001), the Financial Literacy and Education Commission in the United States (2003), and the Financial Literacy Foundation in Australia (2005). The Organisation for Economic Co-operation and Development (OECD) announced a two-phase financial education project in January 2004 concerned with the protection of individual investors, the uninformed insured, and the shift in risk to the investor that accompanies defined-contribution retirement plans in contrast to defined-benefit retirement plans.

Many factors have stimulated international interest in increasing the financial literacy or financial capability of consumers and citizens in economically developed countries. Aging populations in these countries have stressed the financial capabilities of social welfare programs. Improving financial literacy encourages greater individual preparation for retirement and may relieve some of the financial stress on national budgets. The growing interconnectivity of the global economy, especially the restructuring of global financial markets and deregulation of major financial institutions, has made it virtually impossible for individual nations to maintain monetary independence, stable exchange rates, and access to capital investments. Improving financial literacy converts consumers into partners working collaboratively with national economic goals. From a national perspective, elevating financial literacy among consumers is a protective strategy internationally and internally.

Definitions

Financial literacy is the most common of a variety of terms (e.g., financial capability, economic literacy) used to refer to consumer financial acumen. Attempts to define financial literacy presume adequate reading literacy and mathematical proficiency, but extend beyond these basics to include access to the knowledge, skills, or resources necessary to make effective financial decisions. The explicit goal of improving consumer financial literacy is to change financial behaviors. All economically developed nations define the desired financial behaviors with little concern for subjective consumer desires. Substantial differences exist, however, between the United States and other economically developed nations regarding the means by which the desired financial behaviors are pursued.

In the United States, financial literacy means knowledge and skills for individual economic maximization. Areas of concern include budgeting, savings, investing, asset accumulation, spending, credit/debt management, avoidance of predatory financial products, consumer and investor rights, and participation in mainstream financial institutions. The financially literate decision is the decision in each of these areas that produces the maximum return at the minimal costs to the individual decision maker. The underlying assumption is consistent with classic free market capitalism in which individual self-interest produces collective benefits.

Other economically developed nations place their emphasis on the national economy rather than the individual. Areas of concern expand beyond the individual profit motive to include a variety of national interests as diverse as increasing social inclusion, decreasing social deprivation, reducing overall consumer debt, increasing household savings, or improving the efficiency of government-sponsored social welfare programs. The means of achieving the goal of financial literacy is not the education of the individual but rather increased access to informational resources. Thus, the financially literate decision is that which conforms to national goals rather than that which serves the individual consumer.

Financial Education

Outside the United States, financial education programs tend to focus on improving consumer confidence in the national economy and increasing access to financial advice in the form of financial professionals or online financial information. In the United States, the more decentralized and complex social welfare mosaic has created a larger variety of financial education programs that address the needs of specific populations (e.g., debtor counseling or investor advice) or prepare participants for inclusion in the mainstream economy (e.g., potential homebuyers or credit repair). Nonprofit organizations serve target groups as diverse as victims of interpersonal violence, who may be reluctant to leave an abusive relationship for financial reasons, and ex-offenders returning from incarceration, who may be completely unfamiliar with modern innovations such as debit cards and the Internet.

The U.S. Federal Reserve Board provided seed money for the nonprofit Jump$tart Coalition for Personal Financial Literacy in 1995 to promote some degree of collaboration with a modicum of success. Today, Jump$tart is a coalition of 150 organizations and 49 state coalitions dedicated to the financial education of primary, secondary, and tertiary students through resources, advocacy, research, and standards development. Further centralization of financial education in the United States since 2001 has been promoted by the free Money Smart financial education curricula and training available from the Federal Deposit Insurance Corporation (FDIC). The FDIC claims that 2.75 million consumers have benefited from Money Smart.

Diversity

Financial literacy programs rarely promote diversity. The explicit focus, changing consumer behaviors against a normative standard, promotes conformity. These normative standards are almost universally determined from the perspective of the financial services industry, with a high degree of insensitivity to the context of the financial decisions and avoidance of the subjective consequence of financial outcomes to the individual consumer. Those on the margins of national economic activity are prepared to and persuaded by these programs to move into the economic mainstream.

Critiques and Criticisms

Educational programs to improve financial literacy may be unstated justifications for a new form of laissez-faire economics in which the consumer loses protective financial regulations and access to formal state assistance. In the worst case, the individual consumer's personal financial interest may be vulnerable to subversion by state and corporate objectives. This critique of financial literacy programs is particularly acute in those nations with a robust and growing alternative economy for people with low and unstable incomes. Characterized by payday lenders, pawnbrokers, buy here–pay here auto dealers, rent-to-own stores, tertiary labor markets, and a close affinity with illicit economic activities, the alternative, fringe, or underground economy receives little more than cursory attention in most financial literacy programs. Accordingly, financial literacy programs, especially those sustained by financial institutions, are little more than training programs to promote middle-class and higher economic behaviors. To households without the stable incomes to sustain middle-class lifestyles, financial literacy programs are often irrelevant. When financial literacy programs understand that financial decisions are bounded by different contexts, participants in these programs will be more likely to benefit from the training.

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See Also: Economic Support and Services; Employment/Career Assistance Services; Life Skills Training; Microlending Programs; Services for Victims of Domestic Violence; Prisoners and Exprisoners.

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Food Desert

Food deserts are generally defined as areas with a lack of access to affordable good-quality food that allows for a healthy diet. The term *food desert* has a variety of definitions. In one definition, there is no access to a supermarket with annual sales of $2 million or more within a specified area, either a mile or 10 to 20 miles. The U.S. Department of Agriculture (USDA), offers an online Food Access Research Atlas that shows what areas of the United States are food deserts. Food deserts are found in both urban and rural areas. An estimated 13.6 million people throughout the United States live in food deserts. People living in food deserts are generally of low income, have high levels of food insecurity, and have very poor access to affordable food, particularly fresh produce. Since low-income people throughout the nation live in food deserts, obtaining knowledge of what they are, what causes them, why they persist, and their impact are crucial to address problems of poverty, inequality, and food insecurity in the United States.

Description of Food Deserts

People who live in food deserts are far from supermarkets and often lack access to the food required to maintain a healthy diet. Lacking supermarkets, food deserts are often served by high-priced convenience stores and gas stations with limited food options. Food available in food deserts tends to be less healthy, more expensive, and of low quality. The processed foods available may contribute to rising rates of obesity. In addition, high concentrations of food deserts exist in areas with high rates of regressive taxation, such as Mississippi and Alabama. In fact, these two states have some of the highest rates of food deserts, have sales taxes on food that are high as 10 percent, and they tax foods that in most states are exempt from sales tax, creating further problems for food affordability..

What Causes Food Deserts

As stated, food deserts are often in low-income communities. Several factors lead to the creation of food deserts. One is the shift over the past several decades from local food stores to supermarkets and increasingly to superstores. This shift occurred as many urban areas were declining. Many urban cities lost supermarkets and smaller businesses, such as butchers, as poverty increased and middle-class people fled to the emerging suburbs. Certain rural areas have similarly experienced population loss. The economic downturn of 2007 through 2009 exacerbated the problem when many food stores

Lacking supermarkets, food deserts are often served by high-priced convenience stores and gas stations with limited food options. Food available in food deserts tends to be less healthy, more expensive, and of low quality. The consumption of processed foods is thought to contribute to rising rates of obesity.

throughout the country were forced to close, leaving rural areas in particular deeply impacted.

Location and Population of Food Deserts

Food deserts are located in both urban and rural communities. Poverty rates are one of the best predictors of the location of food deserts. In most areas, the higher the percentage of the population who are people of color, the more likely an area is to be a food desert. Communities with large numbers of African Americans and Latinos also have a higher probability of being food deserts. Rural areas that are not experiencing population growth are also likely to be food deserts.

The USDA has identified several areas of concern to policy makers when addressing food deserts. Designing the right public policies requires a knowledge of the factors shaping food deserts. Among the concerns identified were income and transportation. Many rural areas have little to no public transportation, and isolated rural communities are often more than 20 miles from a grocery store.

Some studies of people living in food deserts have contradicted the stereotypes of people uninterested in health food. These studies seem to suggest that lack of access rather than personal habits shapes eating habits. When healthy food is available in cities such as New Orleans, people are likely to consume items such as fresh fruits and vegetables. Indeed, a food bank in Sacramento, California, experienced success when it worked to encourage healthier eating.

Impact of Food Deserts

Food deserts have the potential to have a significant impact on public health in areas such as obesity, heart disease, and diabetes. The lack of access to healthy food creates the potential for many public health problems. Increasingly, reports suggest that low-income children growing up in food deserts will be part of a generation that faces a lower life expectancy than their parents. Eating processed foods can lead to increased obesity, and the unhealthy diet that many food desert residents experience can have a profound impact on health, increasing the cost of programs such as Medicare and Medicaid.

Academic and Public Policy Responses to Food Deserts

In June 2011, the University of Nebraska at Omaha held a forum on food deserts and public policy. Attendees represented a cross section of those attempting to formulate policies who brought up many issues. Since food deserts are beginning to get more attention, it is possible that there will be more coordinated policy responses; in fact, in the past 15 years, responses have emerged.

Politicians at the federal, state, and local levels have worked to create solutions to the problem of food deserts. The federal New Markets Tax Credit (NMTC), established in 2000, provides much support to promoting food banks and other responses to food deserts. In 2010, the Obama administration unveiled the Healthy Food Financing Initiative (HFFI), based on a program that originated in Pennsylvania. The program aimed to eliminate food deserts within seven years through measures such as $250 million in tax credits and providing federal funds to assist local efforts. At the launching, then Governor Ed Rendell noted that even strong school lunch programs made little impact without access to healthy food at home.

State and local efforts have also been devoted to combating food deserts. Pennsylvania's policy, the basis for HFFI, resulted in 80 supermarkets opening in former food deserts over a period of five years. The Pennsylvania initiative provided one-time loans and grants to help entrepreneurs start businesses in underserved areas. These initiatives improved access to a healthy diet for an estimated 400,000 people while also creating an estimated 5,000 jobs. The New York State Food Policy Council was founded in 2007 by then Governor Eliot Spitzer to combat the problem of food deserts and other food issues. Conducting public hearings throughout New York State, the council compiled a report exploring issues and possibilities.

First Lady Michelle Obama has devoted a great deal of attention to combating childhood obesity and promoting healthy eating, particularly through her Let's Move program. She has made creative efforts to promote healthy eating and combat food deserts, even appearing on an episode of the television show *Restaurant Impossible* in which a nonprofit organization redesigned its space to serve healthy food to a larger number of children.

In addition to public policy efforts that can assist food deserts are initiatives under discussion that could potentially exacerbate problems. Since 2000, there has been a tremendous growth in enrollment in the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps). Proposals to reform SNAP could make it more difficult for stores in food deserts to accept SNAP funds, thereby reducing eligibility. In addition, potential cuts in safety-net programs that focus on nutrition could make access to food more difficult.

Moving beyond governmental action, nonprofit organizations also attempt to work in food deserts, sometimes by providing meals rather than education. One Massachusetts organization, the Food Project, grows fresh produce in the affluent suburb of Lincoln, the Roxbury section of Boston, and the North Shore. It sells the produce and donates the proceeds to local hunger-relief organizations and homeless shelters. Other programs, such as the Texas Hunger Initiative, work to combat food insecurity through access to meals using the community and civil society. Efforts across public and private sectors are ongoing.

Conclusion

Food deserts are located throughout the nation and have the potential to create extensive public health problems, such as obesity. They are characterized by a lack of access to affordable, healthy food. People who live in food deserts often depend on convenience stores and gas stations for food. Public policy efforts at every level of government

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See Also: Food Insecurity; Food Support; National Health and Nutrition Examination Survey.

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Food Insecurity

Currently, about 1 billion people live on less than $1 a day. As a result, one-fifth of the world's population is suffering from hunger or undernutrition. Most of these people are poor farmers who lack arable land or have difficulties in accessing clean water. Moreover, climate change; global warming; natural disasters such as earthquakes, tsunamis, and hurricanes; erosion; and deforestation are all affecting the world's food and water resources. The enormous population growth is signaling increasing scarcity of food and water in the near future.

Definition

Food security is defined by the World Food Summit of 1996 as existing "when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life." In this respect, the concept of food insecurity can be defined as the lack of physical or economic access to sufficient, safe, and nutritious food. The levels of food production and distribution are among the root causes of food insecurity. Moreover, a third factor can be added, which is consumption. Responsible consumption results in a decrease of the level of food waste and thus hunger and malnutrition because less food waste in one part of the world translates into less food loss in other parts of the world.

Relationship Between Food Insecurity and Poverty

Many people in the world do not know where or when they will find their next meal. These people, who suffer from hunger or undernutrition, are generally poor farmers. In this respect, a strong relationship exists between poverty and food insecurity. Extreme poverty is mostly seen in the regions with the lowest levels of per capita income in the world; in addition, both famines and undernutrition continue to affect a great many people. According to the 2005 research results of the World Bank, 880 million people were living on less than $1 a day, which was then the poverty line. In 2009, more than 1 billion people in the world did not have enough to eat, and 98 percent of the world's hungry lived in developing countries.

In 1993, of the world's 1.271 billion extreme poor, 1.036 billion who lived at less than the poverty line ($1.08 a day at that time) were from rural regions. Similarly, in 2004, of the world's 1.165 billion extreme poor, 0.882 billion were living in rural areas. According to these results, more than three-quarters of all poor people live in rural areas in the world.

Today, most of the poor still live in the rural areas of the world. Gemmo Lodesani, head of the World Food Program office in Brussels, is tasked with fulfilling the organization's primary commitment of fighting hunger worldwide. He reported in 2010 that "three-quarters of the more than one billion hungry people in the world are poor farmers." The vast majority of the rural poor are self-employed in agriculture.

For the rural poor, historically scarcities of water and arable land have caused great hardship with the growing population, which will continue to be a big problem. A contemporary projection by Population Action International (PAI) regarding available arable land for humanity indicates that whereas there was a lack of 7 percent arable land for the world population in 2005, this lack will increase to 10 percent by 2025.

Food insecurity stems from the injustice in the distribution of food globally rather than the insufficiency of food. In this respect, current levels of food production are enough for all people in the world both for today and the future. However, current studies and contemporary projections show that the gap between the amount of global food and the world population is increasing. The International Rice Research Institute's Web site shows, for example, that the world population is increasing every second while the amount of the world's productive land is decreasing. There are about 1 billion hungry in the world today, and it is expected that number will reach 3 billion by 2050.

Conflicts Arising From Food Insecurity

According to studies commissioned by the University of Toronto and the American Academy of Arts and Sciences, many conflicts in the world have been caused by the scarcities of renewable resources. As Thomas F. Homer-Dixon claimed, “These conflicts may foreshadow a surge of similar violence in coming decades, particularly in poor countries where shortages of water, forests and, especially, fertile land, coupled with rapidly expanding populations, already cause great hardship.”

Rich countries can overcome such scarcities in renewable resources, but poor ones cannot. The most important thing about these scarcities in renewable resources is that they are a problem only in the case of poverty. Of the 50 countries in sub-Saharan Africa, 31 (more than 60 percent) experienced conflicts during the 1980s and 1990s. Not surprisingly, 21 of these conflict-torn countries are among the world’s 40 poorest countries. Other poor countries, such as Bangladesh, Haiti, Myanmar, and Afghanistan, have also experienced conflicts. The common thing among the 40 poorest countries of the world is that their average annual income level is US$995 or less. In this regard, James D. Fearon and David D. Laitin assert that “$1,000 less in income corresponds to 34 percent greater annual odds of outbreak.” Four different recent studies addressed the relationship between national income level and conflicts, and concluded that when per capita gross domestic product (GDP) decreases, the risk of conflict in a country increases.

Based on all aforementioned arguments, poverty, which is directly related to food insecurity, is the key root cause of conflict. Poor countries have experienced conflicts within their borders, and this is also going to be seen in the future unless precautions are taken to alleviate poverty, hunger, and malnutrition.

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See Also: Food Desert; Food Support; National Health and Nutrition Examination Survey.

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Food Support

The food service industry consists of various components, including companies and community-based services that provide prepared meals in restaurants, hotels, hospitals, schools, shelters, correctional facilities, and other institutions with cafeterias, catering, or meal services. Some institutions work with food service distributors to provide bulk inventories of food and nonfood products such as disposable kitchenware. Food services can also include nonprofit/charitable organizations such as food banks, nutrition programs, and federal and state food regulatory agencies.

Food Banks and Charitable Organizations

Food banks are nonprofit, charitable organizations that provide food for shelters, residential child care facilities, soup kitchens, and predominantly low-income schools. Food banks solicit donations from large and local businesses, faith-based organizations, federal programs, and individuals through food drives conducted in the community. One of the largest food banks in the United States is Feeding America, a nonprofit organization that serves more than 37 million Americans through corporate and community partnerships. Feeding America also conducts research about the issue of insufficient nutrition and provides insight into the impact of hunger on communities and individuals. Therefore, not only do food banks provide food for individuals in need, they also work to provide hunger-free advocacy efforts.

Nutrition Programs

The Food and Nutrition Center (FNIC) was formally established in 1977, through the Food and Agriculture Act of 1977, to collect and provide the public with health and nutritional information and resources. FNIC offers updated resources lists and other educational materials for multiple nutrition and food service program Web sites such as the Supplemental Nutrition Assistance Program (SNAP), Health Meals Resource System (HMRS), and the WIC Works Resource System (WWRS). The SNAP program provides nutrition assistance and education for low-income families, HMRS is an online resource for individuals working with or in child nutrition programs, and WWRS offers resources for nutrition professionals.

The U.S. Department of Agriculture administers several programs geared toward child nutrition, which include: the School Breakfast Program, the Fresh Fruit and Vegetable Program, the Special Milk Program, the Summer Food Service Program, the Child and Adult Care Food Program, and the National School Lunch Program.

The School Breakfast Program provides financial assistance to school- and residential-based nonprofit breakfast programs for children. The program is administered on the federal level and operates in more than 89,000 institutions. The Fresh Fruit and Vegetable Program is a federally administered program that provides fresh fruits and vegetables to schools in order to combat obesity and offer healthier food choices to children. The program primarily targets schools serving large numbers of children who receive free or reduced-cost lunches in all 50 states, the District of Columbia, and Puerto Rico. The School Milk Program reimburses schools and child care agencies that provide milk to students who do not participate in other federal meal programs. This program serves approximately 4,700 schools, residential child care facilities, summer camps, and other child care institutions.

The Summer Food Service Program is a state-administered program that provides free meals and snacks to low-income children in order to ensure that they continue to receive nutritious meals when school is not in session. This program targets areas in which the majority of children come from families with incomes at or below 185 percent of the national poverty level, and can be sponsored by many types of community and private organizations that provide meal services. The Child and Adult Care Food Program is a nutrition, education, and meal-reimbursement program that aims to increase the health and wellness of at-risk and low-income children, older adults, and persons with disabilities. The National School Lunch Program, established under the National School Lunch Act of 1946, is a federal meal program that serves public schools, nonprofit private schools, and residential child care facilities, and provides free and reduced-cost lunches to approximately 31 million children.

Food Regulation

The U.S. Food and Drug Administration (FDA) publishes a food code designed to provide guidelines to states regarding the regulation of retail food service industries. The FDA is the authority regarding food safety in the United States. While the federal government provides a model for regulation and may conduct inspections, as needed, it is primarily the duty of the states to inspect and supervise the over 1 million food establishments. States also contract with the FDA to provide oversight for various FDA-regulated programs and services, with 80 percent of inspections conducted at the state and local levels. The FDA provides evidence-based regulation standards that help state health agencies protect against food-borne illnesses. State agencies primarily govern licensure revocation and the penalties associated with violations of federal and state food regulation codes.

The National Association of State Departments of Agriculture (NASDA) seeks to create a consistent system of food regulation among the different regulatory agencies through oversight of the agencies and reform of the policies governing national- and state-level food regulation codes. NASDA highlights food-borne illnesses and the many other threats to the U.S. food supply. The United States has various food suppliers around the world, which increases the nation's potential for exposure to contaminants due to food quality issues and makes the U.S. food supply a potentially vulnerable target of bioterrorism. Evidence-based and uniform programs help increase efficiency and information-sharing regarding food regulation.

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See Also: Food Desert; Food Insecurity; Nutritional Services and Assessment.

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Foster Care Agencies

Foster care agencies are licensed agencies that have the responsibility for recruiting foster parents or finding foster homes and placing in their care individuals for whom placement outside their own homes is necessary for a temporary or extended period. Although foster care placement now has expanded to include some mentally or physically disabled adults and (more rarely) the elderly, it historically has been concerned with the placement of children who continue to make up by far the greatest part of the fostered population. Because child welfare services are the province of individual states in the United States, each state has in place administrative and legal structures and programs for the welfare of children. Typically, the foster care system falls under the direction of a division of family and children's services, and state agents superintend county social services departments and private foster care agencies licensed by the state. Private foster care agencies range in size from small, local agencies to large, multistate agencies, such as the Casey Family Programs and Girls and Boys Town that place hundreds of children in family-based foster care. The historic role of private agencies in the evolving foster care system is a central one, predating most state services, which were established after the Social Security Act of 1935 authorized the first federal grants for child welfare services. The federal role in the foster care system has grown in size and scope since those early, relatively small grants.

Government regulations at the national, state, and local levels determine such issues as requirements and training for foster parenting and procedures for termination of parental rights, but a substantial amount of the day-to-day operations of the foster care system is performed by county social services agencies, whose authority varies from state to state, as well as private foster care agencies licensed by the state. Private agencies may receive government funds, but they are usually dependent to some degree upon charitable contributions. The county agencies and the private agencies provide training sessions for foster parents, place children in foster homes, work with birth families for reunification when possible, advocate for adoption for those children who cannot be reunited with their families, and generally handle the details of each child's movement through the foster care system.

In the 18th century, children who were orphaned or whose parents were unable to care for them were frequently indentured to families willing to put them to work. It was not until the early 19th century that the practice of placing such children in orphanages began, usually established by private religious and charitable organizations. Toward the end of the 19th century, private agencies began placing orphans and destitute children with foster families, but orphanages continued to be the placement of choice for most children who could not live with their birth families. The first private children's charity, the New York Orphan Asylum Society, was founded in 1806. Similar institutions were soon in place in Boston, Massachusetts, and Baltimore, Maryland. By 1910, the United States had more than 1,000 orphanages. These institutions were committed to providing a basic education for their residents and then to placing them into apprenticeships or indentured servitude.

In the mid-19th century, economic recession, industrialization, and the influx of immigrant families into large eastern cities such as New York and Boston were stretching social resources thin. The problem of vagrant, indigent children begging and engaging in petty thefts was an increasing concern. According to some contemporary accounts, as many as 30,000 such children roamed the streets of New York and Boston. Despite the proliferation of orphanages, there was no room for many of these children other than almshouses, where they were placed with adults, including the ill, the diseased, and the insane. The lack of jobs in urban centers made the usual routine of apprenticing impossible, so states authorized orphanages and other institutions in charge of children to place males under age 21 and females under age 18 in homes outside the state that were willing to accept them and train them to work.

It was in this environment that Charles Loring Brace, a young minister horrified by the street children of New York, founded the Children's Aid Society in 1853 to raise the funds, obtain the necessary legal permissions, and arrange the trips that would move thousands of street Arabs, as the children were called, to new homes in rural America, where the need for labor in the expanding farming communities was significant. Between 1854 and 1929, an estimated 200,000 orphaned, abandoned, and runaway children were placed aboard trains to find new lives in more than 48 states, the District of Columbia, and Indian Territory locations, although most by far were placed in the Midwest.

The placing out of children, as it was called, did not begin with Brace's program, and the Children's Aid Society was only one of several agencies that placed children on trains that took them to new foster homes. It was Brace's orphan trains, however, that captured the public imagination and sympathy. Experts christened this period of mass relocation of children the orphan train era and acknowledged the efforts of Brace and his agency as the precursor to the modern foster care system.

The Federal Role in Foster Care

The Social Security Act of 1935 authorized the first federal grants for child welfare services under what came to be known as Title IV-B. The grants were not large, but they were enough to encourage those states that did not have child welfare agencies to establish them and to develop programs to deliver the services. Foster care was one of the services. Statistics reveal that by 1950, the number of children in foster care was greater than the number in institutions. By 1960, the foster care number had doubled. The antipoverty program of the 1960s increased federal funding for foster care, and a dramatic increase in the number of children in out-of-home family placements followed.

Even after the Social Security Act of 1935, the federal role in the work of foster care agencies remained limited. That role began to expand in 1960 with what became known as the Louisiana incident, in which Louisiana removed 23,000 children from its welfare rolls because their mothers had borne children outside of marriage. Although Louisiana's expulsion of clients was not an isolated occurrence, it was the one that motivated the U.S. Department of Health, Education, and Welfare

(DHEW), which administered Aid to Dependent Children (ADC), to put in place a new rule that a state could not ignore its responsibility to children living in homes the state deemed to be unsuitable. DHEW required the state to either provide services to make the home suitable or to remove the child from the home to an appropriate placement while continuing to support the child financially. Amendments to the Social Security Act in 1961 made the new rule law, creating the foster care component of ADC, which provided federal matching funds for foster care payments made on behalf of children who were removed from unsuitable homes if the children would have received ADC funds had they remained in their homes. In 1962, ADC changed to Aid to Families with Dependent Children (AFDC). In 1967, Congress again amended the Social Security Act and, among other changes, made Aid to Families with Dependent Children–Foster Care mandatory for all states. Foster care soon became the main form of assistance provided to poor children in the United States who could not remain in their own homes because of neglect or abuse.

With increased federal funding came increased federal laws and regulations that governed the decisions foster care agencies were required to make. In 1978, the Indian Child Welfare Act recognized that tribal courts have jurisdiction in child welfare issues involving Native Americans and that placement with relatives should have preference. The Adoption Assistance and Child Welfare Act of 1980 required reasonable efforts to be made to prevent placement in foster care; the statute also required case and permanency planning for all children and youths in foster care and established time limits on reunification and adoption subsidies. Other laws required opportunities to be created for young people in foster care to prepare for independent living; forbade making foster care and adoption placement decisions routinely on the basis of race, culture, and ethnicity; and mandated that the state initiate termination of parental rights when a child has been in state care for 15 of the previous 22 months (excepted in certain circumstances).

Successes and Failures in Foster Care

Despite a decline in the number of children in the foster care population since 2002 and the improvements of increased adoptions, funded legal guardianships, and greater attention to the needs of young people aging out of the foster care system, progress made by foster care agencies is inconsistent and limited by financial constraints. The quality of care varies not only from state to state but also within states and even cities, as large numbers of foster care agencies are involved. New York City alone has more than 40 foster care agencies. The statistics for children in foster care and for those who have been shaped by the system are dismal.

Foster care was intended as a temporary solution, but children in foster care today have already spent an average of two years separated from their families without a permanent solution. More than one in 10 children will experience five or more placements during their time in foster care, with overwhelming evidence that such a lack of stability puts children at high risk for reactive attachment disorder, which leads to a lifetime of disrupted relationships. One in seven children (one in three teens) in foster care live in nonfamily settings, often not because of anything they have done or to meet their special needs, but simply because the system has failed to connect them with a family.

Children often enter the foster care system with chronic health, developmental, and psychiatric disorders, reflecting the neglect and abuse they experienced in addition to the trauma of being separated from their families. However, the U.S. General Accounting Office found that many foster children fail to receive adequate preventive health care and have significant problems that are not diagnosed and treated while they are in foster care. Nearly 40 percent will wait longer than three years, even though studies find many families willing to adopt.

Disparities plague the system. African American children, who made up more than one-third of the foster care population in 2002, had declined to slightly over one-fourth by 2012. Nevertheless, the rate of African American children in foster care is twice the percentage of African American children in the general population in the United States. African American and Native American children are more likely than other groups to suffer disparity within the foster care system. Not only are they more likely to be reported, investigated, substantiated, and placed in foster care, but they are also less likely to receive comprehensive services, and are less likely to reunify with their families than white children. Latino children in the foster care system increased from 17 to 21 percent between 2002 and

2012. The highest increase was among children belonging to two or more races. Although numerically small (only 6 percent), this group doubled in percentage between 2002 and 2012.

Latino immigrant children are underrepresented in the foster care population, but the problems confronting those who do enter the system are magnified. These children may not speak English, they are likely to have different cultural backgrounds from child welfare workers and often from foster families, and they may lack relative networks. They are more often placed in group homes and institutions than children from other ethnicities.

Research has consistently shown a higher percentage of males in foster care. In 2011, 52 percent of the children in foster care were male, and 48 percent were female. Despite their smaller numbers, girls, many of whom have histories of sexual abuse and numerous parental transitions, are more likely than boys to be at risk for such problems as health-risking sexual behaviors (HRSB), involvement in the juvenile justice system, substance use, failed placements/foster care drift, homelessness, and serious educational problems as they enter adolescence. But adolescent girls are less likely to receive specialty mental health or school-based services than are their male counterparts. A major study in 2010 revealed that most former foster children struggle with limited success to live productive, satisfying lives as adults. By age 23 or 24, fewer than half of the former foster care youths in the study were working. Close to a quarter had no high school diploma or equivalency degree, and only 6 percent had completed a two- or four-year postsecondary degree. Nearly 60 percent of males had been convicted of a crime, and 77 percent of females had been pregnant. Problems with recruiting, maintaining, and training a qualified workforce and foster parents plague agencies at every level. Children are removed from their homes with insufficient cause, and this happens disproportionately with children of color.

At the other extreme, other children are left in unsafe homes, as headlines detail the examples of children who die of abuse and neglect. The percentage of children who return home within 30 days of being removed from their homes varies across the states, from 11 to 48 percent.

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See Also: Abuse and Neglect; Adoption and Foster Care Analysis and Reporting System; Aid to Families with Dependent Children, Historical Role of.

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Fostering Connections to Success and Increasing Adoptions Act of 2008

The Fostering Connections to Success and Increasing Adoptions Act was passed with strong bipartisan support and became federal law in fall 2008. The act was largely considered to include some of the most significant federal reforms to the child welfare system since the passage of the Adoption and Safe Families Act in 1997. This legislation was passed with the intent to keep at-risk children out of the foster care system, provide support to relative caregivers, and increase adoptions. Furthermore, the act has a number of provisions aimed at improving the overall care of both children in the foster care system and youth aging out of foster care. Due in large part to the fact that racial and sexual minority youth are disproportionately overrepresented in the foster care system, this law has widespread implications for diversity and human services.

The Fostering Connections to Success and Increasing Adoptions Act addressed six different areas, many of which have plagued the federal child welfare system for decades: (1) incentives and assistance for adoption, (2) improved educational stability and opportunities, (3) coordinated health services, (4) support for relative caregivers and family connections, (5) support for older youth and youth aging out of foster care, and (6) tribal foster care and adoption.

According to the U.S. Department of Health and Human Services, at the time of the passage of the Fostering Connections to Success and Increasing Adoptions Act, more than 100,000 youth in foster care were awaiting an adoptive family. The act included a number of provisions aimed at ensuring that states have the resources necessary to support adoptive families. Among the most notable of the adoption provisions included efforts to unlink eligibility for federal adoption assistance support from the child's birth family's eligibility for welfare services. Prior to the passage of this law, just under half of foster children were ineligible for federal IV-E adoption assistance due to the fact that their birth parents' income exceeded the eligibility level. New eligibility requirements in this legislation ensure that children awaiting an adoptive family will be eligible for federal adoption support regardless of their birth parents' income. This provision addresses the long-standing concerns of linking a child's eligibility to his or her birth family when parental rights have already been terminated.

In an attempt to reduce the number of older children and children with special needs awaiting adoption, the act reauthorized the Adoption Incentive Program, significantly increasing the amount of adoption incentive bonuses available to states. Shortly after the program's reauthorization, states' adoption incentive earnings rose significantly, from $7.3 million in 2006 to more than $40 million in 2010.

Improved Educational Stability and Opportunities

For decades, research on the educational experiences of foster youth has highlighted a number of areas in which these youth are at an increased risk educationally. These areas include academic achievement, drop rates, and higher rates of grade retention. In fact, only about half of youth in the foster care system complete high school and less than 10 percent attend college. A goal of the Fostering Connections to Success and Increasing Adoptions Act is to address a number of the issues that have historically been identified as barriers to the educational success of youth in foster care. One educational challenge for many youth in foster care is mobility. Frequent placement changes, school changes, and considerable amounts of time out of the classroom often result in youth repeating courses—in many cases even grades. The most significant educational provision in the act requires that all school-age children be enrolled full time. Furthermore, the law is clear in that it is the intent of these provisions to keep children in their school of origin whenever it is in their best interests.

Coordinated Health Services

Each year nearly half (48 percent) of youth entering the foster care system have some form of chronic heath problem. Similarly, Healthy Foster Care America reports that many foster youth have a history of prenatal substance exposure and/or premature birth. In addition, studies suggest that the use of mental health services by youth in foster care can be up to 10 times greater than that of other at-risk youth populations. The State Health Oversight and Coordination Plan that is required in the Fostering Connections to Success and Increasing Adoptions Act was developed with the intention of improving coordination between child welfare agencies and Medicaid agencies in developing a plan of health care and oversight for foster youth. Each plan must include a schedule for physical health, mental health, and dental screening. Furthermore, the plan must provide detailed steps necessary to maintain the continuity of health care services, including oversight of prescription medications, most of which are psychotropic medications.

Support for Kinship Care and Family Connections

In recent years, the number of kinship families or relative caregivers has increased significantly. Research suggests that these kinship caregivers often have less training and resources than nonkinship caregivers. Studies on kinship caregivers have also brought to light a number of the burdens and challenges that often accompany caring for a relative child. The kinship provisions in the current act establish a strong federal preference for relative care. Among the most notable of the provisions includes a requirement that state agencies make due diligence to provide notice to adult relatives when a child is removed from a family home. To address long-standing concerns about the resources available to kinship care providers, provisions were created to offer federal support to states that offer subsidized guardianship payments to relative caregivers.

The issue of placing siblings together has come to the forefront of child welfare practice and policy in recent years. Forty-four percent of youth placed in foster care are separated from at least one sibling. Many child welfare professionals have advocated for federal intervention to assist in reducing the number of sibling separations. The Fostering Connections and Increasing Adoptions Act is the first federal law to address this issue. The act requires reasonable efforts on the part of the state to place siblings together when it is in the children's best interests. In addition, the act includes provisions requiring frequent visitation for youth who are separated from their siblings.

Support for Older Youth and Youth Aging Out of Care

Recent studies of foster care alumni have shed some light on how youth and young adults fare after foster care. The Casey National Foster Care Alumni Study found that emancipated youth often experience negative outcomes in the areas of education, physical health, mental health, housing, and employment. Fortunately, research suggests that remaining in care beyond the 18th birthday is largely associated with more positive outcomes for youth who have aged out of foster care. The current act continues a number of provisions that provide support for youth to remain in care to assist in their education, employment, and family connections. The act also calls for a personalized transition plan for all youth 90 days prior to their leaving the foster care system that addresses the areas of housing, employment, mentoring, continued support, and insurance.

Tribal Foster Care and Adoption

At the time of the passage of The Fostering Connections to Success and Increasing Adoptions Act more than half of all federally recognized tribes did not have an agreement with states to administer their own foster and adoption programs. Under the current act, tribes are eligible to receive access to Title IV-E funds for foster care, kinship care, and independent living.

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See Also: Administration of Children, Youth, and Families; Adoption and Safe Families Act; Child Welfare Services; Indian Child Welfare Act; John H. Chafee Foster Care Independence Program.

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Fundamentalist Christian Americans

Fundamentalist Christians believe in one universal truth and adhere to a literal interpretation of scripture. Fundamentalists represent a distinct culture of clients with their own set of therapeutic needs. Fundamentalists face barriers to seeking mental health services, from a lack of trust in mental health professionals to the belief that all answers lie within scripture. Fundamentalist Christians may believe that mental health professionals will not respect their religious beliefs. Recommendations for providing mental health services to fundamentalist Christians include being culturally sensitive and ensuring the helping relationship is egalitarian. In addition, many persons in this population may feel more comfortable with a mental health professional who adheres to Christian beliefs and practices or a specialty form of counseling such as pastoral or Christian counseling.

Who are Fundamentalist Christians?

Fundamentalists believe there is one set of religious teachings containing a universal truth about humanity and deity and that this truth must be followed exactly according to past practices. Those who do so have a special relationship with their deity. They contend that this fundamental truth is opposed by forces of evil that must be fought vigorously. Thus, fundamentalist Christians have separate and distinct lives from nonbelievers. Fundamentalist Christians (also called conservative Christians) believe in the inerrancy of scripture, evangelism, and the literal interpretation of the Bible. They also believe in the deity and virgin birth of Jesus Christ, Christ's death as a substitution for humanity's sins, Christ's literal resurrection from the dead, and the destruction of the world and the literal return of Christ.

Fundamentalist Christians as a Culture

Culture has been defined as having a set of shared worldviews and adaptive behaviors as a result of simultaneous membership in various contexts (i.e., religious background, minority status, political leanings, or values derived from partaking of single historical moments or particular ideologies). Thus, fundamentalist Christians are considered a distinct culture because of their similar beliefs, similar behaviors, similar religious backgrounds, and similar political leanings. Fundamentalist Christians are not a homogenous group, and individuals may not share all of these beliefs. This group represents a culture unique from other groups of Christians (e.g., evangelical Christians) because of their lifestyles and scriptural interpretation. Fundamentalist Christians traditionally shun attending movies, use of alcohol and tobacco, and listening to secular music, and they don conservative clothing and hairstyles.

Barriers to Seeking Mental Health Services

Because of their beliefs, fundamentalist Christians face several barriers to seeking mental health services. One barrier is the belief that all issues of the soul and emotions are resolvable through spirituality, usually through the church. Spiritual bypass occurs when one tries to heal psychological wounds only at the spiritual level while avoiding important work at other levels including cognitive, physical, emotional, and interpersonal. Fundamentalist Christians may seek assistance from their spiritual leader to deal with psychological illness rather than seeking assistance from a mental health professional. Other barriers include the beliefs that (1) focusing on the self is selfishness and is a sin, (2) Christianity is the only true and necessary way to God and salvation, (3) the Bible has all the answers to problems and is the only source for answers Christians need, (4) feelings of joy and peace are the only acceptable emotions, and (5) social issues, such as divorce, same-sex attraction, and abortion, are evil and Christians should not participate in them.

Fundamentalist Christians are considered a distinct culture because of their similar beliefs, similar behaviors, similar religious backgrounds, and similar political leanings.

Human services professionals providing mental health services to fundamentalist families and children face an added set of barriers: (1) a strong "we-they" mentality that involves members seeking help only from the "right" church, (2) a reliance on faith leading to a passive approach to life in general, (3) an insistence on forgiveness that may prolong adjustment and other difficulties because the work ends when the person is perceived to be genuinely sorry, (4) the dominance of men over women, which could complicate the helping relationship if only the mother is available, and (5) a strong prohibition against divorce and remarriage.

Fundamentalist Christian Perceptions of Mental Health Professionals

As previously stated, fundamentalist Christians may distrust mental health professionals and have negative anticipations with regard to engaging in mental health services with secular professionals. Fundamentalists may fear that professionals will ignore their spiritual concerns. Fundamentalist Christians also may fear that mental health professionals will not understand some of their religious beliefs and concerns, and might assume that they share the same standards as many secular clients. Further, fundamentalist Christians may fear that mental health professionals will recommend behaviors or solutions that are immoral or may doubt the usefulness of what is learned through prayer and Bible study.

Recommendations for Providing Mental Health Services to Fundamentalist Christians

Mental health professionals have to exhibit cultural sensitivity, which includes having open conversations determining the role of faith in the lives of fundamentalist Christians. Mental health professionals must differentiate among behaviors that are universal to fundamentalist Christians, those that are transcultural, those that are cultural, and those that are idiosyncratic. Mental health professionals should be able to discriminate between situations where culture has clinical relevance and those where culture is tangential.

Professionals should attain a culturally relativistic framework with regard to assessment and intervention and recognize their own cultural concepts and behaviors that may result in ethnocentric biases. They need to avoid the use of all stereotypes and be aware of any preconceived notions about fundamentalist Christians. Professionals need to be willing to ask questions to increase their understanding of fundamentalist Christians, make the helping relationship collaborative and egalitarian, and give the client's faith full voice in the helping process.

When working with all families and children, mental health professionals should exhibit true transparency. Fundamentalist students or families value honesty and despise deceit or manipulation. Trust could be established if the professionals are up-front regarding their values. Professionals should validate the family's religious experience and its perspective on life. Professionals should recognize that fundamentalists may expect to be ridiculed and challenged because of their religion and that they do not believe that a professional with differing religious values could be of assistance. The validation has to be genuine. Mental health professionals have to be open to honest inquiry with families with regard to thoughts, feelings, and meanings. The helping relationship has to be egalitarian because fundamentalists may be suspicious of nonchurch authority figures. Mental health professionals should not challenge the family's religious authority figure and should make allies with the parents rather than adversaries. Mental health professionals in this setting should recognize that the fundamentalist family may limit access to information divergent from their church. Importantly, professionals could also consider referral if they believe they are not equipped to work with fundamentalist families.

Many Christians prefer to work with mental health professionals who are Christians and practice utilizing a Christian rather than a secular orientation. Fundamentalist Christians may believe that a professional who is Christian will understand their belief system and accept them as individuals. As a result, Christian counseling has emerged as a counseling specialty. Christian counseling has origins in the founding of the Association for Spiritual, Ethical, and Religious Values Issues in Counseling, a division of the American Counseling Association. Christian counseling is a relatively new field and needs more empirical research.

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See Also: Mental Health Services, Adult; Religion and Clients; Spirituality/Religion and Diversity.

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Gambling Addiction

Compulsive gambling is the only behavioral addiction included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) of the American Psychiatric Association. About 2 million Americans, twice as many men as women, meet the criteria for gambling addiction. Blacks and Native Americans have a higher rate of disordered gambling than whites, but gambling patterns do not differ among the races. Addictive disorders are chronic, multifaceted disorders, with physical, social, emotional, and behavioral components. Comprehensive services for the treatment of gambling addiction provide intervention, treatment, and recovery support for compulsive gamblers and their families. All addictions have a high impact on the social system in which they operate; therefore, services for gambling addiction include public awareness and support for treatment providers.

Service Providers

The National Council on Problem Gambling (NCPG) is a tax-exempt organization that offers information about gambling and gambling services and regulates the certification of gambling counselors. Many state lotteries fund gambling addiction intervention and treatment, operating 24-hour help lines, distributing materials for public awareness, and training professionals who treat gambling addiction.

Because gambling addiction is a *DSM-5* diagnosis, it is within the scope of practice of psychiatrists, psychologists, counselors, and social workers to treat gambling addicts. Gambling addiction counselors can be certified at two levels. Level I certification requires a bachelor's degree or equivalent; a passing score on the Certification Examination for Gambling Counselors; 30 hours of gambling-specific training; 2,000 hours of clinical experience; and signed statements from two coworkers, a site supervisor, and an NCPG board approved clinical consultant (BACC). Level II certification has the same education and test requirements as Level I plus 60 hours of gambling-specific training; 100 hours of clinical experience; and signed statements from two coworkers, a site supervisor, and an NCPG BACC. BACCs must have Level II certification, a graduate degree, and expertise as evidenced by research, publication, or clinical work.

Gambling addiction treatment takes place at community mental health centers, substance abuse treatment centers, or private residential treatment centers. Comprehensive treatment programs include individual counseling, couples and family therapy, group therapy, and financial management counseling.

Continuum of Gambling Addiction Services

Intervention is a concerted effort by family and friends to convince an addict to enter treatment.

A counselor prepares the participants by instructing them to write a letter to the addict explaining how they have been affected by the gambler's addiction and urging them to go into treatment. The counselor leads the intervention, in which the letters are read to the gambling addict, often followed by an ultimatum to get treatment or face a severed relationship. The interventionist arranges for the addict to go directly from the intervention to treatment if the intervention is successful. This entails assuring that the treatment center has an available bed, confirming insurance coverage or private payment, arranging transportation, and having a packed suitcase ready.

When addicts enter facilities, they are assessed for their gambling addiction, personal background, medical conditions, emotional status, and co-occurring disorders. Based upon the results of the assessment and the available resources, the assessment counselor determines the level of care necessary to achieve the treatment goals. Outpatient treatment allows patients to return to their homes and often to continue to work. Inpatient treatment is 24-hour care with intensive therapy and support. Residential treatment is less intensive than inpatient care and extends the length of treatment. Further residential support may occur in a halfway house after treatment. Treatment facilities provide or arrange aftercare to support recovery. Twelve-step recovery programs and ongoing financial counseling generally extend far beyond treatment and aftercare.

Addressing the Issues

The overarching physical condition with gambling addiction is associated with brain activity that occurs during gambling, which is similar to the brain activity of drug addicts. Serotonin, epinephrine, and dopamine are neurotransmitters associated with pathological gambling. During gambling, the brain produces dopamine, which is associated with pleasure. The threshold in the pleasure center of the brain is raised, and when the gambling stops, cravings ensue. Effective treatment provides education to addicts about their physical cravings, supports addicts through the cravings, and teaches methods to reduce cravings.

Social consequences of gambling are far-reaching. Gamblers may have betrayed their partners; put their families in financial peril; lied to get money; stolen from friends, family, and employers; and incurred unmanageable debts to loan and credit card companies. Effective services provide couple counseling and family counseling to assist in the repair of relationships that will ultimately support the recovering gambler. Financial counseling assists addicts and their families in determining how much debt has been incurred and making a budget. Financial recovery often requires the involvement of consumer credit counseling to contact lenders and credit card companies and manage payments. As a diagnosable emotional disorder, compulsive gambling may be regarded as covered under the Americans with Disabilities Act, requiring employers to retain employees if they are seeking treatment. Legal consequences might also be deferred contingent upon treatment efforts.

The emotional component of gambling addiction requires extensive attention. Many gamblers are the offspring of alcoholics and addicts, and thus may themselves have co-occurring addictions to alcohol or drugs. Addictions often interact to maintain their rhythm of satiation and deprivation, increasing the potential for another addiction to emerge when the gambling subsides. Gambling addiction may also co-occur with depression, bipolar disorder, and anxiety disorders, any of which might exacerbate when the gambling behavior stops. Low serotonin levels are associated with depression, and gamblers in early recovery should be monitored for severe depression. Because of the overwhelming losses of money, relationships, and dignity, gamblers are at high risk for suicide. Trauma-informed treatment is a new standard for all addiction services. The gambling addict in early recovery should also be assessed for post-traumatic stress disorder (PTSD) from childhood physical or sexual abuse or violent encounters while in the throes of addiction. The onset or increase of PTSD symptoms may occur when the addictive behavior is deterred.

Effective treatment services focus extensively on the behavioral aspects of gambling. Especially in early recovery, gamblers are vulnerable to cravings triggered by people, places, events, and emotions. Many gamblers have rituals associated with payday. Early in recovery, behavioral interventions might include enlisting the help of another to manage money and requesting that paychecks be directly deposited to bank accounts. Some gambling events occur at specific times and days. A gambling addict with a co-occurring anxiety disorder may have reduced anxiety through gambling. Behavioral interventions, such as relaxation training, hypnotherapy, and balanced breathing, are effective in anxiety reduction. If gambling has mediated depression, exercise is an effective intervention that raises levels of serotonin. Positive affirmations and social engagement may help recovering gambling addicts manage their emotional responses. Attending Gamblers Anonymous (GA) meetings during trigger times can provide a distraction as well as emotional support for changing the behavior. Gamblers Anonymous is a 12-step program based on the model used in Alcoholics Anonymous, which is replete with behavioral strategies for recovery and personal growth.

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See Also: Family Crisis Intervention Planning; Peer Support and Counseling Services; Twelve-Step Programs.

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Gangs: Social Issues and Intervention

The term *gang* has been in existence for at least several hundred years, as evidenced by the writings of Geoffrey Chaucer in the 14th century and the 16th century penning of William Shakespeare. Named gangs were present in England as far back as the 17th century. The history, emergence, and subsequent development of gangs in the United States also extends back for centuries. Unfortunately, no available written studies provide information on the details related to these gangs. Many people believe that the early birth of gangs in the United States is directly connected to mass immigration, rapid industrialization after the Civil War, and the unbridled urbanization in northeastern and midwestern cities.

People in the United States became familiar with gangs through the onset of ethnic gangs in general and most notably the Italian Mafia in particular. Italian organized crime rose to national prominence during the late 1800s and early 1900s. Infamous gang members and iconic mobsters such as Scar Face Al Capone, Machine Gun Kelly, and Lucky Luciano became household names familiar to the majority of the U.S. population (adults and children alike) during the early 1900s and remain known to many today. In fact, with the help of modern media, young and old gang members today memorialize, worship, and hold these gangsters from the past as heroes and superheroes of the highest esteem. The movie *Gangs of New York* is a fictional historical drama immortalizing the activities of gangs that ruled New York around the turn of the 20th century.

Despite the fact that gang violence has existed for centuries across the United States, gangs have grown and advanced into the new millennium of the 2000s. Gang members and their families moved around and established gangs in their new neighborhoods and communities. The impact of waves of population migration on the emergence and growth of gangs is reflected in the presence of gangs in new urban and rural communities. Gang members migrated to other locations as the general population moved across the United States seeking the American dream of opportunity and success in business and employment. Traditionally, gangs were located, operated, and flourished in large, urban metropolitan areas.

Gangs and Diversity

Modern media, especially television, continues to present the stereotypical image of gang members as minority males. It is a common misconception that gang members are primarily inner-city, urban African American or Hispanic males. This narrow mythological conceptualization of gangs fosters the development of a simple, yet untrue, generalization about gangs, which in reality are much more complicated and complex. Diversity-competent human services providers understand that gangs comprise a diverse set of individuals not limited to the racial, ethnic, and gender characteristics of African American or Hispanic males. In addition to all-male gangs are female, lesbian, bisexual, gay, and transgender gangs.

Another misconception about gangs is that members are all poor. Gangs have never been exclusively confined to the poor. Gangs cut across the socioeconomic status of the United States, as middle- and upper-class individuals form gangs.

Furthermore, diversity-competent human services professionals recognize that diversity in the geographical settings in which gangs operate plays a significant role in understanding the social issues related to gangs. In the United States, gangs in urban settings have been born out of a completely different set of circumstances and impacted by conditions vastly dissimilar from gangs in small towns and villages. As a direct result, gangs formed in different community settings will often have differing reasons for their existence and sustainability. Diversity in gangs requires human services professionals to take into consideration the many similarities and differences in gangs and among their members.

Defining gangs can be tricky. Some groups that define themselves as gangs include motorcycle gangs and skinheads. Street gangs are typically defined by their geographic territory or streets over which they maintain dominance and control. Each gang has a predesignated, predetermined area that has been won with the hard-fought blood of its members and leadership. In order to maintain control of the streets or to protect their territory, it is often necessary for gangs to kill or be killed. Thus, a great deal of the violence that occurs in the streets is associated with the activities of street gangs. Additionally, nowadays much of the gang operations are conducted in the streets. These facts give new importance and significance to the term *street gang*.

Social Issues of Gangs

In general, social issues of gangs can be defined as those related to gang activities that negatively impact large numbers of a society or a group in a destructive way. These matters are considered to be problems or serious concerns because they are considered dangerous, life-threatening, harmful, perilous, and often contrary to the moral values, life promotion, life protection, or safety of the larger population or individuals in the society. It should be noted that social issues and social problems are often used synonymously to represent the same concept. Social issues of gangs are subjective in that people's personal perceptions shape their development and construction of what they call a problem or an issue. One can hardly argue against gangs as a social issue.

The single most notable, provocative, inflammatory, and destructive activity of gangs is violence. Over the years, persistent and spreading gang violence has captured the attention of the public and subsequently raised the issue of gangs to the level of a social problem. All too often, gang or gang-related violence in the United States has persisted in being one of the most injurious and harmful acts facing society. Gang violence instills terror, promotes fear, and incites horror, especially when it strikes the family or close to home. Stubborn and gruesome gang violence in the streets and homes of victims and innocent bystanders remain the principal standard operating procedure for gangs.

Financial challenges and adversity often impact children in single-family, female-headed households, creating poverty. Likewise, inner-city urban ghettos, where underprivileged and impoverished minority youth often aimlessly drift without positive male role models, have been prime recruitment zones for gangs. Poverty as a social issue has been closely connected to gangs, as gang activities have prospered and grown in low-income and poverty-riddled neighborhoods. For many young residents of poverty-ravaged communities, gangs offer the only glimmer of hope for a life of prosperity, a way to make money, or an escape from the misery of poverty. The power and influence of older gang members that serve as negative role models, the media, low educational attainment, and the absence of positive male role models often render youth incapable of escaping the lure of gang recruitment efforts. Simply put, youth who crave role models can easily find them readily available in the gangs.

The distribution and sales of illegal drugs in the United States represent a prominent social issue inextricably tied in a network of mutuality with street gangs, motorcycle gangs, and prison gangs. Gangs are responsible at every level of creating, maintaining, and protecting the logistics channels that ensure the distribution of illegal drugs such as marijuana, cocaine, ecstasy, and heroine. Gangs process cocaine into so-called crack to increase and improve marketability on the streets. Gangs also produce PCP and methamphetamine. As a result of drug distribution and sales, gangs accumulate billions of dollars annually and wreak havoc in the lives of individuals, families, and communities.

Another social issue tied to gangs is the lack or absence of strong positive social and cultural opportunities for youth to develop positive identities and behaviors by participating in group, collective, or communal activities.

- Gangs help fill the social and cultural void and isolation created by poverty and the resulting lack of opportunities.
- Gangs offer youth and adults an entire cultural solution.
- Gangs provide an environment to love and be loved by their peers, the fellow gang members.
- Gangs offer opportunities from members and leaders to be protected and respected.
- Gangs offer rules and order.
- Gangs have laws that guide the behavior and clearly spell out the do's and don'ts for gang members to follow.
- Gangs provide members with a sense of order as members have rank and position of power and authority.
- Gangs offer a sense of direction and provide guidance from older, more experienced members serving as mentors to younger and less experienced members.
- Gangs provide members with a common history shared by all of the members.

As a part of the requirement for membership in the gang, members are required to memorize and internalize the gang's history. Furthermore, the cultural motif of the gang is filled with names, symbols, and colors. Even though law enforcement and researchers have learned a great deal about gangs, the significance and meaning of the names, colors, and symbols are sacred and secret. Above all, gangs offer a complete rite-of-passage experience for members, including isolation, education, guidance, testing, initiation, and ultimately membership. Gang members must live and die by the laws of the gang or suffer the consequences.

Gang Intervention

Law enforcement programs, initiatives, and strategies have been dominated by gang suppression efforts. The hallmark of gang intervention efforts utilizing the suppression approach rests upon the assumption (often proven false) that gang leaders, members, and their associates will respond appropriately to suppression by desisting in their criminal activities or learning from the error in their ways. Similarly, it is assumed that gang members will conduct either a profit-and-loss or a cost-benefit analysis and determine that their best move would be to withdraw or cease their criminal behavior, or that still others ensnarled by suppression programs will be removed from the field of action (the streets) and somehow learn from their errant ways. Suppression interventions give very little and often no credence to crime prevention or treatment efforts and consider these methods or approaches as outside of their professional capacity. Suppression initiatives are often closely tied to law-and-order political platforms with the goal of increasing the impacted communities' perception of safety through gang crime reduction.

Community-based gang intervention programs often take the form of prevention programs. These programs conduct community gang assessments and typically address the social conditions that promote and fuel gang involvement. Prevention programs attempt to stop or curtail youth from joining gangs. Recognizing the important relationship between drop-out rates and gang involvement, they attempt to improve student educational attainment levels; teach students interpersonal, problem-solving, and conflict resolution skills; and teach parents and teachers to recognize early youth who are difficult to manage, resistant, and disruptive.

Gang Intervention: Desistence or Extraction

Gang interventionsists in the form of counselors, faith-based ministers, case workers, mentors, teachers, social workers, and community activists who are often former or reformed gang members work in community settings targeting services to gang members. These professionals understand the factors that motivate gang members to abandon their gang membership and involvement. Finally, gang interventionists develop extraction plans, remove barriers, and communicate with gang leaders to gain permission and sanction for the member to leave the gang.

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See Also: Community Corrections; Community-Based Services; Gangs in Schools; Juvenile Delinquents; Juvenile Detention Centers; Juvenile Justice System;

Office of Juvenile Justice and Delinquency Prevention; Peer Pressure; Prisoners and Ex-Prisoners; Rites of Passage; Youth Risk Behavior Surveillance System.

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Gangs in Schools

Gangs are defined as a group of adolescents and/or young adults who have sworn allegiance to each other, have selected a name or a label to represent their allegiance, and seek to enhance their status by engaging in criminal and violent activities. Myths about gangs concern where gangs are located and who is involved in gang activity. First, research on gangs is typically focused on individuals living in urban areas; however, gangs are found in suburban and rural contexts. At the core, gang activity is associated with poverty and social disorganization, factors that span beyond an urban context. Although once a problem exclusively in large inner-city schools, youth gangs have branched out to schools in suburban and rural areas. Gangs are indeed major concerns in urban, suburban, and rural schools. Second, researchers often thought gangs were a male-dominated activity. Over the past 20 years, however, women clearly have been involved in all aspects of gang life that span from informal auxiliary roles (e.g., sex objects) to formal membership (e.g., selling drugs).

Youth gangs frequently engage in violent acts, particularly when they have skirmishes with other youth gangs. Gang activities include bullying and threatening others, receiving and selling stolen goods, and other criminal activities with the purposes of strengthening their reputation and providing members with money and material goods. Although gang behaviors might vary from one community to another, some common gang identifiers include attire, hand signs, colors, and gang graffiti. Media coverage of criminal acts and violence committed by youth gangs on school property has heightened concerns about school violence.

Characteristics and Presence of Gang Problems in School

Gang activity in schools may in part be influenced by engagement in and access to social media. For example, an important aspect of gang activity is claiming territory and intimidating rival gangs. For many years, graffiti served as the so-called billboard of gang violence. However, as society becomes more technologically advanced, so too are gang-related activities.

Recent media reports have highlighted a new trend in which individuals who are perceived to be gang affiliated are using social media sites (e.g., Facebook, Twitter, YouTube) called “Internet banging,” with several key elements: (1) promoting gang affiliation and/or communicating interest in gang activity, (2) gaining notoriety by reporting participation in a violent act or communicating an impending threat, and (3) sharing information about rival gangs or networking with gang members across the country. This is particularly important, as spats that develop on social media sites have the potential to carry over into school and vice versa.

School-Based Prevention and Intervention Services

The percentage of students reporting gang activities in their schools rose from 21 percent in 2003 to 23 percent in 2007. Reports document higher levels of school violence despite a general decline in youth crime rates. Several high-profile cases, such as the Columbine shooting in 1999, have resulted in preventive and security responses. Most frequently, a school’s response to gang-related offenses is suspension or expulsion, which may seem to be necessary for serious violent offenses but is ineffective for other types of youth problems. Regrettably, once gangs have been established, programs designed to reduce gang involvement and gang-related activities have been ineffective and at times counterproductive. Likewise, relatively few rigorous evaluations have been conducted on gang prevention programs in school.

Nevertheless, prevention and intervention programs that involve all aspects of the school and those that facilitate the development of appropriate

For many years, graffiti served as the so-called billboard of gang violence. However, as society becomes more technologically advanced, so too are gang-related activities. Recent media reports have highlighted a new trend in which individuals who are perceived to be gang affiliated are using social media sites (e.g., Facebook, Twitter, YouTube).

behavior and healthy emotional adjustment of youth have demonstrated effectiveness.

Such programs include multicontextual services such as Striving Together to Achieve Rewarding Tomorrows (CASASTART), Gang Avoidance Initiative Now (GAIN), other tertiary programs that involve individual behavioral and skill-building strategies, and wraparound services that address multiple needs.

GAIN is a tertiary program for first-time in-school youth gang offenders and a viable alternative to suspension or expulsion. In response to a gang-related incident in Chicago in 1996 in which a former student shot a current student at a bus stop, GAIN was developed under the auspice of the Title IV Safe and Drug Free Schools and Communities Grant. The program comprises the following nine lessons:

1. Getting off to a good start
2. Second chances
3. Drugs, alcohol, and violence
4. Juvenile law and drugs
5. Juvenile law and bodily injury
6. Conflict resolution
7. Family and peers
8. Getting out
9. Developing a life plan

Youth who participate in the program also participate in a field trip to a rehabilitation hospital and an in-school presentation by correctional officers and prisoners from a correctional institution. These field trips and lessons help illuminate the consequences of gang-related behavior and activities. The GAIN curriculum also includes a team-teaching approach in which several adults, such as police officers, support service personnel, counselors, and former gang members, are involved in teaching the curriculum. Overall, the program has demonstrated effectiveness in improving outcomes for participants.

Suggestions for Prevention and Intervention Services

Conducting a comprehensive assessment of gang activities in and around the school is a necessary prerequisite to responding effectively to gangs. Assessment of gang activities needs to consider a number of factors, such as local demographics (e.g., communities), crime and law enforcement data, perceptions of students and school personnel, social media behavior, and available resources. It is also necessary for school personnel to create a systemic approach to reduction and prevention of gang involvement and membership. There is a critical need for administrators to create a diverse task force consisting of students, staff members, school administrators, law enforcement, and other agencies in order to develop action plans. Such action plans might include gang awareness, classroom management, dress-code policies, and provision of mentors. Prevention programs might also include providing at-risk youth with knowledge and skills to help them avoid gang involvement, implementing after-school activities that facilitate prosocial behavior and positive peer relations, and parental involvement in gang prevention plans.

A number of evidence-based school gang intervention programs for school-aged children (ages 6 to 17 years) include the following components:

- Building a comprehensive framework for integrating youth services programs that link juvenile justice systems with human services and other agencies (e.g., schools, child welfare services).
- Creating a cross-agency client referral and networking protocol.
- Targeting at-risk and serious youth offenders for resources, providing case management.
- Coordinating services for youth offenders and families.
- Offering mentoring services and gang conflict mediation.
- Providing close monitoring and supervision of youth gangs by various agencies.

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See Also: Community Corrections; Community-Based Services; Gangs: Social Issues and Intervention; Juvenile Delinquents; Juvenile Detention Centers; Juvenile Justice System; Office of Juvenile Justice and Delinquency Prevention; Peer Pressure; Rites of Passage; Youth Risk Behavior Surveillance System

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Gender and Clients

Women's welfare and health issues have significantly gained in international visibility and political commitment in recent decades. Across a range of services from education to health, the majority of clients as well as providers are women. The majority of concerns that women bring to welfare counselors and workers are connected to their relationships with men. Gender-aware, gender-sensitive, or gender-responsive practices, for instance in such areas as reproductive and sexual health, family planning, violence protection, postabortion care, and safe motherhood, will require a dual focus of male and female client groups. More specifically, they will have to take note of constructions of femininity and masculinity, as these inform a range of client, provider, and hence client-provider factors. Moreover, such constructions cannot be productively studied in isolation of those of economic privilege, race, ethnicity, sexuality, and generationality. Gender-aware practices are key, too, to broader transformational objectives proposed at the many intersections of feminism, critical studies on men and masculinities, critical social work, and multiculturalism.

Gendering Clienthood

Since the 1960s, gender has become integral to the conceptualization and study of welfare distribution and social work (the bibliography of F. Ellen Netting's *Women and Macro Social Work Practice* provides an impression). As Mary Daly recently discussed, neither gender nor welfare is a unitary and unproblematic notion. They are certainly related in complex ways. A recent cross-national European study finds that public attitudes toward gender issues are largely consistent with welfare regimes (e.g., southern European, liberal, continental, and social democratic) and reveal a clear direction of moving away from traditional views of gender, family, and work issues in economic hard times. The subject of gender is fundamental to the human services field in a number of ways.

First, gender informs the basic demographic makeup of the client base, found to be impacting on access to service, service needs, and service pathways, as well as client engagement, response, and satisfaction—all used in determining intervention options such as client-worker matching. Specific client groups face gender-based or strongly gendered needs, with obvious areas including fertility counseling and assisted reproduction, abortion care, pre- and postnatal counseling, first time and teenage motherhood, intimate partner and gender-based violence, sex work and human trafficking, and eating disorders (including body image). Client gender may form an integral or central part of presented problems. The latter is true for gay, lesbian, bisexual, and transsexual (GLBT), as well as intersex, questioning, and asexual client groups.

Second and equally important, assumptions and constructions of gender and gender difference color client-worker relations in many, often imperceptible, ways. Related issues ranging from gender-biased language, pay gaps, stereotypes, and glass ceilings to sexism and sexual harassment in social and care work have been duly highlighted since the 1960s. Gender, cultural, and individual differences in underlying assumptions are well documented, and their ascertainment and tackling in practice situations is often a precondition for successful interventions.

Third, theories of clienthood across the human services field have been historically influenced by the lay women's movement, feminist perspectives on social work, and gay and lesbian advocacy in ways that go well beyond these specific planes of interest. Engagements with feminist citizenship models identify a variety of objectives in mainstreaming gender in the human services delivery sectors. They prominently include recognition of women's diversity; bridging the public/private divide; addressing women's oppression; acknowledging women's agency; and facilitating women's active participation in social, political, and community life.

Including Women and Girls, Engaging Men and Boys

Providers of client-centered services notice how gender impacts on a variety of factors outside and inside facilities. Many women experience gender-related sociocultural, physical, and financial constraints on their ability to seek care. Family planning programs worldwide, for instance, face biocultural beliefs about female anatomy and physiology as much as logistical problems with traveling distance and cost. Within the walls of facilities, issues of privacy, confidentiality, office hours, and availability of gender-matched professionals may be of key importance to many female clients.

Female access is a top concern across health care services. According to *Women's Health USA 2012* (http://www.mchb.hrsa.gov/whusa12/index.html), women were more likely than men to report having delayed care due to logistical barriers in the past year. Women were also slightly more likely than men to have forgone needed health care due to cost. Women's expenditures significantly exceeded men's only in the category of office-based medical services. The overall mean health care expense was greater for women due to the greater percentage of women incurring more expensive services.

Of specific note, gender matters across the age spectrum. Studies have found significant gender differences in sources of referral and factors contributing to referral and service utilization among children. For example, girls are more likely to be referred by child welfare workers for sexual abuse victimization and family problems, such as parental substance abuse and poor parenting skills. Boys are more likely to be referred by family court workers for mental health issues, including suicidal ideation and gestures, peer relations, behavioral problems, and delinquency.

Community organizations traditionally attuned to gender include women's hospitals, feminist health centers or women's health resource centers; rape crisis centers; LGBTQ community centers; and domestic violence shelters, transition, or safe houses. Gender is considered of key relevance to service effectiveness across the entire field of human services. For example, the number of women under criminal justice supervision in the United States has risen dramatically in recent decades. Researchers argue that this requires a gender-responsive approach, including comprehensive services taking into account the content and context of women's lives. This means not only their cultural backgrounds, but also the larger social issues of poverty, abuse, and race and gender inequalities, apart from individual factors that impact women in the criminal justice system.

Other areas where gender is becoming a cornerstone parameter for consideration include group work as a therapeutic modality, microfinance, women parolees, women's violence, women veterans, immigrants and refugees, substance abuse and rehabilitation, learning difficulties, genetic counseling for women with intellectual disabilities, career counseling, and (especially men's) health literacy. Gender-sensitive approaches to any of these subjects are needed and are frequently shown to be effective. For instance, data recently collected for the National Treatment Improvement Evaluation Study suggest that for substance abuse treatment services to women, a positive client–provider relationship is related directly to treatment duration and indirectly to reduced post-treatment drug use.

Notwithstanding the generally accepted necessity for gendered approaches, feminist theories of social work and human services have historically been diverse. Accordingly diverse are constructions of gender and clienthood. In a mid-2000s assessment, Vicky White found that among largely United Kingdom social workers, "feminist" principles are predominantly subsumed by larger anti-discriminatory and/or antioppressive frameworks for practice. Moreover, she points especially to the diversity of women's positions on working in and against managerialist contexts. Lena Dominelli also stresses the importance of the recognition of diversity and differences that exist among women as well as among men. Recent collections of essays on counseling psychology edited by Carolyn Zerbe Enns and Elizabeth Nutt Williams, and on mental health and education edited by Marie Miville, stress the rich interfacing of feminist and multicultural approaches to service provision. Differences among women provide challenges and opportunities. A recent two-volume anthology on the psychological health of women of color edited by Lillian Comas-Díaz and Beverly Greene, for instance, aligns challenges in working with lesbians of color, multiracial women, female immigrants of color, and women with disabilities, with the opportunities in working with midcareer women high achievers, leaders, mentors, athletes, and artists among women of color.

An increasingly mainstreamed focus has been securing male involvement in couples services, as well as developing specific models for working with men and understanding masculinities. Bob Pease and Peter Camilleri, prefacing an edited collection on the subject published in 2001, argue that neglecting to name men as men in social work and the human services limits the potential for challenging gender injustice. They call for a critical analysis of men in the human services. Published as of 2011, the *Routledge Series on Counseling and Psychotherapy with Boys and Men* already includes six specialized titles picking up on this.

Promoting and Standardizing Change

A large number of global, national, federal-level, community-level, and institute-level initiatives facilitate gender visibility and awareness in the human services landscape. In the United States, the following initiatives closely reflect developments within the health sciences in prioritizing sex and gender as a research and policy focus, especially since the early 1990s:

- The International Council on Women's Health Issues (ICOWHI, since 1983; www.icowhi.com) and the Global Alliance for Women's Health (GAWH, since 1994; www.gawh.org) specifically promote collaborations between public and private sectors to enhance women's access to basic health care services.
- The Office on Women's Health (OWH) is an interagency body within the U.S. Department of Health and Human Services (HHS). Rolled out from 1991 onward (www.womenshealth.gov), OWH collaborates with consumer groups, government agencies, nonprofit organizations, and associations of health care professionals, providing national leadership and coordination to improve the health of women and girls through policy, education, and model programs. OWH covers agencies including the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA).
- The Maternal and Child Health Bureau (MCHB) of HRSA supports access to comprehensive women's health care to improve their health across the life course through the Title V Maternal and Child Health Serviceds Block Grant, Home Visitation, and Healthy Start programs.

Awareness of gender diversity is firmly established in social work as well. The U.S. National Association of Social Workers' (NASW) *Code of Ethics*, revised in 2008, repeatedly refers to "sex, sexual orientation, and gender identity or expression" when discussing cultural competence, intercollegial respect, discrimination, and social and political action. Similarly, the Educational Policy and Accreditation Standards (EPAS) of the Council on Social Work Education (CSWE) recognize gender and gender identity and expression as diversity dimensions for both the explicit and implicit curriculum. The Council on Sexual Orientation and Gender Expression (CSOGE), a council of the Commission for Diversity and Social and Economic Justice, was instituted to promote development of social work curriculum materials relevant to the experiences of individuals who are LGBTQ, or two-spirit (a person whose body simultaneously manifests both a masculine and a feminine spirit). A separate Council on the Role and Status of Women in Social Work Education oversees development of educational resources relevant to women's issues within social work education.

Beyond nondiscrimination policies, various practice guidelines, policy statements, service charters, "best practices" toolkits, and councils have been advanced in the context of specific gender-based client groups. In 2011, 21 guidelines for psychological practice with lesbian, gay, bisexual, and transgender clients (www.apa.org/pi/lgbt/resources/guidelines.aspx) were adopted by the American Psychological Association Council of Representatives, replacing an earlier set of guidelines from 2000. These guidelines comprehensively deal with issues from diversity and economic and workplace issues to training and use of research. The leading clinical guidelines for the care and treatment of people with gender identity disorder are provided by the World Professional Association for Transgender Health Standards of Care (www.wpath.org). Addressing both professionals and clients with their families, the 2011 68-page "Standards of Care" represent the seventh instalment since the original 1979 document. Although detailed, these standards of care are reported to be too narrow and proscriptive by some transgender clients.

Monitoring Outcome

Many international and national agencies actively monitor client-related gender outcomes. The HHS National Health Interview Survey includes a variety of parameters on health care needs including sex; in 2011 it was announced that it would ensure the collection of useful national data on minority groups, including for the first time LGBTQ populations. The *Manual to Evaluate Quality of Care from a Gender Perspective*, developed in 2000 by International Planned Parenthood Federation/Western Hemisphere, offers an evaluation and quality improvement tool, available in English and Spanish, describing how to conduct an assessment of quality of care from a gender perspective. It recommends observation of client reception and a client exit interview as two of six steps. This manual formed the basis of a system to certify the service delivery and management support of nongovernmental organizations (NGOs) as gender-sensitive.

The Interagency Gender Working Group (IGWG), established in 1997, is a network comprising NGOs, the U.S. Agency for International Development (USAID), cooperating agencies, and the Bureau for Global Health of USAID. Among its tasks is to collect empirical data and identify best practices on gender issues and the interface with reproductive health/HIV care. International examples include the "Gender and Diversity Lens" developed for the Victorian Government Department of Human Services, Australia, and "Positive Women Monitoring Change," published by the International Community of Women Living with HIV/AIDS (ICW), both offering toolkits for monitoring and enhancing female access to care, treatment, and support. Internationally, a "Policy Scorecard for Gender Mainstreaming" has been applied to local and country-specific policies, revealing governments' commitments to women, and how well gender equity goals are embedded into policies and programs.

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See Also: Cisgender; Institute for Women's Policy Research; LGBTQ Clients; Transgender Individuals; Women Minorities.

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Gender Issues and Roles in Developing Countries

Gender issues concern the relationship between men and women in society. Concerns about gender in the world center on the positions and roles played by women in both public and private spheres. Women in developing countries are objects of discrimination, oppression, abuse, exploitation, and inequality. The United Nations defined gender issues as issues affecting women simply because they are female. These issues concern fundamental human rights—the civil, political, social, and economic rights of women. Most of the developing countries have witnessed Westernization, modernization, and globalization, but gender affirmative action has not been instituted in these nations. The social gaps between women and men in terms of gender equality in different spheres of life are basically wide. The nature of discrimination, oppression, and domination faced by women in developing countries is different from that in developed nations. The conditions of women in developing countries are more daunting and precarious. Women in developing countries need adequate attention and support from government, nongovernmental organizations (NGOs), human rights groups, and women's groups all over the world.

Women in Developing Countries

The global world can be divided into north and south poles, sometimes called the Global North and Global South. Developing countries are in the south pole of the globe (e.g., Pakistan, Iran, Afganistan, Mali, Nigeria, Ghana, Gabon, Indonesia, India, Malaysia, Chile, Venezuela, Brazil, Mexico, Cuba, Saudi Arabia, Egypt, Tunisia, Algeria, Guatemala, Congo, and Burundi, among others). Gender issues in different countries of the developing world are the same because most gender issues are attached to culture, tradition, religion, custom, and other forms of patriarchal orientations, which subjugate women to the whims and caprices of men. Women have no voice in public or private affairs. The patriarchy orientation treats women as the property of men. Once a woman gets married to a man, she cannot seek divorce because the institution of marriage allows men to pay a bride price for women and dominate these women for the rest of their lives. Women in developing countries suffer untold social, economic, and political consequences of such male domination. They lack social supports such as care benefits, nursing mother benefits, unemployment benefits, stipends for women with domestic concerns, and other forms of allowance that could provide security and improve living conditions in developing countries. Lisa Anderson conducted an opinion poll on the countries in which it is most dangerous to be a woman, where women face dire consequences of discrimination and even death. Afghanistan tops the poll in terms of dangers to women, followed by Congo, which is plagued by rape as a weapon of war. In addition, Pakistan is blighted by acid attacks and so-called honor killings, India is cited for human trafficking and sexual slavery, and Somalia is seen as having a full gamut of risks.

History of the Gender Movement in Developing Countries

Women's groups have formed different organizations to address gender issues in the world. The gender movement has a long history, dating back to the 18th century in the United States. It started as feminist movements that later became women's movements. The idea of gender identity and division among women as the focus of the women's movements led to the emergence of the gender movement, which incorporates the relationships between men and women in society. Like their counterparts in the developed world, women in the developing world formed various movements and associations, such as KULU–Women and Development; the Caribbean Association for Feminist Research and Action (CAFRA); Development Alternatives with Women for a New Era (DAWN); the Thai Labour Campaign; the Centre of Concern, Gender and Economic Reforms in Africa; African Women's Economic Policy Network (AWEPON); Shirkat Gah in Pakistan; Tanzania Media Women's Association (TAMWA); National Council of Women's Societies (NCWS); International Federation of Women Lawyers (FIDA); and Fiji Women's Rights Network. All of these act to champion various issues affecting women in developing nations. Women's associations and organizations from developing countries participate in the Beijing women's conference and other conventions on women to discuss issues affecting women in general. Consequent to the Beijing declarations, the United Nations (UN) developed treaties and conventions, such as UN Security Council Resolution 1325, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), to protect women's interests across economic, social, and political spectrums.

Issues Affecting Gender in Developing Countries

Different issues affect women in developing countries in modern times. These issues include domestic violence, which is largely unreported to the authorities by the affected women because culture obliges a woman to endure the situation in her husband's home. Rape of young girls, underage girls, and women is also common. Women cannot report cases of rape to the authorities because of the stigma associated with reporting in developing countries. Some countries do not include punishment for rape offenders in the constitution because women's issues are invisible and misrecognized.

Patriarchy is the rule in developing countries; women have no say in social, economic, and political space. Gender equality is an abomination in developing countries because of culture and tradition, which disallow women to participate with men on an equal basis. In some developing countries, girls' education is worrisome, so girls are forbidden from attending a formal school. Some girls are subjected to early marriage and sexual abuse.

Genital mutilation is another issue in developing countries that requires global intervention. Trafficking of women is rampant because of the high level of poverty. Women are trafficking for sex exploitation in Europe and North America. Women's economic empowerment is also an issue of concern in developing countries. Women face economic discrimination, they have no access to land, and they have no capital to establish a cottage industry. Women's participation is not welcome in developing countries; men dominate both elective and appointed positions. The affirmative action approved by the United Nations to ensure gender equality in political positions is merely rhetorical in developing countries.

Gender Roles in Developing Countries

There is no significant change in gender roles in the 21st-century developing world, despite the fact that many of the developing countries approved and domesticated various UN treaties and conventions on gender equality and empowerment in both the private and public sectors. Women in developing countries are still confined to private life. Women are faced with performing unpaid household chores and provision of care services for their children and husbands. Women's economy is an appendix of their husbands' work. They work on their husbands' farms or cottage industries, and the proceeds are garnered by the men, who may use them to marry additional wives. Women are forbidden to participate in politics or engage in public paid work in some developing countries.

Gender and Social Services

To promote gender equality in developing countries, mass educational opportunities for girls is very important. Women in developing countries also need credit facilities to create cottage industries and become economically independent. Women's entrepreneurship, vocational training, and access to land could reduce poverty among women in developing countries, Social supports, such as care benefits, nursing mother benefits, unemployment benefits, stipends for women with domestic concerns, and other forms of allowance could provide security for women and improve their ways of life.

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See Also: Family Violence Prevention and Services; Interpersonal Violence; Women, Battered.

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Gender Issues and Roles in Non-Western Countries

In recent years, gender roles and related issues have been addressed as socially constructed variables. Consequently, according to A. Giddens, gender relations (i.e., "societally patterned interactions between men and women" highly differ from place to place and across time. Knowledge about gender roles and issues in non-Western countries has been developed over many years by the dominant voice of Western women and scholars, often providing essentialist descriptions about both. In fact, women in non-Western cultures have been frequently perceived and portrayed as either oppressed by patriarchal structures and lacking agency to tackle so-called backward and harmful practices, or as exotic, sensual, and mysterious *One Thousand and One Nights*–type characters. This approach has overlooked relevant differences (e.g., rural/urban, intergenerational struggles, role of education) around the world, as well as the efforts by women to challenge traditional roles and taboo issues. Non-Western postcolonial feminists and other scholars, activists, and individual women who rebelled against oppressive structures have increasingly shed light on gender dynamics, also through the use of social networks. A lesser-explored topic concerns gender roles and issues beyond the gender binary, such as in relation to transgenderism.

International Debate on Gender Roles and Issues in Non-Western Countries

Roles that men and women are expected to play in the family and in society are space- and time-contingent. International interest has focused above all on women's roles in non-Western society, the roles of men being often indirectly addressed as being socially dominant. According to most traditional behavioral expectations, men are breadwinners and should protect their family members from danger. Since the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was signed in December 1979, and entered into force in September 1981, many items related to gender roles and issues in non-Western countries have been internationally analyzed through the lens of the protection of women's rights from gender-based violence, discriminations and other kinds of abuse in both the private and public spheres. In the field of family relations, for example, even when the roles of women (mothers, sisters, and wives) enjoy respect from the men in the family, women do not easily partake in family decisions, which are made by the males. Patriarchal structures and customary law serve to preserve male hegemony and male privileges. This might result in relegating women to household duties and, in worst cases, in setting lower or no legal age for women to marry (as seen in Afghanistan, India, and Pakistan), in forced or arranged marriages, in dowry-related violence (India), as well as in other abuses. These practices prevent girls from completing their education (or even from accessing it) as well as from entering into or staying in the labor market and gaining economic independence.

Other economic dimensions of these types of family roles concern denying or limiting women's rights to own or manage property. Some legal systems (e.g., sub-Saharan Africa) also deny widows equal rights to inheritance, leaving them economically disadvantaged at their husbands' death. Some cases of *sati*, the practice according to which a widow voluntarily jumps or is thrown by members of the community into her deceased husband's pyre, are still recorded in some rural communities of India. Beyond family relations, separation of women and men in public spaces, such as the practice in Saudi Arabia, has frequently been justified with the will to protect women from violence and harm.

Moreover, relatives and the local community might play key roles in the perpetuation of ritual practices, such as female genital mutilation, particularly in rural areas. In these and other cases, the control of women's bodies and sexuality is carried out by both men and family or elder women (aunts, grandmothers, and old women in the community).

Voices of Women From Non-Western Countries

In many non-Western countries, women increasingly occupy political and economic ruling positions and have actively promoted better living conditions for women living in rural areas and, more broadly, women's access to education and independent life.

In some cases, political and economic instability continuously put women's rights at risk in several areas, such as in the case of the Taliban regime in Afghanistan. Postcolonial feminists, activists, and many other women from non-Western countries have contributed to deconstructing the stereotyped image of non-Western women as subordinated and slavishly complying with oppressive rules. They have investigated and contrasted power dynamics and gender hierarchies in their societies, at the same time rejecting many gender issues and roles supported by Western women.

Some well-known examples of girls from countries such as Pakistan, Afghanistan, and Yemen portray fighting against forced marriages or striving for education and independence. The use of the Internet (e.g., blogs and social networks) has proven to be a powerful tool for women's activism and resistance. For example, Malala Yousafzai, a young Pakistani blogger and pupil, wrote a diary in a blog for the British Broadcasting Corporation (BBC)—under a pseudonym—describing life in her village after the Taliban imposed its rules. After her identity was revealed, she survived a Taliban attack and become a prominent symbol of girls' emancipation. In Saudi Arabia, women launched the October 26th Campaign to lift the ban on women driving their own cars.

At the same time, Muslim women also used the Web to reclaim their own agency in response to the paternalistic approach of Western feminists toward Muslim women. For instance, a Facebook page titled "Muslim Women against Femen" was opened in April 2013 as a reaction to the launch of a so-called topless jihad by Femen's topless activists to support Tunisian activist Amina Tyler, who was imprisoned after posting her topless photos online. In the online discussion that followed, Muslim women contrasted, among other things, the perception spread in Western societies about the veil as a means of Muslim men's oppression on women.

Beyond the Gender Binary (Transgenderism)

Going beyond heteronormativity and binary gender roles might be a sensitive issue in many non-Western countries. In some other cases, different gender identities have been considered sacred, such as the Hijras (eunuchs) in India, Pakistan, and Bangladesh. Hijras belong to a special caste in the Indian culture because of their identification with the Mother Goddess, even if they face discrimination in daily life. They often live in defined Hijras' communities and make their living by dancing and singing at birth ceremonies and weddings. Serena Nanda maintains that this group, born men but adopting female roles, actually become "neither men nor women" and "function as an institutionalized third gender role." Since November 2013, Hijras' gender designation can appear on their passports in Bangladesh, whereas in Pakistan they can opt to identify themselves by E (for eunuch) on their passports and government forms.

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See Also: Female Genital Mutilation; Gender Issues and Roles in Developing Countries; Institute for Women's Policy Research; Multiculturalism; White Privilege; Women Minorities.

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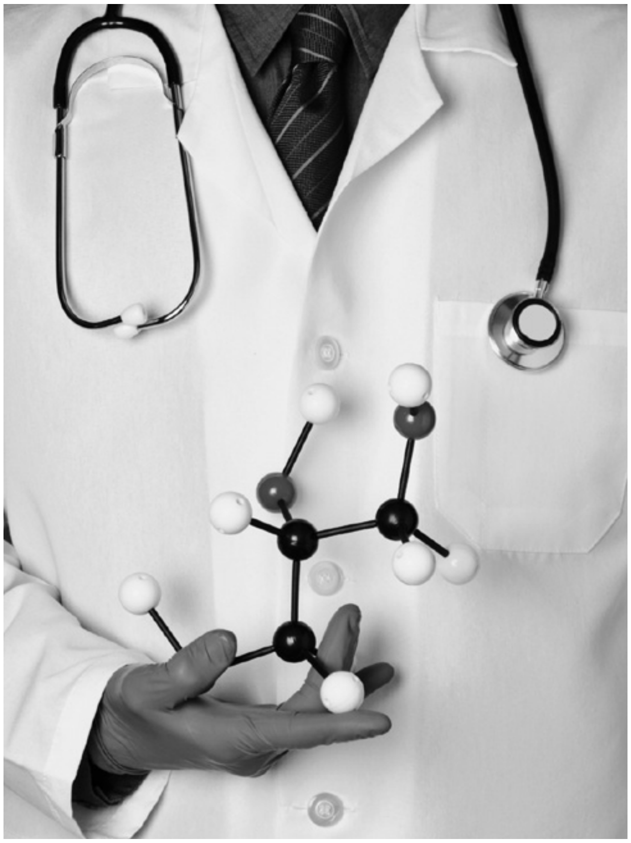
Genetic Counseling, Cultural Aspects of

The National Society of Genetic Counselors, which was founded in 1979 and is the largest genetic counselor association in the world, defines genetic counseling as the process of helping patients understand the medical, reproductive, familial, and psychological implications of information about their genes. This encompasses the study and interpretation of personal and family medical histories; the determination, according to the most recent data and available genetic information, of the likelihood of a genetic disease occurring; guiding the patient through education about the prevention or management of such a disease; and one-to-one or family counseling when it comes to understanding the choices to be made and their consequences. For example, a couple expecting a child may seek genetic counseling because of a condition or risk discovered through prenatal testing; a couple whose newborn child has a genetic condition may seek counseling; an older child or adult diagnosed with a genetic condition may also seek out counseling. Counseling may help a person with a hereditary condition make decisions pertaining to family planning, as well as understand and come to terms with the condition itself.

Genetic counselors serve a broad variety of needs and people, helping patients to understand the conditions they have inherited or could inherit. In addition, genetic counselors put medical information in context for patients and their families; advocate for patients; provide patients and their families with information about relevant support services, both public and private, including health care services and financial help; conduct research in medical genetics; educate legislators and health care professionals about genetic conditions; and work for genetics firms in the private sector. The role of the genetic counselor has always been one that has evolved in response to changes in technology and the health care industry, and this role is expected to expand and change significantly in the near future in response to the rise of genetic testing services. Such services have increased the demand for professionals to help patients understand or manage these risks.

Not everyone who seeks out a genetic counselor (or is referred to one) does so because of a diagnosis of a genetic condition. Genetic counseling is sometimes recommended for women past age 35 who are or are planning to become pregnant, especially if it is their first pregnancy; for couples who are planning to have another child and already have a child with a genetic disorder or birth defect; women who have suffered more than one miscarriage; or people who have a family history that includes a genetic condition.

Genetic testing, which is conducted on body tissue or fluid, reveals the genes that a patient carries. However, understanding what those genes indicate is constantly in flux. Comparative studies, for instance, have helped show correlations between certain genes or certain combinations of genes and certain conditions. In some cases, the correlations are strong and the mechanism by which the conditions are caused may even be understood. In other cases, the correlations



Genetic counseling has evolved in response to changes in technology and the health care industry, helping patients understand the conditions they have inherited or could inherit, or could pass on to offspring.

constitute the scientific equivalent of a strong hunch, or research is still in its infancy. This is true even for diseases that are known to be hereditary—the genes associated with them are not confidently identified in all cases.

Cultural competence is important for all professionals who deal with a diverse clientele, but genetic counselors may find themselves dealing more frequently than some medical professionals with culturally sensitive matters. This is particularly true because of (but not only because of) the role of family planning in genetic counseling. For this reason, cultural competence training is increasingly recommended for genetic counselors; since the 1990s, there has been widespread recognition that linguistic competence—that is, simply employing a translator to liaison between a medical professional and a patient when there is a language barrier—is not sufficient to bridge the gap and inculcate mutual understanding. Further, cultural competence training means recognizing what is culturally specific about one's own beliefs, expectations, norms, behaviors, values, and habits, rather than assuming (as is easy to do) that what one is familiar with is either a universal or the so-called correct version, while competing versions are alternatives to be corrected at worst and tolerated at best.

To this end, genetic counselor Nancy Steinberg Warren developed the Genetic Counseling Toolkit with funds awarded by the 2009 Jane Engelberg Memorial Fellowship. Warren was later awarded the 2013 National Society of Genetic Counselors Cultural Competence Award for her work. This toolkit provides cultural competence tools for genetic counselors, with the goal of facilitating better communication and better work. Warren followed the model used for cultural competence toolkits developed for other professions. The Genetic Counseling Toolkit encourages self-assessments as well as the acquisition of cultural knowledge about the patients and communities the counselor serves and the management of the dynamics of difference.

When genetic counselors are better able to understand their own biases and unspoken assumptions, they are also better equipped to perceive the aspects and nuances of other cultures. They become better communicators and better able to understand their patients, their patients' needs, and how their patients react to the information the counselor is able to give them. Courses in cultural competence for genetic counselors include hypothetical cases such as interacting with a prisoner facing a medical dilemma who also faces the unique cultural conditions of prison; discussing family issues and using appropriate language with gay, lesbian, and transgender couples; deciding when an interpreter is needed; understanding deaf culture; dealing with refugees and understanding the issues they face; and understanding the wide variety of religious cultures and how religious background may impact medical understanding and medical decisions.

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See Also: Counseling and Psychotherapy Services; Cultural Competence, Training In; Disabled Clients.

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Genogram

A genogram is a graphical representation of intergenerational familial relationships, primarily biological and legal ones but also those that are fictive kinship in nature. Genograms are similar to family trees, but because they include attention to nonblood relations, and illustrate relationship dynamics, they are more comprehensive "maps" of family histories. Genograms have existed in various forms since the mid-20th century, but it was not until the early 1980s that a generally agreed-upon format for how a genogram should be constructed was established in the human services arena. A working group established by the North American Primary Care Research Group undertook the task of developing a standardized design and core symbols for genograms so that, once created, they could be understood across an array of human services practioners. Since these criteria were generated, they have been revised and expanded several times, as new perspectives on and insights into family structures and interactions have emerged. Computer technology has further faciliated the construction of genograms, especially in enabling various forms of coding the data they document.

Perhaps not surprisingly, early genograms—even those that used the original format customs—were inclined to view families from traditional or hegemonic points of reference; for example, as a nuclear family. As a result, genograms have been limited as tools for charting and interpreting multicultural families, broadly considered on the basis of, for example, race, ethnicity, language use, genographic origin, immigration status, caste, socioeconomic class, employment standing, sex, gender, gender identity and expression, sexual orientation, dis/ability (physical, developmental, and psychological), veteran status, age, generation, religious and secular affiliation, and physical appearance, among other dimensions of identity. Ongoing changes to the layout and icons used in genograms have sought, and continue to seek, greater accuracy in representation as well as in the understanding and analysis of all family configurations.

Use of Genograms Among Human Services Practitioners and Clients

Genograms are generally used in human services work in one of two ways. First, genograms are shared by practioners who work with the same families from different points of entry (e.g., a social worker, counselor, and psychiatrist) and/or with different members of the same family. Second, practioners have clients develop their own genograms to foster (or reveal) awareness of and insight into (or understanding of) genetic and behavioral patterns. Once identified, these patterns can be discussed and corresponding therapeutic service interventions can be recommended. In both ways, genograms generally operate as data-gathering devices and/or assessment tools.

To be used effectively in either way, human service workers and their clients need education and training on how to generate meaningful genograms; for clients, this preparation must also include attention to the range of emotions that may surface for them in the genogram development process as well as strategies for coping with those feelings productively.

Typically, genograms represent, to the extent possible given the clients' ages and access to various types of kinship information, at least three generations in both directions (backward and forward), in which the clients' generation is made the central focus. In other words, the vantage point in the genogram extends backward two generations to the clients' grandparents' generation (even if these individuals are not known), and forward two generations to the clients' real or would-be grandchildren's generation. Accordingly, genograms are said to provide a form of historical voice through a visual expression of previously silenced, faint, and/or unacknowledged nexuses in kinship relations across time. Genograms can convey only a limited amount of information; however, they do so in a way that reveals the larger essence of complex patterns embedded in familial systems, thus enabling hypotheses as to how clients' seemingly immediate life challenges have actually evolved from more distant ancestral origins.

Need for Resource Remediation

The academic bases from which genograms were developed and continue to be developed in human services disciplines, as well as the professional contexts in which genograms are used in human services practice, are largely reflective of contemporary and complex views of family. However, ill-conceived iteration and use of genograms still permeate societal institutions. For example, many high school biology textbooks use genograms to promote—perhaps inadvertently, perhaps intentionally—heterosexist familial norms. A genogram depicting same-sex parents is used to illustrate a so-called incorrect application of genogram gender icons (two circles for females, two squares for males), as well as to reveal so-called erroneous understanding of hereditary progressions. Children of same-sex parents, however, would use two same gender icons to accurately depict their parents. Further, if a child is the biological offspring of one parent and the opposite sex sibling of the other parent, a genogram would also express the child's accurate genetic patterning. Brazilian educator Paulo Freire has argued that erroneous co-optation of popular ideals is inevitable, but such co-optation must still be exposed and corrected. This is especially the case in human services arenas where the consequences of not doing so are more significant because the focus of service is health promotion among already vunerable client populations.

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See Also: Cross-Cultural Service Models; Cultural Competence, Training in; Culturally Diverse Practice, Definitions of; Culturally Diverse Practice, Theories of; Families, Nontraditional; Family Structure, Diversity of; Multiracial Individuals and Families; People of Color: Service Delivery, Psychological Assessment, Cultural Issues; School Social Workers, Racial and Ethnic Issues for; Social Work, Diversity Practice in.

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Gentrification

The concept of gentrification refers to a residential development that brings new residents to a deteriorated neighborhood. Typically, the process is described as one in which young, well-educated, salaried and professional people move into an area where poor people live. Gentrification consists of a change in neighborhood character, displacement of older and/or poorer residents, and a physical change or upgrades to housing stock.

The process of gentrification occurs when the newly rich and mobile see an opportunity to remake neighborhoods in a new image, capitalizing on cheaper rents and reconstruction costs. Gentrification begins when a deteriorated and/or partially abandoned neighborhood appeals to housing speculators. Old housing stock is bought, upgraded, and resold at higher prices than originally obtained.

During this period, economic revitalization also takes place, and the pace of gentrification and displacement of original residents increases. The result of gentrification is typically a much-desired, socially vibrant neighborhood that has little of its original residents or character. Some cities welcome gentrification as a means to rejuvenate neighborhood buildings, raise rents, and increase property values; others see gentrification as a means to displace the homeless, the poor, and the vulnerable, along with disrupting neighborhood life.

Gentrification and the Economy

Urban scholars debate the causes of gentrification. Some have stressed the preference toward the social life of the city as one factor that drives the process. Cities usually have a variety of cultural, social, ethnic, and racial components in a concentrated local area (i.e., a neighborhood) that is attractive to a particular demographic. This intergenerational, intercultural mixing produces many outputs, such as museums, art galleries, concerts, libraries, cafes, trendy nightspots, and other cultural institutions that are in short supply in suburban and rural areas. Therefore, when young, urban professionals see an opportunity to move closer to these institutions, they do so in droves.

Other scholars have pointed to job growth as a key indicator or factor leading to gentrification. Young professionals seeking to reverse-commute gentrify neighborhoods so they will be in close proximity to work. Also, many cities in the 1970s and 1980s offered tax breaks to corporations to reinvest in central city districts. Generally, gentrification has occurred in larger, older cities on the U.S. East Coast, moving westward over time.

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Still others have pointed to the housing market as the primary driver of this type of redevelopment. As the United States grew, the inner cities (primarily the economic engines of the late 1800s and early 1900s) declined, and residents moved to the suburbs. During this period, single-room occupancy hotels, multifamily units, apartments, and townhomes were the primary styles of residence for city dwellers. The growth of the suburbs far outside the city from the early 1900s on, however, changed the economic landscape dramatically. Suburbs provided safety, cheaper single-family housing, land for economic development, and the peace and quiet that cities could not offer. Deindustrialization, or the rapid restructuring of urban economics marked by factories and businesses leaving the inner cities for cheaper rents, increased urban displacement. Once suburbs became the preference of young professionals, city housing stock deteriorated and businesses followed workers to suburbia. This left an abundance of cheap urban housing stock for speculators to renovate.

Changes in housing stock, coupled with public policy, have also been found by scholars to drive gentrification. In the 1960s and 1970s the federal government encouraged the demolition of old public housing units and promoted the construction of condominiums and townhomes in their place. Tax increment financing instruments, such as tax-free bonds given to developers to incentivize relocating in cities, also spurred gentrification. In the late 1960s, President Lyndon B. Johnson encouraged cities to gentrify through his signature Model Cities program, the Urban Renewal program, and the creation of the Department of Housing and Urban Development, which, for the first time, made the economic health of urban centers a part of public policy.

Gentrification: Race and Class

Gentrification's negative connotations have often been portrayed in terms of class or race discrimination. Suburbanization, in its earliest forms, was biased. Redlining, or the practice of denying (or charging more for) credit to residents based on race or ethnicity, was a practice enforced by national policy into the 1970s, beginning with the National Housing Act of 1934. The result of this strategy was to concentrate minorities (and the poor) in central cities. As whites moved out of the cities to capture cheaper rents in the suburbs, the residents of the central city were left to manage on their own.

Changes in redlining practices led to reinvestment in the city. The Urban Renewal program of Johnson's War on Poverty platform provided federal dollars to cities for private entrepreneurs to build highways, parkways, parks, and condominiums. It utilized eminent domain to procure property. The use of these funds to demolish and forcibly remove residents led to a backlash from minority and poor communities across the country. The Community Development Block Grant program, an offshoot of Urban Renewal, used a competitive grant process to provide for redeveloping existing neighborhoods rather than demolishing them.

Gentrification: Displacement and Renewal

The crux of the debate surrounding gentrification is between the issue of displacement at the cost of urban renewal. Displacement occurs in many ways during the gentrification process. Some residents find that, as the values of their homes rise, they cannot afford to pay their property taxes. Renters find that rents increase, or that their buildings become unlivable as they are readied for conversion into luxury apartments. Older, poorer residents may feel a strong pressure to sell because they cannot take advantage of the new market. Finally, many residents who lived in a neighborhood pregentrification move on since the social and economic networks that used to be in place are eliminated or abandoned by new residents.

Cities, bound by economic competitiveness, can benefit from gentrification, namely, in the form of increased property values; the development of new infrastructure, such as road and sewer improvements; increases in collected property tax; and high rents. Local economies benefit from having new residents bring much-needed skills and knowledge to the industries and businesses located in the central city. Tourists and visitors to gentrified neighborhoods feel safer as well.

To ensure negative aspects are minimized, local and state governments have many tools. They can closely monitor evictions, allow existing tenants the right of first refusal, provide emergency assistance to poorer renters, and institute so-called property tax circuit breakers to ensure that residents on fixed incomes are not forced out of their homes. Local governments can require developers to create mixed-income units within buildings and protect single-room occupancy housing by bringing these properties under public control.

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See Also: Social and Economic Justice; Social Darwinism; Socioeconomic Status.

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Global Burden of Disease

In 1663, John Graunt (1620–74) published the first survey of mortality as a result of disease epidemics by analyzing Bills of Mortality in England. His epidemiological research revealed patterns of death by gender, age, and urban versus rural location due to plague and disease. His work demonstrated the importance of gathering facts in a systematic manner and generating vital statistics in order to identify, characterize, and classify health conditions. Graunt's efforts led to an increased awareness of public health issues and patterns of diseases that in the 18th and 19th centuries gave rise to a sanitary revolution, which ushered in better health and extended life opportunity for the majority of the population in the developed world.

In the 20th century, the creation of the World Health Organization (WHO) in 1948 offered visionary goals for global health. Among the founding principles of the WHO is the idea that health is more than the absence of disease or the lack of infirmity; health includes comprehensive physical, mental, and social well-being. Furthermore, every human being has a fundamental right to live a healthy life, and no political, economic, or social conditions should force any persons to live degraded, unhealthy lives. The WHO constitution advocates that advances in scientific, medical, and psychological knowledge benefit all, and it calls for commitment and cooperation on the part of governments and the public to make efforts to improve the health status of all. In 1990, toward these goals, the WHO, in conjunction with the World Bank and Harvard University, launched the Global Burden of Disease (GBD) project aimed at providing a comprehensive evidence-based system for understanding conditions of health, illness, and disability, and projecting the likely outcomes for affected populations.

Because human health, labor productivity, and economic growth are closely connected with the quality of life of individuals as well as national development, understanding how best to support public health and development as well as set priorities for national health agendas is critical for government officials, policy makers, and health and human services professionals. Having accurate national and global data on illness, disability, and death enables these various experts to make informed decisions about creating and implementing national or international health programs. The aim of the original GBD study in 1990 was to create a consistent data set to identify and benchmark the health effects of more than 100 diseases and some 483 sequelae (ill health as a result of a previous disease) across five age groups in eight World Bank regions. The 1990 study, published as part of the 1993 World Development Report, was not without flaws, but it attempted to produce internally consistent estimates of mortality and morbidity by age, sex, and geographic region. The study also attempted to clarify the burden of diseases by quantifying early deaths among populations and the number of years individuals lived in ill health due to injury and sickness. The project's first researchers designed a metric, the disability-adjusted life years (DALYs), to measure both the number of years of life lost (YLL) due to premature deaths and the healthy years of life lost to disability (YLD). DALYs enable policy makers and professionals to assess which diseases, illnesses, or injuries are most significant in creating a gap between the desired outcome of a long life in full health and the reality of disability or early death.

Numerous factors contribute to the health and illness of a population. The economic and social conditions and government policies under which people live have important influences on people's health. The GBD study does not attempt to address or ameliorate the negative conditions that influence individuals' health and life chances. Instead, the study provides data necessary to make likely predictions of mortality and disability based on indicators of health risks such as age, sex, cultural norms, income, social status, education, and awareness of healthy behaviors. The question thus becomes: Can policy makers and other professionals understand and sort out the issues surrounding the validity and reliability of the indicators to improve national health and the quality of life for people around the world?

The GBD project rekindles a century-old public health debate. On one side of the debate is the idea that increased health is necessary to enable people to arise from poverty and despair. On the other side of the debate is the idea that people's health will improve only when their economic and social positions are improved. Critics of the quantitative accounting of the GDB project argue that simply collecting data and making projections does little to improve public health or change the day-to-day lived reality for the world's poor. Instead, it encourages a top-down bureaucratic approach to public health spending that funnels funding to projects that can report success based on achieving certain metrics rather than actually changing the conditions that lead to death, disability, and diminished quality of life. Supporters of the project argue that the data allow researchers to draw causal connections between the environment and disease. Armed with this information, policy makers and health and human services professionals can use the data to compare the costs of allowing the conditions or disease to go unchecked (per DALY of lost productivity) with the costs of using public funds to improve conditions for the poor and design cost-effective remedies for increased health and well-being.

The collection and refinement of data on the global disease burden not only allows but also encourages conversation on issues of health, poverty, and development. The project enables scientists, academics, and development and health and human services professionals to assess the state of global health, identify the critical health problems that confront the developing and the developed world collectively and individually, and access the existing resources to promote health and find ways to mobilize them effectively. Since 1990, the Global Burden of Disease project has collected, analyzed, categorized, and made available the data necessary to improve world health. Since the original

1990 study, the WHO, working with participating organizations, has expanded and updated the GBD project. GBD 2010 was truly an international effort, which involved 488 coauthors from 303 institutions in 50 countries and took five years to complete. Twenty years after the first GBD report, the 2010 report provides estimates on premature death and disability for 291 diseases and injuries, 1,160 sequelae, and 67 risk factors for both males and females in 20 age groups in three time periods, 1990, 2005, and 2010. In total, GBD 2010 produced data for 187 countries, 21 world regions, and generated nearly 1 billion estimates of health outcomes.

The data from the two-decades-long GBD project demonstrate rapid transformations taking place on the global health landscape. The global population is increasing and aging as people are living longer and childhood mortality has been significantly reduced in many countries. The causes of death and disability in adults as a result of noncommunicable diseases are now more significant factors in terms of poor health and mortality than the problem of childhood communicable diseases that once confronted many nations. These increases in life expectancy require a shift in public health policies as many nations face the challenges of aging populations with disease burdens that are a matter of disability rather than premature mortality. The data also indicate clear inequalities between the rich and the poor in terms of health status, life expectancy, burden of disease, and disability conditions. For example, obesity from overeating has replaced malnutrition as a leading risk factor for illness in the developed world. These countries have lowered their rates of mortality, but have increased their rates of disability and ill health. People are living longer but less healthier lives. In peripheral nations in Sub-Saharan Africa, high rates of mortality continue to be attributable to the lack of adequate nutrition and clean water, communicable diseases, and maternal and newborn diseases. In Africa, having the data alone is insufficient to generate the political will or the capital necessary to assure peoples' health. The data also indicate that the shared problems of smoking and mental disorders contribute significantly to worldwide mortality and disability rates. The descriptive epidemiology about changing patterns of disease made available in the GBD project is critical for helping nations design public health and development projects to promote the well-being of their populations.

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See Also: National Healthcare Disparities Reports; Public Health; Quality of Life, Measurement of; Social Determinants of Health; Social Epidemiology.

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Global South/ Global North

Socioeconomic and political differences among the countries has led to the emergence of new concepts. Global South/Global North is one of these examples that indicates the social, political, and economic division among the countries. This division pertains to both diversity and applications of human services because of the differences in improved services, accessibility, and promotion of well-being between Global South and Global North. Global South is widely considered poorer in terms of its social and economic development.

The regions of the Southern Hemisphere, such as developing Asia, Africa, the Middle East, and Latin America, are generally categorized in this group. In contrast, socioeconomically advanced regions and countries (for instance, North America, Europe, Australia, Japan, and Russia), which are part of the Northern Hemisphere, represent the Global North.

Historical Change in the Definition of the Global South/Global North

The historical background of country categorization commenced shortly after World War II. The ideologies that the countries represent divided the West and East in terms of their political characters, which were the representative powers of liberalism and communism, respectively. The countries of the West (namely, the United States and its allies, mainly in western Europe), and the countries of the East (led by the Soviet Union and China), created a bipolar world during the Cold War period after World War II. The countries of the West, which are ideologically liberal and capitalist, represented the First World, and the communist and socialist countries of the East were defined as the Second World. Additionally, the countries that were nonaligned during the Cold War era were classified as Third World. The Third World countries were mainly postcolonial countries of Africa and Asia, and these countries were overwhelmingly underdeveloped. However, some countries in Europe, such as Switzerland and Finland, also remained neutral. Moreover, Latin American countries were categorized as Third World.

After the collapse of the Soviet Union in 1991, communism lost its popularity, and the Cold War period ended. Accordingly, this landmark change in the political spectrum influenced the definitions of First, Second, and Third World. Socioeconomic development of the countries has started to play a greater role in the definition of the Global South/Global North division, more than the political ideologies of the countries after the early 1990s. Therefore, some First World countries, such as New Zealand and Australia, are located in the Southern Hemisphere but have taken their places in the Global North. In other words, a developed economy, high-technology industry, and political stability have become the indicators of the country to be classified in the Global North, and the lack of these features has become the main factor to be included in the Global South. The Third World countries came to the fore as underdeveloped countries that have widely had a colonial past, so the politically impartial status of those countries during the Cold War era lost its importance. Developed and postindustrial countries, such as the United Kingdom, Germany, France, Italy, the United States, and Japan, continue to be part of the Global North. However, there is no particular list that categorizes each country either in the Global South or Global North. Instead, there has been a trend in the last decades to identify the Global North with the Organization for Security and Co-operation in Europe (OSCE), whose members are predominantly from the First World and some countries of the Second World (e.g., Russia).

Social Problems, Diversification, and the Future of Global South/Global North

The Global South/Global North divide has been under the influence of new global trends such as globalization, movement of people, life expectations, environmental pollution, quality of education, and quality of the health system. Hence, the Human Development Index (HDI), which has been devised and measured by the United Nations Development Programme, is used to rank countries through the criteria of life expectancy (index of population health and longevity), education index, and the standard of living (income index).

These indices offer a well-presented panorama for human development comparison among the countries and the diversification around the world. In this context, the Global North has a better score than the Global South in all areas. The main reason behind these differences lies in political instability and poor economic performance, which are related to exporting raw material, not producing a high standard of industrial and manufactured goods, ineffective public policies, and social problems. Furthermore, colonized countries of the Western countries in the Global South suffer from the heritage of incapacity and limited resources. As a result, there is an immigration trend from the Global South to the Global North, with people seeking better life conditions. The positive impact of globalization, however, has decreased the division between the countries through flow of money, transfer of knowledge, new opportunities in telecommunications, and transportation. What is more important is the rapid economic development of the countries that are traditionally in the Global South. For example, it is expected that China, India, and Brazil will be listed in the top five countries that have the highest gross domestic product (GDP) by 2030. Finally, the United Nations has implemented a program called Millenium Development Goals to fight poverty, AIDS, and other diseases; to provide environmental sustainability; to promote obligatory primary education; and to encourage gender equality. Therefore, both national and global policies will fill the gap between the Global South and Global North.

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See Also: Colonialism, Lingering Effects of; Critical Race Theory; Diaspora; Displaced Persons; Ethnic Diversity and Values; Food Insecurity; Human Trafficking; Immigrant Populations, Human Service Needs of; Pluralism; Poverty; Power, Race, Ethnicity and.

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Grassroots Leadership

In the modern digital age, "community" can be defined in geographic terms, cultural terms, as well as virtual terms. Communities exist wherever there are shared interests or a collective identity. From time to time, and for a variety of reasons, communities seek change. The change communities desire can be short-term and goal-specific, such as reducing neighborhood violence, or long-term, such as creating sustainable economic development and growth. When communities seek change, leadership is necessary to organize community members for advocacy and action.

Grassroots leadership is an effective approach to leadership for community change. The term *grassroots* implies from the ground up, or homegrown leadership from within. Grassroots leaders emerge from disenfranchised communities and give the voiceless a voice and empower their community to reclaim its destiny. Grassroots leaders employ strategies that foster collaboration and use culturally appropriate tools to maximize citizen participation among community members. To ensure leadership continuity, grassroots leaders seek out community members to mentor and develop into future grassroots leaders. The 20th century is rich with examples of grassroots leaders from various communities, such as the suffragettes who won the right to vote for women, Harvey Milk from the gay community in San Francisco, Cesar Chavez from the community of Latino farm workers, and the psychiatric survivor/consumer movement in mental health services. The core concepts of community—shared collective identity and interests—remain, but in the 21st century, communities are becoming more diverse. It is imperative for grassroots leaders to be able to mobilize multicultural communities to action around shared concerns and goals.

Grassroots Leaders Are Members of the Community

Unlike community organizers, who sometimes are outsiders contracted to work with a community to achieve an identified goal, grassroots leaders are members of the community that is seeking change. By virtue of their community membership status, grassroots leaders have a personal stake in the outcome, and their credibility comes from being part of the community and working side by side with the very people who will benefit from the desired change. Their stature within the community may be formal or informal. Grassroots leaders can be church ministers or small business owners, but they can also be students or grandmothers. Although their opinions matter to the rest of the community, grassroots leaders know the expressed goals and outcomes are not about them but rather about the community's enhanced welfare. Grassroots leaders have earned the respect and trust of other community members.

As members of their communities, grassroots leaders are uniquely positioned to be able to measure the scope of the community's identified problem, recognize barriers to community collaboration, and assess the community's capacity to effect change. A key quality that grassroots leaders must possess is the ability to inspire and galvanize other community members to act. The quality of the relationships that grassroots leaders have with other community members influences their ability to motivate others. Grassroots leaders promote the emotional ownership of the identified goal among community members. They are change agents who are able to generate buy-in from other community members to turn the community's vision into reality.

Grassroots Leadership Styles in Diverse Communities

Across cultures, a universal human experience is that all people have a need to belong to a community that wants, needs, and appreciates them. For this reason many grassroots leaders employ a collaborative leadership style and convey an expectation that the talents and contributions of every community member are needed in order to achieve the desired change. This is particularly important for communities that are diverse. Grassroots leaders recognize differences in perspectives that exist within the community, bring community members with multicultural viewpoints together, and lead a process that assures that all the varying points of view are welcomed, honored, validated, and considered. This collaborative process can be time consuming but needs to be done to generate strategies for addressing the shared concerns of the community that all community members can own and visualize themselves taking some action to achieve the collective identified goal. By undertaking this consensus-building process, grassroots leaders create a community of purpose. Power is shared among the community members in decision making and collective action.

Grassroots Leaders Seek to Groom the Next Generation of Community Leaders

For desired community change to be sustainable, there must be continuity in community leadership. Leadership development is an essential function of grassroots leaders. Grassroots leaders see their roles as a combination of mentor and role model. They identify up-and-coming community members whom they can guide and support into the next generation of community leaders and create opportunities for these individuals to step into leadership roles. Grassroots leaders seek out community members who are representative of the community's emerging composition so that these junior community members possess the cultural competencies and community credibility that will ensure future citizen participation among the community.

Tools for Grassroots Leaders

As the Arab Spring has demonstrated, social media can be a powerful tool that grassroots leaders can use to mobilize community members to action, especially for communities that are not geographically based. Forums such as Facebook, Tumblr, and Twitter provide the capacity for grassroots leaders to raise awareness, spread information, organize actions, and manage activists. The exclusive reliance on social media is discouraged, however. The credibility of grassroots leaders fundamentally rests on the strength of their interpersonal relationships with members of their community, so social media should be regarded as a supplement to, rather than a substitute for, face-to-face community organizing.

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See Also: Community Action Agencies; Community Organizing; Cultural Competence, Model of; Human Capital Development Initiative; Social Capital, Role of.

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Group Homes for Adults

Group homes for adults are designed to provide assistance to those with mental or physical disabilities, people who are experiencing substance abuse problems, or those who are elderly and no longer able to independently care for themselves. Historically, individuals within these groups were likely to be institutionalized. In the latter decades of the 20th century, however, considerable efforts were made to provide environments wherein such adults could live as independently as possible. For many, group homes provide the necessary support in an environment that reflects typical family and community life. Group homes are often located in residential neighborhoods and look similar to the homes that surround them. They typically house six to eight residents, but more residents may be housed in larger homes. Some group homes are located on campuses made up of a cluster of group homes. While group homes may be private and associated with certain religions or organizations, they must be licensed by individual states. Thus, group homes may require the supervision of human service professionals. Group homes provide benefits not only to adult residents but to their families because of relief from financial, emotional, and physical burdens. Most group homes are located near the families of residents, allowing them to maintain close family ties. Group homes also benefit society because they reduce overall health costs and promote diversity.

Background

Before the mid-20th century, most adults unable to live on their own were placed in institutionalized settings such as hospitals, nursing homes, institutions for the mentally or physically impaired, or rehabilitation centers. In 1963, Congress set up a grant program for group homes through the Community Mental Health Centers Act. Six years later, Bengt Nirje, Sweden's director of the Association of Retarded Children, introduced the concept of normalization, insisting that disabled individuals were best served by providing them with residential services that allowed them to live as closely as possible to the way their peers lived. The concept of normalization became a major influence on the way that human services professionals and governments around the world dealt with both children and adults who required living assistance. In the 1970s, a number of class-action lawsuits were filed concerning the right of such individuals to live outside institutions. In 1990, Congress passed the Americans with Disabilities Act, stipulating that segregating the disabled in institutions was legal discrimination. Subsequently, most large state facilities were closed, and residents were transferred into group homes in local communities. In 1999, the U.S. Supreme Court held in *Olmstead v. L.C.* that disabled individuals have a legal right to live in group homes in community settings.

By the 1990s, the concept of placing adults requiring living assistance in group homes had become known as supported living. In the case of developmentally impaired adults, this meant providing educational opportunities and job training that allowed such individuals to live independent lives. The move toward independence continued into the 21st century, assisted by new laws at both the federal and state levels, as well as increased professional and financial support. While communities may be supportive of the abstract concept of group homes, individuals may balk when faced with a proposal for a group home in their own neighborhoods. Thus, human services personnel must constantly deal with the "not in my backyard" (NIMBY) syndrome.

Substance Abusers

Adults who have experienced problems with substance abuse often find that living in group home settings provides them with the necessary support to live their lives free of drugs and alcohol. Residents are able to learn from one another, and they generally experience high levels of diversity. One of the best-known examples of group homes for individuals recovering from drug or alcohol abuse is Oxford House, which was founded in 1975 in Sandy Spring, Maryland, as single-sex group homes that allowed residents to govern themselves. Oxford House rents the homes in which residents live in communities throughout the United States, and stays are not limited to any specific period. In order to remain, residents must accept bans on substance abuse and refrain from disruptive behavior, and they are required to pay rent and utilities and purchase their own food. The minor children of female residents are allowed to live with their mothers. By 2008, Oxford House had grown to encompass 1,200 group homes in the United States as well as 30 in Canada and eight in Australia.

Developmentally and Mentally Impaired

Group homes for the mentally and physically impaired are usually supervised by trained nurses who may use behavior modification techniques when working with residents. The level of modification is dependent on the level at which such adults are able to function. Workers in group homes may be called upon to educate residents in such basic skills as personal hygiene or routine housekeeping chores. For others, the focus is on acquiring language and/or social skills or providing job training. The ultimate goal, except in severe cases where individuals will never be autonomous, is to teach those with impairments to live on their own with only as much outside assistance as is necessary.

While group homes have distinct advantages over institutionalized settings, they are not ideal for all developmentally impaired adults. For instance, Jenny Hatch, a 29-year-old female with Down syndrome, went public in 2014 with her frustration about being placed in a group home by her mother. Hatch stated that the home made her feel as if she was imprisoned, and she resented being denied access to her computer, church, and job. Hatch solved her problems by going to court to win the right to live with her employers, Jim Talbert and Kelly Morris, who have a physically disabled daughter.

Experts in the field, including Robert L. Schlalock and Miguel A. Verdugo, insist that in any group home setting, human service professionals must ensure specific elements that allow residents to enjoy quality of life. These elements include recognizing basic rights and acknowledging the need for residents to experience emotional, physical, and material well-being, interpersonal relations, personal development, self-determination, and social inclusion.

The Elderly

It has been estimated that from 10 to 50 percent of nursing home residents are there because they lack assisted living options. At the end of the 20th century, about 75 percent of seniors lived on their own, 19 percent lived in group homes, and 5 percent lived in nursing homes. The 21st century ushered in an increasing need for living assistance for the elderly as the first baby boomers began to reach retirement age. Professionals have discovered that group homes fill a major need for the elderly who do not require long-term care in an institutionalized setting but do need varying levels of assistance that range from providing food, housekeeping, and transportation services to assuaging loneliness or boredom. Building on this idea, William Thomas devised the greenhouse model of group homes that allowed elderly residents to live in their own rooms surrounded by their own belongings with access to assistance only when needed.

Group homes for the elderly have the advantage of being less expensive than nursing homes, but they are not always available in certain communities. The communities that are most likely to provide the option of group homes are located in the northeast and are neighborhoods in which there are high- or medium-cost rents, a large number of physicians, and residents with high per capita earnings and high levels of education. In communities that do not meet these criteria, the number of residents living in long-term facilities may reach only12 percent.

All group homes are licensed by state human service departments and are protected by state and federal laws. Communities vary in their support for group homes. Even though financial support may be forthcoming, group homes continue to battle the NIMBY mentality that increases fear of those that are considered different than the community norm. Thus, it may become the responsibility of human services professionals to combat such fears and protect the rights of those diverse individuals who look to group homes to fulfill their needs.

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See Also: Americans with Disabilities Act of 1990; Behavior Support and Management; Disability Services; Group Homes for Children; Mental Health Services, Adult; Nursing Home Care.

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Group Homes for Children

Residential group homes represent key components of the systems of care in the child welfare, juvenile justice, and mental health fields. These facilities are designed to provide community-based, congregate residential supports, which promote safety and stability for children and youth who have been removed from their homes because of the family's inability to address their needs. Specifically, children under the age of 12 years are rarely placed in congregate care settings unless they undergo formal psychological and psychiatric evaluations that indicate that they require highly structured, therapeutic environments such as residential treatment centers (RTCs) or psychiatric inpatient facilities. For adolescents, however, parents may voluntarily place them out of the home within a public system of care to obtain scarce and costly mental health services or to ensure the safety of a child who is beyond parental control and is in need of adult supervision. In these instances, the parent may maintain full authority, although the child is physically placed in the care of the professional provider of community-based residential congregate services.

Family courts also remove children from their caregivers because of child maltreatment, physical and/or sexual abuse, neglect, and parental abandonment or failure to supervise. If timely family reunification does not occur after a child has been removed, and the child begins adolescence after extended periods of placement or multiple, failed placements in temporary foster family care, the child often manifests significant symptoms of unresolved postseparation trauma and associated behavioral difficulties that cannot be contained in a normal family setting. On the other hand, juvenile justice systems may place adolescents directly into congregate care because community efforts to divert them from engaging in escalating delinquent behaviors and a negative, dangerous peer culture have failed. In short, group homes target youth who need around-the-clock care and supervision, education, recreation, health services, vocational and employment supports, as well as substance abuse and mental health treatment to successfully adjust in the community.

Characteristics of Group Homes

Group homes are more restrictive than family foster care settings, yet they are less confining and less expensive than residential treatment, psychiatric, or detention centers. These congregate facilities vary by size, characteristics of the population served, location, staffing ratio, licensure and credentials, program design, local/state regulations, and reliance on national standards of accreditation. Group homes are generally underwritten by public state contracts, and providers may receive funding from federal programs passed through the respective state for the provision of foster care or juvenile services. Private contributions may supplement the funding base because many group home facilities are sponsored by nonprofit and charitable organizations. Group homes may be therapeutic, high intensity in their structure, coed, same sex, or specialize in treatment modalities that address substance abuse, sexual offending, homelessness, running away, teen pregnancy, maternity, and parenting.

Typically, children placed in group home settings exhibit high-risk behaviors, are likely to come from low-income, chaotic families with limited access to services, and have previously resided in violent, urban communities. They often possess histories of chronic school failure, multiple foster care or residential placements, and parental rejection, and may be involved in delinquency, including sexual offending, theft, and assault. Many youth present with serious emotional disturbance or aggression (which may be directly related to histories of child maltreatment), behaviorally act out, defy parental authority, use drugs and/or alcohol, engage in inappropriate sexual activity, and fail to conform to family limits. Generally, the mission of a group home environment is to assist the youth to positively adjust to community living, master essential life skills, and establish a sense of safety, well-being, and stability, while learning to manage behaviors that prevent the youth's transition into healthy, productive adulthood. Group homes may also facilitate the effective transition of children and youth from more restrictive, institutional settings back to their families, or to independent living within natural communities and social networks.

Controversies

The utilization of group homes as an out-of-home placement resource for children and youth is controversial for several reasons frequently debated by policy makers and service providers. First, there is a perception that the iatrogenic effects of congregate care outweigh the benefits. In other words, children and youth who present with severe behavioral or emotional problems are viewed as likely to have a negative influence on one another in a group setting. Some advocates believe that group home residents pass on dysfunctional ways of coping with and managing adult authority, limits, and community expectations. Close interactions in the group home setting, it is argued, compound the youth's difficulties presented at the time of initial admission. For younger children, such settings may be deemed unsafe and developmentally inappropriate. Second, there has not been sufficient or rigorous study about the variation of group homes (e.g., respective treatment approaches, length of average placement, age of children served, program size, and location of the setting), and the implications for achieving positive youth outcomes. Although many group care models report anecdotal success for their graduates in terms of educational and employment goals, avoidance of re-arrest or conviction, or family reunification and sustained improvement in family relations, others acknowledge that determining long-term effectiveness is financially prohibitive. In addition,

Santa and members of the motorcycle safety group of U.S. Navy Strike Fighter Squadron 143 in a photo with children at St. Mary's Home for Disabled Children in Virginia Beach, Virginia. The group collected clothes and other items for the children as holiday gifts.

establishing a true control group for research purposes raises ethical issues and methodological challenges (i.e., withholding treatment and keeping track of youth after discharge from the group home). Third, group care is viewed as more restrictive than family-based care and wrap-around community supports. Critics of group homes believe that significant family relationships for the youth may be weakened, even when these relationships must serve as the basis for the youth's successful return to his or her community of origin.

Program Elements

Despite the scarcity of program evidence, and the recent movement by numerous states to reduce their reliance on group homes in favor of therapeutic foster homes or wrap-around supports for families who maintain their children, group homes are still considered essential. For youth whose psychosocial and behavioral health issues are best handled by the comprehensive care of a multidisciplinary team, this component of a continuum of services is necessary to ensure that the needs of all children and youth in a community are adequately met, and that they are safe and developmentally thriving. Group homes typically provide structure and resocialization on a 24- hour basis, ensure safety from problematic families and neighborhoods while the youth relearns and unlearns negative behaviors, and with the youth's buy-in, establish an individual, tailored treatment approach, supported by a team of trained youth professionals. Although there is a broad range of group home models, certain program elements are standard and associated with highly reputable and quality service delivery, as follows:

- A shared philosophy that is strength based and assigns personal assets to youth in care program objectives that promote positive youth development, rather than a deficit perspective, policing, or punitive adult responses. Teams who build their approach on such agreement are able to establish constructive relationships with young people who need at least one caring, nonparent adult they can trust as they strive to improve and maintain their life skills and functioning.
- A "learning" organizational culture that relies on a positive behavioral reinforcement system that is flexible, organic, predictable, rewarding, and responds to the changing demographics and needs of the residents.
- An individualized treatment approach that centers on the development of an individual treatment plan (ITP) that is owned by the youth, designed with the resident's input, and engages the family, when possible, as well as other important stakeholders. This plan also addresses the resident's transition from the program and identification of aftercare supports in the community.
- A culturally competent staff development and training model that goes beyond minimal governmental regulations to enhance the team capacity to accurately assess the youth's problems and to facilitate targeted, youth specific strategies for recovery and growth.
- Overall program emphasis on the youth's need to achieve self-sufficiency by age 21. This includes the resident's mastery of basic daily living skills, self-advocacy, and recognition of their expertise regarding their life journey, employment and educational success, and the opportunity to give back to the community through service and contributions. These program elements foster self-worth, confidence and self-esteem in high-risk youth.
- Recognition of the importance of family engagement to access specific cultural knowledge on family as well as cultural resources for both the youth and the program. This minimizes cross-cultural misunderstandings and conflicts and increases the likelihood of family reunification and healthy lifelong adult connections for youth.

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See Also: At-Risk Youth Services; Child Welfare Services; Children in Foster Care; Juvenile Delinquents.

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Group Therapy

Group therapy is a form of psychotherapy in which one or more therapists conduct psychotherapy with a group of patients. The roots of group therapy are in the practice of medicine. In the early 1900s, internist Joseph Hersey Pratt held educational meetings for patients with tuberculosis. Pratt's method incorporated inspirational messages and testimonials from successful patients in what Pratt called the lecture method. As Pratt and his colleagues recognized the positive effects of emotional support and patient-to-patient interaction, the medical element of the lecture method diminished. Pratt's method was used with patients with a wide array of chronic illnesses, and ultimately with psychiatric patients as part of a movement to promote social, recreational, and creative groups as treatment modalities. A support group, Recovery, Inc., extended benefits of group interaction to discharged psychiatric patients. By the 1940s, group therapists organized their efforts and founded the American Group Psychotherapy Association (AGPA), which defines group psychotherapy and ethical practice. AGPA also generates clinical guidelines and compiles research results that define the best clinical practices. In 2007, AGPA developed formal guidelines for group psychotherapy.

Practitioners

The American Group Psychotherapy Association regulates the practice of group psychotherapy. Psychiatrists, psychologists, counselors, social workers, and psychiatric nurses may conduct group therapy as part of their regular practices. Activity therapists may also do extensive group work with psychiatric patients, but most of the creative and recreational activities, although therapeutic, do not meet the criteria for group therapy. Self-help groups, even though they may be professionally facilitated at times, are also excluded from the definition of group therapy.

Types of Groups

The group format can be open to changes in membership or closed, meaning maintaining the same membership for all sessions. Generally, closed groups also have a set number of sessions, allowing for the development of intense dynamics among members. A typical closed group has eight members and meets for eight sessions. Open groups are usually ongoing, with no limit to the number of sessions that any one member can attend. Due to the fluid membership of open groups, trust levels may fluctuate, and members may be reticent to self-disclose as new members join the group.

Group Process

The first step in the process of group therapy is client selection. Therapists may select group members from their own individual cases. Conjoint therapy occurs when group members are receiving individual therapy from a therapist other than the group therapist, and is most successful when the therapists can freely communicate with each other. Homogenous groups serve a specific population, such as men, women, adolescents, or veterans. Heterogeneous groups are demographically diverse, but often address an issue that group members share, such as depression, anxiety, addiction, grief, or adjustment.

A group therapy session usually meets for 90 minutes. Group process refers to how the group and therapist interact. Task groups carry out goal-driven activities assigned by the therapist and process their experiences when the task is complete. Psychoeducational groups focus on a single factor and begin with the therapist presenting information to the group. After the educational presentation, the therapist facilitates a discussion pertinent to the subject of the presentation. Traditional group therapy, however, has a more open format. The therapist guides the interaction of the group members, whose issues often emerge in the course of the session.

Psychotherapy groups progress in stages. In the initial stage of group therapy, the therapist and participants introduce themselves. The therapist may then review the procedures and ground rules for each group session. Some therapists enlist input about ground rules from the group members. In the first one or two sessions, the therapist may be very active in directing the interactions of the group members.

During this early phase of the group process, the therapist may encourage group members to address any apprehension they have about being in the group, setting the stage for members to begin disclosing their emotional experiences. The second stage of group therapy is the working stage. An effective group therapist often expedites movement to the working stage by exploring resistance to the group process. During the working stage, group members identify and resolve tension in the group, listen to and give feedback on each other's issues, and express emotions openly. In the closing stages of the group process, members are able to articulate what they have gained from their participation and say good-bye to the rest of the group. In a successful group, the therapist's participation decreases as the group progresses. The group members, by the final stage of group therapy, should be interacting with very little input from the therapist.

Inpatient psychotherapy groups do not have a stable membership, so trust may be difficult to establish. In 1983, psychiatrist Irvin Yalom introduced a model for conducting groups in inpatient settings, where group membership changes rapidly. In Yalom's model, each group session is self-contained. Tasks of the beginning, middle, and closing sessions of a traditional group are included in every session. In the initial stage, each patient identifies a problem he or she would like to work on, and states how the group might be of help. A closely facilitated work stage follows. In the final stage of the therapy, members summarize what they are able to take from the session. Within the parameters of Yalom's model, group members may learn basic interpersonal skills, such as how to take turns, how to give support, and how to work with others. Members have an opportunity to feel the support of others as well as the opportunity to develop a sense of purpose and belongingness.

Group therapy is often conducted in institutional settings, such as locked psychiatric facilities, residential programs, and correctional facilities. In some residential and hospital settings, privileges are contingent upon attendance and participation in group therapy. A challenge of correctional therapy groups is to overcome the inherent distrust of both peers and staff. Court-mandated outpatient groups, and groups required for reinstatement to employment, are similar to institutional groups. Participants of such groups may resist therapy by being disruptive, hostile, or insincere. Difficult clients and other group members often benefit from working through this type of resistance.

Environmental factors can also affect the group process. Ideally, group therapy is conducted in an environment that provides privacy and safety from interruptions. Typical therapy groups sit in a circle of chairs that are approximately the same size and height. If a regular group member is not in attendance, the extra chair is removed. The day, time, and location of the group, as well as the furniture, lighting, and noise from surrounding activities, can influence the quality of participation in a therapy group. Each member of a group should be able to see and communicate with all other members. Skilled therapists give advanced notice that food, drink, cell phones, or any other distracting items are not permitted in the circle.

Group Facilitation

Effective group therapists integrate the components of individual dynamics, interpersonal dynamics, diversity, and whole group dynamics to promote therapeutic outcomes. Content and process are essential components of group work. Content includes the stories and issues of the individual group members. Process refers to what occurs within, between, and among group members. Group process is the core of group therapy, and effective group therapists provide process observations that promote insight and change in the group members. Therapists who are excessively active in the group process diminish opportunities for group members to participate. Effective group facilitators are skilled at maintaining therapeutic silence.

Conversely, if a group leader provides too little intervention, group members will often assume the leadership of the group. Some therapy groups have cotherapists who work together to provide process observations and direct interaction. An excellent collegial relationship between cotherapists assures that they can read each other's intentions, build upon each other's interventions, and model open and direct communication. The group therapist monitors individual dynamics, such as emotional responses, insight, and energy. Interpersonal dynamics include patterns of exchanges between and among group members and the therapist. Whole group dynamics are monitored to assess the group's progress through the stages of group development and to assure adherence to therapeutic objectives.

Effective group therapists are skilled at processing the dynamics of diversity. Fundamental attribution errors rooted in a client's experiences of age, gender, sexual orientation, racial, or ethnic differences can be an obstacle to deeper personal work. Minorities generally have less access to health care and may be referred to cost-effective therapy groups rather than individual therapy without consideration of cultural norms regarding disclosure of problems outside of the family unit. From a socioeconomic standpoint, shame may be triggered in a group member who is of a significantly lower socioeconomic status than other group members. Culturally competent therapists mobilize the dynamics of diversity to assist clients in the pursuit of their individual treatment goals as they monitor their own internal processes.

Theories of Group Therapy

A therapist's theoretical orientation structures how the therapist conceptualizes cases and conducts therapy. Psychoanalyst Trigant Burrow conducted the first theory-driven therapy groups. In what he termed "group analysis," Burrow processed group dynamics as they occurred, establishing the interaction of the group as a type of free association. Psychoanalytic therapy groups explore underlying fears, avoidance of conflict, ego defense strategies, and transference. Group analysis leads to insight, catharsis, and personal responsibility. Neo-Freudian Carl Jung initially forbade the use of Jungian techniques in groups, but contemporary Jungian therapists recognize the goodness of fit between group therapy and Jungian creative techniques. Alfred Adler's work focused on the client in a social context, and Adlerian group therapy provides a format amenable to the exploration of clients' relationships with others.

Humanistic theorists base their work on the premise that humans inherently seek to reach their full potential. Carl Rogers, the founder of person-centered therapy, purported that therapy groups recognized the unhealthy aspects of their processes and sought to eliminate those processes so a healthier group could emerge. Gestalt therapy is a directive, phenomenological approach that requires participation in so-called experiments designed by the therapist. Gestalt theory asserts that human suffering emerges from unfinished business of the past and anxiety about the future. Gestalt therapists work in the here and now to assist clients in fully experiencing the present moment. Gestalt techniques of enacting and exaggerating interpersonal dynamics are easily adapted for use in group therapy.

Cognitive behavioral therapy is based upon the premise that patterns of thinking determine emotions. Cognitive restructuring changes thinking patterns that cause or exacerbate anxiety, depression, and distress by disputing the faulty beliefs, guiding clients in developing and practicing new ways of thinking, and assigning behavioral tasks from which the client can develop new ways of responding to difficult situations. Cognitive behavioral therapy is a preferred treatment for mental and emotional disorders, including anxiety, depression, and addiction.

Group therapy is a clinically effective approach that is also cost-effective. Clients and third-party payers incur fewer expenses than they would for individual therapy, and the therapists, with multiple payers for a single session, can earn more than they would for a session of individual psychotherapy. Evidence-based practice refers to treatments that research has proven to be effective. Cognitive and behavioral approaches are widely researched with favorable results. The empirical evidence does not rule out the effectiveness of psychoanalytic and humanistic approaches, which are difficult to study.

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See Also: Counseling and Psychotherapy Services; Peer Support and Counseling Services.

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Habitat for Humanity

Habitat for Humanity International (HFHI, or Habitat) was founded by Millard and Linda Fuller in 1967. It is a nonprofit, Christian housing ministry that believes that every man, woman, and child should have a decent, safe, and affordable place to live. Its operational headquarters are located in Americus, Georgia, and its administrative headquarters are in Atlanta, Georgia. Habitat builds and repairs houses all over the world using volunteer labor and donations. Homeowners invest hundreds of hours of their own labor into building their own Habitat house and the houses of others.

Habitat affiliates are community-level Habitat for Humanity offices that act in partnership with and on behalf of HFHI. Each affiliate coordinates all aspects of Habitat home-building in its local area. Affiliates are formed by a group of concerned citizens who want to address the problem of poverty housing in their community. These citizens research the community's needs and resources, and they evaluate the potential success of Habitat's model in their community. The group then applies to HFHI for formal affiliation.

Affiliates operate within the framework of the Habitat Affiliate Covenant but remain independently run, nonprofit organizations. Habitat affiliates build houses, while HFHI provides a wide range of support services and resources. Some affiliates in developing countries also receive funding grants from HFHI. All Habitat affiliates are asked to tithe a percentage of their contributions to fund house-building work in other nations. These contributions provide much-needed funds for international building and give affiliates the opportunity to demonstrate the spirit of Christian partnership.

As a nonprofit, ecumenical Christian ministry that builds for people in need regardless of race or religion, HFHI welcomes volunteers and supporters from all backgrounds. Habitat includes more than 1,500 local U.S. affiliates and more than 80 national organizations around the world. They are controlled and managed by an ecumenical, international board of directors who are deeply concerned about the problems of poverty housing around the world. Habitat relies on gifts from individuals, corporations, and other groups to fund its house-building mission worldwide. Designated donations are allocated in support of specific affiliates, national organizations, or programs of the donor's choosing. Undesignated gifts are invested through the Global Impact Fund to projects with the greatest impact. Habitat has built or repaired more than 600,000 houses and has served more than 3 million people worldwide. In fiscal year 2012, HFHI served a record 94,618 families worldwide through construction, rehabilitation, and repairs.

The world presently is experiencing a global housing crisis. Globally, nearly 2 billion people live

San Antonio-area U.S. Navy sailors volunteer to help build a house for Habitat for Humanity in 2011. Habitat for Humanity builds and repairs houses all over the world using volunteer labor and donations. Homeowners invest hundreds of hours of their own labor into building their own Habitat house and the houses of others.

in slum housing, and more than 100 million are homeless. In the United States alone, 48.5 million people are living in poverty. The minimum wage is not keeping up with the rising cost of living, and many workers struggle to afford decent housing. Lack of clean water and sanitation claim the lives of more than 1.8 million young children every year. The percentage of people without access to decent, stable housing is rising. Habitat helps by building or renovating simple, decent houses in partnership with those in need. Families left homeless by natural disasters, war, and civil unrest often face dire housing situations as they struggle to rebuild their lives. HFHI provides shelter and housing assistance to help these families recover. In the United States, Habitat's partner homeowners' no-interest monthly mortgage payments are used to build more Habitat houses. On a global scale, Habitat uses innovative housing finance practices and/or partnerships with microfinance organizations to build and repair homes. Donations to Habitat for Humanity provide vital financial support to help the organization build and repair houses. In addition, more than 1 million people volunteer annually to assist with Habitat's construction projects under trained supervision.

Habitat's vision is "a world where everyone has a decent place to live." Its mission statement is, "Seeking to put God's love into action, Habitat for Humanity brings people together to build homes, communities and hope." The organization operates under five guiding principles. First is to demonstrate the love of Jesus Christ. Second is to focus on shelter in order to create opportunities for all people to live in decent, durable shelter. Third is to advocate for affordable housing—Habitat supports the global community's commitment to housing as a basic human right and advocates for just and fair housing policies. The fourth principle is to promote dignity and hope. Last, the fifth principle is to support sustainable and transformational development.

Individuals in need of decent, affordable housing can contact their local Habitat for Humanity affiliate to apply. The local affiliate will explain the application process and provide information on the availability, size, and cost of Habitat homes in the area. A list of local affiliates can be obtained by using the online search tool (http://www.habitat.org/local/) or by calling a help line.

Each Habitat affiliate follows a nondiscriminatory partner family selection policy to become Habitat homeowners. Neither race nor religion is a factor. Partner families are always selected based on their level of need, ability to pay, and willingness to partner. Generally, this includes those whose income is 30 to 50 percent of the area's median income. Prospective Habitat homeowner families typically make a $500 down payment and contribute 300 to 500 hours of sweat equity on the construction of their home or someone else's home. Mortgage payments are kept affordable because Habitat houses are built using donations of land, material, and labor.

Habitat works with the government in several ways. First, it asks legislators and housing regulators to increase support for affordable homeownership and eliminate poverty housing. Second, Habitat monitors public policies related to housing, community, and international development. Third, Habitat advocates policy choices that increase access to decent, affordable housing for people around the world. Fourth, Habitat also accepts government funds as long as they have no conditions that would violate the principles or limit its ability to proclaim its Christian identity.

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See Also: Grassroots Leadership; Homelessness; Housing Services; Housing Support and Homeless Services; Natural Disasters, Service for.

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Haitian Americans

The term *Haitian Americans* refers to an immigrant, diasporic, and ethnic group composed of individuals who have immigrated from the country of Haiti to the United States and whose children were born in the United States. Like African Americans, Haitian Americans are a people of African ancestry and cultural heritage. Enslaved Africans who were brought by European slave traders to the Americas founded the land of Saint-Domingue-Haiti in 1804. After 13 years of strenuous wars against Spain, Britain, and France from 1791 to 1804, commonly known as the Haitian Revolution, Haiti became the first postcolonial black-ruled state and second independent country, succeeding the United States, in the Western world.

Precisely, the phrase Haitian Americans denotes individuals who have acquired U.S. citizenship either by way of naturalization or natural birth. The history of the Haitian immigration or diaspora in the United States should be studied and understood from the different angles of the social, economic, and political factors that shaped the Haitian experience and forced many native-born Haitians to escape oppression and poverty in hopes of finding a better life in the receiving country. The reality of the diasporic experience played a major role, as Haitians had to learn to forge a new transnational ethnic identity and culture as well as new cross-cultural relationships and alliances in the land of resettlement. Haitians also had to adopt and regroup themselves in large Haitian American ethnic communities across the states in search of survival, hope, opportunity, and political peace, as well as in the pursuit of the American dream. Because of the important place of revolutionary Haiti in world history and its historic contributions to slave abolition, human rights, and freedom, Haitian immigrants came to the United

States with a sense of dignity and racial pride of their heritage and history.

Haitian immigration to the United States chiefly came in three peak periods. The earliest presence and settlement of Haitian immigrants in various U.S. cities (e.g., New York, Philadelphia, Baltimore, Norfolk, Savannah, Charleston, and New Orleans) occurred during the turbulent era of the Haitian Revolution. The brutal period of U.S. occupation of Haiti (1915–34) also drove many Haitians away from their native land to establish a diasporic enclave in New York City and Boston, and to join family members in other northern and northeastern cities in the United States.

The third mass exodus of Haitian immigrants to the United States occurred during the ruthless and oppressive years of the Duvalier regimes of François Duvalier ("Papa Doc") and Jean-Claude Duvalier ("Baby Doc"), in 1960–71 and 1972–86, respectively. In the 1950s and 1960s, the United States received a substantial number of professional and highly skilled Haitians who either had been forced into exile or left the country voluntarily because of the Duvalier totalitarianism. Likewise, in the 1970s and 1980s, South Florida received a significant group from the middle- and lower-middle–class Haitian society. They settled in various communities in Miami, Fort Lauderdale, Pompano Beach, and West Palm Beach. Today, the Haitian ethnic communities constitute a dynamic and visible presence in four major U.S. cities: New York, Miami, Boston, and Chicago, contributing to the cultural mosaic of the United States.

The plight of Haitian immigrants is widely known in the United States. According to Haitian scholar Flore Zephir, an estimate of "between 30,000 and 60,000 people were killed by state terrorism" during Papa Doc's 14-year reign; similarly, political corruption, state violence, and extreme poverty in both urban Haiti and the rural areas intensified under Baby Doc's despotic government. As a result, undocumented immigrants, who the U.S. media called "the Haitian boat people," came to the United States in the second half of the 20th century, especially in the late 1970s and early 1980s, leaving their homeland for socioeconomic and political reasons. During the Carter and Reagan administrations, the Haitian boat people were considered economic refugees and therefore were placed in various U.S. detention camps or prisons in several states, where they experienced hardships, discrimination, isolation, and ultimately deportation.

Grass-roots movements, human rights and humanitarian groups, and sociopolitical activists (e.g., the Congregational Black Caucus, the U.S. Roman Catholic bishops, the Executive Council of the American Federation of Labor and Congress of Industrial Organizations, or AFLCIO; and the Council on Hemispheric Affairs) responded swiftly and criticized the U.S. mistreatment of and racism toward Haitians and the violation of their human rights. Haitian boat people, however, were never granted refugee status by the U.S. Immigration and Naturalization Service *(*INS; now the Citizenship and Immigration Services, or USCIS, and the U.S. Immigration and Customs Enforcement, or ICE).

Interestingly, Cuban immigrants who left their country for similar reasons were treated differently as political refugees. The Immigration and Naturalization Service granted political asylum to practically all of them; Cuban immigrants also received financial assistance from the state of Florida and were given free cultural coaching and educational training on how to adapt and assimilate in the host land.

In March 1983, the U.S. Centers for Disease Control and Prevention (CDC) accused Haitians along with homosexuals, intravenous drug abusers, and hemophiliacs as being high-risk groups for the acquired immune deficiency syndrome (AIDS) and for introducing and spreading this newly discovered disease. Haitians also were labeled as disease-ridden voodoo (Haitian *vodou*) practitioners and illiterate immigrants. Haitian community leaders and activists in New York, Boston, Miami, Chicago, Washington, and other U.S. communities (both black and white) were outraged and urged the federal government to "fight AIDS, not nationality." Like any other ethnic groups, Haitians are determined to stay in the United States and will not return to their home country. The Haitian American diaspora believes in the U.S. promise and ideals of liberty, equality, and justice for all.

The Haitian Way of Life in America

Haitian Americans are a resilient people, attesting to their ability to survive in mainstream U.S. society. As Zephir puts it, "They have the ability to live through the best of times and the worst of times."

The population of the Haitian American diaspora is estimated at 1 million, commonly viewed as Haiti's so-called tenth department, as the country itself is divided into nine governmental or organizational departments. Michel S. Laguerre argues that the immigrant life of Haitian Americans is marked by "continuity" rather than "disruption," and "rerootedness" rather than "uprootedness." Zephir describes Haitian American ethnic communities as "a heterogeneous group, reflecting the various strata of Haitian society." For example, poor Haitian Americans settle in areas of New York that are distinct from districts settled by the upper classes. Language is also important in establishing class distinction, color discrimination, and social segregation or alienation among Haitian American compatriots. According to J. Michael Dash, because of the social stigma attached to the Creole language, upper-class and light-skinned Haitian Americans insist on using the French language as a vehicle to achieve social mobility in the United States and isolate themselves from the predominantly lower-class Haitians.

The Haitian American diaspora actively engages itself in transnational ethnic practices and border-crossing cultural performances. For example, Little Haiti in Miami, an extension of the homeland, in the words of Laguerre, "represents the rerootedness of a large spectrum of the population of Haiti and constitutes one visible point of insertion of the diaspora in American society"—where different forms and manifestations of transnational practices and cultural traditions are more noticeable. Religion and the Creole language are central to the Haitian American ethnic identity and cultural practice in the United States. Haitian Creole serves distinctively as a cultural marker, as Haitian Americans are the largest Creole-speaking immigrant group. As it is customary in the homeland, Haitian American religious services in Protestant and Catholic churches are conducted almost exclusively in Creole and French. Haitian Vodou temples can be found in various diasporic locations in Miami, Boston, Louisiana, and New York. In her anthropological fieldwork, Zephir observes that adherents to the Vodou faith attend services regularly; Vodou priests (*ougans*) and priestesses (*mambos*) conduct their routines privately in their homes, and they are known to the community where word of mouth (*teledyo*l) is always a good source of information. Vodou ministers provide healing to the faithful, comfort in time of distress, and are cultural and spiritual advisors to various Haitian American communities.

Haitian Americans form a vibrant cultural symbol and have a dynamic presence in U.S. life; they intermingle with white Americans and other ethnic groups such as African Americans and other Caribbean immigrants. In highly concentrated Haitian populations, such as in New York, Miami, Boston, Philadelphia, and Chicago, Haitian Americans have established their own businesses, clubs, music shops, money transfer companies, restaurants, and community and cultural centers. They also have created Haitian media outlets (e.g., Tele Kreyol, Tele Diaspora, Tele Energie, Obri Blag, Piman Bouk, Radio Lakay, Radyo Pa Nou, Radio l'Union), and political and human rights organizations, such as the National Coalition for Haitian Rights, Haitian-Americans United (HAU), Haitian American Community Association of Dade (HACAD), Haitian American Foundation (HAFI), and Haitian Women of Miami (FANM). Haitian Americans have their own multilingual newspapers (the *Haitian Times*, *Boston Haitian Reporter*, *Creole Connection*, *Haiti Observateur, Haiti en Marche,* and *Haiti Progres*) and scholarly journals and organizations (the *Journal of Haitian Studies, KOSANBA,* Haitian Studies Association, *Le Club Haitien de St. Louis,* Association for Haitian American Development (AHAD), and Haitian-American Professionals and Entrepreneurs (SHAPE)), which publish in Creole, French, and English.

Integration and Assimilation and the Impact on American Life

The ethos of the Haitian American life is full of complexity and paradoxes. Zephir has grouped second-generation Haitian Americans into three broad categories: (1) "those who display a strong form of Haitianess; (2) those who display a weaker form of Haitianess; and (3) those who have absolutely nothing to do with Haiti, the undercovers." Whereas the first Haitian immigrants, who had immigrated to the states in their adolescence, have to some degree managed to isolate themselves from the greater U.S. society, second-generation Haitian Americans, who were born in the United States or had arrived before adolescence, are fully integrated and assimilated in the U.S. culture. Second-generation Haitian

Americans are more heterogeneous in their thinking, cultural practices, and lifestyle than those of the first generation; they possess a native command of the English language and U.S. culture, but they are not fluent in Creole nor are they well versed in the cultural traditions of their parents' homeland. They are more comfortable in the U.S. culture than in the traditional Haitian way of life. Those who have called themselves African Americans rather then Haitian Americans do not exhibit outright Haitianess and do not champion their heritage or history as their parents do.

A large segment of the second-generation Haitian American population, however, has committed itself to the Haitian community and cultural heritage as well as to the U.S. cultural value system and life. The Haitian American impact on U.S. society is substantial, and Haitian Americans have become "a significant component of the fabric of contemporary American society," according to Zephir. As any other ethnic groups in the United States, Haitian Americans have also achieved the American dream.

Among the well-known Haitian Americans are Wyclef Jean, hip-hop artist and composer; Victoria Duval, professional tennis player; Samuel Dalembert, National Basketball Association (NBA) center; Vladimir Ducasse, offensive tackle for the New York Jets; Pierre Thomas, running back for the New Orleans Saints; Jozy Altidore, soccer player for Sunderland; Edwidge Danticat, novelist; Jean-Michel Basquiat, artist and painter; Garcelle Bauvais, actress and model; Ludmya Bourdeau Love, politician and mayor of Saratoga Springs, Utah; Marjorie Judith, former journalist and 1991 Miss America; Marvin Bernard (Tony Yayo), chief executive officer (CEO) of G-Unit Philly and rapper; Marie St. Fleur, former Massachusetts State House representative; Sybil Elias, municipal court judge in East Orange, New Jersey; Rodrigue Mortel, well-known specialist in women's cancer; and Dumarsais Siméus, chairman and CEO of Siméus Foods International, Inc. (SFI). Furthermore, many Haitian Americans are currently serving in U.S. political life, including Massachusetts State senator Linda Dorcena Forry, member of the Florida House of Representatives Ronald Brise, New York City councilman Mathieu Eugene, and Illinois State senator Kwame Raoul. In various degrees and different ways, the Haitian American diaspora has made recognizable contributions to U.S. society.

Haitian Americans continue to contribute to the advancement of U.S. civilization and its democratic experiment—from Haitians fighting for U.S. freedom in the American War of Independence in Savannah, Georgia; to former Haitian slaves inspiring the American Civil War against slavery; to Jean Baptiste Point du Sable, the "Founder of Chicago." Nevertheless, the Haitian American population continues to experience ongoing challenges in 21st-century America. Haitian Americans in Miami, New York, Chicago, and Philadelphia struggle to find employment, to secure suitable housing, and to support their children through school.

The poverty line in the Haitian community, especially in south Florida and New York, surpasses any other ethnic group in the United States. The population does not have adequate educational preparation and training to meet the high demands of today's technological age, nor does it have the financial resources to afford adequate medical services and competent mental health that are culturally and linguistically sensitive. In addition, the U.S. anti-immigrant political climate affects Haitian refugees and their families more than any other ethnic group in south Florida; subsequently, Haitian refugees continue to be subject to an indefinite detention policy. These areas are real challenges to take into account in providing human services to and fulfilling the unmet needs of the Haitian American population in the 21st century.

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See Also: Housing Services; Low-Income Housing Tax Credits; Supported Housing.

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Harm Reduction Programs

Harm reduction programs utilize a public health approach to alcohol and substance use that relies on principles and practices designed to reduce the personal, familial, and societal harms of substance use without requiring abstinence. Unlike treatment programs that require abstinence from alcohol and other drugs (AOD), harm reduction practitioners and programs conceptualize abstinence at the end of a larger range of positive outcomes. These outcomes include reduced substance use; safer use of substances (e.g., avoiding sharing needles, using clean needles); the use of safer substance alternatives (e.g., methadone or buprenorphine instead of heroin); the provision of housing and other medical, social, or psychiatric services that are not contingent upon abstinence; and the use of education to help people manage symptoms and develop healthier lifestyles and habits.

The most widely recognized harm reduction programs include needle exchanges in which intravenous drug users exchange used (dirty) needles for clean needles. Another common harm reduction program includes opioid replacement therapy, whereby addicted persons substitute the opioid heroin for supervised use of the synthetic opioids methadone or buprenorphine (e.g., Suboxone). These substances are longer acting, do not require intravenous administration, and produce fewer euphoric effects than heroin, making them less dangerous. Another form of harm reduction treatment is the use of the opioid antagonist naltrexone. This substance blocks the euphoric effects of opioids and alcohol and can assist addicted individuals in managing the cravings associated with addiction. Harm reduction practices in community mental health settings can include providing low-threshold access to desired services and other practical supports without requiring abstinence as well the provision of unconditional support, motivational strategies, and education and practical guidance to reduce the harmful effects of AOD use.

Harm reduction practice requires human service practitioners to respect consumers' decisions to use substances and to be tolerant of substance use behaviors while encouraging open dialogue around substance use in order to develop collaborative partnerships with consumers designed to support them in seeking out healthier and safer alternatives. Harm reduction started in the Netherlands in the early 1980s as a response to the rising prevalence of hepatitis and human immunodeficiency virus (HIV) among intravenous drug users. Street workers would engage in assertive outreach efforts to identify drug users and provide them with access to clean needles, safe housing, and places supervised by medical personnel so that they could use drugs more safely. Other strategies included the provision of educational pamphlets that contain information regarding safe sexual and drug use practices and opportunities to enter into treatment programs. These interventions led to a reduction in the spread of infectious diseases, including hepatitis and HIV. Harm reduction programs soon spread to other parts of northern and western Europe and Australia.

Harm reduction remains a controversial approach in the United States, although less so recently, because it contradicts a U.S. drug policy that has focused mainly on controlling supply through interdiction and punishment of drug users at the expense of reducing demand or providing treatment. In the United States, AOD treatment has also remained focused mainly on abstinence. Critiques of harm reduction have included claims that the approach condones drug use and thereby increases the use of drugs and riskier forms of drug use such as intravenous. Another critique is that harm reduction programs shield drug users from the natural consequences of their actions, thereby enabling drug users to continue their problematic behaviors. These claims have largely gone unsupported. Needle exchange and methadone maintenance programs have been shown to significantly reduce the rates of overdoses and infectious disease transmission without increasing the incidence of drug use. Likewise, the provision of on-demand independent housing and other community-based physical and mental health services have led to higher rates of engagement and retention in services, an increase in stable housing, and higher consumer satisfaction without a corresponding increase in drug and alcohol use. However, practitioners often struggle to practice harm reduction due to the high tolerance of drug-using behaviors the approach requires. Adequate ongoing supervision and training are necessary for the effective implementation of the approach.

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See Also: Alcohol and Substance Abuse Services; Medical Necessity; Mental Health Services, Adult.

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Hate Groups

Hate groups are organized bodies that target and denigrate specific individuals and groups, often committing crimes against others based on stereotypes, negative biases, prejudices, bigotry, and hatred. The U.S. Federal Bureau of Investigation (FBI) posits that the major goal of these groups is to promote hatred, hostility, and animosity against people belonging to a specific race, ethnicity, or group that may be different from the members of the hate group's organization. The hate crimes in which these groups engage are defined by the U.S. Congress as criminal offenses against individuals or property motivated by biases against a race, religion, disability, ethnic origin, sexual orientation, gender, or gender identity. These crimes against individuals, groups, or property include vandalism, arson, marches, and murder.

Ideologies

Within the United States, hate organizations have based their philosophical or moral views on the following topics:

1. Nonexistence of the Holocaust and revisionist history that claims or minimizes the eradication of more than 6 million Jews and other ethnicities.
2. White superiority with the position that people of color are inferior.
3. Fundamentalist Christianity.
4. Not giving equal rights to lesbians, gays, bisexual, transgendered, questioning, intersex, or asexual individuals (LGBTQIAA).
5. Immigration policies in the United States, with groups asserting vigilante roles in monitoring U.S. borders, restricting access for immigrants to enter the country through illegal means.
6. Ending the spread of Islam in the United States.
7. Not paying taxes nor adhering to U.S. laws or policies.
8. Opposition to racial integration.

Hate Map

The Internet has helped cultivate hate group movements in the United States by using online access as a vehicle for communicating ideologies, recruiting potential members, and invoking hate against targeted groups. The Southern Poverty Law Center (SPLC), a prominent U.S.-based organization, has consistently monitored activities of hate groups and movements, and has published a hate map and intelligence reports on their activities. SPLC began monitoring hate group activities in the 1980s and

Westboro Baptist Church pickets a Jewish community center. Hate groups are organized bodies that target and denigrate specific individuals and groups.

has asserted that, since 2000, hate groups have increased by more than 65 percent, with an alarming rate of 1,018 groups in 2012. The SPLC hate map shows the top four states, with reported activities of more than 50 hate groups based on evidence of numerous activities, as California (82), Texas (62), Florida (59), and Georgia (53). The SPLC asserts that these movements are spurred due to many factors, including the increase of people of color as immigrants, the decline of whites in U.S. census figures, and the symbolic election of the first African American and person of color as president of the United States. Racially motivated incidents have accounted for more than 50 percent of hate crimes reported in the United States.

Major Hate Groups

Ku Klux Klan. The Knights of the Ku Klux Klan (KKK) is a historical organization founded in 1956 in Louisiana. It advocates white supremacy and dominance, racial hatred, prejudice, and segregation. Historically targeting African Americans, the KKK has expanded its hate propaganda against immigrants, Jewish people, some Christian groups, and the LGBTQIAA community. The KKK boasts of owning the largest number of organized hate groups in the United States. It has also collaborated with other hate groups—skinheads, Neo-Nazis, and White Nationalist movements—in purporting white supremacist propaganda and actions in many U.S. states. These actions include symbolic efforts such as committing hate crimes, encouraging members to distribute flyers in communities and on college campuses, and producing online video games with images of swastikas advocating for white dominance and hatred.

Patriot Movement. The Patriot Movement targets the federal government with the belief that government is the enemy. The group arose in the latter part of the 1990s after a series of antigovernment protests, including the 1993 Waco conflict in Texas and the 1996 Oklahoma City bombings. Mark Potok has asserted that the Patriot Movement's numbers have shifted, with about 858 in 1996, 512 in 2009, and an increase to 1,274 organizations in 2012. These groups are described as militias who are opposed to paying taxes and are concerned that the federal government will take away people's rights regarding gun ownership.

American Family Association. The American Family Association (AFA) was founded by Donald E. Wildmon in 1977. Originally known as the National Federation for Decency, the name changed to American Family Association in 1988. Its advocacy borders around strengthening U.S. moral values with activism directed toward the preservation of marriage and family. The SPLC has labeled the AFA as a hate group based on its biblical antihomosexuality position. The AFA is outspoken about antigay issues and is strongly opposed to equal rights for LGBTQIAA individuals, including denying them marriage equality or the opportunity to serve in the U.S. military.

Hate Group Monitoring Organizations

Southern Poverty Law Center. The Southern Poverty Law Center is the nation's leading organization that monitors and publishes information on hate groups' activities and movements. It was founded by civil rights lawyers Morris Dees and Joseph Levin Jr. in 1971, and is based in Montgomery, Alabama, with offices around the United States. The SPLC is committed to combating hate, prejudice, and bigotry through advocacy work, publications, and filing lawsuits. Its publications include *Teaching Tolerance*, a reputable magazine full of teaching materials, which is produced and distributed at no cost to educators around the United States. The SPLC is noted as one of the few organizations that have been able to successfully link the Ku Klux Klan to hate crime activities in a U.S. court. In 1995, the SPLC won the largest case ever fought against a hate group.

Anti-Defamation League. The Anti-Defamation League (ADL) is a premier organization noted for fighting against anti-Semitism. In 1913, attorney Sigmund Livingston gathered Jewish leaders together to create a vehicle to combat bigotry and hate within the fabric of society. This collaboration of people created the organization and currently has offices in 27 regional U.S. branches, including New York City, and in Israel. The ADL is a dominant force in lobbying and advocating Congress and the United Nations to take action against anti-Semitism. The ADL is a leading source on comprehensive resources and curriculum on the Holocaust.

The U.S. government has taken a vocal public stance against hate crimes and organizations. Under its jurisdiction, it has empowered the FBI to investigate and prosecute crimes that are considered hate crimes. In 2009, the Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act was created to provide funding to state, local, and tribal jurisdictions to more effectively investigate and prosecute hate crimes.

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See Also: Ethnocentrism; Power, Race/Ethnicity and; Prejudice, Theories of; Racial and Ethnic Categories, U.S. Census; Racial Microaggression.

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Hawaiʻian Native Americans

Native Hawaiʻian Americans, the original peoples of Hawaiʻi, are a community included under the broader designation of Native Hawaiʻian Americans and Pacific Islanders (NHPI), as advocated by the Native Hawaiʻian and Pacific Islander Alliance and the Asian and Pacific Islander American Health Forum as the preferred and appropriate reference to the communities of persons having origins in any of the Hawaiʻian islands, Guam (including people of Chamoru living in Guam), Samoa, Tonga, or other Pacific Islands, including the Federated States of Micronesia, Marshall Islands, and the Commonwealth of the Northern Mariana/Mariana Islands, Palau, Papua New Guinea, the Solomon

Islands, and Fiji. The NHPI people represent more than 50 ethnic backgrounds and speak more than 100 different languages.

Pacific peoples are one of the fastest-growing groups in the United States. Whereas NHPI composed approximately 4 percent of the U.S. population in 2000, the 2010 U.S. Census reported that the NHPI population in the United States grew by 40 percent since then. More than 50 percent of Native Hawai‘ian Americans and Pacific Islanders live in Hawai‘i and California. The states with the next-largest NHPI populations are Washington, Texas, Florida, Utah, New York, and Nevada.

Health Disparities Among NHPI People

Extensive public health research has recognized that the NHPI, along with American Indians and Alaska Natives, have suffered from considerable inequities in health status compared to other Americans. Native Hawai‘ians, specifically, have the highest rate of deaths due to cancer (229 per 100,000 people) compared to other groups in Hawai‘i, and the third-highest rate in the United States. Native Hawai‘ians are more than five times as likely to experience diabetes between the ages of 19 and 35 years compared to non-Hawai‘ians (11 percent versus 2 percent) and are more likely and at greater risk to experience morbid conditions more often than other ethnicities living in Hawai‘i. Native Hawai‘ian elders experience shorter life expectancies, poorer overall health, disabilities, lower socioeconomic status, and engage in less interaction with health services compared to elders in other ethnic groups. Hawai‘ian Native Americans generally have low participation in cancer screenings. Advanced disease disparities could be related to these factors.

NHPI, broadly speaking, have a higher risk for developing and dying from cancer, heart disease, diabetes, and other diseases, and have the second-highest rate of diagnoses of human immunodeficiency virus (HIV) infection and the second-shortest acquired immune deficiency syndrome (AIDS) survival rate of all Americans. NHPI have been identified as having higher rates of suicide and mental illness, cardiovascular disease and related conditions, and communicable diseases such as tuberculosis, HIV, and hepatitis B. Given the increased risk of developing type 2 diabetes mellitus and obesity, public health services need to understand cultural beliefs and differences when providing care. It is especially vital because the age-adjusted prevalence of type 2 diabetes in this population is 18 years or older (23.7 percent), a rate three times higher, for example, than the non-Hispanic white U.S. population. NHPI also have a higher prevalence of complications from diabetes, including the highest age-adjusted rate of incidence of end-stage kidney failure.

Cultural Values in Health Strategies

Health care providers who are unaware of the rich diversity of NHPI languages and cultures contribute to the lower use of health care resources and preventive care among these people. Few physicians and other health care practitioners, particularly those serving clients in the continental United States, speak NHPI languages.

The Center for Native and Pacific Health Disparities Research of the Department of Native Hawai‘ian Health, the Office of Minority Health of the U.S. Department of Health and Human Services, and others are collaborating to develop culturally appropriate strategies to help lower the risk of diabetes and other diseases and increase health literacy and awareness among NHPI. Guided by the notion of *Ulu Hina*, *Kū Papa* (thriving and enduring), these organizations work with community leaders, policy makers, and health care providers to make meaningful decisions and take informed actions to address health inequities.

Community members recommend Native Hawai‘ian cultural values as a basis for a holistic care model that foregrounds respect, concern, adequate open and direct communication, and understanding of Native Hawai‘ian spiritual beliefs and practices. Important factors are mutual respect between patients and providers, and providers' ability to find appropriate intersections between Western medicine and Native Hawai‘ian cultural practices and cultural history, particularly the interrelatedness of individual, *ohana* (family), community, and *kokua* (helping one another). Cultural understanding and community and family involvement at all levels of health care may yield more positive health care experiences and improve health outcomes of NHPI.

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See Also: Administration for Native Americans; Alaskan Natives; American Indian Movement; Asian Americans; Asian and Pacific Islander Health Forum; Asian Immigrants; Filipino Americans; National Congress of American Indians; Native Americans; Nutritional Services and Assessment; Pacific Islanders.

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Head Start and Prekindergarten Programs

In his 1964 State of the Union address, President Lyndon B. Johnson declared a War on Poverty. President Johnson's vision for the Great Society produced an array of legislative reforms aimed at combating poverty and social injustice. One of the first pieces of legislation to emerge out of the Great Society was the Economic Opportunity Act of 1964. This act created a variety of social programs including Volunteers in Service to America (VISTA), the Job Corps, and Project Head Start.

Seeing education as a pathway to end poverty, the Johnson administration commissioned a team of academics, pediatricians, and civil rights activists with the task of designing a social program that would address the inequities in early childhood education. Research revealed that children entering kindergarten from low-income families lagged significantly behind their more affluent peers in early language and literacy skills as well as in their overall school preparedness. This deficit had the potential for long-lasting implications on students' future academic performance and eventual economic and work opportunities. Advocates maintained a poor start in early education would contribute to the continuation of the cycle of poverty. As a result of their efforts, the team of experts led by Sargent Shriver proposed Project Head Start, a federally funded program aimed at bridging the kindergarten readiness gap between economically advantaged and disadvantaged 3- and 4-year-old children. The underlying philosophy was to give children living in poverty a head start on their futures.

By design, the Head Start program created a preschool learning environment focused on developing the whole child. In addition to providing an academic curriculum, Head Start was designed to help foster the social, emotional, and physical development of the child. Its goal was to provide children with access to medical, dental, and mental health, nutrition, and social services, in addition to traditional lesson plans. Its structure was also designed to empower the parents of the preschoolers through education, training, and parental involvement in the program. Head Start was intended to meet both short-term and long-term objectives that would benefit children, their parents, and society as a whole. Project Head Start commenced in summer 1965, with an eight-week pilot program that premiered in more than 2,000 child development centers across the country. This first summer Head Start project served approximately a half million children from low-income families who were preparing to enter kindergarten in the fall.

Head Start Today

Today, Head Start programs can be found in all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. More than 1 million preschool-age children from low-income families attend Head Start programs each year. Since its beginning, Head Start has provided more than 30 million children with the cognitive tools necessary to start school. Head Start also prepares families for success in the real world by encouraging positive parent-child relationships, community involvement, leadership, and advocacy.

Current data show that the majority of students, more than 60 percent, began a Head Start program at the age of 3 years, and the remainder entered the Head Start program at the age of 4 years. The children come from a variety of racial and ethnic backgrounds: more than one-third of the children enrolled in a Head Start program are of Hispanic or Latino origin, more than one-third of the children identify as African American, and approximately one-fifth to one-quarter are white. In addition, more than 25 percent of the children currently enrolled in a Head Start program are dual language learners. Head Start programs focus on early language, literacy, math, general knowledge, and strategies for learning. They provide services for physical, emotional, and social development, and they emphasize the overall health of the child while being attentive to differences in race, ethnicity, culture, and language.

Head Start has evolved over time, expanding from its original eight-week pilot program to a variety of different formats including both half-day and full-day year-round preschool programs. The programs are offered in a variety of locations as well, including school buildings, home-based child care centers, and even in a child's own home through the home visitor option. Head Start's evolution also includes the birth of the Early Head Start program in 1995. This program is designed to address the cognitive, social, and emotional needs of children beginning at birth. As with Head Start, Early Head Start acknowledges the importance of parental involvement and provides services to support families, including offering prenatal education to expectant mothers.

Research Findings

Studies indicate that children from all economic backgrounds benefit from quality preschool and prekindergarten (pre-K) programs. The research suggests both short-term and long-term benefits from improved literacy skills to success in the labor force. Students entering kindergarten from quality preschool and pre-K programs do better academically in language, literacy, math, and other skills, and they are less likely to repeat a grade than children who do not attend a preschool program. Children who attend preschool or pre-K programs also demonstrate more positive social interaction skills than children who do not.

In 1998, the U.S. Congress mandated that the Department of Health and Human Services collect data on the long-term impact of the Head Start program. These longitudinal studies indicate that Head Start has a positive impact on children's success early on, but there is little evidence to suggest that, in comparison to a control group, attending a Head Start program will produce significantly different outcomes by the end of the third grade. Researchers note, however, that the control group included children who attended other preschool programs. A more recent study suggests that even though the impact of Head Start may dissipate over time for children, the influence on parents proves to be more long-lasting as they tend to continue to play active roles in their children's education over time.

The Future

Pre-K and Head Start programs will likely maintain a significant presence in the U.S. education policy. Like President Johnson, President Barack Obama believes early childhood education can have a positive impact not only on the individual child but also on the larger society. In his 2013 State of the Union address, President Obama called for expanding access to high-quality preschool education for all children, whatever their economic backgrounds. President Obama's plan recommends the development of state and federal partnerships focused on producing high-quality preschools. It also includes a plan for increasing investments in the Head Start and Early Head Start programs and advocates for providing greater access to full-day kindergarten.

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See Also: Day Care for Children; Equal Opportunity and Civil Rights; Parenting Skills Training; Poverty; War on Poverty Programs.

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Health and Sickness, Differing Attitudes Toward

According to Professor Philomena Essed of Antioch University's Leadership and Change program: "Homogeneous societies are quickly becoming relics of the past. Continuing migrations, intercultural communications, international agreements, transnational corporations, [and] cross-cultural coalitions all testify to the fact that we have entered the age of diversity." This fact confronts the United States and other modern societies with serious challenges pertaining to health care and other human services organizations, as health and illness are perceived differently by the various social and ethnic groups.

Defining the Core Concepts

The World Health Organization (WHO) defined health in 1946 as a state of complete physical, mental, and social well-being, and not only as the absence of disease. This definition of health was later developed in the Ottawa Charter (1986) to identify personal and social resources as factors that enable people to set and attain goals and satisfy various needs. Although objective criteria are used to measure and determine health, the definition of health is not confined to the medical context. Health is also perceived by individuals within sociocultural contexts defined by family, social networks, and health providers.

Studies report that people define health in multiple ways. As examples, health is viewed in terms of (1) absence of illness, (2) reserve (e.g., recovering from a surgery rather quickly or having good genes), (3) doing (e.g., regular exercise, a healthy diet), (4) physical fitness and vitality, (5) psychological well-being (e.g., being in harmony and experiencing positive emotions), and (6) independent functioning (i.e., being able to fulfill one's daily duties without being too dependent on support from other people). In most cultures, health is a default state that is often taken for granted until illness or pain is experienced.

To understand the concepts related to health, it is important to differentiate the various concepts related to states of nonhealth. Disease is related to diagnosis and treatment and refers to pathological reactions and states in the body. Illness refers to the experience of having a disease and is related to having a particular disease and how to cope with that. Thus, illness refers to the sociocultural context within which disease is experienced. To a great extent, this experience is dependent on gender, ethnicity, and other sociocultural variables. David Mechanic, a pioneer in the study of illness behavior, describes illness behavior as "the varying ways individuals respond to bodily indications, how they monitor internal states, define and interpret symptoms, make attributions, take remedial actions and utilize various sources of formal and informal care." For instance, people ranking low in socioeconomic status have been shown to delay seeking professional health care even when severe symptoms are present.

Disease and illness do not always presuppose each other. In some cases, disease precedes illness; that is, the disease is diagnosed in a medical examination on the basis of bodily states, changes, and symptoms that the individual has not yet conceived and is not aware of. Thus, disease does not always mean that the individual has felt unwell. In other cases, the experience of disease precedes the diagnosis of it, and this feeling of being unwell may not vanish even after the physician has told the patient that no disease exists.

While disease and illness are connected to the body and to the individual's perception, the term *sickness* is much broader. This is a societal and cultural term in that it refers to the surrounding environment of the ill and the social status and the meanings associated with a certain disease.

Diversity in Health Perceptions

All cultures encompass health beliefs in order to explain what causes illness, how it can be treated, cured, or managed, and what kinds of people should be a part of this process. Modern Western countries such as the United States view disease as a result of natural phenomena that can be explained scientifically. With this approach, illness is treated by medicines that combat microorganisms and the use of sophisticated technology to diagnose and treat diseases.

Various explanations can be given when discussing specific cases of illness. Endogenous or internal explanations place the causes of ill health within the individual (e.g., genetic factors, lifestyle), whereas exogenous or external explanations place the causes of illness in the environment (e.g., germs, pollution, unhealthy work conditions). Notions of personal responsibility and nonresponsibility or whether ill health can be avoided or is inevitable are also of concern. Many cultures explain some states of illness as being caused by mediated or unmediated causes. Mediated causes are of three kinds: causes related to fate (i.e., God's will), causes imposed unintentionally by looks or words (e.g., evil eye), and causes imposed intentionally through magic or witchcraft. Unmediated causes are related to seasonal changes, for instance, cold or heat.

In discussing differing attitudes toward health and sickness, an interesting question that arises is along what dimensions people make decisions about how to act pertaining to health-related issues. A widely used framework is the health belief model, which identifies four such dimensions—perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. A U.S. study revealed that those using health care services the most were individuals who (1) reported high likeliness for developing or being exposed to a certain disease (susceptibility), (2) viewed these diseases as serious (severity), and (3) saw that seeking medical advice and starting a particular treatment would make a difference (benefits).

Each ethnic group brings its own cultural beliefs to the health care system, and many health care beliefs and health practices differ from those of mainstream U.S. health care culture. Cultural beliefs affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. In addition, culture-specific values influence patient roles and expectations, how much information about illness and treatment is desired, how death and dying will be managed, bereavement patterns, gender and family roles, and processes for decision making. Cultures can be formed by communities who share religious beliefs, political beliefs, or similar lifestyles; ethnicity does not have to have much to do with health beliefs.

Many Americans do not have access to regular health care, and this very much impacts health and sickness beliefs. Lack of regular access to care may lead to fatalistic thinking—at the very least, it means that health care–provided screenings are not taking place regularly, and that means that chronic problems are likely to go untreated. Lack of coverage can lead to more reliance on self-treatment or over-the-counter medicines that may not address root causes of ill health. This in turn leads to many people living with chronic, untreated illnesses that impact their quality of life.

Implications of Differing Attitudes Toward Health and Sickness

Large-scale global migrations contribute to heterogeneous and diverse societies, implying that health care practitioners must learn more about the distinctiveness of other cultural and ethnic groups. Heterogeneous societies require diversity-integrated organizations. A prerequisite for achieving this is to have human services professionals who come from diverse backgrounds. An effective human services organization places strong demands on educating, recruiting, and retaining competent and diversity-conscious workers. Human services workers can promote self-efficacy by providing knowledge and access to health-promoting activities.

Strategies for working with clients in multiethnic and culturally diverse societies are to a great extent based on knowledge and personal experience. Effective human services workers make a point to learn about the cultural traditions of the client groups with whom they are working; are attentive to the body language, lack of response, or feelings of tension in their clients; ask clients (and family members) open-ended questions to learn about their assumptions and expectations concerning their health status; and remain nonjudgmental, in particular the clients communicate views signaling values that differ from the human services worker's own views.

Research Outlets

Research in this area is published in scientific journals such as *Sociology of Health and Illness*, *Annual Review of Public Health, Journal of Health and Social Behavior,* and *Social Science and Medicine*.

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See Also: Agency for Healthcare Research and Quality; Behavioral Health Disparities for Racial and Ethnic Minority Populations; Public Health; Racial and Ethnic Approaches to Community Health; Social Determinants of Health.

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Health as a Human Right

Health and human rights are intimately related, as the World Health Organization (WHO) notes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. Successive scientific investigations and research have shown that people's health is situated in the complex interactions with their structural and contextual environments. Public health specialists and humanitarian figures, such as Michael Marmot and Paul Farmer (with his work in Haiti and other places), have mapped the relationship between achievement of health and fulfillment of human rights. Linking ill health and infections with inequalities and human suffering, findings have unequivocally laid out that ill health is more often than not a symptom of poverty, violence, and inequality; the fight for healthy outcomes in society has to address these entrenched societal and structural conditions that highlight health as a human right.

What Are Human Rights?

The United Nations Universal Declaration of Human Rights, enacted in 1948, defines human rights as universal, indivisible, interrelated, and inalienable rights inherent to all human beings across the globe without discrimination. The declaration holds states responsible to provide for attainment of human rights and fundamental freedoms of all their citizens without regard to political and socioeconomic contexts. Article 25 of the declaration enshrines the social and economic rights of everyone, leading to the health and well-being of people and their families. It further underscores the health, well-being, and social protection of mothers and children. Achievement of human rights in a community thus involves the achievement of health outcomes.

Meanings of Health

Multiple researchers have documented the polysemous nature of health and uncovered the multiple meanings it carries for global communities. Health means having access to work, money, life balance, sound mental health, and social networks, among other benefits; what is manifest in all these local meanings is the connectedness of the concept of health to the achievement of all other social, economic, and political rights. The right to life, liberty, freedom, security, dignity, nondiscrimination, leisure, work, education, and so on makes life meaningful for human beings physically, mentally, and emotionally. The universally accepted WHO definition of health similarly defines health as a state of complete physical, mental, and social well-being. Therefore, health is not only the absence of illness and disease, but symptomatic of the realization of human rights of communities.

Who Ensures Health and Who Ensures Human Rights?

Per the Universal Declaration of Human Rights, the United Nations vests the responsibility of ensuring human rights to citizens in the duty bearers, namely, nation states and their representatives who constitute the governance structure. Extending the duty bearers concept, the responsibility also is vested with the civil society structure and its representatives. The question of health is more complex. There is constant dialogue between the large body of health scholars and practitioners, who hold individual human behavior responsible for health, versus those that hold social and government structures responsible for ensuring healthy outcomes for their citizens. Nevertheless, increasing understanding from a rights-based framework purports that access to health care and health outcomes goes beyond individual behaviors and is not only a social and economic right but also critically important as a civil right to be safeguarded by the governments. The governments who are mandated to take care of the health of their populations too often fail in their duties and neglect the health of their most needy, marginalized population.

Marmot states that the failure to meet the fundamental needs of autonomy, empowerment, and freedom of the citizens leads to ill health. Increasingly, these populations, who are minorities, who face abuse and disenfranchisement, and who are denied a voice, are the ones with the worst health outcomes. These very communities—women, the poor, men who have sex with men, people engaged in sex trade, migrants, refugees, prisoners, and drug users—are the ones most affected by diseases and ill health.

Farmer contends that social and economic inequalities based on race, ethnicity, gender, class, religion, and color are the driving forces behind most human rights violations manifesting in unhealthy outcomes, mortality, and morbidity. Thus, addressing human rights violations—the inherent structural violence in the lives of the marginalized and disadvantaged populations—is critical in ensuring their good health. The most serious epidemics and challenges cannot be reasonably addressed unless these fundamental rights in the communities are protected and health interventions factor these needs into their design.

Health and Human Rights Linkages

WHO noted that promoting and protecting health and respecting, protecting, and fulfilling human rights are inextricably linked. They present three excellent illustrations to bear this out. The first outlines that violations or lack of attention to human rights can have serious health consequences. It includes harmful traditional practices such as female genital mutilation, child marriages, slavery and bonded labor, cross-border and in-country human trafficking, and violence against women and children as circumstances that result in serious health problems.

The second illustration outlines that various health policies and program interventions can promote or violate human rights in their design or implementation and further exacerbate the existing health problems. Examples include ensuring or ignoring the rights to participate, express views, and vote; nondisclosure/privacy; inclusion; and nondiscrimination. This is a very important illustration, as research has noted that much of the health problems are either created or facilitated by faulty program policies and design that do not take a human rights–based approach to programming. The third illustration is that the vulnerability to ill health of global populations can be reduced by taking steps to recognize, respect, protect, and fulfill human rights by ensuring the rights to education, food and nutrition, water, sanitation, protection/security, and information.

Conclusion

As Farmer, Gerald M. Oppenheimer, Marmot and others have outlined, health is a fundamental human right, and achieving the human right of health means individuals have to understand how poverty and structural violence seep into and influence every aspect of health and human rights. The question is how to shift the agenda toward the disenfranchised and the poor. The narrative is well established, as Rudolph Virchow articulated when he said that physicians are the natural attorneys of the poor. Thus, a health angle can promote a broader human rights agenda, and a rights-based framework can promote health outcomes. The work of both public health professionals and human rights professionals contributes to each other's struggle for achieving their common goal: the ultimate realization of health and human rights.

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See Also: Health Disparities, Role of; Poverty; Public Health; Social Determinants of Health.

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Health Care, Disparities in

Defining and identifying disparities in health and health care are critical to improving the health status of an overall population. The causes of such disparities, even though they are distinct, are also intertwined and are not fully understood by the research community. Such a lack of understanding has significant implications for improving the health status and health care experience of select as well as overall populations.

Defining Health Disparities

Health disparities are identified when a select population bears a disproportionate burden of disease given the size of the population. Health disparities reflect the difference in health status between populations. For example, African Americans represent about 12 percent of the population of the United States, but in terms of human immunodeficiency virus (HIV) infections among persons 13 years of age and older in the United States, African Americans represent 44 percent of all new cases, according to the Centers for Disease Control and Prevention (CDC).

Generally, health disparities are examined in terms of racial and ethnic populations in the United States. Examining health disparities as they relate to gender or lesbian, gay, bisexual, transgender, or questioning (LGBTQ) status is also possible. In order to be a disparity, the select population must experience a proportion of the disease that is significantly higher than for the population in general with regard to disease prevalence, incidence, mortality, and morbidity rates.

Disparities in Health Care

Disparities in health care are differences in the quality of health care that populations experience after controlling for factors associated with access to health care services, clinical needs, patient preferences, and appropriateness of the intervention. In other words, select populations, particularly racial and ethnic minorities, do not receive the same level and/or quality of health care as their counterparts, even when controlling for access to health care and other factors that influence the use of health care services. For example, a study by R. C. Maly, B. Leake, and R. A. Silliman found that older and Latina patients with breast carcinoma were less likely to receive interactive informational support from their physicians compared to their counterparts. These differences persisted after controlling for sociodemographic, psychosocial, and physician factors. Numerous other examples from other disease and illness areas are available in the literature.

These disparities in health care then create and perpetuate health disparities. In other words, since select populations do not receive the same level and/or quality of health care, then these populations are more likely to have a poorer health status than their counterparts. As such, the health status of the overall population suffers.

Causes of Disparities in Health Care

In order to improve the health status of the overall population, identifying and understanding the causes of health care and health disparities is critical. An overarching cause of disparities in health care is the historical context and pervasive discrimination that exist in many aspects of U.S. society. The following variables have also been identified as causes of disparities in health care:

- *Patient-level variables*: Patients bring who they are to the health care system. Patient variables include individual and collective attributes, such as mistrust of the health care system and/or providers, lack of understanding of how to utilize the health care system, and poor interactions with the health care system and/or providers. While such attributes have an impact on the quality of services received, the amount of impact on disparities is speculated to be minimal.
- *Health care–level variables*: Health care systems are set up and organized in light of various laws, regulations, and standards from a variety of state, local, and federal sources. These laws, regulations, and standards dictate how services should be offered, financed, and made available. As the Affordable Care Act in the United States continues to be defined and implemented, the health care system will continue to evolve with an unknown impact on disparities in health care.
- *Care process–level variables*: Due to the fast-paced nature of today's health care system, providers are expected to make decisions in a limited amount of time based on the information at hand. Not only patients bring who they are to the health care experience, providers do the same. As such, providers bring their biases and stereotypes to their interactions with patients. These variables can unknowingly impact the interactions with patients and the treatment recommendations that are provided.

Causes of Health Disparities

Disparities in health care and their associated causes can contribute to health disparities, but social determinants of health have also been identified as factors that contribute to the existence of differences in health status. Social determinants of health are those factors in the social and physical environment that influence health status. According to the Office of Health Promotion and Disease Prevention, these determinants and examples of each include:

- *Neighborhood/built environment*: Access to health foods and quality housing, and exposure to crime and violence.
- *Education*: High school graduation rates, enrollment in higher education, and school environments conducive to learning.
- *Economic stability*: Poverty, employment status, access to employment, and housing stability.
- *Health and health care*: Access to health care, including primary and preventive care, and health technology.
- *Social and community context*: Family structure, perceptions of discrimination, and incarceration.

The persistence of health disparities and disparities in health care will continue to impact the health status of the overall population. Identifying and understanding the causes of these disparities is increasingly important. Continued work is needed to identify, test, and institutionalize strategies to address these disparities.

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See Also: Agency for Healthcare Research and Quality; Diversity and Quality in Health Care; National Center on Minority Health and Health Disparities.

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Health Care Delivery, Models of

The roles of social workers and other providers of health services employed in the health care profession have undergone profound evolutionary changes necessitated by the changing requirements and settings of the entire spectrum of practice settings in health care. Contemporary practice settings and the functions of providers are rapidly changing as care becomes more community based, rather than institutional, as in hospital settings. Because of the fluidity of policy discussions on the American health care system, opportunities for health care services workers to emerge as leaders have developed in health care administration, management, and direct service delivery to patients. Social work is in a unique position, because of the diversity of the functions that social workers provide in the treatment and discharge planning of patients, to creatively craft social work in health care organizations alongside other health care practitioners. The overhaul of the U.S. health care system has broadened the scope of every discipline in the health care field.

Documentation of the first hospital goes back to Egyptian temples, where care was provided in accordance with the person's religion-based healing beliefs. In ancient India (11th century B.C.E.), the movement started to change the health care system from a monastic model to a secular model. Almshouses and hospitals emerged and played prominent roles in social welfare and medical care. For centuries, the care of physically and mentally ill individuals has been the domain of the helping professions. Nurses tended to wounds and acute (urgent and immediate) illnesses. The early role of social workers was to ensure that people received the help that they needed. Sometimes, it was in the role of an advocate—to connect the person to a physician, or broker a connection with a service provider. The assessment skills of the social worker directed care and services in accordance with the person's expressed need. Sometimes, that would be food or shelter. Other times, social workers have been skilled care coordinators, similar to today's case managers.

In the early part of the 20th century, hospitals emerged as the one-stop shop for physical and mental health needs. Institutions were burgeoning and teemed with physicians, nurses, and social workers, who wore a variety of utilitarian hats. Much of the care that the medical team provided became a function of what the patient and insurance company could pay. When health care maintenance organizations (HMOs) emerged under President Richard Nixon's administration (1969–74), utilization reviews were key to budgeting, and still play an important role today.

In a utilization review system, the diagnoses of persons served are grouped according to their health condition (diagnostically related groups, or DRGs), and insurance companies only pay a predetermined amount based on the person's diagnosis. So, for example, people who are admitted for appendicitis can expect their bill to be paid if they fall within the appropriate margins of time in the hospital. If the diagnosis of appendicitis created an average of three days in the hospital, then the maximum reimbursement that the insurance company will pay to have a person's appendix removed is for three days of care.

This model created a significant incentive system for hospitals to provide care faster, better, and cheaper than their competitors. Individuals whose care fell either beneath or above that reimbursable amount were called "outliers." The hospital and patient absorb the cost of patient days that fall outside the upper payment margin, thus creating a management and care delivery system driven by profit. Hospitals make a profit from people whose care can be managed below the lower level of reimbursement. Utilization review managers track patient days for each of the diagnoses, and report the information to the administration.

Contemporary Models

Hospital care delivery systems have changed throughout the years, and there is little alignment between countries—each predominantly uses the following payment/patient care models: The Beveridge model is named for the man who designed Britain's system. In this model, many (but not all) of the facilities are owned by the government. Some doctors collect their fees from the government and can either be government employees or private providers. In Britain, the patient never receives a doctor bill. Per capita costs tend to be lower because the government is the sole payer and dictates what providers do and what they charge. Countries using the Beveridge model include Cuba, England, Spain, most of Scandinavia, New Zealand, and to a lesser extent Hong Kong.

The Bismarck model is named for the German chancellor who invented it in the 19th century. This system closely resembles the American model. It uses an insurance system, where employees manage "sickness funds." This is an insurance system jointly financed by employees and employers, and employees pay through payroll deduction. Unlike the United States, though, Bismarck health insurance plans have to cover everybody, and they do not make a profit. Doctors and hospitals are usually private entities, not managed by the government. Countries that use this model are Germany, Japan, France, Belgium, the Netherlands, Switzerland, and to a small degree, Latin America.

Elements of the Beveridge and Bismarck models are contained in the national health insurance model. Private providers are used, and payment is provided by a group of funds to which everyone contributes. This "single payer" system has enormous leverage to negotiate the most favorable rates. This system operates in Canada, Taiwan, and South Korea. The Canadian system, for example, has negotiated such low rates for pharmaceuticals that some Americans cross the border to have their prescriptions refilled. Because the national health care system rarely has to deal with competition, it can dictate what it will and will not cover. It can also delay patients who are waiting to be treated as a means of cost containment.

In the out-of-pocket model, hundreds of millions of people (approximately 15 percent of the world's population) in less industrialized countries and rural regions have never seen a doctor because they cannot afford to privately pay for care. Oftentimes, service bartering is used as "currency." Some countries trade goat's milk or potatoes, for example, in exchange for medical care. The rich receive medical care, and the poor stay ill or die. In rural regions of Africa, India, China, and South America, millions of people live their whole lives without ever seeing a doctor. Often, "faith healers" using home-brewed remedies are their only treatment option, and they may or may not be effective against disease.

United States

The United States operates a complicated system that contains parcels of each of these four models. The issue of cross-cultural competence and diversity in health care has only recently become an operational challenge for health care delivery systems. U.S. 2010 census data show an increasingly large melting pot of Americans: The number of individuals who are black or Hispanic are growing exponentially larger than the growth rate of Caucasian Americans. In both the patient mix and the evolving picture of diversity in the employee workforce, diversity needs to be embraced. From translation services to hospital cafeteria selections, organizations can increase the diverse profile of their organizations by increasing awareness, providing education, and developing accountability mechanisms and performance indicators that point to how behavioral change is occurring throughout the organization, at all levels. Cross-cultural competence starts with three questions: What are one's personal stereotypes regarding specific cultures and ethnicities? What are the social stereotypes of a given population? What are the evidence-based practices regarding the provision and delivery of services to the specific population?

Patients are increasingly taking charge of their health care, and are heavily influenced by the exposure of disease management via the media. The roles of electronic and social media are changing the face of health care. Patients are becoming aware of new intervention strategies for their disease based on media reports and electronic testimonials by other patients. Partially educated patients march into a physician's office demanding the latest treatment advertised on television or promoted via social media. The pressure is on the health care team to inform the patient how alike or dissimilar a patient is compared to the media portrayal. Physicians who are not used to being challenged now need to provide justification for, and have immediate knowledge of, pharmacological breakthroughs for a growing number of diseases. Treatment providers should consider the patient partnership model proposed by Elois Berlin and William Fowkes, called LEARN. The acronym spells out the following steps: listen to the patient's perception of the problem, explain one's perception of the problem, acknowledge and discuss similarities/differences, recommend treatment, and negotiate treatment.

Despite pressure to address diversity issues from accrediting bodies, such as the Joint Commission, leadership in the vast health care network of the United States is still homogenized and Caucasian. Facilities and programs need to incorporate cross-cultural sensitivity into employee training programs if they are to be good stewards of the populations represented in the communities in which they are located. Migratory patterns of a variety of ethnicities have resulted in Asians being the fastest-growing race or ethnic group in 2012, according to the 2010 U.S. Census. Their population increased by 530,000, or 2.9 percent to a total of 18.9 million citizens. Hispanics were the second-fastest growing minority group, with a growth rate of 2.2 percent, for a total of 1.1 million citizens.

Future of Health Care

The U.S. health care system is fundamentally broken at the patient and payer levels. President Barack Obama proposed and Congress enacted reform measures that should make care more egalitarian and accessible. It is still too early in his plan's administration to measure the plan's effects. It is estimated that by 2020, one in three hospitals will close or reorganize: that is nearly 35 percent of America's 5,754 registered hospitals. Additional factors that contribute to America's health care problem, according to David Howle and Jonathan Fleece, are: the average American worker costs their employee $12,000 per year, and this figure is increasing 10 percent a year; three times as many people die in hospitals than on the highway, and one out of every 370 admissions will die, primarily from medication errors; and the average wait time in an emergency room is four hours.

The emergence of electronic medical records can increasingly put control of care in the patient's hands. This means that consumers can shop around for quality, cost, and service. Social workers and other health care providers can play a significant role, especially in communicating and advocating for the voice of the customer (or patient) in any system redesign. Social workers have a rich history of advocacy and organizing. It is time to return to the very roots of social work, to ensure that social workers and patients have seats at the table of this very crucial policy and implementation issue in social welfare.

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See Also: Health Care, Disparities in; Health Disparities, Role of; Health Insurance; Health Insurance Portability and Accountability Act of 1966; Medicine, Workplace Diversity in.

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Health Disparities, Role of

Health disparities occur when overall health status or health outcomes differ between different populations or groups of people—as examples, between people who identify as Hispanic/Latino and those who do not, or between people who are employed and those who are unemployed. This variance can reflect differences in both physical and mental health. A person's ability to achieve good health can be affected by genetics, behavior, education, income, the physical environment, discrimination and racism, and health services.

Worldwide, determinants of health include clean water, clean air, sanitary and safe living conditions, nutritious food, quality education, and affordable health care. Every continent has both large and small differences in the overall physical health and/or the mental health of different groups of people. Health disparities are frequently experienced by vulnerable populations—groups affected by factors such as minority race or ethnicity, gender and sexual identity, socioeconomic status, employment status, geographic locale, or a combination of these.

Social Determinants of Health

Social factors contribute to health disparities or inequalities in the way different groups of people are affected by physical problems (e.g., obesity, diabetes, cancer, cardiovascular disease) and mental problems (e.g., major depression). Social factors that contribute to differences in health are termed social determinants of health. The World Health Organization (WHO) has described social determinants of health as the environment or surroundings in which people are born, as well as the places where they grow up and live, where they work, and where they age or grow older. Social conditions are influenced by the availability of resources at various levels (local, state, national, international), financial resources (e.g., money), and power (the influence that others have on people's circumstances). Major social conditions affecting health include housing, employment status, stress, and social exclusion or social support.

Geographic Locale: Urban and Rural Social Health Disparities

People who live in large urban areas, such as the inner city, and those who live in expansive rural areas, such as agricultural or farming communities and mountainous regions, are more likely to experience health disparities than persons who live in suburban areas. These disparities result not only from differences in access to and utilization of health care and the costs associated with that health care, but also from differences in the environment and public health and differences between urban and rural health behaviors.

Urban areas may have wide gaps in socioeconomic status (e.g., employment, education, health insurance coverage), high rates of violence and crime, and stressed physical environments (e.g., poor air quality, high lead exposure, dense living conditions with compromised sanitation). Rural areas may also have wide gaps in socioeconomic status, as well as challenges in travel to care, lack of primary care physicians, underdeveloped infrastructure, high economic needs, and unhealthy behaviors (e.g., smoking, lack of exercise, unhealthy diets, failure to wear seatbelts). Among urban and rural peoples and among populations living in other geographic locales, clear differences exist in the rates of victimization; lead exposure; and the prevalence of asthma, infectious diseases, cancer, obesity, diabetes, and high blood pressure.

Employment Status: Health Disparities Between the Employed and Unemployed

People who are unemployed have a higher chance of poor health status and outcomes than those who are employed. One significant reason for this is that in some countries, people's benefits, such as private health insurance, sick leave, and vacation time, are directly connected to their jobs. Typically, people who are employed full time will have some level or type of health insurance coverage and sick leave.

People who are unemployed, however, may not have the same amount of preventive services, such as immunizations, well-child checkups, dental and vision care, and prenatal care. Further, health disparities may result from differences in the degree to which populations practice prevention. For those without health insurance, preventive medicine is generally absent.

Differences also exist in medical treatment. The treatment and services available for those accessing health care through government-subsidized or government-provided care or through local urgent or emergency medicine facilities or traveling clinics may differ from the services available to those with private providers.

Gender and Sexual Identity: Differences in Health, Outcomes, and Life Expectancy

Although more boys are born than girls, women generally live five to eight years longer than men. In areas where there are armed conflicts and war, this difference can be greater. Yet women tend to have poorer health outcomes than men as a result of sexually transmitted infections; the impact of poor nutrition and childbearing; violence, abuse, and gender oppression; and rates of internalized mental illness, including depression. For lesbian, gay, bisexual, and transgender (LGBT) individuals, additional health disparities exist, including increased risk of suicide; homelessness; alcohol, tobacco, and other drug use; HIV/AIDS infection (particularly among gay men, men who have sex with men, and both men and women who exchange sex for drugs or money); and lack of access to health care.

Race/Ethnicity: Health Disparities by Race, Ethnicity, and Culture

Even when factors such as socioeconomic status, employment status, and geographic locale are accounted for, health disparities by race and ethnicity persist. These disparities are evident in the rates of infant mortality, chronic disease and certain health conditions (e.g., obesity, diabetes, hypertension, heart disease, stroke, and asthma), HIV/AIDS, disability, and death. In addition, people of color are often underrepresented in clinical trials.

Addressing Health Disparities

In the United States, Healthy People 2020 defines health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.” Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” Addressing these obstacles will take concentrated efforts to provide high-quality education, nutritious food, decent and safe housing, affordable and reliable public transportation, clean water, clean air, health insurance, and culturally sensitive health care. This is true not only in the United States, but globally; in some countries, the obstacles, such as lack of public transportation, are much greater.

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See Also: Behavioral Health Disparities for Racial and Ethnic Minority Populations; Health Care, Disparities in; LGBTQ Clients;Overweight and Obese Adults and Children; Socioeconomic Status.

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Health Insurance

Health insurance pays for medical expenses incurred by the insured, generally including visits to doctors, hospital care (inpatient and outpatient), surgeries, medicines, and other medical treatment. Coverage may be purchased by individuals from private insurance companies, provided through an employer, or provided through government programs. Policies vary widely in costs, the amount of deductibles or copayments, the specifics of coverage, and limitations imposed on treatment and delivery of services. Although the earliest health insurance in the United States was available by the mid-19th century, the term itself dates from the Progressive era. The health insurance policy as it exists in the 21st century evolved from “sickness insurance” of the early 20th century and the prepaid hospital plans of the

Depression. The debate over the role of government in health insurance has endured for nearly a century. Although the United States spends a higher percentage of its gross national product on health care than any other developed nation, tens of millions of Americans lack health insurance and thus adequate access to the health care system.

The Evolution of Health Insurance

The U.S. Congress established the Marine Hospital Service in 1798 and required the owners of merchant ships to contribute 20 cents a month into a sickness fund for each seaman in their employ. The earliest private health insurance, however, developed considerably later, in 1850, when the Franklin Health Assurance Company of Massachusetts offered accident insurance to cover injuries suffered by travelers on trains and steamboats. A 15-cent weekly premium paid $200 for an injury, and double that in the case of total disability. Thirteen years later, Travelers Insurance Company offered a policy that became a template for others: a $5 weekly premium paid a $1,000 benefit in case of accidental death. By the end of the 19th century, 47 companies had issued 463,000 disability policies, but those who bought such coverage remained a relatively small group. Before the medical advances of the 20th century, the sick were usually cared for at home and medical expenses were low. Most people—with some justification, given the generally poor quality of health care—were suspicious of hospitals.

Of greater concern to the average American was the loss of wages if the family breadwinner was unable to work due to illness or injury. During the 1870s and 1880s, various companies in such industries as mining, lumber, and railroads provided group industrial clinics to treat the common illnesses and industrial accidents of their employees. More common was industrial sickness insurance. These funds were so popular in Europe in the late 19th and early 20th centuries that many countries, including Germany, Austria, Hungary, Norway, Serbia, Great Britain, Russia, and the Netherlands, made sickness insurance compulsory for many industries. Sweden, Switzerland, and Denmark subsidized voluntary funds that workers formed among themselves. Reform-minded Progressives were eager to see the United States follow Europe's lead, and President Theodore Roosevelt included compulsory sickness insurance in his platform. But life insurance companies and many physicians opposed the plan, and the anti-German feeling that followed the outbreak of World War I effectively destroyed it.

With a rise in the quality of health care that accompanied medical advances, such as antitoxins, vaccines, and new technologies (e.g., x-ray radiography and blood pressure meters), came a greater demand for medical services even as the supply of doctors and hospitals was limited. The result was an increase in medical costs and a growing interest in some form of medical insurance to meet those costs. The first group health insurance plan in the nation was set up by Montgomery Ward for the company's employees in 1910. Weekly premiums assured workers that one-half of their salary (from a minimum of $5 to a maximum of $28.85) would be paid directly to them in the event of their being unable to work. Like the earlier sickness insurance, it established a connection between health insurance and the workplace.

Nearly 20 years later, another step in the evolution of health insurance occurred when Dr. Justin Ford Kimball, an administrator at Baylor University Hospital in Dallas, Texas, grew concerned about the inability of schoolteachers to pay their medical bills. His solution was the Baylor Plan, which allowed teachers to pay 50 cents each month in exchange for the assurance that they were entitled to medical services for as many as 21 days a year. This idea, which eventually developed into Blue Cross, began to look attractive to other hospitals as Depression economics left increasing numbers of people unable to pay medical bills. At the same time, prepaid plans emerged that covered doctors' services, including the California Physicians' Service in 1939. In 1946, these physician-sponsored plans combined into Blue Shield.

Meanwhile, the issue of affordable health care was gaining the attention of leaders in labor and government as well as in medicine as the problem expanded beyond the poor and indigent. Medical costs had replaced lost wages as the central concern. The Committee on the Cost of Medical Care (CCMC), independently funded over its five years of work by private foundations such as the Rockefeller Foundation and the Carnegie Corporation, issued its report in 1932. The CCMC's almost 50 members included physicians, public health officials, hospital administrators, dentists, economists, and others. The group published the first reliable estimates of health care expenditures in the United States (about $3.7 billion in 1929, or 4 percent of the national income). It also recommended such controversial ideas as group medical practices, networks of clinics in rural areas, and health insurance, although it stopped short of supporting compulsory insurance because of the large subsidies such a mandate would require from employers, government, or some partnership between the two. The report failed to win wide support at any level, but the Social Security Act of 1935 provided federal grants to the states for public health service programs, one of the CCMC's recommendations, and in 1937 the CCMC's proposal for voluntary group prepayment of hospital costs culminated in the formation of the Blue Cross program. Much of the financial structure of the health care system recommended by the CCMC in 1932 resembles the organization in place more than 80 years later.

The Expansion of the Industry

During the 1930s, life insurance companies began to offer health insurance. Eventually, premiums reflected calculations of relative risks, issuing policies to older people or to people with a history of medical problems. The 1940s and 1950s brought an emphasis on health insurance as part of employee benefits packages, in part as a result of strong union negotiations. The health insurance package was also one way that companies competed for labor during World War II, when wartime wage controls limited incentives employers could offer. In 1940, only 9 percent of Americans had health insurance coverage. A decade later, 50 percent had coverage. By the early 1960s, most full-time workers and their families had health insurance coverage. The disadvantage was that job-related insurance ended when one retired or lost a job.

In 1965, with a Democratic majority in Congress, Medicare and Medicaid programs were introduced. Medicare provided low-cost hospitalization and medical insurance to those 65 or older with no restrictions regarding income or medical history. President Lyndon B. Johnson, who signed the bill into law, was the fourth president to champion health insurance as part of the Social Security system. Medicaid provided health insurance to low-income people. In 2010, Medicare provided assistance for approximately 45 million people, and Medicaid served approximately 58 million.

The 1970s and 1980s saw health care costs escalate rapidly, in part due to the increased use of medical technology and medications. In response, employee benefit plans transformed into managed care plans (networks of health care providers who have been verified for health care quality and have agreements with the insurer about price and related issues), and health maintenance organizations (HMOs) developed. President Richard Nixon signed legislation that provided federal endorsement, certification, and assistance for HMOs. The new law required employers with 25 or more employees who provided traditional health care benefits to offer federally certified HMO options. Managed care slowed the growth of health care costs only briefly. In the 1990s, health care costs rose at double the rate of inflation.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 allowed U.S. workers to transfer and continue health coverage for themselves and their families when they changed jobs or when they lost their jobs. The act also required the protection and confidential handling of protected health information. The Children's Health Insurance Program (CHIP), which went into effect in 1997, helped provide health insurance to children of low-income families, expanding coverage to nearly 8 million children from families whose incomes were too high to qualify for Medicaid, but who could not afford private coverage. Despite expansions in coverage, by the end of the decade, 44 million Americans had no health insurance. In 2012, the number of nonelderly uninsured was 47 million, a drop from 49 million in 2010.

The Plight of the Uninsured

Most private health insurance in the United States is purchased through employer-based group insurance policies. Such policies make up about 85 percent of all private coverage. By the end of the 20th century, rates of workplace health insurance had already dropped from those in the 1970s. The decline was related to company size. Two-thirds of workers employed by firms with more than 1,000 employees were offered insurance, but that number dropped to 52 percent in firms with 25–99 employees and to less than 30 percent in firms with fewer than 25 employees. Some economists believed that the shift from a manufacturing economy to a service economy was also a factor because many service economy jobs are minimum-wage positions, some are part time, and thus they more likely not to have employer-subsidized health insurance. Some researchers warned that the changing demographics of the workplace signaled the end of the employer-based system of insurance.

The uninsured are predominantly low- and moderate-income adults under age 65, with periods of being uninsured ranging from a month to many years. According to the Medical Expenditure Panel Survey, 26.1 million people were uninsured for the two-year period from 2004 to 2005, and 82 million people—nearly a third of all nonelderly persons—experienced at least one month without health coverage over that two-year period. Contrary to public perception, most of the nation's uninsured come from working families; more than 60 percent are in families with at least one full-time worker, and 16 percent are members of families with part-time workers. Being employed is no guarantee that one can afford insurance. In 2012, 61 percent of uninsured adults cited an inability to pay for coverage as a reason they were uninsured. Racial and ethnic minorities are far more likely than others to be uninsured. In 2012, the uninsured rates decreased as household income increased, from 24.9 percent for those in households with annual incomes less than $25,000 to 7.9 percent in households with annual incomes of $75,000 or more.

Health insurance is related directly to the quality of health care an individual receives. One-fourth of uninsured adults go without the health care they need each year due to costs, and numerous studies confirm that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases. They are more likely than the insured to have undiagnosed serious health conditions and less likely to receive follow-up care once a diagnosis is made. It is hardly surprising, then, that the uninsured also have significantly higher mortality rates than those with insurance.

The Debate Over Health Insurance

Yale economist Irving Fisher reminded his audience in a 1916 speech that the United States was the only industrial nation without compulsory health insurance, but Fisher was confident that universal health coverage in the United States would be enacted within a matter of months. He was wrong. Once the United States entered World War I, not even the efforts of such distinguished Americans as Louis Brandeis, Jane Addams, and Woodrow Wilson were sufficient to overcome the plan's association with Germany, where the European plan originated. A century after Fisher's speech, his description of the United States still holds true, and politicians, economists, sociologists, medical professionals, and citizens are still debating health care and the government's role in providing it.

The United States spends $8,233 per person per year for health care, more than 2.5 times that of most developed nations, including European countries such as France, Sweden, and the United Kingdom. Norway, the Netherlands, and Switzerland, the next-highest in health expenditures, spent at least $3,000 less per person than the United States, which spends 17.6 percent of its gross domestic product (GDP) on health care. The Netherlands is the next-highest, at 12 percent of GDP, and the average among Organisation for Economic Co-operation and Development (OECD) countries is almost half that of the United States, at 9.5 percent of GDP. Despite this level of spending, tens of millions of uninsured Americans go without access to the country's high-quality health care. Although the United States leads the world in health care research and cancer treatment, and U.S. survival rates for breast cancer and colorectal cancer are higher than in any of the other 33 OECD countries, the United States falls short on some other key measures. Life expectancy at birth increased by almost nine years between 1960 and 2010 for Americans, but that is less than the increase of more than 15 years in Japan and 11 years on average in OECD countries. The average American lived 78.7 years in 2010, more than one year below the average of 79.8 years. Among OECD countries, only Mexico and Turkey had higher infant mortality rates in 2010 than the United States. The United States also falls below the OECD average in the number of physicians per person and the number of hospital beds per 1,000 population. Most OECD countries have some form of nationalized health care coverage available to 100 percent of their populations.

While partisan battles rage in legislative halls, on talk shows and Internet sites, beside water coolers, and at family dinners over the details and value of the Patient Protection and Affordable Care Act of 2010 (popularly known as the Affordable Care

Act), polls show that a majority of Americans favor fundamental changes or a complete restructuring of the health care system. The economic crisis of the 2000s made many aware for the first time of their vulnerability in a work-based health insurance system. Even as the nation awaited a Supreme Court ruling on the constitutionality of some of the provisions of the Affordable Care Act, 77 percent of those participating in a CBS poll thought that if the law were declared unconstitutional, the president and Congress should immediately begin to work on new health care legislation. Some experts advise that the focus be shifted from extending health insurance to concerns that would do more to improve the health of all Americans, specifically reducing racial and ethnic health disparities, preventing disease and promoting health, developing and regulating pharmaceuticals, and improving consumer information.

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See Also: Health Insurance Portability and Accountability Act of 1996; Medicaid.

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Health Insurance Portability and Accountability Act of 1996

Providing equal availability and provision of human services to diverse populations requires a standard of privacy and security for personal health information. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by the U.S. Congress to set this standard. HIPAA protects individuals and their families from prejudices based upon preexisting conditions or other differences evident in personal health information. HIPAA also improves the ability of individuals to take insurance coverage from job to job. Prior to HIPAA, insurance companies as well as health care programs and providers were able to deny coverage, and therefore services, to diverse populations based on their personal health information.

Health information professionals administer HIPAA as a complex compendium of expanding rules and regulations designed to protect health information. The increased regulation of medical records privacy, breach reporting, and electronic information management that HIPAA requires has been introduced in phases, with compliance standards and penalties for noncompliance progressively increasing under the provisions of not only HIPAA but other related legislation, including but not limited to the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and the Omnibus Final Rule in 2013.

Covered entities are required to adhere to privacy and security standards. These entities include health care organizations, hospitals, mental health clinics, health plans, managed care plans, public health authorities, health care payers, health care clearinghouses, and direct care providers (e.g., physicians, dentists, pharmacists, therapists, and psychiatrists, among others). The Office for Civil Rights enforces HIPAA compliance and protects individuals from prejudice and discrimination based on ethnicity, gender, age, ability, and religious preference in addition to any other individually identifying information that may be included in a person's health record.

Privacy

HIPAA privacy and security standards provide recipients of health services with protection from unauthorized persons who want to gain access to their confidential information. HIPAA describes these confidential data as protected health information (PHI). PHI is any information detailing an individual's physical or mental health condition, information regarding health services and treatments received by individuals, and any payments or insurance claims made for those health services. Pregnancies, illnesses, past insurance claims, and past behaviors are all considered confidential data. Genetic information that may indicate future proclivities toward inheritable diseases or conditions is also protected. PHI covers past, present, and future health information for individuals and their dependent family members. The protection of this information limits access to only those providers and authorized persons with a need for data in order to properly serve individual health care needs. The HIPAA Privacy Rule allows disclosure of PHI necessary for patient care and safety. The HIPAA Security Rule requires that disclosure is authorized. Information that could lead to prejudices and denied insurance coverage can be released only on a need-to-know basis.

HIPAA also guarantees that individuals will have new or continuing access to health insurance when they switch jobs. It also imposes limits to the ability of new employers to exclude coverage for preexisting conditions when switching to their health plan. It allows opportunities for individuals to enroll in a group health plan if other coverage is lost or certain life events take place. Although HIPAA protects PHI and guarantees insurance access is provided by new employers, there are limits to its provisions. For example, HIPAA does not require that employers offer health coverage or guarantee that any past or present conditions are covered by the new employer's health plan. An employer is permitted to impose a preexisting condition exclusion period that includes the six months prior to the enrollment date in their plan if medical advice, diagnosis, care, or treatment was recommended or received during that time.

Security

Security and Breach Notification Rules describe the particular ways information can be shared, the specific ways it must be destroyed, and the reporting responsibilities required when a breach of security protocol is discovered. If information is transmitted to unauthorized persons, strict penalties are enforced. HIPAA also provides for substantial penalties for failures to certify or comply with standards and operating rules. Civil penalties for willful neglect range from $250,000 to $1.5 million.

The HIPAA Security Rule sets national standards and specifies the safeguards that must be used to assure the confidentiality, integrity, and availability of electronic protected health information (ePHI). The HIPAA Breach Notification Rule requires all service providers to provide notification following a breach of unsecured PHI or ePHI. These rules, along with the Enforcement Rule and specific rules regarding coding and identifying numbers, are all designed to apply nationally and contribute to administrative simplification.

Enforcement

Legislation related to HIPAA, including HITECH and the HIPAA Omnibus Rule, have expanded protection provisions as the demand for ePHI has increased. New systems require new forms of vigilance. HITECH encourages the adoption of electronic health record (EHR) systems, increases liability for noncompliance, and provides for increased enforcement. The HIPAA Omnibus Rule revises the HIPAA Privacy, Security, Breach Notification, and Enforcement Rules. Covered entities and direct care providers will need to adapt policies and procedures to conform with the changes required by HITECH and the Omnibus Rule.

Under HIPAA, an individual cannot bring a cause of action against a provider, but state attorneys general can bring a cause of action on behalf of their constituents. Civil penalties based on specific violations and the harm resulting from those violations are determined at the discretion of the secretary of the U.S. Department of Health and Human Services (HHS). Penalties range from $100 to $1.5 million. HHS is also required to conduct periodic audits of covered entities and their business associates. Covered entities are criminally liable if they obtain or disclose PHI; commit offenses under false pretenses; or commit offenses with the intent to sell, transfer, or use PHI for commercial advantage, personal gain, or malicious harm. Fines and maximum sentences are, correspondingly, up to $50,000 and imprisonment for up to 1 year, $100,000 and imprisonment for up to 5 years, and $250,000 and imprisonment for up to 10 years. Responsible individuals may also be found criminally liable under HIPAA. Individuals not directly liable under HIPAA can face criminal charges of conspiracy or aiding and abetting.

HIPAA provides protection to recipients of health services through rules and regulations that control access to PHI and ePHI. Confidential data that cannot be shared with unauthorized persons include ethnic, religious, genetic, and gender identifiers; treatments and diagnoses for physical, mental, and emotional conditions; and previous insurance use and claims history. Limiting access reduces the risk of discrimination based on prejudices that these data may reveal. HIPAA ensures that only entities with an interest in the health and safety of a recipient will have access to their personal health information.

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See Also: Americans with Disabilities Act; Health Insurance; Information and Referral; State Children's Health Insurance Program; Workplace Health Services.

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Health Promotion Services

Health promotion is a multidisciplinary and holistic approach that focuses on helping people achieve and maintain good health. The diversity of health-related behaviors and beliefs in different groups makes work in community-based health promotion a challenging but exciting field for human services workers. Health is broadly defined in the health promotion arena, encompassing not only physical well-being but also mental and social well-being. Among the key components of health promotion is empowerment, the ability of the individual and community to take action to promote health. Health promotion focuses on determinants of health, including factors that are related to the physical and social environments of diverse groups. Social inclusion is considered an important aspect of health in this approach, and social capital—interpersonal relationships and social support—is a key factor in promoting health in individuals and communities. Communities can help promote health through education and policy support as well as by financing or otherwise supporting health promotion services.

Health promotion services provide a broad range of activities and programs for individuals and groups. They may promote specific health-related goals, such as immunizations and vaccinations, so that children are protected from specific diseases, or focus on more comprehensive projects and programs that address multiple health determinants, such as day care programs and clubhouses for adults with mental health needs and/or functional disabilities, which help promote social capital and overall well-being.

Health promotion services are preventive in nature; they are meant to help people remain in optimal states of well-being and avoid ill health. For example, services that encourage people to exercise with other family members and friends on a regular basis can be expected not only to help these exercisers strengthen social ties, but also to avoid excess weight, which in turn can prevent the onset of diabetes, high blood pressure, heart disease, and other conditions. Screenings for diseases and related risk factors for overall health are also considered health promotion services because they help identify these conditions before the effects of ill health are felt, which allows people to return to healthier states of being.

Health promotion services are conducted by a number of different groups, including health care providers, mental health professionals, and community volunteers. Human services workers play important roles in the provision of health promotion services, both as liaisons between community members and complex health and social services systems, and as professionals involved in providing these services. A few examples of human services workers who provide health promotion services include life skills instructors, client advocates, adult day care workers, probation and parole officers, family services workers, community organizers, and case managers for health promotion programs.

Health promotion services at the community level focus on empowerment of neighborhoods and groups and on partnerships between service providers and clients. Community members are viewed as experts in terms of being able to identify both supports and barriers to good health. Many human services workers and other health promotion professionals rely on strong support from community members when following the health promotion process of developing, implementing, and evaluating local programs, using various forms of community-based research. In this research approach, community members take the lead in identifying health concerns and in proposing appropriate strategies to address these concerns.

Health promotion workers often state that health promotion services are cost-effective in the long run because it is less expensive to prevent illness than to treat it. This argument makes sense on an intuitive level. Certainly, the long-term costs of a series of classes aimed at promoting better nutrition and exercise habits for several dozen individuals who show risk factors for heart disease are far less than the cost of a single coronary bypass surgery. The cost-effectiveness of individual interventions is not always easy to measure, however. Behaviors such as how much people eat and how often they exercise are not always consistent, so it is difficult to judge how effective some services are in real-life conditions. Problems also arise in quantifying the

The health promotions officer at Naval Health Clinic, Hawai'i, educates service members on the dangers of smoking and tobacco use during the Great American Smokeout. Many human services workers rely on a combination of education and training to help individual clients develop the knowledge and life skills they need to enjoy better physical and mental health.

value of some health determinants. For example, how can the effect of counseling sessions at a family support services clinic be measured over time? Although multiple studies have identified the economic impact of various health promotion services, and many other studies have linked health promotion to a reduction in risk for ill health, it is equally important for human services workers to consider the effect of these services on the quality of life of individuals and communities. The prevention of chronic lung disease for a young mother who successfully completes a smoking cessation program, for example, does not just save her health insurance provider the costs of underwriting many expensive treatments, it also allows her to spend many more years with the people she loves.

What is the Most Effective Way to Provide Health Promotion Services?

Many human services workers rely on a combination of education and training to help individual clients develop the knowledge and life skills they need to enjoy better physical and mental health. The Health Belief Model states in part that active approaches, including education and training, lead individuals to feel an increased sense of self-efficacy, which in turn helps people develop consistent habits that lead to better quality of life. At community and national levels, however, it is difficult to promote health at this individual level—such services would need to provide educators and training modules for every person in the country. Health promotion services at state and federal levels are supported through passive approaches, such as through policies and enforcement actions. Passive approaches do not require that a decision for change be made at the individual level; rather, these approaches regulate health behavior through legal and administrative means. For example, no-smoking regulations are now legal requirements for healthy behavior in most communities, and are enforced by fines. Human services workers who want to work with both individuals and communities to promote health will understand the importance of working with both active and passive approaches.

Challenges in Health Promotion Services Today

Human services workers are working with a number of different populations that experience complex needs. Older people, new immigrants, the severely mentally ill, and people with functional disabilities all require health promotion services that are specific to their own life circumstances. Many at-risk groups lack consistent access to good nutrition, adequate housing, and appropriate preventive care, so human services workers are increasingly faced with working with clients who experience multiple needs. In high-risk situations, human services workers must focus on meeting basic and immediate needs, such as food, shelter, and life-saving medical treatments, before focusing on health promotion. The life expectancy in the United States is now upwards of 82 years for both sexes, so Americans also experience increased risks for some health conditions, and social exclusion continues to challenge many groups. The need for health promotion services is thus more important than ever, as is the need for human services workers who are able to partner with community groups to develop, implement, and evaluate these services.

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See Also: College and University Health Services; Community Health, Racial and Ethnic Approaches to; Maternal/Infant Health Services; Mental Health Gap Action Program; Racial and Ethnic Approaches to Community Health.

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Help-Seeking Behavior, Cultural Differences in

Help seeking is an interaction with others that focuses on a specific problem or emotional pain and aims at alleviating distress by means of informal or formal sources of support. It is a process that includes acknowledging a problem, deciding to get help, and determining a source of support. Choosing a source of support depends on an individual's tendency to seek or to resist formal or informal intervention during a time of crisis or following prolonged discomfort. The decision to seek professional help is influenced by individual, interpersonal, and sociocultural factors.

Help seeking is an interpersonal experience influenced by the context in which it takes place. There is evidence that sociocultural norms may exert a direct influence on help seeking, and it has been suggested that professional help seeking is related to a variety of psychosocial and cultural issues. Many scholars believe that attitudes toward help seeking are transmitted by family and social networks. All cultural groups seek help for their distress based on the meaning that culture assigns to the distress.

How Culture Influences Help Seeking

Culture includes the shared values, traditions, norms, customs, religion, arts, history, folklore, language, and/or institutions of a specific group of people. Cultural variability in the tendency to seek professional help has been a focus of empirical interest among researchers. A number of culture-related variables have been tested by researchers in search of explanations for ethnic and racial differences in the willingness to seek counseling and psychotherapy. To date, empirical findings have linked the cultural divergence in help-seeking patterns to extrinsic factors such as institutional biases and barriers, as well as intrinsic, cultural factors including acculturation, ethnic identity, self-construal, individualism-collectivism orientations, spirituality, and culture-based mental health beliefs.

Differences in relational patterns across cultures have implications for seeking help from professionals. In collectivistic cultures, such as in Asia, disclosing one's problems to professionals (an out-group) could be interpreted as dysfunctional by the in-group and viewed as a threat to in-group functioning. Therefore, people from collectivistic cultures might be more reluctant to seek professional help than people from individualistic cultures. Collectivistic cultures emphasize interdependence and social harmony within the group, with each individual viewed as fundamentally interconnected in a larger social unit. In contrast, individualistic cultures, such as in the United States, emphasize independence, distinguishing the individual as autonomous and distinct from others, with personal aims overriding group interests. Thus, seeking help is not viewed as an affront to the in-group.

Racial Differences in Help Seeking

African Americans, Asian Americans, and Latinos tend to underutilize outpatient health services and overutilize emergency health services. Lack of cultural competence, lack of health insurance, and geography have been cited to explain the help-seeking patterns of people of color in the United States. Although lack of health insurance is a valid explanation for observed utilization patterns, African Americans with health insurance are still less likely to use outpatient health services than whites with similar coverage. Some researchers suggest that the tendency of African Americans to rely on informal support and on religious services hinders their access to health services. Although Latino use of specialty services and mental health services is low, their rates of physician use may be equal to that of whites, suggesting reasons other than those provided may be at play. Some researchers have suggested that the underutilization of formal services may be due to differing culturally based help-seeking strategies, and that Latino familial and kinship networks may serve as protective resources and may also act as barriers to seeking formal care.

Gender Differences in Help Seeking

Gender is another factor that influences help seeking. For example, women, across demographic variables, are more likely to seek professional help and have more positive attitudes toward help seeking than men, regardless of culture or ethnicity. This willingness among women in different cultures to seek professional help has been attributed to the tendency of women to have closer friendships and be socialized toward providing help. Women use social networks to a greater degree than men do and are more skilled at using these networks. They may also be more comfortable with seeking out others for help with coping with their problems. In contrast, men across cultures that adhere to dominant masculine gender roles characterized by avoidant coping, aggressiveness, and emotional inexpressiveness have decreased willingness to seek psychological help—they hold more negative attitudes toward seeking help and seem to be less willing to utilize their social support networks.

Social Beliefs as Help-Seeking Determinants

Social beliefs are causal statements about relationships between events and entities and refer to people's understanding or expectations about how their world operates. Research suggests that individuals' willingness to seek counseling is likely to be determined by their culturally conditioned beliefs. In the existing literature, cultural groups have beliefs about the causes of mental disorders. Their beliefs toward mental illness and psychological problems might mediate attitudes toward receiving mental health services. For example, some traditional Mexican folk illness beliefs imply that mental health problems are the result of supernatural influences that may be cured with the help of a folk healer. Adherence to this belief in the Mexican culture might discourage favorable attitudes toward professional help seeking.

Influence of Enculturation and Acculturation

Enculturation is the process of being socialized into and retaining the cultural norms of one's heritage culture, a process whereby cultural values are conceded at a slower rate than behaviors in each successive generation, which influences help seeking. Acculturation, or the process of adaptation to the norms of the majority culture while downplaying the process of retaining one's heritage cultural norms, may influence help seeking as well. The evidence on enculturation and acculturation is inconclusive. Several studies have reported a direct relationship between acculturation and help-seeking attitudes, but others have revealed that less acculturated individuals had a greater willingness to seek counseling.

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See Also: Cultural Competence, Human Service Providers and; Cultural Competence, Measuring and Assessing; Cultural Competence, Model of; Cultural Competence, Professional Standards of; Cultural Competence, Training in

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Heterosexual Privilege

Initially, the scholarly writings on privilege focused on gender and the unearned benefits that were bestowed upon males. Later, the notion of privilege was expanded to include race, and then sexual orientation as well. Heterosexual privilege involves unearned benefits bestowed upon the heterosexual majority but denied to those who view themselves as sexual-orientation minorities, such as the gay, lesbian, bisexual, transgender, and queer (LGBTQ) community. Understanding heterosexual privilege is relevant to understanding diversity. This article provides an overview of privilege, a definition of heterosexual privilege, and examples of heterosexual privilege. It differentiates heterosexual privilege from homophobia, and concludes by offering possible explanations for the existence of heterosexual privilege in society.

Overview of Privilege

To fully comprehend heterosexual privilege, one has to review the scholarly writings on how it was initially applied to gender and subsequently to race. There is an abundance of scholarly writings on gender privilege. Numerous scholars who study privilege often refer to the works of feminist Peggy McIntosh, who coined the term *invisible knapsack*. McIntosh noted how males have bestowed on themselves a special status because of their gender. She purported that males are oblivious to the privileges and rewards that they receive because they are males, and that they carry this knapsack, which is full of the tools and resources that allow them to succeed easier than someone without the knapsack. The owners of the knapsack, therefore, believe that they have achieved a certain level of success based solely on their own merits; they are not aware that they have unearned privileges that may have contributed to their successful achievements. They are aware that others may not have certain advantages; however, usually they do not acknowledge and understand that many of the privileges that they possess are related to another's lack of privileges.

Scholarly interest expanded beyond an examination of gender privilege as numerous scholars argued that this privilege extends to race, with whites the beneficiaries of this privilege. Unearned privileges that are afforded to white people are called white privileges. Like the male privilege, this privilege is obvious to those who do not have it and yet invisible to those who possess it. As a member of the dominant group, one is afforded certain opportunities and entitlements to which a person who is not a member of the dominant group will not have access. McIntosh created a list of examples of the privileges she enjoyed as a white person—for example, she could easily find an academic institution and courses that give attention to white people.

Definition and Examples of Heterosexual Privilege

"Heterosexual privilege" is a term used to describe privileges that favor heterosexuals as the norm over homosexuals or people who identify as LGBTQ. Heterosexual privilege, or straight privilege, refers to rights and unearned advantages that heterosexuals have in society. Many of these unearned privileges take place in everyday life without any forethought. Heterosexual privilege is similar to white privilege in that the beneficiaries do not have to think about their status or put forth any extra effort to be recipients of the benefits. The following examples are based on McIntosh's article on white privilege: Heterosexuals can pick up a magazine, watch TV, or play music and can be certain that their sexual orientation will be represented. People never ask heterosexuals why they chose their sexual orientation or to think about why they are straight. Also, heterosexuals can easily find a religious community that will not exclude them for being heterosexual.

Distinguishing Homophobia From Heterosexual Privilege

It is important to understand the differences between homophobia and heterosexual privilege. Homophobia can be characterized as acts or thoughts that specifically target gay people in the form of discrimination, gay bashing, and derogatory comments. In the extreme, homophobic actions may be the commission of hate crimes against gay people that may result in death. Heterosexual privileges are benefits that heterosexual people experience daily with no effort on their part and that often occur unconsciously.

Explanations for Heterosexual Privilege

Scholars in the psychological literature have argued that heterosexist beliefs are the products of internal psychological repression of same-sex desires that heterosexual people have; in other words, the negative way in which heterosexuals respond to their own same-sex desires. Other scholars have suggested that heterosexism and heterosexual privilege are related to the need of heterosexual men to maintain a patriarchal structure that benefits men because it maintains the current structure of women being connected to men, masculinity, and the traditional family as ideal.

Conclusion

Heterosexual privilege is a concept that helps one understand inequality directed toward those whose sexual orientation may not be viewed as traditional or the norm in society. Gender studies and the scholarly contributions of McIntosh helped identify the notion of gender and race privilege, which are unearned benefits that are bestowed upon the dominant group in power. Similarly, heterosexual privileges are unearned benefits that benefit the heterosexual majority while excluding groups that identify as sexual-orientation minorities. Overall, heterosexual privilege is an everyday experience that is afforded to the majority and is a phenomenon that often occurs on an unconscious level.

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See Also: Bias in Service Delivery; Discrimination and Institutional Racism; Implicit Bias; LGBTQ Clients; Monoculturalism; White Privilege.

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Hispanic Americans

One in every six Americans comes from Hispanic origins, making this population segment the largest ethnic group in the United States. Unfortunately, many human services professionals have minimal exposure to Hispanic Americans, leaving professionals unprepared the first time a Hispanic client walks into the office. Culture influences an individual's behavior; therefore, it is imperative that human services professionals seek to understand the client in the context of his or her own culture.

Hispanic Americans are the fastest-growing minority in the United States with numbers approaching 20 percent of the U.S. population. The Hispanic population is expected to reach 30 percent by the year 2050, making it increasingly likely that human services professionals will encounter Hispanic clients. Although much of the Hispanic American population has immigrated to the United States over the last 100 years, a sizable population is indigenous to the areas in which they live. Examples of states with large indigenous Hispanic American populations include California, Arizona, New Mexico, and Texas.

Many professionals mistakenly assume that all clients of Hispanic origin share the same cultural values, but just as there are many cultures among Anglos and African Americans, there are also numerous cultures in the Hispanic American population. Differences exist based on country of origin as well as on the states or regions within that country. The terms *Hispanic* or *Latino* are generally defined as "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race." Some Hispanics take offense to being labeled Hispanic or Latino, believing it is an overgeneralization. These individuals prefer to be associated with their country of origin (e.g. Mexican, Colombian, Cuban).

In Hispanic culture, a common subculture group distinction is skin tone. Hispanics with dark skin are generally believed to be from indigenous origins. Individuals with light skin are considered to be decedents of the Spaniards. To many Hispanics, skin tone represents a social class distinction. Human services professionals should be aware that referring to a light-skinned Hispanic as any race other than white is considered a cultural blunder.

Family Dynamics

Hispanic cultures place heavy emphasis on the family unit. Most families are either highly matriarchal or patriarchal, and the decisions of the elders are typically accepted as law. Respect for the family elders is taught from a young age and is present throughout an individual's life. If a client's family deems a particular treatment as inappropriate, it is unlikely the human services professional will convince the client otherwise. To avoid this from happening, the counselor should include important family members whenever possible. Although a break from common practice, including a Hispanic client's close family members in treatment planning uses the individual's orientation toward family as a resource and creates allies out of the client's family members. When including family members in a client's treatment, special care must be taken to protect the client's confidentiality and to ensure proper releases are signed for each family member involved.

An exception to this inclusion, of course, applies in circumstances related to domestic abuse. Hispanic families are very private and do not like anyone outside the family to become involved in what they consider to be family matters. It is common for immediate family members to try to protect the abuser, sometimes going so far as to pressure the victim to remain silent. When the professional suspects domestic abuse, the client should be discreetly separated from family members before being questioned about possible domestic violence.

Large families are the norm in Hispanic cultures, and it is not uncommon for an individual to have six to 10 siblings. Hispanic culture treats children as assets due to the value they add to the family. Because of the tight family orientation, siblings often serve as a support network to each other. Brothers and sisters are quick to defend one another—to threaten one is to threaten all. Extended family members (aunts, uncles, cousins) often play an integral part in the family dynamics. It is common to refer to close family friends as cousins, aunts, and uncles, even when no blood tie exists.

In Hispanic cultures, a major family event occurs when a girl turns 15—the age when a girl becomes a woman. A large celebration is thrown called a quinceañera. This age-old tradition is one of the major events in a young Latina's life. A culturally sensitive individual counseling a Hispanic adolescent girl should be aware of the importance placed on this event. There is really no equivalent in Anglo cultures.

Family get-togethers and dinners are an integral part of the lives of many Hispanic families. These events may occur weekly, monthly, or annually, and are a time when the entire family comes together; often friends and neighbors also attend. Attendance is expected, and an individual who misses one of these events may fall into family disfavor. As acculturation increases among Hispanic Americans, this tradition is slowly falling by the wayside and it is most likely to be encountered in first- and second-generation families.

Language Barriers

Probably the most obvious cultural barrier encountered when working with Hispanic Americans is language. The primary language spoken in Hispanic countries is Spanish, and for many Hispanic Americans, English is their second language. Although the Spanish language has common features regardless of the country or state of origin, each region has specific differences and nuances. When speaking in Spanish to a client, if the client shows a look of confusion or surprise, it is best to clarify specific word meaning with the individual.

The U.S. Department of Health and Human Services reports that 35 percent of Hispanics state they are not fluent in English. Individuals who report some English competency may still possess comprehension problems. When working with clients who are not fluent in English, the human services professional should speak in Spanish whenever possible. Spanish is the second-most widely spoken language in the United States, and culturally diverse professionals should make learning this language a high priority. Speaking in English to someone with minimal English comprehension may prevent the individual from properly voicing his or her complaint, or may lead to confusion and misunderstanding concerning the diagnosis. If the professional does not possess fluency in Spanish, the Spanish-speaking client should be referred to someone who does.

Perhaps the most common barrier encountered with Spanish-speaking clients is in regard to forms. It is unethical to have a client sign a document he or she cannot read or comprehend. Unfortunately, even agencies that have a staff member fluent in Spanish rarely have Spanish forms. At a minimum, the professional who treats Hispanic Americans should have Spanish versions of the consent to treat or client rights and release forms.

Acculturation

Working with Hispanic Americans requires that the professional consider the client's acculturation when evaluating cultural values and attitudes. Acculturation refers to the changing of values from a nondominant group to those of the dominant group. Acculturation is a significant factor with both immigrants and Hispanic Americans moving from a predominantly Spanish-speaking neighborhood to a more mainstream neighborhood. Based on the degree of acculturation, the professional receives an idea as to the level of cultural influence the individual experiences.

Numerous acculturation measurement instruments are available for Hispanic Americans. At a minimum, the professional should ask the client questions pertinent to acculturation, such as, "For how many generations has your family lived in the United States?" or "What is the primary language spoken in your home?" By measuring the client's degree of acculturation, the professional gains an idea of the degree of influence of the client's culture.

Psychological testing presents an often-overlooked problem when working with Hispanic clients. Psychological testing compares an individual's test answers to a known group of participants. Based on the client's answers, deviation from the norm can be measured and assessed. The problem is that the vast majority of psychological tests are based on a mainstream participant group, often college students volunteering for the project. Because of the difference in cultural values and attitudes, Hispanic clients are unlikely to respond in the same manner as the participant group, thereby invalidating the test results for clients within this group. The less acculturated a Hispanic client is, the less likely he or she is to answer questions in the same manner as a mainstream client. When the baseline is no longer present, the test values lose their relevance.

Attitudes Toward Human Services Professionals

Traditional Hispanic values place high importance on respect for authority, and these individuals are unlikely to question or challenge a human services professional. These clients view the professional as an authority figure and may therefore believe asking questions is disrespectful to that authority. The professional must realize that the Hispanic American client may not ask questions even when he or she does not understand something. It is the professional's responsibility to explain diagnoses and treatment options until there is no doubt that the client understands.

Likewise, Hispanic American clients may not want to openly disagree with their provider or voice doubts and concerns. Clients may hinder their progress by not following treatment recommendations or not taking prescribed medications, either through lack of understanding or by open defiance. The human services professional should never assume that because the client remains quiet, he or she has no questions. Attitudes toward human services professionals are directly linked to the degree of acculturation of the individual.

Stereotyping

Racial bias and stereotyping are so common for Hispanic Americans that many have come to expect it from non-Hispanics. Non-Hispanic professionals are often guilty of stereotyping simply by not knowing any better. Not all Hispanics are undocumented Americans; most of the clients a professional is likely to encounter are not. Not all Hispanics work as gardeners or maids; Hispanic Americans can be found in every occupation imaginable. The best way for a professional to avoid stereotyping a Hispanic client is never to assume anything, and always ask.

Because traditional Hispanic families see human services professionals as authority figures, if a counselor makes an incorrect assumption, the client may be reluctant to correct him or her. Traditional families typically hold a strong sense of cultural pride; respectfully asking the client to explain something invites the client to disclose more freely and reduces the likelihood of cultural stereotyping.

Health Care and Insurance

The U.S. census reported that 30 percent of Hispanic Americans were uninsured in 2011, making this population segment the largest uninsured ethnic group in the United States. Lack of insurance or inability to pay prevents many Hispanics from seeking health care. Hispanic cultural values further discourage paying for intangible items, such as health insurance and mental health care. The attitude among many Hispanic Americans is that if they can't touch it or see it, it must not be real or necessary.

Mental health practitioners and human services agencies should be aware that lack of insurance presents a huge barrier for this cultural group. Many uninsured individuals spend a great deal of time building up their courage before they come in for help. A provider who immediately focuses on the ability to pay may intimidate the client enough to never come back. Building trust with the client during the first visit is essential if there is to be a second.

Trust Issues

Hispanic Americans are often distrustful of strangers. Family members are trustworthy; all others must prove themselves. These clients are particularly wary of non-Hispanics and frequently reluctant to self-disclose. To help a Hispanic client, a professional must first gain the client's trust. Communicating sensitivity toward the client's culture will go far toward building a trust relationship.

Trust is usually extended slowly but can be lost quickly over any perceived deception. A high value is placed on personal integrity. Breaking a promise or agreement, no matter how slight, can cause any trust extended to be immediately withdrawn. One of the fastest ways to develop a trust bond is through the use of client-centered therapy. When the counselor is transparent and forthright, the client is more likely to view the professional as a trustworthy individual.

Seeking Help

Pride is a very dominant characteristic among Hispanics, sometimes to the degree that it becomes detrimental. Children are taught from a young age to be independent and to trust no one outside of the family. Asking for help is seen as a weakness. Admitting to a mental illness is seen as a bigger weakness. In traditional Hispanic culture, seeking help for a mental disorder is discouraged; the individual is expected to resolve his or her own issues.

As stated previously, the more acculturated an individual is, the more likely he or she is to be open to counseling. A culturally sensitive professional recognizes how difficult it is for traditional Hispanic Americans to seek help, and, beginning with the first session, does everything possible to make the client feel comfortable. Standard practice for most professionals is to conduct an assessment during the first meeting. If the assessment is used strictly for gathering clinical information, the counselor risks never seeing the client again. Sensitivity to the client's cultural needs and empathy toward the difficulty the client had in seeking help will set the stage for building the trust relationship that is essential to the helping process.

Addiction

In recent years, drug use among Hispanic teens has increased at alarming rates, making this group the most likely ethnicity to abuse drugs or alcohol during adolescence. Studies have confirmed that drug use has become a normalized behavior among Hispanic teens. Many Hispanic American parents complain that they are helpless in regard to curbing their teens' illicit drug use.

Among Hispanic adults, drug use has decreased slightly in recent years and alcohol abuse has increased. Generally speaking, U.S.-born Hispanic Americans are significantly more likely to abuse alcohol or drugs than foreign-born Hispanics. Studies have shown that the percentage of Hispanic Americans who abuse alcohol increases in direct proportion to the degree of acculturation.

A significant barrier to treatment for clients who speak only Spanish is the low number of Spanish-speaking residential treatment facilities. These facilities are not proportionate to the demand. Waiting lists are common, and Hispanic Americans often fail to receive appropriate care due to language, distance, or financial barriers. Because of the traditional Hispanic's reluctance to disclose to strangers, professionals often overlook substance abuse problems as they focus on more apparent client needs.

Conclusion

As the percentage of Hispanic Americans continues to increase, human services professionals are increasingly likely to encounter them as clients. The thoughts, attitudes, and belief systems of an individual are closely linked to his or her dominant culture. To work responsibly with Hispanic American clients, professionals are strongly encouraged to become familiar with Hispanic culture. Cultural differences between Hispanic clients and the dominant culture become apparent in the client's behavior. Understanding the attitudes and values of the Hispanic client is essential to providing optimum care.

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See Also: Hispanic Health and Nutrition Examination Survey; Hispanic Immigrants; National Alliance for Hispanic Health.

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Hispanic Health and Nutrition Examination Survey

The Hispanic Health and Nutrition Examination Survey (HHANES) was the largest and most comprehensive nationwide health survey of Latinos and Latinas in the United States. Designed and conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) from July 1982 to December 1984, the HHANES analyzed the health and nutritional status of 16,000 persons, taken from a sampling frame that included approximately 76 percent of the 1980 Latino/a-origin population in the United States. Respondents, ranging from 6 months to 74 years old, were from three Latino/a groups: (1) Mexican Americans residing in Arizona, California, Colorado, New Mexico, and Texas, who were surveyed from July 1982 through November 1983 (9,894 persons sampled, 8,554 interviewed, and 7,462 examined); (2) Cuban Americans residing in Dade County, Florida, who were surveyed from January 1984 through April 1984 (2,244 persons sampled, 1,766 interviewed, and 1,357 examined); and (3) Puerto Ricans residing in the New York City metropolitan area, including parts of Connecticut and New Jersey, surveyed from May 1984 through December 1984 (3,786 persons sampled, 3,369 interviewed, and 2,834 examined). Findings from the HHANES include 24-hour recall, adolescent and adult history questionnaire, alcohol consumption, blood and urine assessments, body measurements, child history questionnaire, dental health, diabetes and oral glucose tolerance test, dietary practices and nutrient intake, drug abuse, gallbladder ultrasound, hearing, electrocardiogram, depression, pesticide data, physician's examination, and vision.

The Hispanic Health and Nutrition Examination Survey was developed and implemented as a response to the five population-based national health examination surveys conducted by the NCHS between 1960 and 1980. While Mexican Americans, Cuban Americans, and Puerto Ricans were included in probability samples of the national health surveys conducted between 1960 and 1980, the number of persons in these groups was insufficient to enable adequate estimation of general Latino/a health conditions, and specifically of these groups. Similar to the previous national health examination surveys, data collection for HHANES was conducted through interviews to collect medical histories, surveys, direct physical examinations, and laboratory and clinical tests and measurements (e.g., of blood lead levels and prevalence of specific conditions). De-identified data for HHANES and all National Health and Nutrition Examination Surveys are publicly available and housed in the Epidemiology Data Resource Center. The description of the HHANES sample design and operational plan is available through the U.S. Department of Health and Human Services.

One compelling set of findings from HHANES related the prevalence of diabetes, which is higher among Mexican Americans than among the non-Latino/a caucasian population. Higher serum levels of organochlorine pesticides in Mexican Americans, discovered through the questionnaire and laboratory data testing to exposure to pesticides and other environmental toxins, led to further research to analyze associations between pesticide exposure and diabetes.

The collection of the HHANES pesticide laboratory data was a collaborative effort by the U.S. Environmental Protection Agency (EPA), in collaboration with the NCHS. During the direct physical examination, urine and blood specimens were obtained from a half sample of persons aged 12 to 19 years and a group aged 20 to 74 years. Blood and urine specimens for each person surveyed in the HNANES subsample were analyzed at the EPA's Environmental Chemistry Laboratory Toxicant Analysis Center. Farm work histories and pesticide exposure data were collected in the HHANES Adult Sample Person Questionnaire implemented in each household in the sample. Additional information on pesticide exposure was collected as part of the Adult Sample Person Supplement survey instrument administered in the mobile examination center. The Environmental Chemistry

Laboratory Toxicant Analysis Center analyzed the blood and urine samples for seven pesticides or pesticide metabolites, including p,p'-DDT (dichlorodiphenyltrichloroethane), p,p'-DDE (dichlorodiphenyldichloroethylene), dieldrin, oxychlordane, β-hexachlorocyclohexane, hexachlorobenzene, and transnonachlor. Studies reported a link between higher serum levels of certain organochlorine pesticides and an increased prevalence of diabetes.

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See Also: Hispanic Americans; Hispanic Immigrants; *Journal of Immigrant and Minority Health*; Migrant Workers; National Alliance for Hispanic Health; National Center on Minority Health and Health Disparities.

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Hispanic Immigrants

Providing human services to Hispanic immigrants involves working with both legal and undocumented individuals, collectively referred to as foreign-born immigrants. In some ways, the needs of these two groups are similar; in many ways, however, they are very different. Hispanic Americans are frequently divided on their feelings toward undocumented immigrants. Hispanic Americans who were born in or who have legally immigrated to the United States may harbor resentment toward individuals who chose to immigrate illegally. In recent years, the resentment felt by legal immigrants has become diluted as feelings of compassion and empathy have increased toward those who immigrate to the United States covertly. Many Hispanic Americans now realize that undocumented immigrants are seeking to escape the deplorable living conditions and corrupt governments that often place seemingly insurmountable barriers in the immigration path, and now look more favorably on both legal and illegal immigration.

This developing acceptance appears to coincide with the growing crime and violence present in many Hispanic countries. Between 1990 and 2010, the estimated population of undocumented immigrants in the United States increased more than threefold, from 3.5 to 11.4 million. This unprecedented growth dramatically increased the likelihood that service professionals will encounter undocumented immigrants in their professional practice.

Mexico is by far the leading source for undocumented Hispanic immigrants, followed by El Salvador, Guatemala, and Honduras. Hispanic immigrants often gravitate to cities with large Hispanic populations, such as New York City, Los Angeles, Chicago, and Houston. These destinations make it easier to blend in because of the common culture and language. Cultural differences and language barriers may serve to reinforce ethnic stereotypes. Human services professionals are ethically bound to treat all Hispanic clients the same, regardless of immigration status.

Split Families

Human services workers should be aware that split family dynamics are fairly common among immigrants. Immigration to the United States, legal or otherwise, is a very expensive proposition. It is fairly common for one family member to immigrate first in order to work and earn the money necessary to bring additional family members into the United States. Families may be split between two countries for years. Furthermore, in some cases

Mexican immigrants march for more rights in San Jose, California, in 2006. Approximately one out of every 27 people living in the United States is an undocumented immigrant, and the number continues to climb each year. As violence and government corruption in Hispanic countries steadily increases, more of these individuals are seeking refuge in the United States.

a Hispanic family may be split because a family member is deported to the country of origin and thus separated from family and children. Undocumented immigrants may be reluctant to seek help out of fear of deportation.

Language Barriers

Probably the most obvious problem encountered when working with Hispanic immigrants is the language barrier. Hispanic immigrants typically speak Spanish, and therapists and social workers fluent in Spanish are often scarce in remote locations. The language problem is compounded because required forms, such as informed consent and release of information forms, are rarely available in Spanish. It is unethical for clients to sign forms they do not understand.

Human services workers should never make assumptions concerning Hispanic clients based on language fluency. Not speaking English does not automatically label an individual as an undocumented immigrant. Citizenship requires an individual to speak, understand, and write English; however, legal immigration does not. An individual who does not speak English may still be in the United States legally. Furthermore, surveys report that 75 percent of Hispanic households speak Spanish in the home. It is not unusual in a Hispanic household for children to be more fluent in English than their parents and to act as their translators.

Health Insurance

Health insurance among undocumented immigrants is nearly nonexistent. Insurance companies require a valid Social Security number at the time of application, which undocumented immigrants do not have. Some immigrants possess forged identification documents to aid in securing employment;

however, in regard to health insurance, most consider the risk of exposure too great. Practitioners may discover that immigrant clients will participate in services only when they can pay cash. These same clients may forgo or postpone services if they are not able to afford them at the time of service.

Trust Issues

Undocumented immigrants have a lot to lose by trusting others. Deportation by U.S. Immigration and Customs Enforcement (ICE) can change lives, separate families, and forever alter a person's future. Many immigrants were raised in poor and unsafe countries, where unscrupulous and corrupt officials often betrayed their trust. These individuals learned to associate authority with corruption, and human services workers represent authority to them. It should not be surprising that these individuals have difficulty trusting human services workers.

In many Hispanic countries, human services are a luxury afforded by the rich and are not available to the lower classes. A stranger in the United States offering help may seem unusual and even suspicious to many immigrants. Being real with clients and taking a genuine interest in their culture will go a long way toward building the initial trust bond. Immigrant clients need to feel safe before they can disclose.

Confidentiality

Client confidentiality extends to immigration status. Inquiries regarding clients' immigration status may serve to frighten or intimidate clients and prevent them from making full disclosure regarding their need for help. When working with undocumented immigrants, it is best to limit personal identifying information to those questions necessary for the clients' assessments and diagnoses.

Clients may view specific questions regarding contact information as intrusive or disrespectful. When interviewing clients with unknown immigration status, the professional should practice empathy and consider what he or she would personally be comfortable in disclosing. The human services worker should use this insight when selecting the right questions to ask; clients should never be pressured into disclosing anything they feel uncomfortable sharing.

Approximately one out of every 27 people living in the United States is an undocumented immigrant, and the number continues to climb each year. As violence and government corruption in Hispanic countries steadily increases, more and more of these individuals are seeking refuge in the United States, and human services providers are increasingly likely to encounter Hispanic immigrants in professional practice. Professional ethics dictate that practitioners familiarize themselves with the culture and idiosyncrasies relevant to this growing population.

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See Also: Hispanic Americans; Immigrant Populations, Human Service Needs of; Immigration, Human Services Issues.

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Hmong Immigrants

The Hmong (pronounced hmoong or hmawng)—a group identifying strongly as Hmong, Hmong American, or generally Southeast Asian—has language, cultural practices, and traditions that are unique from other Asian groups. Those living in the United States today identify mainly as coming from Laos; they were granted refugee status because of their alignment with the United States during the Vietnam War. Even though the Hmong are a smaller ethnic group, they are cohesive and prolific, characteristics that helped preserve the qualities of a discrete cultural group despite the lack of a true motherland. In balancing their role as a diasporic group, the Hmong are culturally proud while open to growth, building inroads and connections with the larger community. A group in transition, some

Hmong have flourished since arriving more than 35 years ago; however, the service needs of the Hmong must not go unnoticed or lumped into a larger category of model minorities.

Background

The early history of the Hmong is challenging to trace, partly due to their multiple migrations. Caution should be used with regard to equating the history of the Hmong with that of the Miao or Meo—terms viewed as derogatory by the Hmong. Hmong groups began a gradual southward migration from China in the 18th century due to political oppression. Historically known for being frequent migrators with a preference for mountain living, the Hmong people's isolation may have contributed to their tight clan structures. The Hmong were agrarian; they cultivated rice, bred fish, and developed irrigation systems for their crops. The Hmong value family and typically have large families. In Laos, the Hmong were mountain-dwelling farmers as well as lowland inhabitants attaining education, working for the government, and conducting commerce. Prior to the Vietnam War, between 300,000 and 400,000 Hmong lived in Laos. Hmong in Laos were mainly White and Green Hmong. The dialects of these two subgroups are mutually intelligible.

Migration of the Hmong to the United States

In Laos, many Hmong fought in the so-called Secret War, serving the U.S. Central Intelligence Agency, and resulting in their persecution after the war. Some Hmong are fiercely proud of this service to the United States, which has mostly gone unnoticed. The disproportionately high death toll of more than 100,000 bespeaks a circumstance in which nearly every Hmong family in the United States has a tale of loss and tragedy related to the war.

Between 1976 and 2005, about 100,000 Hmong immigrated to the United States. The lag in migration implies that some Hmong may have spent significant time in Thai refugee camps. The 2010 U.S. census data show that 260,073 Hmong resided in the United States, with the largest communities in California (91,224), Minnesota, (66,181), and Wisconsin (49,240). Hmong individuals live in every state in the United States, and the majority are under 30 years old, representing one of the youngest populations per capita.

Hmong Written Language

Many Hmong are illiterate in their own language. Scholars postulate that the ancient written language of the Hmong was lost after being banned centuries ago. To communicate, Hmong women disguised their alphabet in the intricate patterns of their tribal dress, a tradition passed down from mother to daughter but inevitably lost due to frequent forced migration. The current language is in the romanized popular alphabet developed in the 1950s by Western missionaries in Southeast Asia. The Hmong language has eight distinct tones, which are noted by assigned letters that are not pronounced, a format contrasting with that of the pronunciation-driven letter system in the English language. The Hmong prefer to pass down traditions orally and visually, a tradition that can be seen in *Pa Ndau*, flower cloths with intricate embroidery patterns communicating well wishes through symbols.

Oral Language

Unlike the written language, there is stronger emphasis by Hmong families to continue speaking Hmong. Most Hmong are bilingual, speaking Hmong and the language of the country. For older Hmong, the second language is likely Laotian and/or Thai, whereas for younger generations it is English. The 2000 U.S. census data show that 34.8 percent of Hmong were linguistically isolated. (This statistic is 4.1 percent of the U.S. population) Sixty percent of Hmong in the United States speak the White Hmong dialect and 40 percent speak the Green Hmong dialect. Green Hmong speakers are more likely to learn White Hmong than vice versa, and younger generations are more likely to speak White Hmong.

Education and Socioeconomic Conditions

Prior to coming to the United States, many Hmong had little or no access to schools. Many Hmong immigrants were adults or young adults upon arrival in the United States. Data from the 2000 U.S. census show that 45.3 percent of the Hmong in the United States have had no formal schooling. (This statistic is 1.4 percent of the U.S. population.) In general, the lack of education, language barrier, and lack of job training contributed to poor socioeconomic conditions for the Hmong, with 29.8 percent in poverty (14.3 percent of the U.S. population), relying on self-employment, menial jobs, or welfare programs for income and health services. As an evolving group, about 13 percent have attained a bachelor's degree or higher, a proportion that has doubled between 2001 and 2010. Data also support that among Hmong women, 80.3 percent were attending college, a slightly higher rate than their male counterparts (78.2 percent).

Religion

About two-thirds of Hmong in the United States continue to practice the traditional animism and shamanism. Visible examples of adherence to this practice can be seen in some Hmong wearing accessories such as red necklaces, white cloth bands, and red or white strings. Hmong traditionally believe that these amulets ward off evil spirits to keep the soul inside. Shamanism continues to play an integral part in Hmong culture in the United States, particularly around life events such as births and deaths. Most of the remaining third are Christians, although the proportion may be higher in some states. Additionally, some Hmong hold a combination of traditional and Christian beliefs.

A People in Transition

Although more is known about general adjustment issues, not much is known about continued growth and assimilation. There is limited information on women and gender equity within the culture. Traditionally paternalistic, Hmong have had to adjust to greater roles for women in U.S. society. While arguably a small percentage, information on success strategies of middle-to-upper-class Hmong professionals is currently lacking. Finally, there is limited information on the persistence of influences of elders in a judicial society. As a group balancing sustaining identity and assimilation, more attention needs to be focused on these and other changing trends.

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See Also: Acculturation; Asian Immigrants; Refugee Assistance; Southeast Asian.

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Holocaust Survivors

During Word War II, German Nazis and their collaborators murdered some 6 million Jews. Others were forced into ghettos and concentration camps, where they lived under unspeakable conditions. Large numbers starved to death, and those who survived retained the memories of constant hunger for the rest of their lives. While incarcerated, they lost access to proper hygiene and sanitation and had no preventive health care. The Holocaust has been relegated to history by generations born long after World War II, but it remains a vivid and terrifying memory to those who survived it.

World War II ended in 1945, and those in hiding and in concentration camps were freed. This means that most survivors were children during the Holocaust. The trauma experienced by these survivors included the loss of the right to live in safety and develop as normal children. The traumas they suffered have also affected the emotional health of their own children and grandchildren. Human services professionals and members of the medical community have spent decades helping these survivors and their descendants deal with the aftermath of the Holocaust.

In 2013, approximately 500,000 Holocaust survivors were living around the world. That number declined from 687,900 in December 2008. Approximately 120,000 survivors were living in the United States in 2013, and their average age was 80. Three out five were female, and two-thirds

Holocaust survivor Rose Schindler shows the prisoner number tattoo on her arm. As they have grown older, many Holocaust survivors have experienced recurrences of the traumas associated with the period they spent in concentration camps, hiding from the Nazis, and watching family members and friends die or be taken away never to be seen again.

lived on their own. Between 2005 and 2013, the number of Holocaust survivors needing home care increased by 450 percent. Nearly one-third of these survivors live in poverty. The poverty status is particularly common among those who came to the United States after the fall of the Soviet Union in the late 1990s and for those living in large cities, such as New York, where more than half of all Holocaust survivors live in poverty. As they have grown older, many Holocaust survivors have experienced recurrences of the traumas associated with the period they spent in concentration camps, hiding from the Nazis, and watching family members and friends die or be taken away never to be seen again. Once labeled victims of the so-called concentration camp syndrome, Holocaust survivors are now considered victims of post-traumatic stress disorder (PTSD). The survivors often look to government agencies for help in meeting their daily needs and in dealing with the continued impact of the Holocaust. Others turn to Jewish organizations, which help with everything from counseling to housekeeping and personal grooming services. In 2013, the current German government acknowledged the sins of the past and agreed to pay a billion dollars over a four-year period to meet the needs of Jewish Holocaust survivors.

Lingering Traumas

Even Holocaust survivors who went on to build successful lives and seemed to have adjusted well emotionally may begin to experience traumas as they age, resulting in a variety of illnesses and feelings of dependency, isolation, institutionalization, a loss of family members, and a constant feeling that death is drawing near. The limitations caused by an increasingly frail human body may bring on recurrences of feelings experienced during the Holocaust, particularly the loss of privacy and the lack of control over their own lives. Aging Holocaust survivors may also experience an ongoing sense of loss. Major illness, such as a cancer diagnosis, can send a Holocaust survivor into a spiral, and trauma may be brought on or worsened through conditions such as dementia. Institutionalization, which may include nursing homes, assisted living quarters, or prolonged hospital stays, has proven to be particularly traumatic for many Holocaust survivors, who equate institutional life with the years spent in hiding or in concentration camps. Because survivors frequently suffer from PTSD, taking showers, having blood tests or surgery, or experiencing smells and sounds similar to those associated with Holocaust experiences can trigger flashbacks to the Holocaust. Survivors living in Israel during the Gulf War of 1990 were hit with an onslaught of memories that led to a recurrence of traumatic symptoms. Emotions common to many Holocaust survivors include anxiety, depression, impaired cognition, impaired memory, nightmares, psychosomatic symptoms, changes in personality, general rigidity, and emotional withdrawal.

Somewhat surprisingly, researchers have learned that those who were children during the Holocaust have often experienced more severe traumas as they age than were experienced by those who were adults at that time. The most traumatic aftermath has been observed in those who were small children and thus were still in their formative years. For the rest of their lives, these survivors may feel abandoned, experience memory loss or fragmentation of memories, and have trouble revealing their emotions to others. Immediately after World War II, researchers found that surviving orphans often clustered together in orphanages and were unable to trust anyone outside their own groups.

By the 1980s, a number of major studies had been conducted on survivors who were children during the Holocaust, generally revealing that children under 4 years of age during the Holocaust tended to exhibit neurotic tendencies as adults. The most common emotion felt by those who were ages 11 to 14 during the Holocaust was anxiety, and children older than 14 experienced reactive depressive symptoms. Symptoms were often more severe among survivors who had been separated from their families during the Holocaust because young children have an intense need to feel safe. As adults, members of this group continued to exhibit feelings of loneliness, bitterness, anger, and grief. Their ingrained fear of abandonment often prevented them from forming healthy relationships with their own children.

More specifically, those aged 5 to 8 years during the Holocaust may be unable to recall their experiences because they have buried them deep within. Even in the absence of conscious memories, they may still experience sadness, loneliness, a lack of belonging, and a feeling of detachment from others. Survivors who were between the ages of 8 and 12 may constantly seek validation, approval, and admiration because these significant elements in building self-esteem were missing when they were forced into ghettos and concentration camps. They may also be unable to concentrate well. Survivors who were between the ages of 12 and 15 were immediately forced out of childhood. This taking on of adult roles too quickly has often led to disillusionment, anger, and bitterness.

Experts do not agree on the therapeutic benefits of disclosure of Holocaust experiences. Trauma victims are generally encouraged to recount their experiences out of the belief that it is cathartic. In Holocaust survivors, however, the recounting of past traumas may be counterproductive, triggering recurrent distress.

Second and Third Generations

Even though many survivors refused to talk about their lives during the Holocaust, even to their own families, the traumas experienced by Holocaust survivors have frequently influenced the lives of their children and grandchildren. In the United States in the 1970s, 250,000 survivors' children entered adulthood at a time when political activism was particularly strong. These descendants used that momentum to find their own voices in addition to speaking for their parents, making sure that the Holocaust was never forgotten.

These activists had been motivated in large part by the publicity surrounding the trial of Adolf Eichmann, the Nazi official responsible for coordinating anti-Jewish activities for the Nazis, who was executed in Israel in 1962, and the Six Day War of June 5–10, 1967, in which Israel faced off against Egypt, Syria, and Jordan. The conscious-raising of the children of survivors led to the creation of a number of Holocaust museums and memorials. The most famous of these is the U.S. Holocaust Memorial Museum in Washington, D.C. President Jimmy Carter appointed a Commission on the Holocaust, which made recommendations for ways in which Americans could remember the victims, honor the survivors, and become educated about the Holocaust so that such an event could never again take place.

Despite the place of Holocaust survivors in the public consciousness since the 1970s, members of the third generation often suffer from their own traumas. They often experience anxiety, isolation, nightmares, insomnia, and constant fatigue. Those emotions may be triggered by specific events such as the death of the grandparent who was a Holocaust survivor.

Congressional Action

In December 2010, the U.S. House of Representatives unanimously passed a resolution (H.Con. Res. 323) pledging support for Holocaust survivors and promising to assist them through existing federal programs. At that time, more than half of the 127,000 survivors living in the United States were living below the poverty line. The following year, Representative Debbie Wasserman Schultz (D-FL) sponsored H.R. 2686, the Holocaust Survivors Assistance Act, with the intention of adding Holocaust survivors as a protected group under the Older Americans Act of 1965, charging the Administration for Aging within the Department of Health and Human Services with responsibility for assisting Holocaust survivors living in the United States, and establishing a grant program to fund transportation services for this vulnerable group. However, the bill did not pass Congress.

On May 21, 2013, Wasserman Schultz introduced the Responding to the Urgent Needs of Survivors of the Holocaust (RUSH) Act in the House of Representatives. Co-sponsors of the bill included Ileana Ros-Lehtinen (R-FL), Ted Deutch (D-FL), David Joyce (R-OH), and Henry A. Waxman (D-CA). The RUSH Act was designed to meet the needs of aging Holocaust survivors by funding home care services, including meal delivery, home modifications, and monitoring services; providing transportation assistance; and offering mental health counseling for those who need it.

The RUSH Act would also add Holocaust survivors to the list of priority groups already targeted for assistance by the Older Americans Act, first passed in 1965 as part of President Lyndon B. Johnson's War on Poverty. A similar bill was introduced in the Senate by Ben Cardin (D-MD), Mark Kirk (R-IL), and Barbara Mikulski (D-MD). Jewish organizations, including the Jewish Federations of North America, the Metropolitan Council on Jewish Poverty, Survivor Initiative, Association of Jewish Family and Children Agencies, the Anti-Defamation League, the Jewish Council for Public Affairs, and Self-Help Community Services, Inc., announced their support for the RUSH Act. Despite strong bipartisan support for the bill, however, it stalled in committee.

Conclusion

The needs of Holocaust survivors will continue to be a significant factor in the allotment of human services resources in the 21st century. In addition to the vulnerabilities that affect other aging Americans, Holocaust survivors have needs that are significant to their unique experiences. Even when there are no more surviving witnesses to the Holocaust, second and third generations will look to human service agencies to help them deal with the impacts of being descendants of those survivors. As more is known about PTSD and its effects on family members, it may be possible to tailor human services responses in ways that are most suited to the needs of those descendants.

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See Also: Aging and Adult Services; Home Care Services; Hospitals; Mental Health Services, Adult; Nursing Home Care.

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Home and Community Services

Human services workers who work with clients who experience long-term illnesses or disabilities must be aware that risk factors, health behaviors, and responses of social support networks of clients vary by race, ethnicity, gender, national origin, and geography. To meet the widely ranging needs of their clients and to be effective, service providers need cultural competence and knowledge of diverse populations. Clients who experience long-term illnesses or disabilities often need support to live independently. Home and community services to meet these needs are provided by volunteers or via state and federally funded programs. These services, aimed at supporting clients to live as independently as possible, are client-centered and individualized. As far as possible, clients are involved in decision making regarding which services are provided. These services are usually long term in scope, and are primarily aimed at supporting individuals who might otherwise require care in nursing homes, hospitals, or other institutions due to illnesses, and/or physical, mental, or functional disabilities (including traumatic brain injuries, spinal cord injuries, chronic severe mental illnesses, dementia, and cognitive impairments, among many other conditions).

Many people with needs for assistance with homemaking, personal care, and developing and maintaining good social support networks are given help with these needs from family members, neighbors, and friends. In the United States, the number of informal caregivers who provide this kind of unfunded voluntary support is estimated to be 52 million or more.

Assistance and services are also provided via formally organized needs-based programs, and such programs are usually referred to as home- and community-based services. Financing of these programs is usually provided by pass-through funds, from federal to state governments. The majority of clients receiving state-administered home- and community-based services, often referred to as waiver programs, are qualified for other federally funded assistance programs, including Medicaid, Medicare, those of the U.S. Department of Veterans Affairs, and state insurance programs. States normally determine eligibility criteria for home and community services, and are able, under federal guidelines, to target services to specific illnesses or conditions. To qualify for these state-administered services, clients must meet both medical and financial guidelines.

Human services workers play important roles as advocates, referral sources, and providers of home- and community-based services. Human services workers are often the people who are responsible for the overall case management for clients who often experience complex medical and social disabilities. Human services workers who understand and can help clients and their caregivers navigate the numerous routes to obtaining home- and community-based services can play meaningful roles in helping individuals and their families maintain a good quality of life. An understanding of the diversity of social networks that provide informal support to clients can help human services workers and the client's community better provide personalized support.

Historical Background

The implementation of publicly funded home- and community-based services has undergone many changes in the past decades. Beginning in the 1960s, social reform movements and medical advancements, particularly in the treatment of mental illnesses, resulted in mass discharges of individuals from long-term care, many of whom had spent years living in hospitals and other institutions. Local health care providers often were not equipped to meet the needs of many of these individuals, who not only experienced complex medical needs, but also needed support in being able to live independently. The expansion of federally administered insurance programs, including Medicaid and Medicare, over the following decades was accompanied by a growing realization that local care, including home-based care, was often just as effective as care at a facility—if not more so—in helping clients maintain independence. Many of the programs developed at this time were limited in scope, however. In the early 1980s, new guidelines emerged that allowed states greater flexibility in developing and administering services. Greater emphasis was placed on ensuring that the services provided were at least equal to similar services that would be provided in nursing homes or other long-term care institutions. The increased emphasis on human rights for people with chronic illnesses and other disabilities was also influential in expanding access to these programs. Human services workers have played important roles in advocating for increased access to services for a more diverse group of clients and in helping evaluate the administration of these services at federal, state, and local levels to ensure that requirements for quality and level of services for clients are met.

Examples of Home- and Community-Based Services

Home-based services can include, but are not limited to, homemaker visits, support from home health aides, and help with personal care. Community-based services can encompass a range of activities and programs outside clients' homes, including day care programs for adults. Community-based programs can also benefit informal caregivers, who receive respite from their caregiving responsibilities.

Some human services workers who provide home services are referred to as direct care providers. These professionals work as home care aides and personal attendants for adults who need assistance due to medical issues or other disabilities. When clients' needs are more substantial, human services professionals take on coaching roles, helping clients learn how to manage budgets and maintain homes in good order. Other human services workers are employed with assistive technology services, helping clients find equipment and adapting home environments to their needs.

Human services workers who are employed in community-based services have a variety of job titles and responsibilities; they can work as educational assistants, as clubhouse managers and workers, as adult day care professionals, and as counselors and managers of community clinics. Human services workers with experience in home- and community-based services are also employed as managers and administrative personnel of programs providing these services.

Challenges to Home- and Community-Based Services

The need for human services workers in programs providing home- and community-based services is expected to grow. Aging populations and better availability of medical and technological supports for independent living, among other factors, have resulted in substantial growth within this area of human services. However, home- and community-based services face substantial challenges, including limited funding for programs, limited accessibility to programs, and the need for well-trained professionals to staff these programs. Given the sheer number of volunteers providing informal home and community services, there is also a challenge to develop and implement more formalized support for these caregivers. Human services workers who are engaged in home- and community-based services play important roles in ensuring that these issues are addressed at local, state, and national levels.

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See Also: Community Action Agencies; Community Development Block Grants; Community Development Corporations; Community Health, Racial and Ethnic Approaches to; Community-Based Participatory Research; Community-Based Services.

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Home Care Services

Home care services are as diverse and individualized as the patients requiring those services. Services include medical, mental health, or behavioral interventions (or a combination thereof), which occur in an individual's immediate living environment. Home care service is becoming an increasingly necessary treatment modality. While home care may be provided to individuals of all ages, races, and socioeconomic backgrounds, population demographic changes imply an increasing global life expectancy, and as such, an aging population as a whole. Policies that have led to deinstutionalization and outpatient mental health services, as well as the increasing cost associated with inpatient health and mental health care, have led to a heightened importance of outpatient health and mental health treatment options that serve as alternatives to limited inpatient bed use.

Services provided may be dependent upon external issues such as insurance type, financial income requirements, and/or geographic factors. Geographic factors, such as whether the patient resides within a rural or urban area, affect both the availability of home care services and the cost of care. Patients living in rural communities face additional challenges, including limited community resources, increased care provision costs (e.g., additional mileage, provider transportation time, and care supply shipping), and lower availability of emergency medical or mental health interventions.

Ideally, prior to service provision, a client's level of functioning on health, mental health, and behavioral health outcomes will be assessed by a comprehensive team of practitioners, which may include physicians, psychiatrists, psychologists, social workers, and home care providers. After thorough assessment of client functioning, the treatment team collaborates with the patient to identify and design an appropriate plan of treatment. Such treatment plans are also referred to as discharge plans, plans of care, aftercare plans, or individual service plans.

Typically, treatment plans are diagnostically driven via medical, psychological, or behavioral health standards, and are considerate of best practice approaches for meeting patient needs. Each treatment plan should be formally written with specific, measurable, and objective goals, as well as a projected time line for the achievement of health or behavioral health landmarks. A patient's treatment plan will include analysis of his or her personal and community resources, and will identify the level of home care services from which the patient will benefit most.

Type and Duration

The type of home care services provided to any given patient are dependent upon his or her forms of disability, severity of disability, and possible resources for fulfilling the patient's needs. Home care services providers may fulfill an array of client needs, including medical care (e.g., medication management and administration, physical therapy, round-the-clock care, vital monitoring, patient mobility services, communication with a medical team, and nutritional consultation), mental health care (e.g., in-home mental health counseling, case management, and ongoing mental health assessment), behavioral health care (e.g., psycho-education, self-care strategies, and psychosocial behavioral modification), or personal care (e.g., personal hygiene such as bathing and grooming, dressing, food preparation, housekeeping, and grocery shopping). In addition to providing services within these three categories, home care service staff may be charged with providing companionship or supervision. Home care service provision can be categorized two ways: long term versus short term, and intensive versus nonintensive.

The duration of home service provision greatly varies by the severity of patient needs, and should be continuously reviewed by the treatment team. Long-term home care is provided to patients whose care needs are permanent or presumably slow-changing (e.g., patients who are deemed terminal, permanently disabled, or elderly) and may transition into end-of-life care, including hospice and palliative care. Short-term home care is provided to patients whose conditions are not permanent and are anticipated to improve (e.g., patients recovering from surgery or physical trauma and who are expected to experience recovery through occupational or other therapeutic services).

Intensity

Intensity of home service provision also greatly varies by the severity of patient needs and the extent to which the patient is able to function in the health, mental health, and behavioral health arenas. Intensity of care should be expected to change over time, depending on a patient's speed of recovery and incidences of readmission or reinjury. Intensive home service provision is often characterized by a treatment plan indicating need for support in multiple arenas of functioning (i.e., medical, mental health, and behavioral health) or life-dependent needs in any one arena. Intensive home services may include a need for specialty medical equipment or provider specialization. Nonintensive home service provision is often characterized by a treatment plan indicating need for support in a few arenas of functioning and by support needs upon which life is not dependent. To ensure that patients receive the most effective and highest quality of care, the accuracy and appropriateness of a patient's treatment plan should be regularly assessed by his or her comprehensive treatment team.

Standard home care services are typically delivered in a stepped-down care approach. Stepping down is generally defined as transitioning a person from an initial level of care down to a lower level of care as health or healing improves. To achieve this, practitioners continually assess patient or client needs and adjust case plans appropriately.

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See Also: Aging and Adult Services; Case Management Services; Disability Services; Elder Care/Geriatric Services; Nursing, Public Health.

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Homelessness

Homelessness is experienced by approximately 700,000 Americans on any given night. People are considered homeless if they lack access to a fixed, regular, and adequate nighttime residence. This problem affects individuals and families across racial, ethnic, geographic, and educational classifications. Agencies serving the homeless and their staffs are required to be familiar with a vast array of social services options in the public, private, and nonprofit sectors. Due to the diversity of homeless clients, agencies must provide expertise in a variety of service areas, including mental health, substance abuse, legal aid, financial counseling, public benefits, job training, and educational opportunities.

Homeless Service Systems

The U.S. Department of Housing and Urban Development (HUD) divides the nation's homeless service delivery systems into continuums of care, or CoCs. Each CoC is a specific geographic jurisdiction to which federal homeless services funds are distributed. CoCs also serve as a guideline for cross-agency coordination of services, planning, and data collection. The CoCs range from exclusively rural to urban cores. Moreover, some CoCs comprise entire states (e.g., Delaware), whereas others are single cities (e.g., Nashville). The CoC diversity creates unique challenges in the production, administration, and implementation of homeless services with respect to outreach, housing placement, transportation, and coordination of social service coalitions. As a result, CoC leadership and management must be trained in and have knowledge of program administration as well as the unique federal, state, and local policies governing their respective jurisdictions.

CoCs were developed as part of the McKinney-Vento Act, the first major legislative response to homelessness. Passed in 1987, the act established 15 programs for homeless assistance. In FY 2013, programs covered under the McKinney-Vento Act were allocated $2.03 billion in funding. McKinney-Vento remained the only major legislation targeting homeless relief and assistance until the passage of the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act) in 2009. The HEARTH Act changed the administrative, jurisdictional, and operational management of homeless programs and provided clarification on ambiguities (including the official definition of homelessness) across governmental units. The McKinney-Vento and HEARTH acts established rules and programs governing homeless-specific programming, but homeless clients also utilize resources across public programs, including public benefits and the War on Poverty programs.

Service Coordination

Homeless clients face diverse needs; therefore, homeless service systems must create processes to assist clients in accessing a multitude of services to meet those needs. Whereas larger service agencies are often able to provide a number of onsite services, many homeless social services organizations coordinate services to ensure access for clients across the service area. For example, within a CoC, one organization may serve as the primary provider of mental health counseling while another provides bus passes. CoCs work across sectoral and territorial boundaries to identify the best procedures to establish service delivery for clients. Nonprofits and government agencies work together in an increasing number of innovative ways. Moreover, over the last decade, CoCs across the nation have implemented Homeless Management Information Systems (HMISs) to create streamlined service delivery and case management. HMISs use a coordinated database across homeless service agencies, which allows organizations to share basic client and service information to facilitate collaboration and fast-track service delivery. Through HMISs, CoCs have been better able to collect aggregate client data, which, in turn, assists in planning, needs assessment efforts, and gap identification.

Agency Diversity

Homeless citizens seek services from agencies ranging in size from small volunteer-based and faith-based food closets to large affiliates of multinational nonprofit organizations. Agency diversity necessarily results in diversity of staff qualification and training. Volunteers at a faith-based food closet are less likely to have obtained specific training in nonprofit management, social work, or human services. They are also less likely to be fluent in the processes of public benefits administration and eligibility. At the same time, all homeless service agencies are filling a specific need. In addition to the aforementioned agency types, homeless clients seek assistance from a wide variety of social services agencies in both the nonprofit and public sectors. Public mental health, substance abuse, housing, and veterans and human service agencies, as well as nonprofit street outreach, mental health counseling, educational training, and housing agencies all serve homeless citizens. The private sector also participates in homeless service provision in health care, housing, counseling, and employment. This diversity necessitates the enhanced efforts at agency coordination currently taking place in CoCs across the nation. These efforts are aimed at integrating services among all agency types to ensure clients have access to accurate information and pathways toward assistance.

Client Diversity

Homelessness occurs in every population and in every geographic location in the United States. Men, women, and children of every race and religion with a diverse number of health and economic needs face homelessness each day. The previously discussed areas of agency and service diversity have been established and planned to meet the needs of this clientele. These systems are constantly changing as information regarding client needs and demographics is being collected and analyzed. Moreover, professional training is being modified to ensure that staff can better serve clients facing unique challenges through culturally competent and appropriate procedures.

Over the past 20 years, researchers have identified a key factor in homeless client diversity— the homeless type. Clients can usually be identified as transitional, episodic, or chronically homeless.

- Transitional homeless clients are those experiencing homelessness due, most often, to an unforeseen economic or familial event that temporarily displaces them. These clients are best assisted through short-term housing placement with referrals to public aid, employment opportunities, and/or other case-specific needs (e.g., legal services, credit counseling, rental assistance programs).
- Episodic homeless clients face ongoing, short to medium bouts of homelessness due to ongoing economic, health, familial, and/or legal concerns. These clients often

Passersby helping a homeless person in New York City by giving him food. People are considered homeless if they lack access to a fixed, regular, and adequate nighttime residence. Individuals and families across racial, ethnic, geographic, and educational classifications can become transitional, episodic, or chronically homeless.

require transitional housing placement (six to 12 months) and wraparound supportive services and case management.
- Chronically homeless clients are those individuals who have experienced one year of homelessness and/or four bouts of homelessness in three years and have an accompanying disability.

Qualifying disabilities include physical and mental disabilities as well as HIV/AIDS and substance abuse addiction. Chronically homeless individuals require long-term, often permanent, housing placement with broad supportive services, medical care, and case management. Single males between the ages of 30 and 60 years constitute the majority of chronically homeless clients. The large majority of the chronically homeless have co-occurring mental health and substance abuse disabilities and have spent years in and out of homeless and housing programs as well as hospitals, treatment centers, and jails.

Since the recession began in 2008, the fastest growing homeless demographic is families with children. These clients usually face transitional homelessness and were specifically targeted by the American Reinvestment and Recovery Act of 2009 through the Homelessness Prevention and Rapid Re-Housing Program (HPRP) administered through HUD. HPRP focused on preventing homelessness before it occurred by providing eligible clients with monies needed for rent, arrears, legal fees, utility fees, and other items contributing to the threat of homelessness. The rapid rehousing portion of the program focused on getting clients into long-term, stable housing right away rather than emergency shelters or transitional options.

Another population facing increasing rates of homelessness is that of veterans. The economic and medical effects of the wars in Iraq and Afghanistan created a new subpopulation among veterans. Veterans face unique needs, and collaborative efforts between Veterans Affairs and social service organizations are imperative to ensure that an appropriate plan of action is established for each client.

Caring for the Homeless

As previously indicated, homeless clients face diverse and unique circumstances requiring a cadre of professionals ranging from shelter night staff to medical doctors and psychiatrists. Industries as diverse as pharmaceuticals to higher education are involved in aspects of homeless social services delivery. Therefore, it is vitally important that training on homelessness and competencies related to accessing services and caring for the population are included in training and educational curricula across vocational and academic disciplines.

These competencies include promoting cultural and personal sensitivity to homelessness as an economic, medical, and social phenomenon; understanding public policies impacting homeless services; navigating systems of care; and fostering professionalism in day-to-day management of and interaction with homeless clients.

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See Also: Housing Services; Housing Support and Homeless Services; Mental Health Service Delivery, Cultural Characteristics of; Poverty; Veterans Services; War on Poverty Programs; Wraparound Services/Systems of Care

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Honor Killings

Honor killings refer to the acts of homicide that generally take place in a family or a closed social group. In such cases, a member of a family or any other radical member of an orthodox culture or community kills another member on the charge of bringing dishonor or shame for that familial or social group by any act generally taken as taboo therein. There may be any number of reasons for making a person the victim of honor killing. Generally, these include a love marriage rather than an arranged marriage, free sexual conduct, a woman's entering into a relationship without the consent of the elders, interreligious/intercaste marriage, adultery, being the victim of rape, dressing unconventionally, and a homosexual relationship. Honor killing is culture-oriented and has emerged as a crime of passion.

Since human services aims at providing direct care services for humankind at large, and it is committed to ameliorate human problems, the information on honor killing requires scrutinizing different stakeholders on this practice. Its implication has greater importance in policy making and executing the policies concerned.

Although religions never dictate such practices, the orthodox lobby therein has always cited the scriptures on the act of honor killing. The Napoleonic Code (1804), prepared in the regime of Napoleon Bonaparte, legislated for honor killing. Under the provisions of the code, the punishment for the murder of a wife by her husband in a situation in which he finds her in the act of adultery could never be treated similarly to that of a premeditated murder; rather, the husband would be charged with other lesser offenses. The wife did not have even the right of defense. Napoleonic Code has been a source of legislation in many countries, and thus for centuries has affected the system in favor of honor killing.

Cases of honor killing have been found in almost all regions of the world; the practice is seen more frequently in the countries of India, Pakistan, Afghanistan, Egypt, Jordan, Lebanon, Morocco, Haiti, Syria, Turkey, Yemen, France, Italy, and Germany, as well as among some communities of the United Kingdom. In these countries, honor killing is a unique form of practice followed by members of various communities despite the forces of modernization, urbanization, and globalization. In a random survey in societies where the practice of honor killing is seen, people argue that it is done in order to save the family from shame and embarrassment. Many times, such deaths are not reported by the family members for obvious reasons. Whatever the argument of the supporters of honor killing, it is quite an unholy tradition that has not only tainted humanity but also human conscious and values. The very basic question that would likely be posed by progenies would be, "What is honorable in honor killing?"

This tradition is surviving on the whims of orthodoxy-ridden power-hungry elders of the culture. Various attempts have been made by social reformers across the globe for doing away with the practice of honor killing, and much has been done in this direction. Some of these efforst include the United Nations (UN) Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which forces the member countries to put a ban on practices such as honor killings. CEDAW General Recommendation 19 states that "traditional attitudes by which women are regarded as subordinate to men or as having stereotyped roles perpetuate widespread practices involving violence or coercion, such as family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision. Such prejudices and practices may justify gender-based violence as a form of protection or control of women. The effect of such violence on the physical and mental integrity of women is to deprive them the equal enjoyment, exercise and knowledge of human rights and fundamental freedoms." The UN General Assembly Resolution working toward the elimination of crimes against women and girls committed in the name of honor is another international effort designed to curb the practice of honor killing. It calls upon the UN member states to do the following:

- Intensify legislative, educational, social, and other efforts to prevent and eliminate honor-based crimes by involving public opinion leaders, educators, religious leaders, chiefs, traditional leaders, and the media in public education
- Encourage, support, and implement measures to increase the understanding of legal and health professionals of the causes and consequences of honor-based violence;
- Establish, strengthen, or facilitate support services, such as appropriate protection, safe shelter, counseling, legal aid, rehabilitation, and reintegration into society, for actual and potential victims

- Create, strengthen, or facilitate institutional mechanisms to assist safe and confidential reporting for victims and others to report honor crimes
- Gather and disseminate data on honor-based crimes.

Both the UN General Assembly Resolution for working toward the elimination of crimes against women committed in the name of honor and the UN General Assembly Resolution for working toward the elimination of crimes against women committed in the name of honor (A/RES/59/165, (2005)) both call upon UN Member States to take similar actions to eliminate honor-based crime and violence. The Human Rights Committee's General Comment No. 28, "Equality of rights between men and women," states that the commission of so-called honor crimes that remain unpunished constitutes a serious violation of the Covenant and in particular of articles 6, 14, and 26. Laws that "impose more severe penalties on women than on men for adultery or other offences, also violate the requirement of equal treatment" (HRC, Article 3, Para 31, general comment no 28). The International Convention on Economic, Social and Cultural Rights (ICESCR) entrusts a specific legal obligation upon Member States to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including female genital mutilation, that may eventually become reasons for honor killings.

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See Also: Domestic Violence; Domestic Violence, International Variations in Attitudes Toward; Domestic Violence, Victims of; Female Genital Mutilation; Subcultures; Women, Battered.

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Hospice Services

Hospice services are becoming increasingly less stigmatized and more utilized in the United States, especially due to Medicare changes, length-of-stay limits in inpatient hospitalizations, and a changing public dialogue on death and dying. Once viewed as the final option in care for those who were terminally ill, offered only at the point when medical treatments were no longer available or accessible, hospice care is now often represented and understood as a treatment option that includes holistic care, pain control, and a focus on quality of life. In 2011, 1.65 million people in the United States received hospice services, an increase from 1.4 million in 2007. Of the people receiving hospice services, almost 600,000 of them either continued on with services into the next year, or were discharged due to an improvement in condition/prognosis or to continue to seek active treatment.

History of Hospice

Hospice services date back centuries, as they were first provided as a way for ill and dying travelers and crusaders to receive care. In the 1900s, care became more focused on patients with common diagnoses and less on care for travelers. Most hospice services, however, were tied to religious organizations. In the 20th century, two pioneers of the modern hospice movement brought care for terminally ill patients into public acceptance. Dr. Cicely Saunders, who in 1967 founded St. Christopher's, the first modern hospice, conceptualized the three tenets that hospices still use across the world. These specifically addressed the concept of "total pain," including physical, spiritual, and psychological discomfort; the proper use of opioids for patients with physical pain; and attention to the needs of family members and friends who provide care for the dying. During the same time period, Elizabeth Kubler-Ross published *On Death and Dying* in 1969, which shed light on the end-of life journey of terminal patients. Kubler-Ross even recommended in-home care for the terminally ill in front of the U.S. Senate in 1972. Hospice care provided in the United States shifted in the 1970s to a unique medical specialty and was no longer a service provided on a religious or volunteer basis.

Hospice Eligibility

Hospice services are still often misunderstood as to what, and how, the services are provided. In 1982, Congress passed a Medicare Hospice Benefit in an effort to improve end-of-life care and reduce medical costs associated with terminally ill patients. Private insurance, the Veterans Administration, and Medicaid all have a hospice benefit included in their plans. In 2011, 84 percent of hospice patients were covered under the Medicare Hospice Benefit. Managed care, private insurance, and self-pay patients composed approximately 14 percent of people receiving hospice services. For those who are uninsured or impoverished, hospice services are still available to them. Over 7 percent of hospice patients receive care through either the Medicaid Hospice Benefit, uncompensated or charity care, or through another payment source. This commitment to providing comprehensive end-of-life care to everyone, regardless of payer status or ability to pay, makes hospice services a viable option for every American with a terminal illness.

The Medicare Hospice Benefit covers a set menu of services; most hospices provide these services as a part of their care whether the patient is using the Medicare benefit or not. Hospice services include nursing care to provide intermittent assessment, support, skilled services, treatments, and case management services; social work to provide supportive counseling, coordinate other community services, and assist with planning aspects like health care surrogates and advance directives; chaplain and religious support/counseling; home health aide and homemaker services; speech therapy, nutrition, physical therapy, and ocupational therapy services; bereavement support; a hospice medical director; medications and supplies for management and palliation of the advanced illness; and durable medical equipment including a hospital bed, commode, wheelchair. The hospice benefit also provides for short-term general inpatient care for problems that cannot be managed at home, such as pain, dyspnea, delirium, and other acute skilled needs; short-term respite care to permit family caregivers to take a break; and continuous care at home for short episodes of acute need (crisis care).

Although specific criteria can often vary from agency to agency, there are general guidelines for hospice eligibility. Typically, in order to qualify for hospice services, a patient must have a terminal diagnosis. This is specifically defined as a disease that, if it were to follow its normal course, would not result in a life expectancy greater than six months. Patients agree to no longer be hospitalized or actively treated for their disease and instead use hospice services to provide end-of-life care.

Diversity of Hospice Patients

Hospice services are provided to patients with many different diagnoses. Although over a third of hospice patients (37.7 percent) have some form of cancer, the other half have a wide variety of illnesses, including heart disease, lung disease, liver disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), dementia (including Alzheimer's), and failure to thrive. Any condition that has a physician-certified prognosis of less than six months would qualify for the care hospice provides.

The largest age group receiving hospice services in the United States (almost 40 percent) are people over 85. However, hospice services are not only for elderly patients; services are provided to all ages, including newborn babies who are born with terminal conditions. In fact, almost a quarter of hospice patients are under 65 years of age.

Although the majority of people who utilize hospice services are Caucasian, minority clients still make up a substantial portion of hospice patients. Over 8 percent of patients identify as Black/African American, 2.4 percent Asian, Hawai‘ian, or Other Pacific Islander, 0.2 percent American Indian or Alaskan Native and 6 percent multiracial or other race. Additionally, 6 percent of all patients were identified as being Hispanic or Latino.

Inpatient Hospice Versus In-Home Hospice

Because hospice is a service and not a place, people can receive hospice services in different locations. Forty percent of patients receive hospice care in their home, where they can be in their own surroundings and with no restrictions on visitation. This option often works best when the patient also has a family member or friend who can provide 24-hour care when the hospice staff is not in the home. In fact, many hospice agencies will require, if the patient is receiving hospice care at home, that they have a caregiver prior to admitting them to the service. Hospice services generally include 24-hour care only in times of crisis and when death is imminent.

There are also times when people will receive hospice care in a facility. Hospice services can be provided in hospitals, nursing homes, assisted living facilities, and hospice houses. In all cases, the patient is not to receive any medical treatment that is intended for curative purposes. Receiving hospice care in the hospital is rare, since hospitals are used to provide acute care. Occasionally, a patient will be too ill to transfer to another facility or to their home and hospice will take over care of the patient while they are in the hospital. Hospice care in nursing homes and assisted living facilities is more common. Hospice services can be implemented in these facilities as a supplement to the custodial care the patient already receives and an additional caregiver is not necessary. Many hospices contract with nursing homes and keep several beds as "hospice beds" to accept patients when they are discharged from the hospital on hospice or otherwise started on hospice care. Hospice houses are homes or buildings that are exclusively for hospice patients and are often geared to people who lack a strong support system or financial means. In a hospice house, all hospice services and lodging are provided in the facility.

Palliative Care

The formal World Health Organization description is that palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. Although the distinction between hospice care and palliative care is sometimes misunderstood or even omitted, there is a primary difference between the two forms of care. While hospice services are provided instead of active, curative treatments, palliative care treatments can be administered along with other active treatment measures.

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See Also: Hospitals; Medicare; Pain Management; Palliative Care.

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Hospitals

The delivery of medical care, in general, is in a constant state of flux. Postrecession United States has seen higher rates of uninsured Americans, rising health care costs, and a polarization of support for and opposition to the Affordable Care Act. With a population over 317 million, a life expectancy rate of 76 years for men and 81 years for women, and almost 14 percent of Americans age 65 and older, the United States is experiencing health care utilization in steadily increasing numbers. The dilemma of how to most effectively deliver adequate and accessible health care services continues to be a primary focus of private and public sectors and community and political interests. As a result, inpatient medical care in hospitals in the United States has experienced a metamorphosis in recent years, changing the way Americans view and understand hospital care.

Hospitals in the United States

In 1751, Dr. Thomas Bond and Benjamin Franklin founded the first hospital in the United States. Bond, an American who had studied medicine abroad and was exposed to the hospital movement in Paris, conceived the idea of opening a hospital in Philadelphia. Although the idea met resistance at first, the bill to establish a hospital to care for the sick poor of the province was eventually passed by the Pennsylvania Assembly and then signed into law by Lieutenant Governor James Hamilton on May 11, 1751.

Over the next century, many more hospitals were established in the United States. Hospital care, however, continued to primarily serve poor or isolated patients while middle-class and wealthy patients were treated in their homes. As the country became more industrialized, improvements in medical education and scientific advancements began to shift hospitals to highly modern and equipped medical training and research centers that provided cutting-edge medical treatment to paying middle-class and wealthy patients. By the early 1900s, scientific medicine was proving profitable and influential; the hospital had become an institution designed to cure conditions and advance medical knowledge. The period between 1910 and 1973 in scientific medicine has been referred to as a "golden age" of increasing influence, status, and wealth.

It was not until the later part of the 20th century that the effects of commercialized and corporate medical care began to change health care. Cost constraints and resource limitations in the United States changed the way many medical services were delivered. Procedures and treatments that were once typically inpatient hospital services were now provided on an outpatient basis and/or with limited inpatient treatments.

In the early 1980s, Medicare changed the way it provided payment to hospitals. Prior to this time, if a person was hospitalized, their care, treatment, and procedures would be itemized and insurance would pay the bill—a process that made it difficult to contain costs.

Policy makers changed this to a system of diagnosis-related groups (DRG), which categorized reasons for hospitalizations and paid the hospitals a set rate for delivering the services. Every admitting diagnosis, from heart failure to pneumonia to vaginal delivery, has a set price attached to it. If a patient is hospitalized for one of these diagnoses, the hospital receives the set rate for the diagnosis regardless of how long the patient actually stays in the hospital. The longer a patient stays in the hospital under the DRG payment system, the more money the hospital loses.

Hospitals Today

In 2012, according to the American Hospital Association (AHA), there were 5,723 registered hospitals in the United States; 4,999 of these were community hospitals—nonfederal, short-term general, and other special hospitals including academic medical centers or other teaching hospitals. (Registered hospitals that are not considered community hospitals are those not accessible by the general public, such as prison hospitals or college infirmaries.)

Nearly a million staffed hospital beds in the United States accommodated almost 36.2 million admissions in 2012. The total expenses for all U.S. hospitals in 2012 was $829.7 million

In the United States, hospitals are categorized in systems and networks. A "system" is defined by the AHA as "either a multihospital or a diversified single hospital system. A multihospital system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization. Single, freestanding hospitals may be categorized as a system by bringing into membership three or more, and at least 25 percent, of their owned or leased non-hospital preacute or postacute health care organizations. System affiliation does not preclude network participation." Networks are defined as "a group of hospitals, physicians, other providers, insurers and/or community agencies that work together to coordinate and deliver a broad spectrum of services to their community." Network participation does not preclude system affiliation.

Diversity in Hospital Care

In 1986, Congress passed the Emergency Medical Treatment & Labor Act (EMTALA), which requires hospitals to provide medical care to those experiencing a medical emergency, regardless of ability to pay. Because of this law, initial triage and life-saving measures are available to all members of the diverse U.S. population. A myriad of diversity issues arise in hospital care, ranging from cultural competency to treatment of the LGBTQ community. Issues of socioeconomic status, race, and ethnicity are particularly relevant to access and utilization of hospital care; poor and minority Americans are more likely to receive their medical care in a hospital outpatient department or emergency room than an ambulatory center or private physician's office.

In the event of an illness that renders an individual unable to work, the Family Medical Leave

Act (FMLA) ensures that their job is held for them while they are out. However, this coverage is only for 12 weeks, after which time their job is no longer protected and they can easily be terminated, resulting in the loss of both their income and health benefits. An individual may be able to continue insurance coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA); however, without a steady income, these plans are difficult to afford (even if the patient is sick enough to be considered permanently disabled under the Social Security Administration's criteria, they still will not qualify for Medicare for two years).

Because he or she no longer has health insurance, he or she no longer has access to the treatment received prior to being uninsured. If he or she needs an expensive diagnostic test, he or she will have a hard time getting a facility to perform the test without proof of insurance, the copay that is "due at time of service," or a cash down payment. Needed medications are also difficult to afford without insurance, so one may go without medications that one needs, increasing the likelihood that the illness will worsen.

More options are becoming available in the wake of the Affordable Care Act, but they vary greatly by patient. Getting approval for medical assistance is an unlikely possibility for many people as the rigid income, asset, and demographic criteria that vary from state to state prohibit many people from receiving this benefit (i.e., limiting this program to only people who are disabled, pregnant, or over the age of 65). Many people are forced to deplete their savings and/or retirement accounts, sell their homes, and rely on family and friends in order to maintain their health. Access to health care based on socioeconomic status is a critical consideration in working in any human services capacity. It is also important to assess the health care needs and barriers of other diverse clients—immigrants, the LGBTQ community, veterans, and racial and ethnic minorities, among others.

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See Also: Agency for Healthcare Research and Quality; Community Health Centers; Health as Human Right; Health Care Delivery, Models of; Health Disparities, Role of; Health Insurance; Health Insurance Portability and Accountability Act of 1996.

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Housing Services

The crash of the New York Stock Exchange in 1929, and the ensuing economic crisis commonly referred to as the Great Depression, was one of the first times in U.S. history when individuals and families across virtually all socioeconomic levels were economically impacted at an unprecedented level. The New Deal was a package of comprehensive social welfare programs created by the Franklin D. Roosevelt administration in an attempt to create a federal government safety net to meet the needs of economically strapped individuals and families. Housing services were a part of the New Deal programs. The National Housing Act of 1934 resulted in the creation of the Federal Housing Administration, and the Housing Act of 1937 resulted in the formation of the U.S. Housing Authority. Several legislative amendments later established the current Department of Housing and Urban Development (HUD), which facilitates and provides oversight to a number of housing-related programs.

Housing assistance can include a broad range of services, including home ownership assistance through low-interest loans, housing counseling, and rental assistance. Government housing assistance is provided for an equally broad range of populations, targeting poverty alleviation, as well as special populations, such as single parents, older adults, the physically and mentally disabled, youth, and so on. Most housing services programs are offered through public-private partnerships, in which HUD programs are provided in coordination with state-funded services, and community-based programs offered through local charities and churches.

"The Projects" and Other Subsidized Housing

One of the largest federal housing programs facilitated by HUD is its subsidized rental program. The predecessor to today's program, popular in the 1950s and 1960s, involved the construction of large public housing apartment complexes or high rises in urban areas (often referred to as "the projects"). These types of housing units were originally available to a range of individuals and families from diverse income brackets and were well maintained. Eventually, age, reduced funding, and outright neglect turned these public-housing communities and complexes into residences of last resort for the communities' poorest members, often housing poor ethnic minorities, who were then segregated (and often completely cut off) from mainstream communities in high-crime pockets within the community.

Critics cited several concerns about the dilapidated state of congregated public housing, including the development of concentrated pockets of poverty and crime, particularly gang activity and drug trafficking, and increased racial segregation. Between the1970s and 1990s, most public housing units were torn down, and many were replaced via revitalization programs, such as HOPE VI, a coordinated project between HUD and private partners developed in 1992. HOPE VI targeted dilapidated HUD public housing projects in need of revitalization, replacing them with new mixed-income communities. These scattered-site housing programs were designed to increase integration and mainstreaming of low-income families into the general population, thus lessening their isolation as well as the crime often associated with the original public housing projects.

Another contemporary example of federally funded housing assistance is HUD's Sections 8 and 811 rent- voucher programs, which provide eligible recipients with more control over their housing choices. Section 8 is designed for the general low-income population, while Section 811 is designed for individuals suffering from disabilities (including mental illness). Eligible individuals and families must apply for these programs during open application periods (which may only be a few short periods throughout the year); after having their benefits determined individuals and families are responsible for finding a landlord who is willing to accept a HUD rent voucher as rental payment. Voucher programs are also designed to integrate lower-income individuals and families throughout a community.

Theoretically, the voucher can be used with any rental unit (house or apartment), but either through bias or because of a competitive rental market, many landlords in more expensive communities will not accept Section 8 or 811 rental vouchers. Thus, even though one intention of this program is to avoid the isolation and segregation created by high-rise congregated public housing, in many communities the result is still much the same; because the landlords who own units scattered throughout the city are less likely to accept a Section 8 or 811 rental voucher than are the owners of large apartment complexes in low-income areas, these vouchers create the same sort of isolated high-crime environments experienced with public housing high rises and complexes. The need for affordable housing has not kept pace with availability, and the recent spike in home foreclosures in response to the Great Recession of 2007 has resulted in an increase in homelessness and a decrease in funding for housing assistance programs. Section 8 and 811 housing programs experienced significant funding cuts in the last decade, and there is limited hope that funding will be replaced in the near future.

Understanding Housing Insecurity and Homelessness

The development of any successful housing program is dependent upon a comprehensive understanding of the problem, including an accurate framing of what risk factors are most commonly associated with housing insecurity and homelessness. A comprehensive problem statement recognizes the transient and hidden nature of the homeless population, as well as identifies key risk factors associated with the cyclical path from housing insecurity to homelessness. For instance, there are many variables associated with housing insecurity, such as a history of domestic violence, a lack of job preparedness and chronic unemployment, a childhood filled with poverty and housing insecurity, chronic and severe mental illness, substance abuse, and a history of trauma (ranging from childhood abuse to post-traumatic stress disorder in the veterans' population).

Any effective housing program is based upon the understanding that homelessness is not a static condition, but for most people involves a cyclical nature of housing attainment, economic crises, temporary housing (such as doubling up, couch surfing, or short-term motel stays), and sometimes living on the streets. Far too often housing programs targeted the latter only—those living on the streets— based upon older demographics of those most in need of housing assistance—middle-aged, substance-abusing men. Yet, research indicates that the new face of homelessness involves a dramatic increase in single-parent families (primarily female head-of-households and their children), who often do not live on the streets or in homeless shelters, but rather double up with friends or relatives, "squat" in abandoned buildings, live in their cars, or stay in motels on a short-term, rotating basis. If homelessness is defined using a federal definition (which tends to be more narrow), there is on average about 636,017 individuals who experienced homelessness (sheltered and unsheltered) on any given night in the United States. But this definition is often criticized because it does not include the hidden homeless, or those experiencing housing vulnerability. When homelessness is defined more inclusively, estimates of the homeless and those experiencing housing insecurity jump to, respectively, 2.5 and 3.5 million individuals nationally.

Housing services for any special population requires services above and beyond rental vouchers and targets risk factors associated with housing insecurity. Since most individuals who have experienced homelessness and housing insecurity have done so on an intermittent basis, in which homelessness occurs in an ongoing cycle of temporary or tenuous housing, it is important that housing services address the underlying issues that can increase an individual's risk of becoming homeless. First, since the funding of housing services is directly tied to accurate estimates of those in need, in 2009 the Obama administration significantly amended a large piece of legislation that dealt with housing and homelessness, the McKinney-Vento Act. Reauthorized as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, this law, among its many significant changes, significantly expands the definition of homelessness. The new definition includes housing insecurity, such as those who are at imminent risk of losing their homes (whether owned or rented), those living with others on a temporary basis, and those living in unsubsidized motels or hotels.

The HEARTH Act also addresses many of the gaps and deficits that existed in the previous act by including many of the hidden homeless previously excluded in the former legislation's definition; and by highlighting some of the underlying risk factors associated with homelessness and housing insecurity beyond poverty, including chronic disability, physical health problems, mental health conditions, substance abuse, domestic violence, and childhood abuse. Housing services targeting special populations, such as single-parent families, unaccompanied youth, and older adults, include specialized services targeting the unique challenges these populations face, which contribute to their housing insecurity. For instance, many housing services targeting single mothers and their children address social problems such as domestic violence and child abuse. This is particularly important when it comes to developing housing services programs, since research indicates that about half of all homeless single mothers in the United States have experienced child abuse, including child sexual abuse, and almost all experienced domestic violence at some point in their lives. Thus, housing services targeting female single parents often include court advocacy, individual and family counseling, support groups focusing on empowerment and self-sufficiency, substance abuse treatment (if necessary), and children's services.

Services for Foster Children and Older Adults

Housing services focusing on unaccompanied youth, including youth aging out of the foster care system, often include services targeting job preparedness and financial responsibility, as well as graduated levels of independent living in order to prepare youth between the ages of 18 to 22 to live independently. Yet, research still indicates that youth who are not a part of a cohesive and supportive family unit are at increased risk of housing insecurity and homelessness.

Housing services also focus on older adults—a growing population due to the aging of the baby boomers (a large cohort representing the post-World War II children born between 1946 and 1964), as well as improved medical technology that is allowing people to live longer lives. Although people are living longer, that doesn't necessarily mean that their quality of life is good, or at least good enough to remain in their homes. Thus, the federal government (partnering with state and local governments) has addressed the problem of housing insecurity among the older adult population through the development of government-subsidized older adult housing communities. Such programs target financially and physically vulnerable older adults by providing a direct subsidy in the form of a tax credit, loan, or rental voucher. Other types of government-sponsored programs provide a subsidy to the housing community, which in turn passes on the benefit to the older adult in the form of a rent discount.

Rental subsidies may not address the problems experienced by older adults if they include only a rent subsidy and no other services, or if the housing unit is older and unsafe for the older adult population, who often need special age-related accommodations such as wheelchair ramps and handicapped-accessible doorways. Effective housing services targeting the older adult population should include an array of services focusing on psychological, social, and physical well-being. However, y research on older adults in transition from independent to age-restricted living found that those who had the financial ability to reside in more expensive communities offering comprehensive wraparound services fared far better than those who lived in government-subsidized housing programs for low-income older adults. These studies also highlighted the long-term and cumulative damaging impact of lifetime poverty, including increased health problems and lower life satisfaction in later years.

Many communities also offer housing services that are provided through government-private partnerships. Many of these programs are facilitated on a community level and provide integrated services by partnering with local social service agencies, as well as banks that offer residents low-interest mortgage loans in association with federal programs such as the Federal Housing Authority. Such programs offer the most promise since they can counter the damaging effects of federal cutbacks while keeping individuals and families connected to their local communities, which can have a mediating effect on many people's struggles with chronic housing insecurity.

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See Also: Homelessness; Housing Support and Homeless Services; McKinney-Vento Homeless Education Assistance Improvements Act of 2001.

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Housing Support and Homeless Services

The homeless were once commingled in the super-category of indigents. During the Great Depression, they became more widely identified by community-coping euphemisms: hoboes hopped railroad cars in search of employment and Dust Bowl refugees crowded into temporary encampments, just like other dislocated people worldwide. The word *homelessness* entered into common parlance during the 1980s. As always, economics played a major role, but so did more refined human services and a sense of what was missing from them. In the early 21st century, housing support is again at a crossroads. Bound by fiscal restraints, housing support nevertheless encompasses a greater awareness of homeless demographics. This entry functions as a basic introduction to service models and subpopulations, and how the two are likely to converge in the future.

First Wave: Continuum of Care

Homelessness surged in the 1980s for several reasons. First, a strong interdisciplinary social services movement advocated deinstitutionalization, favoring small, community-based care models over large, hospital-type facilities. Without adequate funding for discharge and follow-up, however, special needs clients drifted onto the streets. Second, gender roles had changed; unsupported responsibility for both caregiving and breadwinning left a growing number of female-headed families homeless. Third, disadvantaged populations as well as the country at large were confounded by a rapidly changing economy, from the decline of major industries in the eastern and midwestern Rust Belt to the emergence of the Sunbelt. Small farms also ceased operation and/or were replaced by agribusiness. Population followed these economic shifts to some extent, with unemployed or differently skilled workers entering rising cost-of-living markets. Books such as *Rachel and Her Children* by Jonathan Kozol verified and explained what Americans were witnessing en masse.

Through the McKinney-Vento Act (1987), the U.S. Department of Housing and Urban Development (HUD) and other federal agencies implemented a policy-programmatic response to national homelessness. The term *continuum of care* subsequently assumed two meanings. It still signifies local, regional, state, or multistate areas that share similar socioeconomic characteristics and, within prevailing public policy and funding limits, developing coordinated systems to determine the right mix of homeless interventions for their locales. The continuum of care also evolved into a four-tiered flow of services:

1. Outreach and needs assessment are the first step in housing placement for any population; some nonprofits also provide supportive services only (ranging from telephone access to medical care) for people between living situations, prospective clients for whom no housing is yet available, and/or a small subculture that opts to remain on the streets.
2. Emergency shelter, the first level of supportive housing, is a residential model typically lasting no longer than six months—enough time to build resources for independent living or to consider specialized housing arrangements. Revolving around case management and planning, it also usually benefits from on-site social services and/or finely tuned referral arrangements. (Comparable facilities for chronically homeless single adults are called safe havens.)
3. Also in the supportive category, transitional housing directs clients toward more ambitious personal goals: therapeutic (e.g., sobriety), economic (e.g., job placement, the acquisition of education/training credentials), or other (e.g., family reunification). Two years is considered a long transitional program.
4. All models, then and now, are united in the goal of permanent housing. Such situations might be facilitated through the regular, commercial marketplace and bolstered by subsidies to the tenant (Section 8) or to developers of affordable housing. Permanent supportive housing pertains to those who require ongoing social services. Affordable housing can take many forms, including single room occupancy (SRO) for individuals.

There is no question that the condition of homelessness takes a toll on all of its victims. Practically speaking, however, continuum service models usually are applied to several major populations: special needs individuals or families with a singular challenge (e.g., overcoming family violence, substance abuse); families whose handicap was primarily economic; and singles, both men and women, simultaneously diagnosed with several physical or emotional problems.

A new emphasis on family housing was necessitated by attitudinal change. Orphanages, maternity homes, and related institutions through the mid-20th century sought economic sustainability—for both parents (typically, women) and children—by dissolving problematic family relationships; since the 1980s, bonding and reunification have guided service goals.

Homeless housing, at its best, featured service integration with interventions appropriate to the given population. The physical dimensions of shelters and especially transitional housing evolved, too. The old standard included separate men's and women's dormitories (large rooms lined with cots), which divided families by gender, even separating young adolescents from their parents. Conscientious supportive housing providers in the 1990s and beyond created increasingly private quarters for households to live and heal together; these family-centered environments usually did not accommodate anyone who refused treatment for potentially harmful behaviors. Family and single housing became more segregated.

Today's Challenge: Housing First

Most models remain intact, but best practices are changing due to improved knowledge—and again, the economy. Continuum-of-care communities by the mid-to-late 2000s were gaining a better grasp of local conditions through homeless counts every other year and annual reports via Homeless Management Information Systems (HMIS).

Then the recession hit. Under the American Recovery and Reinvestment Act (ARRA), a rapid rehousing program was instituted nationally. It offered temporary assistance to those made homeless or at risk by economic conditions. ARRA also elevated homelessness prevention, allowing low-income households to remain in place or, if that failed, to quickly transition to other independent living arrangements. Flexibility was key, with customized grants-in-aid packages including rental assistance, back payments, vouchers for brief motel stays, moving expenses, and additional expenses that otherwise would stress reduced budgets.

Some of the practices introduced under ARRA manifested themselves a few months later, more permanently, when the McKinney-Vento Act was reauthorized under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. This initiative promotes a Housing First strategy. It acknowledges the necessity of permanent supportive housing, but asserts that intermediary placement options are costly and that rapid rehousing can be just as effective over the long term. Generally, Housing First officially seeks to (1) provide affordable housing to people experiencing or at risk of homelessness, and (2) improve permanent supportive housing to prevent and end chronic homelessness.

This evolving policy carves distinctions between homeless housing and homeless services. To end homelessness, at least visibly, a federal Housing First checklist underscores fewer conditions and provisions for admission: no prior incomes are necessary (transitional facilities often require minimal rent, in part to teach budgeting habits), no demands for sobriety or treatment, and no evictions for lapses in program attendance or treatment plans. Emergency shelter grants become emergency solutions grants, incorporating preventive measures.

Some changes already are being felt. While the emergency shelter model endures, for example, continuums of care are limiting the duration of residence, many prescribing a 30-day turnaround. Some transitional housing providers fear their days may be numbered. Several new terms are coming into use, too, that imply, but do not directly state, housing-service boundaries. Rental assistance funding, for example, can be (1) sponsor-based, with units offered under contract by the property owner or lessor; (2) project-based for more dedicated purposes; and (3) tenant-based, considering client needs in a community and/or service context.

Opening Doors

Implementation of the HEARTH Act has been delegated to the U.S. Interagency Council on Homelessness (USICH), a consortium of 19 federal agency heads, originally created along with the McKinney-Vento Act in 1987. Its Opening Doors, Federal Strategic Plan to End Homelessness (2010 and amended or updated annually) contains four ambitious goals:

- Finish the job of ending chronic homelessness in five years.
- Prevent and end homelessness among veterans in five years.
- Prevent and end homelessness for families, youth, and children in 10 years.
- Set a path to ending all types of homelessness.

Opening Doors is useful in several ways. First, it defines four specific homeless subpopulations: chronically homeless, veterans, families (typically with children), and youth. The smallest group numerically, unaccompanied youth, primarily refers to youth newly emancipated from foster care and/or juvenile detention. A distinction also is made between them and teens of comparable age who are homeless with their parents or other household members. Besides family dissolution and the problems rampant in institutional environments, this subpopulation contains a high percentage of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth.

It also appears that in addressing the most immediate (five-year) goals, Opening Doors simultaneously tackles what may be viewed as the easiest and most difficult groups to serve. Chronically homeless people usually bear multiple and diverse health and emotional issues, and some have become acclimated to street life. Veterans are not a homogenous group; age and gender (more women today) notwithstanding, major differences exist between the Vietnam-era contingent and those recently returning from Iraq and Afghanistan. Yet Veterans Affairs (VA) offers more homeless interventions than any other agency, in addition to education, mortgage lending, and hospital benefits, so long a part of the VA system. The system's internal continuum of care is closest to complete.

The Future

Homeless service providers in the future will need to leverage specially targeted housing resources at every level of government, community/social services, and mainstream benefits (e.g., supplemental nutrition and energy assistance, various subsidies, the new Affordable Care Act), generally determined by income. Some continuums are taking a proactive stance, using the homeless count for more in-depth study of their communities, possibly with the goal of applying for large mental health, substance abuse, or other grants.

Finally, the definition of chronic homelessness was revised in 2013 to encompass anyone who "has been homeless and living or residing in a space not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or at least four separate occasions in the last three years where the cumulative total of the four occasions is at least one year." The old, easy dichotomy between families and singles may be diminishing. It is uncertain, however, whether current policy—and the ensuing housing-service models—fully consider the complexities of the varied populations known as homeless.

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See Also: Case Management; Continuum of Care; Domestic Violence, Victims of; Family Preservation Services; Family Violence Prevention and Services Act; Homelessness; Housing Services.

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Human Capital Development Initiative

The Human Capital Development Initiative (HCDI), an entity of the National Community Development Initiative (now called Living Cities), was an $8 million demonstration project designed to promote human capital initiatives in local communities. For the most part, the initiative leveraged community development partnerships affiliated with the Local Initiatives Support Corporation (LISC) and the Enterprise Foundation (now called Enterprise Community Partners) at the local level. On a national level, the initiative tapped into more expansive programs sponsored by industry trade associations of community development corporations (CDCs), and the National Congress for Community Economic Development (NCCED).

This initiative emerged to address the need for increased human and organizational capacity in community-based organizations (CBOs). Pablo

Eisenberg noted that numerous community development corporations are “undercapitalized, overextended, and poorly managed.” Many are spread thin, feeling increased pressure from funders, and straining to increase programs and impact without sufficient resources to meet the demands. As a result, CBOs experience high staff turnover, burnout, and loss of senior leaders.

Roland V. Anglin pointed out that many CBOs function outside the standards for effective organizational practice. Accounting practices are unsystematic. Governing boards are weak with insufficient knowledge and skills to guide the organization. Positional leaders who lack organizational and leadership skills are generally unable to effectively guide the organization and cultivate talent. This leads to, among other issues, high staff turnover. Additionally, some individuals in the field perceive a wage disparity between CDCs and other fields. Finally, a criticism of some community organizations was that their staffs did not reflect the demographic composition of the communities they represent. The Human Capital Development Initiative was designed to address human capital issues in four areas. These included human resource management and compensation, recruitment and retention, education and training, and career development.

Human Resource Management and Compensation

The partnerships promoting CDCs’ human resource capacity was through the sponsorship of organizational assessments and human resource audits, compensation studies, diversity training, and other human resource programs. As a result of the assessments, the partnerships created and upgraded state-of the-art personnel systems that aided CDCs in aligning with professional and legal standards with regard to hiring and firing practices and compensation and benefits. Comparative market analyses helped CDCs compare their positions to those in other fields, thereby increasing their ability to hire and retain quality employees. It also resulted in a more diverse workforce that included community residents, and subsequently led to increased political and network capacity of the leaders and overall organizations within their communities. Some CDCs provided human resource training for employees that involved financial systems, board development, volunteer recruitment, executive search processes, and best practice workshops.

Recruitment and Retention

HCDI utilized experiential learning (through internships, work study programs, and AmeriCorps) as well as marketing campaigns to educate and attract talented people to the community development field. Efforts focused on institutions of higher education, related professions, and the CDCs’ surrounding neighborhoods. A specific focus of the HCDI was with the recruitment of women and people of color. On a national level, the NCCED instituted a national recruitment and retention initiative through numerous partnering organizations, universities, and programs.

Education and Training

The HCDI utilized training models from both the nonprofit and for-profit sectors. It tapped into established programs and opportunities to provide ongoing, needs-based training targeted at all staff levels including board members. CDCs determined their unique areas for development, and the HCDI worked with local intermediaries to provide access to existing institutes, programs, and single-topic workshops. Beyond the general topics, some partnerships focused on specific areas of need, including board training and supervisory training. Formal education included certification and degree programs, utilizing traditional classrooms and distance learning. Some partnerships even provided employees with small scholarships to participate in training.

Mentoring was also included by certain partnerships, although this required a substantial time commitment by all involved. While the CDCs valued the training, initially some CDCs feared that increased capacity building might lead staff to depart in order to pursue other jobs. On the contrary, the staff valued the professional development opportunities, and training led to increased job satisfaction.

Career Development

The CDCs offered community development professionals individualized skill assessment strategies and one-on-one career counseling. The career counseling empowered CDC staff to create specific career plans and identify the training and development necessary to prepare them to progress in the field. Participants reported that the career counseling restored their belief in community development as a viable profession. As a result of discovering potential career ladders that fit their interests and goals, community development professionals recognized that they did not have to leave the field to progress professionally and experience job satisfaction. Such an individualized approach increased the number of minority employees moving from entry-level positions to management positions in many of the CDCs.

One aspect of this individualized approach that led to the most success among the CDCs was the integration of the career development programs into the organizational culture. By having supervisors work with the employees participating in the programs to implement their career development plans, participants were more likely to apply and leverage their new knowledge and skills. One partnership supported this process by giving CDCs up to $1,000 of matching funds to support employee training needs, which increased buy-in and support from upper-level management.

Conclusion

The Human Capital Development Iniative was designed to stimulate four areas of human and organizational capital initiatives at local and national levels. Human resource capacity was promoted through organizational assessments and human resource audits, compensation studies, diversity training, human resource training, and best practice workshops. HCDI developed partnerships with professional organizations and universities to increase recruitment and retention, specifically focusing on women and people of color.

Education and training initiatives utilized established formal educational and needs-based training programs in profit and nonprofit sectors, sponsored scholarships, and provided mentoring and professional development activities. HCDI offered individualized career counseling to community development professionals, which aligned the professionals' interests and goals with available career opportunities. Career development programs supporting employee movement into management were successfully incorporated into some organizational cultures. One lesson learned from the HCDI was the importance of researching best practices and models prior to creating new, untested initiatives and approaches.

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See Also: Community Development Corporations; Educational Services; Educational Support Services; Employment/Career Assistance Services.

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Human Trafficking

Human service providers now recognize human trafficking, also commonly referred to as modern-day slavery, as a complex and insidious social problem of global proportions. Human trafficking occurs within the United States as well as internationally; the International Labour Organization (ILO) estimates that there are more than 20.9 million victims of human trafficking worldwide. Victims of human trafficking are overrepresented as women and children; however, other marginalized or vulnerable populations, such as runaways and impoverished or disenfranchised individuals, are at risk. Traffickers are diverse and may represent large organized crime rings, small gangs, or predatory individuals. The commonality of traffickers is that they aim to exploit their victims as a commodity, continuously abusing their victims (through forced labor or sexual exploitation) for monetary gain.

Human trafficking is thought to be one of the most lucrative crimes worldwide due to the long-term and continual abuse of victims. Eliminating modern-day slavery is a priority for many domestic and international agencies—the U.S. Department of Justice, U.S. Department of State, Polaris Project (a nongovernmental nonprofit agency), United Nations Children's Fund (UNICEF), Shared Hope International, Free the Slaves, and ILO—as they work to develop universal educational initiatives, policies, and procedures to respond to and eradicate this worldwide problem.

Human trafficking is often confused with smuggling, but trafficking does not require crossing international borders. Nonetheless, individuals who have been smuggled from one country to another are at high risk for being forced, coerced, or defrauded into labor or the commercial sex industry due to their vulnerability.

Eliminating modern-day slavery requires a three-prong approach: prevention, prosecution of traffickers, and protection of victims. In 2000, the United Nations adopted the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, sometimes referred to as the Palermo Protocol. The same year, President Bill Clinton signed the landmark U.S. Trafficking Victims Protection Act (TVPA), which set domestic and international standards for these antitrafficking efforts. The TVPA defines human trafficking as "the recruitment, harboring, transporting, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, slavery, or forced commercial sex acts." This act was reauthorized in 2003, 2005, and 2008.

Labor and Sex Trafficking

Both foreign- and U.S.-born victims are trafficked for two purposes, forced labor and sexual exploitation. Victims of sex trafficking may be conscripted as models, dancers, or waitresses, and initially promised glamorous and lucrative careers, but they are then forced into pornography or the sex trade in brothels, cantinas, or prostitution rings. Some sex traffickers are involved in gang-related activities in which victims are objectified and controlled by their trafficker to serve the sex industry through generating revenue or to represent the gang itself (some victims are branded with the gang's logo/symbol). Other times, traffickers appeal to their victims' need for love or protection, developing an abusive and dependent relationship. When the trafficker has groomed and manipulated his victim, he then enlists her in prostitution and serves as her pimp. Minors are recruited or abducted for use in the sex trade. The law prohibits minors from consent and recognizes any activity in which an adult has sexual contact with a child as illegal. The prostitution of children, also known as domestic minor sex trafficking (DMST) or commercial sexual exploitation of children (CSEC), constitutes child sex trafficking.

Labor trafficking occurs in two contexts, forced labor trafficking or domestic servitude. Forced labor typically involves exploitation of victims through industries such as food services and processing, construction, sweat shops, and agriculture. Trafficking in forced labor often involves larger groups; victims may be U.S. or foreign born. Domestic servitude is characteristically manifested in smaller groups of one or two foreign-born victims who are recruited to provide child care or housekeeping services. They usually have established a relationship with their trafficker through a family member or acquaintance from their homeland prior to being trafficked. Victims are lured to the United States with the dream of education, employment, and the capacity to financially provide for their families overseas. In both forced labor and domestic servitude cases, traffickers benefit financially from cheap labor by manipulating their victims through the use of force, fraud, and coercion. Tactics include intimidation, the use of violence or threats of harm to the victims and/or their family members, confiscation of passports and legal documents, instilling fear of deportation, developing and/or exploiting drug or alcohol dependence, rape and sexual assault, and isolation.

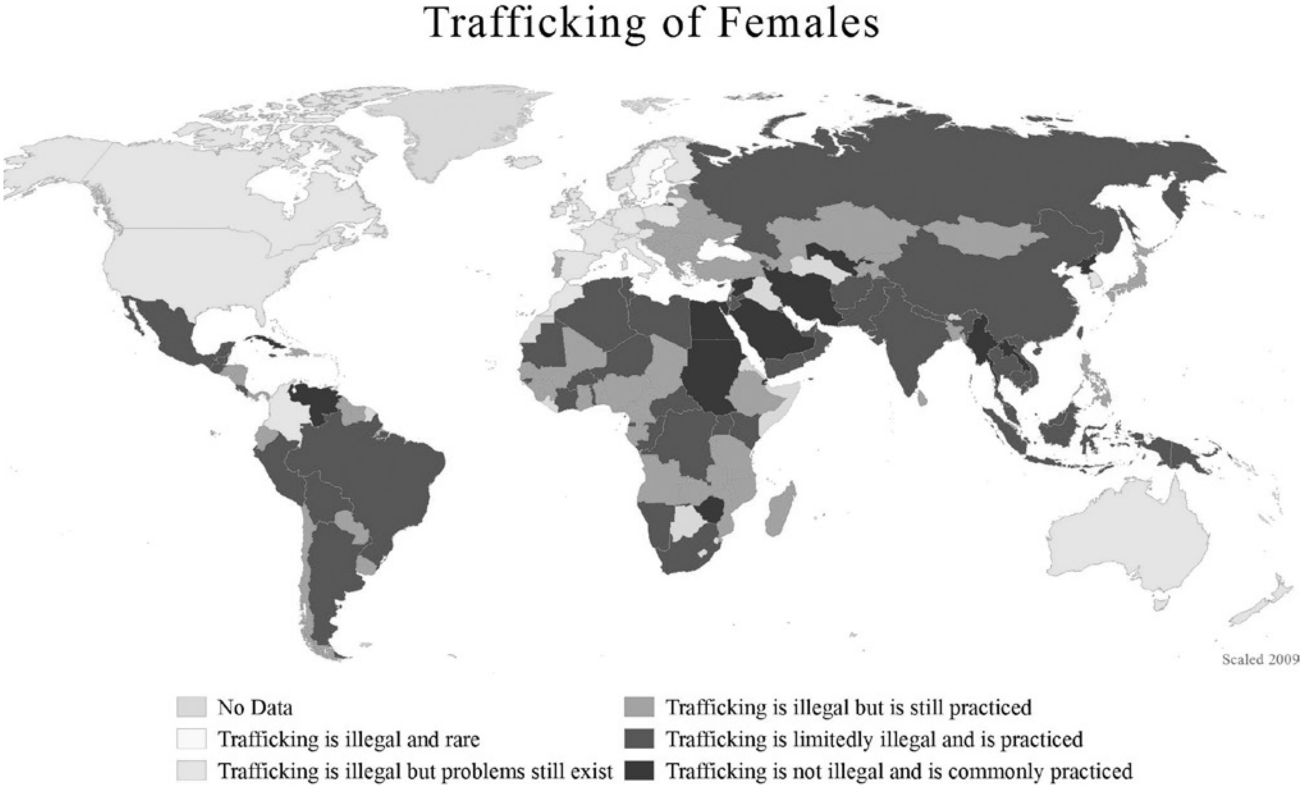
Policy Initiatives and Services

To address the global issue of human trafficking, the U.S. Department of State has developed the Trafficking in Persons (TIP) report to identify and categorize each country's response to combating human trafficking. This tier system (Tier 1, 2, Tier 2 watch list, and Tier 3) ranks countries on their antitrafficking policies and offers a forum for diplomatic dialogue and engagement to counter and eradicate human trafficking.

Through the TVPA, the U.S. Department of Health and Human Services (HHS) is the governmental agency designated to help victims obtain benefits and services. HHS developed the Rescue and Restore campaign to disseminate information on human trafficking, create training resources, and develop the National Human Trafficking Resource Center and Hotline (1.888.373.7888 or text BeFree 233733). This hotline, housed at Polaris Project, receives tips on human trafficking, requests for training or technical assistance, and connects callers to antitrafficking services. Additional nonprofit and nongovernmental agencies, such as Coalition Against Trafficking in Women and Free the Slaves, provide resources for educational, advocacy, and policy initiatives.

The TVPA provides funding through the Office of Victims of Crime (OVC) to facilitate service delivery to victims, and calls for specialized services for this vulnerable group. Foreign-born victims who are residing in the United States are eligible through the Office of Refugee Resettlement (ORR) for social services support and legal assistance that provides them protection from deportation. Although the TVPA also calls for specialized services for domestic victims, most U.S.-born victims today receive services through existing resources in the U.S. social services delivery system, such as the child welfare system, domestic violence programs, and so forth.

Provision of a wide-ranging set of human services to address education, medical, legal, and mental health needs is crucial to begin the process of recovery and to achieve victims' safety, support, well-being, and self-sufficiency. After their initial rescue, victims of human trafficking have basic health needs and services similar to those of victims fleeing domestic violence—attention to physical well-being and safety, shelter, clothing, and food. After these needs are met, victims need to attain self-sufficiency



A world map created by the WomanStats Project shows countries ranked by the prevalence of female trafficking. Victims of sex trafficking may be falsely or legitimately recruited as models, dancers, or waitresses, and initially promised glamorous and lucrative careers, but are then forced into pornography or the sex trade in brothels, cantinas, or prostitution rings.

in employment, transportation, and language, as well as cultural acquisition if they are foreign born. Much like victims of torture, victims of human trafficking require comprehensive, culturally relevant mental health support services to heal from their psychological and emotional trauma. Lastly, foreign-born victims of trafficking who are reunited with their children will require family reunification services to ensure successful cultural integration as well as reintegration of the family.

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See Also: Domestic Violence, Victims of; Immigration, Human Services Issues; Interpersonal Violence; Mental Health Services, Ethnic Models and Multicultural Service; Migrant Workers; Runaway Youth and Human Trafficking; Sweatshop Laborers; Torture, Survivors of; Trauma-Focused Services; Women, Battered.

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ICE Detention Centers, Services in

The U.S. Immigration and Customs Enforcement (ICE) agency is the chief investigative branch of the Department of Homeland Security. In 2003, a merger of the investigative and enforcement divisions of the U.S. Customs Service and the Immigration and Naturalization Service created ICE, which in 2013 had offices in all 50 states and 47 foreign countries. The Department of Homeland Security requested approximately $2 billion in funding for immigration detention for 2014, which would support ICE with funding to maintain a detention capacity of 31,800 people in more than 250 facilities including operational expenses, at an average of $5.05 million per day. ICE detains people in three types of facilities: federal detention centers managed by ICE, privately contracted prison facilities, and state and municipal jails subcontracting bed space for immigrant detainees. Defenders of current laws insist that current detention policies are necessary to ensure that immigrants do not simply disappear after deportation orders, but groups such as the American Civil Liberties Union and the National Immigration Forum as well as individual judges, legislators, and human rights activists argue that the documented inhumane treatment in ICE detention centers as well as the costs make policy changes an urgent priority.

Immigration detention significantly increased in the United States after the passage of the Intelligence Reform and Terrorism Prevention Act of 2004, a response to the attacks of September 11, 2001. Among other provisions, this law directed the increase of the number of detention beds in ICE facilities by 8,000 annually. In 2009, Congress mandated that ICE fill a minimum of 34,000 detainee beds a day. When 2,200 detainees were released from ICE facilities in a February 2013 budget-cutting move by the Obama administration, conservative legislators charged ICE with violating the “bed mandate” statute because the detainee population fell to 30,773. Although the actual number varies daily, at the midpoint of the federal budget year in April 2013, ICE detainees averaged 33,811 a day. Although ICE detains families and women, ICE detainees are overwhelmingly male. The number of Arab, Muslim, and south Asian detainees increased after 2001, but most detainees are Latino. More than half have no criminal record, and another 20 percent are only guilty of traffic or immigration violations.

Service Processing Centers

The federal government was unprepared for the extent of detention that has become the norm. The solution has been to purchase bed space through states and local governments that subcontract their facilities through intergovernmental service agreements. ICE’s Office of Enforcement and Removal

Operations operates six detention facilities called Service Processing Centers (SPCs). In 2013, about 244 state and county jails were contracted to house immigrant detainees on behalf of ICE (nearly 70 percent of the detained immigrant population). Additionally, ICE uses seven Contract Detention Facilities run by private correctional corporations. These contracts have proved lucrative for state and local governments and private companies. Both groups have used political pressure, including hiring professional lobbyists, to keep detention centers open.

Immigrant advocacy groups and investigative journalists have uncovered systemic human and civil rights abuses in ICE detention centers. According to law, ICE detainees are administrative detainees who are held pending immigration cases or orders of removal. Officially, they are not being punished, yet most are forced to wear prison uniforms and are subjected to strip searches, handcuffs, and leg shackles. The constitutional right to legal counsel is not guaranteed in immigration proceedings, and as few as 11 percent of detainees have legal representation. Among those who do, detainees have been denied access to legal representation, and lawyers of detainees have been denied access to their clients. Lawyers sometimes have difficulty locating their clients, who may be moved to another facility without notice. Additional problems stem from limited telephone access, interference with legal mail, and lack of access to a law library.

Conditions

Detainees have been victims of verbal, physical, and sexual abuse. Overcrowding, a common problem, leads to unsanitary conditions in bathrooms and sleeping areas. Many detainees are denied recreation time. Inadequate medical care is a major and persistent problem. Department of Homeland Security auditors found only one facility that complied with the detention standards for documenting initial health screenings, and 40 percent of the centers audited failed to provide even an initial physical examination. The lack of such procedures may compromise the health of those with chronic medical conditions and increase the risk of transmission of communicable or infectious diseases and ongoing nutritional deficiencies. Nongovernmental organizations have documented long delays

The U.S. Immigration and Customs Enforcement (ICE) agency acquired this facility near Phoenix, Arizona, to hold detainees before boarding flights to Central America. ICE detains people in three types of facilities: federal detention centers managed by ICE, privately contracted prison facilities, and state and municipal jails subcontracting bed space for immigrant detainees.

for medically necessary surgeries and unresponsiveness to requests for medical care. Medical staff turnover is high, and shortages in some facilities are acute. A total of 83 deaths of detainees were reported between 2003 and 2008; 32 of the deaths were detainees under 40 years old. More than 36 percent may be attributable to actions taken or not taken by medical staff members in the facilities.

ICE operates under a set of standards specified in the Detentions Operations Manual released in 2000 by the former Immigration and Naturalization Service (INS) and the U.S. Attorney General. Theoretically, these standards are mandatory for all Service Processing Centers, Contract Detention Facilities, and Intergovernmental Service Agreement facilities holding detainees for more than 72 hours. In practice, they are merely guidelines and are not binding under U.S. law. ICE is strictly self-policing and little has been done when standards are unmet.

In 2009, ICE announced that changes were planned for the immigration detention system over a period of three to five years, changes that would result in improved medical care and more effective ICE oversight of all its centers. Among other things, ICE indicated that a move would be made away from housing detainees in penal facilities. Within four years, ICE reduced the number of detention facilities from 341 to about 250, including closing the San Pedro Processing Center in California, which lost its accreditation from the American Correctional Association, but ICE insisted that the loss was unrelated to the closing. In 2011, Human Rights First investigated ICE's progress in making the announced changes, and reported that 14 percent of ICE detainees were housed in nonpenal facilities as required by United Nations policies, but 86 percent remained in jails and jail-like facilities. Critics of the agency's policy continue to point out that alternative methods to detention would provide more humane treatment and save American taxpayers more than $1.44 billion annually. The Department of Homeland Security's estimates reveal that if only persons guilty of serious crimes were detained at costs of $159 per person per day, the rest of the currently detained population could be monitored by alternative methods costing from $0.70 to $17 per person per day. The second group would include noncriminals and those classified by ICE as low-risk criminals, about 80 percent of the detainee population.

Human Rights Advocacy

Human services organizations ranging from the local to the international advocate for immigrant rights and protest ICE detention quotas and the use of civil immigration facilities to house detainees. Local efforts include the University of California Berkeley's Undocumented Student Program that provides help for the more than 200 undocumented students on that California campus. The program has helped students find resources for tuition, housing, food, textbooks, and medical care, and it provides information about immigration law and places individual cases with pro bono attorneys for representation. It has become a model for other colleges and universities. Local groups also work to apply political pressure. Advocacy groups in Northampton County, Pennsylvania, for example, spearheaded successful protests against the building of an immigration facility in their community.

Among the most vocal and effective national advocacy groups is the Detention Watch Network, a coalition of organizations and individuals that works to expose and challenge the injustices of the U.S. immigration detention and deportation system. In January 2014, the Detention Watch Network joined with the Center for Constitutional Rights (CCR), a nonprofit legal and educational organization founded in 1966 by attorneys who represented civil rights movements in the south, to file a Freedom of Information Act lawsuit seeking immediate release of documents that the U.S. government has refused to provide regarding the detention bed quota, which ICE has interpreted to require detaining 34,000 noncitizens per day. The lawsuit charges the U.S. Department of Homeland Security and ICE with failing to disclose information that the public had the right to know prior to the congressional debate on appropriations begun in March 2014. A CCR spokesperson explained that the refusal to release the information interfered with citizens' understanding of how ICE and the Department of Homeland Security use the detention bed quota and undermined the public's ability to debate the issue and to hold their elected officials responsible for the abuses that stem from the quota.

The Detention Rights Network, along with the immigration rights arms of groups such as the American Civil Liberties Union, Human Rights Watch, and various religious organizations are members of the International Detention Coalition, a nonprofit network organization based in Melbourne, Australia, with a membership base of 300 nongovernmental organizations, faith-based groups, academics, practitioners, and individuals working in 50 countries globally to promote greater protection of and respect for the human rights of those held in detention and to raise awareness of detention policies and practices.

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See Also: Immigrant Populations; Immigration, Human Services Issues; Immigration Law, History of U.S.

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Immigrant Populations, Human Service Needs of

For centuries, people have migrated to the United States from all parts of the world seeking the privileges and opportunities afforded to them by the country. However, immigrants face challenges such as anti-immigrant publicity, policies, and discrimination as they acculturate into the United States. Human services professionals are often in the frontline and are first responders to the needs of immigrants. However, knowledge gaps persist in the overall human services needs of immigrants. To address these gaps, a panoramic view of the unique needs of immigrants is needed. In addition, specific culturally competent and literacy sensitive interventions are suggested for human services professionals as they provide social service interventions to immigrants in the United States.

The majority of worldwide immigration took place between the 1800s and 1930, when roughly 60 million people migrated across the globe. Although most of the migrants were European, over half migrated to the United States while others settled in Canada, Argentina, Brazil, Australia, New Zealand, and South Africa. The reasons why people leave their homeland and migrate to a different country are numerous. A primary reason for immigration is economic opportunity, whereby people seek to improve their economic standard via better employment. Others immigrate for political reasons, some to avoid starvation; others leave to flee intolerable family circumstances, reunite with loved ones, and to gain access to public services, whereas others such as Africans were forced to come to the United States as slaves.

The terms *immigrant* and *refugee* are often erroneously synonymously used, but they are very different terms. Immigrants are people who voluntarily leave their countries of origin to live in a foreign country. On the other hand, refugees are people who flee their countries because of persecution, war, or disasters such as famines or epidemics. Technically, voluntary migrants and refugees are both regarded as immigrants if they enter the United States legally through air, land, or sea ports. *Undocumented immigrant* is the term used to describe a migrant who illegally enters the United States and has no formal record of entry at an entry port.

Historical and Current Immigrant Population in the United States

According to the U.S. Census Bureau, the native U.S. population is comprised of all U.S. residents who were born in the United States or a distant area of the United States, such as Puerto Rico, and naturalized citizens of the United States. The native U.S. population also includes those who are foreign born but have at least one parent who is an American citizen. All others who reside in the United States are categorized as foreign born. The earliest record of immigrant census data was the 1850 decennial census. Between 1850 and 1930, the number of foreign-born people in the United States increased from 2.2 to 14.2 million, with the majority coming from Europe.

Foreign-born persons represented 14.4 percent of the total U.S. population in 1870, 14.8 percent in 1890, and 14.7 percent in 1910. From 1930 to 1950, there was a decline from 14.2 to 10.3 million foreign-born persons in the United States, and in 1970, the percentage was at a record low of 4.7 percent because of low levels of immigration. Then, as a result of large-scale immigration, primarily from Latin America and Asia since 1970, the foreign-born population of the United States significantly grew from 9.6 million in 1970, to 14.1 million in 1980, to 19.8 million in 1990, and because of economic expansion of the 1980s and 1990s, to 40 million (13 percent of the total U.S. population) in 2010. According to U.S. census data, between 2000 and 2010, approximately 14 million new immigrants (legal and illegal) inhabited the United States, the largest immigration in American history. Of all foreign-born persons, those from Latin America represented the largest region-of-birth group. A total of 28 percent of the foreign born were born in Asia, 12 percent in Europe, 4 percent in Africa, 2 percent in northern America, and less than 1 percent in Oceania. Of the 21.2 million foreign born from Latin America, 11.7 million, or over half (55 percent), were born in Mexico. Over the past decade, California, Texas, Florida, New York, New Jersey, Georgia, Virginia, North Carolina, Maryland, Washington, Illinois, Pennsylvania, and Massachusetts have had the largest numbers of immigrants.

Immigrants' Human Services Needs

Although most people who migrate to the United States do so legally, approximately three-fourths, many immigrants face discrimination because they are often viewed by the public as having entered the country illegally. Laws such as the Alien and Sedition Act of 1798, the Chinese Exclusion Act of 1882, the Immigration and Nationality Act of 1952, the Enhanced Border Security and Visa Entry Reform Act of 2002, and the Arizona Immigration Law (SB 1070) were all aimed at immigration restriction. However, like most people, immigrants are not always capable of meeting their basic human needs.

In the modern world, life has been complicated by a number of factors. Many circumstances, both extraneous and internal to the individual, such as unemployment and underemployment, mental illness, sicknesses of various types, divorce, and homelessness cause people to seek assistance. As a result, many people can no longer count on mutual aid and support from family and friends because people are in constant flux and transition. Immigrants are also faced with many of life's challenging circumstances such as unemployment, mental illness, sickness, and homelessness. The needs of immigrants can be broadly classified into four areas: language, financial, psychosocial, and health care.

Language Needs

The most important need that non-English-speaking immigrants have as they settle in the United States is the challenge of speaking or communicating in the English language. The language needs of immigrants affect the extent of their acculturation and assimilation. An immigrant's inability to fluently communicate can affect job, educational, and other professional opportunities. For example, Latino immigrants who are used to communicating in Spanish may be unable to seek a job opportunity that requires the ability to communicate in English. Other disadvantages faced by non-English-speaking immigrants include: inability to understand the laws and regulations governing the United States, inability to apply for a driver's license or other government-issued identification, the challenges of transacting business in stores or online, and overt or covert discrimination. A recent example of the language barrier is the report in the news media that some Mexican immigrants were involved in car accidents in the state of Arizona because of their inability to understand road signs and traffic laws.

Some immigrants who learn English are not understood when they communicate. Often, immigrants face the challenge of being stereotyped as speaking with an accent and of being misunderstood when they communicate. Consequently, the English language needs of immigrants in the United States affects all other areas of their socioeconomic socialization. Human services professionals can assist non-English-speaking immigrants to overcome these disadvantages in a number of ways. First, human services professionals can refer immigrants to public and nongovernmental agencies that offer English as a Second language (ESL) classes. Second, human services professionals can provide

New Americans Welcome Area (NAWA) provides extensive information and referral to all Montgomery County, Maryland, residents regarding, but not limited to consumer affairs, education issues, employment, English as a Second Language classes, health care, housing issues, legal assistance, recreation programs, and senior services.

resources for or linkages to interpretation services to assist immigrants. Third, human services professionals can network immigrants who have previously used social services or referrals with newly arrived immigrants. This networking can facilitate faster assimilation, acculturation, and adjustment to the United States.

Financial Needs

Immigrants face huge financial needs because they are often employed at low-paying jobs and frequently engage in strenuous labor activities that are often not wanted by citizens of this country. Most undocumented immigrants are poorly paid, but they generally accept these circumstances, knowing that they may not easily find alternative employment. An additional reason for not complaining is the fear of being reported to law enforcement agents and the fear of deportation. Undocumented immigrants are commonly paid far below the prevailing minimum wage, and this affects their standard of living and opportunities in the United States.

On the other hand, documented or legal immigrants face a similar financial need as their undocumented counterparts. For documented immigrants, the need to settle quickly and repay the loans they often borrowed to immigrate to the United States frequently puts them at a disadvantage to be educationally and skillfully prepared for the professional requirements of the U.S. workforce. Consequently, many documented immigrants who are well educated abroad but do not have U.S.-based qualifications are usually offered menial jobs just to pay accommodations and living expenses. In addition, the jobs that immigrants are employed at often do not have benefits such as health insurance, vacation, and retirement benefits. Furthermore, the working conditions are often deplorable and unbefitting.

As a result, documented immigrants are caught in the cycle of working for survival instead of reinvesting in educational and professional opportunities that could improve their chances of social and economic mobility in the United States. For example, immigrants who fled their countries because of political persecution or civil war do not have the luxury of time to retrain or have an American education that will enable them to obtain jobs that are commensurate with their education. As a result, most immigrants work in highly labor-intensive jobs that pay poorly. Furthermore, most immigrants are under pressure from their countries of origin to send money back home to their families. Often, families, and friends of immigrants in the United States erroneously assume that immigrants earn enough to share and invest in their countries of origin. For some immigrants who are married and have families abroad, the pressure to sustain the family places additional financial pressure on them. Therefore, many immigrants are forced to share their meager paychecks between their families abroad and meeting their own financial needs in the United States.

Human services professionals can assist immigrants with financial literacy skills such as budgeting, job searches, and career planning, and they can provide referrals to job retraining and newer certification and educational programs that can empower professional mobility and opportunities. Moreover, human services professionals can advocate for better working and pay conditions on behalf of exploited and underpaid immigrants.

Psychosocial Needs

One of the major consequences of migrating to another country is leaving family, social, and cultural ties behind in the country of origin. For those who migrate to the United States, other important needs are psychological and social needs. Psychosocial needs are therefore a combination of emotional and social needs that immigrants have because they do not often immigrate with their immediate family members, friends, or other relatives, which causes them to be emotionally lonely and socially isolated in the United States.

Other factors that increase psychosocial needs are new dietary and food patterns, adjusting to different religious or worship orientations, and the challenges of understanding and respecting the rights that women and children have in the United States. Often, these factors are not concerns in the countries of origin for many immigrants. In addition, the demand of the menial jobs that immigrants undertake makes it almost impossible for them to interact and build new friendship and social ties in the United States. Furthermore, the individualized styles of living in the United States, rather than the communal style and social interactions that many immigrants are used to, accentuate the psychosocial needs of immigrants.

However, immigrants partly meet their psychosocial needs by utilizing the friendship provided by their coworkers and new social interactions offered by their national associations and religious organizations. To address these psychosocial needs, human services professionals can assist immigrants in the steps and processes of registering for and forming national or ethnic associations to improve social and emotional bonding with people. In addition, human services professionals can provide referral services to existing immigrant-friendly and immigrant-oriented resources such as religious and nonprofit organizations.

Human services workers can also help immigrants to assimilate and acculturate into the United States by providing courses or training to immigrants about the history, culture, people, laws, and different institutions of the United States. This training—for example,in the area of child welfare and laws protecting women against domestic violence—can help immigrants avoid encounters with law enforcement agents that could precipitate psychosocial crises for an immigrant. Therefore, human services professionals can assist immigrants who are new to the United States to be well acquainted with their parental responsibilities to children, as well as the acceptable respect accorded to women in the United States.

Health Care Needs

Immigrants face enormous health care needs because of the prohibitive cost of health care insurance in the United States. The 1996 welfare reform excluded immigrants from benefiting from government-sponsored health care assistance such as Medicaid. Therefore, immigrants are often without health care coverage when there is a health problem. The absence of health care coverage in the low-paying jobs that often employ immigrants also exacerbate the health care needs of most immigrants.

Often, preventable or easily treatable diseases that immigrants have become costlier and more complicated to treat because of the lack of health care insurance and their fear of paying huge medical bills. Self-treatment or resigning to fatalistic beliefs are common strategies that immigrants resort to when they are unable to afford health care.

For some immigrants who can afford health care insurance, another major challenge is the discrimination and treatment disparities that they confront in the U.S. health care system. Many immigrants complain of not receiving culturally sensitive communication and treatment within the health care system. For example, Latino or African immigrants who have very strong family and communal ties are often not allowed to involve their family members in health care discussions. For some African immigrants who are Muslims, most health care professionals are viewed as not sensitive to the religious and cultural restrictions that are associated with providing health services to women. Consequently, immigrants who are insured and can afford health care often complain of discriminatory and culturally insensitive health care services in the United States health care system.

Human services professionals are well positioned to help immigrants navigate the health care system in the United States. First, human services workers can provide interpretation and help bridge the complaint of culturally insensitive interactions between immigrants and health care professionals. Second, human services professionals can provide preventive and health literacy training to immigrants in culturally appropriate and religiously sensitive ways that reduce the fear and concerns that some immigrants have toward the U.S. health care system. Third, human services professionals can also provide referral services and information about free to low-cost health services to immigrants. Furthermore, appropriate professionals in the human services sector can provide counseling and assessment to immigrants who have mental health needs associated with the challenges of assimilation, culture shock, and acculturation in the United States.

Approaches to Prepare and Develop Immigrants' Capacity for Assimilation

To address and prevent some of the needs identified with immigrants will require three essential approaches that human services professionals could adopt. The central focus of any such approach is to build capacity for immigrants to actualize their potential. Such an approach requires a fundamental shift of the general perspective that currently dominates human services provision, which places the burden of integration on the individual and family to a more collaborative effort involving all stakeholders.

The first approach is to focus on the individual and family units. Immigrants may share common problems, yet there are numerous issues that are specific to groups and families. For instance, among African immigrants, the need for English as a Second Language (ESL) service may vary depending on country of origin. A person who is from a French-speaking country will need different services than a person who is from an English-speaking country. Also, within a family unit, the literacy levels of different family members and the age and sex demographics will require varied services to address their needs. Also, families that have experienced war will require specific types of mental health services. Therefore, it is important that immigrant-based services be available to meet both the broader and specific needs of immigrant families. This will require periodic assessment of services to meet the needs and availability of resources and expertise to provide the services. Each immigrant's local social services agency can tailor its resources and services to meet the needs of the immigrant population. These services may include direct counseling, social support programs, ESL programs with cultural adjustment content, and parenting classes.

Second, to address some of the needs of immigrants will require a collaborative effort with other local human services and governmental agencies. The needs of immigration will require broad-based initiatives to not be a burden on the immigrant family and immigrant-based organizations. Community capacity building to address the needs of immigrants should involve community education activities and collaboration with stakeholders such as immigrant-based agencies, health care providers, schools, law enforcement, school systems, religious groups, and local government. A collaborative effort between the individual/family and community partners will ease the burden of integration on immigrant/family and make the partnership more communal.

Third, to meet some of the needs of immigrants will require advocacy and support from human services agencies to influence policies at the local, state, and federal levels. Various actions and anti-immigrant publicity have had a disproportionately negative effect on immigrants. Immigrants, because of language barriers, nonreciprocity of foreign education, and lack of employment constitute a large portion of underemployed and low-paid employees in the nation. Immigrants also constitute a large portion of the population who do not have health insurance and underutilize the health care system. These and other related issues will require a broader and comprehensive approach to ameliorate these problems. Suggested preventive measures include comprehensive immigration reform, free or affordable primary health care to all with emphasis on preventive care, educational reforms, and employment laws that create an enabling environment for immigrants to be successful.

The uniqueness that each racial or ethnic group brings to the United States (e.g., values, beliefs, customs, and rituals) has challenged people to appreciate ideas that are different from their own. More importantly, the uniqueness that each racial and ethnic group brings to the United States has taught people to be appreciative and sensitive to differences. Immigrants are a heterogeneous group of people whose intragroup diversity affords human services professionals wonderful opportunities for professional development and personal growth.

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See Also: Acculturation; African Immigrants; Asian Immigrants; Cultural Services; Immigration, Human Services Issues.

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Immigration: Human Service Issues

Immigration is considered to be one of the major issues of national and international politics. Immigration is not a new phenomenon; however, its roots trace back into history. Furthermore, contemporary immigration is described as the movement of people from poorer to richer countries and also movements between developed countries. This movement has been continuously rising. According to the Human Development Report from 2013, today, in accordance with 2010 statistics, around 3 percent of people on the globe—or around 215 million—are immigrants, a threefold increase since 1960.

A wide range of factors motivates migration. These motives are described as push and pull factors. The push factor stands for the state of things at the sending country such as the weakness of the economy and political instability; the pull factor is the situation in the immigrant's destination country such as the prospects of finding a decent job and a high standard of living. Inequality in income rates and employment opportunities across and within the countries and particularly economic gradients between developed and developing countries are the main factors of immigration.

Moreover, political instability of the sending countries can lead to immigration. Geographic proximity of the sending country to the receiving country is another factor that explains migration patterns. Countries tend to get immigrants from their zones of influence. Cultural, historical, and linguistic ties along with family relatives' presence at receiving countries may also be considered to be facilitative factors of migration.

World Bank figures from 2010 figures demonstrate that the United States, the Russian Federation, Germany, Saudi Arabia, Canada, and the United Kingdom are the top destination countries pulling the highest stock of immigrants. In contrast, Mexico, India, China, Bangladesh, and Pakistan are the top origin countries pushing the highest number of emigrants to the countries where economic and political opportunities are better off.

So far, the aforementioned issues have been related to pull and push factors of immigration, which are also considered to be the root causes of immigration. Addressing these factors is of utmost importance in terms of determining key human services issues regarding immigration. Thus, in the next section, human services issues related to immigration are discussed.

Some Human Services Issues Concerning Immigration

There are several aspects regarding human services issues of immigrants, thus including economic, social, and political aspects, which are also related to factors of immigration. These aspects, respectively addressed below, shed light on the linkage between human services issues and needs of immigrants.

From the economic aspect, sudden economic emergencies—such as the debt and energy crises of the 1970s and 1980s and the currency crises of the 1990s—resulted in accelerated influxes of immigrants to Organisation for Economic Co-operation and Development (OECD) countries and in large-scale expulsions of immigrants. It is obvious that these crises were economic oriented and immigration emerged as an outcome of them.

The number of foreign-born laborers has increased greatly, with a growth rate of more than 20 percent in nearly all OECD countries. From 1995 to 2005, there was much stronger growth in immigrant employment than in the labor market. This increase, especially after the 1990s, indicates that one of the main components of global economy, labor migration, has become a salient actor in ecopolitics.

Most industrialized countries have green card or highly skilled immigrant programs in order to attract qualified workers. This can be identified as a policy change from restrictive measures to liberal arrangements. Partly, these changes reflect the emerging needs of migrants in labor markets.

From the political aspect, global governance and international viewpoints on immigration have evolved significantly. For example, Article 13 of the Universal Declaration of Human Rights of 1948 states that everyone has the right to freedom of movement and residence within the borders of each state. The 1990 International Convention on the Protection of the Rights of All Migrant Workers has provided insights into immigrant rights.

Immigration and government practices always carry the potential of becoming a matter of international relations. Thus, a United Nations (UN) resolution asks member states and the international community to promote a balanced, coherent, and comprehensive approach to international immigration and developmental approaches particularly by building partnerships and ensuring coordinated action to develop capacities, including for the management of immigration. All these international regulations indicate that human services issues regarding immigration are considered as a priority within the international community.

From the social aspect, nation states are having some concerns about the integration of immigrants into society in the sense that they may experience some problems about integrating immigrants into their societies, like questions about assimilation. Assimilation is another problematic area that some countries may use as a part of their integration policies. For example, the riots in France in 1994 resulted from disenfranchisement of African immigrants.

Fears that immigrants will change the identity or historical fabric of receiving countries may cause immigrants to encounter hostility, discrimination, racism, or xenophobia in immigrant-receiving countries. Thus, extreme-right, anti-immigrant parties use immigration issues as a political tool for winning elections and see immigration as a controversial issue. Anti-immigrant parties in immigrant-receiving countries have exploited these concerns for the sake of their popular interests. Therefore, immigration is more likely to be polemic because immigrants are reluctant to be exposed to assimilation owing to wide-ranging language, cultural, and religious differences in relation to their host societies and the ease of access to their countries and cultures of origin. However, the orthodoxy aspect of integration encourages the promotion of diversity and preserving immigrants' customs.

Public concerns over the presence of immigrants and labeling them as outsiders in their societies, to some extent, are linked to perceptions of an increased security threat concentrating on immigrants. Tough security controls against immigrants before entering the destination countries chiefly result from security concerns.

Furthermore, human services issues are also related to education opportunities of immigrants all around the world. There has been an increase in the number of international students who seek to have a better education background. According to the OECD figures, in 1975, it is estimated that there were around 610,000 international students enrolled for courses outside their home countries. By 2005—30 years later—that had more than quadrupled to just over 2.7 million international students, and the number of international students worldwide has increased at more than 8 percent a year.

Moreover, with the impact of new technologies, people increasingly learn that there are others not only unlike themselves but also like themselves. New categories of us and others are made available for political mobilization and movements. The poor are aware of everyday disparities and inequalities, which force them to migrate to places where they can find better opportunities.

To conclude, immigration is vitally important in terms of not only domestic but also international policy and politics. There are several reasons why people are driven to move from their homes. These reasons are described as pull and push factors. These factors have contributed to addressing the key human services issues with regard to immigration. In line with this factorial approach, human services issues are precisely about social, political, and economic opportunities, which should be provided to all immigrants. Therefore, policy makers and anyone who is focusing on immigration issues should bear in mind human services needs of immigrants while shaping and framing policies in the area of immigration.

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See Also: Immigrant Populations, Human Services Needs of; Immigration Law, History of U.S.; U.S. Citizenship and Immigration Services.

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Immigration Law: History of U.S.

Human services professionals often work with immigrants. These professionals meet immigrants at the airport and help them adjust to life in the United States. Immigrants come to the United States with expectations and dreams. Language and culture differences can be barriers to obtaining these dreams. Human services professionals help immigrants navigate through the obstacles and bureaucracy, so immigrants can gain independence and thrive in their new environments. Working for nonprofit agencies, human services professionals have been aiding immigrants in their resettlement efforts for more than a century. As a way of understanding the bureaucracy and context, knowledge of U.S. immigration history and policy is an essential element for successful practice.

In 1790, the first U.S. act addressing naturalization of immigrants stated that residents living in the United States for a minimum of two years could apply for citizenship. These residents along with any children under the age of 21 were granted citizenship if they were white and demonstrated good moral character. In 1795, it changed, stating that the applicant must be a free white person with five years of U.S. residency, good character, lack of service in the army for England, no claims to property in other countries, and renunciation of allegiances to any other country.

As tension rose between the United States and France, the legislature passed the Alien and Sedition Acts of 1798. The first change included the requirement for citizenship applicants to have 14 years of residency as opposed to the previous requirement of five. The next two changes allowed for deportation of those suspected of threatening the peace and safety of the United States and the incarceration or deportation of any foreigner with allegiances to a country at war with the United States. The final addition made criticism against federal officials illegal.

The Steerage Act (1819) marked the first federal immigration law. This required that all vessels entering U.S. waters give an account of all non-U.S. passengers on board, indicating their country of origin, intentions for citizenship, age, sex, occupation, and intended residence in the United States. It also limited the number of passengers permitted on these ships.

The Passenger Act (1847) further limited the amount of passengers on vessels. It required that captains of larger vessels pay a fee of $5 per non-U.S. passenger, which is equivalent to approximately $143 today. The United States saw a large increase in new arrivals from Ireland and Germany during the 1800s. There were also waves of immigrants from Austria–Hungary, Italy, and Sweden, and many still came from England. Employers such as the railroad company actively recruited foreigners to come to the United States.

In 1857, the Supreme Court heard the famous case *Dred Scott v. Sandford.* This highly criticized decision did not afford the right of citizenship to free Africans. After the end of the Civil War, the passage of both the Civil Rights Act (1866) and the 14th amendment of the U.S. Constitution (1868) had an impact on immigrants. The amendment repealed the *Dred Scott* decision and granted citizenship on both a state and federal level to all residents who were either born or naturalized in the United States. This marked the first time people of African descent acquired a pathway to citizenship. Despite the passage of the 14th amendment, the Naturalization Act (1970) discriminated against Chinese immigrants. Tension was high, especially in California, where Chinese men came to work in the gold mines and for the railroad companies.

In 1875, the Supreme Court issued a decision in *Henderson v. the Mayor of New York.* This decision gave authority over immigration to the federal government and eliminated state regulation and fees. Without the fees, the states would not have the resources to aid these newcomers. State officials lobbied successfully for a federal immigration tax. In 1882, Congress levied an immigration tax of 50 cents (just more than $11 today) on all newcomers. This act also prohibited criminals from entering the country. With the passage of the Page Act (1875), it became illegal for criminals, involuntary Asian laborers, or Asian prostitutes to enter the United States. In 1891, immigrants who may need societal assistance could not legally enter the United States.

Congress passed the Chinese Exclusion Act (1882) for 10 years. It prevented Chinese laborers from coming to the United States and deported those who arrived after November 1880. The Scott Act (1888) prohibited Chinese laborers from entering or returning to the United States. The Geary Act (1892) extended it for another 10 years and added the requirement that all individuals of Chinese origin carry identification. In 1902, this act was renewed indefinitely.

In 1892, Ellis Island was declared an immigration station in the east. Immigrants would arrive first at Ellis Island for an inspection to determine if they would be permitted to enter the United States. Angel Island opened in the west in 1910 as an immigration station.

Twenty-First Century

In 1901, an anarchist, Leon Czolgosz, assassinated President William McKinley. In response to this unexpected and tragic event, Congress enacted the Anarchist Exclusion Act (1903). This allowed immigrants to be deported based on their political beliefs and associations.

The Naturalization Act (1906) enacted the formation of one agency to manage the process of becoming a citizen. It was the first time that an understanding of the English language was a requirement for citizenship. The controversial Expatriation Act of 1907 established that a woman who was a citizen of the United States would lose her citizenship if she married a foreigner and gained her husband's citizenship.

During the years of 1907 and 1908, President Roosevelt was negotiating the famous Gentlemen's Agreement with Japan. This agreement allowed Japanese students to attend San Francisco schools in return for the cessation of the issuance of passports to the United States by the Japanese government.

The Immigration Act (1907) excluded more categories of immigrants and raised the immigration tax to $4, which is $100 today. This act also provided for the establishment of the U.S. Immigration Commission, eventually called the Dillingham Commission. The commission was to investigate the immigrant experience in the United States.

The Dillingham Commission Reports (1910) suggested a literary test to limit the entry of newcomers from southern and eastern Europe because the commission viewed people from these regions as inferior. The commission found that, during the period of 1898 to 1910, immigrants from southern Italy represented the largest migrant group, with Mexicans being ranked as the 28th largest group out of the 31 ethnic groups counted.

In 1910, the Mexican Revolution changed this significantly. Mexican entered the United States in record numbers—most settling in the southwest, which was territory previously settled by Mexico. Some were seasonal workers who returned to Mexico frequently. Mexican immigration continued to increase for the next 20 years.

However, there was little concern over Mexican migration, and the United States continued to show concern about Asians even after the start of World War I. The Immigration Act (1917), also called the Asiatic Barred Zone Act, prohibited Asians from entering the United States. A literary test was instituted as a precursor for immigration. Additional restrictions were imposed that prohibited entry for alcoholics, beggars, and anarchists. The tax was increased to $8 (about $145 today) for all adults over 16 who paid for their own passage. Those who did not pay for their own passage were sent back to their country of origin.

The United States joined the Allies (United Kingdom, France, and the Russian Empire) against the Central Powers (Germany and Austria–Hungary) in World War I. The Allies were victorious in 1918. After the war, the public was particularly nervous about a communist rebellion on American soil. Attorney General A. Mitchell Palmer and his staff detained more than 6,000 immigrants on the suspicion of communist ties. This was called the Red Scare. The most restrictive immigration policy to date was enacted in 1921. Congress passed the Emergency Quota Act (1921) and eventually passed the National Origins Quotas Act (1924). The use of quotas restricted immigration pragmatically and reduced some of the racist undertones in previous immigration acts. The quotas established in 1924 were made as permanent in 1929.

The Cable Act (1922) partially repealed the controversial Expatriate Act of 1907. However, Asian prejudice remained in that U.S. American women who were married to Asian men lost their American citizenship. Upon divorce, white American women could reapply for citizenship in the United States. However, Asian American women in the same circumstance were ineligible for citizenship. It was not until 1931 that the Expatriate Act of 1907 was fully repealed.

In the middle of World War II, the United States instituted the Alien Registration Act (1940). This act required that all noncitizens over the age of 14 register yearly and submit to fingerprinting. Additionally, it banned anarchist behavior and speech. It did allow the attorney general to have discretionary authority to suspend deportation proceedings for foreigners with good moral character.

In contrast, after the bombing of Pearl Harbor on December 7, 1941, the internment of 110,000 Japanese Americans started in 1942 under the executive order of President Franklin Roosevelt. Immediately following the attack on Pearl Harbor, the United States joined forces with China and declared war on Japan. The president repealed the Chinese Exclusion Act in December of 1943. Other Asian countries were still restricted from immigrating until 1952 with the passage of the McCarran-Walter Immigration Act.

The United States started the Mexican bracero program as a way to bring temporary agricultural workers to farm during the war. This program continued long past the war until 1964 as millions of

Mexican men worked temporarily in the United States through this program. World War II influenced immigration policy on another level. Military servicemen married both European and Asian women during the war. In 1945, Congress passed a short-term act enabling European-born spouses to gain entry into the United States. Congress passed legislation two years later allowing Asian-born and other ineligible foreign-born wives to immigrate to the United States. In 1950, the legislature passed a law that allowed spouses of servicemen from Korea and Japan entry into the United States. The McCarran-Walter Act (1952) provided an exemption from the quota for all spouses and minor children of U.S. citizens.

Another impact of World War II was the large number of displaced persons. President Truman, against popular U.S. opinion, allotted half of the quotas for Europeans to displaced persons (DPs) in 1945. By 1948, Congress enacted the Displaced Person Act, which allowed 400,000 DPs to come to the United States over a period of four years above the European quota. The Refugee Relief Act (1953) allowed 200,000 DPs above the quota limit to come to the United States.

As the United States became more concerned about the communist movement becoming an international conspiracy, the legislature enacted the McCarran Act (1950), which excluded communists from entering the United States. The Immigration and Nationality Act (1952), also called the McCarran-Walter Act, encompassed both immigration and naturalization. In the interest of national security and fear of communism, more security measures were added, and race was no longer considered a barrier to citizenship. Quotas were given to a number of Asian countries for the first time, and spouses of American women were included as a nonquota class of immigrants. As Mexican illegal border crossings were becoming a concern, border patrol officers were given more authority to investigate and do searches without a warrant.

In 1954, the United States targeted Mexicans who entered the country illegally. They called this concentrated effort Operation Wetback. In the summer of 1954, the U.S. attorney general deported 1 million people that summer, most of whom were Mexicans, but some were citizens.

As the country favored families, relatives of citizens continued to receive preference in immigration matters. The Hart-Cellar Act (1965) added other categories of preference as well—artistic ability and refugee status were two. In addition, this act abolished country quotas but established an overall ceiling of 290,000 new immigrants a year with no more than 20,000 coming from any one particular country.

The United States continued to be concerned with refugees throughout the world, so Congress passed the Refugee Act of 1980 to eliminate refugees from the overall quota established by the Hart-Cellar Act (1965). The Immigration Reform and Control Act (1986) made it illegal for an employer to hire an undocumented immigrant. Additionally, this act provided a pathway to legal citizenship and a new status for seasonal agricultural labor. With this provision, more that 3 million immigrants applied for legal citizenship.

The Immigration Nursing Relief Act (1989 and 1990) sought to aid in the nursing shortage in the United States. The act gave an option for a registered nonimmigrant nurse to gain permanent residence in the United States if he or she had been working in the United States for a minimum of three years and met certification standards. In 1999, the Nursing Relief to Disadvantaged Areas Act provided for vacancies in rural and urban areas.

The Immigration Act (1990) raised the ceiling on immigration to 700,000 for 1995 and 675,000 thereafter. There was also a limit placed on certain visas. The Illegal Immigration Reform and Immigration Responsibility Act of 1996 required new immigrants to have higher standards of self-sufficiency than in the past. Additionally, it provided more resources for officials to prevent illegal immigration. It also made it more difficult for undocumented immigrants to convert their status to legal.

Conclusion

On September 11, 2001, the United States survived three foreign terrorist attacks on American soil. This marked changes in national security that influenced immigration. In 2002, the PATRIOT Act and the Enhanced Border Security and Visa Entry Reform Act made it more difficult to enter the country and gave officials greater authority in detaining and deporting foreigners. Foreigners from a number of countries (most of them predominately Muslim) age 16 and older were required to register, and thousands were forced to start the deportation process. The Homeland Security Act of 2002 abolished the Immigration and Naturalization Service, moving these services from the Department of Justice to the Department of Homeland Security.

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See Also: Acculturation; Cross-Cultural Skills; Discrimination and Institutional Racism; DREAM Act, The; Equal Opportunity and Civil Rights; Executive Orders; Immigrant Populations, Human Services Needs of; Power, Race/Ethnicity and; Refugee Assistance; White Privilege.

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Immunization

Immunization is a process in which people are made immune or resistant to infectious diseases, typically by the administration of vaccines. Vaccination has proven successful as a relatively low-cost, low-risk means of protecting populations from certain diseases, several of which have nearly been eradicated in many parts of the world. Although smallpox was still endemic in Africa and Asia in the 1960s, by 1980, after decades of fighting the disease on a global scale through efforts by the World Health Organization's (WHO) Smallpox Eradication Programme (1966–80), the World Health Assembly endorsed a statement declaring smallpox eradicated. The eradication program rid the world of a disease that once killed up to 35 percent of its victims and left millions others scarred or blind. After the measles vaccine was licensed in the United States in 1963, measles began to decline by 1965, with a record low reported in 1998, with only 89 cases and no measles-associated deaths. Such statistics indicate the benefit of immunization in preventing death of debilitating diseases that are otherwise preventable.

There are two kinds of immunizations, or vaccinations. The first is active immunization, among the greatest achievements in public health. This kind of immunization naturally occurs when a person comes into contact with a microbe. If the person does not come into contact with it, no premade antibodies are made by the body for defense. A healthy immune system creates antibodies against the microbe, so the next time the body comes into contact with it, the person is immune. This frequently happens with childhood infections that a person contracts once then is immune to thereafter. Passive immunization occurs when elements of the immune system are transferred to a person so that the body does not need to produce its own antibodies. While antibodies can be used for passive immunization, this method does not last as long because the body is unable to produce more antibodies to continue the immunization. This kind of immunization physiologically occurs when antibodies are transferred from the mother to the fetus during pregnancy as a measure of protecting the fetus before and immediately after birth. Artificial passive immunization occurs when an injection is given. This is used if there is a recent outbreak of a disease or in emergency situations; for example, in order to treat tetanus.

Proof of immunization is often required by law in order for children to attend school or adults to enroll in college. An immunization registry, or the Immunization Information System, is a private, population-based, computerized system attempting to collect vaccination data about people in a specific geographic area. This is done by collecting immunization records from several sources for every person living in the specific area. It is an important tool because it has the potential to increase and sustain high vaccination coverage; by consolidating vaccination records of both adults and children, health care providers are better able to forecast the timeliness of doses, recall vaccination notices, provide official vaccination forms, and create vaccination coverage assessments. One goal of this system is to work toward more consistency is vaccination of children under 6 years old. Since 1990, great declines in morbidity have been reported for nine diseases that are preventable with vaccination. While different strains continue to challenge standard vaccinations, immunization overall is seen as a way to encourage the body's natural defenses, and research continues to seek out vaccinations for diseases that have been thought of as otherwise incurable and deadly.

The U.S. Center for Disease Control has collaborated with the WHO and Rotary International to work toward eradicating polio, accelerating control of measles, and globally expanding rubella vaccination programs. Still, childhood vaccination programs in particular are in need of development. An article published in *The Lancet* in 1998 made a link between the measles-mumps-rubella (MMR) vaccine and autism, resulting in parents declining to vaccinate their children as infants or demanding an alternative immunization schedule. While the study was later discredited, it continues to provide justification for some UK and U.S. parents to refrain from vaccinating their children as recommended. Global travel has significantly shrunk the world, making it an increasingly probable danger that a child could pick up a disease from a person of another country through airplane travel.

Immunization and Cultural Differences

Bright Futures, a group associated with the American Academy of Pediatrics, began a project designed to respond to the health needs of infants, children, and adolescents. Sponsored by the Maternal and Child Health Bureau of the U.S. Public Health Service and the Medicaid Bureau of the Health Care Financing Administration, over 100 professionals came together to think about disease prevention and health promotion for children. Bright Futures retains guidelines that support the belief that effective health supervision must be enacted via a partnership between family and health professionals. The organization aims to be sensitive to culturally specific requirements and needs, but also to educate families about vaccination and preventative health care.

A U.S. Navy hospital corpsman affiliated with the Military Sealift Command hospital ship USNS Comfort *gives a civilian patient an immunization shot at Angelica Flores School, August 17, 2007.* Comfort *was on a four-month humanitarian deployment to Latin America and the Caribbean. Vaccination has proven successful as a relatively low-cost means of protection from certain diseases.*

Bright Futures is an example of a public organization that seeks to provide health guidelines for a wide range of culturally diverse children. Its guidelines include promoting healthy nutrition, oral health, immunization recommendations, hearing and vision screenings, and psychosocial and behavioral assessments. Measurements, screenings, assessments, and physical examinations are recommended for all the pediatric life stages, from infancy to adolescence.

These recommendations are for pediatric health care providers, but are complicated by culturally specific beliefs about health care. Certain religious belief systems prefer alternative perspectives on vaccination that differ with the majority medical recommendations. These are based on ethical dilemmas caused by the use of human tissue to create vaccines and the belief that the body is sacred and should only be healed by natural means or God. Polio eradication in Pakistan has been thwarted by the Taliban, which in a strategy to oppose U.S. intervention in the region issued fatwas against polio vaccinators, six of whom were shot dead in Karachi and Peshawar in 2012. Opposition to polio vaccination efforts in Nigeria were the result of claims that vaccines were contaminated with HIV. Christian Scientists have no formal antivaccination policy but overwhelmingly rely on prayer for healing. Several major measles outbreaks originating in religious communities opposed to vaccination—in Philadelphia in 1990, in Illinois and Missouri in 1994, and in Indiana in 2005—signal a need for continued communication and collaboration between health officials, religious and cultural organization leaders, and the public regarding acceptable and effective immunization policies and practices.

Global Disparities

Immunization efforts are also complicated by economic disparity. Social resistance to vaccines as a cause of autism is less common in low- and middle-income countries rather than in high-income countries. Vaccine-preventable deaths are visible, increasing the acceptance of immunization. Confusion and fear of new vaccines, such as initial misunderstandings about the polio vaccine, exist in some low- and middle-income countries. The main contributing factor to lack of vaccination in low-income countries is cost of vaccines and their implementation. Although the WHO introduced the Expanded Programme on Immunization during the 1970s, this effective public health intervention is still not accessible to all, particularly those in low-income countries. Immunization plays an important role in achieving the UN Millennium Development Goal of reducing under-5 mortality by two-thirds between 1990 and 2015. While poliomyelitis (polio), for example, was eliminated by widespread vaccination in the Western Hemisphere in 1994, it continues to circulate in several countries, including Afghanistan, Nigeria, and Pakistan. Public health experts report that vaccinations prevent 2.5 million child deaths per year.

However, if existing vaccines were made available to 90 percent of the global under-5 population, an additional 2 million lives would be saved. Initiatives such as the Decade of Vaccines Collaboration and the Global Alliance for Vaccines and Immunisation (GAVI) continue to bridge health disparities. GAVI, a body of specialists from WHO, UNICEF, government ministries, the pharmaceutical industry, the World Bank, the Bill & Melinda Gates Foundation, and finance organizations including the International Finance Facility for Immunisation, promotes investment for immunization in low-income countries. By highlighting connections between physical health—via immunization—and enhanced economic health in low-income countries, GAVI encourages investors to help fund closing the gap between children in high-income countries for whom immunization is a given and millions of children worldwide with no access to basic vaccines.

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See Also: Immunization Campaigns; Maternal/Infant Health Services; Public Health.

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Immunization Campaigns

Immunization campaigns are designed to increase awareness and encourage the general public to vaccinate, both adults and children, depending on the illness, as a measure of maintaining public health and preventing otherwise unnecessary illness. Campaigns are designed to encourage education and protect the medical profession by sharing information that will explain benefits of vaccination within the larger public sphere. The medical profession considers immunization awareness an ethical obligation, so patients are aware of protections against preventable diseases.

Vaccination was endorsed in Europe and the United States in the early 19th century. Immunization campaigns first came about as a result of a smallpox outbreak in the United States in the late 19th century. Mass campaigns occurred in the mid-20th century. Since then, most large-scale vaccination campaigns have been found to be very effective, helping eradicate smallpox and nearly eradicate polio. In 1988, the vaccine to prevent *Haemophilius influenzae*, a major cause of bacterial meningitis, decreased occurance of the disease by more than 99 percent. Full vaccination in children in the United States saves thousands of lives and prevents well over 10 million infections.

While there is widespread support of immunization, anti-vaccination campaigns have countered efforts to encourage immunization. Opponents of vaccination argue that the drop in infections result from improved sanitation and hygienic education or that the natural decline of these diseases are incidental, with studies attempting to prove immunization effectiveness. Another argument suggests vaccines are temporary and require boosters, while those who survive disease become permanently immune. While most parents understand children benefit from early vaccination, often lack of information, including risk assessments, perceptions that diseases children are vaccinated against initially have changed, challenges negotiating complicated immunization schedules for infants and young children, and exposure to anti-vaccine movements that are not countered with pro-vaccine information impact parents' perceptions of immunization, leading to fear, confusion, and large numbers of underimmunized children. This is complicated by herd immunity, a form of immunity occurring when vaccinated populations provide some protection for individuals who have not developed immunity. This leads to skepticism and mistrust of the pharmaceutical industry as well as governmental legislation requiring immunization. This tension makes it difficult for pediatricians to vaccinate as they see fit. Such risks are very personal, and risks of what might happen as a result of vaccination overshadow risks of developing very serious, and mostly preventable, diseases. An example of how anti-vaccine and vaccine campaigns work from both sides of an issue resulted from a 1998 *Lancet* article reporting autism as a possible side effect of the measles, mumps, and rubella (MMR) vaccine. Studies since then have no conclusive findings linking autism to MMR immunization in young children.

Immunizations for common preventable illnesses, such as measles, mumps, and rubella, for instance, are not the only types of vaccines offered to children. Each year, there are flu shots available to adults that work to prevent or lessen symptoms of the influenza virus and the pneumonia shot, designed to protect against common bacterial pneumonias. The outbreak of swine flu, or H1N1 virus, in 2009 led to a vaccine that treated a specific strain of influenza, which proved severe for children and adults alike. Giving evidence of public sentiment about vaccination at the time, the Pew Research Center reported in its survey of more than 1,000 adults that 47 percent would not get the voluntary H1N1 immunization. The government's response to H1N1 was critiqued for not matching the reality of the situation, arguably because the flu was not as lethal as it originally appeared. However, death is not the only reason to vaccinate; swine flu was highly contagious and problematic in schools and workplaces.

When mass immunization campaigns are enacted, many people are vaccinated in a short amount of time. Such campaigns, frequently used in developing countries but even in the United States, pose safety challenges because, often, vaccinations are implemented outside of typical health care settings, making monitoring safety and health a necessity, so if there is a problem, action can be taken to intervene as soon as possible.

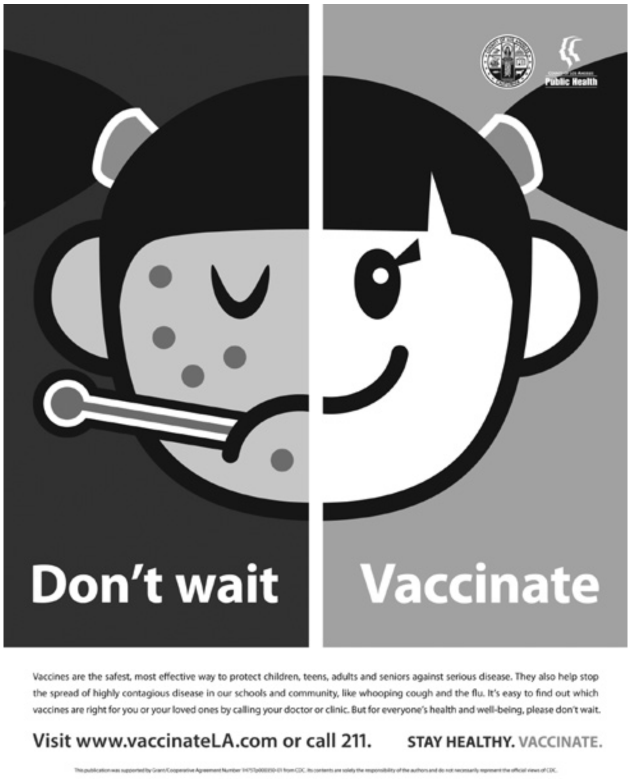
Immunization campaigns are set up so that many, often hundreds, of clinics in a specific area become the site of mass immunization. Seasonal flu vaccines might be offered to older children and adults so long as a guardian accompanies minors. Specially altered vaccines, such as the FluMist nasal spray, are offered to healthy people within a particular age range, or preservative-free vaccines are offered to pregnant women. Pneumonia vaccines might also be offered to adults who are healthy enough, according to criteria set by the Centers for Disease Control and Prevention (CDC). Insurance is often accepted at mass immunization locations.

Campaigns and Cultural Sensitivity

Campaigns must adapt to population differences because not all populations are of the same socioeconomic status or share religious, ethnic, or cultural beliefs. Such health promotion is required in order to fully reach target audiences in a culturally and linguistically competent manner, reflecting understanding and respect toward difference that functions cross-culturally and does not marginalize intended populations. This is done by creating health promotion materials that reflect the health beliefs and practices of specific audiences as well as the values of the health care providers who develop scientific bases for campaigns. Such campaign materials are linguistically competent if they also acknowledge that not all community members have the same literacy skills or ability to take in the materials.

Diversity must be approached in a comprehensive manner to assure that culturally diverse populations not only have different kinds of access to health promotion materials and education but access to health care as well. For example, several studies on ethnicity and socioeconomic status attempt to explain why human papillomavirus (HPV) vaccination rates are lower for African American women, Latinas, and women from Appalachia, concluding education is often a major factor in the decision to vaccinate. Given that cervical cancer is more common and is associated with higher mortality in Latina and African American women than in white women, researchers argue it is especially important to understand barriers to HPV vaccination. Awareness of the federal Vaccines for Children program is key to understanding that the vaccine, which costs $390 to those without insurance, can be covered for uninsured or underinsured children under age 19.

Increasing access of marginalized populations to health care professionals with accurate information can make campaigns more successful; assuming people understand the reason and schedule for a particular vaccine is assuming privilege of socioeconomic status, education, access to public or private health, and regular health care. For example, a study on vaccinations among community pharmacy and noncommunity pharmacy patients reported a greater number of whites (60.9 percent) received influenza vaccination than African Americans (49.1 percent) and Latinos and Latinas (51.7 percent). Vaccination rates were higher among community pharmacy patients, but racial disparities indicate the need for continued and increased education among minority populations. An example of a successful influenza vaccination campaign is that of the Whiteriver Service Unit, a rural Arizona Indian Health Service hospital that implemented a multidisciplinary campaign in collaboration with the White Mountain Apache Tribe Health Board and Tribal Council, disseminating information in the Apache language via the tribal radio station broadcasts and a tribal elder conference, school and home visits, and community health classes.



Vaccines are the safest, most effective way to protect children, teens, adults and seniors against serious disease. They also help stop the spread of highly contagious disease in our schools and community, like whooping cough and the flu. It's easy to find out which vaccines are right for you or your loved ones by calling your doctor or clinic. But for everyone's health and well-being, please don't wait.

Visit www.vaccinateLA.com or call 211. STAY HEALTHY. VACCINATE.

This poster was used in the Los Angeles County Department of Public Health multimedia public education campaign urging parents and caretakers to get their entire families vaccinated.

Another example is the National Hispanic Council on Aging (NHCOA), which trains Latino and Latina community members as *promotores de salud* (layperson health practitioners) for the national *Vacunémonos* (Let's Get Vaccinated) immunization education program. Originally sponsored by the CDC, *Vacunémonos* is a culturally and linguistically sensitive and age-appropriate program raising awareness among Latino and Latina older adults, their families, and caregivers about the importance of vaccinations. Because Latino and Latina seniors get immunized at lower rates than other seniors, *promotores de salud*, chosen for their leadership roles as trusted and well-known members within their respective communities, promote the importance of lifelong immunizations to prevent infectious diseases among seniors, their families, and their broader communities. *Promotores de salud* help reduce barriers affecting vaccination rates, including lack of education and social support networks, and advise on and distribute culturally and linguistically appropriate materials such as NHCOA's *Vacunémonos* brochure, which includes easy-to-read details about infectious diseases for which all adults should get vaccinated, explanations on the importance of immunization, and immunization schedules. Similar to *Vacunémonos*, the American Indian and Alaska Native Vaccination campaign, Protect the Circle of Life: Immunize Our Nations, contributes to increasing immunization rates among diverse communities through layperson health practitioners who empower their fellow community members to improve their quality of life.

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See Also: Communicable Diseases Common in Developing Countries; Fundamentalist Christian Americans; Global Burden of Disease; Global South/Global North; Health as a Human Right; Health Care, Disparities in; Health Disparities, Role of; Maternal/Infant Health Services; Indian Health Service; National Healthcare Disparities Reports; Neonatal Care; Pandemics; Public Health.

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Implicit Bias

An implicit bias is an unconscious preference. In the context of social justice, implicit biases reflect deep-seated preferences against members of a particular group. Unconscious processes may not be reflective of conscious processes. For example, in the civil rights movements of the 1960s, millions of baby boomers made conscious decisions and took decisive action to promote equality of race and gender. The unconscious mind, however, harbors everything to which it is exposed. The baby boom began in 1946, when people overtly expressed racial prejudice and gender roles advantaged males. Despite their social activism, the baby boomers had a high rate of exposure to messages of bias from early childhood. Implicit associations are unconscious cognitions based upon these early messages. The psychological community generally agrees with Freud's topographical model of the mind that estimates more than 90 percent of the mind's processes as unconscious. The content of the unconscious mind is not available for evaluation. It is difficult to determine empirically how much the unconscious mind influences preferences and decisions. Also unknown is whether material held in the unconscious mind is malleable.

Impact on Social Justice

A stereotype is an assumption about a group that is based upon learned associations about that group. It is possible for a person to consciously reject stereotypes and promote social activism while maintaining an implicit bias. Prejudice is an unfavorable evaluation of a group without having any experience with that group. The roots of prejudice are in implicit bias, and discrimination is unfair treatment of a marginalized group that arises out of prejudice. People with implicit biases behave differently toward those against whom they hold biases, even though they are unaware of those biases. Observable, quantifiable behaviors that are associated with implicit biases include differences in eye contact, differences in how verbalizations are directed, and proxemics.

Social injustices that arise from implicit biases are innumerable. In the legal system, bias is evident at every level. A black man striking a white woman draws more negative attention than a white man striking a black woman. Racial profiling relies on stereotypes about race or ethnicity rather than on reasonable suspicion to place an individual under scrutiny. Research shows that white jurors convict darker-skinned defendants at a higher rate than white defendants. Black defendants are also likely to incur longer sentences. Employment discrimination disadvantages women and minorities through unfair hiring practices, failure to mentor, failure to promote, and unfair wages. In the areas of housing, education, service, and health care, implicit bias can override social consciousness.

Micro-Aggression

Implicit bias has been associated with micro-aggression. Micro-aggressions are nonphysical exchanges that demean a person of another race, gender, age, or ability. Micro-aggressions can be verbal, nonverbal, visual, or behavioral and often are carried out unconsciously. Micro-aggressions are categorized as micro-assaults, micro-insults, and micro-invalidation. Micro-assault refers to verbal or nonverbal attacks intended to convey discriminatory and biased sentiment and include using derogatory names for race, gender, or sexual orientation. Micro-insults are unintentional behaviors or comments demonstrating insensitivity or demeaning a person's race, ethnicity, gender identity, or sexual orientation identity. Examples of micro-insults are assuming less capability in a person of color, suggesting that values and communication styles of people of color are abnormal, and racial profiling. Micro-invalidations are comments or behaviors that are dismissive of a group's beliefs or feelings. Assuming that people who appear racially different are foreigners, asserting that a white person does not see race, or diminishing the importance of race and racism are micro-invalidations.

Project Implicit

In 1995, researchers from several universities, including Harvard, hypothesized that memories stored in the unconscious mind do influence actions. Project Implicit was developed to do research and provide training on implicit bias, diversity, and inclusion. The Implicit Association Test (IAT) is a computer-based method for measuring implicit attitudes. The IAT entails a subject looking at images and immediately responding by striking a computer key that indicates the immediate association. For example, if two computer keys represent art and science respectively, the subject strikes the key that represents his or her immediate response to photographs of males and females that are randomly flashed on the screen. The types of associations measured by the IAT can reflect a positive or negative response, a stereotype, or self-esteem (which requires the subject to associate him- or herself with the image.) The IAT has been criticized for a lack of reliability and the effects of cognitive differences in subjects that might affect response times along with comparisons between the IAT results and the subjects' self-reported explicit attitudes, which subjects may be unable or unwilling to accurately articulate. Subsequent studies challenge the assumptions that the unconscious mind has more influence than the conscious mind, and the IAT is openly available on the Internet, not as a study but as a tool for increasing self-awareness.

Decreasing Implicit Bias

Diversity training in schools and workplaces has not been effective at decreasing implicit bias and has been shown to increase difficulties in some settings. In the workplace, creating diverse work teams has proven more effective in creating an inclusive environment. Some health care settings have had success in decreasing provider bias by promoting individuation of patients and deemphasizing categorization. In the legal system, training sessions on implicit bias and administration of the IAT are viable strategies. The overarching strategy for decreasing implicit bias is increasing awareness of the dynamics of implicit bias and its negative effects on social justice.

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See Also: Behavioral Health Disparities for Racial and Ethnic Minority Populations; Conflict Resolution and Diversity Cultural Competence; Discrimination and Institutional Racism; Prejudice, Theories of.

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Incarceration and Sentencing, Racial Disparities in

The United States has the highest incarceration rate in the world, even higher than Russia and China. Despite the fact that only about 5 percent of the world's population lives in the United States, more than one-quarter of the world's prisoners are incarcerated in U.S. prisons. The U.S. prison population has exploded since the 1980s, increasing from around 300,000 to more than 2.2 million in 2010. This increase represents an over 800 percent increase in approximately 25 years.

This dramatic increase in the prison population is directly linked to the U.S. war on drugs, a set of federal policies passed under the Nixon administration that were instituted based upon the belief that drugs were the root of most serious crimes in the United States. The passage of the Anti-Drug Abuse Act of 1986 instituted harsh criminal penalties for drug offenses, including minimum federal sentencing mandates for the possession and sale of certain drugs presumed to be particularly dangerous.

The rate of incarceration in response to the passage of the Anti-Drug Abuse Act of 1986 has not increased evenly across all demographics. Rather, the rate of incarceration among ethnic minority populations has increased significantly over other groups, with approximately 60 percent of the U.S. prison population representing racial and minority groups. For instance, although African Americans comprise approximately 13 percent of the U.S. population, they comprise nearly 40 percent of the U.S. prison population. Hispanics are also overrepresented in the prison population.

Overrepresentation of ethnic minority populations in prison does not appear to be caused by an increased number of ethnic minorities committing crimes. Rather, it appears as though institutionalized racism may be to blame where disparity in criminal investigative policies and sentencing guidelines, particularly with drug offenses, frequently leads to a higher number of ethnic minorities being charged and convicted of certain crimes and then receiving longer sentences. Research has consistently supported what social justice advocates have known for years—that Caucasians use and sell drugs at similar rates as ethnic minorities, and yet they are often not the target of law enforcement efforts, do not tend to be criminally charged at the same rates as ethnic minorities, and if they are arrested and charged, they do not tend to receive as harsh of punishments as ethnic minorities arrested for similar offenses. Additionally, drugs that are more frequently used by ethnic minorities often require much harsher sentences than drugs more frequently used by Caucasians. For instance, federal drug sentencing guidelines implemented after the Anti-Drug Abuse Act of 1986 created gross inequities in sentencing between crack cocaine (used more often by ethnic minorities) and powder cocaine (used more frequently by upper-income Caucasians), where five ounces of crack cocaine would be punished at the same level as 500 ounces of powder cocaine. Additionally, five ounces of crack cocaine would automatically trigger a mandatory five-year prison sentence, and 10 ounces would trigger a mandatory 10-year sentence as stipulated by mandated federal sentencing guidelines. Conversely, individuals who possessed the same amounts of powder cocaine were eligible for probation.

Many believe that these sentencing disparities were rooted in racial stereotypes because crack cocaine tends to be used more by ethnic minorities, particularly African Americans, whereas cocaine tends to be used more by Caucasians, particularly those with higher incomes. Other racial stereotypes included perceptions that crack cocaine was more closely connected to gang activity and urban violence and was more addictive than powder cocaine. In essence, it appears as though Congress voted to punish crack cocaine use disproportionately as a part of the war on drugs based on misperceptions that crack cocaine was more dangerous and more closely associated with gang activity—a perception that is not supported by research. In reality, the majority of crack cocaine offenders are black, while the majority of powder cocaine users are Hispanics, followed by Caucasians, and despite research that indicates similarities in personal and social impact of these two drugs, black crack cocaine offenders have consistently received significantly harsher sentences than powder cocaine users.

The Fair Sentencing Act of 2010, signed into law in August of 2013, was President Barack Obama's attempt at rectifying this injustice. This act reduced the disparity between the amounts of similar drugs and also eliminated the automatic five- and 10-year prison sentences for possessing five and 10 ounces of crack cocaine (respectively). While this legislation represents an attempt to confront racial inequities responsible for the overrepresentation of ethnic minorities in the U.S. prison system, further reforms are still needed.

Unfortunately, the populations that have been decimated the most by the disparity in drug sentencing laws are African American male youth and young adults, two already disenfranchised populations. While the war on drugs purported to be targeting drug kingpins, in reality, it appeared to target low-level ethnic minority male youth, who were often targeted by the kingpins as vulnerable to being recruited into the gang and drug culture due to the high rates of poverty in many black urban communities. Thus, rather than targeting and prosecuting leaders of the drug trade, many young black men have been targeted, often during their adolescent years, charged as adults, and sent to federal prison, sometimes for decades. In fact, youth of color are highly overrepresented in the juvenile justice system compared to white youth, a disparity that is not explained in differential rates of delinquency.

Black youth in particular are overrepresented in the juvenile justice system, experiencing higher rates of arrest than white youth who have committed similar offences, are prosecuted at higher rates compared to white youth, are charged more frequently as adults than are white youth having committed similar offenses, and are consistently detained for longer periods of time. Additionally, black youth are more frequently transferred to adult prison, even when charged as juveniles, than white youth who have committed similar offenses. Some of the reasons for this disproportionate treatment relate to the selective enforcement and targeting of certain types of delinquent behavior, racial disparity in treatment options, socioeconomic factors such as poverty, racially biased risk assessment tools, unequal access to effective legal representation, and as referenced earlier, legislative policies that impact offenders of color more harshly.

The impact of the racial disparity in incarceration on communities of color and society as a whole is significant and has resulted in the disenfranchisement of a significant portion of the ethnic minority population, leading many social justice advocates to frame disparities in legislative and sentencing laws as yet another example of institutionalized racism. For instance, almost all states prohibit voting while in prison, and a majority of states prohibit voting while on probation or parole. In Florida, for instance, nearly one in five black men are not able to vote due to their legal status related to drug offenses. Some estimate that nearly 40 percent of black men in the

United States will permanently lose their right to vote due to drug offences at nearly 40 percent. In addition to the passage of the Fair Sentencing Act of 2010, several states have passed legislation in an attempt to address issues related to disenfranchisement, but advocates assert that federal and state corrective actions must address racial disparities in retrospect in order to amend the unequal treatment the potentially millions of people of color have experienced in the past three decades, often resulting in being sent to prison for 20 years, or even life, when white offenders, if charged, have received minimal sentences by comparison. Additional areas needing increased focus, particularly by human services professionals, include the extremely negative impact that such disparities in sentencing have on ethnic minority families, particularly youth whose parents are incarcerated.

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See Also: African Americans; At-Risk Youth Services; Juvenile Justice System; Office of Juvenile Justice and Delinquency Prevention; Power, Race/Ethnicity and; Prisoners and Ex-Prisoners; Racism, Long-Term Effects of.

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Indian Boarding Schools

During the 19th and 20th centuries, a variety of boarding schools were established to serve Indian children from various tribes across the United States. Some of these boarding schools were national in nature, taking students from a variety of tribes across the country, while others were established specifically to serve children from a specific tribe or region. While the Indian boarding schools were initially established by missionaries, the United States government soon began founding its own schools. Pedagogical methods used in the Indian boarding schools did not meet contemporary standards of practice, as school personnel forcibly cut children's hair, forced them to speak English, and disparaged their home cultures. Although some Indian boarding schools still exist, most Native American children are now educated in schools located near their homes.

Although schools that served Indian children had been extant in the United States since colonial times, after the Civil War, many religious groups organized new schools to serve Native American students. In 1879, Richard Henry Pratt, a captain in the United States Army, founded the Carlisle Indian Industrial School in Carlisle, Pennsylvania. The Carlisle School was the first in the United States and was placed at the site of the Carlisle Barracks, an important army base during the Civil War. Pratt believed that Indian children needed to learn English and adopt European American ways of dress, eating, and work. To that end, Pratt sought to help Indian children distance themselves from traditional ways. Through discussions with tribal elders, Pratt convinced many that they had been cheated in treaties with Caucasians because of their inability to read and write. In order to prevent this from recurring, the elders agreed to send their children to the Carlisle School.

The Carlisle School quickly grew to serve more than 1,000 students. The curriculum emphasized

With the founding of the Carlisle Indian Industrial School in 1879 in Carlisle, Pennsylvania, the U.S. government launched an effort at what is now called cultural genocide where Indian children were taken away from their families and put into boarding schools for three or more years. The school quickly grew to serve more than 1,000 students, although only 158 students ever graduated.

English, mathematics, history, art, and vocational training. Many of the Indian children who arrived at the Carlisle School were unable to speak English, and some students who had been there longer served as interpreters. The methods of the Carlisle School have been questioned as allegations of abuse, punishment for not speaking English, and maltreatment have been made. Indeed, of the more than 12,000 children the Carlisle School served before it closed in 1918, fewer than 8 percent graduated, while twice that number ran away. Children from more than 140 tribes were enrolled at the Carlisle School, and its influence, both positive and negative, was great.

Despite the controversy associated with the Carlisle School, the Bureau of Indian Affairs (BIA) used it as a model for other boarding schools for Native American children. As a result, the BIA formed 26 other boarding schools across the United States. More than 400 religious organizations also founded boarding schools for Indian children, and many of these also adopted practices first used by the Carlisle School, including giving the children English names, cutting their hair, using corporal punishment, forcing conversions to Christianity, and prohibiting the use of native languages or religious practices. In addition to their academic work, Indian children were forced to engage in chores involving the preparation of meals, cleaning, and farming.

During the 1920s, changing mores led the federal government to reassess its practices with educating Indian children. As a result, in 1926, the United States Department of the Interior engaged the Institute for Government Research (later known as the Brookings Institution) to conduct a study of the efficacy of Indian education programs. In 1928, the results of this study, “The Problem of Indian Administration,” (commonly known as the Meriam Report) were issued. The Meriam Report was highly critical of how the Department of the Interior administered Indian schools and issued a call for change. While the Meriam Report applauded the importance placed by the BIA on Indian education, it decried its implementation. Instead of educating Indian children at separate schools, the Meriam Report called for integrating these students into mainstream schools. With regard to the Indian boarding schools, the Meriam Report found their operation to be inadequate and subpar. Specifically, the Meriam Report decried the diet and medical services provided to the Indian children, found them overcrowded and overly reliant upon student labor, and believed that the uniform curriculum did little to raise teacher standards or student performance.

While immediate changes did not take place in Indian boarding schools, the Meriam Report presaged reform of the system. John Collier, who served as the commissioner of the BIA from 1933 until 1945, was instrumental in changing the assimilationist policies favored until that time. Collier, who later taught at the City College of New York and Knox College, was instrumental in assuring the passage of the Indian Reorganization Act of 1934, which restored local self-government to many tribes. The Indian Reorganization Act also ended many of the educational policies that favored assimilation and helped reservations to reacquire lands that had been lost. These changes laid the foundation for many later transformations to the education of Indian children.

Despite the controversy regarding Indian boarding schools and the criticism of them in the Meriam Report, as institutions, they continued to thrive for the next five decades. Indeed, enrollment in Indian boarding schools reached its zenith during the 1970s, when more than 60,000 students attended such institutions. After this, changing tribal demands for appropriate educational experiences resulted in the construction of many more schools located near Indian children's homes, diminishing the need for boarding schools. A variety of Indian boarding schools still exist today, although they enroll fewer than 10,000 children. Such Indian boarding schools that continue to exist are highly regulated to avoid the problems of the past and are intended to provide expanded educational opportunities to Native American children who live in isolated locations.

Special curriculum, focusing on science, technology, engineering, mathematics, the arts, or other combinations are frequently the draw that attracts Indian children to their offerings. Other former boarding schools, such as St. Michael Indian School in St. Michael, Arizona, continue to operate as day schools but have eliminated their residential component.

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See Also: Abuse and Neglect; Educational Services; Indian Child Welfare Act; Indian Civil Rights Act of 1968; National Congress of American Indians; Native Americans.

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Indian Child Welfare Act

The Indian Child Welfare Act of 1978 (ICWA), United States Code Title 25, governs jurisdiction over the removal of Native American children from families and gives tribal governments a voice in child custody cases when a child is a ward of the tribe. This concept of assigning jurisdiction of child custody to tribal governments is a radical and often misunderstood message recognizing that the cultural diversity among Native American tribes is so great that it cannot be judged by nontribal human services. This concept also recognizes that it will take time for tribes to establish or recreate infrastructures without outside interference to address the social challenges that resulted from Indian children being removed from tribal homes. A 1969 survey in 16 states found that about 85 percent of Native American children were placed in nonnative foster homes. While many tribes continue to face poverty that makes delivery of human services difficult, ICWA has provided an opportunity for Native Americans to embrace or reject traditional tribal traditions rather than to be subject to the non-native systems that have sought to alienate Native American children from their own culture.

ICWA came about as a result of the Indian Self Determination and Education Act of 1975. While late-19th-century pro-assimilation reform movements often sought to assimilate Native Americans into mainstream American culture, Congress asserted that preserving Native American traditions trumped assimilation and hoped to protect Native American culture and tribal integrity when state and federal agencies removed children from tribal environments. ICWA recognizes that Native Americans have unique child-rearing practices and traditions that do not fall under the authority of non-Indian values or judgment, and maintaining a child in his or her own home that reflects tribal background is in the best interest of the child and tribe. However, ICWA has been challenged in many states under the non-Indian argument that the 14th Amendment provides equal protection from race-based parental rights. Moreover, the state law implementing ICWA has been found to be constitutionally wanting in California, where many tribes are federally recognized.

The U.S. Supreme Court asserts that federally recognized tribes are domestic dependent nations with a particular relationship to the federal government where the federal government can only exercise plenary authority consistent with that of a guardian toward a ward. State welfare and non-Native American social workers have historically had too much influence on the lives of Native American families: Conflicts of interest arose when parents relied upon social workers for continuing welfare benefits even as the same social workers sought to displace their children. Subsequently, courts rarely consulted with tribal experts on traditional child-rearing practices. A common practice in some Native American communities was to leave a child with extended tribal kin; however, many social workers considered this to be abandonment.

Undoing Violence Against Women and Children

Today, Native Americans living on reservations are challenged to resurrect nurturing cultural traditions destroyed by dominant and aggressive colonizers. In California at the time of the American Revolution, Spanish Franciscans operating missions initiated a system to denaturalize and destabilize the aboriginal sense of self-identity, connectivity, and kinship to the spiritual world, reducing all native people from sophisticated land stewards to children or neophytes. Franciscans established forms of artificial paternal kinship with baptisms of native people, which brought about the demographic collapse of the tribes when Spaniards stood as godparents undermining the authority of tribal headmen within the new political hierarchy. Spanish soldiers further undermined any real potential for kinship when they raped California Indian women, introducing syphilis into mission populations that were unknowingly carried to tribal villages.

Federal Title II funding today for ICWA is insufficient to support even court adoption work without addressing support services to bolster families. Underlying issues threatened Native American families—namely introduction of alcohol into their culture and the destruction of Native American traditions by non-Indians, leading to a catastrophic epidemic of violence against women on reservations. Native American families deal with the same issues of alcohol addiction and methamphetamine use as the dominant American population. However, in many states, up to 35 percent of Native American children have been placed in foster or adoptive homes at some time in their lives. Likewise, Native American children have been removed from homes disproportionate to the dominant population when social workers or judges saw their biological families as unfit by typical cultural standards. Alcohol abuse was cited as the cause for removal in disproportionate numbers to family units with the same challenge in other demographics.

ICWA has been instrumental in educating judges on Native American children and tribal traditions of child rearing, which has promoted multicultural understanding and sensitivity and opened dialogs between state officials and tribal judges. ICWA has strengthened tribal courts and institutions that resolve disputes. It has also proscribed destructive practices that could endanger some tribal societies. More Native American children get placed with extended family members than before the act; however, the rate of Indian children being removed from families remains disproportionately high. While adoption of Native American children into non-Indian homes still occurs, ICWA places conditions on these adoptions that the children get exposure to tribal culture and traditions. Some Native American families are opting to provide foster homes for or to adopt Indian children.

Native American-operated Temporary Assistance for Needy Families (TANF) programs provide assistance to needy Native American families so that children can be cared for in their own homes and to promote employment training, job opportunities, and marriage to reduce out-of-wedlock pregnancies. Native TANF's strategy is to encourage the formation of strong families and bolster two-parent families with a total family income at least equal to 125 percent of the federal poverty guidelines for cash assistance, or at risk of welfare dependency, so that they can sustain self-sufficiency.

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See Also: Administration for Native Americans; Center for Native American Youth; Indian Boarding Schools; Indian Civil Rights Act of 1968; Native Americans.

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Indian Civil Rights Act of 1968

The Indian Civil Rights Act (ICRA) of 1968 was the first piece of legislation from the United States Congress to impose provisions of the United States Bill of Rights on the actions of tribal governments protecting individuals living on reservations. The federal government historically created treaties and initiated negotiations for surrender of tribal lands, but until enactment of ICRA, tribes (due to their extra-constitutional status) were not subject so such constraints. ICRA does not protect tribes or members from federal interests focused on reducing tribal sovereignty or tribal treaty rights. This law provides for due process and other civil liberties in tribal courts. States could no longer assume civil and criminal jurisdiction over Indian land without tribal consent given during special elections, but ICRA limits sentences imposed by tribal courts to misdemeanor jurisdiction in criminal cases. The Native American civil rights struggle coincided with the War on Poverty; it was not just fought for on the reservations but also came out of the trials and tribulations of Native Americans living in urban areas.

Though well intentioned, most significantly, ICRA has created additional challenges for impoverished tribes that do not have funding or resources to secure residents on some reservations facing complexly layered social problems related to alcoholism and substance abuse. As outsiders, federal law enforcement personnel are often too ill prepared and understaffed to operate efficiently on reservations. The Native American per-capita rate for experiencing violence is twice the rate of non-Native Americans in the United States: Adults age 25 to 34 are more than two and a half times more likely to experience violent crime attacks than non-Indian counterparts. One in three Native American women experience sexual violence. The Justice Department found that white Americans committed violent crimes against Native Americans in approximately 60 percent of documented incidents, and alcohol was involved in the vast majority of violent crimes.

The federal government historically wanted to open up tribal lands for settlement. Throughout the 19th century, federal military, state militia, and citizen vigilantes forcibly removed tribes from ancestral lands. The Dawson Act of 1887 allowed for the division of shared community-held reservation lands into 160-acre allotments as a means to get Native Americans to forsake tribal relations and traditional ways in order to become farmers. The black civil rights protests of the late 1950s and 1960s created a model for the American Indian Movement (AIM) to protest the federal government's treatment of native people.

Modern Challenges for Indigenous Women

Women who experience domestic violence, rape, and gang rape have little support and experience retaliation because tribal police are overwhelmed and Federal Bureau of Investigation (FBI) investigators are not local; they sometimes become triple victims when they report assaults, first by the crime, then by the investigators, and then by tribal males who see them as betraying tribal loyalty. Many tribes operate under constitutions drafted by the Bureau of Indian Affairs (BIA) from the 1930s, providing tribal councils with total executive power over all reservation hiring including judges. A complication in ICRA arose when tribal nations were recognized as corporate and poverty-stricken bodies as a result of becoming separate nations, where tribal councils became sponsoring agencies eligible for federal funding. This recognition mandated councils to provide assistance for all residents of the reservations regardless of race to meet eligibility requirements for federal programs.

Reservations are like large extended families where jobs are offered to family members on the condition that they do not work or speak against the tribe. ICRA attempts to reconcile the need for Western law to the desire of tribes to integrate their tribal traditions into justice systems. It also attempts to reconcile the ability of tribes to govern tribal lands to the rights of non-Indians who cannot hold office or participate in tribal elections. Native Americans have maintained diverse legal systems since prior to European contact. Approximately 20 traditional Native American courts remain that administer unwritten established cultural law where conflicts are resolved. Reservations were perceived as lawless communities without legal systems; the general public sought to impose systems of litigious Western-styled law and order to advance assimilation.

The ICRA guarantees that most but not all sections of the United States Bill of Rights apply to Native American individuals in dealing with their tribal governments, which parallels the protections that U.S. citizens have with state and local governments. ICRA made a significant amount of Constitutional law applicable in tribal courts. In short, it protects the individual rights of all people living on reservations against arbitrary actions by imposing Constitutional norms on tribal government actions to protect the rights of all residents. The United States government under the Constitution and the Bill of Rights covers federally recognized Native American tribes as nations. ICRA protects the free exercise of religion, but tribes can establish their own religious traditions and restrictions.

More than 140 tribes maintain tribal courts, and they are diverse in nature and operation. Each tribe establishes criteria for its judges. Tribal judges are not generally attorneys with Western legal training but receive legal training from the National American Indian Court Judges Association, which is not equal to a JD degree, and they may not be state-licensed attorneys. Tribal courts are not generally courts of record; therefore, many opinions are not recorded. They build legitimacy within the tribe. Tribes are not required to have means for appealing decisions.

Native Americans and the First Amendment

Tribal governments are exempt from the Freedom of Information Act of 1967 that provides guarantees that citizens can inspect unclassified government documents. Tribal journalists traditionally could not use the First Amendment because of tribal sovereignty, but ICRA included a provision for freedom of the press. In practice, tribal governments shape the news for their communities with funding, hiring and firing practices, banning journalists from tribal government meetings, restrictions on press access to tribal government documents, and threats of retaliation. The Native American Journalist Association has made efforts to bridge tribal loyalties to open to the media.

NAGPRA and the Most Fundamental Right of American Indians

The underlying logic of the ICRA has been to restore basic civil rights to indigenous people. Native American Graves Protection and Reparation Act (NAGPRA) enacted in 1990 surfaced a basic issue of Indian civil rights: the right to a decent burial. NAGPRA compelled examination of all Native American and Native Hawai‘ian remains held in museums, universities, and state and federal repositories and bolstered tribal and government laws related to grave desecration and reburial. Having centuries of Native American bodies dug up and moved for academic, commercial, and “progressive” purposes is a human rights issue. American Indians Against Desecration, the

National Congress of American Indians, and the Native American Rights Fund led efforts for NAGPRA consultation and reparations with tribes in relation to human remains and sacred objects held by public agencies. The result of these consultations has been an exchange of information and tribal acquisition of cultural traditions and identity from sacred objects that were removed, which has led to tribal preservation of traditional interests that include indigenous languages and dialects, food, culture, and governing structures.

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See Also: Administration for Native Americans; Center for Native American Youth; Indian Boarding Schools; Indian Child Welfare Act; Native Americans.

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Indian Health Service

The Indian Health Service (IHS) is a comprehensive health program specifically for American Indians and Native Alaskans (AI/ANs or Native Americans). It provides services to this limited population due to a unique federal Indian trust relationship between the U.S. government and Native Americans. Funding is by discretionary appropriations authorized by Congress but based on the federal Indian relationship. In 2013, the IHS operated most of its facilities on reservation lands including 320 health centers, 45 hospitals, 115 health stations, and four school health centers.

AI/ANs can be from federally recognized tribes or not, they can live in reservation states or not, or they can live on reservations or in urban centers. They have diverse tribal memberships, cultural norms, and ancestral languages. The IHS provides different services depending upon the sociopolitical and geographic situation of each individual, although all services fail to meet parity with those available to non-Indians. The history, policies, and practices of the IHS demonstrate the disparity of human services available to Native Americans.

Federal Indian Trust Relationship

The IHS was created by the Indian Health Transfer Act during the Termination Era of federal policies toward Native Americans. After World War II, Congress was intent upon ending treaty rights and decreasing services. Because some Native Americans had served in the war as U.S. citizens, Congress determined it was time to assimilate all Native Americans into the general population. But the trust relationship between tribal nations and the U.S. government obligated Congress to provide AI/ANs with health care services equal to those provided to non-Indians. In an effort to both hasten integration and improve health services, Congress passed the Indian Health Transfer Act of 1955, transferring promised services from the Bureau of Indian Affairs into the Public Health Service (PHS).

Meanwhile, on Native American reservations, tuberculosis was the number one killer, infant mortality was high, and illnesses eliminated from non-Indian populations lingered. The remote locations within large reservations and prevalent unsanitary conditions coupled with poor career incentives for physicians meant that IHS services were often provided at great distance and by temporary staff. Congress promised services but did not authorize the appropriations needed to provide services beyond crisis care. Underfunding, understaffing, and a lack of infrastructure were the challenges facing the new IHS. Reducing tuberculosis, reducing infant mortality, and improving sanitation were the priority projects.

Improving Environmental Health

The greatest success of the IHS has been in the area of sanitation. To provide healthier environments and create greater opportunity for improved health, infrastructure needed to be modernized. Congress passed the Indian Sanitation Facilities Construction Act of 1959 to provide IHS the authority to construct sanitary structures and fund home improvements for IHS service recipients. Reducing environmental deficiencies by providing clean water, indoor plumbing, proper ventilation, and solid waste disposal facilities led to improved Native American health. Tuberculosis declined as the leading cause of death, the infant mortality rate decreased, and life expectancy increased. But transportation difficulties for both patients and personnel, high rates of staff turnover, and lack of funding remained as impediments to health parity.

From Objects to Participants

During the 1970s, allegations that the IHS took advantage of service recipients were verified. The least of these allegations were claims that the IHS did not adhere to the concept of dual citizenship and regularly denied services to AI/ANs. State, local, and federal health programs, as well as IHS services, were open to Native Americans. The IHS would refer recipients to local service providers, who in turn would refer them back to IHS service providers. Caught between two systems, many eligible AI/ANs did not receive care.

The worst of the verified allegations were of forced sterilizations and undisclosed medical experiments. Patients were sterilized either without their consent or coerced to accept sterilization with threats of denied federal support if they did not comply. The number of forced sterilizations performed by the IHS through the 1970s is estimated in the thousands for women and the hundreds for men. Children and adults were also given experimental treatments, medications, and placebos. Native American activist groups organized to put pressure on the IHS to end these practices and provide services that recognized traditional beliefs and cultural differences.

As a result, Congress passed the Indian Self-Determination and Educational Assistance Act of 1975 and the Indian Healthcare Improvement Act of 1976. The former was intended to maximize Indian participation and make federal services more responsive to the needs and desires of communities. The latter removed the prohibition of Medicaid and Medicare reimbursement to the IHS, provided for AI/AN educational funding, and set the goal of achieving health care parity within seven years.

These laws enabled AI/ANs to move from objects to participants in the provision of health care at the IHS. The first Native American director, Everett R. Rhoades, was appointed in 1982. Medical aides and paraprofessional health care staff lived and worked in their own communities, qualified members of federally recognized tribes were given preference for employment, tribally controlled hospitals were accredited by the Joint Commission on Accreditation of Health Care Organizations, and by 2006, traditional medicine services were available at IHS hospitals and clinics.

The IHS has never been funded to meet the health care needs of Native Americans. The goal of achieving parity has never been met. In 2013, Congress allowed sequestration cuts to reduce already parsimonious budget allocations for the IHS while maintaining budget allocations for programs that benefited the health services provided for non-Indians. The health of AI/ANs remains a generation behind non-Indians, and the IHS remains the only health care provider for approximately one-third of all Native Americans.

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See Also: Alaska Natives; Assimilation; Community-Based Participatory Research; Native Americans; Native Americans, Suicide Among; Poverty; Self-Determination and Education Assistance Act; Traditional Medicine.

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Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) is a federal law that was created to ensure educational services are provided to children with disabilities throughout the United States. Enacted in 1975, IDEA originally was called the Education for All Handicapped Children Act (EAHCA) and supported states and local education agencies in providing early intervention, special education, and related services to infants, toddlers, and children with disabilities. Prior to 1975, about half of all children with disabilities were denied educational opportunities in the United States. The IDEA guaranteed a free, appropriate public education (FAPE) to every child with a disability, who due to disability was not benefiting from the available education. In 1990, the EAHCA was renamed the Individuals with Disabilities Education Act. The IDEA has evolved since its origin through court decisions, amendments to the law, and improved knowledge of providing for the educational needs of children with disabilities. It has proven to be an essential law for ensuring that our society provides all diverse children with disabilities the equal opportunity to benefit from their local public schools.

History of Special Education Services and the Origins of IDEA

Education of children in the United States historically has been the responsibility of individual states. While states made publically funded, locally controlled schools available to students, states largely excluded students with disabilities. Some students from wealthier families received an education through charitable institutions such as for deaf

Today, more children with disabilities fully participate in kindergarten through 12th grade education in the United States than at any time previously. More than 6.5 million school children in the United States age 3 to 21 received special education services under the Individuals with Disabilities Education Act (IDEA) in 2011.

and blind students. In the late 1800s, a few publicly funded schools began serving children with disabilities; however, these were mostly residential schools that required students to be separated from their families. Public day-school programs for children with disabilities became more common in the early 1900s in a few large cities, though most students with disabilities attended residential schools or no school at all.

The federal government first began taking steps to support the education of students with disabilities by enacting the Elementary and Secondary Education Act of 1965. In addition to providing funding to state institutions, the act created the first federal grant program for local schools educating students with disabilities and created the Bureau of Education for the Handicapped, now known as the Office of Special Education Programs. The Rehabilitation Act of 1973 was the first law to make it unlawful for schools receiving federal funding to exclude children with disabilities. Finally, in 1975, Congress passed the EAHCA, which guaranteed all children with disabilities a FAPE.

Evolution of the IDEA

1973: Rehabilitation Act of 1973. This act provided that schools receiving federal funding could not exclude children with disabilities. Additionally, schools could not deny services for lack of funding or make a child's family pay for necessary educational services. Public education had to be free for all children.

1975: EAHCA. For the first time, the federal government required all public schools to provide a FAPE to all students in the least restrictive environment (LRE) for the students and that is appropriate for the child's needs. Schools were required to evaluate students with disabilities and create an individualized education plan (IEP) with parent input that would provide a beneficial educational experience much like that for students without disabilities.

1982: Supreme Court decision in Board of Education v. Rowley, 458 U.S. 176 (1982). The Supreme Court established a two-part inquiry to determine if the FAPE requirement was satisfied: (1) the school must have complied with the procedures set forth in the act; and (2) the IEP developed must be reasonably calculated to enable the child to receive educational benefits, which in general only included enabling a child to achieve passing marks and advance from grade to grade. The school does not have to maximize each child's potential.

1983: EAHCA amended. These amendments granted federal funding to create parent information centers for parents to learn how to protect their child's rights. Additionally, it created financial incentives for schools to expand preschool services (from birth to age 3) for students with disabilities and services to assist high school students with disabilities in transitioning from school to adult life.

1990: Amended and renamed IDEA. These amendments replaced the term *handicapped child* with the term *child with a disability,* required transition services for students by age 16, added distinct disability categories for children with autism and traumatic brain injuries, defined assistive technology devices and services for inclusion in the IEP, and extended the LRE to require, to the maximum extent appropriate, that the child be educated with (in the same class or classes as) children without disabilities.

Implementation of the IDEA

Today, more children with disabilities fully participate in K through 12 education in the United States than at any time previously. More than 6.5 million school children in the United States ages 3 to 21 received special education services under the IDEA in 2011. Educators are better trained to work with children who have disabilities. Children without disabilities today do not know a world where children with disabilities were excluded from education.

However, implementing the IDEA has been at times a highly adversarial task for many parents and schools. In practice, schools sometimes only provide a basic minimum of services due to factors such as insufficient funding, the shortage of appropriately trained teachers, or a lack of institutional will. Disputes about the appropriateness of a child's IEP can lead to administrative hearings and civil suits. Some educators and disability advocates believe that the U.S. legal system, which is an adversarial system, is inconsistent with the intent of the IDEA, that is, to facilitate collaborative planning among school staff and family for a child's educational benefit.

The Future of the IDEA

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is an instrument intended to protect the rights and dignity of people with disabilities internationally. As of August 2013, the United States has signed but not ratified the CRPD. If the United States does ratify the CRPD, the IDEA may require altering or expansion as it currently does not require the full development of human potential as well as the maximization of academic and social development in students with disabilities that Article 24 of the CRPD requires.

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See Also: Children With Special Needs; Convention on the Rights of Persons with Disabilities, United Nations; Special Education.

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Infant Mortality/Sudden Infant Death Syndrome

In the United States, the infant mortality rate (IMR) has shown a steady decline, from 26.0 per 1,000 live births in 1960 to 6.14 per 1,000 live births in 2010. The United States' IMR world ranking has also steadily declined, from a ranking of 18 in 1980 to 31 in 2008. When compared to countries with lower IMRs, this ranking is due in large part to higher rates of low birth weight (LBW) and short gestational age births, or premature births, and racial and ethnic disparities. The leading causes of infant death include congenital abnormalities, preterm and LBW, sudden infant death syndrome (SIDS), and newborns affected by maternal complications of pregnancy.

LBW due to shortened gestation or inadequate fetal growth is a major determinant of infant mortality and morbidity. Infants who weigh less than 5.5 pounds are considered to be low birth weight. In 2010, 8.2 percent of infants born in the United States were born with LBW, and 1.4 percent of infants were born with very low birth weight. Compared to infants of normal weight, LBW infants may be more at risk for many health problems. Some babies may become sick in the first six days of life or develop infections. Other babies may even suffer from longer-term problems such as delayed motor and social development or learning disabilities. Exposure to lead, solvents, pesticides, and air pollution during pregnancy has been associated with LBW. A pregnant woman may increase her chances of having an LBW baby if she smokes, drinks alcohol, does not gain weight while pregnant, is younger than 15 years of age or is older than 35 years of age, if she has had a previous preterm birth, or if she is exposed to air pollution (both indoor and outdoor) and drinking water contaminated with lead. Social and economic factors such as low income, low educational level, stress, domestic violence or other abuse, and being unmarried may also contribute to LBW.

While the exact causes of SIDS are unknown, sleep patterns, brain abnormalities, LBW, and respiratory conditions are all factors that are associated with SIDS. In 1994, the Triple-Risk Model for SIDS was proposed, which suggests that SIDS occurs when the following three factors are present simultaneously. The first factor is an underlying vulnerability in the infant; the second, a critical developmental period; and the third, a stressor, such as asphyxia. According to the Triple-Risk Model, SIDS does not cause death in normal infants but, rather, only in vulnerable infants with an underlying abnormality. Therefore, the change to a supine sleep position is effective because, once the stressor (e.g., facedown position) is removed, the vulnerable infant passes unharmed through the critical period. Infants who are born with brain abnormalities may have one of the underlying abnormalities that can contribute to SIDS. In many of these infants, the portion of the brain that controls breathing and arousal from sleep doesn't work properly. Environmental risk factors include poverty, prenatal exposure to alcohol or drugs, and postnatal exposure to smoke and alcohol or illicit drugs. Postnatal exposure to cigarette smoke may trigger intrinsic responses in the vulnerable infants as this exposure may have a direct effect on neurotransmitter systems that are critical to homeostatic control in the developing human brain. Premature birth or being part of a multiple birth increases the likelihood that an infant's brain hasn't matured completely, so he or she has less reliable control over such automatic processes as breathing and heart rate. Many infants who have died of SIDS have recently experienced a cold, which may contribute to breathing problems.

Research suggests that infants who sleep on their backs are less likely to die from SIDS than infants who sleep in a prone position or on their stomachs. Both partial and exclusive breast-feeding may be associated with a reduced risk of SIDS. Infants who are placed on their stomachs or sides to sleep may have more difficulty breathing than those placed on their backs. The risk increases if the infant sleeps in the same bed as his or her parents in part because there are more soft surfaces to impair the infant's breathing. However, women in lower social classes may be less likely to receive this public health information than other women. When they do hear the message, African American mothers are less likely to adhere to the recommendation that an infant sleep on his or her back. Some African American women, as well as other mothers, may perceive that the best preventive measure was for them to be vigilant and watch over their infants. However, it is disconcerting to think that mothers' efforts to be vigilant of their newborns may cause them to sleep with their infants, which actually increases the chances of SIDS. Further, some mothers and health care providers alike perceive that sleeping on his or her back could increase an infant's chances of choking and is therefore more of a risk than an infant sleeping on his or her stomach. Thus, more needs to be done to understand the cultural barriers to adapting this preventive health measure to prevent SIDS. Rather than relying simply on distributing

The Safe to Sleep campaign from the National Institute of Child Health and Human Development, formerly known as the Back to Sleep campaign, focuses on actions that can be taken to help reduce the risk of sudden infant death syndrome (SIDS) and other sleep-related causes of infant death. Research suggests that infants who sleep on their backs are less likely to die from SIDS.

the guidelines, mothers may benefit from detailed explanations of the sleep guidelines.

Infant mortality among African Americans in 2008 was twice the national average. The SIDS death rate among American Indian and Alaska Natives is nearly two times the rate of non-Hispanic white mothers. Racial and ethnic disparities in infant mortality cannot be explained by socioeconomic status alone. Other contributing factors include strenuous working conditions and toxic exposures, neighborhood violent crime, and residential environmental exposures such as air pollution, substances in drinking water, and industrial chemicals. Paternal exposure to pesticides, solvents, and lead in the workplace before conception may affect infant health. Black fathers are more likely than black mothers to be exposed to toxic substances at work.

Within the African American community, maternal education and marital status may ultimately influence infant mortality, mediated by biological and demographic factors, health care, and infant health status at birth. Despite relatively low incomes, low formal education, and lack of access to medical care, everyday pregnancy care may explain why Mexican immigrant women have positive birth outcomes. Although socioeconomic and behavioral factors contribute to adverse birth outcomes, factors such as income, education, prenatal care, marital status, and substance abuse do not fully account for these ethnic disparities. There is now emerging evidence that the disproportionate rates of infant mortality, LBW, and preterm delivery in African Americans may result from group differences in exposure or susceptibility to prenatal stress, including stress related to racism and discrimination as well as physiological differences in physiological responses to stress.

Prevention can do much to reduce infant mortality as a result of SIDS and LBW. Such strategies would include increasing access to health care for women who are pregnant, public health campaigns to increase awareness of ways to prevent SIDS and LBW, and reducing social and environmental stressors that contribute to LBW and SIDS. Prenatal social supports and health education for women and at-risk families along with access to health care and other services holds promise for reducing LBW deliveries among at-risk women and adolescents.

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See Also: Infant/Toddler Development; Infanticide, International Variations in Attitudes Toward; Pregnancy and Parenting Services.

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Infanticide, International Variations in Attitudes Toward

> "May you be the mother of a hundred sons." (Hindu wedding day blessing cited in *Society for the Protection of the Girl Child*, 2011)

Infanticide is deemed to exist primarily within India and China for the simple reason that their respective population sizes create the actual or perceived need to produce children who can best create an economic impact such that the family is better equipped to survive in often financially difficult circumstances. For the most part, the children of choice or priority have been boys. However, it is worth observing that infanticide, albeit perhaps to a lesser degree, has also been observed in Azerbaijan, Armenia, Georgia, Montenegro, Albania, Vietnam, and Pakistan, where the ratio ranges from 109.9 to 117.6 boys per 100 girls, reports C. Hitrova.

It is certainly arguable that female infanticide and sex-selective abortion are two sides of the same coin given that, both individually and collectively, they diminish the number of females in the population in an unnatural manner. However, they are distinct. Sex-selective abortion occurs during gestation and female infanticide within hours or days of an infant's life, and it is the latter that is the focus here. A. Gray has argued that they each form part of what she terms *gendercide*, that is, the deliberate killing of a person based solely upon his or her gender. Gray maintains that a major driver that sits behind cultural and societal determinants of gendercide is a growing awareness of the goods available in Western democracies.

Thus, television, for example, depicts for the population in India perceptually typical Western small families and provides an array of advertisements that encourage a high level of materialism among the populace. One argued consequence of this world of opportunity has been an increase in female infanticide and sex-selective abortion. The process of dowries (which although illegal are still commonplace), in which the father of the bride bestows relatively great wealth upon her husband and his family, has become yet more onerous given that it sits alongside the costs of the increased materialism driven by exposure to the West. Dowries can place the bride's family into long-term and often crippling financial debt and, given that the daughter is no longer available to look after her own family but must move her allegiances to her husband's, the loss is both financial and personal for her parents. Gray maintains that female infanticide, rather than sex-selective abortion, has become the key vector for reducing the perceived burden of a female child because it costs the family nothing, at least in purely financial terms.

In India, the existence of infanticide is deemed, by Hitrova, for example, to be borne out by the gender ratio of that country. In 2011, the ratio for children under 15 years of age was 117 boys per 100 girls with the average ratio at birth falling between 103 and 108 boys per 100 girls. Poverty in India is a key driver of infanticide, which exacerbates other factors such as cultural norms. The *Economist* reported in 2010 that, in India, an estimated 100 girls are born for every 124 boys and that the number of female births continues to decline on an annual basis. The Azad India Foundation notes that, in the period of some 15 years, some 5 million girls have "disappeared," that is, presumed to have been killed by their parents. M. Kamdar notes that, for the world in general, the disappeared figure is in the order of 50 to 60 million girls.

There is a cultural imperative operating in India, predominantly exercised by families in poverty, which determines that baby girls should be killed in preference to baby boys who can, perceptually at least, become future economic providers. According to A. Jones, the cumulative cost of a daughter amounts to some $35,000 over her lifetime for a family whose annual income is likely to fall within the $3,500 range. Although illegal in India, the dowry still persists. The economic cost of the dowry can be exacerbated in circumstances in which the family is unable to meet the full cost and subsequently becomes debt bonded to the husband of the daughter. That financial indebtedness appears to be a practical burden that families are unable or unwilling to undertake. Arguably, the determination of the relative worth of boys and girls is driven in part by the position women hold in Indian society. Hinduism is argued to have played a role in this perpetuation of the value divide, given that it provides for male dominance and priority over women.

Similar societal constructs of relative worth are apparent within Chinese society also. Confucianism provides for fathers and sons to be the head of the family, with women required to be passive toward both their parents and their husbands. However, the greatest driver of infanticide lies in China's one-child policy, which prohibits families from having more than one child unless both parents were only children. Although less strictly policed in rural areas, in the increasingly urbanized China, there is denial of public services for those who infringe the policy and rewards for those who do not, in the form, for example, of better education and preferential homes.

While there are rumors of a potential relaxation of the one-child policy (with A. Harjani observing in August 2013 that this might come into being by the end of 2013 with, for example, parents being allowed two children if one of those parents was themselves an only child), there are commentators such as Y. Zhang who maintain that the policy generates huge income for the government through so-called social support fees, which are charged to parents who breach the one-child policy. One investigation discovered that social support fees levied in 2012 in just 17 provinces were in the order of $2.7

billion. So long as the policy remains in place, the propensity for infanticide will continue unabated. In 2009, there were 118 boys to every 100 girls. Equally, without the removal or significant alteration of the policy, the current disproportionality of female to male offspring will continue through the vehicle of infanticide.

In India, unlike China, the driver for change does not require a governmental policy shift but rather an alteration of entrenched cultural norms and attitudes. Poverty may be deemed to be a precursor or facilitator of such attitudes, and it seems as if there is a vital need for the Indian government to recognize the connection between poverty and infanticide, the former driving families to commit the latter because daughters are viewed societally as an economic burden rather than a potential economic asset. The increased use by women of microfinancing activities, which provide them with an opportunity to generate revenue, is a key example of how steadfast attitudes might be overcome by objective proof of a woman's economic power. Equally, the Indian government needs to consider the development of a form of social security for its elderly population; the requirement to care for the elderly falls currently upon their children and invariably leads to the forsaking of female children who are deemed incapable of providing economic support to their parents in later life.

Both China and India could take stock of or heart from the recent experience of South Korea, which through a series of systematic steps has reversed the once disproportionate female-to-male ratio that had resulted from infanticide. The first step involved the establishment of a national family planning campaign to control unwanted births rather than to leave such births to be resolved by means of abortion. Thereafter, there was a systematic promotion of a two-child family plan in which the benefits of two children were extolled and, importantly, the equal status of both male and female children, encapsulated, for example, in an advertisement that stipulated, "Sons or daughters, let's have two and raise them well!" Finally, incentives were introduced for two-child families, which led over time to both urban and rural families shying away from the historical practice of infanticide of young girls.

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See Also: Family, International Variations in Definitions of; Family Structure, Diversity of; Infant/Toddler Development; National Survey of Family Growth.

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Infant/Toddler Development

Child development refers to the physical, cognitive, and social-emotional growth of the child. Specifically, infancy covers birth to 1 year of age, and toddler development covers 1 to 3 years of age. Development is about the changes that occur as children grow. All areas of development are interconnected; we can talk about specific themes, but progress in one area depends on progression in other areas. Achieving developmental milestones such as sitting up, talking, and problem solving is the mark of one developmental period ending and a new phase beginning. Infants and toddlers progress through a series of milestones that allows their development to be monitored.

Maturation

Maturation is the process by which individuals meet developmental milestones based on their genetic background. Hereditary information passed from parent to child plays an important role in how and when individuals master various skills. Maturation plays a part in why every human being progresses through a similar sequence to reach specific milestones. Maturation is central to development in the infant and toddler stages. While maturation plays a key role in all aspects of development, another crucial factor is experience. Experience or learning builds upon the skills that emerged through maturation and is dependent on the familial environment and the broader culture the child is raised in. For example, humans are born with the ability to learn language, and in every culture, babies speak one word at a time before they can put two words together, but culture determines whether one speaks English, French, or Spanish.

Language Development

Language development follows the same sequence in all infants and toddlers, but it may occur at different rates depending on the child. Babies follow

It has been acknowledged that there is a strong link between play and learning for young children, especially in the areas of problem solving, language acquisition, literacy, numeracy, and social, physical, and emotional skills. Peer interaction begins around 6 months of age, and by 15 to 18 months, toddlers begin interacting and socializing with peers.

similar paths no matter what language they hear and learn. Humans have an innate ability to learn language, but the specific language learned is highly dependent on culture.

While infants do not speak at birth, they can successfully communicate through vocalizations such as crying and are responsive to the language around them. By crying, infants are able to gain attention from caregivers and have their needs, such as being fed, met. Around 2 months of age, infants start cooing or producing vowel sounds. Next, they make sounds that have no meaning, such as ba and da, the stage referred to as babbling.

Before 6 months of age, infants communicate at the same time as the individual who is speaking to them so as to imitate what is being vocalized to them. Later on, they begin to take turns communicating with another person. Western adults tend to speak slower and change the pitch or loudness of their voice while speaking to infants. In other cultures, parents may not adjust their speech, but the infants progress at the same rate as they tend to be exposed to a language-enriched background provided by many adults.

After the first year has passed, toddlers lose the ability to recognize sounds that are not part of their native tongue. The ability to understand language develops faster than the ability to verbally express one's self. By their first birthday, infants have a vocabulary of around three words, but vocabulary acquisition grows rapidly, and toddlers begin to combine two words into sentences as they near their second birthday.

Cognitive Development

Cognitive development focuses on the ability to acquire processes such as decision making, recall and memory, problem solving, and understanding the world—in other words, the development of intellectual skills. Two key theories of cognitive development have played an influential role in understanding how infants and toddlers reach developmental milestones. The most widely known theory is that of Jean Piaget (1896–1980). Piaget believed that children are curious, and this allows infants and toddlers to actively explore their environments. By interacting with the environment, children progress through cognitive milestones.

Piaget argued that cognitive development occurs in a series of four stages, two of which occur before the age of 3. Infants are classified under the sensorimotor stage. Infants in this stage use their senses and motor movements to explore and acquire new knowledge. Three key ways that infants can use their senses to become familiar with their environment are through grasping, sucking, and locomotion. Furthermore, during this stage, infants acquire the concept of object permanence, which is a realization that objects continue to exist in the world, even when the infant is no longer looking at the object. Object permanence is a universal concept seen across all studied cultures.

Toddlers fall in the beginning of the preoperational stage, where they begin to use symbols such as language to extend their current knowledge base, but their thinking is not yet fully logical. During this time, toddlers are considered egocentric; that is, they only see the world through their eyes and cannot take another person's perspective.

Piaget believed that new experiences and information are added to preexisting knowledge through a process he termed *assimilation*. When information cannot simply be added, knowledge can increase through accommodation; that is, new experiences or information changes previous knowledge to better fit what has just been experienced.

The theorist Lev Vygotsky (1896–1934) has also had a strong influence on the understanding of cognitive development. His sociocultural theory emphasized that children learn through their social interactions with other individuals. For infants and toddlers to progress, they must engage in social interactions; otherwise, they cannot gain appropriate knowledge. Through social interaction, infants watch what others do, imitate those actions, and finally master the modeled skills. Another key part of Vygotsky's theory is that learning and development may differ depending on one's culture. Different cultures have different norms and beliefs, and this may have a profound effect on what children learn through socialization. Vygotsky argued that the social world has a strong influence on cognitive development.

Newer theories tend to focus on the acquisition of information-processing skills such as memory and attention to explain cognitive development.

Social-Emotional Development

Cross-cultural studies suggest that there are striking similarities in social development across ethnic groups. Babies display basic emotions such as happiness, sadness, anger, and fear. More complex or secondary emotions like embarrassment, pride, and guilt develop around 18 to 24 months of age. Facial expressions are a good indication of an infant's emotions. More specifically, around 5 to 6 months, infants show a predictable change in their facial expressions based on a response to an ongoing event. This ability starts to become evident only after infants have developed the ability to differentiate among different facial expressions.

Early on, infants develop the ability to regulate their emotions. At the early stages, this involves simple strategies such as crying or moving away from something that scares them, but as they get older, they are able to improve and use more effective strategies. Between 2 and 3, toddlers begin to use language to help them self-regulate their own emotions.

Around 8 to 9 months of age, infants begin to form strong attachments with familiar adults. The first social-emotional attachment is normally with the mother, who is typically the main caregiver. How attachment is displayed does differ in different cultures; different cultures may value different characteristics, and in so doing, this influences their development. For example, co-sleeping is normative in some ethnic groups such as Asians and African Americans, who believe it promotes a stronger attachment, but it is frowned upon in Western cultures, which believe it is less safe, yet they all have securely attached babies.

Peer interaction begins around 6 months of age. Babies do not play with peers yet, but they start to become more aware of them. By 15 to 18 months, toddlers enjoy interacting and socializing with peers.

Motor Development

Rapid physical growth and maturation take place during the first years of life. Within the first few months of life, birth weight normally doubles, and by an infant's first birthday, weight typically triples. Infant bodies tend to be disproportionate, with larger heads and trunks giving them a top-heavy appearance.

All infants are born with innate reflexes that aid in survival as infants do not have voluntary control over most movements. By 12 months, infants can reach, grasp objects, and walk. This is a result of gradual use of their thumbs, coordination with both of their hands, eye–hand coordination, and muscle growth. In a one-year period, an infant who displayed no voluntary motor movements becomes a toddler who can walk and run independently. Maturation and experience are both crucial for the development of motor skills. While all infants and toddlers follow the same sequential pattern in meeting milestones, practice has a role, and even culture is important. Some ethnic groups limit the amount of gross motor activity via, for example, swaddling or carrying the infant, while others encourage early motor development. Babies of African heritage tend to develop motor skills earlier than other babies, but otherwise, infants in all cultures develop at the same pace and quickly catch up if motor movements were initially restricted.

From birth, newborns have a well-developed sense of smell, touch, taste, and hearing. However, sight is not as mature and becomes more developed during the first year.

Conclusion

In a short period of time, infants develop into toddlers and change from being nonspeaking, nonmoving, trial-and-error problem solvers into talking, walking, thinking little people. Their development follows a maturational schedule provided by their genetic background but also reflects the environment they grew up in and the experiences they had, affected both by family and the broader culture. Culture and ethnic variations have stronger influences on development as children get older, yet those who work with diverse populations should recognize that there are many acceptable variations of bringing up infants and toddlers that will lead to positive outcomes.

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See Also: Child and Adolescent Needs and Strengths; Developmental Disabilities, Attitudes and Myths in Services for; Developmental Disabled Individuals; Early Childhood Development.

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Information and Referral

Many entries in this volume have a natural affinity for the diversity dimension inherent in their topics where the discussion can address any of several issues such as race, gender, and socioeconomic status. At first glance, information and referral (IR) would not be one of those topics. Perhaps because of that reason, the diversity dimensions of IR go largely unappreciated, and it is that lack of recognition that perhaps has caused some not to realize the full complexity of this topic.

The Alliance of Information and Referral Systems (AIRS), the nation's oldest formalized IR service, defines IR as the "art, science, and practice of bringing people and services together." In practice, a referral may be as straightforward as providing a number to an agency in the community. If someone contacts an IR service, such as 2-1-1, then provisions are also made to assist callers in making that phone call or providing some form of crisis intervention as needed.

The professionalization of IR can be viewed from the AIRS standards, which cover six areas that any agency wishing to portray themselves as an IR service need to address. Those areas include service delivery, database of services, performance measures, relationships with service providers, emergency and disaster preparedness, and organizational effectiveness. AIRS also publishes a journal, *Information and Referral*, yet no indexing for the journal can be found other than on the AIRS Web site with a note that access is limited to AIRS members and subscribers.

The full diversity of the IR landscape begins to emerge where 2-1-1 systems have been implemented. While 2-1-1 has been able to address the basic information needs of callers, most of these systems have also formally partnered with existing IR call centers already functioning in many communities. Many of these call centers have a specialized function such as mental health; homelessness; domestic violence; aging; lesbian, gay, bisexual, transgendered, and queer (LGBTQ) youth; and other services. Indeed, each of these specialized call centers represents a diversity dimension in the continuum of human services. Often staffed by personnel with specialized training in their respective fields, the nature of the call and their ability to provide services to a potential client can look different from one call center to another.

Perhaps one of the most significant markers for the professionalization of the IR field lies in its formally developed taxonomy. Originally developed by the AIRS/211 of Los Angeles County and now promulgated nationwide, this taxonomy has more than 9,000 terms that ostensibly cover the complete range of human services. The fact of so many entries alone attests to the diversity of dimensions involved in describing the kinds of human services callers may inquire about. While potentially useful for any number of purposes, access to the taxonomy is fee based, which brings us to the next issue.

The Commons

As noted by N. Shank, the interoperability of IR databases, that is, the ability to compile an integrated database of all the services, both basic and specialized information across a vast array of services in a community, is the future of the IR field. People will always need this information, and agencies will have providers of these services. What remains is how the two will remain linked. Despite its vast taxonomy of more than 9,000 terms, in no way should the AIRS taxonomy be viewed as a one-stop shop for all information needs, and it does not claim to be so. Indeed, as a taxonomic instrument, it only provides the placeholders for the data about services that can only be provided by local agencies in our communities. As such, there have to be database tools developed to provide that linkage, and the notion of a data commons is beginning to emerge to fill that need. Born out of Commons Movement, Open211 seeks to build an open, interoperable resource directory that uses web-based technologies to pull data from a multitude of online databases into a common directory, describes G. Bloom. IR services, such as

2-1-1, could still tap into this directory and offer their unique skill sets, but the information could also be made available to other services to be delivered via smartphones or other devices as the user needs. This latter notion reiterates the diverse nature of the IR process from the perspective of service users, service providers, and managers of the information.

The Future

While the need for IR services will be invariant, how those services are found and delivered will no doubt change largely because of the quickening evolution of technology into any number of devices. A logical next step once these processes become more digital will be the use of electronic referrals to supplement the person-to-person referrals commonly made today, predicts Dale Fitch. Research on all of these processes will be essential, especially research on referral follow-up outcomes. Taken together, the field of IR is much more diverse than commonly perceived, and its diversity will become only more complex as new information technology tools provide accessibility to rich stores of data.

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See Also: Adolescent/Youth Services: Overview; Adult Education Programs and Services; Service Providers and Diversity.

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Institute for Women's Policy Research

The Institute for Women's Policy Research (IWPR), a nonprofit organization, was founded in 1987 by Heidi Hartmann and other activists whose purpose it was "to develop comprehensive, women-focused, policy-oriented research." Created in Washington, D.C., the IWPR was crafted in response to "gender-based economic injustice," conducting research and providing testimony before the U.S. Senate "on the costs to American women and taxpayers that result from women's lack of job protection after an absence due to childbirth." Since its founding, IWPR has also served as a knowledge base regarding policies that impact women both in the United States and across the globe. Its Web site defines its current mission as "Informing policy. Inspiring change. Improving lives." The IWPR claims to provide thorough research on the status of women in order to "promote public dialog, and strengthen families, communities, and societies" and appears to be successful toward that end.

According to Stephen Rose and Heidi Hartmann, the IWPR focuses on conducting and utilizing "women-oriented policy research" to create awareness and understanding regarding "economic and social policy issues affecting women and families" for "policy makers, scholars, and public interest groups." In addition, the IWPR collaborates with "the graduate programs in public policy and women's studies at The George Washington University." One of the most significant contributions of the IWPR has been a series of reports, inaugurated in 1996, on *The Status of Women*, for the purpose of providing dependable and consistent information about women's experiences and issues in the United States to institutions that create policy.

Reports have been generated for all 50 states as well as the District of Columbia. The rationale for this massive project is to assess "the progress of women in their state relative to women in other states, to men, and to the nation as a whole." Resulting from these accounts, additional reports have chronicled trends and compared information about women's lives across states; moreover, research methods have been created and promoted to produce reliable information about the status of women in the United States.

Five Key Program Areas

Five key program areas include: (1) employment, education, and economic change; (2) democracy and society; (3) poverty, welfare, and income security; (4) work and family; and (5) health and safety. In its efforts in employment, education, and economic change, the IWPR conducts research in areas related to "employment and job quality, status of women in the States, pay equity and discrimination, access to higher education, and unemployment and the economy." Largely as a result of work in this area by the IWPR, the Family and Medical Leave Act (FMLA) was passed in 1993. Programming in democracy and society focuses on issues that include immigration, religion, unions, and politics, while the third emphasis on poverty, welfare, and income security examines issues such as retirement, social security, poverty, and welfare reform. Finally, emphasis on work and family investigates matters that include education, family leave, sick days, and flexibility in the workplace, while health and safety investigate how women's health issues are influenced by health insurance, preventative health services, and domestic violence, and to what extent race and ethnicity forecast health care access and concomitant outcomes.

Dissemination of Information

Information from the IWPR is disseminated in four primary ways. First, *The Status of Women* publications help both to chart progress of women in political, business, health care, child care, and family settings as well as to "identify and measure the remaining barriers to equality." Second, the Women's Policy Research Conference, inaugurated in 1989, was held biennially, and its proceedings were published until it was discontinued in 2005. Since that time, symposiums have been held in 2009 and 2013.

Third, the IWPR produces a quarterly newsletter "to highlight new projects and initiatives." Finally, *RNR Online* (*Research News Reporter*) is a monthly newsletter that is produced electronically and features a wealth of materials including a FemChat blog, student–parent success initiative section, additional LISTSERV information, and a forum on resources and toolkits.

Future Aims

The IWPR has a number of goals as it moves past the quarter century mark in 2013. Goals for the next 25 years include exploring the gender wage gap, workplace discrimination, Social Security, child care, and education. Within the organizational structure of the IWPR, internship and fellowship programs will be increased to expand opportunities for young women "to gain career experience while expanding their knowledge of research and policy issues." The impact of the IWPR in its short history has been significant on social, political, and private sectors in the United States, and its future direction appears to be similarly ambitious in scope.

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See Also: Empowerment Research; Legal Services; Single Parents; Women Minorities.

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Institute of Education Sciences

The Institute of Education Sciences (IES) is a research agency of the United States Department of Education that provides support for various areas of education practice and assessments, such as education research, special education, and learning assessment and evaluation. The mission of IES is to conduct research that provides evidence on the best practices in education as well as to offer guidance for developing and implementing educational policies and training programs.

The institute identifies which methods yield the best learning outcomes, promote the most effective teaching methods, and assist in educational efforts that serve students who are at risk. IES is a nonpartisan agency, and its activities are not intended to reflect partisan influence. Instead, IES provides teachers, researchers, administrators, and the public with unbiased information about the state of education in the United States. The institute was established under the Education Sciences Reform Act of 2002. IES receives oversight from the National Board for Education Sciences.

IES Operations and Functions

IES operates with a budget of more than $200 million and comprises almost 200 staff members. The institute's work is conducted at four centers throughout the country: the National Center for Education Research, the National Center for Education Statistics, the National Center for Education Evaluation and Regional Assistance, and the National Center for Special Education Research.

John Easton became the director of IES in June 2009. He has been praised for establishing more collaboration among researchers and education practitioners and has placed more emphasis on translating education research into information for public consumption.

In compliance with the Education Sciences Reform Act, the institute is required to give a biannual report on its accomplishments and activities to the president, the education secretary, Congress, and the general public. These reports typically include summaries of grant projects funded, contracts, and ongoing research projects.

Projects Conducted and Supported by the IES

IES conducts peer-reviewed scientific studies that investigate the current quality of education in a variety of settings throughout the United States. The institute collects statistical data from surveys and longitudinal studies examining the current condition and nature of education. Examples of research might include examining the training programs that are most successful in preparing educators or the effectiveness of certain types of textbooks and other educational materials. One of their well-known projects is the annual National Assessment of Educational Progress (NAEP), often referred to as the Nation's Report Card. The NAEP is the nation's largest assessment of students' competencies in reading, math, writing, science, economics, civics, U.S. history, and geography. In 2014, the NAEP also measured technology and engineering literacy. Other research projects conducted through IES assess federal education reforms fueled by the American Recovery and Reinvestment Act, which has included efforts to improve state-level educational programs. In addition to its own research and outreach endeavors, the institute provides grant funding for education research projects conducted by faculty and educators. These studies investigate educational practices within preschool through postsecondary levels as well as special education settings.

The institute also engages in public service and outreach programs designed to provide information and strategies that help improve education and teaching effectiveness. Some of the technical support systems provided by IES include the Education Resources Information Center (ERIC) database, the What Works Clearinghouse, as well as several national research and development centers. IES conferences, peer-reviewed journals, and training products are also available. Through their outreach programs, IES strives to improve the educational abilities of school districts and statewide organizations in the way they develop and evaluate their own curricular plans as well as to conduct their own education research.

IES Resources

One of the main functions of IES is to enable the public to search for information. One of the resources the institute provides is a database for colleges, schools, and libraries throughout the United States. The public can also search for statistical data collected by IES. With the data analysis system available on the IES Web site, users can conduct their own statistical analyses on one or more of the available data sets. In addition, information seekers can scan and investigate the results of any national assessment conducted by the institute or its collaborating agencies. Education researchers can also take advantage of many online resources such as webinars on research methods, information about the peer review process, and help in searching for funding opportunities with IES.

Praise and Criticism for the IES

IES is widely known for its rigorous, high-quality research. The institute received an effective rating from the U.S. Office of Management and Budget, the highest level earned. This rating receives support from the U.S. Government Accountability Office (GAO) in how IES has contributed to the improved quality of education research. This observation was noted at a late 2013 hearing held by the U.S. House of Representatives Education and Workforce Committee. However, when considering the reauthorization of the Education Sciences Reform Act, House committee members questioned whether this type of rigorous research is still being used or considered relevant by the general public.

The GAO echoes stakeholder complaints that IES has slowed in their ability to produce and disseminate research in a timely manner, partly because their research has spent a great deal of time in peer review. The stated problem with this slowing of information dissemination is the reported inability to implement education interventions when they are most needed. In addition, GAO reports that IES lacks an adequate system for implementing input into the improvement of their research and programs. Another criticism is the need for IES to update its performance measurements and assessments to keep up-to-date with current education programs across the country. The institute has also been scrutinized for its inefficient organization of its funding programs, partly because IES has to coordinate with other agencies. This inefficiency has been argued to hinder how IES conducts important educational evaluations and learning assessments. To begin to address current criticisms and deficiencies in operations, IES has collaborated with the National Science Foundation (NSF) to construct more concrete guidelines to improve the quality of education research.

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See Also: Children With Special Needs; Department of Education, U.S.; Educational Services; Educational Support Services; Special Education.

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Institutional Oppression

Institutions may inadvertently disadvantage groups in society such as gays and lesbians, people of color, non-English-speaking clients, persons with disabilities, women, the elderly, or the economically disadvantaged. This phenomenon, known as institutional oppression, may result in clients' failure to receive services, inability to benefit from services, or premature termination of services. In some cases, it can even lead clients to decompensate, or get worse, as a result of service provision. This is important to human services workers because clients in these categories are those most likely to

Protesters at a 2006 gay pride event in Union Square, San Francisco, California. Institutions may inadvertently disadvantage groups in society such as gays and lesbians, people of color, persons with disabilities, women, the elderly, or the economically disadvantaged. Oppression can be material, resulting in a denial of benefits, or symbolic, resulting in shame or exclusion.

need their assistance. Because it is possible to overlook or contribute to client oppression, even while attempting to be helpful, human services workers are often advised to pay attention to this issue.

Social Services Agencies

Social welfare institutions and their personnel may oppress clients in a number of ways including but not limited to the following: providing services in inaccessible locations, having unrealistic eligibility criteria, failing to understand cultural norms related to services, compromising clients' safety or privacy in exchange for services, engaging in protocols that expose clients to traumatization or victimization, and having unrealistic fee schedules for populations needing the services. For example, a crime victim services agency may be inaccessible by public transportation; a domestic violence shelter may have no ramps or interpreters; a homeless person may not qualify for public assistance without a permanent address; or culturally specific child-rearing practices may be deemed abusive by formal authorities. Social services agencies that do not hire gay people, older workers, minorities, women, or individuals with disabilities (who may reflect the demographics of the population being served) can also be said to practice institutional oppression.

Other Institutions

In the larger society, institutions such as schools, hospitals, police departments, churches, courts, banks, news outlets, real estate agencies, political systems, and military organizations may practice institutional oppression. This is important to human services workers because they may need to collaborate with, or provide referrals to, these services. Oppression can be material, resulting in a denial of benefits or services, or symbolic, resulting in shame or exclusion. For example, schools that celebrate Christian holidays but not Muslim or Jewish ones may make non-Christian children feel stigmatized or ashamed of their faith. The indirect effect of this could be taunting, avoidance, or violence from peers. Thus, institutional oppression can have wide-ranging and indirect consequences even when it takes symbolic forms.

Inaction as Oppression

Institutional oppression can take the form of inactions as well as actions, as for example, in the situation previously described. Schools using history books that portray only white males as important scientists can, for example, be construed as practicing institutional oppression.

Service providers in social agencies, in the course of conducting intake interviews, may fail to ask questions allowing for the possibility of gay relationships. Assisted-living facilities may assume their clients cannot have romantic relationships (and therefore allow them no privacy). Agencies that fail to install accessible bathrooms for their physically disabled clients, realtors who neglect to show nonwhite clients homes in upscale neighborhoods, and policies that discourage doctors from offering Medicaid (but not other) patients pain relief are additional examples of institutional oppression by omission.

Individual Versus Institutional Oppression

While service providers already inclined to be discriminatory may enact oppressive policies, so may those who would not normally be discriminatory. Thus an antiracist, pro-gay, or feminist worker could potentially engage in institutional oppression. This is because oppressive practices are enshrined in the bylaws, written protocols, and informal policies of organizations. In addition, absent insight into the perspectives of the populations being served, institutional oppression may be imperceptible to mainstream service providers.

Language, Labeling, and Stigmatization

One way in which institutions may oppress clients is through the use of labeling. Labels can be psychiatric (e.g., borderline), cognitive (e.g., learning disabled), or criminal justice based (e.g., juvenile delinquent, drug abuser, or prostitute). Labeling can allow professionals a shorthand to discuss cases or may enable clients to qualify for services; however, labeling (especially of younger people) can produce a negative self-image and social stigmatization (devaluation by others). This is especially relevant to cultural minority clients for whom a bad reputation may have negative results for their families and communities. People more likely to be labeled may include ethnic and racial minorities, economically disadvantaged women and men, people who deviate from culturally valued roles (such as those with multiple sexual partners) immigrants, and those having gay or bisexual orientations. Clients required to accept a negative label in exchange for services may prefer to sacrifice the assistance in exchange for dignity and privacy. Labels imply that individuals are static and best defined in terms of their deficiencies; thus, human services workers may refer to a client as a schizophrenic rather than a person who happens to (perhaps intermittently) suffer from schizophrenia. Intake forms, assessments, and other official documents that omit a discussion of client strengths and focus exclusively on deficiencies may fail to identify latent resources a client possesses. These may include his or her spiritual beliefs, extended family members, internal attributes, hobbies or interests, or social networks.

Deviance, Social Control, and Institutional Oppression

Institutions may conflate caregiving with social control functions; indeed, the two purposes frequently overlap in areas such as child protection, rehabilitation programs for the disabled, income maintenance programs, drug treatment clinics, psychiatric hospital wards, and court-ordered batterer intervention programs. In these settings, clients may be sanctioned for failure to follow through on workers' recommendations; as a result, they may lose jobs, housing, or liberty. Clients who do not accept services on terms offered to them may be labeled resistant or unmotivated and forfeit eligibility for future services. Clients who pay cash for services or have more generous insurance plans may have greater latitude in determining what services are provided, by whom, and with what degree of privacy. In this way, institutions may reinforce and replicate class differences among the clients they serve.

This process can disadvantage ethnic or minority clients whose understanding of service provision may be at variance with the worker's. Such clients may be psychiatrically hospitalized for behavior that is normative within their cultures of origin, experience communication impasses that appear to reflect resistance, or have standards for gendered behavior that defy local mores. For example, a client who practices voodoo may be diagnosed with a delusion of mind control; a Chinese client may fail to make eye contact with his or her clinician (in order to show respect); an Orthodox Jewish male client may refuse to shake hands with a female service provider. While these clients may need care, accessing appropriate services may be difficult for them if their actions are interpreted as hostile or pathological. Without cultural awareness training, this risk is highlighted.

Revictimization of Abuse Survivors

People who come to the attention of authorities may have histories of abuse by others. Characteristics of hospitals, police stations, correctional facilities, therapy offices, schools, or other settings may resemble the circumstances under which such clients were abused. This may elicit feelings of extreme distress, noncompliance, withdrawal from services, or behaviors such as self-mutilation or aggression. Institutional policies and protocols may fail to take this into account. For example, substance abuse treatment facilities that incorporate confrontation and breaking down of residents (generally by male authority figures) may remind female survivors of earlier emotional, sexual, or physical abuse.

Asking clients with abuse histories to surrender to a higher power (as is common in Alcohol Anonymous meetings) may undermine their hard-won efforts toward self-determination. Common environmental cues that stimulate intense stress responses include physical restraint, violations of personal space, strobe lights, sounds that resemble explosions, and visible weapons; however, responses are unique based on individual histories. Institutional agents may also label client survival strategies as pathological or criminal. For example, actions taken by a person in captivity may involve criminal behavior (e.g., prostitution or robbery) that would not have occurred under other circumstances. Such inattention to the subjective experiences of client populations can be viewed as an element of institutional oppression. Trauma-informed care protocols, designed to mitigate this problem, have been developed for institutional application. However, these have not been widely disseminated or adopted.

Medication and Institutional Oppression

In difficult fiscal times, when human resources are scarce, providers may rely more heavily on medication and restraint than psychotherapy when addressing agitated clients. A specific form of institutional oppression is overmedication, or forced medication, when used primarily for purposes of restraint. It can be difficult for an outside observer to ascertain whether a prescribed medication is a form of treatment or control. It is possible for institutions to blur the distinction and present an intervention as beneficent when its use serves institutional, rather than client, needs.

Solutions: Empowerment, Cultural Competency, and Inclusion

Human services providers who are aware of institutional oppression have taken steps to address it. Some agencies have developed policies to minimize this problem. A key element is client empowerment, which includes offering as much control as possible to clients and adopting a symmetrical or egalitarian stance. This includes behaviors such as sharing diagnoses with clients, developing shared goals, honoring client perspectives on problems, detailing client strengths in assessments, incorporating clients' cultural values or practices into interventions, helping clients, acting as a liaison between clients and other institutions, and advocacy on behalf of client populations. The latter may include making changes in agency policies that affect clients, developing grants to offer more client-friendly programs, or activism at community, state, or national levels.

Some agencies approach the problem by working with staff members on the assumption that organizational cultures can be changed one employee at a time. Staff may be offered experiential trainings to heighten their awareness of, and empathy for, minority groups. These are for purposes of decreasing tension among diverse staff and increasing success with minority clients, and may include self-exploration, debunking of stereotypes, education, hypothetical case conferences, or role playing. Members of particular groups, or survivors of particular difficulties, may be invited as guest speakers.

Some agencies have attempted to minimize institutional oppression of clients by including members of the client population on boards and as staff. Current or past service recipients may identify issues that would otherwise be overlooked. For example, by hiring people with disabilities and placing them in visible locations, an agency for the disabled may send the message that people with disabilities (1) are valued by the organization,

(2) can become successful, and (3) are included in the development and provision of services.

Controversies

Controversies may emerge in discussions concerning institutional oppression. There are questions about whether anyone can be considered oppressed; for example, Caucasian male workers whose traditional advantages are being eroded by the influx of minorities. Another controversy concerns to what degree institutions should cater to the needs of minority or traumatized groups (as opposed to expecting them to conform to social norms in exchange for services). In a conservative fiscal environment, what expenditures should occur in order to ensure equal access to services by all clients? On an individual level, questions may arise regarding the best way to address clients of different backgrounds without becoming excessively preoccupied with form over content. Given the difficulty of understanding all minority groups and the risk of stereotyping people on the basis of their characteristics, is it worth the effort to become culturally competent and antioppressive? On a broader level, there are those who may question the wisdom of equal access for all people, believing that only the most persistent and normative deserve help. Human services workers may feel overwhelmed with current responsibilities and take issue with attempts to add more expectations to their roles. Despite these ongoing controversies, there is general agreement that the ideal of equal access to effective services has not yet been actualized.

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See Also: Cultural Competence, Human Services Providers and; Providers, Institutional Racism and; Victim Services.

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Intangible Cultural Heritage

Culture is an abstract and amorphous concept that has plagued many scholars in how to adequately define it. It is generally thought of as an overarching concept that can be broken down into various components in order to serve the purpose of the current conversation in which it is being deployed. Intangible cultural heritage moves beyond this perplexing conceptualization of culture by encapsulating the very essence and numerous tangents that culture, as defined in the past, has been linked to. Intangible cultural heritage is best understood as an accumulation of immaterial aspects of culture and how they represent the living components of that culture while emphasizing a very diverse understanding of culture in general. By employing this definition, intangible cultural heritage suggests a definition of culture that is no longer expository but suggests the ability to engage in activity and create specific processes that define culture and cultures internationally.

Intangible cultural heritage is commonly thought of as a Western concept that originated as a need to explain growing diversity and exchange of cultures all over the world. Basic concepts of culture primarily involve notions of tangible items such as food, clothing, proximity of persons in relation to one another, and so on. Intangible cultural heritage moves beyond this scope to address idiosyncrasies of thought, emotions, language, ideas, and customs. In this sense, intangible cultural heritage is the catalyst that propels tangible forms of culture to be sculpted and manipulated and, more specifically, to be read using a certain lens. In doing this, intangible cultural heritage creates a platform in which access to countless cultures and heritage communities are provided. However, to correctly engage intangible cultural heritage in everyday conversations requires a sensitive awareness of various cultures and the motivation and purpose for why they have chosen the specific set of intangible cultural artifacts to convey meaning and substance about their culture. The assignment of understanding, creating an environment where intangible cultural heritage can thrive, and its historical conception will be further explained so as to understand the value it has in current conversation and scholarship.

Heritage and the passing down of culture is an age-old concept that has morphed into various forms over the centuries. Intangible cultural heritage emerged in the 1950s to assist in creating a platform for the ever-growing conversations, and sometimes conflicts, that arose when various cultures started engaging with one another. Historically, cultures and people all over the world have engaged in knowledge exchange with one another, but the 1950s proved to be a decade that catapulted the world into truly being a multicultural arena in which businesses, lives, and attitudes would be forever altered. One of the more important concepts to understand about intangible cultural heritage is that it is not meant to necessarily replace previous impressions about culture, but rather, it is a supplement that should allow a richer and more nuanced understanding of culture, how it is employed, and the deeper complexities that are often visualized through tangible artifacts; yet these tangible artifacts are not a definitive means in which to understand the process that is intangible cultural heritage. This cautionary note is necessary in understanding intangible cultural heritage and the current prescriptions in place to protect and preserve it. It is unfathomable to restrict intangible cultural heritage solely into concrete tangible items and terms; it is necessary to always concentrate on it as a process and performance that is rooted in the evolution of daily living. Intangible cultural heritage is the performance and presentation of everyday lives and events and more importantly how they interact with one another. Given this circumstance, the major discussion surrounding intangible cultural heritage is how to protect and preserve it.

Various reports articulate the necessity to preserve and protect intangible cultural heritage. A movement that began in the 1950s and is currently in progress is the protection and preservation of intangible cultural heritage. This conversation first emerged in the Hague Convention of 1954 to first address the potential threat that intangible cultural heritage might accrue in cases of armed conflict. It wasn't until the 1960s and 1970s that the movement began to concentrate on adequately defining intangible cultural heritage. The 1980s indicated a shift in not only defining intangible cultural heritage but also in making large strides in creating concrete legal sanctions to protect it. These changes came about during a campaign spearheaded by the United Nations Educational, Scientific and Cultural Organization (UNESCO). The most recent undertaking in preserving, protecting, and understanding intangible cultural heritage has been the Proclamation of Masterpieces of the Oral and Intangible Heritage of Humanity, which was enacted by the executive board of UNESCO in the 1980s. Current debates that fuel the need to protect intangible cultural heritage stem from the overarching need to label agency and understand how such concepts, which are embodied in intangible cultural heritage, are conveyed. Ownership of intangible cultural heritage, identifying who transmits the concepts associated with intangible cultural heritage, and the ethics surrounding the protection and preservation of intangible cultural heritage lie at the heart of contemporary discourse.

The areas are considered important challenges because of the very nature that intangible cultural heritage is—actually, how it is presented. Speaking to larger concepts again, tangible components of culture require a less myopic view in understanding and employing them because they can oftentimes be physically seen and held, and therefore, ownership and agency can be readily argued and remedied more easily than aspects of culture that are based primarily as concepts. In contemporary dialogues, it is paramount to conclusively define the multifaceted components of intangible cultural heritage because they, just like their tangible counterparts, are no longer encased within physical or social boundaries. With the ever-increasing interaction of cultures on various social stages, it is not only essential to understand how intangible cultural heritage is understood but also the results of its interactions. The importance of understanding the functionality of intangible cultural heritage accurately is primarily associated with fully understanding that the function of immaterial culture is often best understood by the person assigning the meaning; this is particularly useful while engaging in current debates as stated previously. The current debates concentrate on the invariable need to protect and preserve intangible cultural heritage and have sculpted arguments to refined situations due to occurrences that have required the necessity to view intangible cultural heritage through a myopic lens. But many of the arguments are reminiscent of the first convention and purpose for protecting and preserving the culture, which hinged upon potential threat during times of armed conflict. This is important to discuss because at the core of intangible cultural heritage is the concept of the highly theorized notion of tangible and intangible artifacts and the fluidity between the two. It is imperative that intangible cultural heritage concentrates on the psychological process of culture rather than confining it to the tangible artifacts currently used in cultural discourse because this will allow the vague notion of intangible cultural heritage to become easily vocalized and better understood.

If previous events are demonstrative of anything, it is that any future conversations about intangible cultural heritage will be discussed and critiqued in the arena of politics. The way to move forward with intangible cultural heritage, either to protect it, preserve it, or fully understand the idiosyncrasies involved with it, is to dissect the elements of it within the political arena. This is particularly important because heritage, whether tangible or intangible, is equivocal with power in today's conversations. Current debates emphasize the need to protect intangible cultural heritage because it is easily misunderstood and pliable due to its interpretative nature. In this aspect, it becomes imperative to secure the neutrality of intangible cultural heritage while at the same time protecting and preserving it. Intangible cultural heritage, at best, is a process of lived experiences that cannot, and should not, be confined to tangible artifacts. It is an ideology that serves to move beyond the traditional conceptualizations of culture. Therefore, contemporary dialogues concentrate on preserving and protecting intangible cultural heritage, not only for reasons previously mentioned but also so that a more concrete definition can be applied to the idea of intangible cultural heritage, presumably assisting in the preservation process.

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See Also: Communication Styles, Ethnic and Cultural Differences in; Cross-Cultural Knowledge; Cross-Cultural Skills; Western Communities and Cultural Competence.

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Intelligence Testing

The field of intelligence testing has had a long and controversial history. Today, intelligence tests are used throughout the world to make important decisions for individuals in education, medicine, vocation, the military, employment, and many other areas needing to answer questions concerning a person's aptitude and ability. Many different definitions of intelligence exist in the scientific literature; therefore, many different techniques and methods have been developed to assess intelligence for various purposes. For example, certain intelligence tests must be given individually in a one-on-one setting, administered and interpreted by a trained professional, while other types of intelligence tests can be given to a group of individuals and provide a screening of cognitive abilities. However, with no cohesive, all-encompassing definition or theory of intelligence, no single test of intelligence can give a full understanding of an individual's cognitive functioning.

Most traditional intelligence tests give a single score of global functioning. However, a low score on an intelligence test may not be an appropriate indicator of intelligence or ability but may instead be affected by other factors such as education quality and opportunities, socioeconomic status, health, and level of acculturation. The trend in the psychological and testing community is moving toward assessing patterns or profiles of various cognitive abilities rather than attempting to interpret an overall general score of intelligence. Most current assessment instruments published today help determine that an individual has adequate functioning in a specific environment such as work, school, or social settings.

Thus, a pattern of certain cognitive abilities of an individual may indicate higher intelligences in some societies or cultures than the same pattern in an individual from other societies or cultures. As a global community, there are many intellectual abilities we share, such as verbal comprehension, speed of cognitive processing, and memory, and different cultures place different values on each of these abilities.

The ability of intelligence tests to make life-altering decisions regarding individuals is questionable in terms of diversity and culture. For example, representations of intelligence scores differ among various ethnicities. In the United States, Asian Americans tend score above average, African Americans tend to score below average, and white Americans tend to score on the average with most major intelligence test published. The reasoning behind such differences is debatable, with cultural bias of the actual intelligence tests being the main topic of discussion. However, with better representation among the major ethnicities, socioeconomic statuses, and education levels during the development of these intelligence tests, these differences among scores are becoming less pronounced.

Attempts have been made to create culture-free tests to reduce the error associated with these differences among individuals. Because there are countless cultures and subcultures in the world, it seems impossible to completely avoid any cultural bias in standardized intelligence testing. Human beings exist in a world where culture and diversity evolve as a result of new social structures. As an example, language is a major part of any culture. Some word usage may be prominent in one area of a country, but it may be unheard or have a different meaning in another part of the country. Therefore, to simply translate an intelligence test word for word into the native language of the test taker, the test would lose its ability to adequately assess the individual in a consistent and reliable manner. Even the most culturally sound standardized intelligence test given today will not be culturally sound in 10 years because culture and social structures are constantly changing.

More questions exist than answers when intelligence testing and its impact on diversity are considered. Also, as there is no unifying and global theory of intelligence, no particular test can adequately measure all the abilities of an individual needed for successful development in this world. Other factors that can affect test scores or intelligence are education quality and opportunities, socioeconomic status, and health. Therefore, intelligence tests must be written and administered with cultural sensitivity in mind to give a test taker the most precise results. If an intelligence test does not accurately measure one's intelligence without sensitivity to his or her background, but is the determinant of his or her future, the results can be detrimental and ruin opportunities.

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See Also: Children With Special Needs; Cultural Competence, Human Services Providers and; Education for Diversity in Human Services; Educational Services; Learning Disabilities, Services for Individuals With; Psychiatric; Psychiatric/Psychological Assessment; School Psychologists; Special Education.

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Interethnic Adoption Provision

The guiding principle in child welfare practice and policy decision making is the best interest of the child. This principle informs decisions about child abuse substantiations, case planning, and placement decisions. A secondary goal is to achieve permanency for children as all children deserve a secure, caring, and safe environment. Although the majority of children in the public child welfare system reunify with their families than are adopted, adoption and adoption practices have received a fair amount of legislative and policy attention.

This secondary goal has been a source of controversy in child welfare practice and policy in relation to the role of race and ethnicity in placement decisions. Race and ethnicity are sometimes used interchangeably, but there is a distinction. Race is used as a category to group persons who have shared physical and genetic characteristics. Ethnicity as a category is based on common ancestry, culture, language, customs, beliefs, nationality, or a combination of these aspects. The United States Congress passed a pair of laws in the 1990s to address race-based preference in placement decisions in foster care and adoption. The Removal of Barriers to Interethnic Adoption (Interethnic Adoption Provisions), the second law, reinforced race-based preferences and permanency for children in the public child welfare system.

Outcomes and Racial Preferences

The outcomes for children involved in the public child welfare system or foster care have been scrutinized over time. Particular attention has been given to minority children. Minority children in foster care have disproportionately more disparate outcomes compared to white children in foster care. The role of race in child abuse reporting, abuse substantiations, and placement decisions has a long and complicated history in the public child welfare system in the United States. Historically, minority children have comprised the largest amount of children in out-of-home care. African American children are disproportionately represented in out-of-home care and within foster care in general. State and local statistics report similar disparities for children of color. Moreover, children of color face a number of barriers to permanency, particularly in the area of adoption. Minority children are adopted at lower rates and remain in the foster care system longer compared to white children.

Historically, race-based matching was the standard practice for foster and adoptive placements. Although this was not the only factor considered, race, ethnicity, and national origin were important factors. Proponents of this practice suggested that children needed racially matched but safe homes to promote racial socialization and develop a positive self-identity. On the other hand, critics argued that racial matching contributed to the high numbers of children of color, particularly African American children, remaining in foster care for too long. Moreover, critics suggested appropriate homes for these children could be found if was race were not a key factor in placement decision making. In short, if was race was not a primary determining factor, children could be placed in stable homes with foster or adoptive parents of a different race.

Predecessor to the Interethnic Adoption Provisions

To address the concerns about permanency for youth and racial matching in placement decision making, in 1994, the United States Congress passed the Multiethnic Placement Act (MEPA, P.L. 103-382). Prior to the passage of MEPA, standard practice within child welfare agencies regarding adoptive placements was to consider the race and ethnicity of adoptive parents along with the ability to meet the child's needs when evaluating potential placement. MEPA attempted to address these barriers but prohibited federally funded agencies from preventing adoptive or foster care placement solely on the basis of race, color, or national origin of the adoptive or foster child and the adoptive or foster parent. Moreover, MEPA required agencies to actively identify and recruit foster and adoptive families that reflected the racial and ethnic diversity of children in the foster care system. Race and ethnicity remained one factor for placement consideration, but this was one of several factors used to evaluate placements.

Interethnic Adoption Provisions

The Removal of Barriers to Interethnic Adoption (Interethnic Adoption Provisions) was inserted into an omnibus bill, the Small Business Protection

Act, and became law in August 1996. The law is now a part of the Social Security Act under the Title IV-E Foster Care and Adoption Assistance. This legislation was introduced and passed because Congress believed the original intent of MEPA was not being followed. Moreover, the Interethnic Adoption Provisions remove any existing ambiguity about whether race, color, or national origin could be deciding factors in foster or adoptive placements. The Interethnic Adoption Provisions rescinded and changed portions of MEPA.

Specifically, the Interethnic Adoption Provisions reinforced the prohibition of race and ethnicity as the primary factor for consideration in placement decisions. Furthermore, similar to MEPA, the Interethnic Adoption Provisions explicitly stated that any person or government entity involved in public agency adoption and foster care placement could not deny a prospective adoptive or foster parent placement consideration on the basis of race, color, or national origin. Additionally, the legislation prohibited persons or government entities from delaying placement based on race, color, or national origin. Lastly, the Interethnic Adoption Provisions removed language found in MEPA that allowed consideration of race, color, or national origin when assessing the best interest of the child and the prospective parents' abilities to meet those needs. If an agency placed children based on these considerations, the legislation called for the agency to provide a compelling reason for making this decision.

The legislation's language included rules for enforcement. Agencies in violation of the requirements that failed to implement a corrective action plan within six months received a reduction in their Title IV-E payments of 2 percent for each quarter of the fiscal year for the first violation, increasing to 3 percent for the second violation and 5 percent for the third. Moreover, other entities in the state receiving Title IV-E funds that violate the Interethnic Adoption Provisions must return all Title IV-E funds.

Similar to MEPA, the passage of the Interethnic Adoption Provisions was controversial and difficult to implement. Prior to the passage of these laws, child welfare professionals and researchers emphasized racial matching in placement decisions as a matter of solid social work practice and law. Professionals in favor of some race matching suggested these placements. Under these new regulations, agencies and practitioners were expected to change practices that were institutionalized.

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See Also: Adoption and Safe Families Act; Child Welfare Services; Multiethnic Placement Act of 1994.

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Interfaith Couples

Difficulties and problems are regular occurrences with any couple; however, *interfaith couples*, a term used to describe partnerships between two people of differing faiths, which may or may not include religious affiliations, present unique and complex trials in addition to typical challenges. It is rare to find couples that have not, to an extent, overlooked important issues during the dating or courtship stage of the relationship. Many issues are important to discuss for any couple, but for interfaith couples, those issues can become magnified when they include sociological, historical, and existential factors. Often, interfaith couples face a lack of acceptance from their parents and religious communities. Dilemmas arise that include decisions about life events, holidays, and raising children. Dynamics of interfaith couples are complex and multilayered culturally and psychologically.

Sociological, Historical, and Existential Factors

Historically, research has indicated interreligious relationships between individuals from major religious influences have higher divorce rates than couples who differ in faith but share the same religion. A common experience interreligious couples face is the lack of acceptance by religious institutions and parents. Many parents affiliated with traditional religions are not supportive in their children's attempt to integrate different customs and traditions into the traditional religion. Some religious institutions may view it as a significant threat to their religious existence, enacting religious laws against such acts. Interfaith couples may also experience significant guilt from parents, who may insinuate the child is destroying the history of the religious tradition by integrating faiths.

During the courtship experience, couples are often so overcome by the excitement of the new relationship that they miss out on the opportunity to discuss important dynamics of the potential long-term relationship. This phenomenon is not unique to interfaith couples. Later, interfaith couples may experience emotionally charged conversations or disagreements that may stem from fundamental differences in the manner in which each partner views existential aspects of the world or his or her existence. On the surface, the disagreements may not be obvious, but underlying differences were developed from the way in which each views themes of life, death, mortality, inferences on the nature of man, meaning and purpose of existence, and the relationship between self and community in a broad sense. The result is a much more complicated discussion than those that all couples tend to experience; interfaith couples may end up arguing over issues involving the nature of their existence and identities.

Decisions and Dilemmas

Even if each partner is not particularly religious, it is not uncommon for partners of interfaith couples to realize they care more about their respective faith traditions than they had originally thought when the relationship began. With this comes the meanings and celebrations of religious holidays, the value of raising their children as a specific religious follower, or the desire to integrate certain aspects of his or her faith into their offspring. As the couple continues to progress through their lives, common decisions inevitably arise and often become very emotional. A short list of decisions regarding the interfaith couple's life cycle include but are not limited to the wedding ceremony and officiate, holiday plans and choosing which holidays to celebrate, how thoroughly to celebrate specific holidays based on religious traditions and ties, joining religious congregations, baptism, circumcision, formal religious schooling, and religious rituals or rites of passage into symbolic adulthood. In addition, the way the couple goes about making decisions will impact their child's identity and security because decision making will elicit dynamics within the couple's interpersonal relationship, which may display underlying power battles or control needs.

Dynamics of the Relationship

In couples, it is common to not share the same faith despite sharing the same religion. An individual's faith mirrors his or her ultimate concerns for existence. The way in which an individual goes about his or her daily life is, most likely, directly correlated to his or her faith in the way life works or the general purpose of life. All marriages experience problems, but interfaith marriages are complicated by differences within existential and sociological factors. It is absolutely possible for an interfaith couple to maintain a successful relationship. It requires tremendous amounts of authenticity, communication, and intentionality. Partners can meet the difficulties head-on by communicating and learning to listen and understand their own, and their partner's, religious and faith backgrounds. Learning to articulate theologies, as well as listen with an open mind to their partner's theologies, builds trust and vulnerability within the relationship. Techniques used in counseling to assist in strengthening communication include role-playing the other's view, as well as reading books or taking classes together in order to discuss each other's traditions, and to provide the vocabulary to open verbal dialogue.

Differences must be transformed from a battle of power into a valuable opportunity to engage in problem solving as a unit. Finding solutions, rather than avoiding the problems, will inevitably provide structure and solidify identities for the couple and their children. Religion is essentially utilized to cope with and improve the quality of one's life. Faiths and religions utilize rituals and traditions that work to provide inspiration and comfort as well as enhance the lives of those who partake in them. Interfaith couples and families would do well to embrace this view as an introduction to integration.

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See Also: Biracial Couples; Divorce; Fundamentalist Christian Americans; Interfaith Couples; Jewish Americans; Marriage Counseling; Mormons; Muslims; Native Americans; Pacific Islanders; Religion and Clients; Spirituality/Religion and Diversity.

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Internal Revenue Service's Migration Data Files

The Statistics of Income (SOI) Division of the United States Internal Revenue Service (IRS) annually publishes data, based on individual tax returns, providing data about migration within the United States, in the form of the IRS Migration Files. One set of files provides information about in-migration and out-migration from one state to another (state-to-state migration), and the second provides information about in-migration and out-migration from one county to another (county-to-county migration). Although these files are based on tax records and are therefore not a complete census of population movement within the United States, as discussed below, they can provide valuable information about patterns of migration within the country.

The IRS Migration Files are produced by the U.S. Census Bureau from the IRS Master File (IMF) for each year, which includes administrative data from all individual returns filed by late September (95 to 98 percent of all individual tax returns for a given year). The IMF provided to the Census Bureau includes the following information: tax filing units, that is, the filer, filer's spouse, and exemptions claimed; mailing address; age classification (under or over age 65); income data, including wages and salaries, interest income, dividends, royalties, and gross rents; adjusted gross income; and a Protective Identification Number (PIK) to identify the return without jeopardizing confidentiality (names and Social Security numbers are stripped from the returns before they are sent to the Census Bureau). Note that the year of the IMFs is the tax year, which is the calendar year following that in which the income was earned—for instance, income earned in 2012 would be reported on an individual's 2013 tax return—and migration is always reported in two-year increments, such as the 2012 to 2013 migration data.

The Census Bureau assigns geocodes (geographic codes) for state and county to the IMF data, with county-equivalent codes assigned to the District of Columbia, Puerto Rico, military addresses (AFO/FPO), and similar regions. Migration status is assigned by the Census Bureau by comparing the current year's returns with those of the previous year: If the geocodes for both state and country are the same, the individual is classed as a nonmigrant, while if they differ, he or she is a migrant. For those classified as migrants, they are in-migrants to the locations identified on the current year's tax return and out-migrants from the location of the previous year's return.

After the data are geocoded and the migration status calculated, the data are returned to the IRS, who checks them for outliers and formats and prepares the files for public release. The data are made available to the public as comma-separated values files (*.csv), which can be opened and analyzed using a spreadsheet program such as Microsoft Excel, and as generic ASCII files (*.dat), which can be opened and analyzed in a statistical program such as SAS or SPSS but require the use of a record layout, which is available on the same Web page as the data files. As of December 2013, IRS Migration File data for 1990 through 2010 are available for free download.

For each state, inflow and outflow files provide the number of returns (used to estimate the number of households), the number of exemptions (used to estimate the number of individuals), and aggregate adjusted gross income. Migrants and nonmigrants are listed separately, and migrants are further broken down into those who migrated to or from foreign countries, other states in the United States, and total migrants (either another state or country). Similar information is provided in the county-to-county migration files, with the addition of a category for those who migrated to or from a different county within the same state.

Limitations

The IMFs are not a perfect record of internal migration for several reasons. First of all, not everyone is required to or does file an income tax return, and those individuals (and members of their households) who do not file are not present in the IMFs; this makes the files not only incomplete but also biased because the poor and elderly are less likely to file a return and thus be included in the data. Second, persons who file after September are excluded, as noted above, and this also introduces bias into the data because very late filers are disproportionately those who have complex returns and high income. For these two reasons, the IMFs are likely to underrepresent both the very poor and the very rich. Regions with only a few filers may also be underrepresented because some data is removed from the public files for reasons of confidentiality—in state data tables, cells with fewer than three returns are suppressed, and in county data tables, cells with fewer than 10 returns are suppressed

Some returns are excluded because of matching problems; for instance, if a married couple files jointly one year, then divorces and files separately the next year, only the primary taxpayer will be matched over the two years. If a married couple files jointly one year and separately the next, this also will result in only the primary taxpayer being matched across the two years. Migration can be over- or undercounted because it is based on the filing address, which might not represent the person's true residence; for instance, it might be a place of business, a post office box, or a tax preparer's office. In addition, the address might be that of a college student who files from his or her home address one year and college address the other or a person with dual residences who files one year from one address and the second year from another address. Finally, a person could have moved during the period under study and still be classified as a nonmigrant; for instance, if they moved to a different address within the same county.

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See Also: Acculturation; Assimilation; Border Communities; Isolated Communities and Cultural Competence; Rural Communities; Southern Communities and Cultural Competence; Urban Communities and Human Services; Western Communities and Cultural Competence.

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International Adoptions and Families

International or intercountry adoption is a process of legal transfer of parental rights and responsibilities for a child from a different country of one's citizenship. Through this process, the child gains the citizenship of the parent(s). In the United States, international adoptions can either be completed with the help of a nonprofit adoption agency that is licensed in the state of operation, or independently (also known as parent initiated or direct 31 adoption). Both types of international adoption use a third party, such as an adoption agency or lawyer, to help reduce bureaucracy. From 1999 to 2012, American families completed over 242,000 international adoptions. Over 172,000 of these adoptions were of children ages 3 and under. China, Ethiopia, and South Korea are the top countries for international adoption. In 2008, Guatemala was number one, but it has since closed to international adoptions with the United States. International adoption can be a long and difficult process because it involves the governments of two countries. Adoptive parents often need support and services pre- and post-adoption.

Pre-adoption services that families may require include home study or assessment conducted by a state-licensed social worker. Families beginning the process of adopting internationally will be required to meet state, federal, and foreign government regulations. Families build an adoption dossier filled with complete paperwork such as a home study, letter of intent to adopt, photographs of family and home, and an application for adoption, among many other forms. Families benefit from meeting with a social worker to assess their readiness for adoption. Perspective adoptive parents are usually required to complete parent training before completion of the dossier. Social workers track perspective adoptive parents' progress through the training. Families often seek out the support of adoption groups to assist with not only the emotions and uncertainty that are common during the process, but also to learn more about what to expect in country and once home. Along with the joys of anticipation, families can feel the sadness of lost referrals or delays. Families may benefit from counseling to cope with issues such as anxiety, sense of loss over lost referral, and grief over delays.

There are several services that families may require post-adoption. The most common services that families with children internationally adopted require include therapy and counseling, support groups, heritage activities, respite care, and educational resources.

Therapy and Counseling

International adoptions vary, and the needs of families and children are equally diverse. International adoptions are a result in loss of birth rights of birth parents. Children are usually placed in an orphanage or with a foster family. Children who endure such loss and/or neglect may require therapy or counseling. Common issues that internationally adopted children may face include attachment, trust, or behavioral problems. Parents may face unexpected effects of the adoption, including strain on relationships like marriage or with other children in the home. Families become accustomed to waiting for and dreaming of the adoptive child. Families may face what is commonly referred to as the "adoption blues" after returning home with the child. Because international adoption is a long and often challenging process, the completed adoption may not match expectations. The services of a professional therapist or counselor may help a family with any of these issues before they become a serious problem.

Support Groups

Families often choose to continue participation in face-to-face support groups and/or online groups once the child is home. In a support group, families with internally adopted children find a sense of belonging not often found among family and friends. Adoptive families gain from interacting with others who experience similar events, challenges, and joys. In addition to families, the adopted children may benefit from participating in support groups. Many communities offer international playgroups organized by adoptive agencies, social workers, or adoptive parents. As they grow, the children will have questions and gain from hearing from other children who may share a similar perspective. Children adopted internationally often feel a sense of loss and confusion of identity. Interacting with peers who share a similar beginning in life may help with feeling "normal." Families created through international adoption share a unique perspective.

Heritage Activities

Ethnic heritage camps provide families and children an opportunity to form significant friendships. Families spend time together in a camp setting doing both traditional camp activities and ethnic-focused activities. Families need a chance to be among similar families, especially transracial families, creating a positive environment for children. It is common that international adopted families encounter intrusive questions from others. Ethnic heritage or adoption camps provide a safe environment for children to interact without the intrusive questions and feeling that they are on display. Adoptive families may participate in adoptive parent-led groups that often offer group and recreational events. Children benefit from learning about their birth countries. Research shows that a healthy identity begins with understanding one's ethnic heritage.

Respite Care

The international adoption process is often overwhelming. Children who are adopted internationally can have a bumpy transition into their new homes. Many of what a person encounters in his or her everyday life can be dramatically overstimulating for the child. Children often face attachment and trust issues that can be draining. Parents may need temporary relief and time to refuel during the time when the child is transitioning and the family is establishing a new normal. Respite care provides parents with a skilled social worker to assist with childcare for a temporary period of time. Such care provided through a respite care program is more skilled in adoption issues than a regular babysitter. State and county agencies provide respite care for adoptive families.

Educational Resources

Social workers and other adoption professionals provide adoptive families with information about the transitioning process as well as other issues they may face. These professionals provide referrals to services. Families often benefit from attending workshops on relevant topics. The international adoptive family is ever changing, as is the need for support services. Children grow and needs change over time. It is important that families receive ongoing access to support services, not just during the time when the child enters the family. Services are provided by many different organizations including public state and county adoption agencies and health and mental health providers.

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See Also: Adoption Agencies and Services; Adoptions, Infants, International and Older/Special Needs Children; Adoption, Special Needs.

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International Federation of Social Workers

The International Federation of Social Workers (IFSW) is the global body for professional social work. As an international organization, the IFSW works in cooperation with the world regional social work bodies, national organizations, and other related associations in representing the interest of social workers around the world. The purpose of the organization is to contribute to achieving social work through professional social work activities. The IFSW is a global federation of national organizations of social workers endeavoring for social justice, human rights, and social development. The organization and its partners seek to promote social work as a profession, review and set the international standards for social work, and provide the definition of social work and policies that promote best practice outcome.

History

At the 1950 International Conference of Social Work in Paris, an agreement was reached to create the IFSW, an international organization (federation) of professional social workers. The federation was to be a successor to the International Permanent Secretariat of Social Workers (IPSSW), which was founded in 1928 at the first International Conference on Social Work in Paris, France. A part of the 1950 decision was that the IFSW would come into existence when seven national organizations at that time agreed to become members. Meanwhile, the IPSSW operated form offices in Berlin, Geneva, and Prague until the formation of IFSW. It was not until 1956, at the time of the meeting of the International Conference on Social Welfare in Munich, Germany, that the IFSW was finally founded. Thereafter, a new secretariat was established in New York in the United States, sharing office space with the National Association of Social Workers.

With a joint effort with its partner organizations, the International Association of Schools of Social Work (IASSW) and the International Council on Social Welfare (ICSW), IFSW published the journal *International Social Work* in 1958. In 1959, IFSW was granted consultative status with the United Nations Office of Economic and Social Council (ECOSOC). The participation and contribution of IFSW at the 1960 10th World Conference Special Session in Rome, Italy, expanded the organization's recognition and prestige in a policy development role. Further, IFSW gained more international respect in 1963 when it asked and was accorded the opportunity to contribute to the United Nation survey on international training for social workers.

During the later years of the 1960s, the organization began decentralization efforts based on regional formations. Litsa Alexandraki was elected for three terms as president of IFSW, a position she administered from 1962 to 1968. Also, she was a founding member of the Hellenic Association of Social Workers and served as its president from 1961 to 1963. She (1918–1986) was highly regarded for her work in Greece on child welfare and the protection of migrants and refugees. During her presidency, she expanded the IFSW membership to Asia, Africa, and Latin America. A few other key founders and leaders of IFSW include Jane Hoey, Chauncey A. Alexander, Eileen McGowan Kelly, Celia B. Weisman, Andrew Mouravieff-Apostol, and Professor Gary Bailey. Recent secretary generals and chief executive officers include Tom Johannesen and Dr. Rory Truell. The first region was formed in Europe in 1965 and followed a regional conference for Asia in 1967. In a historical context, the South African IFSW membership was suspended in 1970 due to its Apartheid regime involvement. In 1971, the executive committee located a permanent and compensated secretariat in Basel, Switzerland, which was later moved to Geneva in 1975.

The IFSW had successful operational initiatives during the 1980s and 1990s. It developed the global definition of social work and was declared a peace messenger by the United Nations in 1985. In the 1990s, IFSW significantly increased its membership to more than 80 member associations. With a strengthened secretariat and expanded activity levels, the secretariat was moved to Oslo, Norway, in 1992 and later to Berne, Switzerland, in 1999. From the year 2000, IFSW has made significant growth and accomplishments.

Operational Organization

The IFSW is governed through an international executive committee that is democratically elected every two years at a general meeting of members. This governing committee consists of a president, treasurer, regional president, and member at large for each region. The five geographical regions of the IFSW are Africa, Asia-Pacific, Europe, Latin America, and the Caribbean and North America. Each of the regional memberships is represented by a regional president. A general meeting is convened every two years at the same time as an international conference. An elected global president and secretary general along with an elected executive committee steer the IFSW meetings and conferences. Regional seminars and conferences are held regularly in most regions and are presided over by each regional president. There is a program link called Friends of IFSW connecting associating social workers, social work students, and organizations to the international community.

Currently, the IFSW is comprised of 90 member associations representing more than 750,000 social workers worldwide. New members to the IFSW are recruited by reaching out and offering membership to emerging social work groups in nonmember nations. Retention of existing members is maintained by effectively and efficiently representing the diverse interests of social work associations and organizations around the globe. All regional and national members maintain membership status through membership dues based on the number of members. The IFSW provides member organizations in developing nations with discount membership fees.

Operations of the IFSW

The IFSW represents its members by providing a global stage for the issues of interest to the profession. IFSW has special consultative status with the United Nations Children's Fund (UNICEF), and works with the World Health Organization (WHO), the Office of the United Nations High Commissioner for Refugees (UNHCR), and the Office of the United Nations High Commissioner for Human Rights (OHCHR). IFSW also maintains partnership with Amnesty International. Activities covered in the policy papers of IFSW include displaced persons, global climate change and the environment, health, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), indigenous people, women, older persons, peace and social justice, poverty issues, and many more.

In 2004, the IFSW, in cooperation with the IASSW, adopted the Statement of Ethics in Social Work, Statement of Principles of Social Work, and the Global Standards for the Education and Training of the Social Work Profession. In 2005, IFSW consultative status was extended. These accomplishments are in addition to the global definition of social work, which IFSW and IASSW adopted in 2001. Noteworthy publications by the IFSW include *Human Rights and Social Work: A Manual for Schools of Social Work and the Social Work Profession* (1994), *Social Work and the Rights of the Child* (2002), *Human Rights Manual* (2010), and *Standards in Social Work Practice Meeting Human Rights* (2010). Recently, the IFSW, the IASSW, and the ICSW have collaborated in the production of the global agenda for social work and social development commitment to action. This agenda commits these three organizations to working collaboratively for the foreseeable future to improve the life chances of all of the world's people. The agenda also works to increase the articulation of the social work profession in realizing social justice for all in the international arena.

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See Also: American Academy of Social Work and Social Welfare; Social Work, Diversity Practice in; Universal Declaration of Human Rights.

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International Mental Health Research Organization

The International Mental Health Research Organization (IMHRO), established in 2008 as a nonprofit organization, is "committed to raising awareness and finding neuropsychiatric research to find preventions and cures for severe mental illnesses, focusing on schizophrenia, bipolar disorder, and major depressive disorder, within a generation," according to the organization's Web site. The Staglin family's personal experience with their son's

1990 diagnosis of schizophrenia influenced their decision to take steps to not only bring attention to mental health needs of persons with mental illness but also the need for additional research funds to forward the prevention and treatment of mental illness. To that end, they launched an annual music event, called the Music Festival for Mental Health, as a response to their personal experience and to raise both awareness and financial support for mental health research.

IMHRO's total revenue as of December 2011 was $4,487,185, with total expenses of $3,579,289, reported GuideStar. During the 2011 17th Annual Music Festival for Mental Health, IMHRO raised a total of $3.3 million to support their research mission, according to Idealist. This festival has emerged to be one of the most significant fund-raisers for mental health research in the United States, according to the Office of Congressman Fattah Chaka. Since the organization's early beginnings, IMHRO has raised $150 million to support research programs for both the prevention and treatment for mental health disorders.

This organization has reached beyond its original mission and been part of developing two additional nonprofit organizations. For example, IMHRO was instrumental in helping found Bring Change 2 Mind in 2009, along with Fountain House, Glenn Close, and the Balanced Mind Foundation. This foundation's mission "is to emerge as the world's most effective organization working to erase the stigma and discrimination around mental illness by creating carefully targeted and powerful messaging, informed and measured for effectiveness by an Advisory Council of the leading scientists in the field" (Staglin Family Vineyard, 2013). Garen Staglin also played a significant role in serving as co-chair of the launch of ONE MIND for Research, alongside former Congressman Patrick Kennedy. The aim of this campaign is "to dramatically reduce the global burden of brain disorder disability in the next 10 years," states the Staglin Family Vineyard, via partnering on an international level with scientists, advocacy groups, policy makers, and industry.

In July 2010, the Staglin IMHRO Center for Cognitive Neuroscience opened at the University of California Los Angeles (UCLA). The center's cross-disciplinary collaborative research teams (e.g., psychiatrists, neurologists, electrical engineers, physicists, and psychologists) study emotional and cognitive processes with respect to their impact on decision making and mental health, reports S. Wolpert. Garen and Sharalyn Staglin have donated a total of $4 million over 10 years through IMHRO and their annual Staglin Family Music Festival for Mental Health.

In 2008, Johnson and Johnson Corporate Office of Science and Technology entered into a collaborative effort with IMHRO to provide a $250,000 grant to support the establishment of the Rising Star Awards. IMHRO matched this grant and funded the first awards in 2010, reported Enhanced Online News. The research section on IMHRO's Web site features a description of the two different Rising Star Awards. The first award, the Janssen/IMHRO Rising Star Translational Research Award, was established to "advance the translation of scientific knowledge of underlying disease mechanisms in bipolar disorder, schizophrenia, and major depression toward benefits to patients and the health care system." Two researchers are awarded $150,000 in direct costs to support their programs of research. The second award, the IMHRO Rising Star Basic Research Award, is geared toward "the best and brightest young brain scientists" to conduct basic research into the nature of bipolar disorder, depression, and schizophrenia. The $250,000 award supports a project for a maximum of three years.

Web Site Resources

One of the most interesting resources available on the IMHRO Web site is called "Brain Waves," where registered viewers may watch videos interviewing real, professional brain scientists providing information on recent, cutting-edge topics such as "Understanding Dopamine's Role in Schizophrenia" by Dr. Vikaas Sohal and "Finding the Roots of Mood Disorders" by Dr. Jun Li. Registered users may also have their questions answered by these experts. The education resources section provides three separate tabs for information about schizophrenia, bipolar disorder, and depression. The research section highlights current research conducted by the Rising Star Award recipients—for example, "Advances in Autism Prevention, Consciousness Detection, and Bipolar Disorder Diagnosis" by Dr. Susan Bookheimer and "Early Detection and Intervention for Psychosis" by Dr. Carrie Bearden.

The news tab provides timely updates around IMHRO-sponsored upcoming events, board of director assignments, and research updates. Under the “Get Involved” tab, users find information about upcoming events, volunteer opportunities, and donation opportunities. The online community provides registered Web site users opportunities to sign up for e-newsletters about events and recent scientific advances. Interested parties may sign up for the IMHRO Facebook page.

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See Also: *Diagnostic and Statistical Manual of Mental Disorders*, Cultural Responsiveness of; Mental Health Services, Adult; Mental Health Services, Children; Mental Health, International Variations in Attitudes Toward; National Center for Minority Health and Health Disparities; National Institute of Mental Health; National Mental Health Association.

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Interpersonal Violence

Interpersonal violence is frequent among human beings because of differences and diversities in human nature. The enormity and consequences of interpersonal violence on victims necessitate the close examination of actors in interpersonal violence and different types and forms of interpersonal violence such as sexual assault, abusive relationships, and stalking. Services and support available for victims of interpersonal violence include advocacy, therapy, and medical and legal action. Interpersonal violence occurs between two individuals who are always in close contact such as members of a family, husband and wife, co-wives, workmates, colleagues in school, and neighbors.

This form of violence is spontaneous; it is unplanned for but happens regularly. Interpersonal violence is defined by the World Health Organization as any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Violence is considered the intentional use of physical force or power, threatened or actually, against another person that results in a high likelihood of resulting in injury, psychological harm, or death.

Interpersonal violence can be perpetrated by a partner or ex-partner, an acquaintance, or a stranger, though the latter do not occur most frequently. Most cases of interpersonal violence involve men perpetrating violence against women; it is understandable that interpersonal violence occurs in same-sex relationships and that women can perpetrate violence in heterosexual relationships as well.

Nature of Interpersonal Violence

Interpersonal violence could be categorized into three types. Interpersonal violence can be in the form of sexual violence, abusive relationships, and stalking. Sexual violence is when a victim is pressured to act against his or her will to allow sexual advance from a perpetrator. Victim free will is absent, but physical force, persuasion, and acts of threats such as physical, verbal or emotional, coercion, or alcohol or drug injection are used. Sexual violence includes rape, which involves penetration of any body opening by any object without consent. Consent here means verbal permission, which either implies yes or no. Rape victims may not be able to resist sexual penetration because they might be injected with date rape drugs by the perpetrators. In addition, they might not be aware until eight to 12 hours after it occurs as a result of lapses. To prove a rape case, an evidence kit or rape kit is needed by the victim. Sexual harassment is another form of sexual violence, which involves the misuse of power, involving two people of perceived unequal authority and status. It is sexual advances to solicit support, gratification, and gains.

An abusive relationship is in the form of domestic violence, dating violence, intimate partner violence, elderly abuse, child abuse, and family abuse or relationship entered into by two partners, which could result in verbal, physical, psychological, emotional, or sexual abuse.

Stalking is frequent harassment of or by another person or course of conduct directly, indirectly, or by a third party with willful and without legal purpose. Three important evidences are tenable in stalking: (1) frequent occurrence, (2) deliberation, and (3) an actor with a particular aim to institute fear or cause substantial emotional distress such as death, bodily injury, and continued harassment.

Perpetrators and Victims of Interpersonal Violence

A perpetrator or abuser is someone who uses violence and other abusive behaviors to control and dominate in relationships. A survivor or victim is someone who has experienced the crime and trauma of interpersonal violence. The term *survival*

A sign states that "North Hampton Is a Domestic Violence-Free Zone" in North Hampton, Massachussetts, 2008. Community organizations work to prevent interpersonal violence by offering safe shelter, crisis intervention, advocacy, and education and prevention programs. Screening for violence take place in health care settings, emergency departments, behavioral health settings, and court systems.

is often used instead of *victim*, particularly when survival is healing or empowered after the violence. A secondary survivor is someone who knows a friend or family member's story of interpersonal violence.

Most people are secondary survivors who know a survivor who has experienced sexual assault, abusive relationships, or stalking. Sadness, confusion, anger, helplessness, fear, guilt, disappointment, shock, anxiety, desperation, and compassion are all common reactions for survivors and their loved ones. Being aware of these emotions will ultimately help a victim better understand the survivor's experience and be more supportive.

Services Available to Victims of Interpersonal Violence

There are different services available for victims of interpersonal violence. The services range from reporting, counseling, and advocacy to prosecution of perpetrators. Advocates or companions are specially trained volunteers and staff who provide 24-hour crisis line services for the victims of interpersonal violence. Advocates can follow the victim to the hospital, police station, court, or media house. Advocates can provide the victim with professional counseling, but they cannot work as therapists.

There are also forensic nurse examiners and sexual assault nurse examiners (SANEs) who are trained nurses; they provide information on available medical care options and reporting. They collect evidence with physical or sexual assault evidence collection kits and prescribe medications for prevention of infections and pregnancy, such as human immunodeficiency virus (HIV) prophylaxis medication and the pregnancy morning-after pill or Plan B.

A victim of interpersonal violence can also ask for safe housing if she or he feels a sense of lack of security or revictimization at the hands of the abuser. A victim or secondary survivor may also file an anonymous report, blind report, or full report through nongovernmental organizations, women's organizations, or Crime Stoppers International. Victims may also call a 24-hour hotline manned by specialists. Survivors or secondary survivors can call to advocate about experiences in an anonymous way. These services are available in the United States and the United Kingdom, where people can call 911 and 999, respectively.

Survivors of sexual violence can suffer a significant degree of physical and emotional trauma during, immediately after, and over a considerable time period after the rape. They can experience nightmares, fear of being alone, fear of physical contact and sex, and possibly eating, sleeping, and menstrual pattern disruption. To heal, survivors of interpersonal violence could seek support from family, friends, counselors, and support groups.

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See Also: Family Violence Prevention and Services; Family Violence Prevention and Services Act; Women, Battered.

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Interprofessional and Interdisciplinary Practice

Human services organizations are being entreated to create sustainable impact and changes in the lives of individuals and families accessing social services. With the growing diversity in the U.S. population and complexity of social issues experienced by individuals and families, comprehensive approaches for addressing these challenges often necessitates interprofessional collaboration and practice. Interprofessional practices not only improve quality of services delivered but also enhance the work lives of practitioners. The importance of interprofessional practice has led to the development of interprofessional competencies by the Interprofessional Education Collaborative

Expert Panel and the Center for the Advancement of Interprofessional Education (CAIPE). Several disciplines—for example, nursing, education, and gerontology—are at the cutting edge of implementing interprofessional educational models where students from different professional programs learn with and from each other. The purpose of this entry is to define and postulate rationale for growth of interprofessional practice, illuminate the skills needed for interprofessional practice, provide illustrations of interprofessional practice, and elucidate interprofessional education.

Interprofessional care and practice entails that two or more individuals from different professions integrate their respective assessments, perspectives, and interventions for understanding and solving problems whose solutions are beyond the scope of a single field. Such an integrated approach greatly enhances the quality of services delivered to service beneficiaries.

Rationale and Skills

Complex and dynamic challenges experienced by individuals accessing human services cross social, economic, physical, spiritual, and emotional health boundaries; these challenges are further compounded by the growing diversity of the U.S. population. Providing a comprehensive, culturally proficient, seamless system of services necessitates invoking the expertise of several professionals. Often, solving complex problems transcends the knowledge and skills of any one profession (e.g., teachers, human services professionals, nurses, physical therapists, etc.). Moreover, shrinking public funding, devolution of social services to state and local levels, and demands of managed care are compelling an integrated approach to delivering human services in a more cost-effective fashion.

Human services professionals exchange information and coordinate the services—with other professionals—they deliver to ensure an integrated approach to clients' challenges. Interprofessionality is a process in which professionals develop integrated ways of practicing and providing cohesive responses to clients' needs and problems. For practicing in an interprofessional fashion, human services professionals require excellent communication and group process skills to maintain continuous interactions with participating professionals, sharing knowledge, negotiating, resolving conflicts, and participating in teamwork. For interprofessionality to succeed, collaborative practice skills, openness to alter one's perspectives while interacting with other professionals, and the ability to implement discipline-specific interventions are vital. Knowledge of the community and context, ability to work across different systems, and cultural proficiency are also essential to interprofessionality.

Interprofessional Practice

Practitioners in mental health, education, health care, child welfare, domestic violence, and several other fields that require the expertise of various professionals and disciplines are currently delivering interprofessional care. Comprehensive interprofessional understanding of issues occurs when practitioners are able to view situations from the perspectives of each participating profession. For example, in community-based mental health organizations, mental health practitioners interface with professionals from several different fields—often from several different organizations—to provide comprehensive and seamless service delivery. Often, these clients experience several social and economic challenges as well. Collaboratively with psychiatrists, nurse practitioners, social workers, client advocates, and family members, mental health practitioners are assessing clients and developing integrated care plans.

Similarly, in schools serving children with special needs, teachers, counselors, social workers, psychologists, psychiatrists, and family members collaboratively assess students and their circumstances to develop integrated interprofessional action plans. Illustrations also exist in the health care and long-term care arena, where professionals and paraprofessionals—for example, doctors, nurses, nurse practitioners, patient advocates, physical and occupational therapists, social workers, human services workers, and certified nursing assistants—work on interprofessional teams to provide care and services to clients in institutional and community-based settings. For reasons already mentioned, interprofessional interventions are quintessential for addressing the multidimensional needs of a diverse client population.

Interprofessional Education and Training

Interprofessional practice cannot occur by accident, it needs to be intentional, requiring unique competencies and skills. Implementation of interprofessional practice today has largely occurred based on the in-service training and on-the-job experiences of practitioners. Ideally, graduates of professional programs should possess the knowledge and skills—for example, teamwork, conflict resolution, group process, and so on—for interprofessional practice prior to entering human services, health care, and educational arenas. Owing to the limited focus on interprofessionality in most professional education programs, graduates are often ill prepared for interprofessional practice. Many encounter conflicts and role ambiguities when serving on interprofessional teams. Often, adhering to ethical standards of the various participating professionals becomes challenging in such settings unless prior interprofessional training and practice has occurred.

Professional programs can integrate interprofessional practice—what, why, and how—into their curricula and enable graduating students to effectively address their clients' complex and dynamically changing circumstances. These programs must utilize appropriate teaching methodology (e.g., experiential and transformative learning opportunities), resources, and topics to impart the knowledge and skills to graduating students. More specifically, human services programs can invite faculty from related fields to design an interprofessional capstone courses and internships for their students. Institutions of higher learning will need to transform their educational models for building a true interprofessional educational environment. Community-based human services organizations can assist these institutions by providing interprofessional internship opportunities to students.

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See Also: Children With Special Needs; Deinstitutionalization; Domestic Violence; Mental Health Services Delivery, Cultural Characteristics of; Social Innovation.

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Interstate Compact for Juveniles

The Interstate Compact for Juveniles (ICJ) offers statutory contractual authority and guidelines for the movement of juveniles across state lines. The aim of the ICJ is to protect communities while also holding juveniles who may have broken the law accountable. Today, more than 20,000 juveniles are apprehended in states other than the one in which they were adjudicated, taken into custody, or where they reside. ICJ serves as a mechanism for returning juvenile nonoffenders (minors in need of supervision) and offenders, whether status offenders or delinquents who may have been on parole, probation, or other correctional supervision but who have left their states often by running away, escaping, or absconding. Status offenders are minors who have committed an offense that, had it been done by an adult, would not be a crime (e.g., juvenile curfew violation, truancy, or underage smoking); delinquency refers to an offense by a minor that, if done by an adult would be a crime; for example, robbery. At times, the need for a juvenile to leave a state in which he or she was adjudicated is a legitimate one, such as a need for the juvenile's family to relocate. ICJ serves as a means for shifting the supervisory responsibility to another state or U.S. territory that has adopted the ICJ by documented permission routed through the receiving state's office of ICJ.

The agreement requires that a receiving state fulfill the judicial orders of the sending state; see to it that persons are not at risk from the juvenile in the sending and the receiving states; return offenders who have run away from their states if their return is requested; contract with compact states for special services for juveniles as needed; assist other states in locating juveniles and equitably sharing the cost of serving juveniles; data collection; compliance monitoring; and training and education. Compacts have been used in the United States since the 18th century. They are agreements to resolve boundary issues between states, to establish procedures when these issues arise, and to define administrative responsibilities associated with the ICJ.

The current ICJ was preceded by a 1955 compact that was in effect in Washington D.C., all 50 states, Guam, and the Virgin Islands. This compact was problematic to utilize. The problems included different terms and definitions across states, rules that were difficult to follow, a lack of compliance, and a lack of timely exchange of information. An advisory group, the National Interstate Commission for Juveniles, was formed in 2000, which included persons from different states and the Office of Juvenile Justice and Delinquency Prevention to draft the existing compact. In 2003, a draft of the compact was circulated to stakeholders for input. These persons included juvenile and family court judges, defense and prosecuting attorneys, legislators, the American Probation and Parole Association, and the National Center for Missing and Exploited Children. North Dakota was the first state to enact ICJ in 2003, followed by 11 other states that year (Arizona, Connecticut, Delaware, Louisiana, Maine, Michigan, Missouri, Montana, New Mexico, Rhode Island, and Washington). Ten more states enacted in 2004 (Alabama, Colorado, Idaho, Kansas, New Jersey, Oklahoma, Pennsylvania, South Dakota, West Virginia, and Wyoming) and seven more in 2005 (Arkansas, Florida, Kentucky, Nevada, North Carolina, Texas, and Utah). In 2006, South Carolina and Wisconsin adopted; in 2007, Maryland and Virginia; and in 2008, Illinois and Tennessee. Each of these states has a commissioner or voting member on the Interstate Compact for Juveniles Commission. This person is appointed by a governor or a state council. The commission has rule-making authority. The National Center for Interstate Compacts serves as a center point for various compacts. The Association of Juvenile Compact Administrators (AJCA) collects data on compact operations. By March 2012, the only states or territories that were not a part of ICJ were Georgia, Puerto Rico, Guam, American Samoa, and Northern Marina Islands.

Juveniles in detention in a receiving state may not be held longer than 90 days pending a requisition. The juvenile's home or sending state has 60 days to prepare the requisition after being notified about the juvenile's location and unwillingness to return voluntarily. The sending state holds the authority to terminate or discharge a juvenile's case. Such action may be in response to such a request from a receiving state. Sending states bear the responsibility for victim notification, and receiving states have five days to supply details requested for this purpose. A juvenile's willingness to return to his or her sending state should be honored expediently (normally within five days). A state that demands the return of its juvenile shall be responsible for the transportation costs. The ICJ is to be coordinated with the Compact for the Placement of Children. The latter is an agreement among the 50 states to coordinate the movement of minors across state lines for treatment, adoption, foster care, group homes, or trial placement with potential adoptive parents. It includes the need to move juvenile offenders across state lines for placement in private facilities. Common to public interest are juvenile sex offenders. In 2013, 16 percent of parole cases and 10 percent of probation cases transferred according to the ICJ were sex offenders.

States outside of the ICJ have little guarantee of prompt or safe return of its juveniles. Without adequate supervision, juveniles can eventually become missing again or engage in further lawbreaking activities. Member states of the ICJ have the advantage of uniformity in the transfer operations, communication, and information sharing, which is increasingly electronically efficient. Information that is shared between states may include treatment plans, school records, medical records, commitment orders, and orders of adjudication. Compact state judges follow an advisory bench book for handling transfer cases. The response to member states' noncompliance with the ICJ may include remedial training, fines, legal enforcement, or suspension from the ICJ.

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See Also: Interstate Compact on the Placement of Children; Office of Juvenile Justice and Delinquency Prevention; Probation and Parole Officers.

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Interstate Compact on the Placement of Children

The Interstate Compact on the Placement of Children (ICPC) is a statutory agreement delineating legal responsibilities in cross-state placement of children for adoption. With a history dating back to 1960, today, the ICPC is operational in all 50 states, the District of Columbia, and the U.S. Virgin Islands. In 1974, the Association of Administrators of the ICPC (AAICPC) evolved, with the charge to support member groups. The American Public Human Services Association (APHSA), a nonprofit entity representing the health and human services needs of states, has since served as secretariat to the association.With forecasts predicting an increase in adoption needs comes the added need to streamline a process that can take up to two years.

The overriding objective of the ICPC, of course, is the safety of all children—to that end, the ICPC has established procedural guidelines spanning specifics such as child care itself and financial obligations of related agencies and states. As part of that expressed mandate, policy requires the careful screening of receiving homes, which includes a thorough social history and specifics such as employment history, financial screening, criminal background checks, training for parents in some cases, and in others, an investigation of parenting style. Timely provision of necessary support for adopting parents is critical to successful and desired permanent placements and is particularly pointed in special needs children, who evidence more cases of interrupted adoptions. Perhaps expectedly, placement is far from being an easy undertaking; navigating related agencies across state lines and achieving associated checks and balances is challenging. Adding to the inherent complexity of matching children with adopting parents is the court dynamics—any movement of a child from one home to another (foster care, birth parents, agency care, etc.) must meet with its approval. Other layers of complexity point to the welfare system of individual states where resources can prove a debilitating factor to a child's transition.

The initiating state creates a portfolio on the child's case, which includes medical, educational, and social histories and information on the prospective placement. A completed portfolio is forwarded to that state's central ICPC office. Once vetted, the portfolio is then forwarded to the central office of the planned recipient state. That agency conducts its own review of the portfolio and then forwards the same to its local entity. They are charged with screening the planned recipient home. Once home study is completed, a report is sent to the recipient state's central ICPC office for approval. The portfolio then is sent to the central office of the ICPC initiating state and then to that state's local office.

Compacts: The Binding Nature

Support and, thus, legitimacy for interstate compacts are rooted in the U.S. Constitution. The clear advantage of ICPC is the increased likelihood for placement. The contractual nature of such compacts, which provide for a range of services in the United States, serve to not only guide the internal operations of each party to an agreement but aim to carefully establish guidelines and regulatory responsibilities of all entities. By their very nature, partnerships through compacts present one way by which states can solve problems. The United States has used interstate compacts for decades—the ICPC is just one such where the charge is the careful placement of children in foster homes. Further, the binding nature of interstate compacts mirrors that of any other legal contractual arrangements entered into by willing parties—in this case states having entered into arrangements or agreements with the purpose of legally guiding how they will relate to each other across geographic boundaries on the specifics of the compact. In the case of children and their placement across state lines in foster homes, or other configurations of cross-state adoptions, funding is backed by Title IV-E funds requiring a state license, related training for parents, careful pre-investigation, and ultimate recommendation of case workers.

Case Diversity

A close look at the children in need of services reveals that these placements go beyond traditional foster care; for example, expectant mothers participating in adoption procedures out of state, foster parents who are blood relatives, agencies, children in treatment facilities, and parents hoping to regain lost custody. The significance of longer time frames in interstate arrangements can impact older children in more negative ways; historically, older children experience longer wait periods in successful adoptions. Lengthy delays translate to aging in the system and older children in need. The literature attests to the fact that prospective parents are more likely to adopt younger children—another reason to streamline the process. The need is further made clear when one examines the numbers involved—an estimated 399,546 children are in foster care, and on any given day, possibly 8,000 children need placement.

Title IV-E

The intent of the federal government under Title IV-E is the provision of support for children in the public foster care program—specifically, financial support for the adopting parents. The assistance is for domestic adoptions—those originating and terminating within the United States. Questions have arisen as to the support, if any, available in adoption cases involving countries outside of the United States. The Social Security Act does not expressly address this dynamic. There are special conditions under which financial support for parents involving out-of-country adoptions may be tapped; these guidelines are addressed in 45 CFR 1356.41.

Issues in the Process

Expectedly, in-state adoptions take less time to complete than cases necessitating two or more states. Navigating the bureaucracy of related agencies is time-consuming. For this express reason, the APHSA, in efforts to save time, moved to study the issues—their approach was bifurcated, taking aim at short-term as well as long-term reforms for ICPC. A uniform approach (preceding adoptions) across state lines was undertaken. To facilitate this, the implementation of a uniform template was proposed. The issue surrounds the delay in completion of home studies. Once the actual home study is completed, the process is delayed further by the standard practice of mailing sizable documents across states. Florida resolved to implement an electronic filing system. Completed home studies are uploaded and made electronically available through the state's Interstate Compact System central office, where receiving states' assigned personnel have access. Other sources of delay pinpointed by bodies such as the American Bar Association (ABA) and the National Court Appointed Special Advocates organization (National CASA) surround slow returns on criminal background checks, judicial orders, and incomplete or poorly prepared ICPC documents.

The Future

Future success of the ICPC is heavily contingent on a number of factors: its own incremental successes as a body and successes in joint efforts with the many associated agencies—all part of the machinery to effect speed, safety, and appropriate placements for all children. Some associated agencies in this consortium of sorts include the AAICPC, the American Association of Public Welfare Attorneys (AAPWA), and APHSA. Resources will always be an issue, and what is certain is that the need for oversight will increase, not decrease.

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See Also: Adoption Agencies and Services; Adoption and Foster Care Analysis and Reporting System; Association of Administrators of the Interstate Compact on Child Placement; Interstate Compact for Juveniles.

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Isolated Communities and Cultural Competence

The definitions of *isolated community* vary significantly due to differences in local governments', humanitarian agencies', and international organizations' policies and objectives in categorizing certain groups of people or communities as isolated communities. In general, isolated communities may be a result of the geographical location of the community (e.g., mountain terrains or distant and small islands), the lack of social infrastructure (e.g., transportation, electricity, and telecommunications), their demographic composition, and the historical, religious, political, and socioeconomic backgrounds of the region or community. Isolated communities can vary in their degrees of isolation and can exist in underdeveloped regions as well as developed countries. For example, as of 2007, Brazil's National Foundation of the Indian (FUNAI) has documented 67 uncontacted tribes that live in isolation from the rest of the modern world. In Canada, there are fly-in communities that have scheduled flights and telephone services but rely solely on bush aviation to connect to the outside world.

Communities can become isolated through unintentional or purposeful separation. For example, geographical disparities can significantly impact communities' access to government infrastructure or health care. On the other hand, resistance to other cultures may encourage certain communities to voluntarily hide or withdraw from the outside world, resulting in cultural inclusivity. For example, the Amish in the United States form isolated faith communities, reject the use of most modern technology (e.g., automobiles and electricity), and wear distinctively conservative clothing. Some communities choose to avoid or resist further contact with outsiders due to tragic or unpleasant experiences in the past. Many Indian tribes in the Amazon rainforest in Brazil remain secluded from the outside world but currently face extinction from land loss and disease. The Brazilian government has established policies to prohibit contact with these tribes, with the exception of a few selected workers from FUNAI, to prevent the invasion of their land and to preserve their autonomy.

Impacts of Globalization and Modernization

Many isolated communities have their own histories, cultures, social structures and institutions, modes of social interactions, and languages. Some isolated communities have existed as a cloister for thousands of years, similar to the ancient people of Brazil and Venezuela who have been separate populations for about 2,000 years. Today, isolated communities are up against the influences of the impeding outside world due to globalization and modernization that may challenge their sustainability and destabilize their indigenous cultures. Foreign investments, modern industries, tourism, and technological and ecological changes have all threatened the survival of isolated communities' cultures, ways of life, and territories.

While outsiders may believe that changes will bring prosperity and development to isolated communities, the "progress" often comes at a price of transforming, reducing, and even rejecting local beliefs, traditions, and cultural values, which are essential to the identities and survival of these communities. Promoting and acknowledging the presence of isolated communities and their cultural differences in the modern world requires behaviors, attitudes, and policies that suit the isolated communities' situations.

Bridging Cultural Gaps

Culture is a system of shared meanings. Culture can be expressed in various ways such as customs, rituals, food, religious practices, or taboos. It is transmitted from generation to generation through many different ways such as languages, performances, plays, and art. Culture provides a way of thinking and interacting and generally involves specific customs, worldviews, ideas, values, methods of communication, and behavior. Cultural groups are shaped by, among others, race, ethnicity, religion, language, region, gender, sexual orientation, and background.

Cultural diversity brings together positive and negative influences of a society. On one hand, it creates a colorful and vibrant community that allows an exchange of cultural products and lifestyles. On the other hand, it creates fragmentation and conflict, which can evolve into discrimination, oppression, and violence. The literature suggests that diversity is never problematic in and of itself. It is individual and institutional responses to diversity that can be problematic. The challenge of today's cross-cultural interactions lies within individuals and group behaviors that hinder the ability to promote equality and equity among different groups, resulting in prejudice, discrimination, and stereotyping. Cultural competence in this context requires a complex processing and understanding of other cultures' values, worldviews, and practices, which are attributable to a variety of factors (e.g., race, ethnicity, gender, and sociopolitical contexts, among others).

Serving Isolated Communities

Any policy or effort aimed at strengthening and empowering isolated communities needs to be conducted with cultural sensitivity. Miscommunication may occur when one party views their actions as offering a solution to poverty condition or opening up access for the flow of resources, while the other party views this action as a form of invasion on their beliefs, values, and traditions. From this perspective, cultural competence requires one to understand cultural differences in normative practices and worldviews, employ cross-cultural knowledge and skills, and honor and celebrate cultural diversity.

Addressing the needs of isolated communities through community engagement and participatory action requires careful attention to avoid problematic social control over isolated or disadvantaged groups. Community-based action has the potential to encourage and motivate community members to actively participate in the process of change. By incorporating local, direct involvement and interactive communication, individuals from the outside world can avoid miscommunication and maintain effective, meaningful interactions with community members.

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See Also: Community-Based Services; Cross-Cultural Knowledge; Cross-Cultural Skills; Empowerment Research; Ethnic Diversity and Values; Service Providers and Cultural Diversity.

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Jail Diversion Programs for Children and Adolescents

Diversion is a term that refers to keeping children and adolescents outside the formal juvenile justice system or minimizing their penetration into the system. Programs designed to achieve these objectives are called diversion programs.

The beginning of the diversion movement in the United States is often attributed to the 1967 President's Commission on Law Enforcement and Administration of Justice Report, which called for the establishment of community-based youth service bureaus as an alternative to encapsulating troubled youth in the formal juvenile justice system. During the late 1960s and early 1970s, these bureaus and other diversion programs sprouted up across the nation.

Examples of early diversion programs include runaway houses where young runaways could avoid secure confinement and receive individual and family counseling, college students and other volunteers serving as mentors with troubled youth, and informal probation programs for young offenders who admitted to their offenses and agreed to certain conditions (e.g., restitution).

Reasons for Jail Diversion Programs

In the early 1970s, two noteworthy events focused attention to developing alternatives to the secure confinement of young offenders. First, in 1972, Jerome Miller, superintendent of juvenile corrections in Massachusetts, closed virtually all the state's secure juvenile institutions and transferred confined youth to community-based residential alternatives. Second, in 1974, Congress passed the Juvenile Justice and Delinquency Prevention Act, which encouraged states to develop alternatives to confining young offenders in detention centers, secure institutions, and adult jails. Several reasons spurred these noteworthy events and currently provide support for diverting of young offenders from confinement in secure public and private institutions. First, most secure juvenile facilities are dangerous—typically overcrowded, antiquated, poorly staffed, and often subjecting wards to violence, abuse, and other types of maltreatment such as solitary confinement often for prolonged periods. Second, they are ineffective; youth often emerge from these institutions worse off than they were before being confined. Youth housed in adult jails, for example, are typically supervised by staff ill prepared to meet their needs and who often fail to provide even basic attention to their care and rehabilitation. Post-confinement recidivism rates for these youth are typically high, and their employment and educational prospects are diminished. Third, they are unnecessary; most institutionalized youth pose minimal risk to public safety. Many youth are confined for committing noncriminal status offenses such as truancy and disobedience. Others are incarcerated for noncriminal probation or aftercare (i.e., juvenile parole) violations, failing to admit to or express remorse for their actions, and low-level property and public order offenses. Fourth, they are obsolete; contemporary delinquency research has distinguished several interventions that appear to consistently reduce future offending. These strategies are inconsistent with confinement and effective when applied in nonsecure, community-based settings. Fifth, they are wasteful; institutionalizing young offenders is extremely costly, particularly considering its poor results. Programs that divert children and adolescents from secure confinement can produce equal or better outcomes for considerably less cost.

Jail Diversion Programs

There are several effective alternatives to the secure detention of juveniles waiting juvenile court processing. For example, home detention has become a widely used alternative. With small caseloads, home detention supervisors provide random, frequent, unannounced, face-to-face home visits with youth. Behavior contracts signed by youth and their parent or guardian are often used to establish clear behavioral goals. Some programs also employ community supervisors or advocates to support and participate with youth in educational and recreational activities. For more serious young offenders, electronic monitoring can be used to enhance, not replace, personal contacts.

Day reporting centers are also popular as an alternative to secure detention. In these nonsecure, community-based centers, youth participate in structured educational and recreational activities until their cases are resolved. Some jurisdictions also utilize evening reporting centers that provide youth with structure and attention during high crime after-school and evening hours. Another alternative is time-limited residential housing in which youth receive around-the-clock supervision. In these residential attention centers, youth participate in structured educational and recreational activities. Some jurisdictions also contract with foster homes to house younger children and lower-risk cases waiting juvenile court processing. Foster parents receive special training to help them supervise these youth and are backed up by juvenile court personnel. Another detention alternative gaining in popularity combines case advocacy with intensive case management. For young offenders who volunteer to participate, personalized case plans are developed followed by multiple daily contacts with case managers who handle small caseloads and respond to crises on a 24-hour basis.

Institution and Jail Diversion

Meta-analyses of hundreds of studies have helped delinquency scholars distinguish several characteristics of effective nonsecure alternatives to institutionalizing or jailing young offenders. Effective alternatives are those that teach troubled youth new personal and social skills, to recognize and correct for unhealthy thinking, to better manage anger, to improve self-control, and to address personal challenges and risk factors. Ineffective interventions are those based on custody, confinement, surveillance, deterrence, and discipline (e.g., scared straight).

Several evidence-based institution diversion programs treat troubled youth and their families in their own communities. For example, several forms of intensive family therapy (e.g., Multidimensional Therapy and Functional Family Therapy) have demonstrated effectiveness with serious juvenile offenders. Cognitive-behavioral and social learning skills training programs have shown considerable success with high-risk young offenders. Other alternatives include intensive vocational training programs offering career-focused education, on-the-job experience, and ongoing counseling; intensive advocacy and mentoring programs; and high-quality mental health and substance abuse treatment programs. Wilderness programs are also effective alternatives to secure confinement. Outward Bound programs, for example, teach young offenders survival skills during long hiking expeditions or canoe trips in wilderness settings. Group counseling sessions occur each evening around a campfire. Associated Marine Institutes offers an incarceration diversion program in which serious young offenders live in military-style barracks and carry out work assignments such as clearing land, hauling logs, and caring for plants and animals in the Florida Everglades.

The restorative justice model has spawned several new forms of detention and institution diversion. This three-pronged model emphasizes victims' rights, community protection, and offender responsibility and rehabilitation. Diversion approaches based on the restorative justice philosophy include community courts, gun courts, and drug courts. Juvenile drug courts, for example, grew out of the adult drug court movement. Compared to traditional juvenile court processing, drug courts provide earlier and more thorough intake assessments of drug-dependent young offenders; rapid involvement of youth and their families in treatment; coordination of the school, family, juvenile court, and community agencies in assessing and responding to youths' needs and risk factors; more intensive supervision; and rewards for progress and immediate sanctions for noncompliance.

Special Groups

Clearly, some youth need secure confinement for their own protection or the protection of the community. However, considerable research shows that detention is not an equal opportunity experience. For example, while African American and Latino youth make up about 41 percent of the overall youth population in the United States, these youth account for more than two-thirds of youth placed in secure detention. Also, compared to Caucasian youth, youth of color are more likely to face institutionalization for given offenses. These differences are not explained by differences in delinquency and appear to have more to do with biases and subjective decision-making practices within the juvenile justice system.

Also, there has been a dramatic rise in secure detention for girls—an increase of about 50 percent from 1992 to 2009. There has also been an increase in the detention of lesbian, gay, bisexual, transgender, and queer (LGBTQ) girls. Compared to detained male juveniles, girls are detained for less-serious offenses, are more likely to have experienced trauma (e.g., sexual abuse or domestic violence), and are more likely to have mental health and human services needs (e.g., trauma treatment or pregnancy care). Based on these differences, detention can be particularly counterproductive for girls.

Thus, it is important for juvenile justice systems to prioritize the reduction of racial, ethnic, and gender disparities in secure detention; to utilize objective risk-assessment detention decision tools; and to develop detention alternatives that focus on the particular needs of these groups.

Conclusion

Significant advances have been made in specifying the causes of delinquency and developing evidence-based alternatives to confining troubled youth in juvenile detention centers, secure juvenile institutions, and adult jails. It appears reasonable to conclude that, if states move funds currently applied to the secure confinement of young offenders to evidence-based diversion programs that focus on the needs and risks of troubled young offenders, the result will likely be less crime and healthier, more productive young men and women.

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See Also: Deinstitutionalization; Group Homes for Children; Mental Health Services, Children.

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Jewish Americans

There are three main categories of Jews that fall within the broad term of Jewish Americans. This includes Reform, Conservative, and Orthodox Jews. The fundamental commonality among these groups is a monotheistic belief in the God of Abraham. The *Torah* is the historic holy book of the Jewish faith for all factions within Judaism. However, over time, Conservative and Reform Judaism developed as a modified approach to traditional Jewish observance. Of the three sects, Orthodox Judaism bears the greatest resemblance to traditional Judaism, with strict adherence to commandments of the *Torah* and adherence to *halachot* (the Hebrew term for laws that govern daily life). Orthodox Jews continue to maintain the greatest separation from mainstream secular American culture. This results in Orthodox Jewish Americans as culturally different clients. Across sects within Orthodox Judaism, there is an emphasis on being a member of the community. Thus, marriage, which is at the core of a religious community lifestyle, is arguably the most essential practice of Orthodox Judaism. Interestingly, social science research often studies categories of Orthodox Jews, such as Modern Orthodox and Ultra Orthodox Jews, separately. This is due to the great diversity of religious practice and customs among these groups of Orthodox Jews. Therefore, Orthodox customs related to dating and marriages are vastly different between Modern Orthodox and Ultra Orthodox Jews. The Orthodox approach to marriage highlights their status as culturally different clients.

Introducing the Spectrum of Orthodox Judaism

Orthodox Jewry is often perceived as a religious sect shrouded in mystery. Therefore, to understand Orthodoxy's diversity, it may be helpful to consider Orthodox Judaism as a spectrum of religious observance with Modern Orthodox and Ultra Orthodox Jews representing opposite ends of the religious spectrum. It is not that one group keeps more or less religious practices; rather, Ultra Orthodox Jews keep more traditional interpretations of religious decrees than Modern Orthodox Jews. Modern Orthodox rabbis (Jewish spiritual leaders) attempt to consider the secular world in their computations and understandings of *halachot.* This can be further understood by realizing the role the rabbi plays in Orthodox communities. In Ultra Orthodox circles, the rabbi or *rebbe* is the community authority on religious law and often influences personal and

An Orthodox Jewish wedding takes place using a traditional chupah. The juxtaposition of tradition and modernity in Modern Orthodox practice is evident and seen in dating and marriage customs. This division of Judaism follows modern dating practices, but the dating process involves using a traditional approach and couples are required to follow these restrictions.

family decisions as well. Hassidic communities are a type of Ultra Orthodox sect that heavily relies on the opinion of the rabbi in all matters. The Modern Orthodox position also attributes great respect to rabbinic leaders, but this community has been noted to involve greater degrees of personal choice and less reliance on rabbinic opinion. It is vital to understand that many Orthodox neighborhoods appear and function differently because of different interpretations of God's commandments, but practices generally stem from divine scripture and historical traditions.

Ultra Orthodox Dating and Marriage Practices

In Ultra Orthodox communities, men and women are kept separate from a young age. Boys and girls attend different schools and are not allowed to mingle with one another; therefore, for many individuals, the dating process is their first encounter with nonrelative members of the opposite sex. In Ultra Orthodox communities, men and women are introduced, with the purpose of marriage, by their parents or through *Shadchanim (*matchmakers). Individuals rely on their family members to seek assistance from these special matchmakers and consider potential matches on their behalf. If the family approves of the *shidduch* (match), only then will the couple meet. Depending on the Ultra Orthodox community and family, the couple may meet once or twice at a quiet home with parents in the next room before agreeing to or rejecting the marriage. This mainly occurs in Hassidic communities in which engagements are announced after one sit-in date. In non-Hassidic, Ultra Orthodox households, the couple meets first in a quiet home but then continues their courtship for about three to eight more dates in public locations like a hotel lobby or park. Ultra Orthodox communities consider it imperative that the couple meet in public so that the couple does not violate the prohibition of *yichud* (the prohibition against any man and woman who are not married to each other being alone in a room). Moreover, the couple is expected to uphold the laws of *shomer negiah*, literally translated as "guarding from touch." Orthodox law dictates that individuals of different genders may not touch each other until after the wedding ceremony. This restricts individuals from acting on their sexual attraction for one another.

Once a couple is married, they may experience unique stressors as culturally different clients. One such struggle is financial instability. The emphasis on *Torah* learning in Orthodox communities influences the family structure. Husbands often learn in *yeshivahs* (schools of Jewish study) for several years, while their wives serve as the financial providers, often performing specialized jobs following a short vocational course. The issue of being a one-salary household is compounded by the community's value of having many children. Another unique stressor faced by the Ultra Orthodox community is sexual difficulties. Men and women must be sexually inexperienced upon their first marriage. In some cases, this leads to sexual ignorance or a lack of comfort with sexual communication. These issues have obvious ramifications. Furthermore, Orthodox Jews are expected to keep the laws of *taharat hamishpacha* (family purity), which stipulate that a husband and wife may not engage in sexual relations or even touch one another while the woman is in *niddah* (ritual impurity). The woman is in *niddah* while menstruating and for seven full days after the cessation of her menstruation. During this time, the couple may not share a bed but can sleep in beds separated from one another.

Modern Orthodox Dating and Marriage Practices

Modern Orthodox Jews experience the pull between opposing factors, tradition, and modernity to a much greater degree than the Ultra Orthodox because of their engagement with secular American society. The juxtaposition of tradition and modernity in Modern Orthodox practice can clearly be seen in dating and marriage customs. These Jews follow modern dating practices by meeting potential mates via dating Web sites, events, or at universities in contrast to the more traditional approach of arranged marriage. However, the dating process includes a traditional approach as the Modern Orthodox community is also bound by the restrictions of *yichud*, *shomer negiah*, and *taharat hamishpacha*. Thus, the purpose of marriage is generally clearly identified between couples during their courtship.

Furthermore, modern ideals, such as feminism, influence the structure of Modern Orthodox unions. Some women adapt the traditional Orthodox marriage ceremony because they believe that it places them in a subservient role to their husbands. More offensive to their feminist ideals is the Jewish divorce process. When Orthodox Jews marry, they marry both under civil law and religious law with two separate marriage documents. In the case of divorce, civil divorces are obtained in accord with standard secular practices. However, according to Jewish law, the husband holds the power to divorce his wife. He must release his wife from marriage by giving his wife a *get* (Jewish divorce); without it, she may not remarry within Orthodoxy and is labeled an *agunah* (chained wife). The Modern Orthodox community has taken action to limit this possibility but has not abandoned the traditional Jewish process of divorce. This is very representative of Modern Orthodoxy, maintaining the traditional while attempting to account for modern and secular ideals.

It is beneficial for practitioners to display a heightened sensitivity to the unique stressors facing some of their Jewish American clients such as community pressure to marry and financial instability. An awareness of these factors is necessary for culturally competent practice. Furthermore, traditional customs have significant implications for human services delivery to Jewish American clients. Human services personnel are advised to refrain from touching clients of the opposite gender. Even extending a handshake may make a Jewish Orthodox client uncomfortable because of the aforementioned religious prohibition of *shomer negiah*. It is difficult to learn all the traditional customs of Jewish Americans, so when in doubt, practitioners should politely ask a client about his or her faith in order to gauge appropriate behavior.

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See Also: Acculturation; Anti-Semitism; Assimilation; Holocaust Survivors; Religion and Clients.

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Public child welfare agencies encounter numerous challenges in their missions to protect children and assist families. While recent child welfare legislation has focused on quick reunification, adoption, and relative placement as permanency options, some young people remain in the foster care system until their emancipation. Each year, approximately 30,000 young adults emancipate from foster care. Although this population has historically received minimal attention at the practice and policy levels, recent efforts have been made to provide more support for aging out youth to transition into adulthood. Most notably, the Chafee Foster Care Independence Act (CFCIA) was signed into law in 1999 to offer assistance in the areas of education, employment, housing, financial management, and emotional support by nearly doubling the allotment for independent living programs.

The most notable of the provisions included in the CFCIA include: (1) increasing funds to states to assist youth making the transition from foster care to independent living, (2) recognizing the need to further assist youth ages 18 to 21 who have left foster care, and (3) offering states greater flexibility in developing their independent living programs. As a result of the sweeping reforms included in this act, as well as the fact that racial and sexual minority youth are disproportionately over-represented in the aging-out population, CFCIA has had a significant_impact on issues of diversity in the child welfare and human services fields.

Increased Funding for Youth Transitioning to Independent Living

When compared to young adults in the general population, youth who age out of foster care have significantly higher rates of homelessness, unplanned pregnancies, health and mental health conditions, and criminal justice involvement. Similarly, these young adults have lower rates of employment, college attendance, and social support. A long-standing concern of many child welfare advocates has been that the system lacks the resources necessary to adequately prepare foster youth for the challenges of adulthood. The passage of the CFCIA doubled the amount of federal funding for independent living programs from $70 million to $140 million. In addition, to be eligible for federal funds, states must contribute a 20 percent match for independent living funds.

Expansion of Services for Youth Ages 18 to 21

In addition to the increased funding for independent living programs, the CFCIA also expanded the population of youth eligible to receive independent living services, including youth who have left care through the age of 21. Many child welfare advocates have argued that a youth's need for a family and assistance does not end at age 18, often citing the fact that most young Americans rely on certain levels of emotional and financial support from their parents long past their 18th birthdays. Two of the most prominent provisions impacting youth ages 18 to 21 include increased funds to cover room and board for youth who have left foster care as well as the expansion of Medicaid services to cover youth ages 18, 19, and 20 who have emancipated from foster care.

Greater Flexibility in Designing Independent Living Programs

Independent living programs are designed to assist in preparing youth for adulthood, usually providing assistance in career exploration, budgeting and financial management, preventative health measures, high school or general education development (GED) completion, and higher educational enrollment and retention. One of the provisions included in the CFCIA that has generated the most excitement from foster care advocates and professionals is its emphasis on including youth in all aspects of their own independent living plans. A consistent theme in numerous qualitative studies on foster care alumni has been that youth feel that they have very little voice and involvement in their care and service planning. Language in the CFCIA requires states to ensure that youth are active in designing their own program activities that prepare them for independent living. Historically, child welfare practice has viewed clients in terms of need rather than strengths; therefore, children and youth have largely been excluded from key decisions about their futures. In many ways, the CFCIA facilitates a youth development perspective by empowering youth to increase their involvement and responsibility in planning for adulthood.

Analysis of the CFCIA

Since its passage in 1999, numerous studies have evaluated the effectiveness of the CFCIA. This data suggests that young adults who have aged out of foster care are faring much better today than they had prior to the passage of the CFCIA. Rates of employment, higher education enrollment, and income are up significantly, while rates of homelessness, unplanned pregnancy, and criminal justice involvement have declined steadily.

One of the provisions that seems to have had the most profound impact is the expansion of the population of youth eligible for independent living services. Findings from the Midwest Evaluation of Former Foster Youth suggests that youth who remain in care as late as age 21 tend to experience an easier transition into adulthood than youth who emancipate at age 18. This study found that young adults who remained in care were about twice as likely to attend college, had significantly higher earnings, and were much less likely to experience an unplanned pregnancy.

Several analyses have been conducted assessing the impact of the CFCIA's increased emphasis on the involvement of youth in their case planning. While findings have recognized a number of strengths that have resulted from this emphasis, a number of barriers to effective youth services have also been identified, most notably, a lack of placement options for youth ages 18 to 21 as well as significant gaps in youth-specific training for foster parents and other child welfare professionals.

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See Also: Adoption and Safe Families Act; Aftercare Services for Children Aging Out of Foster Care; Child Welfare Services; Fostering Connections to Success and

Increasing Adoptions Act of 2008; Indian Child Welfare Act; Protective Services for Children.

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Joint Commission, The

The Joint Commission is an accreditor of health care organizations in the United States and other countries. The commission evaluates the quality of health care provided by an organization. The accreditation or certification offered by the Joint Commission is similar to a grade of quality. Health care organizations voluntarily seek accreditation by following preset standards for care delivery. Compliance with standards is measured through self-report of performance and through visits by trained personnel, called surveyors. The quality of care offered by the health care organization is measured through these methods, and final determinations are reported to the public. Joint Commission accreditation is sought to improve care, improve management practices, and meet expectations of patients, insurers, and government health programs. Health care organizations pay to have their performance and outcomes evaluated by The Joint Commission.

History

The original idea for what became The Joint Commission was developed in 1910 by a surgeon, Ernest A. Codman, who had noticed a difference in patient death rates and other outcomes between various surgeons and hospitals. He worked with other interested surgeons to develop a method to track care delivery and surgical outcomes. Based on this work, in 1917 a group from the American College of Surgeons (ACS) developed Minimum Standards for Hospitals. In 1951, ACS partnered with many other health care organizations to develop the Joint Commission on Accreditation of Hospitals (JCAH). Over time, other types of health care organizations were accredited by JCAH and the name was changed to Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1987. This name was shortened to The Joint Commission in 2007.

As stated on its Web site, www.jointcommission.org, the current mission of the Joint Commission is, “To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.” The Joint Commission is governed by a board of commissioners with representatives from the American Hospital Association, American Medical Association, American College of Physicians, American College of Surgeons, and American Dental Association. Additional members represent the fields of behavioral health care, home care, long-term care, and nursing.

Types of Standards

Quality can be evaluated by monitoring processes or by measuring the results of processes, called outcomes. Until 1997, all Joint Commission standards and expectations addressed care processes; that is, they provided and measured compliance with guidelines on the way health care organizations should operate. Now the commission measures care outcomes as well as care processes. The performance measurement system is called ORYX. Hospitals report data related to specific measures and the results are available publicly at The Joint Commission’s Quality Check Web site.

To earn and maintain The Joint Commission’s Gold Seal of Approval, an organization must undergo an on-site survey by a commission team at least every three years, except for laboratories, which are surveyed every two years. These survey visits are unannounced.

Emphasis on Diversity and Cultural Competence

The Joint Commission’s resources division offers publications and a video about communication, cultural competence, and patient- and family-centered care. These include the books *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide; Patient-Centered Communication Standards for Hospitals; Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals;* and the video *Promoting Health Equity and Patient-Centered Care*. In addition, many required commission accreditation standards highlight the need for patient- and family-centered communication and care.

Accredited Organizations

In the United States, The Joint Commission accredits or certifies about 20,000 hospitals; facilities providing behavioral health, home care and hospice, and ambulatory care; nursing and rehabilitation centers; and laboratory service organizations. It provides certifications for disease-specific care for chronic diseases and conditions such as asthma, diabetes, and heart failure. Providers of health care staffing services can also earn Joint Commission certification. Approximately 82 percent of U.S. hospitals are currently accredited by the commission.

Internationally, Joint Commission International (JCI), a subsidiary of The Joint Commission's resources division, has a presence in more than 90 countries and seeks to help organizations improve health care quality. Staff from JCI evaluate quality in health care organizations worldwide and provide educational and advisory services. The World Health Organization (WHO) partnered with JCI and The Joint Commission to establish the first WHO Collaborating Centre for Patient Safety Solutions.

Deemed Status

The Joint Commission's accreditation can qualify hospitals and other organizations to receive reimbursement from the U.S. Medicare and Medicaid programs; this is called "deemed status." In order for a health care organization to participate in and receive payment from the Medicare or Medicaid programs, it must meet the eligibility requirements for program participation, including a certification of compliance with the conditions of participation found in federal regulations. Usually, this certification is based on a survey conducted by a state agency on behalf of the Centers for Medicare & Medicaid Services (CMS). However, The Joint Commission is one of the organizations that have been determined to enforce standards that meet or exceed Medicare's requirements. Therefore, CMS will not conduct its own survey if the organization is accredited by The Joint Commission.

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See Also: Home Care Services; Hospitals; Medicaid; Medicare; Outpatient Medical Care.

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Journal of Ethnic and Cultural Diversity in Social Work

The international *Journal of Ethnic and Cultural Diversity in Social Work* (http://www.ingentaconnect.com/content/rmp/dehc) can trace its origins to a pilot 2004 special fifth issue of the well-known journal *Health and Social Care in the Community* coedited by professors Paula McGee and Mark Johnson. The well-known publishers Radcliffe Medical of Abingdon offered these editors the opportunity to create their own journal that would join the publisher's stable of world-class medical journals, including *Education for Primary Care*, *The London Journal of Primary Care*, *Mental Health in Family Medicine*, and *Quality in Primary Care*. The journal adheres to the standards of the International Committee of Medical Journal Editors (ICMJE) and the Committee on Publication Ethics (COPE), and all papers are peer-reviewed.

Originally published as *Diversity in Health and Social Care* (ISSN 1743-1913, e-ISSN 1743-4904), the first volume appeared in late 2004, with a major focus on migration, ethnicity, and health, and also health inequality in general. Over time, the journal increasingly attracted papers that also examined issues of gender, disability, and sexual orientation. Starting in volume six of January 2009, the title was revised to *Diversity in Health and Care* (ISSN 1759-1422, e-ISSN 1759-1430) following a refocusing of the publisher's interest on health service delivery. In 2012, after the purchase of the publishers by Electric Word, the title was finally revised to reflect the increased focus on inequality and diversity, including attention to intersecting inequalities across more than one strand of disadvantage, to the present *Diversity and Equality in Health and Care* (ISSN 2049-5471, e-ISSN 2049-548X). Earlier issues are indexed in the same sequence but may be identified using older ISSN numbers.

Diversity and Equality in Health and Care dedicates space for the publication of research and debate papers that address issues relating to the equitable provision of health care and services for members of diverse social groups and settings in all countries in the world. It recognizes that many such papers find it difficult to gain acceptance in mainstream, discipline-led journals, where such issues are seen as marginal or contentious and therefore are not always acceptable to conventional reviewers. This journal welcomes papers relating to all aspects of diversity in health and care and the inequalities experienced as a result of ill health, marginalization, prejudice, stigma, and issues in service provision. Papers may report on qualitative or quantitative research, describe and evaluate good practice, put forward arguments for debate, or discuss educational matters. *Diversity and Equality in Health and Care* particularly encourages multiprofessional perspectives, attention to the views of service users and caregivers, and papers exploring the international dimensions of diversity and equality across and within cultures.

Diversity and equality are seen as very broad concepts, embracing areas that include but are not limited to race, culture, and ethnicity; sexual orientation; gender; migrants; caregivers; physical, communication, and learning disabilities; spirituality; and underserved or marginalized populations. Diversity also extends to the wide variety of settings in which care takes place and in the multidisciplinary nature of professional practice. The journal carries theoretical papers but also insists that materials published should contribute to the improvement of practice and professional development. All issues also carry a section titled "Knowledgeshare," which carries a mixture of good practice studies, book reviews, and reports of meetings. A recent initiative has been the inclusion of a regular continuing professional development feature in each issue, highlighting new knowledge in a specific field of practice. Selected papers may be offered on open access terms, and the journal is hosted online by IngentaConnect.

As of September 2013, the editorial board of *Diversity and Equality in Health and Care* included 20 individuals representing the United Kingdom, South Africa, Switzerland, Jordan, the United States, Saudi Arabia, and New Zealand. The editors welcome research papers that address any aspect of diversity including evaluative studies and methodological debates; practice papers that provide examples of culturally competent practice or that address the practicalities, policy, or managerial aspects of delivering services to members of diverse groups; debate papers that address key issues in diversity or that focus on under-researched topics; and knowledge-sharing reports that may include book, Web site, video, and other resource reviews and papers about specific initiatives to improve practice.

The journal receives submissions from, and is read by, individuals from all around the world including Australasia, North America, Europe, the Middle East, and Asia. While nearly all submissions are initially returned to the authors with the comments of two independent, blinded reviewers, approximately one-third are subsequently accepted for publication following revision.

Diversity and Equality in Health and Care is indexed in the following:

- CINAHL
- Health Policy Reference Centre
- SocIndex (FT)

- Family and Society Studies Worldwide
- Gender Studies Database
- Race Relations Abstracts
- Social Care Online
- British Nursing Index
- Health and Social Care Abstracts
- CSA Sociological Abstracts
- CSA Social Services Abstracts
- DH-Data
- Ulrich's International Periodicals Directory
- SCOPUS (SciVerse)
- NHS Evidence

Subscriptions to *Diversity and Equality in Health and Care* include the printed issues, access to online current content, the full text archive, Internet reference linking with search facilities, and an e-mail contents alert service. Individuals can also purchase online-only access to the journal for a reduced rate. This includes online current content, the full text archive, Internet reference linking with search facilities, and an e-mail contents alert service.

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See Also: Association for Multicultural Counseling and Development; Behavioral Health Disparities for Racial and Ethnic Minority Populations; Communication Styles, Ethnic and Cultural Differences in; Discrimination and Institutional Racism; Disabilities, International Variation in Attitudes Toward; Ethnic Diversity and Values; Health Care, Disparities in.

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Journal of Human Services

The *Journal of Human Services* (JHS), formerly *Human Service Education*, is the flagship journal of the National Organization for Human Services (NOHS). JHS is a national, refereed scholarly publication; therefore, every article is reviewed by experts in the field prior to acceptance. Reviews are double-blind so that both the authors' and the reviewers' identities are concealed from one another. The principal audiences of JHS are human services faculty members, administrators, practitioners, and undergraduate and graduate students. Sample areas of interest include teaching methods, models of internships, faculty development, career paths of graduates, credentialing, accreditation, models of undergraduate and graduate study, clinical issues in human services treatment, and supervision of human services practitioners. The journal is published annually and has recently printed its 33rd volume. Members of NOHS obtain a copy of the journal as part of their membership benefits. Typically, new volumes are published during fall of each year. Individuals, libraries, institutions, and agencies can purchase subscriptions to the journal.

The journal was first published in 1979 as *Human Service Education*. In 2010, the journal officially changed its name to the *Journal of Human Services* to reflect the broader readership that it had and to better signify to the public the kinds of articles found in the journal. The journal can be found through the Gale database, the Elton B. Stephens Company (EBSCO) database, and through the Web site for NOHS (www.nationalhumanservices.org). At the NOHS Web site, all issues since the journal's inception can be found in PDF format and are accessible to all members of the organization. The most recent journal is accessible to the public.

The *Journal of Human Services* publishes three types of submissions: (1) articles, (2) brief notes, and (3) critical reviews. Manuscripts for articles are approximately 18 typed pages. Articles primarily address contemporary issues in human services, innovative approaches to human services education and practice, and both qualitative and quantitative research on topics related to the field of human services. Brief notes include succinct reports of research projects or program innovations. Manuscripts for brief notes do not exceed four pages. The results and implications occupy at least half of a brief note. Critical reviews of textbooks, other instructional materials, and scholarly books of interest to human service educators and practitioners are also published by JHS. Manuscripts of critical reviews are approximately three pages unless two or more related books are included in one review, in which case manuscripts may be five pages. Publications in JHS conform to the style of the sixth edition of the *Publication Manual of the American Psychological Association* (APA). A typical volume of the journal includes up to eight articles, three brief notes, and three book reviews.

The journal has two coeditors, Drs. Ed Neukrug and Tammi Milliken, who manage most details of the review and publication process. Two associate editors, Drs. Jill Dustin and Laurie Craigen, secure advertising for the journal and subscriptions to libraries and work with copyrights. An assistant editor, Brett Gleason, manages the day-to-day functioning of the journal and ensures that all proposals are sent to the coeditors and editorial board without identifying information.

Once the assistant editor receives a manuscript, he or she sends it to one of the coeditors, who reads it to ensure that the content is appropriate for the journal and that it follows APA format. If not, it is sent back to the authors with an explanation as to why it is not appropriate for the journal. If it is deemed suitable, the article is sent back to the assistant editor, who then sends it to two or three editorial board members for review. Editorial board members who review a manuscript complete a manuscript evaluation form, which asks for feedback about the format of the article (e.g., does it follow APA format, etc.), whether the content of the article is of interest to the readership, the presentation (e.g., clarity and organization) of the article, and a series of ratings concerning article components (e.g., clarity of the problem statement, the literature review, research design, limitations, etc.).

Then, the editorial board member makes a recommendation as to whether the manuscript should be accepted as is; accepted with minor revisions; returned for rewrite and resubmit, rewrite as a brief note, or submit as an article for *The Link* (NOHS's newsletter); rejected; or suggested to submit elsewhere. The manuscript is then sent back to the assistant editor. Once the assistant editor receives all reviews, they are sent, blind, to one of the coeditors, who examines them and makes a decision about publication. Authors receive a letter from the editor explaining the decision.

Tammi F. Milliken
Ed S. Neukrug
Jill C. Dustin
Laurie M. Craigen
Old Dominion University

See Also: Department of Health and Human Services, U.S.; National Organization for Human Services; Urban Communities and Human Services.

Further Readings

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Journal of Immigrant and Minority Health

The *Journal of Immigrant and Minority Health* (JIMH), formerly the *Journal of Immigrant Health* (JIH), is a quarterly journal published by Springer, a part of Springer Science+Business Media. Its ISSNs are 1557-1912 (Print) and 1557-1920 (Online). JIMH serves as a forum where scholars and practitioners present critical issues related to immigrant and minority health and explore possible solutions. Various disciplines are represented in JIMH including public health, epidemiology, medicine and nursing, communication, anthropology, sociology, population research, immigration law, and ethics, among others.

Concerned with health disparities experienced by immigrant populations, scholars have explored these issues from their disciplinary perspectives. However, due to its interdisciplinary nature and context-specific characteristics, researchers and practitioners have urged the necessity and importance of generating an interdisciplinary and international forum to facilitate exchanges of the latest findings and information. Launched in 1999 by Kluwer Academic/Plenum Publishers, JIH was the first scholarly journal featuring immigrant health. As a quarterly journal, JIH published articles on health issues and social welfare related to immigrants and refugees. On average, 26 articles were published annually. Sana Loue, founding editor of JIH, noted, "The launching of this journal signifies a recognition of both immigrant health as a field in its own right and a growing consensus that immigrants have unique health needs that require further study." Along with the merger with Springer Science+Business Media in October 2004, JIH changed its name to the *Journal of Immigrant and Minority Health* in January 2006. Since then, there has been a steady increase on the coverage of minority health in addition to the original focus on immigrant health. From 2008, JIMH began to publish bimonthly. On average, 110 articles have been published annually. The journal now features online-first articles, allowing manuscripts accepted for publication to be distributed promptly and electronically prior to the official publication via hard copies.

JIMH publishes peer-reviewed, original research that contributes to the theories of and practices for immigrant and minority health. The journal also publishes review articles, theoretical and policy papers, short communications, letters to the editor, and notes from the field. Publications in JIMH include both macro- and micro-level examinations of immigrant and minority health. Both qualitative and quantitative approaches are welcomed. While some explore broad-based, fundamental research questions (e.g., social determinants of immigrant health and population-specific health disparities), others focus on community-based or individual-level health topics (e.g., cultural-specific illness ideology or behaviors and population-specific health interventions and outcomes). Since 2009, each issue often includes a special thematic focus. Some of the themes include communicable disease, global migration and health, language and acculturation, mental health and substance abuse, occupational and environmental health, and health care utilization and access to care. Although the editorial office is based in the United States, many of the publications include immigrant and minority populations outside of the United States and explore issues relevant to international audiences.

Editorial Board

JIMH's editorial board reflects its interdisciplinary and scholarly emphasis. Sana Loue has served as the founding editor and the editor in chief since 1999. She is a professor and director in the Department of Epidemiology and Biostatistics and the director of the Center for Minority Public Health of the School of Medicine at Case Western Reserve University. She holds three doctoral degrees with a J.D. in law and two Ph.Ds. in epidemiology and medical anthropology. Four associate editors represent different topic areas of JIMH. Declan Barry (assistant professor of psychiatry, Yale University) serves as an addiction and behavioral medicine editor. He has a Ph.D. in psychiatry, and his work involves issues related to addictions, psychotherapy, and culture. Susan Hatters-Friedman (associate professor of psychiatry and pediatrics, Case Western Reserve University) serves as a behavioral and mental health editor. She holds an M.D. in forensic psychiatry. Her research primarily focuses on the interface of women's mental health and forensic psychiatry. Douglas M. Brugge (professor of public health and community medicine, Tufts University) serves as the environmental and occupational health editor. He has a Ph.D. in cellular and developmental biology. His research largely employs the model of community-collaborative research. Elaine Hsieh (associate professor of communication, University of Oklahoma) serves as the health care communication and relations editor. She holds a Ph.D. in health communication. Her research centers on language barriers and health disparities among immigrant populations. There are also many prominent scholars included in the JIMH editorial board.

With contributions from these leading scholars, JIH and JIMH have provided a vision for where both scholars and practitioners must go in the future in order to address the health needs of immigrant populations. All submitted articles go through double-blind review by two anonymous scholars in order to ensure the quality in original research.

JIMH was first indexed in *Journal Citation Reports* in 2010. In 2012, JIMH had an impact factor of 1.007 and a cited half-life of 3.5 years. Cited half-life refers to the median number of years being cited by other journals within a specific year. JIMH is also widely indexed in major scholarly databases including the Social Science Citation Index, Journal Citation Reports/Social Sciences Edition, Social SciSearch, PubMed/Medline, SCOPUS, PsycINFO, EMBASE, Google Scholar, Elton B. Stephens Company (EBSCO), CSA, ProQuest, Academic OneFile, Academic Search, AGRICOLA, Cumulative Index of Nursing and Allied Health Literature (CINAHL), CSA Environmental Sciences, Current Contents/Social and Behavioral Sciences, EMCare, Gale, Health Reference Center Academic, Online Computer Library Catalog (OCLC), SCImago, and Summon by Serial Solutions.

Sachiko Terui
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See Also: Behavioral Health Disparities for Racial and Ethnic Minority Populations; Diversity and Quality in Health Care; Hispanic Health and Nutrition Examination Survey; Mental Health Services, Ethnic Models and Multicultural; National Center on Minority Health and Health Disparities; Racial and Ethnic Approaches to Community Health; Social Determinants of Health.

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Juvenile Delinquents

A juvenile delinquent, or a juvenile offender, is a person under the age of 18 who commits an act that would otherwise have been charged as a crime if he or she were an adult. Juvenile delinquency has been recognized as a serious public concern. In 2009, approximately 1.9 million juveniles were arrested, which represented a 17 percent decrease from 2000. However, according to the Office of Juvenile Justice and Delinquency Prevention, about 15 percent of violent crimes and 24 percent of all proper crimes have been committed by juveniles.

Considering that delinquency is a major public health concern, understanding individual (e.g., race or ethnicity, sex, or socioeconomic status) and contextual factors (e.g., family, peer, or school) associated with delinquency is imperative as research suggests that overlooking multiple factors and imposing punitive measures increase recidivism and reduce academic and employment opportunities.

Individual-Level Risk Factors

The juvenile justice system has long struggled to understand and address the overrepresentation of African American youth involved with the courts. Significant differences in the rate of delinquency among racial groups in the United States have been observed for decades. In 2010, African American youth accounted for 41 percent of detained youth, compared to 32 percent white and 22 percent Hispanic youth. However, to date, most conclusions about the development of juvenile delinquency have focused on individual-level factors rather than multilevel analyses that include contextual and system-level factors. If social work is to help address disparities at the front end of the juvenile justice system, policies and practices must consider important domains of risk at both the micro and macro level.

At the micro level, gender and income are critical factors. Males engage in more delinquent and criminal acts than do females. Yet, the rate of female delinquency is increasing, and the gap between the rate of delinquency among boys and girls has narrowed. In 1980, males were four times as likely as females to be arrested; in recent years, they are only twice as likely to be arrested. This demographic shift has important implications for gender-specific approaches to juvenile crime. Research also reveals an overrepresentation of low-income children in the juvenile justice system, particularly those living in persistent poverty and those who reside in urban areas where weak neighborhood social organization and social bonds are prevalent. Both direct and indirect associations between economic hardship and delinquent behavior have been examined. Adolescents living in impoverished neighborhoods, environments where deviant peer influence and criminal activities are frequently observed, are at an increased risk of engaging in delinquent behaviors.

Contextual-Level Risk Factors

Considering that an individual socialization begins in the home, family-level factors, such as family functioning, social bonds between the parent and the child, and family structure are critical to the upbringing of a child, which could lead to or mitigate delinquent behaviors. Children's aggressive and antisocial behaviors are reinforced when there is a lack of positive parenting practices, poor parental monitoring, and abuse in the family. Additionally, children growing up in a home where a father figure is absent are significantly more likely to engage in delinquency than children from two-parent households.

Coercion theorists purport that family influences an adolescent's interpersonal style, which in turn influences peer group affiliation. Social control theory proposes that weak social bonds in the family can increase self-interested behavior (e.g., delinquency). Studies largely lend support for the hypothesis that deviant and antisocial peer affiliation significantly increases the likelihood of delinquent behavior. Moreover, peer-level factors, such as peer delinquency, peer approval of delinquent behavior, attachment or allegiance to peers, time spent with peers, and peer pressure, are all significantly related to antisocial and delinquent behaviors during adolescence.

In addition to the context of peer groups, social work professionals need to address the problem of delinquency from a systems perspective. Adolescents spend a significant amount of time in school, and the relationship between school factors, such as poor academic achievement, academic failure, and delinquency, is well documented. Classroom observations also indicate that delinquent youth spend less time in school and report fewer academic survival skills (e.g., attendance and answering questions)—all of which are necessary for effective learning and grade attainment. These findings are informed by social control and social bond theorists, who assert that negative consequences of weak bonds to school, poor grades, low educational expectations, and poor motivation can heighten youth involvement in delinquency. In contrast, youth who develop strong bonds to school are more likely to conform to the norms and values that schools promote and are less likely to engage in delinquent behaviors. A recent focus on the relationship between child welfare and juvenile justice further supports the need for a systems approach to delinquency—especially if the field is interested in addressing the issue of disproportionate minority contact (DMC). Child welfare is a significant source for DMC in juvenile justice. Although the overrepresentation of racial minorities has been a focus of interest for juvenile justice practitioners and researchers for more than 20 years, there is virtually no mention of child welfare or allied service systems as a possible contributing mechanism or pathway that could be targeted for prevention. Understanding the role of the child welfare system in both the development and process of delinquent cases should not be interpreted as blaming the child welfare system but rather as an opportunity for social workers to develop prevention efforts at the systems level.

Prevention and Intervention Programs

Characteristics of adolescents are commonly used as a basis for development of delinquency prevention and intervention programs. Delinquency prevention and intervention efforts seek to redirect youth at risk for delinquency or those who engage in delinquency from further involvement in the juvenile justice system. Many of the intervention efforts have focused on education and behavior management for youth in middle and high schools rather than on children in elementary schools. Other interventions seek to remediate disruptive and violent behaviors and delinquency after these behaviors have emerged.

However, researchers and practitioners have argued that prevention—particularly early prevention—is a more effective approach that can reduce the risk of future offense. In response, a number of prevention and early intervention programs, such as the First Step to Success, Linking the Interests of Families and Teachers, Perry Preschool Project, Promoting Alternative THinking Strategies (PATHS), Strong African American Families, and the Incredible Years have all been recognized as effective programs.

In addition, given the complexity and interrelatedness of the risk factors, it is also critical that intervention efforts should not focus exclusively on individual behavior but should target conditions at the systems level (e.g., family, school, and neighborhood). A number of multiple-level programs have also emerged in recent years such as the Adolescent Transition Program, Families and Schools Together, Multisystemic Therapy, and Triple P—Positive Parenting Programs. In other words, a multifaceted approach, which targets the risk factors at various levels of the social ecology, is crucial, especially as it relates to African American youth and those living in poverty.

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See Also: Interstate Compact for Juveniles; Juvenile Detention Centers; Juvenile Justice System; Office of Juvenile Justice and Delinquency Prevention.

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Juvenile Detention Centers

Early laws and responses to delinquent behavior demonstrated no consideration for age as seen in contemporary law. In the 19th century, the American legal system treated adjudicated youth offenses with the same penalties as adult offenders. With the overwhelming growth of the population, American cities experienced increases in impoverished youth engaging in delinquency. In response, laws were established to grant states the authority to remove children from the care of "unfit" parents. Reform schools were built as residential facilities to provide education and training. Placement of youth in adult facilities was discouraged, yet reform schools still maintained strict environments where physical punishment and discrimination were commonplace.

The child-saving movement influenced the formation of the first juvenile courts. This group emphasized the need for government intervention among families with wayward children. Juvenile courts echoed these sentiments as youth were confined for noncriminal status offenses, such as disobedience. This practice persisted into the 1970s, when laws prohibited youth with status offenses from being confined to secure detention facilities. Other changes to juvenile law came later, including the separation of youth and adults during detainment, no longer allowing delinquent youth to be housed among adults when awaiting sentencing. Current trends in juvenile correctional facilities vary between get-tough attitudes and stronger focuses on treatment and rehabilitation.

Characteristics and Prevalence

A juvenile detention center, also known as a youth detention center, juvenile hall, or correctional facility, is a residential facility with construction fixtures or staffing models for youth, often termed *juvenile delinquents.* Detention centers are utilized for the placement of any youth adjudicated of having committed a crime or any other individual convicted of a criminal offense; of these, 52 percent are youth younger than age 16, 28 percent are female, and 64 percent are white.

According to the Office of Juvenile Justice and Delinquency Prevention, there were 4,857 arrests

The Cook County Juvenile Detention Facility and Court in Chicago, Illinois. Detention centers are utilized for the placement of youth adjudicated of having committed a crime.

for every 100,000 youth (ages 10–17) for all offenses in 2010; 1,084 arrests for every 100,000 for property crimes; and 225 arrests for every 100,000 for violent offenses. In 2009, 1,504,100 youth were involved in the juvenile court. Although delinquency rates declined from 1996 to 2009, the number of caseloads rose nearly 300 percent between 1960 and 2009; cases involving detention centers increased from 246,300 to 318,000 from 1985 to 2009. In 2010, 70,792 youth were held in detention or residential facilities, of which 61,358 were males and 9,434 were females.

Racial and ethnic minority youth are disproportionately represented at all levels of the juvenile justice system. More than 62 percent of detained youth in 2010 were black, Hispanic, or Latino, which made up almost double their percentage of the juvenile population. Additionally, correctional placements are influenced by systemic gender and racial biases rather than rehabilitative or behavioral health needs. This demonstrates the need for appropriate and culturally sensitive services and staff in juvenile correctional facilities to meet the diverse treatment needs of delinquent youth in detention center settings.

An Overview of Services

Effective services are necessary given that detained youth with minimal or no treatment are likely to recidivate or engage in crimes during adulthood. In particular, educational and mental health needs of detained youth are special considerations. There have been recent attempts at developing alternative programs such as the Juvenile Detention Alternatives Initiative (JDAI). Established in 1992, the JDAI aims to reduce the number of youth in detention centers and the number of youth who fail to appear in court; to redirect public funds toward successful reform strategies; and to improve the conditions of detention centers. JDAI seeks to create services without compromising public safety.

Special educational needs of detained youth warrant serious attention; however, many centers do not comply with the Individuals With Disabilities Education Act, which mandates that detained youth are entitled to "free and appropriate education in the least restrictive environment." However, the Ohio Community Collaboration Model, which includes strategic connections with family and community resources, has been effective in improving school performance and reducing behaviors that might lead to arrest. Communities nationwide also developed mental health programs for detained youth, such as the Bernalillo County Juvenile Detention Center, which developed an intake process to identify youth's mental health needs and divert them to community mental health centers.

Several residential treatment programs, from therapeutic interventions to punitive correctional systems, have been established to provide housing for youth with mental health or substance-use problems who are incompatible with nonsecure environments but whose cases do not merit commitment to psychiatric hospitals or correctional facilities.

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See Also: Interstate Compact for Juveniles; Juvenile Delinquents; Juvenile Justice System, The; Office of Juvenile Justice and Delinquency Prevention.

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Juvenile Justice System

The American juvenile justice system has faced an unprecedented period of transition in recent years. Juvenile crime in the United States followed a downward trend since the early 1990s, and the juvenile crime rate in 2010 was 24 percent below the rate in 1980 and 55 percent below the peak year of 1994. After a period of decreasing rates of juvenile crimes, the moral panic that fueled the get-tough approaches of the 1990s and early 2000s, which exposed juvenile offenders to harsh punishments (e.g., placing juvenile offenders in adult prisons), has waned. In recent years, state legislatures have reconsidered the harsh punishments they had enacted as politicians and the public have questioned the high economic costs, the ineffectiveness of the so-called reforms, and the harshness and negative outcomes of the punishments.

Evolution of the Juvenile Justice System

The juvenile justice system and public perceptions of juvenile offenders in the United States are marked by major changes over the last 100 years. Following the trend of English laws, youth who were accused of crimes were imprisoned with adults, and there was no legal term for *juvenile delinquency.* In the early 19th century, the idea of reforming juvenile offenders took root in the United States. The House of Refuge in New York, the first juvenile house of reform, was established by the Society for the Prevention of Juvenile Delinquency and opened in 1824 with the idea of housing juvenile offenders in a separate facility. Other states subsequently followed suit. The idea of reform was vigorously supported in the 18th and 19th centuries by emerging research and science regarding child development, and reformers across the country supported the idea of rehabilitating juvenile offenders rather than punishing them as adults.

The Chicago Reform School opened in 1855 to protect juvenile offenders by separating them from adult criminals and to advocate for rehabilitation. However, it was not until 1899, when the juvenile court was created in Cook County with the goal of reforming policies with regards to juvenile offenders, and within 30 years, that most states followed suit and established juvenile courts. The early juvenile courts shared the ideas of rehabilitation with reform schools, based on the legal doctrine of *parens patriae* (giving the state the power to serve as the guardian). The goal was to guide juvenile offenders toward life as law-abiding adults, and the courts had the power to order juvenile offenders to be removed from their homes and be placed in institutions as part of their rehabilitative process. However, hard labor, strict regimentation, whippings, physical and sexual abuse, and discriminatory treatment against racial and ethnic minority and poor white children were common problems. Discipline in the juvenile reform schools was extremely brutal, which demonstrated a significant disparity between theory and practice.

Nevertheless, by 1945, all states had juvenile courts, and for the first half of the century, the juvenile justice system in which juvenile cases were processed went largely unchallenged. Although there were some differences among states and jurisdictions, there was a general agreement with regards to the goals and objectives of juvenile justice systems and how those systems should be similar to and different from the adult criminal justice systems with the universally accepted goal being treatment rather than punishment.

In the 1960s, however, there were a number of court cases where juvenile offenders were being sentenced to institutions that were similar to adult prisons or transferred to criminal court but without due process protections common to criminal court. Criticisms of juvenile courts were highlighted in a number of Supreme Court cases, such as *Kent v. United States*, *In re Gault*, *In re Winship*, *McKeiver v. Pennsylvania*, and *Breed v. Jones*. The U.S. Supreme Court case *In re Gault* maintained that juvenile offenders were entitled to the same constitutional due process rights as adults, which began a nationwide reform in the juvenile justice system, granting juveniles many of the same rights that adults have in court. Many of the distinctions between juvenile and adult laws have begun to fade, and there have been discussions about the possibility of merging the juvenile and adult criminal justice systems, which were based upon beliefs about juvenile crime and whether juvenile offenders should be held accountable similar to adult offenders. Some of these changes can be understood as negative unintended consequences of the *In re Gault* decision.

In the 1970s, community-based programs, diversion, and deinstitutionalization had a profound impact on the juvenile justice policy. A number of lawsuits challenged the conditions and policies of juvenile institutions, which alleged cruel and unusual punishment. In 1974, Congress enacted the Juvenile Justice and Delinquency Prevention Act, which mandated separation of juvenile offenders from adult offenders. As stipulated by the act, the deinstitutionalization of status offenders and nonoffenders requirement mandated that juvenile offenders who were not charged with acts that would be crimes for adults would not be placed in detention facilities or correctional facilities. Moreover, the act also stipulated that juvenile and adult inmates cannot have contact with each other. Juvenile courts also considered the individual and social problems that likely influenced the offender's behavior, and sentences were based on the nature of the crime as well as the offender's treatment needs.

In the 1980s, the rate of juvenile violent offenses increased, and there were growing public safety concerns that continue to this day. As a result, many state legislatures responded by passing punitive measures such as removing juvenile offenders charged with violent crimes from the juvenile system, mandating the juvenile justice system to resemble the criminal justice system, and treating more serious juvenile offenders as criminals but in the juvenile court. In the 1990s, state lawmakers began to pass measures to crack down on juvenile offenses as the public voiced growing concern over highly publicized offenses such as school shootings.

Consequently, every state enacted measures that made it easier to expand eligibility for adult criminal court processing, sentence juvenile offenders to adult correctional facilities, and reduce confidentiality protections. These legal reforms resulted in the transfer of juvenile offenders into the adult criminal system, thus changing the status of an estimated 250,000 juveniles per year. Juvenile justice experts differ in their opinions regarding the outcomes and consequences of the statutory changes in the juvenile justice system. Research findings have been also mixed as to whether tougher laws are indeed associated with reductions in juvenile crime. Nevertheless, the laws have resulted in more number of juveniles being waived to criminal court prosecution and serving time in adult correctional facilities.

Recent Juvenile Justice System

Death penalty sentences for juvenile offenders convicted of murder have been a major controversy. From 1973 through 2004, a total of 228 juvenile death sentences were imposed, of which 22 (14 percent) resulted in execution and 134 (86 percent) were commuted to prison sentences (usually life terms). The number of states that allow the death penalty for juveniles under 18 was declining when, on March 1, 2005, the Supreme Court ruled in *Roper v. Simmons* that the death penalty for individuals under age 18 at the time of the offense violated the Eighth and Fourteenth Amendments of the Constitution and was thus unconstitutional. The Supreme Court's decision was based on the idea that juveniles are susceptible to immature and irresponsible behavior; even a heinous crime committed by a juvenile offender is not evidence of depraved character, and juveniles' diminished culpability would not adequately justify imposing the death penalty.

In 2010, the Supreme Court also ruled that life sentences without parole for youth under 18 years of age who had not committed murder at the time of offense were unconstitutional. Until then, the United States stood alone worldwide in imposing life-without-parole sentences on such juveniles. Life sentences without parole were limited to offenders who committed murder. The issue of life without parole for juveniles received considerable international attention, and the case of *Graham v. Florida* paved the way for review of the imposition of life sentences that bar any possibility of parole for all juvenile offenses.

In 2012, the Supreme Court decided that juveniles convicted of a criminal offense cannot be automatically punished the same way as adult criminals without considering their ages and other factors. Specifically, the Supreme Court ruled that youth who are convicted of murder may not receive mandatory life sentences without any possibility of parole. The judge and the jury are required to take into account the offender's age and other factors before handing down a sentence.

Suggestions

The future direction of the juvenile justice system is unclear. On the one hand, research documenting the relative immaturity of adolescent thinking and emotional regulation and their susceptibility to peer influence has moved research-based advocates to push for more rather than less separation of the juvenile justice system from the adult criminal justice system. On the other hand, a general public perception that juvenile justice programs are ineffective, coupled with the dominance of ultraconservative ideology, creates a continuing demand for get-tough policies and practices. Research has demonstrated that the try-and-sentence-juveniles-as-adult ideology has resulted in more, not less, recidivism.

Some of the more innovative approaches to juvenile offenders focus on the need to offer simultaneously cognitive restructuring (changing ideas about aggression and antisocial behavior) and behavioral rehearsal (offering concrete opportunities to practice prosocial and cooperative, nonaggressive behaviors as an alternative to patterns that have brought the juvenile to police attention). Cognitive-behavioral therapy for children as a way to prevent childhood conduct disorder from escalating into serious delinquency in adolescence is a prime preventive strategy. Moreover, a large number of states that house juvenile justice involved youth in secure confinement have been faced with situations in which the majority of inmates consist of racial and ethnic minority populations, most notably African Americans and Chicanos or Latinos.

Disproportionate representation of racial and ethnic minority youth in the juvenile justice system necessitates an array of culturally relevant services that are designed to reduce disproportionate minority contacts in the juvenile justice system. And finally, providing mental health services should be the standard response to juvenile delinquency in addition to the obvious need for effective policing to protect the community and the juvenile from his or her own ultimately self-defeating and self-destructive behavior.

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See Also: Office of Juvenile Justice and Delinquency Prevention; Juvenile Delinquents; Juvenile Detention Centers.

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K

KIDS COUNT

KIDS COUNT is a project funded by the Annie E. Casey Foundation with the primary focus of monitoring and promoting the educational, social, economic, and physical well-being of children in the United States. Over the past 23 years, KIDS COUNT has served as a catalyst for various initiatives, all of which are aimed at improving the lives of children in the country.

One of the program's first projects was the KIDS COUNT data book. This book, which has continued to be an annual publication, presents data for the nation and all 50 states on key indicators of child well-being. KIDS COUNT operates on both the state and national levels and utilizes data collection and trend analysis that has informed policies and programs that enhance the experiences and quality of life for all children. The organization is concerned with making data available to community leaders, policy makers, service providers, parents, and others who want to take a closer look at the local factors that affect the lives of children and families. KIDS COUNT has also paid particular attention to the needs of vulnerable populations, including children who are growing up in poverty, involved in the child welfare system (e.g., foster care or kinship care placements), involved with the juvenile justice system, or who are members of racial or ethnic minority groups. Since its inception, KIDS COUNT has written and disseminated numerous publications about the condition of children in the United States.

At the national level, KIDS COUNT operates a data center that compiles information on the educational, social, economic, and physical well-being of children using more than 4 million data points. The data center brings together information from numerous sources including the Decennial Census, the American Community Service, the National Child Abuse and Neglect Data Systems, and the National Survey on Drug Use and Health. The center offers statistical information for a variety of geographic areas including the nation as a whole, states, counties, cities, school districts, and congressional districts, much of which is available to the general public online. The data center also produces a series of publications that report on what is available in particular topic areas and makes recommendations on specific issues at the national and state level. Recent data center reports, for example, have focused on issues such as youth incarceration, kinship care, and high-poverty communities. These reports highlight the challenges of economically disadvantaged children who are African American, Native American, and Latino. KIDS COUNT works with numerous national outreach partners to disseminate the data and their reports to policy makers, nonprofit and philanthropic organizations, advocacy groups, and researchers. These outreach partners help promote KIDS COUNT research through partnerships with stakeholders.

The KIDS COUNT data book is one of the most significant contributions of the organization. The book, which is now available in hard copy and electronic formats, has been published for 23 years. It provides an overview of key statistical indicators related to child well-being in the United States. It has recently expanded to include 23 child-level indicators across four domains: (1) economic well-being, (2) education, (3) health, and (4) family and community. This shift to a domain-based approach is the most significant change to the KIDS COUNT data book since it began tracking child well-being more than two decades ago. In addition to providing background information on demographic and family income trends in the United States and each state, the data book now addresses a variety of social issues impacting children and families. These include low birth-weight babies, infant mortality rates, child mortality (including deaths related to accident, homicide, and suicide), teen pregnancy and parenting, underemployment and unemployment among parents and youth not attending school, high school graduation and dropout rates, children in poverty, and families with children headed by single parents.

As part of the data analysis process, the KIDS COUNT data book ranks states on the well-being of children. The data book provides an overall ranking as well as ranking in each of the four domain areas (economic well-being, education, health, and family and community). The online data book also offers interactive, customizable options. Individuals can create customized reports on the condition of children in a specific state using the 23 key indicators. There is also an option to compare the report for one state to that of another state.

KIDS COUNT has developed organizations in all of the 50 states, Puerto Rico, the U.S. Virgin Islands, and the District of Columbia. KIDS COUNT state organizations receive grants from the Annie E. Casey Foundation to promote initiatives that focus on conditions of children who reside in their state. These organizations identify their own priority areas and employ KIDS COUNT resources to develop and promote programs that address state-specific needs. Recent efforts in states have addressed a range of topics including early reading proficiency (South Carolina and West Virginia), youth unemployment (Montana), and racial and ethnic disparities relating to school readiness (Rhode Island and Colorado). State organizations also provide input and advocacy on state-level legislative and budget decisions regarding children and families.

Since its inception, KIDS COUNT has had a significant impact on the condition of children in the United States. The program's efforts to compile and disseminate data on children and families have helped make issues pertaining to children more visible. Programming at both the state and national level has helped promote discussions and encourage action, thereby increasing an understanding of the needs of children nationwide. KIDS COUNT efforts have raised awareness and worked toward eliminating disparities along racial, ethnic, and socioeconomic lines.

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See Also: Child Welfare Services; Children in Foster Care; Children of Incarcerated Parents; ChildStats; Early Childhood Development; Kinship Care; National Center for Children in Poverty; Quality of Life, Measurement of.

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Kinship Care

Kinship care is the full-time care, nurturing, and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child. The kinship care relationship may be permanent or temporary as well as formal (established legally) or informal. Kinship caregivers are more likely to be poor, single, older, less educated, and unemployed than families where at least one parent is present.

Grandparents provide the majority of kinship care, with the number of children living with grandparents increasing 50 percent between 2000 and 2010. Recent census data indicate that 5 percent of all children in the United States are living in a household headed by grandparents, and the majority of these children are under the age of 18. Most of these caregivers are female and unmarried and are disproportionately, in comparison to their proportions in the population, black and Hispanic.

Children enter kinship care for a variety of reasons including parental substance abuse, neglect, abandonment, parental physical and mental illness, incarceration, and domestic violence. The 2008 Fostering Connections to Success and Increasing Adoptions Act recognized the important role of kinship care through its provision of federal resources to support kinship care families and instructions that states ensure that relatives are identified and involved when children are removed from the parent's home.

However, only one-fourth of children in kinship care are in the formal child welfare system. The majority of the children live in informal kinship care arrangements that have not gone through a legal system. Informal care is often preferred due to concerns about terminating parental rights or further stressing relationships with the child's parent. In addition, grandparents often do not want to submit to the licensing requirements associated with the foster care system. To ease this situation, many states have made it easier for kinship families to become licensed and thus able to receive foster care benefits.

Kinship care benefits children as it maintains familial bonds and provides children with a sense of security. It helps minimize trauma and loss associated with separation from parents. In comparison to those in nonkin foster care, children in kinship care change schools less frequently, have fewer behavioral problems, and if reunited with their birth parents, are less likely to enter foster care again. They are also more likely to report feeling loved and to want their placement to be their permanent home.

Needs of Kinship Caregivers

Families who provide kinship care have many needs themselves. With the majority of the care provided by grandparents, the needs of these caregivers have been given the most attention. Grandparent caregivers are more likely to be living in poverty and experience financial strain than their peers who are not raising grandchildren. They also report greater stress and poorer physical and mental health.

A man with his granddaughter in New Orleans, Louisiana. The number of U.S. grandparents providing kinship care increased 50 percent between 2000 and 2010, with an estimated 5 percent of children living in a household headed by a grandparent.

Having adequate housing is a challenge for many grandparents, particularly for those who are renters. Those living in public housing may face occupancy restrictions that force them to move when the grandchildren become part of the household. Restrictions are often greater when persons have been residing in senior housing that does not permit children. To meet the housing needs, specialized grandparent housing has been developed in several cities, although funding for these projects is limited.

Dealing with legal issues presents a further challenge to caregivers. They frequently have had little experience with the legal system and find themselves having to deal with custody arrangements, medical consent, educational consent, as well as assuring the future of their grandchildren. Finding affordable legal assistance can be difficult, particularly for those with incomes above the poverty line but with limited resources.

Contributing to the stress experienced by the grandparents are the grandchildren themselves. In comparison to children in the general U.S. population, children being raised by grandparents have a higher prevalence of behavioral and emotional disturbances. These children are prone to both physical and emotional problems due to the fact that many were born addicted or were abused and neglected before moving to the grandparent's home. The special needs of these children can further tax the skills and resources of these caregivers.

Resources for Kinship Caregivers

Under the 2008 Fostering Connections Act, states may provide subsidized guardianship funds for kinship caregivers. These programs are available for children who have been in kinship care for at least six months and for whom reunification with the parents and adoption are not possible.

Kinship care families may be eligible for Temporary Assistance for Needy Families (TANF) if their income falls within state eligibility guidelines. However, these grants are limited to 60 months and may have employment requirements attached. TANF "Child Only" grants provide financial assistance to children based only on their resources. However, less than 12 percent of kinship families receive any TANF funds, although almost all would be eligible. Little information about the program, feelings of stigma, and a lack of needed documents act as barriers to participation. Without participating in TANF, families are also failing to receive benefits such as Supplemental Nutrition Assistance Program (SNAP), Medicaid, and child-care assistance.

Kinship care is a vital, positive resource for many children. Policies and services are recognizing the role that these families play, but they must be strengthened to assure that supports are available and accessible. Increasing resources is critical for the well-being of both caregivers and the children they are raising.

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See Also: Aging and Adult Services; Child Support Agencies and Services; Children in Foster Care.

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Kinship Care, Cultural Aspects of

Kinship care is a temporary or permanent living arrangement for children who cannot live with their biological parents and live with a relative or nonrelative that is part of their community and to whom they have formed a close bond, often called fictive kin. This arrangement can be for any number of reasons, such as parental illness or death, parental drug or alcohol abuse, physical or emotional abuse and neglect, poverty, and more benign issues, including parental work obligations that take them away from their children.

Kinship care can be formal or informal and either sanctioned by local social services agencies through a foster care arrangement or decided privately among individual families. Kinship care has cultural issues that pertain to its structure and is more often seen in marginalized populations. Historically, kinship care was born out of racist and oppressive practices that have forced different subjugated racial and ethnic groups to form more communal cultures and bonds where children are the responsibility of the larger family and greater community.

In a U.S. context, the history of the racist institution of slavery, and specifically the slave trade, forced the separation of families and necessitated that the children be raised in kinship models. While these kinship relationships were required, they ultimately strengthened the communal nature and history of the African American family. Nevertheless, the eugenics era soon followed, which perpetuated the discourse that African Americans among the immigrating populations were intellectually inferior and not fit to raise children. White social movements soon developed with perceived well-intentioned plans designed to acculturate and civilize communities of African Americans in providing education in the trades and teaching them white norms of child care. While these early social workers believed they were providing a service, their philosophy denigrated the history of the African American family in its belief that they were in need of such charity. This served to further reinforce kinship systems in African Americans working together against continuing pernicious and pervasive forms of racism.

Globally and due to a similar history of atrocities, there now exists a trend in developed and developing countries toward kinship care in other subjugated cultures. This was only after a similar toxic history developed between racially and ethnically oppressed groups and human and social services agencies that believed falsely that their original child-in-out-of-home placement policies were in the best interests of the children. In Canada, for instance, First Nations' children were taken from their homes and placed in residential facilities in hopes of assimilating them into mainstream Canadian culture. Despite Canada's attempts at reparations to First Nations' families, the legacy of trauma still haunts the individuals who were affected. Canada's policy trends for First Nations children now seek to preserve the cultural heritage, but the system, like that of other countries, still has problems and continues to evolve.

In a United States context, kinship care is more often utilized by African American families. A collective sense of mistrust developed, understandably so, between African Americans and the very agencies that were designed to help them. Currently, there exists a disproportionate amount of African American children in out-of-home placements and specifically in residential care facilities. Due to this and historical factors, African American families have been more fervent than other racially marginalized groups to utilize kinship models when children cannot be cared for by their biological parents.

Individual states have varying policies that govern kinship care models, and there exists no uniform standards. In the case of Alaska Native Children and Native American children, however, the Indian Child Welfare Act (ICWA), P.L. 95-608, states that tribes have the right to input regarding the placement of native children. Otherwise, individual states make the decision on issues such as the rate of pay for kinship versus foster families, and it should be noted that kinship families more often fall below the poverty level than traditional foster family homes. Kinship homes that do not fall under the jurisdiction of the foster care system, as many do not when the prevailing issue is not abuse or neglect, must rely only on state entitlements to make ends meet rather than a substantial monthly check that those who are foster parents receive to have a child in their home. Further, individual states define who counts as a relative and often do not recognize the relationship of fictive kin, and this is detrimental in the case of African American families where there exists a long tradition of the family unit extending outside blood relatives.

Kinship care has benefits over more traditional foster care arrangements where the children get placed with virtual strangers. Children can experience great trauma in the initial removal from their home even when heinous abuses are happening. The unknown is equally as scary. It is further traumatizing to move into the home of people with very different values, customs, religious practices, and rules. Foster care is important for children with no safe options, but even most foster care workers will agree that it remains very difficult for the innocent child. Kinship placements provide a more familiar environment that often preserves family customs, rituals, religion, and a greater familiar support network for the individual child. Children in kinship care have fewer placement changes when in the care of relatives and are less apt to reenter the foster care system after reunifying with their birth parents.

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See Also: Children in Foster Care; Children in Special Living Arrangements; Family Services; Family

Structure, Diversity of; Foster Care Agencies; Kinship Care; Parenting Skills Training.

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L

Language Assistance

Language assistance refers to the provisions made for speakers who have difficulty with the dominant language of a country because it is their second language. In the United States, the National Center on Immigrant Integration Policy estimates that there are up to 25 million people who have limited English proficiency. As such, according to the U.S. Department of Health and Human Services, language assistance must be provided for individuals who have limited English proficiency. The settings in which language assistance is provided include federal and state offices of health and human services, courthouses, and any other departments and offices in which limited proficiency English speakers may seek out services. Examples include the National Institutes of Health, the Internal Revenue Service, and the U.S. Welfare System. In addition, many private companies such as insurance and medical providers contribute language assistance services. The types of language assistance offered can vary but usually include a range of translated documents and/or computer programs. Language assistance can also include having an interpreter on hand to help with language barrier issues.

Limited English proficiency (LEP) is the name given to individuals who are second-language learners of English and who do not have proficiency in English. In the United States, a series of laws have provided the framework for ways in which language-limited individuals can still reliably access federal services, regardless of their English proficiency. The first relevant law is Title VI of the Civil Rights Act of 1964. It states that individuals in the United States cannot be discriminated against on the basis of national origin regarding services provided by any agency that receives federal funding. Title VI was the first step toward addressing the growing needs of LEP individuals in the United States and instances of discrimination based on language barriers.

In 2000, President Clinton signed Executive Order 13166, called the LEP Executive Order, which required language assistance to be provided to LEP individuals engaging in federally funded programs and agencies. The purpose of the order was to improve the accessibility of federal services so that they could be rightfully rendered to LEP individuals. The LEP Executive Order was designed to enable full compliance with Title VI. According to the order, relevant agencies must take steps provided by the federal government to dissolve language barriers in order to deliver equal services to all individuals, regardless of their proficiency in English. Sections of the U.S. Department of Justice enforce the policies set forth by Executive Order 13166.

In addition to translated documents and informational materials, many agencies employ bilingual staff members and interpreters who help carry out the requirements of the LEP Executive Order. When LEP individuals have questions or need to speak with a person regarding specific details of the services provided, an individual is needed who can fluently speak both English and the language of the LEP individual. Interpreters, also called translators, are individuals who are utilized in such settings. Interpreting is a challenging task because it involves both the understanding of what the LEP individual says in his or her native language, and the ability to translate the information into English for other individuals within the interaction (e.g., a doctor, nurse, or agent), and back again. Medical interpreters, for example, are very useful and important because small details lost in conversation because of a language barrier can be detrimental to the health of the LEP patient.

Bilingual staff members carry out similar interpretation duties; however, they are also regular employees of the agency or business. Interpreters may be used on a consulting basis and may not work in a particular office or location for the entire workday. Conversely, a bilingual staff member is hired on the premise that he or she is an employee with the skills needed to carry out a job beyond interpretation. For example, a receptionist at a doctor's office may be hired as a bilingual staff member, but his or her duties include both receptionist duties and interpretation, when needed. Although it may be feasible to have a bilingual staff member who speaks a common second language in a region (e.g., Spanish), it is often not possible to have several staff members who speak different languages because of funding and space issues.

Since the implementation of the LEP Executive Order in 2000, methods of language assistance have continued to evolve. At a basic level, agencies are required to have pamphlets printed in multiple languages. For example, the Office of Veterans Affairs (VA) has implemented the use of wallet-sized cards that say, "I Speak _____." Individuals seeking VA services can write in their native languages, and the card can be easily used to express the need for language assistance. Such methods are used to minimize language barriers in order to more efficiently deliver services to individuals in need.

Technological advances have enabled more sophisticated methods of language assistance. For example, one-way handheld electronic devices can be preprogrammed with common phrases, and when an English-speaking individual selects a particular phrase, it is translated aloud in another target language to facilitate communication with an LEP individual. More recent technology through the use of the World Wide Web has enabled almost instantaneous, free translation for real-time conversation between individuals. As the use and availability of wireless technology expands, this type of language assistance will become highly utilized in order to easily and quickly facilitate the rendering of federal services.

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See Also: Biculturalism; Border Communities; Children of Undocumented Aliens; Department of Education, U.S.; Education Support Services; Immigrant Populations, Human Services Needs of.

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Learning Disabilities, Services for Individuals With

Learning disabilities describe a cluster of disorders related to brain functioning that impedes the individual's ability to receive, process, store, and respond to information from the environment. Typically identified in childhood due to the large amount of information needed to learn in the school setting, these disabilities vary from person to person and affect various aspects of the curriculum. These disabilities are lifelong and never cured. However, most individuals who receive treatment can learn skills to compensate for these weaknesses in their learning that can allow them to be successful in their goals. It is important to note that a learning disability is a separate classification from other types of disabilities typically identified in children such as intellectual disability (formerly known as mental retardation), visual disability, hearing disability, or an autism spectrum disability. In addition, a learning disability is ruled out if environmental, cultural, and economic factors, or limited English proficiency, are the primary reasons for the symptoms. More often than not, children with a learning disability have average to above-average intellectual ability, yet they have difficulty receiving, processing, storing, and responding to information from a particular set of curriculum such as reading, mathematics, or writing.

Educational Interventions

In the United States, schools that are federally funded must provide a free and appropriate education to all students within their districts. Before the enactment of Public Law 94-142 in the 1970s, students who had disabilities did not have access to the same educational opportunities as their peers who did not have disabilities. Since Public Law 94-142 and its revisions, known as the Individuals With Disabilities Education Act (IDEA), all students now have the chance to receive an education in the least-restrictive environment and in the same environment as their peers.

Several general steps are involved in the identification of a child with a learning disability in the public school system. First, the child's classroom teacher notices that the student is struggling with his or her academics. At this point, the classroom teacher should attempt to make adjustments to the way information is presented to the student and provide more individual assistance. After a period of time, if the student continues to struggle and not make gains in the curriculum, the teacher refers the student to a teacher assistance team, which is made up of master-level teachers and administrators. The team meets and discusses the situation with the referring teacher. After conferring with the teacher, the team creates an intervention plan for the teacher to take back to the classroom and implement with the student. During the implementation of the intervention plan, the teacher collects data concerning the student's progress while utilizing the strategies discussed with the teacher assistance team. After a period of time, typically six weeks, the teacher returns to the teacher assistance team and presents the data collected during the intervention phase. The team evaluates this data and, if the student is adequately progressing in the classroom, recommends that the teacher continue implementing the interventions in the classroom. However, if the data reveal that the student is not progressing, the teacher assistance team recommends a multidisciplinary evaluation. Multidisciplinary team members always include the child and the parent as a part of the assessment process. The results of this evaluation determine if a learning disability exists, and the team decides if special education is appropriate for the student.

For adults with learning disabilities, there are less-standardized procedures for identification and diagnosis. Typically, adults with learning disabilities, if they have not been identified in childhood, are assessed by a psychologist specializing in educational disabilities. However, colleges and universities are not required by law to provide special education services like those in elementary and secondary education. Most postsecondary institutions have provisions in place to allow accommodations in the classroom; however, these accommodations only change the presentation of material, not the curriculum level required of the other students in the classroom. Some examples of accommodations include extended time on tests, providing textbooks on tape, and a copy of the teacher's notes covering each lecture. For many individuals with learning disabilities, this transition from secondary to postsecondary education can be overwhelming, and many students with this disability drop out before completing a degree.

Federal Laws Affecting Individuals With a Learning Disability

For any adult or student diagnosed as having a learning disability, there are four federally mandated laws aimed at protecting their rights and providing for services and education. The first law, IDEA guarantees a free and appropriate education for any student between the ages of 3 and 21. This act provides information to schools on how students are identified, how they are diagnosed, and how interventions are to proceed. In addition, this act outlines the rights provided to children and their parents or guardians, including the right to a timely evaluation, access to paperwork and meetings, and transition planning.

The Elementary and Secondary Education Act (ESEA) and No Child Left Behind (NCLB) affect all students in kindergarten through the 12th grade. It requires schools to meet tough standards for student achievement and educational content. It requires schools to make adequate yearly progress for all students, including those diagnosed with a learning disability.

The Rehabilitation Act of 1973 and the Americans With Disabilities Act make it illegal to discriminate against a person in federally funded programs and activities based on disability. These laws do not provide funding but can remove funding from those entities failing to comply with the law.

Cultural Implications

Research has indicated that approximately 15 percent of the U.S. population has some form of a learning disability. Approximately 80 percent of those identified as having a disability have problems with reading. In the public schools, students with learning disabilities make up approximately 5 percent of the population in this setting. Approximately two-thirds of those with a learning disability are male, with more males than females across all age categories. The most discrepancy between sexes occurs within the 7- to 18-year-old age range, with 3.9 percent males and 2.0 percent females identified as having a learning disability. In all age ranges, whites tend to be more identified than other ethnicities. Hispanic, Latinos, and African American students, however, follow closely behind white students identified as having a learning disability. Asian Americans, Hawaiians, and Pacific Americans are the least identified. In the adult population, those living in poverty are more likely to report having a learning disability than the rest of the population. Families with children living below the poverty rate reported 4.1 percent of their children had a learning disability, while those living above the poverty line reported 2.7 percent of their children had a learning disability. The same is true for working adults. Adults who have a learning disability are more likely to be living below the poverty line (3.1 percent) than those living above the poverty line (1.5 percent).

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See Also: ADHD, Services for Individuals With; Children With Special Needs; Cultural Competence, Human Services Providers and; Educational Services; Educational Support Services; Intelligence Testing; Psychiatric/Psychological Assessment; School Mental Health Project; Special Education.

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Legal Services

Human services workers help transform human rights (as set forth in the Declaration of Independence and by the Constitution) into civil rights, protected and enforced by law. Human services workers help define such rights through litigation, legislation, and daily practice, ensuring their application through agencies, communities, schools, or workplaces. Such legal services are critical to a diverse population and workforce in no small part because of the historically unequal distribution of resources; decades of studies by the American Bar Association have found that most low-income individuals and more than half of middle-class individuals fail to have their legal needs met. Further, access to legal services is unequally distributed to whites, as is consistently shown in comparative studies of criminal trials. Immigrants with poor English skills and the rural poor are also chronically underserved. The Department of Justice recently opened the Access to Justice Office in recognition of these long-lived and ongoing problems.

Laws at the federal, state, and local levels regulate, guide, and advance all areas of human services practice. Many issues, such as placement of children or commitment of the mentally ill, employment and all conditions, privileges, and immunities of the workplace for older workers, the disabled and individuals of every race, religion, color, or national origin, and both genders, are protected by laws and implemented by human services professionals. Collaboration with lawyers in aiding a battered woman, a brutalized child, an abused or neglected parent or homeless person is essential, for example, to get an order of protection, a placement, or commitment. Attorneys often call upon human services professionals to assess family dynamics and evaluate the capacity of their clients in diverse forums such as criminal court, family court, and special courts such as those for the commitment of the mentally or developmentally disabled or users of illegal drugs.

Human Services Personnel Key to Employment Rights

Human services personnel are the gatekeepers to most complaints of discrimination, harassment, or retaliation and calls for fair dealing, workers compensation, collective bargaining, or occupational health and safety.

They meet with all parties in labor or personal disputes, try to resolve problems, and oversee the processing of grievances as provided in law. Title VII of the Civil Rights Act of 1964 as amended (barring bias against anyone on the basis of race, gender, religion, color, or national origin) and the Age Discrimination in Employment Act (ADEA, protecting those 45 and older) have similar threshold requirements. The defendant must either be a labor union, an employment agency, or an employer who employs at least 15 persons. The complainant must initiate a claim of discrimination with an office of the Equal Employment Opportunity Commission or a state agency delegated with similar powers within 360 days of the incident (or of the employee's first learning) of alleged discrimination. In addition, the ADEA contains the Older Workers Benefit Protection Act, which establishes special rules and procedures in the retirement or separation of older workers.

The Equal Employment Opportunity Commission (EEOC) or state agency may investigate and mediate the claim or file suit on behalf of the charging party. Alternatively, once he or she has exhausted the administrative requirement of filing with the EEOC or state agency, the complainant may be granted a notice of right to sue. Federal employees must first have their cases reviewed by an administrative law judge who can issue a judgment.

Most large employers have their own offices where human services personnel investigate and seek resolution of the complaint. They will examine any direct evidence where there is an open admission by the employer of intentional discrimination. Far more common, however, is the examination of inference. The *McDonnell Douglas* case sets the guidelines to establish a prima facie case of job discrimination: (1) A job opportunity was posted. (2) The complainant was qualified for the opportunity and was a member of a protected class. (3) The plaintiff applied and was rejected or denied the opportunity. (4) The opportunity either went to another not in the protected class of complainant or remained unfilled.

The employer may disprove discriminatory motive by providing nondiscriminatory rationale for its employment decision. The complainant may prove that defendant's rationale was mere pretext for discrimination.

The complainant may also allege retaliation where employer undertakes an adverse employment action against an employee because the employee engaged in an act protected by the laws against employment discrimination. Such reprisal may be proven by direct evidence or inferred by timing or other workplace patterns. This is a cause of action independent of the merit of the employee's initial act.

Another theory of job bias is defined in *Griggs v. Duke Power*, where an employment decision, neutral on its face, has a discriminatory impact on a protected class, and there is an alternative way to do the job with less discriminatory impact.

Harassment on the job violates Title VII. Human services personnel are key in reviewing complaints by employees based on the conduct of employers, supervisors, customers, contractors, or any party in frequent contact with the employer. There are two kinds of harassment: (1) quid pro quo, where a benefit or favorable employment action is made contingent on granting the employer a sexual favor, and (2) a hostile work environment, where unwelcome advances, obscenity, touching, feeling, posting signs, or innuendo take place in the work environment.

The Americans With Disabilities Act (ADA) protects qualified individuals with a disability (QIDs) who, with or without a reasonable accommodation, can perform the essential tasks of the job. Administrative prerequisites are the same as those summarized for EEOC complaints, except that the number of employees required for the employer to be subject to a complaint is 25, and the law does not protect employees of the state.

A disability is defined as the impairment of a major life function. A reasonable accommodation may consist of special equipment; modifying spaces, access, or schedules; or any adjustment that is not an undue burden to the employer. The accommodation applies to the workplace and to any and all spaces in which his co-employees gather, even if off-site. The law applies to those (1) with a disability, (2) with a history of a disability, (3) whom the employer believes has a disability, or (4) is associated with persons with a disability.

In reviewing the applicant for a job, the employer cannot inquire about a disability, and the applicant cannot be required to submit to a physical examination prior to being accepted for the job. The employee's medical records and any references to his or her health must be kept confidential, stored in files separate from his or her standard personnel documents, and his or her condition shared only with those on a need-to-know basis.

Personal Responsibility and Ethical Mandates

Human services professionals are liable for maintaining a standard of care in their practice, one which may be subject to judicial review and sanctions. Some of these standards are summarized in codes adopted by each of the specific human services occupations. The National Association of Social Workers (NASW) Code of Ethics is illustrative. All social workers are mandated by the NASW Code to address the causes of their client's or community's presenting distress (see Section 6, Social Workers' Ethical Responsibilities to the Broader Society). Specifically,

> Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

Often, this requires legislation or litigation in which collaboration with attorneys who practice, make, and defend the law would prove beneficial.

Guidelines for social programs using public funds or set by public policies evolve through public procedures that routinely invite public comment in the process and before finalizing the rules. Attorneys assist human services professionals in their presentations to public bodies. For example, Congress established the Personal Responsibility and Work Opportunity Reconciliation Act, which included Temporary Assistance for Needy Families (TANF), which set a lifetime limit of payments to 60 months. But it took more than three years of hearings, including widespread comments and studies from social agencies for the federal government to define *assistance*. The final product, the result of intense negotiation and compromise of lawyers and human services professionals, confined coverage to food, shelter, and clothing and excluded items such as short-term cash in cases of family crisis, subsidies to employers to cover wages for TANF recipients, or supportive services like child care, transportation, counseling, and programs to find work. A human services worker may represent his or her client in many federal and state administrative tribunals such as appealing a denial of benefits or advancing a complaint of discrimination or harassment based on race, gender, religion, national origin, color, age, or disability.

Professional Duty: Standard of Care and Liability

Human services professionals help implement the law and work with lawyers in child abuse cases, adoptions, custody disputes, marital mediation, parole, and commitment procedures, and their work is subject to challenges in courts.

Virtually every jurisdiction now legally regulates practice through licensing laws. The legal regulation of social work practice includes professional licensing and provisions for public accountability. A social worker, psychotherapist, psychologist, psychiatrist, or other human services worker may be found liable for a breach of professional duty in not maintaining standards of care as articulated in the National Association of Social Workers Code of Ethics or as otherwise established by practice of comparable practitioners in the local community. Sanctions and damages may be levied for mishandling of client's funds, improper sexual conduct, violation of confidentiality, or other improper conduct. Laws regarding professional practice have changed dramatically in recent years, especially regarding confidentiality and the legal requirements to control one's clients. The once-inviolate standard of confidentiality, however, now bears an exception where the safety of others are involved. Workers may be held legally accountable for failing to accurately predict violent behavior in their clients, warning a threatened third party, and reporting to the police. In *Tarasoff v. Regents* of the University of California, the California Supreme Court ruled that, despite the value and importance of protecting the therapist–client relationship, the clinician's duty to society as a citizen of that society places certain limitations on the clinician's loyalty to a client's secrets, divulged in the context of the therapeutic relationship. That position has been adopted by other states and is codified as Tarasoff statutes throughout the nation.

The Law of Civil Commitment

Consent to voluntary treatment must be competent. If incompetent, as in developmentally disabled persons or infants, the court may appoint a guardian who voluntarily admits the individual. Human services workers are often petitioners or advocates providing information to the court, preparing reports, or serving as administrative hearing officers.

Involuntary Commitment

Commitment includes compulsory treatment, hospitalization, confinement, or other restrictions of liberty based on a mental disability or temporary mental condition. Generally, commitment will only apply to one if he or she has a mental illness and, as a result thereof, is a danger to him- or herself or others, or he or she is so gravely disabled that he or she is unable to care for him- or herself.

The following case is illustrative: Billie Boggs was involuntarily confined at Belleview Hospital. She had been homeless, living and panhandling on the streets. Hospital doctors diagnosed her as delusional, paranoid schizophrenic, incapable of caring for herself, hostile, obscene, and dangerous. But New York Civil Liberties Union (NYCLU) psychiatrists found no delusional or psychotic behavior. She was coherent and logical, and her recollection

A legal class at Palacký University of Olomouc Faculty of Law. Legal clinics originated as a method of teaching law school students, but today they encompass free legal aid with no academic links. In the academic context, these law school clinics provide hands-on experience to law school students and services to various (typically indigent) clients.

was good with her judgment slightly impaired. Her defecation on the streets was not nice but not delusional, and she was not suicidal. On the stand, she was coherent and spoke clearly, but even if mentally ill, the city must prove her acts were likely to result in serious harm to self or others. There was no evidence that she ever caused any harm. She was able to care for herself and get food; her lack of shelter was due to us, not her. Absent documentation of having a mental illness that poses a danger to oneself or others, the party must be released unless either a court order or voluntary and informed consent is secured. Public intolerance or animosity cannot justify deprivation of one's physical liberty. It can occur with or without court involvement, depending on state law, which may, for example, authorize commitment by a mental health professional.

The process of involuntary commitment to a state institution is controlled by state law. When one's behavior poses a threat to self or others, an emergency detention of a limited duration of 48 to 72 hours may be invoked. It may be initiated by anyone filing a petition naming the respondent, citing facts with reports by mental health professionals in affidavits to certify need.

Rights of the Person Charged

The court may appoint a human services worker as a visitor or guardian ad litem to represent the best interests of the respondent and to (1) explain the proceedings and inform the respondent of his or her rights and to ascertain his or her wishes as to guardianship; (2) investigate the need for guardianship and interview family members or professionals; (3) investigate the proposed guardian or the availability of a possible guardian; (4) investigate alternative arrangements; and (5) present a report to the court that describes nature, cause, and degree of incapacity; advises the court on need for counsel; evaluates the appropriateness of the proposed guardian; informs the court if an alternative may be appropriate; advises the court if a limited guardianship is appropriate and, if so, what limits and disabilities should be placed on the incapacitated person; tells the court of any expression of approval or disapproval made by the respondent on the proposed guard or guardianship and recommends to the court who is in the best position to serve as guardian and what limits, if any, should be placed on the guardian.

If a guardian is appointed, the ward should have periodic reviews to determine if there is a continuing necessity of guardianship. A person in need may file a petition requesting guardianship; he or she is more likely to get the guardian of choice, especially where he or she is frail or has a degenerative disease but is alert. While still of sound mind, one can state, should it ever be necessary, that he or she wants a designated person to be appointed as guardian.

Working With the Court for Commitment

Restrictions of civil confinement are balanced by certain due process rights, including the right to notice of the hearing and all papers on which the court is asked to rely in a language understandable to the respondent at a time when he or she is not overly agitated, confused, or medicated. The respondent must be advised that he or she has the right to be present, to be represented by counsel, and to trial by a jury of less than 12, who may render a decision that need not be unanimous.

The petitioner—that is, the party seeking to confine the respondent—must prove by clear and convincing evidence that commitment is required. The individual should not be asked to share equally with society the risk of error when the possible injury to the individual is far greater than any possible harm to the state. The petitioner needs proof more substantial than a mere preponderance of the evidence. Moreover, the respondent has a right to the names of examining mental health professionals and all who might testify for commitment along with a summary of their proposed testimony.

The court considers if (1) the respondent is a danger to self or others because of a mental illness, (2) he or she is likely to benefit from treatment, and (3) he is confined in the least restrictive setting and is receiving the least restrictive method of containment available. And these considerations are balanced by (1) the respondent's right to be free from harm, (2) his or her right to habilitation, (3) his or her right to have treatment provided to reduce or eliminate the mental health problem that necessitated confinement, and (4) his or her Fourteenth Amendment liberty interest in refusing medicine. However, the court may allow the state to administer psychotropic medicine if it can show that the respondent is a danger to him- or herself or others and treatment is necessary to reduce the danger.

Community Placement

State-employed treatment professionals determine that community placement is appropriate and when such placement is reasonable, taking into account the resources available to the state. It is required for the person to not oppose living in the community. Moreover, under the Americans With Disabilities (ADA) Act, the individual cannot be excluded from qualified federally funded programs because of his or her mental illness or other disability.

Community placement requires that the previously confined person be regularly supervised to assure that he or she takes prescribed meds and otherwise accords to the treatment program.

Right to Treatment

The Mental Health Patient's Bill of Rights mandates each state to review its laws to ensure that mental patients receive the protection and services they require and, if institutionalized, are afforded rights including the right to appropriate treatment. Personal security is a historic liberty interest protected by the due process clause of the Fourteenth Amendment, not extinguished by lawful confinement, even for penal purposes.

The developmentally disabled have a right to habilitation; that is, training and development of needed skills appropriate to their capabilities. The state is under no obligation to provide substantive services for those in its border, but a duty to provide certain services and care does exist when a person is institutionalized and wholly dependent on the state, and training may be necessary to avoid unconstitutional infringement of the liberty interest but may need certain restraints to avoid a danger of violence. Courts do not second-guess professionals or make their own decisions about treatment. Courts only make certain that professional judgment was in fact exercised. To get reimbursement from Medicaid, a facility for care of the developmentally disabled must provide individual treatment plans. Treatment must be provided in the least restrictive manner. The Mental Health Patient's Bill of Rights advocates freedom from restraints and seclusion.

Mental institutions routinely require patients to work for institutional rewards (e.g., TV privileges), for therapeutic reasons, for minimal monetary rewards, or to maintain the institution with minimally paid staff. Although some courts have found that mandatory employment violates the Thirteenth Amendment, institutions defend it as part of therapeutic process. But claims against minimum wage laws are sustained where patients can show that the agency derives monetary benefits from enforced employment.

Rights of Committed Patients

Patients have the right to refuse treatment. Any informed consent must be voluntary, competent, and given with knowledge of the risks of and alternatives to a specific treatment. They have First Amendment rights of speech, religion, and assembly, but such rights may be restricted because of therapeutic concerns or institutional needs. They have an unqualified right to petition for redress of grievances. Although it may be qualified or limited at times, patients have a right to privacy. Patients have due process protections when transferred from one institution to another, especially if the new facility is far from their family. Attorneys are obligated to maintain confidentiality, no matter what home conditions are like. Human services workers in all states, however, are mandated to report child abuse and neglect. However, if one is employed by a lawyer, he or she is covered by the attorney–client privilege and may not have to report neglect or abuse.

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See Also: Mental Health Services, Adult; National Institute of Mental Health; National Mental Health Association.

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Levels of Intervention

This entry defines the levels of intervention in human services. This is a complex concept.

Practitioners using these levels may be employed in many types of agencies, may have that level as a main focus, or may have several levels as the foci of work. Curricula of human service, educational institutions may be organized by level or in other ways. This entry analyzes how these levels may be further defined, how the concept of systems is employed in this analysis, and how the existence of diversity in our society and in client populations is important at all levels of practice.

Definition of Levels

A level of intervention means the size of the system (which is defined later) that is the focus of the practitioner's attention. These systems are typically referred to as micro level, meso level, or macro level. Micro level refers to practice with individuals, families, or groups; meso level refers to practice with communities; and macro level means practice with organizations (often the practitioner's employing agency) or political levels, namely a city, state, region, national government, or even worldwide entity. This latter is sometimes referred to as policy practice.

Practice Levels and Systems

In order to clarify these categories further, we find it helpful to use systems terminology to discuss the various systems that practitioner's take into consideration in planning their activities. Systems are defined as follows: (1) something consisting of a set of entities, (2) among which a set of relations is specified (e.g., cell organization, human interaction, or grammar, or culture (3) so that deductions are possible from some relations to others.

The entities could be cells, people, words, or beliefs, and the relations could be an organization, human interaction, grammar, social structure, or culture. A system is a set of components directly or indirectly related in a causal network such that each component is related to at least some others in a more or less stable way within a particular period of time.

Systems can be thought about as entities, some of which deal with matter or energy, some of which deal with information, and some of which deal with all three. Seen in this light, systems could be families, individuals, organizations, communities, or the history of these. The units in the human services have a history, and what happens today or tomorrow depends in part on what has happened in the past. Systems have complex interconnections of smaller systems with them and, at their own level, function as wholes.

A social system is an organized entity that possesses a distinctive total unit beyond its component parts that is distinguished from its environment by a boundary and whose subunits are at least partially interrelated within fairly stable patterns of interactions. Put even more simply, a social system is a set of interrelated activities that together constitute a single entity. This entity has defined boundaries. Thus, the boundary of a family may be those who live in the same household or are related to each other (e.g., mother, father, offspring, and grandparents). The boundaries of a city are often designated in state legislation.

Having defined the concept of system, we return to discuss the way the systems of concern to the social practitioner are conceptualized. One such system is the client system, defined as persons who ask for professional help to deal with a problem or seek a change, are expected to benefit from it, and contract to receive it. The term *client system* is used here rather than simply client as this may consist of an individual, family, group, community, organization, or larger entity.

The target system refers to the focus of change efforts. When client systems seek changes in themselves, the client system and target system are identical. More often, an individual seeks change in an organization; an organization may seek changes in individuals, or a community may seek change in a political policy. In these situations, the client and target systems are different.

A third system of concern is the action system, which refers to those formal or informal resources and persons that the practitioner needs to cooperate with to accomplish a purpose. For example, a practitioner may have a client system that consists of a child with school difficulties. The work plan may require the practitioner to help the teacher to better meet the needs of the child; when the practitioner discusses this with a teacher, the teacher becomes an action system. The teacher may also be a target system if the aim is to change the actions of the teacher with respect to the child (e.g., of the macro client).

Another example is a practitioner assigned to a school to help the staff develop relationships with other staff of varied genders, ethnicities, ability or disability statuses, and sexual orientations. The reason for this was the extent of the existence of cliques whose members were reluctant to work with other staff members because of animosities related to these social categories. The practitioner viewed the school as his or her client system. One major goal that evolved was to change the policies of the larger school system that discriminated against specified groups. Thus, the school system became a target system, and a committee selected to develop strategies was an action system.

Another system is conceptualized as the agency system, which is a subset of an action system that includes the practitioners and formal service systems involved in work on the target problems. As the practitioner in the previous example was employed by the school system, we see that system as the agency system.

This set of categories makes the question of defining a level of practice a less than clear-cut question. The organization of a school's curricula can be seen as defining a level as will be discussed shortly. On the other hand, how the agency system defines itself at least communicates what type of expertise with regard to levels the agency seeks to hire—although even that is unclear as agencies may hire a person who specialized in a level of practice that varies from the definition of a position because of the broad nature of education in human services and the kinds of experience the person has had. A common example is the micro-level educated practitioner who advances to a management position; that is, a position that requires a focus on the organizational level.

A level of practice is largely related to what the nature of the client system is. Thus, when the client system is the individual, the practice level is often defined as micro level; when the client system is the community, the practice level is often defined as meso level.

The complication here is that, whatever or whoever the client system is, the solution of client system problems may require the target or even action systems to be any or all of the practice levels. For example, the client system may be the agency or an organization. The action system may be an individual or the executive whose support is needed for a policy change. The action system may be a group such as an executive committee whose decisions may help achieve the policy change. The action system may be representatives of the agency as a whole such as a meeting of the entire staff whose desires regarding the policy will be determined. The action system may be the city council as the passing of legislation is required because the policy change will require resources that the city can supply.

Thus, as the standards of many human services professional organizations indicate, the human services practitioner should have competencies at all levels. The differences in how these competencies are utilized relate to the purposes desired by the client system and are accomplished through the action system. When the client system is an individual with a behavioral problem, the work with that client system may well utilize the application of psychological treatment methods. When the client system is the organization or community, work with individuals as action systems will not involve psychological change as a primary purpose; instead the work with individual action systems is more likely to entail helping the individual to accomplish tasks related to the goals of the organization or community. The knowledge bases drawn upon come from organizational and community change theory as well as theories of policy creation, analysis, and implementation.

Practice Levels and Curricula

Many schools in the human services divide their curricula concentrations and specializations into at least a micro track and a macro track as sometimes the meso or community level is contained in the macro track. Other schools have separate tracks for individual, group, and sometimes family practice. The curricula for these tracks vary. Often, the individual track contains courses or course content on relevant behavioral approaches and theories (e.g., psychodynamic, behavioral, and ecological), stages of the work, and applications to different populations (e.g., people with mental illness, children in the child welfare system, and people in the correctional systems).

A macro policy track may contain courses on policy development, policy implementation, and policy analysis. The meso community track may contain courses on social action, grassroots organizing, and the creation of interagency coordination mechanisms, approaches to community needs assessment, and the analysis of community structures, processes, cultural dynamics, and power structures.

The professional organizations in the human services, however, are likely to condone a broad education of social practitioners that may involve concentration or specialization, but all practitioners should be able to engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities.

The Human Services Practitioner as Generalist

The previous discussion may imply that we favor the concept of the human services practitioner as a generalist or a jack of all trades, so to speak. While there are undoubtedly some practitioners who, by virtue of experience and training, may see themselves in this light, some educational institutions may seek to educate such practitioners. This may not be a desirable educational goal as there is a great deal of specialized knowledge about practice models, behavioral science theories, relevant policies, and practice settings, and it may not be feasible to include all of these in a limited-year program including both classroom and education in the field (such as internships). Some students desire, however, dual sets of competencies, and the educational program may allow and encourage this, such as specializations in both micro practice and management. In addition, some programs require a specialization in a field of practice such as mental health, child welfare, or community-focused organizations, and this may require competency in more than one level of practice. The human services fields are in flux on these issues, and it is difficult to predict how it will all come out.

Levels of Problems and Relevant Target and Action Systems

In reviewing this material, one can envision a matrix in which the column headings are the system levels experiencing a problem or issue: biological, individual, family, group, organization, community, society, and the world. Row headings refer to where the causes of difficulties lie and the same set of systems is used as the labels. Thus, an individual may be experiencing a problem whose cause may lie in one or more of the systems.

For example, an individual may be experiencing a drug use problem (biological level), an individual problem such as a lack of knowledge to fulfill a role requirement (individual level), a family problem such as a lack of adequate family resources (family level), an organizational problem such as the organization is discriminating against the individual because of his or her sexual orientation (organizational level), a community experiencing conflict that affects the individual negatively (community level), the national government failing to supply adequate medical coverage needed by the individual (societal level), or the individual losing his or her job due to a shift of employment in the industry to other countries (world level). Given this analysis, the practitioners have to utilize action systems (i.e., the level of intervention chosen by the client and practitioner systems) to work to ameliorate the problem.

This may sound as if the practitioner is a master manipulator orchestrating all sorts of change. This is not intended. Modern empowerment-oriented practice sees the practitioner operating more as an educator, cognizant that all parties share this educational function and have unique ways of viewing and understanding the world. Any and all interventions should be planned with as well as on behalf of the client system. In addition, this discussion may imply that one practitioner can or might do it all. Rather, the practitioner is part of the whole human services system and can and should collaborate with practitioners who specialize at levels of intervention required by the situation.

Diversity and Social Justice

An understanding of diversity and an application of this understanding to practice are essential for all social work practice. Many of the sources of diversity such as ethnicity, national origin, sexual orientation, gender, age, physical ability, and acculturation to the society are and have been sources of oppression, and all of us have multiple identities that are composed of these and other social designations. Thus, the idea of social justice becomes important. The goal of social justice is to ensure that every individual has an equal opportunity to be a contributing member of society and has access to health care, education, employment, and other needed resources. A socially just society is one that makes this possible for all citizens.

This means, therefore, that human services practice at all levels must be committed to meeting the needs of diverse client systems and that all choices of systems for service and ways of offering service conform to principles of social justice. To this end, a set of assumptions has been developed about socially just practice (one that fully examines the implications of having socially diverse client systems). These assumptions include the following:

1. Socially just practice requires visioning how the achievement of the purposes of the service can make a contribution to a more just world. The practitioner and the stakeholders in the situation will be evolving their own concepts of such a world.
2. Practice occurs within a broad array of social contexts. Terms that are used to refer to these contexts include the political, social, cultural, structural, organizational, community, family, and group circumstances surrounding the practice. These contexts may serve to either enhance or constrain the attainment of social justice goals; both enhancing and constraining forces may be present in the same situation and operate in complex ways.
3. Collectivism is an important concept in that people are social beings who depend on one another for the satisfaction of most of their primary and social needs. Because of this, groups are a major resource for client systems to utilize to accomplish their purposes and attain their goals. There are important differences, however, in the ways in which people in different cultures view the individual in relationship to various groups and collectivities, and this has major implications for how and when practitioners and client systems seek to work through groups to attain socially just goals.
4. Problem conception varies among social groups. Problems that the practice situation seeks to address are brought about by a complex array of forces. One of the most significant of such forces ensues from the structural circumstances surrounding the practice situation. An important question in the identification of such forces is who benefits by the way the problem is defined as well as if the problem is reduced or eliminated. This analysis is enhanced by a recognition that the personal is political, that personal problems are reflections of structural conditions, and that structural conditions are reflected in the problems of people individually and collectively.
5. The interests of the client system are the primary consideration rather than the interests of practitioners, the service agency, and other entities in the environment.
6. Processes and outcomes are inextricably linked. Thus, the practitioner should use processes and actions that promote social justice and challenge and reduce mechanisms that sustain injustice.
7. The practitioner should engage in multiple kinds of theorizing and analyses alone and with others at all phases and levels of practice.
8. The practitioner should attend to interconnections across and within levels.
9. The practitioner should examine how issues and problems are defined, conceptualized, and framed by external bodies and the service system, and determine whether these definitions benefit or disadvantage service users and are sources of oppression or sources of empowerment.
10. Practitioners should assess their own positionalities on multiple dimensions and should take these into account in terms of their impact on practitioner–client system interactions.
11. The levels of intervention that are chosen as action systems should be chosen by what will achieve client goals and social justice goals rather than chosen by professional preferences and experiences.
12. Client systems should regularly leave time to uncover and learn from conflict. They are likely to learn about power and injustice by dialoguing in conflict situations how to act in the face of conflict and how to resolve conflicts in

ways that are peaceful and just, and that reduce or eliminate unjust and unequal uses of power.

13. Practitioners should regularly work with others including client and action systems to determine whether goals, and especially social justice goals, were identified initially and developed further over time—this is a requirement in general for an evaluation process that also considers the attainment of social justice goals.

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See Also: Changing the Client Versus Changing the Environment; Community Organizing; Conflict Resolution and Diversity; Counseling and Psychotherapy Services; Group Therapy; Marriage and Family Therapy.

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LGBTQ Clients

Living in America as a lesbian, gay, bisexual, transgendered, or queer and/or questioning (LGBTQ) individual can bring about many challenges. The unique needs of this population have resulted from the challenges they face. Support during various stages of development of individual identity is an important need of LGBTQ individuals. Commonly, support is needed during the acceptance of self, coming-out process, and transitioning process. However, the primary barrier many have to overcome is self-acknowledgement and acceptance of being an LGBTQ individual. The coming-out process happens once self-awareness has been reached. Frank Floyd and Roger Bakeman describe the coming-out process of sexual orientation development as a standard set of life experiences that take place prior to and after self-identification as lesbian, gay, bisexual, or transgender. Furthermore, Arlene Noriega concludes that this process includes the time in which LGBTQ individuals disclose their sexual orientation to others. LGBTQ individuals come out in a number of ways and to many different groups of people. Natalie Hill notes that, as LGBTQ individuals are not a dominant group, they face unique challenges such as the coming-out process in which they have to explain their sexual orientation, and heterosexuals do not. They often find themselves coming out continually as they meet new people, acquire new jobs, or find themselves on different paths in their lives.

The coming-out process can be an exhilarating yet difficult process to navigate. Many LGBTQ individuals face extreme challenges as a result of the disclosure of their sexual orientation. The needs of this population include support and assistance in navigating the coming-out process. Some may need assistance processing their disclosure to various populations in various social contexts. Nicole Legate, Richard Ryan, and Netta Weinstein concluded that LGBTQ individuals are more likely to disclose their sexual orientation in contexts that are supportive and that LGBTQ individuals experience more positive well-being. In contrast, disclosure and positive well-being in more controlling contexts are less likely to occur.

Although there are benefits associated with coming out as an LGBTQ individual, there are also some risks to the process. Natalie Hill contends that risks consist of the lack of understanding or acceptance of everyone; the loss of support system and relationships with friends, family members, or coworkers that could be negatively impacted permanently; individuals that may be thrown out of their homes and experience homelessness, cut off from any financial support; and discrimination or harassment based on sexual orientation or gender identity, which in many cases, provide no recourse to legal protection. Lack of legal protection can put LGBTQ individuals at risk of losing their employment, denied housing, or even denied access to health care or insurance. These risks contribute to the special needs of LGBTQ populations and the coming-out process.

The coming-out process can be much more difficult for individuals who identify as transgender. Just as lesbians, gays, and bisexuals come out, transgender individuals come out during all stages and times in their lives. The National Center for Transgender Equality contends that this population may come out when they are adolescents, adults, or seniors; married or single and when they have children or even when they do not. LGBTQ individuals face many of the same challenges during and after the coming-out process, ranging from strained relationships to verbal and physical attacks. However, transgender individuals experience some different challenges.

Navigating the world daily as a transgender individual presents many challenges. It can be overwhelming for those whose gender identity, or internal feelings about their sense of gender, differs from the one they were given at birth. Making the decision to transition, living in one gender to living in another, can put the transgender individual into a more public light. The National Center for

The Los Angeles Gay and Lesbian Center is a clinic serving lesbian, gay, bisexual, transgender, and queer (LGBTQ) people. Its clinic and on-site pharmacy offer free and low-cost health care, mental health care, HIV/AIDS medical care and HIV/STD testing and prevention. It also offers legal, social, cultural, mental health, and educational services, including a 24-bed transitional program for homeless LGBTQ youth.

Transgender Equality contends that transitioning can bring on increased ridicule and the continuous disclosure to family, friends, employment, and medical professionals. At this stage, it becomes more important for individuals transitioning to surround themselves by individuals and communities that will support them through the process.

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See Also: Behavioral Health Disparities for Racial and Ethnic Minority Populations; Children With Special Needs; Heterosexual Privilege; Legal Services; National Center on Minority Health and Health Disparities; Prejudice, Theories of; Same-Sex Couples/Marriage; Sexual Reassignment Surgery.

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Life Book

Life Book is a tool to chronicle the origins of an adopted child for generating a stable self-concept and identity. As a tool in therapy or case work, Life Book is a critical tool for the client and practitioner starting mental health and well-being discussions with foster and adopted children and to maintain and nurture the links between the adopted child's family of origin and life after adoption. The overall format of Life Book varies. It is constructed to give space for the child, the child's lost family, the adopted family, and the professional supports such as the therapist, and to make obvious and subtle linkages among them while maintaining a distinct identity for the adoptee. The Life Book has limitations but is a way for the child to share and make sense of his or her story for him- or herself and for others through engagement with the therapist, family members, and other professionals in its creation. It is aimed at creating a sense of self and relationships, both lost ones and new ones. It encourages imagination and reality to come together for a positive perspective.

There is no exact record of the origins of Life Book in the literature, but it is traced to Mary Horn of the Los Angeles Children's Bureau in the 1960s. Although there was a wide range of acknowledgment of its clinical use, there is limited research on the Life Book. K. A. Backhaus conducted an exploratory study of the use of the Life Book. She conducted open-ended interviews of 15 social workers working with foster and adopted children placed in private and public welfare agencies in Connecticut. Most of the respondents reported positive outcomes of the Life Book in allowing children to experience more control in their lives by integrating their feelings, organizing their experiences, and reframing their memories. The respondents also viewed it as a helpful tool for practitioners in understanding children's experiences. The Life Book has helped the child and others (e.g., the workers or adopted parents) realize the uniqueness of adoptees' lives and value their identities as people. Furthermore, it helped the adoptees understand the reasons for separation and adoption in their lives, which contributed to resolving anger about separation and placement in foster care or adoption.

There is no predefined format, but a loose-leaf structure is encouraged, as suggested by professionals, as it allows for the flexibility of adding and removing information in different types of adoption histories and varying sources of information and the adoptee child's knowledge about it. The Life Book is a collection of images and stories, which are valued because they can give a structure to life and the experiences of the child. The process could entail gathering a whole gamut or some of the following pieces of information: workers collecting photos and personal documents; identifying support and involvement of people in this process; preparing photo albums, scrapbooks, or built-in books; organizing contents such as photos, drawings, letters, or cards from family members or friends; child and worker narratives created through dialogue of the adoptee's history; other things the child might wish to include; and information and photos of travels or places that can be helpful for the adoptee to deal with his or her history.

The Life Book is organized to include the following categories: child's birth name; birth information, birth home, birth family tree; medical, immunization record; biological siblings or parent information; exploring the reasons of separation from birth parents; information of religion and other activities; information of the foster family; exploring the first day in foster family; adopted family tree; exploring the first day in adopted family; exploring birthdays from birth to current; school information; and exploring special people in the child's life. The format of the Life Book has different approaches ranging from albums to videotapes. For instance, a creative videotaped Life Book is used as a vehicle for biological parents to communicate their understandings of the child's family of origin and information of the child's genetic, medical, and developmental history. It also contains childhood stories with details such as favorite foods, first words, familial significance, and other memorable information. This videotaped Life Book can be later used by adopted families to share with their adopted child at appropriate developmental stages. A Life Book initiated by R. Holody and S. Maher proposes the here-and now model with a traditional Life Book that also has a social worker play an active role in placing the child's experience. The limitation of this proposed approach is that it is only preferable for older children because it requires cognitive ability to process their experiences.

There are some limitations of the Life Book in practice. It requires considerable time to gather a child's information and photos from previous foster and adopted families and previous workers. A trusted relationship between caregivers and a child needs to be established in order to begin this process. Third, the memories of adoptees can range from absence of information to negative perceptions of birth parents. To address this issue, the therapist or social worker asks the teenager or child to think of the birth parents' conditions at that time to create a self- and parent identity that is realistic but enabling. Fourth, the Life Book might be a difficult task if the cognitive and chronological age of the adopted child is not a good fit with undertaking the creation of a Life Book. Finally, caregivers need to believe the Life Book process, follow guidelines, and avoid asking premature questions about painful experiences in building a narrative.

Even with the limitations, the Life Book is a document of a life story that functions to help the child resculpt his or her life. The child's scattered memories during separation and transition are interwoven and integrated through the process of developing his or her life story. The integration of memories and restructured perspectives of life lead to a better adjusted one with his or her new family.

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See Also: Adoption, Infants, International and Older/Special Needs Children; Adoption, Special Needs; Adoption Agencies and Services; Adoption and Foster Care Analysis and Reporting System; International Adoptions and Families.

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Life Course Approach

Academic studies of aging date to 1907, when Leo Ignatius Nascher coined geriatrics as the medical study of the aged. Gerontology, on the other hand, can be defined as the sociological study of aging. The life course approach to studies of aging is a relatively recent phenomenon in gerontology, although it can be traced back a century in anthropology to Arnold van Gennep's seminal book *The Rites of Passage (Les Rites de Passage).* Both geriatrics and gerontology traditionally have concentrated on the aged such as the Kansas City Study of Adult Life in the 1950s. Although the Kansas City researchers accomplished a breakthrough with their belief that it was necessary to understand older people in naturalistic settings, Elaine Cumming and W. E. Henry mistakenly argued that disengagement from society was an inevitable developmental event of the life course. However, David L. Gutmann's research among the highland Druze led him to argue that disengagement is not inevitable in traditional cultures. Rather, it results in social rebirth through the mastery of religious roles.

In the 1970s, continuity theorists argued that psychological well-being in old age is the product of enduring patterns of activity over the entire life course. Linda George tested this on 380 people between the ages of 50 and 75 to predict continuity over the life course. She found that personality characteristics predicted psychological health better than did social status or activity. Psychological health is not an outgrowth of activity, contrapose disengagement, in later years. Both are the result of an individual's continuing character or social developments. In other words, the aged have high or low levels of activity because this has been the case over their life courses.

A Shift in Perspective

As people apparently began to live longer in the late 20th century than they did in previous times, it was assumed that the life span had increased due to the shift from rural to urban living, increasing industrialization, and modern medical practices in the north (industrialized countries). However, Peter Coleman, John Bond, and Sheila Peace argue that the greater numbers of older people is the product of a descending trend in birth rates. With lower birth rates, there are fewer infants proportional to the rest of the population; thus, when the infant mortality rate is averaged into the death rate for the entire population, it appears that people are living much longer (after they have reached adulthood) because the average life span has increased. Actually, this means that fewer infant deaths have been included in the calculations. Indeed, aging is not just something that happens in the third trimester of the life course; rather, aging is a lifelong process that begins at birth. Thus, Peter Coleman contends that aging should be studied over the entire life course.

The Longitudinal Argument

In the 1970s, Matilda White Riley observed the life course connection between age and social structure. People in the same age cohorts experience many things as a group, and they will experience them differently than will people in other age cohorts, even when they experience the same incidents. This is to say, adults will have a different experience from a war or an economic recession than will children, and older adults will experience those events differently than will younger adults. These different reactions to how events are experienced result in different courses for different age groups.

In the 1990s, a major change in aging studies eschewed theories in favor of experiential analyses. Vern L. Bengtson, Cara J. Rice, and Malcolm Johnson argued in 1999 that 72 percent of all publications between 1990 and 1994 ignored theory in aging literature as irrelevant to their findings in real-world situations. Katherine R. Allen, Rosemary Blieszner, and Karen A. Roberto established that aging studies began to move into family gerontology. Of the 938 publications at which they looked, the plurality was on caregiving (32.6 percent), followed by social support networks at only 13.7 percent. Aging researchers began to realize the importance of pluralism and life course approaches.

As aging researchers began to appreciate the life course approach, a new methodology began to be required that shifted to the collection of longitudinal data, often placing the individual within a familial environment that necessitated chronological considerations in lieu of definitions of age cohorts and the employment of unpredictable life experiences. Aging individuals may choose what they consider to be their families from a group of possible members: nieces, nephews, friends, or neighbors.

The Life History Method

Life course research should be conducted longitudinally, as it has been conducted in the English Longitudinal Study of Aging (ELSA). The longitudinal argument for life course studies is reinforced by The Irish Longitudinal Study on Aging (TILDA), which began tracking 10,000 Irish people age 55 and older over 10 years, beginning in 2006. Longitudinal research has its problems as methodology and research foci may evolve away from the original hypotheses, or tragically subjects die.

Peter Coleman makes the point that longitudinal research over the life course necessitates accounting for early, formative experiences, not just those extant in the subjects' lives, as much previous static research had done. Bengtson, Rice, and Johnson observed that a life course is a developmental process that requires a longitudinal dimension. Michael J. Simonton overcame the issue of static, cross-sectional research by practicing participant observation on the same subjects over 30 years, with the empirical data reinforced with autobiographical narratives, called life histories in anthropology, where they have constituted an important research tool for more than a century. Narratives allow subjects to reconstitute their life courses, and by gathering multiple life histories, the researcher can begin to understand what constitutes meaning within lives, according to Ricca Edmondson.

It is by utilizing life history data that meaning is given to the life course within a historical context, according to Chris Phillipson. Allen, Blieszner, and Roberto call the use of the life course in the study of aging as the foremost methodological development of the last several decades. They argue that the life course perspective links macro and micro levels by focusing on individuals within society and historical processes to discover how subjects develop chronologically and longitudinally as they construct their lives within a kin (or fictive kin) matrix. Subjects reveal how they constructed meaning within their lives by narratively reconstructing them over the life course, in effect seeing where they have come from to where they are by looking in the rear-view mirror of narratives.

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See Also: Longitudinal Studies of Aging; National Institute on Aging.

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Life Skills Training

Life Skills Training (LST) has been designed to address key risk and protective factors associated with the initiation and escalation of problematic behaviors and unhealthy lifestyle choices. LST has been designed to target social and intrapersonal factors by providing the knowledge, attitudes, and skills necessary to actively resist social influences

Crew members from the USS Forrest Sherman *(DDG 98), based in Norfolk, Virginia, and the U.S. Coast Guard Cutter* Tahoma *(WMEC 908), based in Portsmouth, New Hampshire, build a garden area that provides life skills training to mentally disabled students at the Victory Living Programs care facility in Fort Lauderdale, Florida.*

promoting engagement in unhealthy living practices. LST is typically taught in a logical sequence in which particular material is covered and broken down into three major components: (1) a personal competence component that teaches self-management skills; (2) a social competence component that teaches a set of social skills; and (3) a drug-resistance component that teaches health-related content, resistance skills, and prohealth attitudes.

The personal-competence component consists of sessions that teach problem-solving and decision-making skills; critical-thinking skills to identify, analyze, and resist common media appeals; skills for coping with anxiety and stress; emotional self-regulation skills (e.g., reframing negative thoughts and increasing positive self-talk) in order to manage feelings of anger/frustration; and skills for facilitating personal development (e.g., self-assessment, goal-setting, self-monitoring, and self-reinforcement).

The social competence component consists of sessions that teach skills aimed toward more clear communication (i.e., maintaining congruent verbal and nonverbal ways of communication, specificity in giving instructions or making arrangements, and paraphrasing or simplifying statements for increased clarity); and skills for overcoming bashfulness (e.g., initiating and sustaining social interactions), meeting new people, making new friends, and developing healthy relationships. Individuals are also taught complimenting skills (i.e., giving and receiving compliments); general conversational skills (including terminating a conversation); and general assertiveness skills (e.g., making requests, refusing unreasonable requests, and standing up for one's rights).

The drug-resistance component consists of sessions that expand knowledge and teach the skills needed to increase individuals' ability to resist social pressures to smoke cigarettes, drink alcohol, and use illicit drugs. Included are divisions that focus on the unfavorable consequences of tobacco, alcohol, and illicit drug use; the current prevalence of drug use among both youth and adult populations in efforts to correct or modify normative expectations about drug use; and the immediate physiological effects of cigarette smoking. Additionally, lessons related to substance use and other health matters are integrated into several divisions of the program to further demonstrate the effectiveness of implementing the skills learned.

Methods of Training

Some material in the program is taught using didactic methods; however, a major emphasis is placed on the use of interactive teaching techniques such as facilitation and group discussion, classroom demonstrations, and cognitive-behavioral skills training. Thus, in addition to targeting proximal etiologic factors specific to drug use and resistance, LST addresses more distal etiologic factors grounded in positive development and general competence enhancement. While many skills taught in the program are derived from cognitive-behavioral therapy, the environment is not a therapeutic setting. Instead, the structure and environment are more conducive to instructional learning and continue to focus on remediating existing problems, increasing resilience, and facilitating healthy psychosocial development.

Testing of the LST curriculum has primarily been used with white middle-class individuals; however, several studies have tested the program with inner-city minority individuals. More specifically, the program has been consistently implemented with the youth population. Research with minority youth shows that LST can prevent cigarette smoking with Hispanic and African American youth. Several studies with minority youth from multiple racial/ethnic groups indicate that LST is effective in reducing the frequency and amount of alcohol use. Additional research with multiethnic minority youth demonstrates that it is effective in preventing the use of tobacco, alcohol, and marijuana, as well as the use of multiple drugs. Taken together, these studies show that LST works well with multiple populations, including white, African American, and Hispanic youth.

Additionally, LST has been tested within the university population. There has been an increase in the number of students seeking counseling centers, and this may reflect their sociocultural growth and mental maturation in the ability to request support from others; yet it can also highlight the sophisticated problems they face, leading them to educational decline. The importance of the above issues have led researchers to investigate the efficacy of life skills training on general health in students to reduce their physical and psychological problems and to promote their general health through education of life skills in a new environment (i.e., the university setting).

Not only has LST training been taught within general educational settings, it has also been taught within medical settings. Nurses are exposed to patient illness and critical conditions of death daily, which can often lead to insomnia, lack of assurance, and disturbances in their interpersonal communications, which often leads to an increase in physical problems. Studies on the effectiveness of LST with this population has demonstrated that level of communication skills, self-awareness, and stress management among nurses and midwives can be promoted through education of life skills to prevent the problems and/or lower the level of problems. Research findings suggest implementing life-skill education, along with other educational programs in the curriculum, in order to increase the level of the individual's general health, lower the incidence of depression, anxiety, physical problems, and to amend low social function to prevent physical and mental disorders.

Minority Communities

Several programs have been developed that teach LST, but the traditional LST-named programs do not place a particular emphasis on working with diverse populations and the experience of learning life skills within a nonmainstream framework. Most programs that teach life skills in minority communities are focused more on the personal and social competence arenas. Most of those programs also include a heavy focus on mentoring and collectivist ideologies in order to cope with the experience of "-isms" and discrimination. A significant portion of the program is also spent exploring the history of the minority group and the implications of the "-isms" on their competence levels. As the development of LST training programs and the diversity of the world increase, it is imperative that educators, researchers, and other professionals understand the importance of diversifying the curriculum to be more inclusive of various background experiences and implementing material that reaches wider populations of people and characteristics.

Social learning theory indicates that learning occurs within a social context as a result of a process of observation, imitation, and modeling. Social factors and the modeling of behaviors are powerful influences that shape the lives of children and adolescents, as well as adults. Intrapersonal factors (such as knowledge, attitudes, skills, and personality traits) affect motivation to engage in negative behaviors and interact with social factors to increase risk by affecting vulnerability to those influences. Vast changes in living conditions, social and familial problems, and numerous advances in information technology and communications reveal the necessity of taking individuals' health into close consideration more than before. More recently, psychologists' investigation of behavioral disorders and social corruption concluded that most of the health damages are a result of individuals' inability to analyze personal problems, sustain personal control, and face difficult situations, and they ultimately lack the preparation required to solve problems in an appropriate way. Therefore, preparation of youth, or adults who did not acquire such skills during their youth, to cope with such difficult situations is essential.

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See Also: At-Risk Youth Services; Drug and Alcohol Screening; Life Course Approach; Youth Risk Behavior Surveillance System.

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Linguicism

Linguicism (also called linguistic discrimination or languagism) is understood as treating someone unfairly or worse than others due to one's linguistic skills and performance. Linguicism may be connected with violating linguistic rights (human rights connected with language and communication) and infringing on one's freedom of using his or her mother tongue, dialect, or register in social interactions. Taking into account the scope of languagism, it may concern different levels of linguistic representation. Analyzing the macro dimension, it may involve languages, dialects, or registers. Linguistic discrimination is also connected with communication styles. Thus, some communicative behaviors may be viewed as improper or worse by others and, consequently, the users of some interactional practices as inferior. Linguicism may also be observed on a micro level as it may concern words and phrases. Thus, because linguicism involves social linguistic representation (language) and personal communication style (word), it can be viewed on both individual and group levels. It may concern both verbal and paraverbal elements of communication; one's choice of linguistic repertoire and pitch may be viewed as more prestigious than the phrases or accent in the piece of communication produced by someone else.

Apart from the mentioned issues, linguicism may also concern situations when someone has limited or no access to information due to some impairments or health problems. For example, linguicism may take the form of making information unavailable in Braille or sign language. In addition, linguicism is connected with the juxtaposition of linguistic inclusion and exclusion. It is often represented by the opposition of language or dialect and lingua franca or vernacular. As far as the background of linguistic discrimination is examined, there are various reasons for linguicism. One of them is stereotyping that is connected with thinking that speakers of some languages, or dialects, as well as the users of some styles or nonstandard phrases, lack certain skills or are inferior to others in some way.

In addition, the speakers possessing different verbal and paraverbal features may be perceived as less educated or coming from disadvantaged social backgrounds. Another reason for linguicism may be the lack of financial resources to conduct efficient multilingual policies. For example, the costs of translating some materials into many dialects or minority languages may be too high for some organizations. Consequently, some speakers do not have the possibility to access data in their mother tongues on, for example, corporate Web sites. In addition, linguistic issues do not take place in a vacuum; political, financial, and cultural dimensions influence linguistic attitudes and policies. Thus, linguistic discrimination is often caused by the improper allocation of power, money, and human resources in a given setting. Consequently, historic, monetary, or cultural factors influence the treatment of linguistic communities in a given territory.

Types of Linguicism

One typology may involve the issue of voluntarism and consciousness. Consequently, conscious and unconscious linguicism can be distinguished. Conscious linguicism denotes a situation when the performer of actions is conscious that his or her actions tamper with linguistic rights and cause prejudice. On the other hand, unconscious linguicism encompasses instances when a person is not aware that his or her linguistic attitude violates linguistic rights and freedom of expression. Another classification regarding linguicism may concern a type of language affected. Figurative linguicism encompasses linguistic attitudes toward nonliteral language. For example, metaphors or idioms may lead to problems in understanding because they involve connotations with issues that are culture specific. In addition, even if the source domain is recognized in a given metaphor, it may cause different associations among the target audience. Thus, metaphors in multicultural or multilingual settings have to be chosen with great care because, although they often rely on well-known domains and concepts, they may sometimes impede the process of intercultural communication.

Literal linguicism involves using linguistic tools with defined meaning in a way that limits the processes of understanding. It may be represented by, for example, relying on lesser-known meanings, archaic denotation, or very specialized terminology in expert–laymen communication. Linguicism can be divided according to its consequences. Social linguicism is the type of linguicism that is caused by social attitudes and leads to social isolation. A person who has to face social linguicism does not have the possibility to participate in social life, or his or her participation is infringed. One type of social linguicism is gender linguicism that encompasses all the actions related to treating one gender inferior to another one.

Another type is informational linguicism, which is connected with limited access to information caused by linguistic imbalance in a given setting. As language determines knowledge flows in all directions, both the processes of encoding and decoding data suffer from informational linguicism. As a result, a person is not able to create or understand a message. Social and informational linguicism are interrelated and determine information flow and social contacts. In addition, linguistic discrimination can be categorized by taking into account the sphere of life it concerns. Thus, the following classification can be provided, showing the role of linguicism in both private and social life: educational linguicism, workplace linguicism, and media linguicism (including online linguicism).

Educational Linguicism

Linguicism may be caused and simultaneously affected by education. It may be represented by the lack of access to educational services being prompted by using a minority language or a dialect of indigenous community. As far as learners are concerned, linguicism may be connected with the lack of books, scripts, and other materials in their tongue. When the level of language of instruction is not satisfactory among the pupils, the learning process may be difficult. Moreover, linguicism may concern the instructors as well. As far as the group of teachers is concerned, teachers having a mother tongue other than the language of instruction may find it difficult to get a job. The reasons for this issue may be connected with lower linguistic skills of the teachers as far as the language of instruction is concerned or the aptitude of employing only native speakers. Another issue is native speakerism, which stresses the fact that native speakers are the authorities on the language and the best teachers of a language. In consequence, the teachers of foreign languages who teach a language that is not the mother tongue may not be offered equal job possibilities as native speakers. Linguicism is also related to creating and distributing knowledge. In some scientific writing, researchers draw attention to the issue of global language, with English being the lingua franca of the modern. The benefits of using one common language in science are very visible—access to publications and the possibility to read the works created by researchers from various countries. On the other hand, some discuss the phenomenon of English linguistic imperialism. In the case of education, it is connected with lower possibilities of publishing research in languages other than English because some journals accept only contributions written in English.

Workplace Linguicism

As far as the professional life is concerned, linguicism is connected with prestige or higher status of some languages. In this case, being the speaker of a desired language gives the possibilities of promotion and offers the access and comprehension of corporate documents. Another corporate linguistic issue is organizational linguistic policy, being visible in the attitude to corporate lingo, and the approach to using mother tongues at work. In some organizations, the violation of linguistic rights takes place as employees may not use their native languages even during situations outside the organizational setting such as private chats in canteens. Linguicism may also be connected with the usage of professional varieties and the issue of understanding. In that case, relying on languages for specific purposes on one hand facilitates communication among experts, but on the other, it limits the possibilities for cross-domain discussion and professional–laymen interactions. Relying exclusively on specialized knowledge in contacts with individuals representing different levels of proficiency may hinder data flows and discussions.

Consumer Linguicism

Consumer linguicism may be visible in the following ways. One is related to the availability of information on products or services only in some languages. Thus, linguistic minorities in a given country may have difficulties in having access to the desired information on merchandise they want to purchase. Linguicism can also be related to the way one selects products. It can be visible, for example, in linguistic branding of products. For example, products having foreign names may be associated with some features such as quality, rich taste, reliability, and so on. Thus, some products may be perceived as worse just because of the name they have and the cultural connotations it leads to. Consequently, some companies change the names of their brands because rebranding guarantees a better image of a company in the eyes of stakeholders.

Media Linguicism

Media linguicism is related to the tendency of using one or some languages in modern media. Taking into account the growing role of the Internet in the reality of the 21st century, online linguicism can be observed. It denotes situations when only one or a group of languages are used in online communication, thus the speakers of other languages cannot take part in online discourse. In this case, language works as a barrier to participating in online communities. Language is also crucial for homophily and heterophily in online networks. In the case of homophily in online networks, language serves as a tool of creating such networks. Heterophily in online communication is connected with the participation of diversified individuals in web communities. In this case, participation in such networks is open to people regardless of the language they use. Heterophily can be connected with the participation of people speaking different languages or dialects, or it can be linked with the type of language for specific purposes used. In the second case, it may involve the usage of a professional lingo, understood exclusively by specialists representing the same job.

Methods to Overcome Linguicism

There are various ways of limiting the power of linguicism. Taking into account the cultural dimension, it involves education about culture and training in intercultural communication. Analyzing the linguistic level, attention should be paid to the selection of linguistic tools, in private and social life, including all types of linguistic representation. In addition, proper linguistic policy at different levels (individual, organizational, and national) is required to overcome linguicism and foster communication in a linguistically and culturally diverse setting. Efficient linguistic strategies should concern different spheres of life and involve both offline and online communication.

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See Also: Accommodation; Communication Styles, Ethnic and Cultural Differences in; Cultural and Linguistically Appropriate Services Standards; Language Assistance; Learning Disabilities, Services for Individuals With.

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Literacy Testing

Voting is one of the most important ways in which individuals engage in a participatory democracy. However, the right has not always been equitably applied among America's diverse populations. Over the course of the 20th century, unfettered access to the ballot became a key issue in the struggle for African American civil rights. Literacy testing and other restrictive measures were part of a concerted effort to disenfranchise African American voters.

Historically, literacy testing refers to the government practice of administering a test to potential voters in order to determine their literacy and authenticate their understanding of the civic process. Theoretically, the registration practice of literacy testing was to be applied to both white and black voters who could not prove a certain level of education. However, the tests were disproportionately given to black voters, many of whom were unable to read. Indeed, during the 1890s—when the use of literacy testing became more widespread—40 to 60 percent of African Americans were illiterate, compared to only 8 to 18 percent of whites. When used this way, the practice of literacy testing became an integral part of the larger process of voter disenfranchisement and sociopolitical exclusion that occurred after the passage of the Fifteenth Amendment that gave African American men the right to vote. Although literacy testing has its roots in the 19th century, the practice had a long life span and was not outlawed until the passage of the Voting Rights Act of 1965.

Victory and Violence

The Emancipation Proclamation and the Union victory in the Civil War marked a period of intense optimism for African Americans. The hopes of freedom were made tangible in 1867 and 1868, when African American men were among the many delegates in attendance at the constitutional conventions in the southern states. Each of the former Confederate states held conventions to create new state constitutions. The African American delegates included former slaves, Union Army veterans, and skilled laborers. Some of these delegates went on to serve in political offices in the following years. All of the delegates, both black and white, were united in their hopes of creating new state constitutions. A key provision in these new constitutions was universal suffrage, which granted all men the right to vote. The elections to ratify the new state constitutions began in 1867, and each state elected an African American to political office.

The African American presence in politics was short-lived. During their tenure, African American Reconstruction-era politicians had an impact on a range of issues, including education and industry. However, because they were often in the minority, they were therefore unable to enact large-scale civil rights initiatives. African American politicians and voters faced a rising tide of white supremacy tactics designed to scare them from political discourse and discourage any attempt at social equality. The Ku Klux Klan was founded in 1866 and immediately began a program of extreme violence and voter intimidation. In an effort to protect voter rights, the federal government passed the Fifteenth Amendment in 1869. The Fifteenth Amendment guaranteed voting rights for all African American men with the following words: "The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any state on account of race, color, or previous condition of servitude." The amendment was ratified in 1870 and was viewed as a hard-earned victory in the struggle for citizenship and civil rights.

Testing the Limits of the Fifteenth Amendment

The ratification of the Fifteenth Amendment did little to discourage white Democrats who wanted to debilitate African American voting rights, and by the 1890s, southern states had perfected their use of exclusionary practices. In most cases, county clerks and election registrars applied the rules in a way that privileged white voters. The use of literacy tests, poll taxes, and convoluted registration processes could indeed have an impact on illiterate white voters; however, the targeted application of these rules to African American voters made clear that the intent was to obstruct African Americans' civic participation.

Consider, for example, Mississippi's response to the new legislation. Mississippi law required that all voters be literate. However, illiterate men could still qualify to vote if they indicated their understanding of sections of the constitution if it were read to them. Given the nature of southern social relations, it was also understood that election officials would accept white voters' understanding of the passages. Louisiana officials also found a way to protect white voters from the literacy test through the use of the grandfather clause. The grandfather clause stated that only men who had been eligible to vote prior to 1867—or whose father or grandfather had been eligible—were able to vote. Given that almost no African American men would have been eligible to vote, the grandfather clause, in conjunction with literacy tests, was successful in diminishing the African American vote.

The composition of the literacy test often varied from state to state; however, there were some key components that the tests had in common. For example, all literacy tests were designed so that the test taker would fail. In many cases, the questions were unanswerable (e.g., how many bubbles are there in a bar of soap, etc.). Some questions were so abstract that only a scholar or lawyer would be capable of providing a sufficient answer, as was the case in tests that required the taker to explain complex sections of the Constitution. Other questions were intentionally ambiguous and could be answered any number of ways, thereby guaranteeing that any answer could be considered wrong. Some of the tests had to be completed in as little as 10 minutes despite the fact that many were four pages long. Any single wrong answer would constitute a failing grade.

The Struggle Continues

Despite the persistence of Jim Crow laws, African American civil rights activists continued to protest voter suppression and inequality. The battle for the ballot exemplified the extreme lengths to which southerners would go in order to maintain their power. Civil rights organizations such as the National Association of Colored People and the National Urban League, founded in 1909 and 1910, respectively, helped lead the struggle for equality. In 1920, the passage of the Nineteenth Amendment served as a watershed moment in American history. The Nineteenth Amendment gave women the right to vote, and as a result, African American women joined in the struggle to protect their rights to suffrage.

The Southern resistance to African American voting rights intensified during the early decades of the 20th century. The 19th-century exclusionary practices were still in place, but throughout the Deep South, officials began a more active campaign of economic harassment. The creation of White Citizens' Councils throughout the south added to the existing resistance to African American civic participation. These organizations were comprised of local businessmen—landlords, employers, and bank officials—who would exact economic revenge against African Americans who attempted to vote or achieve some semblance of equality. As a result, potential voters could be fired from their jobs or evicted from their homes if they registered to vote. The Ku Klux Klan also participated in a range of violent activities that was meant to deter African Americans from registering to vote.

Some states' voter registration policies were more egregious than others. For example, the registration and literacy testing in Alabama was particularly onerous. The Alabama Registrar's office was only open for a few hours every other Monday of the month, thus requiring potential voters to leave work in order to register. In the event a white employer approved the time off, they would likely suffer some form of punishment from the Citizens' Council. This particular state test included a section that required the applicant to read aloud from the Constitution. The test also included a set of general questions about state and national politics. In an effort to counter the ever-changing rules of engagement, civil rights activists began to collect different versions of the test in order to help potential voters. Activists opened citizenship schools to prepare registrants to pass the test. These schools were also committed to teaching the adult students about the meaning of citizenship, justice, and freedom.

The abolition of the literacy test and other discriminatory voting practices was a signature feature of the civil rights movement. After a series of court cases that called into question the validity of the literacy tests, Congress abolished literacy tests in the south with the Voting Rights of 1965 and nationwide in 1970.

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See Also: African Americans; National Urban League; Race, Social Definitions of; Racism, Long-Term Effects of; Slavery and Lasting Cultural Effects of Social Biology/Biological Determinism; Voting Rights Act of 1965.

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Locus of Control, Cultural Differences in

Locus of control is a theory proposed by psychologist Julian B. Rotter in 1954 and has become an important aspect of social psychology. Locus of control was derived from the social learning theory that says an individual learns based on the history of reinforcement. The word *locus* is Latin and means "place" or "location." Locus of control refers to the extent to which individuals believe they can control the events in their lives. A person's locus can either be internal or external, and someone who is able to maintain a balance between the two is often reported as being happier in life. When individuals are able to acknowledge what is within their control and what is not, they are more able to maintain a balance between the internal and external locus of control. A large amount of research dealing with locus of control has summarized the different variables that have been linked to this personality theory. Ultimately, this theory focuses on the extent to which individuals believe that events that impact their lives are reinforced by their own behavior.

Internal Versus External Locus of Control

As a part of a social learning theory, Julian B. Rotter believed that an internal or external locus of control is an important part of who you are as an individual—a part of your individual personality. As a person develops from infancy through childhood, behaviors are learned by receiving reinforcement from his or her caregiver. Throughout development, children will learn that their behavior influences reinforcement or reinforcement influences behavior. This experience influences the development of future behavior in almost all situations and creates an expectancy of whether reinforcement is internally or externally controlled.

Individuals with a high internal locus of control believe that they influence or control the events in their lives. They have better control of their behavior, tend to exhibit more political behaviors, and are more likely to attempt to influence other people than those with a low internal locus of control. Individuals with a high internal locus of control are also more likely to assume that their efforts will be successful and are more active in seeking information and knowledge concerning their situation. They also tend to be more self-reliant and take pride in their victories while feeling shamed when defeated.

On the other hand, people with a high external locus of control believe that outside factors (i.e., luck, fate, or other people) influence or control their decisions and events in their lives. They are more likely to lower their goals and expectations, whereas an individual with a low external locus of control would work for achievements and set long-term goals for him- or herself. As part of his theory of locus of control, Julian Rotter proposed that individuals with a high internal locus of control tend to be higher in achievement motivation than those with a high external locus of control.

Some research attention has been directed toward whether people from different cultures vary in locus of control. For example, Asian Americans, African Americans, and Native Americans from upper and lower socioeconomic classes do not have identical world views. Moreover, research in the area suggests that locus of control has been a useful concept for researchers in a cross-cultural field of human services. Ethnic groups within the United States have been compared on levels of locus of control, and African Americans are more external than Caucasians—even within a controlled socioeconomic status. Rotter proposed three potential sources for the development of an internal or external locus of control: cultural differences, socioeconomic differences, and variations in styles of parenting. Finally, he affirmed that those with a high internal locus of control are more likely than externals to (1) learn information about their lives based on their behaviors and make better decisions in the future, (2) commit to change and improvements in their lives, (3) place value on inner achievement, and (4) are less likely to be manipulated by others.

Locus of Control and Cultural Oppression

The field of human services encompasses meeting human needs across cultures and acknowledging cultural differences. These expectations seem especially applicable when various racial and ethnic minorities are discussed within the context of community mental health, counseling, and social work. The issue with understanding an individual's worldview in the field of human services has not been adequately discussed. Furthermore, research fails to address differences in worldview that individuals within a minority group may hold. A worldview can be defined as how a person perceives his or her relationship to the world. In addition to racial and ethnic minorities, economic and social class, religion, and sex are also components of a worldview.

Maintaining a commitment to improving the overall quality of life in individuals within diverse populations includes but is not limited to a critical analysis and understanding of cultural differences. While cultural upbringing and life experiences are highly correlated with worldviews, it is important to recognize the effect culture has on how an individual thinks, makes decisions, and experiences events in his or her life. Overall, human services professionals without awareness of their own cultural biases, and that of the people they serve, may be engaging in cultural oppression—when an individual imposes a particular worldview upon people of different cultures. On the contrary, culturally effective personnel are able to contribute a range of knowledge that is consistent with lifestyles and values of a culturally different population.

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See Also: Cross-Cultural Knowledge; Cross-Cultural Service Models; Cultural Competence, Human Service Providers and; Cultural Competence, Professional Standards of; Life Skills Training; Multiculturalism.

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Longitudinal Studies on Aging

Longitudinal studies on aging involve repeated observations of the same variables over long periods of time, usually at regular intervals (two to three years), and they study trends, life events, and general life experiences across the life span. Although they do not have the strength of experimental designs in terms of building a case for causality (they observe; they do not manipulate situations to study the effect), they are stronger than cross-sectional studies as, in following the same people over time, they may track incidence as well as prevalence of events; rely on current reported rather than recalled information; offer more opportunity to control for, or at least identify where there may be, unobserved individual differences; and consider a time dimension to observations of how differences in people's resources (financial and personal), lives, and experiences translate into different outcomes in older age. A particular focus of many longitudinal studies on aging is identifying the predictors of both onset of disease and types of disease progression. There is also an opportunity to understand if phenomena (e.g., impact of life events) are of short- or long-term duration.

The type of information gathered in longitudinal studies, therefore, is of interest to human services, often helping identify the most salient modifiable factors in disease and disadvantage that human services may then target, including those that are most relevant to diverse populations.

Longitudinal studies are usually either cohort studies or panel studies. Cohort studies sample a cohort, defined as a group experiencing some event (e.g., persons who have experienced a heart attack or a particular age group) within a particular time band and then gather related data (e.g., variables potentially associated with onset of additional heart attacks or success in return to normal functioning) at intervals over time. Panel studies sample a cross-section of a population (a random sample, a particular geographic or sociocultural group, or a professional group such as nurses) and then have members of the panel (who present a range of circumstances and experiences) complete questionnaires and other measures at regular intervals. The target population for a longitudinal study may be individuals or may be households. There are also retrospective longitudinal studies, for example, studies using medical records that look back in time trying to understand trends or to identify common markers in people's histories that may explain outcomes, particularly medical outcomes, in their later lives.

Examples of such studies include the oldest longitudinal study on aging (www.blsa.nih.gov), focused on understanding changes due to normal aging and those due to disease or other causes, and the Health and Retirement Study (HRS, hrsonline.isr.umich.edu). In HRS, data on physical and mental health and health care utilization, on living situations, and on financial and social support resources are available and are being collected over regular intervals. Other studies target more specific health concerns; for example, the Framingham Heart Study (http://www.framinghamheartstudy.org) is focused primarily on cardiovascular disease and the Nun Study on Alzheimer's disease (http://www.mc.uky.edu/nunnet); or particular populations, for example, the Nurses' Health Study looking at women's health over time (http://www.channing.harvard.edu/nhs/history/index.shtml). Several studies have included the collection of biomarker material and informed the development of subsequent longitudinal studies in the United States and other countries. In particular, there has been a more prominent featuring of anthropometric measurement (e.g., http://www.ifs.org.uk/elsa), collection of genetic materials (e.g., www.tilda.ie), and the inclusion of unique populations such as in P. McCallion's Intellectual Disability Supplement to the Irish Longitudinal Study of Aging.

Findings

A recent review by D. C. Stanziano and colleagues of 51 longitudinal studies on aging held in a National Institute of Aging database found that such studies fell into six categories.

Cognitive function. Work to date by K. J. Anstey and colleagues reflects strong interest in relationships between age and mortality, but linkages to cognitive decline to changes in health care utilization and to changing social and economic roles remain to be systematically investigated, according to Stanziano.

Socioeconomic status. Here, the interest has been to understand the link between socioeconomic factors and mortality, morbidity, and functional status outcomes. But few definitive answers have been arrived at, and findings of linkages to health disparities, describe S. S. Bassuk and colleagues, have been challenged as not taking cultural differences between participants and their providers sufficiently into account.

Health and physical performance. Physical performance measures have become a key mechanism to gather critical information in ways that do not rely on self-report. However, their use raises concerns as they add significantly to the cost of studies, report H. H. Atkinson and colleagues along with A. B. Newman. A concern that no one measure has emerged as the definitive predictor of ill health and mortality remains a challenge.

Morbidity and mortality predictors. In studies to date, contrary to expectations, measured morbidity appears to be a poor predictor of mortality with little agreement on markers to be studied. There are also calls for greater consideration of the influence of individual behavior, environmental access, and genetic effects on the emerging predictors.

Health care costs. The relationship between morbidity, treatments, positive health outcomes, and costs is proving to be complex, states D. C. Stanziano and colleagues, but many longitudinal studies do not collect sufficient data to be able to understand both the direct (actual costs) and indirect (e.g., consequences of expending resources on treatment services for chronic conditions among older adults rather than targeting the same resources on preventive steps at younger ages) health care costs.

Genetics. Although the collection of blood and tissue samples has been a feature of many longitudinal studies, genetic investigation of causes of aging is a more recent science. Nevertheless, there are promising longitudinal findings (see, e.g., studies by S. Tyas and colleagues on links between the presence of specific alleles and onset of dementia).

Despite limitations in findings, a number of insights have emerged: (1) Longitudinal studies have helped demonstrate that rates of decline vary among older adults, thereby offering the potential for strategies to prevent or slow such decline; (2) the temporal aspect of longitudinal studies has allowed for testing of whether risk factors in wave-one findings (or in other studies) predict later incidence of disease or changes in independence; (3) tracking of biological, socioeconomic, and psychological factors and highlighting their association with subsequent chronic disease has provided insights into risk factors that might be modifiable; (4) mechanisms that are associated with disease progression have been separated from those that predict onset of disease, and both have been tracked over time; (5) disease and disability pathways have been identified; and (6) the contribution of one condition to the emergence or the more rapid advancement of another or multiple conditions has been established. This has led, as J. M. Guralnick and S. B. Kritchevsky, along with A. B. Newman, to common conditions and characteristics being identified that predict both disease and disability as have commonalities in contributors to different chronic diseases.

Key Design Concerns

In the design of longitudinal studies, consideration must be given to the target population, variables that are likely to increase exposure to the phenomena of interest, data that will track outcomes, and variables that are potential confounds. There are five critical questions.

First, how narrow will the focus on outcomes be? A narrow focus will mean fewer questions and measures and therefore fewer burden on participants, but too narrow a focus may mean giving up opportunities to find unexpected outcomes.

Second, how likely are phenomena of interest to occur? This includes consideration of both the time element and frequency of incidence at each time period with resultant implications for sample size (low incidence at each time point may mean larger sample) and duration of the study (long period to occurrence may mean decades rather a decade of follow-up).

Third, how will missing data be handled? In the early days of longitudinal analysis, the loss of participants or incomplete data meant reliance on complete case analysis only, the carrying forward of prior data or reliance on traditional imputation techniques, which all carry costs in terms of the value of the data set and its findings over time. More recently, there has been consideration of missingness (completely at random, at random, and not at random), reliance on modeling frameworks and inferential paradigms, consideration of situations where missing data may be ignored, and greater reliance on sensitivity analysis; all of which are more possible with advances in statistical software, according to J. G. Ibrahim and G. Molensberghs.

Fourth, how will dropouts and deaths be handled? A longitudinal study of aging is necessarily of a vulnerable population over time, meaning that deaths are likely. Indeed, the occurrence of deaths is an outcome measure of interest. At some point, there is a risk for other outcomes of interest or that there will be too few members of a subgroup of interest, and in extreme cases as the time period advances for the sample overall, the same risk exists for the analyses contemplated. Most importantly, the loss of subjects introduces the potential of biased inferences. There are a range of statistical techniques to at least monitor if not manage such bias, and it may be necessary to replace missing subjects if the study is to continue. Often, replacement subjects are selected using the same techniques as the original sample, and again, report Y. Deng and colleagues, there are statistical techniques to identify and manage any potential resulting biases.

Fifth, what are the ethics of measurement? Normal expectations for the obtaining of informed consent for participants apply, but there are additional concerns over time in longitudinal studies of the aging that capacity to give consent may change. Another concern is that data gathering, whether by questionnaire or physical measure, may identify issues of concern (e.g., scoring as depressed on a standardized screening measure or having an extremely elevated blood pressure reading). Protocols are usually available in longitudinal studies for both monitoring of safety during interviews and for reporting clinically significant findings to the participant.

Limitations of Longitudinal Designs

The broad range of variables gathered in longitudinal studies is often important to gaining an understanding of both predictors and risk factors and of potential confounding factors, whether for the onset of disease conditions or for advancement of quality of life. Risk factors for disease in particular may lead to greater mortality or dropout for those at risk over time and greater representation of the risk factor in those lost to follow-up, resulting in the potential for bias in findings. Also, the contribution to the understanding of confounding factors is only as good as the variables included. Indeed, the unintended absence or poor measurement of what turns out to be a major confounding factor may instead mean that research is encouraged around the wrong factor or the strength of a confound is misunderstood. Finally, the experience of illness over time may have a direct or indirect effect on the risk factor, further influencing bias in findings about that risk factor.

Next Steps in Longitudinal Research Are Emerging

Probably one of the most significant aspects of longitudinal studies on aging has been their evolution. From a focus on understanding of predictors of ill health and challenged quality of life, they have moved to understanding exceptionalism, describe P. McCallion, R. Tappan, and J. G. Auslander: What is different about the person who lives to advanced old age without ill health? Does living longer equate with having quality in longer life? What is the aging experience of diverse groups? Are there steps we can take that may be demonstrated as resulting in changed health behaviors, which in turn result in improved health? What is the impact of new phenomena in older adult lives such as grandparent caregiving, intergenerational exchanges of resources, absence of children able to provide family caregiving supports? What are the contributors to and the significance of increased longevity among adults with lifelong disabilities or with multiple chronic conditions? What do we need to know about the interrelationship between health status, health care access, use and abuse of health interventions, hospitalizations, and health care costs.

These questions are influencing the development of supplemental and alternative questions in existing studies and influencing the establishment of new cohort and panel studies.

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See Also: Agency for Healthcare Research and Quality; Aging and Adult Services; National Institute on Aging.

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Long-Term Residential Care

Long-term care (LTC) integrates a variety of services, both custodial and medical, to meet the needs of people suffering from disability or chronic illness. Most LTC patients are not able to care for themselves over long periods of time, sometimes temporarily, but most often permanently. Although most LTC is provided in the home or community day programs, residential programs such as assisted living facilities or nursing homes continue to grow. According to the Centers for Disease Control, life expectancy continues to increase in the United States as birth rates fall. With the aging of the U.S. population, both the demand and cost for LTC will continue to accelerate.

Although numerous factors impact the overall cost and various types of programs and services are available to assist with LTC services, the critical concerns to the LTC experience are the communication among patients, informal caregivers (often family), and health care providers. The following presents a description of (1) two types of LTC, (2) three delivery categories for LTC, (3) LTC costs, and (4) the role of communication studies in LTC.

The most common form of LTC is custodial care or help with the basic activities of daily life (ADL). Custodial care includes nonmedical activities such as bathing, grooming, using the toilet, preparing meals, housekeeping, and eating. Most custodial care is provided at no fee by family members, friends, or volunteers. The U.S. Department of Health and Human Services (USDHHS) estimates that 80 percent of caregivers are unpaid, and more than half have extensive or intensive care responsibilities. Community groups and service organizations offer entertainment, transportation, and meals for no, or a small, fee. All types of custodial care can also be provided by paid caregivers, both in the home and in residential facilities.

Medical LTC is generally provided by a skilled health care professional and can include functions such as skilled nursing, drug administration, and occupational and physical therapies. Skilled professional health care services such as oxygen, feeding tubes, or serial injections are often prescribed by a doctor or nurse practitioner and administered by trained caregivers. However, more and more frequently, unpaid caregivers, such as family members, provide such care as well. Additionally, home health care service companies and community organizations frequently offer various forms of medical LTC. Most residential facilities also provide some level of medical LTC ranging from 24-hour supervision to minor medical care.

Delivery of LTC is based on any combination of three methods: home based, community based, or facility based. Home-based care includes support services allowing the patient to remain as independent as possible while staying safe and healthy in a home. Most home-based care is provided by unpaid caregivers such as family members, friends, or volunteers; however, professional home-based services

A commonly recognized, facilities-based, long-term residential care option is a nursing home. Nursing homes provide skilled nursing and professional medical services as well as long-term, advanced custodial care. Nursing home residents may have private or shared rooms, and Medicare may provide some coverage based on a resident's income eligibility.

are available. Home health care providers offer medical LTC such as skilled nursing and drug administration. Homemaker services offer custodial care such as housekeeping, meal preparation, bathing and grooming, and other household labors. For those patients who live alone or have little human interaction, companion services offer short social visits. Finally, emergency response services offer professional response to medical emergencies like a fall.

Community-based care can be provided by local government, social services agencies, or privately funded companies. Senior centers, adult day care, transportation and meal services are typically offered on weekdays. Most community-based services are available at low cost, while others are free. Although some community-based services are restricted to those with low incomes, specific disabilities, or other limiting factors, many are available to all. Those needing these services can find help through the local Area Agency on Aging, the USDHHS, or primary care health providers.

Four primary types of facilities-based options are available. First, public housing is available to low- and moderate-income persons who are elderly or disabled. This subsidized housing option is available by applying to federal or state government programs. According to the USDHHS, most eligible persons have annual incomes of less than $46,000, while married couples have an annual income of less than $53,000. Services can include custodial and medical care. Second, assisted living is an available and growing option for those who need limited help with daily activities but desire to remain somewhat independent. Both custodial and limited medical care are included in this context. Select basic services are included in monthly rent, while supplementary services are available at additional fees. Residents generally live in individual units but often share meals and social activities.

A commonly recognized facilities-based option is the nursing home. Nursing homes provide skilled nursing and professional medical services as well as long-term, advanced custodial care. Nursing home residents may have private or shared rooms, and Medicare provides some coverage based on the resident's income eligibility. When entering a nursing home, persons can feel the loss of basic rights, privacy, and dignity; therefore, the Nursing Home Bill of Rights is mandated for all Medicare- and Medicaid-funded facilities. Notorious for institutional-style care, nursing homes are undergoing a recent culture change, stressing patient-centered care, hospitality, and customer service directed toward patients and their families.

Finally, continued care retirement communities (CCRCs) offer a tiered approach to long-term care that often provides great comfort to elderly or disabled persons and their families. Care is planned out for the long-term, from independent apartment living to skilled professional medical services, depending on the client's ability to care for him- or herself. Healthy persons may live independently in a single-family home or apartment then move to assisted living and, finally, to skilled nursing as their care dictates. CCRCs are the most expensive form of long-term care, with costs varying based on the general health and cognitive ability of the person, type of unit desired, and care needed. According to the American Association of Retired Persons (AARP), CCRC residents generally have three contract options: life-care contract, modified contract, and fee-for-service contract. Although the most expensive option, the life-care contracts offer unlimited services without additional charges. The modified contract offers specific services for a set fee for a particular time. After that specified length of time, fees are renegotiated. Fee-for-services contracts offer custodial and medical services at variable market rates.

Beyond the structure and administration of long-term care, human diversity and multicultural approaches to long-term care services have received heightened attention in recent years. Recipients of long-term care are growing in diversity as the same population expands. Health and social services workforces related to long-term care are also growing in numbers and becoming heterogeneous. Medical practitioners and program administrators are now challenged with assessing the cultural appropriateness of their organizations, both in the workforce and in those they serve.

Culturally sensitive care demonstrates respect for all participants and takes into account traits such as ethnicity, religious beliefs, education, and socioeconomic status. These traits all influence one's approach to health concerns and the types of services desired. Long-term care providers are increasingly striving to position a diverse workforce as a strength and offer useful products and services to multiple market segments regardless of ethnicity, religion, or education.

It is important for patients and families to consider the costs and funding of long-term care. According to the USDHHS, consumer surveys prove there are scores of misunderstandings regarding who pays for long-term care. Medicare only pays for skilled medical long-term care for a limited period of time. It does not pay for any custodial care. Medicaid pays for much of medical and custodial long-term care; however, persons must meet income maximums and other state and federal eligibility requirements. Multiple other federal- and state-funded programs exist, all with eligibility and population membership requirements. Private insurance companies' health insurance plans pay for those services generally covered by Medicare for short periods of time. Long-term care insurance is also available from private insurance companies and covers many types of custodial and medical care in a variety of delivery facilities. Such policies are subject to eligibility requirements such as general health at the time of application and preexisting conditions. Care providers can direct patients and families to a variety of models and examples of long-term health care plans at agencies including the USDHHS and AARP.

Communications

Several communication theories have been applied to study the communication challenges embedded in long-term health care communication. Social constructionism, detailed by Peter Berger and Thomas Luckmann, explores the objective, scientific voice of medicine and the subjective, humanistic voice of patients and families. Leslie Baxter's dialectical theory provides a framework for investigating fluctuation and tension within relationships during a health care crisis. Dale Brasher's uncertainty management theory allows for exploration of uncertainty around prognosis, treatment, identity, and social support issues for the patient, family, and health care providers. Sandra Petronio's communication privacy management theory furthers understanding about how patients and family members manage collective boundaries as a means to manage uncertainty, especially about prognosis and terminal illness. Finally, narrative approaches to health care communication can provide in-depth perspectives of patient, caregiver, and clinician experiences.

Effective communication is a vital component of quality LTC services, making it a likely setting for the study of health communication. Vital to all patient populations, decision making and ongoing activity surrounding LTC create an environment for critical communication about patient's desires, goals, and wishes for care central to quality of life. Communication challenges among patients, family members, friends, and health care providers are inherent in the LTC process from beginning to end.

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See Also: Aging and Adult Services; Longitudinal Studies of Aging; National Institute on Aging.

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Low-Income Housing Tax Credits

As cities are revitalized and professionals return to the urban housing market, low-income families are increasingly priced out. To help generate affordable housing stock, the federal government provides the Low-Income Housing Tax Credit (LIHTC) as an incentive. Often pronounced *lie-tech*, it is administered by the U.S. Department of Housing and Urban Development (HUD) and ultimately deployed to for-profit and nonprofit housing developers. Initially intended as a replacement for lost rental housing incentives as part of the U.S. Tax Reform Act of 1986 (TRA86), it has also helped offset the loss of public housing units under HOPE VI (another HUD program). As large-scale housing projects are demolished and replaced by mixed-income developments, LIHTCs are often used by developers to set aside a portion of rental units for low-income households. Without this incentive, these units would be rented at fair-market rates rather than to those with housing vouchers or families in need of below-market housing costs. In the case of mixed-income development, the remainder of the units are rented or sold at fair-market value. This housing model encourages socioeconomic diversity among residents and is viewed as an intervention to high concentrations of poverty.

In 1937, federal housing programs began with the construction of the first public housing project. Designed to create jobs and temporarily house families facing economic hardship, these eventually became multigenerational communities for the poorest citizens, particularly African Americans. Due to underfunding, the infrastructure declined, crime increased, and much-needed human services programs and commerce left. In the 1980s, poverty researchers revealed that public housing was merely warehousing, and people were less likely to become economically self-sufficient. Federal housing policies shifted, and Congress responded. The LIHTC provision encourages the creation of affordable housing by the private sector. Investors receive dollar-for-dollar credit against their federal tax liability for up to 10 years, provided the property remains in compliance.

LIHTC Eligibility and Occupancy Requirements

To receive a tax credit, projects must meet qualification standards. Foremost, it must be a residential rental property. Most often, rental properties are eligible for LIHTC if they also meet HOME eligibility. HOME, another HUD program, provides grants to state and local governments for the sole purpose of increasing housing opportunities for low-income populations and is more flexible than LIHTC. Oftentimes, LIHTC and HOME funds are combined in the same loan package to allow for greater financial leveraging. Once approved, many developers sell the LIHTC credits to investors in exchange for capital or equity. With lower debt, housing units can then be offered at below-market prices.

The project must also meet one of the two low-income occupancy thresholds. These thresholds set the minimum number of units that must be rent and utility cost restricted. They also establish the household average median income rule for occupancy. It is noteworthy that only the affordable housing units within the project receive tax credits. Thus, nonprofit developers are more likely to designate higher portions, often 100 percent, as affordable housing. By comparison, for-profit developers will often comply with the minimal percentage in order to offset debt but allow for maximal profit. In order to claim or sell tax credits on a project, the developer must work closely with the allocating agency to assure the eligible basis is calculated correctly.

LIHTC Allocation and Administration

While HUD is the federal agency responsible for implementation and oversight, the Internal Revenue Service (IRS) deploys LIHTC to designated state agencies. This tax credit allocation is determined by the number of state residents rather than poverty levels, cost of living, and demand for quality affordable housing. As such, this has resulted in housing disparities among different geographies throughout the United States. This is a function of economy rather than poor planning on the part of the state or local urban planning agencies. HUD oversight requires each state allocating agency have an approved plan for tax credit utilization. These credits must be deployed within two years of the allocation, or they revert back to the federal pool for reallocation.

The receiving agency is often a quasi-governmental housing finance agency created by the state and granted authority to conduct business of the state. In the case of housing agencies, they undertake various programs to assist with financing of low- and moderate-income housing needs. With a nongovernmental structure, they can more readily work with federal, state, and local government units as well as establish partnerships with banks and lending institutions and for-profit and nonprofit developers. IRS rules require that 10 percent of the tax credit allocation be set aside for nonprofit housing development projects. These nonprofit developers are often community development corporations that use the tax credits to leverage additional funding sources.

LIHTC Impact

As public policy increasingly shifts low-income housing from the government sector to the private sector, LIHTC is crucial for generating affordable housing stock. As much as 90 percent of affordable housing is currently created as a result of this incentive, and since its inception, the LIHTC has helped stimulate almost 2.4 million affordable housing units throughout the United States. This tax incentive not only counteracted the loss of rental housing tax incentives, but it has also helped replace lost public housing units. Although many community development corporations and housing agencies have developed programs to promote low-income home ownership, this population segment is more likely to rent than own. Hence, this incentive is essential for meeting the housing needs of those who fall below the economic norm of an area.

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See Also: Community Development Corporations; Housing Services; Poverty; Quality of Life, Measurement of; Racism, Long-Term Effects of; Social and Economic Justice; Socioeconomic Status; Urban Communities and Human Services.

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Marriage and Family Therapists

Marriage and family therapists provide services in all segments of the mental health care and human services arena, according to the American Association for Marriage and Family Therapy (AAMFT). Included in this entry is (1) a description of a marriage and family therapist, (2) a brief historical context of marriage and family therapists, (3) an explanation of the qualifications needed to become a marriage and family therapist, (4) a discussion of whom marriage and family therapists work with, (5) a description of the type of mental health and behavioral issues that marriage and family therapists often address and treat, and (6) a summary of the settings where marriage and family therapists typically work.

What Is a Marriage and Family Therapist?

While individual therapists focus on the individual and the intrapsychic influences on behavior, the Bureau of Labor Statistics indicates that marriage and family therapists assess, diagnose, and treat behavioral dysfunction, mental illness, and psychological distress within the context of the marriage and family system. Marriage and family therapists have an extensive knowledge of family systems and ascribe to a systems perspective. A systems perspective suggests that families are systems of interrelated and interdependent individuals that cannot be viewed in isolation.

What Is the Historical Context of Marriage and Family Therapists?

The field of marriage and family therapy is relatively new when compared to other health disciplines. M. P. Nichols and R. C. Schartz, two prominent researchers in the field, have written extensively about the history of family therapy and family therapists. They note that, in the 1950s, researchers and clinicians began to make claims that the family and family interactions had an impact on individuals' behavior and mental health. For example, Gregory Bateson, who is often referred to as the founder of family therapy, formed the Palo Alto group in 1956. This group introduced concepts and theories to suggest that the symptoms of schizophrenia could be understood within the context of families. While much of these findings have been disproven over time, the group is credited for their early research into the impact of families on an individual's well-being. Other pioneers of marriage and family therapy include Murray Bowen for his work at the Menninger Clinic and the National Institute of Mental Health. Additionally, pioneer marriage and family therapists, like Virginia Satir, Carl Whitaker, and Salvador Minuchin, are often credited for their early work in the field.

Since the birth of marriage and family therapists, professional organizations have supported and substantiated their work. A. Carr, a well-recognized researcher in the field, writes that the American Association of Marriage Counselors was founded in 1942, later becoming the American Association of Marriage and Family Therapists (AAMFT) in 1978. Currently, the AAMFT continues to be the primary professional association for marriage and family therapists, facilitating research, theory development, and education.

What Types of Qualifications Are Needed?

Historically, marriage and family therapists have come from diverse educational backgrounds including psychology, social work, nursing, psychiatry, counseling, and education. Educational qualifications include either a master's degree (typically two to three years) or a doctoral degree (typically three to five years). Some marriage and family therapists choose to enroll in postgraduate clinical training programs (typically three to four years). After graduation from an accredited program, a period of post-degree supervised clinical experience is necessary before licensure or certification. This is typically two to three years in length. When the supervision period is completed, the therapist is approved to take a state licensing exam or the national examination for marriage and family therapists conducted by the AAMFT Regulatory Boards. This exam is used as a licensure requirement in the majority of states. In fact, currently a total of 50 states have a requirement for marriage and family licensure. However, requirements vary by state. Typically, therapists who are licensed are referred to as licensed marriage family therapists (LMFTs). In order to be eligible for licensure, some states require that the therapist graduate from a program that is accredited by the Commission on Accreditation for Marriage and Family Education (COAMFTE) or a program accredited by Council for Accreditation of Counseling and Related Educational Programs (CACREP). Marriage and family therapists can also practice if they are certified as a national certified counselor (NCC), a licensed professional counselor (LPC), a licensed clinical social worker (LCSW), or a licensed psychologist.

Who Do They Work With?

While marriage and family therapists understand their clients' symptoms and behavioral patterns in a familial and social context, they work not only with the entire family, but with individuals, couples, and groups. The AAMFT indicates that marriage and family therapists can also provide premarital counseling, relationship counseling, child counseling, and separation and divorce counseling.

Marriage and family therapists work with a diverse clientele (i.e., race, ethnicity, gender, age, socioeconomic status, religion, sexual orientation, and disability, etc.). Thus, educational programs are obligated to provide training that facilitates the development of multiculturally competent marriage and family therapists. When working with clients, marriage and family therapists are ethically obligated to employ cultural sensitivity when working with clients. Cultural sensitivity refers to the knowledge, personal awareness, and interpersonal skills that allow providers to work with individuals from cultures other than their own. In addition to cultural sensitivity, marriage and family therapists integrate and incorporate social context into the therapeutic process with all clients. Further, clinicians are encouraged to deliver interventions and integrate helping theories that are sensitive to the unique needs of their clients.

What Issues Are Treated?

There are some struggles that are particularly suitable for a marriage and family therapist. Nichols and Schwartz write that marriage and family therapists are trained specifically to work with issues relating to marriage and other intimate relationships, divorce, and family transitions. Commonly, families with an adolescent will seek family therapy to address the shifts in developmental needs of the adolescent. In addition to these specific issues, marriage and family therapists can also evaluate and treat various mental health disorders and behavioral problems. For example, on a routine basis, marriage and family therapists may work with different client issues such as self-esteem, self-harm, depression, anxiety, grief, anger, and relationship problems.

Where Do They Work?

Marriage and family therapists work in a wide variety of employment areas, with the majority of practitioners providing direct services with clients. For example, marriage and family therapists may work in outpatient care centers, individual and family services, community mental health centers, social service agencies, and the offices of other health care providers. Other common work settings include private practices, inpatient mental health facilities, courts and prisons, schools, Head Start centers, universities, research centers, and health clinics. Further, some marriage and family therapists may work for health maintenance organizations, employee assistance programs, and business and consulting companies. While most segments of the health care arena have been mentioned, approximately half of all marriage and family therapists work in private practice. One-quarter of marriage and family therapists are located in institutional or organizational settings, and the remaining clinicians practice in both.

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See Also: Counseling and Psychotherapy Services; Family Services; Marriage and Family Therapy.

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Marriage and Family Therapy

Marriage and family therapy, also known as couples and family therapy, is a specialty field of psychotherapy that works to achieve a diverse range of therapeutic goals involving individuals, couples, groups, and families. This branch of therapy focuses on intimate and family relationship dysfunction, emphasizing and promoting healthy dynamics, frequently from a systems perspective. The systems perspective sees couples and families as interconnected parts of a system that cannot be treated in isolation from each other. While marriage and family therapists are trained to deal with many mental health concerns, such as depression, anxiety, or substance abuse, the focus of this specialty is on relationship counseling, premarital counseling, separation and divorce counseling, and child counseling.

Whether the problems identified in sessions focus on one individual or the entire family, marriage and family therapy generally operates from the perspective that family involvement contributes to the development of solutions and healing. The models and theories common to marriage and family therapy, such as Salvador Minuchin's Structural Family Therapy, have had wide-reaching influence on the field of human services for adults and children and can be found in practice in many clinical settings such as outpatient counseling, in-home services, juvenile justice programming, and inpatient care. There are wide ranges of clients interested in receiving couples or family counseling, which requires therapists to be competent in multicultural and diversity counseling skills. For example, clients for marriage and family counseling can come from broad socioeconomic backgrounds or diverse ethnic heritage, sexual orientations, or ability statuses. In addition, the definition of family within the field has expanded beyond the traditional concept of parents and their biological offspring. Today, families can be defined by supportive, caring, and committed roles and relationships among individuals who may or may not be connected through biology or a legally binding commitment.

Professional Training of Marriage and Family Therapists

Most professional mental health clinicians have some basic training in marriage and family counseling; however, specific training is needed to become a certified or licensed marriage and family therapist. Specialty training for marriage and family therapy usually includes a master's degree focused in this area or additional coursework beyond a master's degree in fields such as counseling, psychology, or social work. While states differ on the qualifications needed for certification and licensure, in general, one must have a master's degree in counseling (or a closely related field), receive specific training in couples and family counseling, complete 3,000 hours of internship under a licensed professional in the field, and pass an approved state exam to qualify as a Marriage and Family Therapist (MFT) or a Licensed Marriage and Family Therapist (LMFT). A key component of quality marriage and family training programs is the emphasis on working with multiculturally diverse populations. Marriage, couple, and family makeup displays a broad range of diversity within society, and it is essential for marriage and family therapists to accept all clients with dignity and respect and have the training necessary to work with diverse populations.

There are two main professional organizations devoted to marriage and family therapy: the American Association of Marriage and Family Therapy (AAMFT), with more than 25,000 members in the United States, and the smaller International Association of Marriage and Family Counselors (IAMFC), a division of the American Counseling Association (ACA). Both associations are committed to supporting the work of marriage and family therapists via research, training and education, standards setting, and advocacy efforts on the local, regional, national, and international levels.

The Practice of Marriage and Family Therapy

Marriage and family therapy shares many of the core psychotherapy and counseling techniques basic to master's and doctoral-level training in counseling, psychology, social work, and related fields. These core techniques include skills like unconditional positive regard, usage of summarizing and paraphrasing, empathy, and developing a strong rapport or therapeutic bond with clients. Family therapy in many ways looks like other forms of therapy and shares similar time limits (45, 60, or 90 minutes) and duration (generally five to 20 sessions). Family therapy is regularly conducted in the same clinic, office, or agency as individual and group therapy. Additional techniques specific to marriage and family therapy are often incorporated into the counseling process; these approaches encourage family member interactions, highlight connections between family members, and promote input from each member present. The primary distinguishing feature of marriage and family therapy is the emphasis on problems being interrelated with others rather than within the individual independent of others. However, marriage and family therapists from certain theoretical perspectives, such as psychodynamic, may also emphasize the compounding impact of internal individual client dynamics on family systems. Regardless of the theoretical orientation of the counselor, marriage and family therapists focus their work on the dynamics among individuals.

Some couples and families may enter this form of therapy expecting to focus on one problem individual, often called the identified patient or scapegoat. Marriage and family therapy works to generalize problems and solutions to the couple or family group rather than just this identified patient. Thus, marriage and family therapists align with the systems viewpoint, understanding problems do not happen in isolation in families and require work within the entire couple or family system to achieve solutions.

Marriage and family therapy can occur in many different settings beyond the traditional outpatient clinic. The approach has been frequently used for in-home services, where the family counseling sessions are provided in the naturalistic environment of the family's home. This approach to family therapy allows for the viewing of problems and solutions through the lens of the environment in which they occur. However, providing in-home family counseling can present unique challenges to therapy. For instance, distractions are more difficult to anticipate and control in a home setting as opposed to the confines of an outpatient office. Depending on the theoretical background of the therapist, these challenges may be worth confronting in order to develop the most appropriate treatment to complex relational problems. Other therapists prefer to focus their work in the traditional outpatient office environment.

Family and couples therapy is often incorporated as a component to inpatient counseling, either for psychiatric hospitalizations or for substance abuse treatment. Families, spouses, children, or significant others may be invited to family days or to special couples and family sessions in these therapy settings. Understanding the client individually through one-on-one counseling, interpersonally through group counseling, and as part of a family unit through marriage and family counseling allows for a holistic approach to treatment in these settings.

Marriage and family counseling is also incorporated into pastoral or spiritual counseling, especially when connected to premarital, separation, or divorce counseling. Whatever the setting or the focus of treatment, marriage and family therapy works to resolve dysfunctional symptoms and problems occurring within the context of intimate and familial relationships.

Marriage and family therapists are encouraged to embrace diverse populations regarding race, ethnicity, gender, sexual orientation, religious or spiritual beliefs, ability status, socioeconomic status, veteran status, and other diversity categories. Couple, marriage, and family definitions are diverse within society, and marriage and family therapists need to be appropriately prepared to provide quality services to all clients, regardless of diversity or multicultural differences. This includes self-awareness about conceptions of marriage, families, and couples; understanding of the multiplicity of diverse families; and culturally competent skills to work with that diversity.

Key Theorists and Ideas

Several key therapists and theorists have had broad influence on the field of marriage and family therapy. Some of these individuals include Virginia Satir, Salvador Minuchin, Gregory Bateson, Murray Bowen, and Carl Whitaker. The models, principles, and techniques these pioneers developed stretch beyond marriage and family therapy to influence the larger field of psychotherapy as well as the fields of human services, education, communication, coaching, and even business management.

For example, Structural Family Therapy, developed by Salvador Minuchin, looks at important concepts such as disengaged (or disconnected) family members versus enmeshed (or overly entangled) family members. His model of therapy charts the relationships among family members emphasizing boundary issues and power dynamics. Structural family therapists attempt to alter family dysfunction and aim to create healthier patterns of interaction.

Murray Bowen, a main contributor to systemic therapy, also emphasized key components of dysfunction that occur in family relationships. He used the term *triangulation* to describe the process where two family members who have problems with each other will pull in a third family member in an attempt to resolve their problems by shifting focus or blame. This unhealthy triangle places two people on the inside of the problem and one on the outside, thus two individuals experience conflict as the third individual can step outside the triangle and observe. Family members caught in this triangle may unconsciously work to become the member on the outside, shifting back and forth depending on perceived benefit of the position. Rather than dealing directly with problems, this process permits family members to reduce anxiety and avoid confrontation or resolution of the real problem.

There are many other important pioneers like Satir, Bateson, and Whitaker, who contributed to the field of marriage and family therapy by considering factors such as the influence of low self-esteem on relationships and the contribution of families on individual well-being. Each theorist left a distinct mark that influences newer models of therapy, such as Multisystemic Therapy, an approach that incorporates systems theory and in-home family therapy to work with teens at risk of out-of-home placement due to delinquency or family problems (i.e., neglect or truancy). Many other models exist that incorporate ideas from marriage and family therapy theorists and techniques.

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See Also: Association for Multicultural Counseling and Development; Family Therapy; Marriage and Family Therapists.

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Marriage Counseling

Historically, marriage counseling in the United States was an outgrowth and extension of individual psychotherapy and occurred at the approximate time of the advent of family therapy. Like individual psychotherapy, models of marriage counseling traditionally favored Eurocentric and Caucasian worldviews. Although this has changed considerably—with modern marriage counselors employing a diverse range of theories and taking multicultural course work and continuing education addressing characteristics such as race, ethnicity, gender, and sexual orientation—marriage counselors must strive and are expected to become multiculturally competent. This is true whether they operate in either private practice or within agencies, centers, or institutes devoted to better understanding of communication and interactional patterns between married spouses or partners.

Private practitioners generally operate out of offices and counsel those who have the means to pay for counseling treatment out of pocket or are reimbursed by third-party private health insurers. Marriage counselors working within agencies, centers, or institutes often provide counseling to underserved populations and those with fewer means to pay for services based upon what is termed a sliding-fee scale. This takes into account the number of household members and income, which results in low or no fees whatsoever to the clients themselves offset by state or federal grants to meet the needs of the underinsured and those traditionally requiring supportive assistance. Those operating in the public sector may be more apt to encounter marriages with multiple problems exacerbated by the lack of community or familial support. Those marriage counselors operating in private practice may well encounter similar situations; however, counseling emphasis may be placed upon the primary problem rather than secondary supportive functions. Regardless of whether one serves in a private or public practice capacity, he or she will encounter myriad presenting problems and marital issues in need of resolve.

Marriage counseling may be performed by many different mental health professionals, be they a clinical social worker, psychologist, or counselor.

Professional Training of Marriage Counselors

Marriage counseling may in effect be performed by many different mental health professionals, be they a clinical social worker, psychologist, or counselor. The major difference is the focus of services, theory adhered, and educational background. Regardless, each respective professional may offer formalized marital counseling and psychological assistance. Although some universities offer specialized tracks or degrees in marriage and family counseling particularly at the doctoral level, generally a master's degree with supervised practicum or internship in clinical mental health counseling or marriage and family therapy is all that is required. Both mental health counselors and marriage and family therapists post-degree must be subsequently clinically supervised for a specified period of time and number of client hours, pass a state-recognized national examination, and complete annual continuing education requirements in order to become licensed, which is a requirement to practice. Further, in order to receive third-party reimbursement from health care providers, practitioners must be fully or provisionally licensed (i.e., undergoing required supervision). Noteworthy, at present, is the fact that licensed professional counselors and marriage and family therapists are unable to be reimbursed by Medicare, whereas licensed psychologists and clinical social workers are covered by current legislation. While marriage counseling may appear to be less emotionally demanding than providing family therapy itself, marriage counselors enter into a unique counseling relationship with the spouses and as such are aware of certain intimate marital aspects of their clients' lives perhaps unknown to others, which may necessitate utmost care and concern as well as mandate ethical and professional practice.

Of particular note is that marriage counseling and marital therapy are relatively newer fields, thus other disciplines such as social work and psychology may be better known to potential clients or consumers. Therefore, it appears omni-important for marriage counselors to become advocates for their specialty as well as align themselves with professional organizations such as the American Counseling Association (ACA) and American Association for Marriage and Family Therapy (AAMFT) as well as respective core social and cultural diversity competencies such as utilizing culturally sensitive approaches and delivering interventions that address special needs of clients (e.g., culture, gender, age, socioeconomic status, disability, and couple and family makeup). By maintaining professional linkages, becoming apprised of relevant competencies, and staying connected, marriage counselors and therapists may contribute to the ongoing dialogue and take part in the evolution of the fields, which are ever transforming.

More than ever, with the purported high divorce rates, it is vital that marriage counselors also advertise services by varying means available to effectively compete with other service providers. Furthermore, although marriage counseling and marriage therapy is at times used interchangeably, some construe marital therapy to be more intensive versus marital counseling. This would seemingly appear dependent upon the theoretical orientation and methods and techniques employed by the practitioner him- or herself. By way of example, a marriage counselor or therapist for that matter might choose to examine the long-term origins of the marital discord by focusing upon historical family systems and generational dynamics, whereas another may be inclined to focus on shorter-term spousal patterns in the here and now and prospective future via solution rather than problem focus.

Practicing Marriage Counseling

Many marriage counselors working in private practices maintain a full-time caseload, averaging approximately 20 clients or more per week or, conversely, keep a small part-time practice in addition to another job (e.g., counselor educator seeing a limited caseload). Consideration for private practitioners include acquiring or sharing office space, personnel, and overhead costs in addition to maintaining malpractice insurance, securing accounting and legal advisors to assist in forming a limited liability corporation business entity, as well as innumerable other important details that should not be overlooked. Marriage counselors working in the public sphere, such as agencies, centers, or institutes, often maintain a more extensive caseload with clients scheduled, at times, back to back for 50 minute sessions with 10 minutes between sessions utilized for case notes and record purposes, leaving little time in the average day for personal needs beyond the occasional break, scheduled-in supervisory session, in-service training, or responses to the inevitable crises and immediate client needs posed when dealing with real-world, daily marital and human problems.

Quite often, private practitioners may seek out consultation on a particularly challenging case, and provisional licensees (i.e., supervisees) may seek out their direct supervisor or clinic supervisor on call, which often occurs on a rotating basis, for particularly difficult cases that require a more highly trained and experienced seasoned professional counselor's guidance. Even supervisors themselves are required to undergo a period of sup-of-sup, or supervision of supervision, in order to hone their supervisory as well as administrative and clinical mental health case management skills. While marriage counselors and agency or clinic supervisors experience varied daily schedules often perceived by most to be a reward of the job in terms of workplace flexibility, increasing paperwork and bureaucratic constraints as well as managed care cost containment, and utilization review practices call for what some perceive as extraordinary practices, which must be rendered in order to validate treatment effectiveness and account for reimbursement of service provision.

Marriage or Couples Counseling?

When the term *marriage counseling* was coined and brought into the United States' public consciousness, it represented an era of traditionally married husband and wife as spouses seeking services in the 1950s. Since that time, there have been, for some, a recognition and revelation of sorts that the term *couples counseling* better encompasses the modern conception of extending marital counseling to include premarital, relationship, and same-sex marriage counseling. It should also be noted that there remains debate within the field among practitioners and theorists as to whether marriage or couples counseling can be conducted solely with one spouse or partner, as it were, coming in for treatment. Irrespective of one's stance, marriage counseling is normatively viewed as exclusionary by a number of professional organizations, with couples counseling gaining growth and momentum among practitioners and clients alike for its inclusion of gay and lesbian couples unable to be married in certain states as well as those in committed cohabiting relationships. Although the future of marriage counseling is bright in terms of job outlook, the terminology undoubtedly will continue to provoke controversy.

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See Also: Counseling and Psychotherapy Services; Family Therapy; Marriage and Family Therapy; Marriage and Family Therapists; Same-Sex Couples/Marriage; Social Workers.

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Maternal/Infant Health Services

Maternal and infant health services are part of U.S. public health with a focus on keeping women healthy while pregnant and caring for infants after birth. This kind of public health service also works to determine the future health of new generations and predict possible challenges for families, communities, and the health care system. Maternal and infant health are concerned with a wide range of health conditions, behaviors, and systems that affect health, wellness, and the quality of life of women, children, and families. Pregnancy provides a useful opportunity to identify existing health issues and risks in women to acknowledge future health problems for them and their children. Such risks might include hypertension and heart disease, diabetes, depression, genetic conditions, sexually transmitted diseases (STDs), substance abuse, poor nutrition, and unhealthy weight. Pregnancy-related complications might be reduced by identifying them early and increasing access to preconception, interconception, and gestative care. Healthy births and early identification and treatment of health conditions in infants could prevent death or disability, allowing children to grow up healthy, strong, and to their full potential.

There are many conditions that impact maternal and infant health care, especially factors that affect pregnancy and childbirth. Such factors include preconception health status, age, access to health care, poverty and class status, stress levels at home and work, and exposure to environmental toxins. Women who find themselves in lower income brackets or held back by racial or ethnic socioeconomic boundaries are at a disadvantage for early and regular health care for themselves before, during, and after pregnancy. Their children, likewise, are affected by the differences in care across race, ethnic, and class boundaries.

Certain populations in the United States are at a lesser advantage for maternal and infant health care due to their marginalization within society and differences of cultural practices and beliefs. Immigrant women, for example, are often at a disadvantage due to the language barrier; not being fluent in English is one way nonnative speakers are at a disadvantage because they may not get accurately translated information. Additionally, nonnative speakers are at a disadvantage because they might not have suitable transportation to clinics offering public health services. Immigrant woman are largely disadvantaged economically, and this is reflected in their health status, general living conditions, and less access to health care services. Maternal and infant public health services, therefore, are great assets within culturally diverse populations because of the access to varied types of health care across class, race, ethnicity, and religious affiliation.

Maternal Health Programs in the United States

Individual states in the United States have particular programs designed to care for women and children regionally. Such health programs are administered in rural, urban, and native communities through federally qualified health centers, hospitals, or clinics. Such services do not only treat the body but provide psychosocial assessments, coordinate services with Medicaid, arrange transportation services, and refer patients to local community services for things like mental health, substance abuse, domestic violence, other basic needs, and local childbirth education or parenting classes. Children's cognitive and physical development is influenced by the health, nutrition, and behaviors of their mothers. Breast milk is generally known to be the best form of nutrition for infants because it provides several benefits essential for health, growth, and immunity. Stable, safe, and nurturing families and communities are better for children's development.

The Bureau of Maternal and Child Health, part of the U.S. Department of Health and Human Services, administers community-based programs designed to assure adequate and quality prenatal and pediatric care. Additionally, it offers support services to ensure access to care and provide family planning services. These services are designed to assist pregnant women, infants, and children with special accommodations, from medical to environmental to social needs. The bureau's main focus is on reducing infant mortality.

Such programs are made possible because of the 1935 program Title V Maternal and Child Health Program, part of the Social Security Act. Title V was converted to a block grant program in 1981 and has continued to assure access to and assist in providing quality health care for low-income families or those with limited availability of care. This program is funded by a grant that is applied for every year by state maternal and child health agencies. Every five years, each state must also conduct a statewide, comprehensive needs assessment in order to identify state priorities, a way of evaluating how to best address the needs of the maternal and child health population. The Maternal and Child Health Bureau has worked with state programs to build a data capacity at the federal and state levels to identify population-based services.

Some specific services that focus on maternal and infant health include prenatal care of the mother, which is often overlooked, by a perinatologist, an obstetrician, or gynecologist with complete specialty training of complex medical problems relating to pregnancy; a perinatologist is also known as a maternal–fetal medicine specialist. These problems might be obstetrical, medical, surgical, or pertaining to genetic complications and may occur during pregnancy, childbirth, or postnatal or postpartum. This type of doctor diagnoses and treats women with pregnancy complications, manages a woman's medical condition as related to pregnancy, and manages a pregnancy as it relates to a woman's preexisting conditions. A perinatologist treats a patient when referred to by the primary obstetrician and works with him or her throughout the pregnancy; he or she might also be an educator and researcher of cutting-edge methods for diagnosing and treating problems and therefore is often sought after to lecture and share information.

Maternal and infant care, both prior to and after birth, must be closely evaluated and continued throughout the course of a pregnancy and neonatal care. Its tie to public health services is an important step in intervening in some of the difficulties women of color in America experience. Without the same opportunities of white women in the middle and upper classes, women who are in racial and ethnic minorities and the lower working class or below the poverty line rely on public health services to assist them in having healthy pregnancies, birthing healthy infants, and raising them in stable, supportive, and health-conscious environments.

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See Also: Association for Multicultural Counseling and Development; Behavioral Health Disparities for Racial and Ethnic Minority Populations; Border Communities; Business Incubator; Dominican Americans; Hispanic Americans; Hispanic Immigrants; Mexican Americans; Public Health; Puerto Ricans.

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Maternity Homes

Maternity homes are homes for unwed expectant mothers. There were approximately 300 maternity homes in the United States in the 1960s. That number has dramatically declined since then because social attitudes toward single pregnant women have moderated. Approximately 95 percent of unmarried women now choose to keep their babies. In addition, both abortion and reliable birth control have reduced the number of women with unwanted pregnancies. During the 1800s, Victorian ladies of goodwill created shelters for unwed pregnant women. The first maternity home was founded by the Salvation Army in 1886. The early homes were usually run by religious orders. The purpose was to prepare "fallen" white women for lives on the fringe of society; the illegitimate status of the offspring made them unsuitable for adoption. Unwed pregnant black women were largely excluded from maternity housing, relying on their families for support.

Following World War II, children changed from economic necessities to social necessities, which created a desire in infertile couples to adopt white babies. The number of illegitimate children increased with the return of the servicemen. Even today, it costs less to adopt a minority child than a white baby. Maternity housing peaked in the 1960s, offering women a place where they could go in order to escape the stigma associated with unplanned and unwed pregnancies. Maternity homes were now run by professional social workers, and the clients were seen as redeemable, although they remained overwhelmingly white. Society decided that unmarried mothers could be rehabilitated or married off after being pregnant and giving birth. Maternity homes and policies that had been devised to help mothers and children stay together became the means to separate them as adopting out the baby meant that the mother was redeemed and she returned to society to fulfill her proper role as wife and mother.

However, with the decriminalization of abortion, the widespread availability of birth control, as well as changing attitudes toward single parenting, the number of maternity homes dramatically dropped. Currently, many maternity homes are publicly funded social services programs that provide much-needed housing to homeless pregnant minors. Others are small private facilities that may have religious affiliations. Some group homes are allied with adoption agencies.

In the past, a maternity home was a place of secrecy and seclusion, where pregnant women and teens could hide until their babies were born. The young women typically assumed false identities to conceal their shame along with their pregnancies.

The Salvation Army Women's Home and Hospital, now The Salvation Army's Booth Brown House, is a 1912 brick Tudor Revival-style building designed by Clarence H. Johnston, Sr., in Saint Paul, Minnesota, and listed on the U.S. National Register of Historic Places. The Salvation Army originally used it to provide housing and hospital care for unwed mothers and their children.

They worked at the home to pay for their stay. Rules were generally strict. The girls were not prepared for childbirth. Their babies were then placed for adoption, and the girls returned to their regular lives after their extended "vacation."

According to C. Edwards and E. Williams, the typical resident of a maternity home was white because unmarried racial/ethnic minority women were more likely to keep their babies, and they did not have to hide out at a maternity home. This was partly because the babies were less adoptable, but also because the girls' families were more accepting. The typical resident of today's maternity home is a single adolescent who has probably faced some serious challenges in her life. Many come from chaotic family backgrounds and have been abused, often sexually. Their time in the maternity home may be the most stable period in their lives. The challenge for maternity homes is to help these women transition to parenting and independent living because most keep their babies.

Today's typical maternity home is independent. The bulk of funding usually comes from one major government source (e.g., child welfare or Medicaid), which is supplemented by other sources (e.g., state funds or private contributions). Those who live in the home usually pay no fee for the services that they receive including receiving help in applying for public assistance programs (e.g., food stamps and Medicaid), advice on nutrition, and assistance in determining the next steps in a career or education. Homes tend to offer heavily structured programs that may include life skills, high school coursework, and childbirth classes.

When most people think of maternity homes, they envision the large institutions that held 30 to 50 women, where young women would go to have their babies in secret and give them up for adoption.

Maternity homes now are typically small, dormlike residences that shelter between six and 10 clients at a time. Some just house women for the duration of the pregnancy; others allow mothers to continue living in the home after the baby is born. Maternity homes typically offer a wide range of services for women in need ranging from counseling services and parenting classes to adoption-related guidance and job training.

The antiabortion movement has remained involved with maternity homes as part of its philosophy to support women who choose to carry their pregnancies to term. Many maternity homes had to close after abortion was legalized. Whereas maternity homes in the past were geared toward adoption, today's homes cater to women who have chosen to keep their babies. Maternity homes were affected by the welfare reforms of the 1990s. Under the new rules, pregnant teens ceased to be eligible for welfare benefits unless they were living with their families. Maternity housing rebounded as "second chance" homes were created to provide an alternative stable living environment for pregnant minors who could no longer live at home. Maternity homes provide badly needed assistance to a vulnerable population. Even today, young women may need to live in maternity homes for the duration of their pregnancies.

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See Also: Adoption Agencies and Services; Group Homes for Adults; Maternal/Infant Health Services.

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McKinney-Vento Homeless Education Assistance Improvements Act of 2001

Approximately 1.6 million children in the United States are homeless. These children are more likely than their peers to miss educational opportunities and perform more poorly in school. The McKinney-Vento Homeless Education Assistance Improvements Act of 2001 is a federal act issued through the Department of Education that ensures that homeless children have the same access to free and public schooling as those children with stable housing. It is designed to help these students succeed in school and meet the same academic standards as other children. The act mandates that local educational agencies (LEA), otherwise known as school districts, immediately enroll homeless children in schools and take the necessary steps to maintain retention of these children in the school system. The act defines the term *homeless* and sets provisions for school districts to adhere to when working with homeless children including the assignment of children to a certain school and the enrollment process.

The original McKinney Act, which included 15 programs designed to provide various services for the homeless, was passed into law in 1987 and amended in 1988, 1990, 1992, and 1994. Amendments generally expanded upon programs and services available to the homeless in the United States. In 1994, Congress amended the Education of the Homeless Children and Youth program. This amendment granted schools greater flexibility when utilizing funds, provided children and families with a voice in terms of school placement, required that schools coordinate with housing authorities, and specified a child's right to receive an education. In 2001, Congress reauthorized this program as the McKinney-Vento Homeless Education Assistance Improvements Act as a part of the No Child Left Behind Act, signed into law by President George W. Bush.

Defining Homelessness

The act defines homeless children as those without a stable, fixed, or adequate nighttime residence.

This includes children of families who are sharing or have lost housing due to lack of financial resources; children who live in public places not designated as a form of housing such as a park, train station, or abandoned building; children who are living in hotels, motels, or trailer parks; and children who are living in transitional housing such as a shelter. Additionally, the act distinguishes between children who are in foster care and those who are awaiting foster care. The act defines awaiting foster care as the time between the placement of a child in state care and the 30-day shelter care hearing, when a judge determines whether or not a child is in danger and needs to be removed from his or her home. Those awaiting foster care are recognized as homeless and are protected under the provisions of the act.

Specifications: School Placement, Enrollment, and Transportation

According to the McKinney-Vento Act, school districts must immediately enroll homeless children in school even in cases in which students lack necessary documentation for the enrollment process such as medical forms, previous academic records, or proof of residency. In fact, children must be in attendance the day after attempting to enroll. Furthermore, the act states that school districts must continually improve and revise policies to combat barriers preventing children from obtaining free education in efforts to increase enrollment and retention rates.

LEAs are responsible for school placement and must make decisions in the best interests of the child. A child is typically placed in his or her school of origin unless the child does not wish to remain there. A child's school of origin refers to the school the child was last enrolled in or attended when permanently housed. This is particularly important, as disruptions in the stability of a child's education may lead to stress and impede academic success. Under the act, schools are not allowed to segregate homeless children and place them in separate schools. Additionally, school districts are not allowed to hold classes in shelters or off-site school facilities for homeless children. The act requires that children are enrolled in and physically attend an operating school.

Furthermore, the McKinney-Vento Act states that LEAs guarantee transportation of homeless children to and from the child's school of origin at the request of the child's parent, guardian, or liaison. Thus, the school district in which a child lives must cover the cost of transportation to and from school. If a child begins living in a different school district but still attends the school of origin, the new school district must work with the district of origin to determine how costs will be divided. Both districts then share the responsibility of guaranteeing transportation for the child to and from school.

School districts are required to designate a local liaison that acts as the primary form of communication between schools and homeless families. These individuals are responsible for helping children obtain immunizations and medical records. Furthermore, the liaison must ensure that children and their families are well-informed about their rights such as their ability to dispute enrollment decisions. Most importantly, the liaison continually works to identify homeless children in need of enrollment by closely working with shelters, soup kitchens, and other agencies that provide services to homeless families in efforts to prevent homeless children from going unnoticed.

Funding

The federal government provides grant funding to states that are consequently bound to the terms of the act. Funding from the government is intended to carry out the provisions of the act, which includes providing activities for and services to homeless children in efforts to help them enroll and excel in school. The minimum amount allocated to each state annually is $150,000. States are granted money based on a proportional formula as well as the amount of funding received by the Department of Education through the Elementary and Secondary Education Act of 1965.

A portion of funding is designated to appoint a State Coordinator for Education of Homeless Children and Youth in each state and to develop programs that raise awareness about the education of homeless children and address current issues. The responsibilities of the coordinator include supervising the state's adherence to the act, compiling and communicating information on issues faced by homeless children and the school system, analyzing the manner in which the act provides solutions to problems, providing technical assistance to school districts to ensure compliance with the act, and submitting reports requested by the Department of Education. Coordinators must also facilitate communication between various agencies providing assistance to the homeless, including those that offer mental health services, and the State Educational Agency.

The McKinney-Vento Homeless Education Assistance Improvements Act of 2001 is fundamentally designed to ensure that homeless children have equal opportunity to receive an education and excel in school. Though more adequate funding would aid in the execution of its goals, the McKinney-Vento Act remains a landmark piece of legislation that has helped create and implement concrete plans that provide access to education for all children in the United States.

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See Also: Department of Education, U.S.; Homelessness; Housing Support and Homeless Services.

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Meaningful Access

Care providers and duty bearers providing social and health services need to ensure that the populations have meaningful access to these support mechanisms. Meaningful access can be measured in terms of equity of access, quality of care, timely availability of service, affordability of the service, and participation of the population group or beneficiary in management of these services. This entry explains the various aspects that ensure meaningful access of services to populations. Some of the key principles in meaningful access to services follow, and it is important that service providers and other duty bearers regularly assess them and evaluate their services against these.

Equity of access to different population groups is a critical element defining meaningful access. Different population groups irrespective of their age, sex, or cultural, social, racial, ethnic, economic, or occupational background must receive equitable treatment and care by the service provider without any preference or bias. Similarly, persons with certain medical conditions such as human immunodeficiency virus (HIV) must not be stigmatized against. Language barriers, as well as lack of awareness of various procedures and processes, may lead initial service seekers to feel nervous and apprehensive about the support available. Care has to be taken therefore to bring in language interpreters where necessary as well as to simplify procedures and explain the same to beneficiaries.

Physical access to the services is an important parameter. Service provisions must be within a reasonable distance from the beneficiary to ensure effective utilization. Similarly, working hours at these facilities need to be set in such a way so as to enable populations to use them. For example, commercial sex workers are more likely to access a facility that provides health checkups as well as counseling or treatment if it opens during the night. The facilities also need to ensure access to persons with disabilities (e.g., provision of ramps and wheelchair-accessible toilets). Economic access to the services can be explained in terms of cost for services and ability of the populations to pay for them. In certain countries, government social support systems provide for free or subsidized health care. However, this is not the case in most of the developing and underdeveloped countries, and even if available, support is limited to a basic level (e.g., primary health, primary education, etc.). In such circumstances, it is important that service providers develop and implement support provisions that the majority of the population can pay for and access.

Social support is an important aspect to ensure meaningful access of beneficiaries to services. Stigma or ridicule associated with some of the issues leads to poor utilization of these services. Some of the examples are persons with HIV or acquired immunodeficiency syndrome (AIDS), social norms against rape survivors, and children with learning disabilities. To ensure that these individuals or their families proactively seek support from the social or health services, the service providers could help in different ways: sensitization of the populations on these issues and creating awareness how to accept these persons and support them; maintaining confidentiality regarding beneficiaries; and empathy while dealing with these persons at the facilities so that they feel supported and, therefore, continue seeking support and also inform others with similar conditions to seek support. Regarding rights orientation for service delivery, it is important for service providers to recognize that people seeking services within their institutions have a right to quality services. Many of these rights are enshrined within constitutional frameworks of many countries as well as within various other regulatory guidelines for social services systems. The rights framework therefore provides a strong foundation to enable providers to work toward meeting these rights as well as ask for necessary support from the government (if necessary) to help them deliver quality to the expected standards.

To adhere to the above principles, it is important for service providers to undertake the following strategies that will contribute to meaningful access to services: (1) setting long-term visioning, communicating the same widely to all stakeholders and putting in place measures to achieve these—regular reporting on progress against these visions is equally important; (2) establishing standard service provision benchmarks in line with the government and institutional guidelines; (3) making sure that these are well understood among all the stakeholders and necessary resource provisions (finance, human resource, time, technology, etc.) are allocated for the same; (4) setting up a clear monitoring mechanism against set benchmarks to assess meaningful access service provisions; (5) and explaining all the stakeholders within the relevant continuum of care regarding these benchmarks and measures to monitor and review them at periodic intervals.

Community participation in setting the quality standards within the agreed quality parameters is important to enhance partnership and reporting of issues. This also means communicating and discussing issues of concern in a transparent and regular manner. The following measures will strengthen accountability mechanisms as well:

- Assess and understand contextual challenges and opportunities, and ensure that these are factored into strategies for support and response, leading to enhanced access to services.
- Identify barriers and wastage within the service setup, and remove them.

Creating a learning environment is important to make sure that the professionals involved with the service provision embrace it as a value system and are willing to question and challenge protocols, systems, and roles as well as report any mistakes and challenges without the fear of reprisals from senior management. Technology adoption is another critical need for continual improvement in services and, therefore, ensuring a meaningful access experience for the beneficiaries. New technology application could be in the areas of treatments, documentation and information management, staff training, and so on.

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See Also: Continuum of Care; Health as a Human Right; Health Promotion Services.

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Medicaid

Medicaid was created in 1965 and is an entitlement program administered at the state level under rules set by the federal government that provides payment for medical expenses for individuals and families that are low income who meet certain criteria. Approximately one out of every five Americans is a Medicaid beneficiary, with 62 million people receiving assistance from the program as of March 2013.

As of fiscal year 2010, Medicaid cost $414 billion per year and rises with each fiscal year. The Affordable Care Act (ACA) expanded coverage in 2014 to adults who make up to 133 percent of the federal poverty level, but the Supreme Court ruled that states can choose whether or not to participate in this large expansion of the Medicaid program. Medicaid is one of the largest and fastest-growing parts of state budgets, and in recent years, state finances, already strained by the 2007 to 2009 economic downturn, struggled to support the program. It remains one of the largest programs available to low-income people in the United States.

Creation of Medicaid

Medicaid was created as a result of legislation signed by President Lyndon B. Johnson in 1965. Created in tandem with the Medicare program that provides health care for the elderly, Medicaid was designed to pay for health care expenses for people who are low income. The program provides federal grants to states for medical expenses. States are not required to participate in the Medicaid program. Medicaid is one of the most enduring legacies of President Johnson's Great Society program. While the impact of Medicaid has varied across states, overall, it has improved many health care outcomes for beneficiary groups.

Organization and Coverage of Medicaid

Medicaid has several core eligibility groups including pregnant women, children, adults who have dependent children, people with disabilities, and senior citizens. In some states, there is expanded Medicaid coverage that is generally targeted toward children. In order to receive Medicaid, potential recipients often have to prove that their income is below the federal poverty level. In addition, the Deficit Reduction Act of 2005 added a controversial provision to the process for obtaining Medicaid. That act required proof of citizenship for recipients to access Medicaid services.

Medicaid covers more than 30 million children and approximately 11 million nondisabled adults and finances 40 percent of all births in the United States, nearly 9 million disabled adults, and approximately 4.6 million low-income seniors. Elderly Medicaid beneficiaries are generally also participants in the Medicare program. In addition, many 3.7 million disabled Medicare beneficiaries also received Medicaid. The composition of Medicaid beneficiaries changed substantially in 2014, when many adults in participating states became eligible for the first time.

Medicaid differentiates between mandatory benefits and optional benefits. States are required to offer mandatory benefits, while they can choose whether or not to offer optional benefits. Examples of mandatory benefits include inpatient and outpatient hospital services, nursing facility services, family planning services, and nurse midwife services. Examples of optional services include clinic services, physical therapy, prescription drug services, optometry services, dentures, eyeglasses, and chiropractic services.

As of fiscal year 2010, expenditures for Medicaid services totaled $413.9 billion including state and federal contributions. States also have the option to require out-of-pocket costs and copayments in certain circumstances. A large proportion of Medicaid funding is directed toward nursing home care, with 12.5 percent of service expenditures being devoted toward nursing facilities in fiscal year 2011. By some estimates, two-thirds of nursing home care is financed through the Medicaid program. Many recipients of the Medicare program for senior citizens also receive benefits from Medicaid.

For children, Medicaid is supplemented by the Child Health Insurance Program (SCHIP), created in 1997 and renewed most recently in 2009 by one of the first pieces of legislation to be signed by President Barack Obama. SCHIP provides funding for health insurance for children for families who earn slightly more than those who qualify for Medicaid. SCHIP provides some interesting examples for cost efficiencies in the Medicaid program.

One concern Medicaid has faced from the inception of the program in the 1960s is doctors refusing to accept Medicaid. The variance of Medicaid reimbursements and the relatively low level of payment makes many doctors wary of accepting Medicaid. Ensuring both adequate funding and access to care has been a concern of Medicaid since the program began.

Medicaid and Federalism

Unlike Social Security, Medicare, and the Supplemental Nutrition Assistance Program (SNAP), Medicaid is organized in a way that provides states with a great deal of autonomy, although not as extensive as that of the Temporary Aid to Needy Families (TANF) program. States have a large variance in access and coverage. This has sometimes prevented the program from being uniformly effective but has given states the leeway to experiment.

Arizona was for many years the only state to opt out of the Medicaid program, not joining until the 1980s. States determine their specific eligibility standards for the Medicaid program. In addition, the funding structure for Medicaid has a federal medical assistance percentage, which is determined by state per-capita income. There is a federal spending floor of 50 percent; each state receives at least 50 percent of Medicaid funding from the federal government. Mississippi, traditionally the poorest state in the union, receives the largest proportion from the federal government, 73.4 percent of their Medicaid funding.

In addition to varying amounts of federal funding, states may also provide coverage for certain areas. For example, New York has traditionally offered many option benefits, while Mississippi has offered minimal coverage. The variance in optional benefits by states is one of the ways in which Medicaid costs are differentiated across the nation. New York Governor Andrew Cuomo appointed a commission to look into methods of controlling Medicaid costs.

Many conservatives, concerned about the ever-increasing cost of the Medicaid program support converting the program into a block grant. The United States Congress replaced the Aid to Families

A rally to support the expansion of Medicaid in Jackson, Mississippi, June 28, 2013. Medicaid expansion has profound implications for federalism and for access to health care. The way different states implement or choose not to implement the Medicaid expansion will create a disparity of policies and of access to medical care throughout various states.

With Dependent Children (AFDC) program, colloquially known as welfare, to the Temporary Aid to Needy Families (TANF) block grant program. A block grant program gives states substantially more leeway, which could potentially result in cost savings but also raises the possibility of a race to the bottom, where states offer minimal services and use leeway to transfer block grant funds to other aspects of their budgets.

Medicaid and the Affordable Care Act

One of the key aspects of the Affordable Care and Patient Protection Act of 2010, colloquially referred to Obamacare, is an expansion of Medicaid coverage to adults who earn up to 133 percent of the poverty line. Beginning in 2014, Medicaid will for the first time be available to adults who are not disabled, elderly, or who do not have children. The Supreme Court, in *National Federation of independent Business v. Sebelius*, allowed states to opt out of the Medicaid expansion.

As of June 2013, 26 states were committed to participating, 13 were on record as not participating, and 11 states were considering the issue or instituting alternative options. In Arizona, Republican Governor Jan Brewer, who gained national recognition for strong stances on the immigration restriction bill SB 1070, supported and fought with the state legislature for Medicaid expansion participation. Brewer gained passage of the program in June 2013 despite opposition. In contrast, Texas Governor Rick Perry strongly opposed Medicaid expansion despite the fact that Texas leads the nation in the percentage of uninsured people, with approximately one-fourth of the population lacking health insurance. Other states such as Arkansas are working with the federal government on their own variations.

The Medicaid expansion has profound implications for federalism and for access to health care. The way different states implement or choose not to implement the Medicaid expansion created a disparity of policies and of access to medical care throughout various states.

Conclusion

The Medicaid program was created in 1965 and has become an increasingly costly entitlement program that also provides interesting insights into ideas of federalism. Created in 1965 as part of Lyndon Johnson's Great Society, the program has become one of the largest expenditures of federal and state governments. Providing health care for the poor, particularly children, the disabled, and the elderly, beginning in 2014, Medicaid expanded significantly to other adults as well. The program provides a safety net for approximately one out of five Americans but also faces concern over organization and cost. In the next decades, debates over entitlement reform, state budgets, policy innovation, and cost efficiency will continue to involve the Medicaid program.

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See Also: Department of Health and Human Services, U.S.; Health Care Delivery, Models of; Health Care, Disparities in.

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Medical Necessity

Though the function of medical necessity in the current health care system as a determinant of claims reimbursement is understood, consensus is lacking when it comes to defining and, thus, setting an agreed-upon criteria for this construct. Various government and medical institutions have proffered definitions, while local plans continue to advance and maintain their own, incorporating financial conditions into what was formerly a clinical determination. Denial of claim reimbursement based on failure to meet medical necessity specifications is a substantial problem, though it can be reduced through proactive measures such as proper coding and billing.

Role of Medical Necessity in Health Care

There is no standard definition of medical necessity despite the critical role it plays in health care, and a notable degree of confusion and controversy surround this concept. A cost-control measure that surfaced in the 1940s with the development of insurance, medical necessity serves as a determining factor in whether health services or supplies are reimbursed by insurance or government programs and is intended to exclude unnecessary, elective, experimental, and cosmetic procedures. Unlike coverage, which refers to a benefits package of services and procedures a plan will generally pay for, medical necessity involves what a plan will pay for with an individual patient in a particular case. Medical necessity claim decisions are typically made by reviewing staff or medical directors not involved in the care of the patient in question. Historically, determination of medical necessity was left to the judgment of treating physicians. In the 1960s, however, insurance providers began specifying the criteria for medical necessity in their contracts in an attempt to help contain the rising expense of health care. A key issue of debate has since been the shifting of medical necessity from a clinical decision to a business decision.

Definitional Issues

Section 1862 (a) (1) of the Social Security Act specifies that Medicare will pay for that which is "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." The Centers for Medicare and Medicaid Services has issued national coverage determinations (NCDs) that address what products and services are covered and medically necessary under Medicare; however, when an NCD does not address a particular product, service, or procedure, local coverage determination (LCD) on the part of local carriers dictates medical necessity guidelines along with local medical review policies.

As is widely quoted, the American Medical Association defines medical necessity as "health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider." This definition was established in 1998 in response to the increasing number of health plans using questionable definitions of medical necessity in their managed care contracts. The AMA offers physicians a sample care contract, the *Model Managed Care Contract*, developed to assist in negotiating contracts with health plans; the AMA's definition of medical necessity is provided in this document as is a discussion of the role of medical necessity and how to appeal denials based on medical necessity criteria. One major concern of the AMA has been that inclusion of language about lowest-cost or least-intensive care as criteria for medical necessity is detrimental to the integrity of the provider–patient relationship and the quality of care patients are eligible to receive. A substantial number of insurance plans do currently have such language in their medical necessity requirements. Medical necessity guidelines vary from plan to plan—they can be found in the medical policies on carrier Web sites, under local coverage determinations, or in private carriers' utilization guidelines. Medical necessity criteria and determination processes are not always made public by insurers and insurance organizations, however, and may remain located in confidential contracts and internal documents such as provider manuals.

Medical Necessity Denials and Appeals

Services that were formerly accepted as medically necessary are increasingly subject to scrutiny under stricter regulation by insurers and governing bodies. The Office of the Inspector General (OIG) is charged with maintaining the integrity of the Department of Health and Human Services' (HHS's) programs via audits, inspections, and investigations—one of the areas they focus on is medical necessity. Furthermore, recovery audit contractors (RACs) at the Centers for Medicare and Medicaid Services identify past payouts to hospitals that are deemed undeserved and recover the funds; often, the reason stated for recovery is the provision of services that do not fit the criteria for medical necessity. The American Hospital Association RACTrac quarterly reports, which explore the impact of RACs on hospitals nationwide, have found medical necessity denials to be the most common reason that claims are denied by RACs.

The Patient Protection and Affordable Care Act of 2010 charges the secretary of the HHS with overseeing the process by which medical necessity determinations are made; the HHS defers the responsibility of establishing and overseeing medical necessity criteria to state governments and insurance providers. Because of such decentralization, there is variation in medical necessity identification, review, and appeals, with some states specifying cost as a factor in determination of medical necessity and others more liberally covering procedures considered elective under other plans. For example, a study by the General Accounting Office found that patients in Illinois filing Medicare claims for chest X-rays were 451 times more likely to be denied than patients in South Carolina. After a health plan has denied a claim based on medical necessity, patients and providers have the opportunity to appeal denials—first with the plan internally and then via external review—though the procedure for internal review varies by plan, and the process for external review varies by state. Should the dispute progress to litigation, the courts have been inconsistent in their interpretation of medical necessity, with some maintaining that a patient's physician is responsible for determining medical necessity and others maintaining that the concept is contractual and physicians are obligated to prove that the care provided fits the established plan criteria for medical necessity.

Denial Prevention

To maximize reimbursement and negate the need to appeal, health care providers and staff are encouraged to increase their vigilance regarding the correct coding and billing of claims and to be current and detailed in their understanding of coding and compliance rules, which are known to change frequently. New technology now allows claims, prior to billing, to be run through software and online programs that detect potential errors that could result in medical necessity denials. Proper coding and documentation have been recognized as a preventative strategy highly effective in reducing claim denials.

However, even the most conscientious coding and billing will not quiet the ongoing debate about controlling costs at the expense of quality care and will not alleviate concerns that fiscal criteria is gaining increasing clout in medical necessity determinations that were once the domain of the physician caring for his or her patient.

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See Also: Code of Ethics of the National Association of Social Workers; Health Insurance; Outpatient Medical Care.

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Medical Social Workers, Racial and Ethnic Issues for

Medical social workers are professional social workers (typically individuals with master's degrees) who help people cope with chronic, acute, or terminal illnesses. Medical social workers provide a variety of services to individuals, families, and groups, including advising family care givers, providing patient education and counseling, making referrals for other services, and providing care and case management. They also perform interventions to promote health, prevent disease, and remove barriers to access to health care. Medical social workers have a very specialized skill set that is utilized as they work as part of an interdisciplinary team of doctors, nurses, nurses' aides, therapists (physical, occupational, speech, and respiratory), and management and administration. Medical social workers are often seen as the experts in the areas of psychosocial concerns, community services and referrals, family issues, and mental health diagnoses.

Medical social work is a field with a long-standing history. The first medical social worker was Ida Cannon at Massachusetts General Hospital in 1905. According to an address made in 1930, Cannon characterized the Medical Social Service movement as recognizing that there should be a specific person within the hospital who represents the patient's point of view; the person in this role should be able to work with the physician on a treatment plan for the patient that takes into consideration the patient's psychosocial needs. Medical social work is still filling that same need today and is flourishing as a profession. According to the 2012 Bureau of Labor Statistics, there are now 140,000 medical social workers employed in the United States in settings that vary from hospitals to nursing homes to in-home hospice and home health care.

Diversity in Medical Social Work

Because medical social workers provide services to people who are ill, they see a large cross-section of the population. Illness and disease can affect all people, regardless of race, ethnicity, age, sexual orientation, or class. In this way, social workers are challenged with providing culturally competent services to a wide variety of people. While other social work settings may have a more targeted population—perhaps a counseling center for immigrants or a shelter for single mothers—health care provides service to every population. This requires that social workers have a working knowledge and the capacity to accept and understand the full range of diverse clients.

One of the issues that often arises in medical social work is that of ethnic diversity. People of all nationalities and backgrounds can come in through the hospitals or health clinic's doors. Patients and their family members may not speak English, which can be frustrating for the members of the medical team. Social workers hold dignity and the worth of a person as a core value in their profession. Abiding by this means that social workers are ethically responsible for making sure that the patient still has access to care, is included in treatment decisions, and is treated in a respectful way, even if he or she does not speak English or is unfamiliar with American cultural norms. There are resources that the social workers can help patients access, including interpreters, language telephone lines, and even health care clinics or offices that offer services geared toward a particular population. Additionally, social workers can advocate for patients and families that may be misunderstood, marginalized, or even discriminated against in the medical setting. Cultural differences are not tolerated appropriately by all staff members at all times; sometimes, education and open dialogue is needed to ensure proper treatment of all patients.

Racial issues come into play frequently in medical social work, especially with regard to social justice and access to care. People of color who are often oppressed and discriminated against have barriers to health care that privileged members of society do not, including lack of health insurance or prescription coverage, unsafe living situations, and inability to afford proper nutrition. Conversely, medical staff need to be cognizant of their own potential for racial prejudice and not assume that a person of color will automatically have these issues. There are also issues of blatant racism that occur in medical settings that social workers are called to speak out against; social workers are integral in creating a safe and tolerant environment.

In addition to the issues of discrimination and prejudice that many people of color will face when receiving or trying to access medical care, people of color often have an inherent mistrust or skepticism of the medical system. Studies like the Tuskegee Syphilis Experiment served to exemplify the ways the majority culture exploited and harmed African Americans in this country. In medical social work, professionals can help people of color express their concerns, legitimize their fears, and assist them in getting the care they need.

Another group that is often marginalized and oppressed, the lesbian, gay, bisexual, transgendered, queer or questioning (LGBTQ) population has unique challenges that social workers can assist with; issues of sexual orientation have an important impact on medical social workers. Partners of patients may be excluded from treatment planning, end-of-life care, power-of-attorney decisions, or general medical updates if the staff is not aware of, or not acknowledging, the patient's sexual orientation.

Diseases such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) may be disproportionately expected or assumed by medical staff, which can lead to discrimination, isolation, and even harassment. Discrimination and bias can also occur by those who are unfamiliar or judgmental of these clients. Social workers must be aware of these issues and provide support to patients and families and education to staff.

Class is an omnipresent type of diversity that can polarize staff and discriminate against patients more powerfully than many other types of differences. The health system in the United States is fraught with problems. The high cost of medical care and the high rate of uninsured and underinsured people make receiving adequate health care a problem for many Americans. People who do not have adequate access to health care are often treated poorly by the medical staff or denied care or medications due to inability to pay. Social workers have a responsibility to advocate for these patients and help them explore and access resources that may help them maintain their health and receive treatment for medical problems.

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See Also: Case Management; Global Burden of Disease; Health and Sickness, Different Attitudes Toward; Health as a Human Right; Health Care Delivery, Models of; Health Care, Disparities in; Health Disparities, Role of; Health Insurance; Health Insurance Portability and Accountability Act of 1996; Public Health.

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Medical Supplies, Access to

Medical supplies and equipment are essential for maintaining health and mobility for millions; however, disenfranchised groups have difficulty accessing necessary items. The elderly, poor, minorities, and those with disabilities may not get the mobility devices and diabetic testing supplies they need. Positive health outcomes are associated with adequate access, while underutilization of medical supplies and equipment increases morbidity and mortality. Government and privately funded programs help offset costs, but restrictive policies leave many patients with unmet needs.

The category of medical supplies covers a wide range of items, assistive devices, equipment, and supplies used to manage disabilities or treat health conditions in a patient's home. Private insurers and the Centers for Medicare and Medicaid Services (CMS) group medical supplies into the broader category of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), but the acronym is commonly shortened to DME. DME includes artificial limbs, air purifiers, breast prostheses, continuous positive airway pressure machines, diabetic shoes, enteral nutrition devices (i.e., feeding tubes), lift chairs, walkers, portable oxygen systems, crutches, hospital beds, canes, wheelchairs, and scooters. Diabetic testing supplies, incontinence aids, and ostomy supplies (i.e., colostomy bags) are usually included, but expendable supplies, like bandages or rubber gloves, are not. In order for Medicare, Medicaid, and most insurance plans to cover supplies and equipment, a doctor's prescription is needed. Medicare Part B covers a portion of DME expenses for adults age 65 and over after their deductibles are met. Medicaid, the government health plan for the poor, usually covers all DME costs, although plans and eligibility vary by state. For patients with insurance, high copayments, deductibles, and coverage limits can impede access to needed supplies and equipment.

Access to medical supplies and equipment improves health outcomes for patients with disabilities and chronic conditions. According to the U.S. Census Bureau, 19 percent of the population is disabled, and 3 million people use wheelchairs. Studies show patients who use assistive devices are more satisfied performing daily activities and have an improved sense of accomplishment, while their caregivers report feeling less burdened. Nearly a third of patients with disabilities, however, cannot afford needed equipment. Inadequate access to equipment like mobility devices has detrimental effects; activity restriction because of limited mobility is associated with depression, feelings of social isolation, malnutrition, reduced quality of life, increased reliance on home health services, and higher morbidity and mortality.

For many patients, access to the right equipment is a factor. CMS pays for the least expensive wheelchair that allows a patient to function at home; about three-quarters of Medicare enrollees with limited mobility have manual wheelchairs, although they may actually need and benefit from lightweight or power chairs. Studies show that prolonged use of manual chairs causes injuries in shoulders, elbows, and wrists and ultimately increases health care costs. Medicaid will only consider claims for new chairs every five years, so it's important to get the right chair the first time. Patients with private insurance also have difficulty acquiring the right equipment; coverage limits mean patients pay more out of pocket for lightweight and power chairs, which can cost up to $13,000. Protection and Advocacy for Assistive Technology (PART) and Protection and Advocacy for Individual Rights (PAIR) programs operate nationwide, providing limited financial support for acquiring equipment and free legal services for patients contesting claims denied by Medicaid, Medicare, or private insurance.

The elderly, poor, certain minorities, and those living in rural communities have the most difficulty accessing equipment and supplies; for those with diabetes, the consequences can be deadly. According to the Centers for Disease Control and Prevention (CDC), the death rate is two to four times higher for the 26 million Americans with diabetes. Untreated, it can lead to stroke, heart disease, blindness, kidney failure, and loss of limbs. Blacks, Hispanics, and Native Americans suffer disproportionately; minorities represent the majority of new diagnoses, while only 7 percent of whites have diabetes. Diabetes must be checked on a regular basis, requiring a blood glucose monitor, test strips, and lancets. Testing supplies can cost as much $150 a month. While Medicaid covers most costs, traditional Medicare covers 80 percent; Part B covers testing supplies, and Part D covers needles and syringes for administering insulin. Medicare Advantage plans vary. The Affordable Care Act (ACA) launched a national mail order program in 2013 making it cheaper to have supplies delivered, but the program is limited to traditional Medicare enrollees, and items must be purchased through approved providers. While online vendors offer competitive prices, patients must have computer access to take advantage of savings (computer literacy is a problem, particularly among minority groups and the poor). Research suggests that many forgo routine monitoring, and elderly patients often lack the necessary equipment.

Government and privately funded assistance programs help improve access to medical equipment and supplies. The Federal Assistive Technology Act funds programs in every state. Most programs refurbish used equipment and sell it at deeply discounted prices as well as lend DME free of charge from a few weeks to several months. The American Elder Care Research Organization maintains a comprehensive list of state programs (www.payingforseniorcare.com). Organizations like Area Agency on Living and Independent Living Centers also have assistance programs. The Morgan Project is a nonprofit helping children with disabilities and their families gain access to items like adaptive bath chairs not covered by Medicaid. It also runs a used equipment exchange program. As noted previously, online services limit support to those with computer and Internet access.

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See Also: Aging and Adult Services; Assistive Technology; Children With Special Needs; Disability Services; Elder Care/Geriatric Services; Medicaid; Medicare.

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Medical Transportation

In much of the United States, personal automobiles are the most common means of transportation for individuals and families, particularly when the distance to be traveled is too great for walking to be a feasible alternative. However, relying exclusively on automobiles has many disadvantages, including harm to the environment, time expended in lengthy commutes and in congested traffic, and discrimination against individuals who do not own a car or cannot drive for a multitude of reasons including age (including both those too young to hold a driver's license and those too elderly to drive safely), disability, and poverty. A variety of transportation services are available in many areas that provide an alternative to automobile travel and improve the quality of life in a region while also enabling each resident to fully participate in life.

Transportation services are particularly critical in areas of poverty and high concentrations of minority populations and for the elderly and disabled. For instance, in the United States, members of minority groups are less likely than white Americans to own automobiles, women are less likely than men to have a car registered in their names, and members of poor households generally pay a higher percentage of their incomes on transportation than do middle-class households. In the United States, Title VI of the Civil Rights Act of 1964 forbids discrimination in public accommodations, including public transportation, and this has been interpreted broadly by the courts to include the adequate provision of services and consideration of the needs of all residents. Following this interpretation, when service changes or fare increases are scheduled, they must be examined to see that minority or disadvantaged residents are being treated fairly; particularly in large cities, public hearings are often scheduled to allow residents to provide input into proposed changes.

Because of the key role that adequate transportation can play in an individual's daily life, some organizations, such as the Leadership Conference on Civil Rights and Human Rights, believe that adequate transportation should be considered a civil right. They define transportation equity as a key value in local and regional planning because affordable, reliable transportation provides individuals and families with access to social benefits such as health care, education, and employment. However, in the United States, transportation services often fall short of this goal, and sometimes transportation services are arranged to favor the needs of the more-prosperous residents of a region, while those in greatest need may receive fewer services, although their need is greater. A wide range of resources may be needed to improve access to affordable transportation, and effectiveness depends in part on local circumstances. For instance, an evaluation of the Lifeline Transportation Program in California, meant to increase access to transportation for the poor and underserved, showed that a variety of approaches were useful including increasing public transit services, subsidizing fares, improving bicycle and pedestrian infrastructure, and demand-responsive transportation (flexible, shared transportation that may respond to individual needs).

Even the basic design of transportation services in a region may favor some individuals over others. For instance, city transit systems laid out on a rectangular grid system are often the most useful for individuals who do not own an automobile because no point in a region is too far from a transit line and making connections between different lines in a rectangular grid system is generally relatively intuitive and quick. In addition, grid systems do not need to favor one part of a city over another and provide relatively equitable coverage to all areas of the grid. In contrast, a radial grid system designates one area as central, with transit lines radiating out from this area. This type of design is often used when the focus of the transit system is bringing suburban residents into a central city during the workday and taking them home again in the evening. Such a system may operate only during limited hours, and the transit lines may become widely separated, without connecting services, as they become more distant from the central area. While a radial grid can provide regional benefits in terms of reducing traffic congestion and air pollution, it favors suburban commuters who tend to be more prosperous and

An MTA Access-A-Ride van transports residents in New York City. A variety of transportation services are available in many areas that provide an alternative to automobile travel.

probably own automobiles to use for their personal transportation in the evenings and for trips where the transit lines do not reach, over urban residents, who may have lower incomes and lower rates of car ownership and hence depend on the transit system for most or all of their transportation.

Although transportation services are often associated with urban areas, they play a vital role in rural areas as well. Rural residents have the same need to access education, health care, employment, and other services, as well as the ability to travel longer distances (e.g., between cities), and it cannot be assumed that all individuals in rural areas have access to automobile transportation. In addition, rural residents need to access long-distance transportation services such as bus, rail, and air travel. In the United States, according to the Bureau of Transportation Services, intercity rural transportation services have declined in recent years. As of September 2010, 11 percent of rural residents had access to intercity transportation (by air, bus, ferry, or rail transportation), although 3.5 million rural residents lost access to intercity transportation between 2005 and 2010. The primary decline was in bus transportation, followed by rail transportation, and access was lowest among residents of North Dakota, where fewer than 60 percent of rural residents had access to intercity transportation.

Transportation for elderly and disabled residents who require special services is typically organized at the local level. Many handicapped and elderly residents can be accommodated on regularly scheduled services—for instance, through buses with accommodations for wheelchairs and that have kneeling entry platforms that can be lowered to street level and then raised to the level of the bus aisle. Subway and rail networks can be made accessible by similar means such as providing elevators and gates to accommodate wheelchairs at the stations. Often, handicapped and elderly residents are eligible for free or reduced-price transportation on regularly scheduled transit services. In addition, special on-call transportation services are provided in many areas for rural and handicapped residents by specially equipped vans that can accommodate riders with special need, and provide point-to-point transportation similar to a taxicab service but at a much-reduced fare.

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See Also: Age and Clients; Poverty; Rural Communities; Urban Communities and Human Services.

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Medicare

Medicare (Title XVIII of the Social Security Act) is America’s federal health insurance program for individuals age 65 and older as well as certain younger, disabled former workers. The topic of Medicare is worthy of inclusion in this volume because the elderly and the disabled utilize a variety of human services agencies. Social workers, case managers, and other human services practitioners benefit from resources to better provide services to diverse populations. The aged and disabled constitute two such groups. Knowledge of how the Medicare program operates and an understanding of the challenges facing it are essential for those working with seniors and the disabled. Among these challenges is the uncertain future of this pay-as-you-go intergenerational transfer system that depends on workers paying into its reserve fund. Even if costs to run this very expensive program could be cut, the aging of the U.S. population is a demographic reality to contend with. By 2030, approximately 20 percent of the U.S. population will be elderly. Not only will these individuals stop paying into the system upon retirement, but they will also likely experience costly health problems at a greater rate than their younger counterparts.

Approximately 50 million individuals were covered in 2012 by Medicare. Originally begun in 1965 as a social insurance program for those age 65 and older who had paid a payroll deduction tax into the Social Security system, Medicare expanded in 1972 to include two other groups of beneficiaries (disabled former workers under age 65 receiving Social Security Disability Insurance benefits for more than 24 consecutive months and end-stage renal patients of any age). The Centers for Medicare and Medicaid Services (CMS) has oversight of the program, although initial application to receive benefits is made through the Social Security Administration.

Medicare consists of four parts. Part A covers hospitalization, skilled nursing facilities (posthospital rehabilitative short stays), and hospice care. Everyone who paid into the system is entitled to Part A, but a deductible and coinsurance are involved. Noticeably absent from Medicare’s inpatient categories is long-term care (e.g., nursing homes). Medicare does not cover the cost of custodial nursing home care. Part B covers physician office visits, hospital outpatient care and diagnostic services, home health care, and other medical services and supplies. Part B is optional and has an annual premium in addition to a deductible and co-=payment. The premium can be deducted from the individual’s monthly Social Security or Railroad Retirement check. Part C is a private plan option called Medicare Advantage (covering Part A and B services), which can be chosen instead of traditional Medicare (also known as original Medicare).

The government pays a fee to the company for enrolling each patient, and no CMS reimbursement claims are filed for services. From mid-October to early December each year, Part C beneficiaries can choose from a variety of commercial companies during this open enrollment period. In addition to private fee-for-service plans, the choices include preferred provider organizations (PPOs) and health maintenance organizations (HMOs), which are known for managed care practices involving cost containment. It can be an overwhelming experience for individuals to read the mailings they receive from competing companies trying to convince them that one company’s plan will save them more money than the others. Medicare Advantage originated with the passage of the Balanced Budget Act of 1997 as an attempt to reform a system in trouble. By 2013, about 28 percent of Medicare beneficiaries chose Advantage plans rather than traditional Medicare. Part D (implemented in 2006) covers outpatient prescription medications. It is optional and has a premium, deductible, and copayment. There is a coverage gap (referred to as the donut hole) after expenses reach a certain amount (and benefits stop) and before expenses reach another level (and benefits resume at a more generous rate). Supplemental coverage to Parts A and B combined (Medigap insurance) is available from private companies. These insurance plans have monthly premiums and can cover copayments, coinsurance, and deductibles. About 20 percent of Medicare beneficiaries choose this type of coverage. Others have similar supplemental coverage offered to them through their employers upon retirement.

During one's working years, the individual pays a health insurance payroll tax of 1.45 percent of his or her annual salary, while one's employer pays an additional 1.45 percent. Receipts collected through this mandatory contribution cover approximately 38 percent of the costs to operate the Medicare program (and only apply to Part A). Premiums paid by enrollees in Part B and Part D cover an additional 13 percent of the costs to run the program. Federal income tax revenue covers most of the remaining expenditures of the Medicare program. Under the 2010 Patient Protection and Affordable Care Act (ACA), the wealthy pay an additional tax on earned income as well as on investment income to further finance Medicare. Typically, a beneficiary receives substantially more in benefits than his or her lifetime payroll tax contribution (which for the average worker is $60,000).

Medicare Program Costs

In 2008, Medicare's annual outlays began to exceed its yearly income. In their May 2013 annual report, Medicare trustees listed 2012's expenditures at more than $574 billion and income at almost $537 billion. They predicted the depletion date for the Part A trust fund (reserves) to occur in the year 2026. Part B's trust fund is not facing the same threat of running out of money as premiums paid by beneficiaries can be reset each year to offset costs. With Medicare expenditures surpassing revenues annually, the government cannot pay its Medicare bills and must borrow money. Because such borrowing adds to the national debt, the topic of Medicare reform has become part of a contentious political debate.

Several factors are contributing to the rising costs to run the Medicare program. These include the growth of the aging population, the inflated cost of health care in the United States, waste in Medicare spending, and fraudulent reimbursement claims. Seventy-six million baby boomers (Americans born between 1946 and 1964) will become eligible for Medicare during the next two decades, with the last of them turning age 65 in the year 2029. Health care in the United States accounts for 18 percent of the gross domestic product (the total value of goods and services produced). When it comes to health care, we spend more than twice the average of Germany, Britain, Canada, or Japan. In addition to the United States having an expensive health care system, unnecessary procedures are performed on patients, partly due to the fact that for-profit hospitals, hospices, and dialysis treatment centers depend on Medicare reimbursements. With regard to waste, improper Medicare payments (e.g., errors in billing, coding, etc.), mismanagement, and other inefficiencies account for $48 billion per year. Fraud accounts for $60 billion per year (approximately 10 percent of Medicare's annual expenditures). While the ACA has allocated a sizeable amount of resources to improve efforts to combat fraud, organized crime gangs have infiltrated the durable medical equipment industry setting up bogus companies to obtain fraudulent reimbursements from an overworked, massive bureaucracy. Additionally, sophisticated networks of criminals steal Medicare patient identification numbers to file for reimbursement for care never received.

In an effort to save the Medicare trust fund, several changes have been suggested. The possibility of raising the eligibility age to 67 has received bipartisan support in Congress and could result in a savings of $15 billion per year. Reducing payments to providers is a provision of the ACA. Bundling payments to providers is a three-year experiment begun in 2012. In this model (also known as episode-based payment), a reimbursement covers all services surrounding a single hospital stay. Another suggestion to reform Medicare is to eliminate Medicare's financial contribution to graduate medical education. In 2010, this contribution amounted to $9.5 billion given to teaching hospitals involved in the education of approximately 100,000 residents. A major restructuring of Medicare has been suggested that would gradually phase out traditional Medicare. Some are asking for a system where seniors would receive a voucher each year to choose a private health insurance plan. Others favor premium support, with the individual receiving a subsidy to pay the premium of a private plan and then paying the difference between the cost of insurance and this subsidy. Whatever changes occur to Medicare, it is likely that beneficiaries and providers will both have to sacrifice and compromise. It will likely take a combination of strategies to ensure sustainability of the Medicare system for future generations.

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See Also: Aging and Adult Services; Elder Care/Geriatric Services; Health Care Delivery, Models of; Health Insurance; Hospice Services; Hospitals; Outpatient Medical Care; Social Security Administration.

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Medicine, Workplace Diversity in

Workforce diversity includes but is not limited to race, ethnicity, age, gender, disability, educational level, geographic origin, religion, sexual orientation, and socioeconomic class. The importance of diversity in the health professions workforce is clear as strong support exists within the medical profession for increasing racial, ethnic, and sexual diversity among physicians. In fact, achieving a health care workforce that reflects the diversity of the U.S. population is an explicit goal supported by the American Medical Association (AMA), according to J. J. Cohen, B. A. Gabriel, and C. Terrell. Diversifying the physician workforce is a national and global priority.

The majority (72.4 percent) of the U.S. population is white; minorities include 12.6 percent black or African American, 4.8 percent Asian, 0.9 percent American Indian and Alaska Native, 0.2 percent Native Hawaiian and other Pacific Islander, 3 percent two or more races, and 6.2 percent other. According to the U.S. Census Bureau, the U.S. population is becoming increasingly diverse as minority populations are increasing at a faster pace than the majority population. Minorities are expected to compose 40 percent of the U.S. population by 2050, predicts the U.S. Department of Health and Human Services, which, according to P. Gonzalez and B. Stoll, will help improve their representation in the physician workforce.

The profile of health care professionals does not match the racial and ethnic profile of the country, K. Grumbach and R. Mendoza have found, particularly for physicians, who disproportionately serve minority and other medically underserved populations. Minorities composed only 22 percent of physicians in 2008. Currently, 54.5 percent of physicians in the United States are white, 12.2 percent Asian, 4.9 percent Hispanic, 3.5 percent black, 0.16 percent American Native or Alaska Native, 1.3 percent other, and 23.4 percent unknown, reports the AMA.

U.S. Census Bureau data show that 24.9 percent of the U.S. population is age 55 or older; however, 40 percent of active physicians in the United States were age 55 or older in the year 2010, actually overrepresenting this age group.

The population is 50.8 percent female and 49.2 percent male; however, the 2008 active physician workforce was composed primarily of males (71.1 percent), with only 28.9 percent being female. The number of female physicians, however, has been rising steadily, according to the AMA. Despite increasing, females still composed only 30.4 percent of this workforce in 2010. This number is expected to continue to grow because women made up 46 percent of residents and fellows in 2010 and will soon be entering the medical workforce.

Promoting racial, ethnic, and linguistic diversity across physicians will produce a culturally competent workforce associated with better access to and quality of care for disadvantaged populations. These medically underserved populations typically include the poor, minorities, and rural residents. When minority patients see physicians with whom they share a common race, ethnicity, or language, they experience higher-quality interpersonal care, particularly in primary care and mental health settings. Patients experience better medical comprehension and show a greater likelihood of keeping follow-up appointments when practitioners speak the same language. Thus, physician diversity leads to improved public health. If the medical workforce does not reflect the anticipated demographics, then the delivery of quality care could be compromised with broader public health implications, hypothesize Gonzalez and Stoll.

The diversity sought in the workforce needs to be reflected in medical school admission policies. Health profession schools select and educate the health workforce of the future and therefore must be mindful of protecting the public. If students from all sectors of the population had equal opportunities for and access to high-quality education, the composition of medical school classes and, eventually, of the physician workforce would then correspond more closely with that of the greater population, explain Cohen, Gabriel, and Terrell.

Minority enrollments in medical school are currently rising in the United States, although the majority of all graduates practicing medicine continue to be white. All other racial and ethnic groups have shown steady increases and collectively tripled their number of graduating physicians, with Asians composing the largest group. In general, prior to the late 1960s, the racial and gender profile of medical students, and hence of the medical profession, was a white male. On average, one minority student was admitted every other year by medical schools of the time, which provides evidence of the racial discrimination that existed. Compared with medical school applicants in 1977, in 2011, the number of Hispanic or Latino applicants more than tripled, and the number of black or African American applicants grew 36 percent. However, since 1977, the percentage of American Indian or Alaska Native applicants declined by 19 percent, reports the Association of American Medical Colleges (AAMC).

In 1982, the gender composition of U.S. medical schools was primarily male; 67.3 percent of applicants were men, and the number of male graduates was more than three times that of female graduates. Women now enter medical school and the physician workforce in greater numbers. The year 2003 marked the first year that more women than men applied to medical school. Women comprised 50.4 percent of all applicants in 2004 and 47.3 percent in 2010. By 2011, women medical school graduates had nearly reached parity with men.

Increasing diversity in medical schools and among physicians to ensure cultural competency has been cited as a key strategy in addressing health care disparities. Further information is needed on sexual orientation and disability as measures of diversity. Some of the benefits of diversity, both in medical education and the physician workforce, include enhanced access to care and higher levels of perceived patient satisfaction. Although the numbers of both female and racial or ethnic minority physicians have increased gradually over the years, there is a continued need for physicians whose varied backgrounds, experiences, and training can directly meet the medical requirements of a diverse population.

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See Also: Alternative Medical Systems; Emergency Medical Care; Medical Social Workers, Racial and Ethnic Issues for; Medical Supplies, Access to; Outpatient Medical Care.

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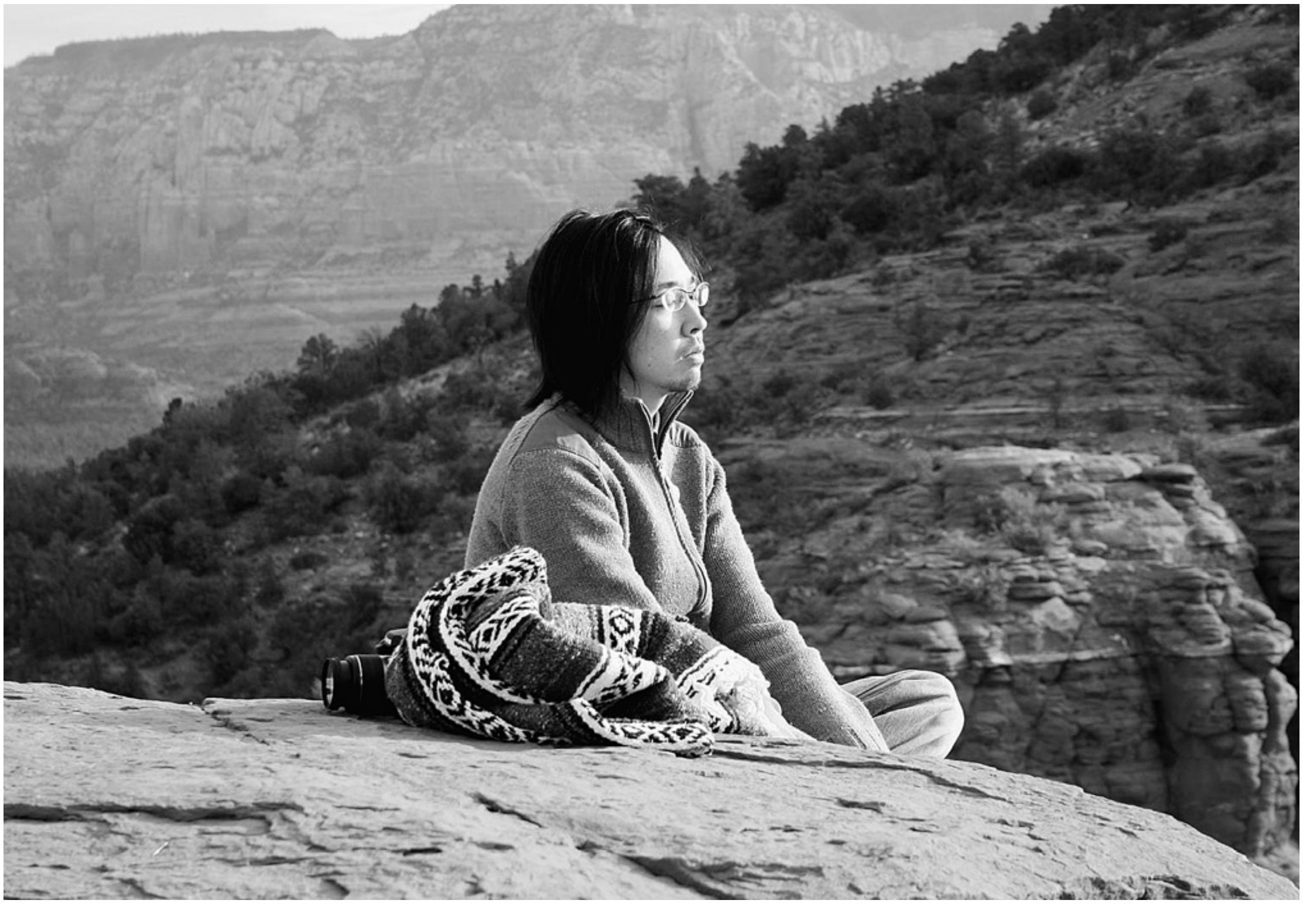
Meditation/Yoga

Meditation and yoga, both considered mindfulness or contemplative practices, aim to cultivate heightened awareness or single-focused attention through breathing exercises, movement, visualization, chanting, reading, writing, or other creative practices, having grown alongside world religions such as Buddhism and Hinduism and also having gained popularity in secular settings such as hospitals, higher education, and the military. Currently, human services providers are employing contemplative practices with a variety of studies illustrating the power of meditation and yoga to vastly improve personal relationships and work experiences among a diverse group of individuals. For instance, the Center for Mindfulness in Medicine, Health Care, and Society, founded by Jon Kabat-Zinn, has been training practitioners in mindfulness-based stress reduction (MBSR) techniques, combining mindful movement, gentle yoga, and meditation, for more than 30 years. MBSR is one of the many growing mindfulness-based interventions (MBIs) studied for its impact on conditions such as insomnia, eating disorders, depression, anxiety, and cancer, among a wide range of physical and mental illnesses.

Furthermore, meditation and yoga can be experienced individually or in groups and, when practiced daily, can assist individuals to improve focus and attention, reduce stress and anxiety, and enhance empathy, communication, and creativity as well as extend an individual's compassionate awareness of the interconnectedness of life. The transformative potential of contemplative practices such as meditation and yoga for human services is the process of self-inquiry these practices inspire, which can result in both personal transformation and social transformation through a recognition of shared suffering. Moreover, practicing meditation and yoga is said to expand one's awareness and appreciation of diversity by cultivating an understanding that everyone is connected by seeking to deepen connections among people by fostering love and reminding individuals of the sacredness of all life. In the United States, yoga popularity continues to rise, touted as a cure-all for almost every spiritual, physical, mental, and emotional ailment. The *Yoga Journal*'s 2012 American Market Study reported that nearly 20.4 million Americans practice yoga, spending around $10.3 billion a year on classes and products, with the five top motivations for practice being improved flexibility, conditioning, stress relief, overall health enhancement, and fitness.

Yoga and meditation in contemporary America is a mostly modern invention, dating back to the late 19th century with a short but extremely important lineage of teachers including Swami Vivekananda, Paramahansa Yogananda, and Sri Krishnamacharya, among others. Yoga popularity in the United States grew exponentially in the 1960s and 1970s with major contributors such as Yogi Bhajan, Swami Sivananda, Maharishi Mahesh Yogi, Richard Hittleman, B. K. S. Iyengar, T. K. V. Desikachar, Pattabhi Jois, Indra Devi, and others. This lineage of teachers revolutionized yoga by democratizing *asana* (physical postures) and meditation by making these practices accessible to all and also highlighting the complementary relationships between the sciences and spirituality. Thus, these practices fuse ideas from East and West, although their contemporary origin is generally traced to the 1893 Parliament of Religions in Chicago, where Swami Vivekananda introduced yoga to the American public for the first time, resulting in a national speaking tour and a series of books. Even so, Swami Vivekananda's approach to yoga was not based in contemporary *asana* practice; rather, it focused primarily on sitting meditation. What is remarkable about Swami Vivekananda's influence on American yoga is that he transformed what was traditionally a closely guarded, initiation-based process involving a guru–disciple relationship into a spiritual technology open to anyone, moving yoga into a new dawn of practice.

Most often, Sri Krishnamacharya is cited as the greatest exponent of modern hatha yoga, revolutionizing yoga traditions by continuing to



Meditating atop a hill in Sedona, Arizona. Meditation and yoga can be experienced individually or in groups and, when practiced daily, can assist individuals to improve focus and attention, reduce stress and anxiety, and enhance empathy, communication, and creativity as well as extend an individual's compassionate awareness of the interconnectedness of life.

democratize the practice through radical inclusion. Not only did he open up space for women to practice yoga, but he also tailored yoga to special-needs populations, insisting that yoga could benefit all people. Krishnamacharya's primary students, who carried his teaching to thousands of Westerners, include his son, T. K. V. Desikachar, who continues his work today; B. K. S. Iyengar, the founder of Iyengar yoga; and Pattabhi Jois, the father of Ashtanga yoga. Hence, modern hatha yoga is an amalgam of traditions, blending wrestling, gymnastics, and a variety of movement arts that merged with a growing renaissance in physical activity in India, wherein ancient traditions were revived with more physically active *asanas.* While *asana* is often the most common way in which many Americans are introduced to yoga, *asana* is only one small part of the practice of yoga. Yoga philosophy and practice also contain seven additional limbs referred to as *astanga*, with *asta* meaning eight and *anga* referring to the limbs or path of yoga practice, composed of the *yamas*—nonviolence, truthfulness, nonstealing, nonexcess, and nonpossessiveness—which firmly ground one in ethical practices of everyday life.

The *niyamas* include the principles of purity, contentment, self-discipline, self-study, and surrender. The *asanas* include a wide range of physical postures that prepare the body for sitting meditation. The fourth limb, *pranayama*, or the science of breath, teaches practitioners to link body and breath, enabling one to become ready to practice and understand *pratyahara*, or the development of sensual awareness, which further teaches one not to be attached to the many distractions that one encounters, achieving single-focused attention. Next, through *dhyana*, one develops a more single-pointed or focused concentration, which results from *pratyahara*. As such, meditation is a process of developing a type of witness consciousness, so one can learn to observe one's thoughts, feelings, and sensations as they occur, not placing judgment on the experience, thus enhancing awareness of one's relatedness with others. *Dhyana*, or meditation, can lead to *samadhi*, which represents the merging or union of individual consciousness with divine consciousness (e.g., a recognition of our interconnectedness) through an unfolding or complete integration of and dissolution of the boundaries that separate all beings.

Much of contemporary yoga and meditation practices endeavor to make our daily lives more livable versus transcending our human existence through reincarnation, more specific to Hinduism and Buddhism tradition. As a result, meditation and yoga are practiced by people with diverse spirituality or faith systems, emphasizing embracing our humanity to foster a greater sense of compassion and connection. Because the emphasis for many has shifted to improving one's life now, both practices can complement diverse religious or spiritual belief systems. Most significantly perhaps, these practices offer individuals an opportunity to reconnect with the body and something beyond themselves, whatever that may be for each person. For some, yoga will be highly spiritual. For others, the practice may remain mostly physical. In the end, there is no right path or one true practice of yoga or meditation; thus, these practices have much potential for expanding diversity awareness, aiding stress reduction and relaxation, improving concentration and communication, and enhancing relationships across a wide range of human services professions.

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See Also: Cultural Paradigms; Health and Sickness, Differing Attitudes Toward; Religion and Clients.

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Melting Pot Theory

Addressing the needs of diverse populations continues to perplex human service professionals. U.S. society reflects the push and pull of conservative melting pot ideologies that propose conformity to a national culture while often denying service recipients the promised benefits of equitable inclusion. Despite social scientific efforts to discredit melting pot ideologies, the metaphor of a smoldering alloy of races and cultures continues to have substantial influence on service recipients. Melting pot ideologies ignore cultural differences and are reenergized in the minds of young human service apprentices by Eurocentric middle-class policies that guide their professions.

Origins of the Melting Pot and the Establishment of White Privilege

The notion of the melting pot originated in 1782 in J. Hector St. John de Crevecoeur's *Letters From an American Farmer*. It was not until Israel Zangwill's 1908 play—*The Melting Pot*—that it took on full force. Large waves of southern and eastern European immigrant groups were resisted by older and more established British, German, and Irish descendants known as nativists. There was an aggressive call for assimilation, intermarriage, and acculturation to decrease the perceived threat of immigrants from Poland, Italy, and Russia. The Chinese, often defined as illegal, were restricted, relegating them to isolated ethnic enclaves. The melding of European identities forged under ideologies of whiteness came to be understood as the norm to be followed. In this way, the foundation of white privilege, within the purview of the protestant ethic, was cemented.

The Melting Pot Versus Cultural Pluralism and the Social Sciences

Early academics such as Randolph Bourne with his 1916 essay *Trans-National America* and Horace Kallen in his 1915 *Democracy Versus the Melting*

Pot article, argued for cultural pluralism: a respect for diversity that would strengthen the nation. However, as most social scientists of the time, they accepted the racial stock or types promoted by contemporary anthropologists. Dr. Ales Hrdlicka, curator of the Division of Physical Anthropology, used racial classifications to argue against the melting pot with respect to American settler descendants. Franz Boas, the father of modern anthropology, however, argued against ideas of racial purity and superiority while advocating for cultural distinctiveness. He realized that there was greater biological variability within the so-called races than between them. He opposed the eugenics movement that sought to rid the world of "weaker races." Ahead of his time, he noted that the repression of cultural differences would delay rather than hasten the acculturation process desired by Nativists.

During the 1940s, John Dewey promoted the idea of cultural pluralism further. Social work and other human service professions, however, have fallen short. Historian Michael Reisch, in his discussion of the melting pot, explains that social work has perpetuated numerous injustices by enforcing political policies that maintain its professional status while contradicting its values of social justice. Individualist values sponsored by political and social service's initiatives have clashed with the collectivist ideals of marginalized groups in self-help ventures.

During the early 20th century, for example, most social workers saw immigrant waves as an obstacle to the politically supported melting pot interventions. African Americans, Latinos, and Native Americans became the targets of aggressive civilizing projects. Jane Addams's work with African Americans in the settlement houses was the most notable exception. For the most part, even after the Depression and New Deal, African Americans and Latinos were denied the protection against discrimination of the Social Security and the National Labor Relations Acts. During World War II, social workers began to focus on universal social welfare programs and intergroup relationships due to the contradictions between military segregation and the struggle against fascism. The ideal of the melting pot remained intact; however, due to the profession's neglect of a systemic policy analysis, they espoused melting pot and professional practices of cultural exclusion that prioritized those of European descent.

From the 1960s to the Present

Although the emphasis in human services has continued to be on professionalization, the 1960s marked a greater move toward diversity. Daniel Glazer's and Nathan Moynihan's sociological study *Beyond the Melting Pot* provided reasons for the continued debate. Alejandro Portes, in his critique of their work, discovered that complete assimilation depended on the immigrant group's mode of incorporation into the nation. Some Euro-American groups assimilated with ease, losing all identifiable ethnic markers; others had to work harder to be accepted but managed to climb beyond the glass ceiling.

Cultural pluralism became a reality for groups who were excluded from the ideal of nation and for those who chose to maintain their culture while making use of the benefits of American citizenship. Other studies, however, have revealed the existence of more complicated dynamics pointing to context-specific cultural allegiances. Ann Rynearson's 1980 doctoral dissertation discusses greater adaptive heterogeneity within specific ethnic groups, thus contradicting the melting pot theory even further. She explores how a particular Mexican American enclave in St. Louis practiced strong ethnic ties within group-specific celebrations but refrained to do so in the wider society.

The metaphor of the melting pot continues to be energized within anti-immigration political discourses while also maintaining a diversity of meanings. It is often used to refer to groups who have lost touch with their ethnic origins depicted as solely American. However, it is also used to portray diversity within a common institutional or situational context. A major difference between the idea of the melting pot and that of cultural pluralism lies in the perspective of those in the positions to observe and judge others. In the melting pot, there is an external view of internal group dynamics where the members are devalued as mechanical components of a dominant cultural system. In cultural pluralism, however, there is a more complex engagement between external and internal cultural dynamics, thus providing a greater validation of its members.

It behooves human service professionals to become aware of the sociopolitical forces at play in the cultural depictions of diverse populations that affect intervention decisions. A promising way to explore adaptive cultural strategies that oppose melting pot homogenization is to employ the paradigms of cultural humility and transformative complicity. By defining service seekers as experts of their own experience and remaining open to difference, cultural humility promotes greater understanding and validation between service providers and recipients. Transformative complicity involves a critical reflection of provider participation in oppressive institutional dynamics while engaging in calculated risk sharing to increase positive transformative agency. Together, cultural humility and transformative complicity promote responsive interventions that validate recipient-defined cultural adaptations and human service social justice values.

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See Also: Acculturation; Assimilation; Cultural Determinism; Cultural Humility, Model of; Cultural Paradigms; Culturally Diverse Practice, Definition of; Culturally Specific Services; Discrimination and Institutional Racism; Ethnic Diversity and Values; Ethnocentrism; Multicultural Education; Race, Social Definitions of.

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Mental Health, International Variations in Attitudes Toward

Attitudes toward mental health are reflected in knowledge about, discrimination of, and advocacy for individuals with mental disorders. Globally, mental health conditions have been regarded with considerable discrimination, lack of knowledge, and limited advocacy, which have a great impact at individual and systemic levels. For instance, worldwide, significant numbers of individuals with severe mental illnesses experience discrimination, which encourages concealment of the disorder and discourages seeking treatment. At the systemic level, negative attitudes toward psychopathology curb resources dedicated to mental health services and reduce accessibility of such services.

Although mental health problems have typically been viewed negatively, attitudes toward mental illness differ among and within nations, depending on factors such as the countries' developmental stage, cultures, and subcultures. For example, various ethnic groups with differing attitudes toward mental illness exist within the United States. Compared to Caucasians, Hispanic and Asian Americans tend to believe that individuals with mental illness are more dangerous. Additionally, African Americans report more positive attitudes toward seeking treatment than Caucasians, but these attitudes become more negative subsequent to seeking such treatment.

These changes in attitudes may result from limited cultural sensitivity of available mental health assessments, diagnoses, and treatments. Furthermore, subcultures exist even within the various ethnic and racial groups of countries. This entry focuses primarily on differences in attitudes as a function of a country's developmental stage. Understanding international variations in attitudes toward mental illness is important as these attitudes impact global responses to mental health and treatment of individuals with mental disorders.

Attitudinal Variations Among Developed Countries

Developed countries are defined by advanced economies, industrialization, and infrastructure and tend to manifest less stigmatization of mental illness compared to developing countries. This may be due to mental health advocacy increasing over the past 30 years in developed nations such as Australia, Canada, and the United States. However, attitudes toward mental illness vary across developed countries. For example, citizens of Japan show greater negative attitudes toward persons with mental illness when compared to citizens of the United States. Similarly, citizens of Hong Kong, China, tend to strongly oppose the development of rehabilitation centers near their living quarters due to beliefs that community violence would increase. This is despite their moderate levels of knowledge and concern about mental health. This stigma may be a result of several modern mental health services originating in the United States, which may limit the efficacy of these treatments for citizens of nations with cultures vastly different from the United States such as China and Japan.

Citizens of European nations, such as Belgium, France, Germany, Italy, the Netherlands, and Spain, have also shown considerable negative attitudes toward mental illness, particularly regarding those seeking help. More than one-third of European citizens reportedly believe that seeking help for mental illness will result in outcomes worse than or equal to not seeking help. However, these beliefs do not always predict behavior as a majority of European, particularly Spanish, individuals report feeling comfortable seeking mental health treatment. German citizens exhibit the least positive attitudes, while citizens of Spain exhibit the most positive attitudes toward mental health treatment compared to other European countries.

Across countries in the Middle East, it appears that citizens of Israel, one of the most developed Middle Eastern nations, display less stigma toward mental illness compared to lesser-developed countries in the Middle East. Citizens of Israel practice greater self-disclosure, are confident in mental health services, and show greater openness to seeking help for mental disorders. These attitudes may be a result of Israel's adoption of a universal health care system and, thus, greater allocation of resources to mental health services in this region. However, variations in attitudes toward mental health exist within Israel, as Jewish and Arabic individuals place different emphases on mental health. Qatar is another highly developed country in the Middle East; however, citizens of Qatar exhibit poor knowledge and negative beliefs about mental illness. The people of Qatar, particularly women, tend to believe that mental disorders are caused by spiritual forces rather than biopsychosocial causes and that mental illness increases violence. Similarly, despite economic development, citizens of Kuwait show greater stigma toward mental health disorders and less confidence in the utility of mental health services, which may be due to Kuwait's limited accessibility to mental health resources.

Attitudinal Variations Among Developing Countries

Developing countries, which are defined by a lack of industrialization, limited economy, and limited infrastructure, have been shown to have twice as much stigma toward mental illness as developed countries. For instance, citizens of the developing nation of India exhibit greater stigma toward mental illness than the developed nation of the United States. Specifically, citizens of India tend to believe that mental illness is controllable by the afflicted individual and place greater confidence in traditional forms of treating mental illness such as social support and spiritual practices.

There appears to be significant variation in attitudes toward mental illness among developing countries within the Middle East. For instance, the state of Palestine holds positive attitudes toward mental health that are comparable to the developed nation of Israel. Palestinian citizens exhibit greater self-disclosure, help-seeking behaviors, and confidence in mental health services compared to other developing nations in the Middle East. However, systemic (e.g., multiple systems of delivery) and physical barriers (e.g., road blocks) increase difficulties accessing mental health services in Palestine. Citizens of Egypt, however, tend to exhibit more negative attitudes, possibly due to the limited availability of services and greater reported need for these services. The lower confidence in modern mental health services exhibited by developing Middle Eastern nations may be a consequence of limited availability and accessibility of these services. Furthermore, because many mental health services originate from developed nations, their efficacy and utility in developing nations may be limited.

Similar negative attitudes toward mental illness exist in developing African nations. For example, in Ethiopia, citizens prefer traditional practices for treating mental illness rather than modern mental health services. Citizens of African nations also may attribute mental illness to supernatural causes, which thwarts the development of mental health services in these nations. In developing Latin and Caribbean countries (e.g., Mexico or Dominica), there appears to be more similarities than differences when compared to developed countries. Citizens of Latin and Caribbean nations generally have more confidence in modern mental health treatments than traditional or spiritual practices used to combat mental illness.

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See Also: Disabilities, International Variation in Attitudes Toward; Ethnic Diversity and Values; Help-Seeking Behavior, Cultural Differences in; Role Flexibility, International Differences in.

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Mental Health Gap Action Program

The World Health Organization (WHO), the directing and coordinating authority on international health within the United Nations' system, launched its flagship program on mental health, the Mental Health Gap Action Program (mhGAP), in 2008. Grounded on the best available scientific and epidemiological evidence related to mental, neurological, and substance use (MNS) disorders, the program has been developed to facilitate the integration of prevention and treatment services into health care systems across the globe. The mhGAP aims to scale up mental health services, especially in resource-constrained settings, for the purpose of bridging the extant gap between population needs and available resources. Through the mhGAP, WHO calls on governments, donors, and mental health stakeholders to expand and improve mental health services worldwide for the purpose of reducing both individual and societal burdens associated with MNS disorders.

Developed to enhance the capacity of member states to respond to the treatment gap challenge, the mhGAP provides a framework for scaling up MNS disorder interventions. However, it is only intended as a guide, one that aims to provide health planners, policy makers, and donors with a clear and coherent set of activities and programs for scaling up care for MNS disorders. Designed to account for contextual variables, feasibility, and barriers, the mhGAP presents a template for intervention packages and provides the flexibility necessary for requisite adjustments and adaptations relative to the context-specific needs of diverse cultures and populations that exist among countries as well as within countries.

Scaling up mental health care is a social, political, and institutional process that engages a range of contributors, interest groups, and organizations. Successful scaling up requires collective action and the collaborative efforts of governments, health professionals, civil society, communities, and families, with support from the international community. In collaboration with partners, WHO will provide technical support to countries in order to implement guidelines for scaling up care.

The Need and the Challenge

MNS disorders are prevalent across all cultures and contribute significantly to morbidity and premature mortality. Although the efficacy of treatment is well documented, population studies indicate that more than two-thirds of the individuals experiencing mental illness receive no treatment. Worldwide, the average portion of those who do not receive treatment lies between 50 and 60 percent; however, that number increases to nearly 80 percent in low- and middle low-income countries. Subsequently, 13 percent of the global burden of disease has been attributed to neuropsychiatric disorders.

However, despite the prevalence of MNS disorders, approximately one-third of the world's countries lack a mental health budget, and of the countries that do allocate funds, many assign disproportionately small percentages of their budgets to mental health services. The disparity between needs and services, defined as the treatment gap, leaves a large unserved population. Exacerbating the problems attendant to insufficient resources are the inequitable and inefficient uses of available resources. Misapplication of funds, in turn, limits treatment efficacy for those individuals who are able to access services.

Mental Health Is Fundamental to Overall Well-Being

Characterized from a holistic perspective, WHO's constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." Implicit in the description is the assertion that mental health is essential to overall health. However, not only is mental health crucial to the optimal development and overall well-being of individuals, it is also essential to the healthy development of societies and countries.

Multiple social, psychological, and biological factors influence an individual's level of mental health at any point in time across the life span. Mental health is adversely affected by chronic social conditions such as poverty, community violence, racism, and discrimination and is linked in complex ways with other health conditions including both communicable and noncommunicable diseases as well as with injuries. Compounding the suffering accompanying MNS disorders are stigma and human rights violations.

While the mhGAP does not address every MNS disorder, it has identified several priority conditions. These conditions were selected on the basis of the large burden they represent in terms of mortality, morbidity, or disability, the high economic costs they incur, and their association with violations of human rights. The priority conditions identified are as follows: depression, psychosis, bipolar disorders, epilepsy, developmental and behavioral disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, and self-harm and suicide.

Mental Health Gap Action Program Intervention Guide

In a majority of countries, scaling up services for MNS disorders means expanding services beyond mental health specialist settings into first- and second-level facilities. Therefore, to assist health professionals, WHO presented the Mental Health Gap Action Program Intervention Guide (mhGAP-IG) in 2010 for use in nonspecialist health settings. The mhGAP-IG places competent MNS disorders diagnoses and management into the hands of nonmental health professionals including doctors, nurses, and other health care providers.

The mhGAP-IG provides a full range of recommendations for delivering high-quality care at first- and second-level facilities located in resource-poor settings. Utilizing protocols for clinical decision making, it presents integrated management of priority conditions. The mhGAP-IG evidence-based guidelines are formatted as flowcharts in order to simplify the diagnostic and intervention process while enabling health care professionals to tailor services to meet the needs of each individual client.

While the mhGAP-IG is a model guide, WHO strongly recommends that it be adapted to national and local situations. Adaptation is necessary to ensure that the conditions that contribute most to the burden in a specific country are included in the mhGAP-IG and that the mhGAP-IG is appropriate for and compatible with the local conditions that affect the care of individuals presenting with MNS disorders in a particular health facility. Adaptation should include language translation as well as necessary adjustments to ensure that the interventions are acceptable in the sociocultural context and suitable for the local health system.

Moving Forward

On May 27, 2010, the 66th World Health Assembly adopted the Comprehensive Mental Health Action Plan for 2013 through 2020. The plan does not duplicate the mhGAP; rather, it both complements and builds upon it. Emphasizing the need to develop a strong civil society and to empower individuals experiencing mental disabilities, this action plan sets important new directions for mental health by highlighting the importance of protecting and promoting human rights as well as advocates for a central role in the provision of community-based care and support. It also addresses a number of social determinants related to mental health including, but not limited to, income and occupational concerns, educational opportunities, housing, and social services.

About WHO

Following the inception of the United Nations in 1945, WHO was founded on April 7, 1948, a date now celebrated annually as World Health Day. WHO is currently comprised of 193 countries and two associate members and presently employs nearly 8,000 people in 147 country offices and six regional offices; and their headquarters are located in Geneva, Switzerland. The organization's goal and subsequent corresponding actions have been and continue to be directed toward ensuring the world's population access to quality health care.

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See Also: Chronic Diseases Common in Developing Countries; Global Burden of Disease; Universal Declaration of Human Rights.

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Mental Health Service Delivery, Cultural Characteristics of

Mental health refers not just to the presence or absence of mental illness but to the ability to cope with life stressors in a manner that does not severely impact daily life functioning. A variety of cultural characteristics can impact a person's ability to seek, afford, and access mental health services and resources. Culture, when defined broadly, includes the beliefs, values, and norms of a specific group. With a vast range of cultural groups, subgroups, and individual variations, cultural characteristics are important because they influence what both seekers of mental health treatment and service providers (clinicians, medical providers, social workers, etc.) bring to the treatment setting. Specifically, cultural characteristics impact three major aspects of mental health service delivery including (1) how and when symptoms are communicated and reported (dependent upon the culture's meaning of symptoms and the amount of stigma of mental illness), (2) the ability of mental health consumers to understand and navigate the system of care and resources offered, and (3) the course of treatment sought and recommended (dependent upon the training and beliefs of both the individual seeking treatment and the delivery service providers).

A shift in the model of mental health service delivery from a more institutionalized delivery of care (pre-1970s) to largely community and outpatient mental health settings (1970s to present) has also impacted the ability to access appropriate mental health care within various U.S. cultural groups.

Stereotyping cultural groups and how they use mental health services can be misleading when focusing on an individual's mental health needs and symptoms; however, an awareness of cultural influences and beliefs can provide service providers with a greater understanding and sensitivity to the diverse needs of their clients. For example, racism, discrimination, and poverty are very real cultural elements that affect the use and access of mental health services. An understanding of the impact of these elements may alter the current model of mental health service delivery to be more responsive to the needs of those cultural groups who have historically underutilized mental health services.

Communication and Reporting of Mental Health Symptoms

Cultural beliefs of what constitutes a sign and symptom of mental illness, the meanings attributed to them, and where their origins lie all impact whether an individual believes that his or her mental health is affected and, if so, how and when they communicate these symptoms. According to the U.S. National Institute of Mental Health, differing cultural interpretations of mental health symptoms include (1) the beliefs that a cultural group holds about whether a mental illness is of the body, of the mind, or both, (2) whether it is a real or an imagined illness, (3) whether it is shameful or stigmatized within the culture, and (4) whether it warrants treatment (and if so, what kind of provider would be most appropriate).

In general, patients tend to communicate or report mental health symptoms to service providers in ways that are culturally acceptable and meaningful to them. For example, Native American populations may believe that certain mental health symptoms are caused or correlated with a spiritual deity; as such, they may be less likely to seek out treatment, and if they do, they may be more likely to use traditional healers than the mental health services found in U.S. professional settings. Similarly, individuals from cultural groups who do not emphasize a mind–body distinction may believe an upset stomach is a natural outgrowth of a negative emotional experience and may describe this symptom as an emotional one. Their expectations of how the symptom would be treated would differ dramatically from what they may receive from Western medical service providers, who may treat an upset stomach as having a physical or biological cause. Similarly, if an individual's culture attaches a great stigma to mental illness, the likelihood of communicating and reporting symptoms of mental illness may be greatly reduced. In some cultures, the individual may be viewed as unmarriagable or may be shunned from society.

Because serious mental illness is disabling to individuals regardless of cultural interpretation, the underreporting or misinterpretation of mental health symptoms may prolong symptoms and hinder the ability to provide adequate medical care. If left untreated, mental illness may also lead to more serious consequences for the individual (e.g., extreme distress or suicide). Mental health service providers that are aware and sensitive to cultural interpretations of mental health symptoms may be better able to address their clients' needs in a manner that navigates the client toward effective mental health treatment.

Navigation of Mental Health Resources and System of Care

Individuals within cultural groups differ in their ability to understand and navigate the systems of care available to them. Traditionally, mental health services are delivered via both the private sector (fee-for-service psychiatrists, psychologists, and clinicians) and public sector (federal- and state-funded case managers, social workers, and clinicians). As there remains a high correlation between one's cultural group and socioeconomic status, individuals from historically underrepresented cultural groups in the United States (e.g., African American, Hispanic, and Native American) often lack medical insurance or the financial resources to pay for private-sector mental health services. As such, in many cities in the United States, these individuals remain largely underserved by private medical professionals and therapists, and their choices for mental health treatment possibilities are often limited to the public sector.

Moreover, individuals who have little experience, funding, or education in navigating large, public institutional systems of care can be at a significant disadvantage when advocating for their mental health needs. The cultural elements associated with poverty and racial discrimination (e.g., lack of insurance, cultural stereotyping, etc.) can affect the amount of information individuals receive about their diagnoses and treatment options as well as the amount of positive interactions they receive from service providers. These elements can significantly impact the quality of treatment they receive.

Course of Treatment Sought and Recommended

Both the cultural characteristics of the mental health consumer and the service provider impact what course of treatment is sought and recommended. Historically, service providers in the United States that are covered by Medicare and private insurance companies were trained to practice traditional Western medicine, which emphasizes scientific inquiry and the use of prescription drugs and clinical therapy to lead to a possible cure of mental illness. These cultural beliefs share wide acceptability within the United States and can impact how providers diagnose and treat mental health issues. For example, many psychiatrists trained in the 1940s and 1950s in the United States were trained to be clinicians and therapists and to operate within a psychoanalytic framework (although theoretical training models varied by U.S. region). The field of U.S. psychiatry training has recently focused on diagnosis and medication of a patient's mental health needs through psychopharmacology and the dissemination of prescription drugs and has focused less on therapy training. Instead, many psychiatrists now refer patients to outside therapy rather than to deliver the therapy themselves. The advent of managed care has reinforced this shift in training and service delivery, creating a culture in which psychopharmacology is more widely accepted than ever before in the United States for the treatment of mental disorders.

Recent Trends in Delivery of Mental Health Services

As the U.S. mental health service delivery model has shifted in recent years from a more institutionalized delivery of care (pre-1970s) to largely community and outpatient mental health settings (1970s-present), the mental health services offered to seekers of mental health treatment have become more fragmented, often occuring within multiple settings away from the treatment seeker's home (e.g., outpatient clinic, regional center, etc.) and often with varying financial obligations and fees. This more-fragmented model of service delivery has impacted individuals within various U.S. cultural groups, making it more difficult for those without adequate tranportation, with limited funds, and with conflicting school or work schedules.

Recent trends in service delivery have sought to address the cultural characteristics that serve as barriers to effective treatment. Cross-system collaboration of mental health services (e.g., mental health community clinics coordinating with existing child welfare and domestic violence systems) and wraparound services (mental health resources and clinical services provided directly within larger institutions such as schools, juvenile justice facilities, and nursing and foster homes) are examples of demonstrated efforts designed to make service delivery easier to access for the mental health consumer. As these recent changes in how and where mental health services are delivered take effect, they may dramatically increase service delivery and usage, particularly among cultural groups who have historically underutilized traditional clinical mental health treatment.

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See Also: Counseling and Psychotherapy Services; Mental Health Services, Adult; Mental Health Services, Children; Mental Health Services, Ethnic Models and Multicultural Services, Cross Cultural Service Models.

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Mental Health Services, Adult

The mental health service system in the United States is a patchwork quilt of a variety of both public and private mental health services provided by an array of mental health professionals in different settings and through different formats. Like child and adolescent mental health services, adult mental health services include the prevention, diagnosis of mental disorders, their treatment (including the use of medications to help control the disorder), and follow-up services. The ultimate goal of adult mental health services is to address the symptoms associated with mental disorders and thus to improve the adult's quality of life, with a focus on providing resources to help them sustain this higher quality of life. Mental health services are financed by private service providers including insurance companies such as Blue Cross Blue Shield and by public insurance providers. Medicaid, which provides physical and mental health services for poor persons, and Medicare provide mental health services for adults age 62 and above. Mental health insurance benefits are usually not as significant as benefits for physical health, although mental health service coverage has increased in recent years.

As with child and adolescent mental health services, human diversity is important to adult mental health services because prevention efforts and treatment responses to the needs of adults with mental disorders will vary depending on their cultural background, race, gender, age, and research advances to help understand the influence of genetic factors on the prevalence and development of mental disorders, among other factors.

Common adult mental health diagnoses include major depression, schizophrenia, bipolar disorder, and post-traumatic stress disorder (PTSD).

Mental Health Assessment and Diagnosis

Accessing and using mental health services may be conceptualized as a traditional linear or step-by-step process or as a nonlinear process in which persons experience setbacks but, ultimately, change or transform their lives into new ones. The nonlinear process is often referred to as the recovery perspective.

In the traditional step-by-step process, the first step in mental health services for adults is recognition of a change in normal behavior through the observation of symptoms. Then, an adult is referred to a mental health professional for an assessment. Adults with mental disorders are diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). This manual provides a list of symptoms and the severity and frequency with which an adult must have experienced them over a certain period of time in order to be assigned the diagnosis. Common adult mental health diagnoses include major depression, schizophrenia, bipolar disorder, and posttraumatic stress disorder (PTSD). An adult's diagnosis may change over time, and frequently adults may have more than one diagnosis.

Adults receive mental health services from a variety of professionals and paraprofessionals. Professionals include psychiatrists and general medical practitioners, who prescribe psychiatric medications when needed. Other professionals include clinical psychologists, licensed clinical social workers, psychiatric nurses, licensed practical counselors, and marriage and family therapists. Paraprofessionals include persons with various levels of training and education such as case management aides, case managers, hospital technicians, and community-based workers. They provide important support services to round out a care plan and follow-up plan.

Crisis Intervention Services

When adults with a mental disorder experience a psychiatric crisis, they may receive crisis intervention services via a community-based psychiatric emergency program or in a hospital emergency room. In either location, the mental health assessment process includes taking a history of mental health needs, assigning a diagnosis, and referring the person to a provider for long-term services that may include inpatient or outpatient mental health services. Outpatient services usually include a follow-up visit with a psychiatrist to monitor medication levels, a therapist or counselor, job training or other skills training, and support groups.

Many adults, like children and adolescents, are prescribed psychotropic medication to help manage the symptoms associated with their mental disorder. While medications alone cannot cure the disorder, they can help the person function better and thus experience a better quality of life. Medications may be used alone or in combination with other interventions or treatments such as cognitive behavioral therapy or individual or family counseling. Medication side effects range from weight gain to blurred vision.

Inpatient Services

Persons diagnosed with a mental disorder may be admitted as inpatients on a voluntary or involuntary basis. When persons are admitted on a voluntary basis, they agree to receive inpatient services. When they are admitted involuntarily, they do not agree to be hospitalized and are admitted because they may be a threat to themselves or someone else. Most persons receive inpatient services from a private or public provider (e.g., state psychiatric hospital) for a short period of time (e.g., one week). Once persons with mental disorders are stabilized, they are discharged from the hospital and referred to outpatient services, which may include individual or group therapy, medication follow-up with a psychiatrist, job training programs, and residential care programs, for example.

Mental Health Recovery Perspective

As with a physical health diagnosis, persons diagnosed with a mental disorder have the capacity to recover from their mental disorders. The Substance Abuse and Mental Health Services Administration, a government organization, has defined mental health recovery as "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential." This perspective is based on self-direction; individual and person-centered care; empowerment; holistic, nonlinear, strengths-based care; peer support; and respect, responsibility, and hope.

Community Support

Advocacy organizations such as the National Alliance on Mental Illness hold local support groups for both persons with mental disorders and their family members. During the last decade, alternative approaches to mental health treatment, such as peer support, have also gained recognition. In peer support services, a current or former consumer of mental health services provides support to someone currently receiving services. Some peer support services are consumer operated, including consumer case management aids and consumer-operated drop-in centers. The International Association of Peer Supporters defines peer supporters are persons who have maintained their own mental health recovery over time through personal commitments to their own recoveries. Through a motivating approach, they share lessons learned about recovery and have completed organized training and workshops in preparation for working with other persons.

Mental Health Services for Special Population Groups: Criminal Justice Settings and Military Veterans

Adults with mental disorders may end up in jails, state prisons, or federal penitentiaries. Many adults in such settings have diagnosed mental disorders. Often, they receive no mental health treatment or a lower intensity of mental health treatment, though they have high behavioral and mental health needs.

The Iraq and Afghanistan wars highlighted the importance of providing mental health services for the up to 20 percent of returning veterans who experience PTSD. Some veterans may not reveal their need or access mental health services for PTSD due to the stigma attached to mental illness. Many veterans have a choice of using a civilian, employer-provided health plan or military mental health providers, and they may choose to use their employer-provided plan or receive mental health services through hospital or community-based providers or clinics. Sometimes, veterans are referred to an outpatient clinic in the community for care, or they may participate in a service program especially developed for veterans with PTSD. President Obama signed an Executive Order in August 2012 to both increase the number of mental health providers in the U.S. Department of Veterans Affairs (VA) and to build partnerships between community service providers and VA providers to enhance access to mental health care for veterans and fill the gaps in mental health services for veterans.

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See Also: Counseling and Psychotherapy Services; *Diagnostic and Statistical Manual of Mental Disorders*, Cultural Responsiveness of; Group Therapy; Mental Health Services, Child; National Center on Minority Health and Health Disparities; National Institute of Mental Health; Self-Harm, Cultural Aspects of; Trauma-Focused Services; Veterans Services.

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Mental Health Services, Children

Child mental health services include the prevention, diagnosis, and assessment of mental disorders, their treatment (including the use of medications to help control the symptoms associated with the mental disorder), and follow-up services. The ultimate goal of the provision of child mental health services is to address the symptoms associated with the mental disorder and thus to improve the child's quality of life. Children receive a variety of mental health services from an array of mental health professionals in different settings and through different formats. Human diversity is important to child mental health services because prevention efforts and responses to the needs of children with mental disorders will vary depending on their cultural background, race, gender, age, and other variables.

Mental Health Assessment and Diagnosis

The first step in mental health services for children is recognition of a change in normal behavior through the observation of symptoms. Then, a child is referred to a mental health professional. Children with mental disorders are diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). This manual provides a list of symptoms and frequency with which a child or adolescent must have experienced them over a certain amount of time in order to be assigned the diagnosis. Common child mental health diagnoses include attention deficit hyperactivity disorder, autism spectrum disorders, oppositional defiant disorder, and conduct disorder. Sometimes, children may have more than one diagnosis, and their diagnoses may change over a short period of time. Children and adolescents frequently convey their mental health needs through their behaviors: withdrawal, problems sleeping, disruptiveness, lying, bed wetting, physical aggressiveness, poor attention span, suicide attempts, poor peer relations, irritability or complaining, defiance, depressive symptoms, or poor social skills. A mental health professional must often figure out which symptoms are the most prominent because what is considered normal varies for children. Recent advances in understanding how genetic components, like the brain, influence behavior, along with a child or youth's environment, have helped further understand child mental disorders.

Medication Intervention

Increasingly, children are prescribed psychotropic medication to help manage the symptoms associated with their mental disorders. While medications alone cannot cure the disorder, they can help the child function better and experience a better quality of life by controlling their symptoms. Medications may be used alone as a single intervention or in combination with other interventions or treatments such as individual or family counseling, play therapy or cognitive therapy. Children and youth may experience side effects from these medications, ranging from drowsiness to weight gain. Medical professionals such as psychiatrists or general practitioners monitor the medication side effects. Medication may have different possible side effects alone or when combined with other medications. Another medication may be prescribed to respond to the side effect, and children may be prescribed more than one medication.

Childhood Trauma

Children who have experienced some type of trauma, such as child abuse or neglect, may experience post-traumatic stress disorder (PTSD). This occurs when children or youth experience some level of anxiety after they have witnessed or experienced, either directly or indirectly, a traumatic event. Children who are witnesses to domestic violence may experience PTSD. Children who have experienced physical or sexual abuse or neglect may also experience PTSD. They may experience different types of symptoms such as difficulty sleeping, flashbacks of the event, bed wetting, refusing to engage in activities or interests that they enjoyed before the event, worry, or depression. The symptoms vary depending on the child and the traumatic event experienced.

Mental Health Service Settings for Children

After a child is diagnosed, treatment goals and objectives (a treatment plan) are developed, outlining the types of service to be provided for each goal. Common interventions include individual or group counseling or medications to help control symptoms associated with the mental health condition. These interventions may be provided in schools or residential care settings. Children also receive mental health services in a variety of mental health settings, both public and private. Mental health services are defined as interventions or solutions that will help children to improve their quality of life and return to their normal standard.

The majority of children and youth attend public or private school, and a smaller percentage of children are homeschooled. As noted, children and adolescents convey their mental health needs through their behaviors. Teachers often first notice a change in a child's usual behaviors. Youth may be referred to a mental health counselor or school social worker or outside mental health services if needed.

Residential Care Services for Children and Youth With Mental Health Needs

Residential care settings are common treatment venue for children and youth. Sometimes, children and adolescents may need a higher level of behavioral and mental health care than their parents can provide due to the severity of their behaviors or symptoms. When this happens, parents may place their child in a residential setting with staff who are more able to address the child's mental health symptoms. Residential child care settings include foster care, group care, and residential treatment. Therapeutic foster services are provided by foster parents who receive training and skills in helping youth with behavioral and mental health needs live successfully in their environment and provide them with needed supports. Children and youth with similar levels of behavioral and mental health needs may live in a group home or on a campus where intensive mental health services are provided.

Children and youth with the highest or most severe level of mental health challenges may be placed in a residential treatment facility, which involves inpatient, 24-hour-per-day, locked, psychiatric care. Residential child-care settings are staffed with trained mental health professionals from various disciplines to help children improve their quality of life and meet their treatment goals. Of special note, children who reside in juvenile justice settings (e.g., boot camps or juvenile justice centers) may receive mental health services while detained.

Telepsychiatry

Telepsychiatry is an alternative treatment method to face-to-face services; this approach uses cameras, computers, special software, and microphones for children and adolescents, parents, and mental health professionals to videoconference as if they were in the same room together. Telepsychiatry is especially useful for children and adolescents who live in rural or underserved areas. Services such as individual or group counseling, mental health assessment and diagnosis, and medication prescription and management may be delivered through this method.

Mental Health Professionals

Children and youth receive mental health services from a variety of professionals including licensed clinical social workers, clinical psychologists, licensed practical counselors, and psychiatric professionals (e.g., psychiatric nurses, psychiatrists, and general medical practitioners). General practitioners prescribe the majority of medications for psychiatric needs. Generally, psychiatrists are the only professionals other than general medical practitioners who can write prescriptions for medications. Over time, the number of qualified psychiatrists in the United States has markedly declined, especially in rural areas. The dearth of psychiatrists has contributed to an increasing gap in addressing the mental health needs of all populations, including children and adolescents. To address the shortage of qualified mental health professionals, some states, like Louisiana and New Mexico, have granted limited prescription privileges for psychiatric medications to doctoral-level licensed psychologists.

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See Also: Counseling and Psychotherapy Services; *Diagnostic and Statistical Manual of Mental Disorders,* Cultural Responsiveness of; Group Homes for Children; Group Therapy; National Child Abuse and Neglect Data System; National Center on Minority Health and Health Disparities; National Institute of Mental Health.

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Mental Health Services, Ethnic Models and Multicultural

For as long as there has been human society, culture has provided prescriptions for living. Broadly defined, culture refers to a common heritage or set of beliefs, norms, and values. Culture is not static, however; instead, it is fluid and emergent. While culture shapes people, people shape culture.

Mental illness is considered the product of complex interactions between biological, psychological, social, and cultural factors. Culture and society play pivotal roles in mental health, mental illness, and mental health services. Not only does it bear upon what each individual brings into the clinical setting, but it also influences how the clinician interprets and responds to the presenting concerns. For instance, culture accounts for variations in how clients view and communicate their symptoms, which ones they report, whether they even seek help in the first place, what types of help they seek, treatment expectations and treatment responses, what sorts of coping styles and social supports they utilize, and the amount of stigma they attach to mental disorders. From the clinician's perspective, culture bears upon assessment, diagnosis, and the types of interventions utilized.

From Homogeneity to Heterogeneity

For much of the country's history, the dominant culture in the United States focused on western European beliefs, norms, and values. However, America today is unmistakably a culturally pluralistic nation; consequently, mental health professionals increasingly encounter clients whose customs, traditions, values, and worldviews differ from their own. Therefore, in order to effectively traverse the diverse realities of the 21st century, it is helpful to conceptualize and practice within a multicultural framework.

Multicultural Theory and Therapy

Multicultural theory and therapy make culture central to the counseling process and facilitate the delivery of mental health services that are culturally and developmentally appropriate. By virtue of its broad lens, the multicultural perspective is nonreductionistic in nature. Enabling a wide-screen view, multicultural theory provides more inclusive identification of the multiple variables related to human development as well as facilitates a more comprehensive understanding of the myriad of complex outcomes that occur as a result of the dynamics among these variables.

The field of therapy is characterized by multiple theories and diverse systems of practice. While there are many variations of multicultural theory, a generic theory of multiculturalism, or "cross-cultural counseling," a term by which it is also referred, has been recognized as the fourth theoretical force in the mental health profession. It joins the other three major traditions—psychodynamic theory, cognitive-behavioral theory, and existential-humanistic theory—as a primary explanation of human development.

Broadly defined, multicultural counseling addresses the personality dynamics and cultural backgrounds of both the client and the counselor in order to create a therapeutic environment conducive to purposeful interaction. Fundamental to the theory of multiculturalism is the idea that both client and counselor bring a variety of variables to the therapeutic dyad, variables related to factors such as age, gender, sexual orientation, education, ability status, religion, ethnicity, and socioeconomic status. Clinical environments that fail to consider and respect these individual differences or utilize interventions that are incompatible with particular cultures risk doing harm.

Developing Multicultural Competence

Culture is not a concept limited solely to clients. It also applies to individual treatment professionals and the treatment profession as a whole. Therapeutic practice is a cultural system itself. Every group of professionals embodies its own culture in the sense that they too have a shared set of beliefs, norms, and values. The culture of the clinician and the larger health care system influences multiple aspects related to the delivery of care.

The counseling profession has responded to changing demographics by emphasizing the need for practitioners to develop multicultural competencies. Developing counseling competence across cultural boundaries requires both specialized didactic and experiential training as part of the professional development process. Consequently, multicultural theory and therapy have become a major focus in counselor education and are recognized and endorsed by leading counselor education-accrediting agencies and professional associations.

Based on the reality of individual differences, no two humans are alike. Essentially, then, cultural diversity is a characteristic of all counseling relationships. However, despite the inherent multicultural essence of counseling relationships in general, multicultural competency is not an innate counselor characteristic. Rather, developing multicultural competence requires deliberate, conscious effort. In order to function effectively in a pluralistic environment, counseling professionals must achieve self-awareness relevant to their own cultural values and biases, acquire cultural awareness or knowledge with respect to the client's worldview, and develop culturally appropriate intervention strategies and techniques.

Competent multicultural counseling is multifaceted. Responsive multicultural counselors take on multiple roles. In addition to the role of mental health specialist, clinicians also serve as advocates, change agents, consultants, advisers, facilitators of indigenous support systems, and facilitators of indigenous healing systems.

Ethical Considerations in a Diverse Society

Ethics are rules of conduct or moral principles that guide the practices of clinical professionals. Ethically conscientious counselors strive to provide the best possible services to their clients and practice in a manner that reflects the profession's highest standards. The nature of the counseling process—that is, the close alliance between counselor and client—makes ethical standards a crucial aspect of the counseling process.

Recognizing diversity in our society and developing multicultural competence are fundamental to ethical counseling practice. Ethical practice requires counselors to be aware of cultural differences so that they can modify their approaches when working with clients of differing cultural backgrounds. Competent cross-cultural counseling recognizes that homogeneity is simply an allusion. In addition to acknowledging between-group differences, it is also essential to understand within-group differences in order to tailor services to each individual client. Tailoring services has the capacity to enhance the therapeutic alliance, improve treatment outcomes, and reduce premature termination.

A mental health professional is first and foremost called on to protect and foster the welfare of his or her client. As such, the psychological perspective cannot be allowed to overshadow the ecological. This is important because psychotherapy is limited in its ability to address issues that require social and political solutions. Unfortunately, discrimination against individuals based on their differences with respect to race, ethnic origin, gender, disability, religion, political affiliation, or sexual orientation is a fact of life in U.S. society. Professional counselors who fail to recognize this and do not assist their clients in coping with this reality do a tremendous disservice to their clients.

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See Also: Cross-Cultural Skills; Cultural Competence, Human Service Providers and; Mental Health Service Delivery, Cultural Characteristics of; Mental Health Services, Ethnic Models and Multicultural Service; Pluralism.

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Mexican Americans

Mexican Americans are the largest Latino group and are expected to number approximately 59 million by 2050. Although the majority of Mexican Americans in the United States are here as a result of immigration, Mexicans were native to what is now the southwestern United States. As such, they are the only other minority group similar to Native Americans in that they were annexed by conquest and have their rights "safeguarded" by a treaty. Despite the longtime presence of Mexican Americans in the United States, there continue to be many barriers to access of human services as well as a continued lack of culturally competent services. These barriers to access as well as Mexican American history and culture are described, thus providing human service professionals with necessary knowledge in order to provide culturally competent services.

Contact and Conflict

Mexican Americans have a 150-year presence in the United States. The annexation of Mexicans through conquest set the stage for the difficult adjustment and continued exploitation still seen today. Prior to the U.S. westward expansion, Mexico extended north to include an area now known as Texas, California, New Mexico, Arizona, Oregon, Nevada, and part of Utah and Wyoming. Already concerned about U.S. encroachment, the Mexican government offered American settlers tracts of land on the condition that they obey Mexican law and become Mexican citizens. By 1835, American settlers outnumbered Mexicans in northern Mexico, and tensions grew. Settlers resented both being governed by a people they viewed as inferior and Mexican policies such as antislavery laws. Conflict erupted when Texas declared itself an independent republic in 1836. When Mexican General Antonio Lopez Santa Anna resumed control of the San Antonio area, the U.S. government responded by sending aid into Texas, resulting in the capture of Santa Anna and the signing away of Texas. Conflict continued, partly due to a difference regarding the boundary between Texas and Mexico; Texas regarded the Rio Grande River as the boundary, while Mexico regarded the Nueces River as the boundary.

After the annexation of Texas in 1846, U.S. President James Polk ordered General Taylor into the disputed land between the Rio Grande and Nueces Rivers, provoking Mexico to battle over what was perceived as an invasion. International war ensued, resulting in Mexico's surrender in 1848 under the terms of the Treaty of Guadalupe-Hidalgo, in which approximately half of Mexico's territory was ceded to the United States. Mexicans who remained in this region became U.S. citizens by default, creating a new minority group within the United States. While the Treaty of Guadalupe-Hidalgo guaranteed Mexicans full rights of citizenship, Anglos considered them an inferior people and did not take their rights seriously. For example, Mexicans were dispossessed of substantial land holdings, leaving both elite and peasant Mexicans as landless laborers located in the bottom of the U.S. stratification system.

The Immigration Context

Mexican immigration to the United States has been shaped by push and pull factors. Political upheaval and economic conditions in Mexico have provided the push factor, while the need for unskilled labor in the U.S. provided the pull factor. The historical trend of immigration has been that of exploiting Mexican labor during labor shortages and then abusing Mexican civil rights during times of economic recession. For example, in the 1910s, immigration restrictions were waived in order to fill labor shortages in agriculture. When the Great Depression hit in 1929, efforts to deport Mexicans regardless of immigration or citizenship status were initiated. This pattern occurs again during the World War II labor shortages with the initiation of the Bracero Program. *Bracero* is a loose translation of a farmhand. This policy, however, stimulated a stream of undocumented workers to fill positions with employers wishing to avoid the bureaucratic red tape of the Bracero Program. The Bracero Program was halted in 1964 due to complaints of mistreatment of Mexican laborers; however, Mexicans continue to be essential to the agriculture industry in many parts of the United States.

Today, Mexicans make up more than two-thirds of the immigrant population. More than one in two Mexican immigrants are undocumented. Destinations for Mexican immigrants have historically been California, Texas, Illinois, and Arizona. However, Mexican migration to new areas such as the southern United States has increased dramatically, posing challenges to human services providers unaccustomed to servicing this group. While Mexican migration flows have diminished due to the economic recession and increased border enforcement, it is estimated that migration flows will continue due to the demand for labor.

Mexican American Cultural Context

Keeping in mind that cultural differences occur within Mexican Americans due to gender, acculturation levels, education, class, and so on, the following section discusses cultural values and characteristics associated with Mexican Americans. Family is highly valued and considered more important than the individual. Extended family members such as aunts, uncles, grandparents, and godparents may be involved in an individual's life. Given this value, human service providers must consider the stress that may result from choosing to go outside the family to solve personal problems. Other concepts commonly associated with Mexican American culture are *machismo* and *marianismo*, which describe gender role expectations for men and women. Men are considered the provider and protector, while the woman must represent purity and selfless love. Spiritualism and religion also tend to be very important among Mexican Americans. Thus, faith-based organizations can play an important role in service provision. Other cultural values include interdependence, respect for those in a position of authority, and *personalismo*, or the value on personal relationships over the task or presenting problem.

Acculturation and Adaptation

While previous acculturation theories of the 1950s assumed that maintaining the culture of the country of origin posed mental health risks, recent acculturation theories suggest that Mexican Americans who try to assimilate have more psychological difficulties than those who remain connected to their culture. The ability to move between cultures creates a psychological flexibility known as a borderlands identity or navigational capital. This model is particularly suited to Mexican Americans who tend to maintain family, social, and economic ties to Mexico.

The predominant form of adaptation for Mexican Americans continues to be that of segregation. Mexican Americans have faced segregation in public facilities such as schools, restaurants, movie theaters, swimming pools, and housing. For example Mexican schools were instituted in Texas in 1902. Current segregation patterns in the schools have resulted in Latino children now being more segregated than black children. Thus, human service professionals should be sensitive not only to the cultural differences with their Mexican clients but also the consequences of discrimination. It is important to note that it is the later generations of Mexican Americans who experience more serious social ills compared to the immigrant generation due to the loss of protective factors associated with Mexican culture combined with continued experiences of discrimination.

Human Service Provision

Undocumented Mexican immigrants face the most challenges, lacking access to human services due to their immigration status and fearing deportation when using services. Providers and agencies should work to develop trusting relationships within the Mexican immigrant community so that, through word of mouth, they become known as a safe place for undocumented immigrants. In regards to acculturation, more acculturated individuals display more familiarity and knowledge about available resources. Thus, those with lower levels of acculturation may need additional information from providers about existing services. Providers should also consider incorporating the use of cultural practices such as *personalismo*. By considering Mexican American history, patterns of immigration, and culture, the human service professional will be more likely to develop trusting and respectful relationships with clients and increase the likelihood of successful outcomes.

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See Also: Assimilation; Cultural Competence, Human Service Providers and; Hispanic Americans; Immigration Law, History of U.S.; Undocumented Immigrants.

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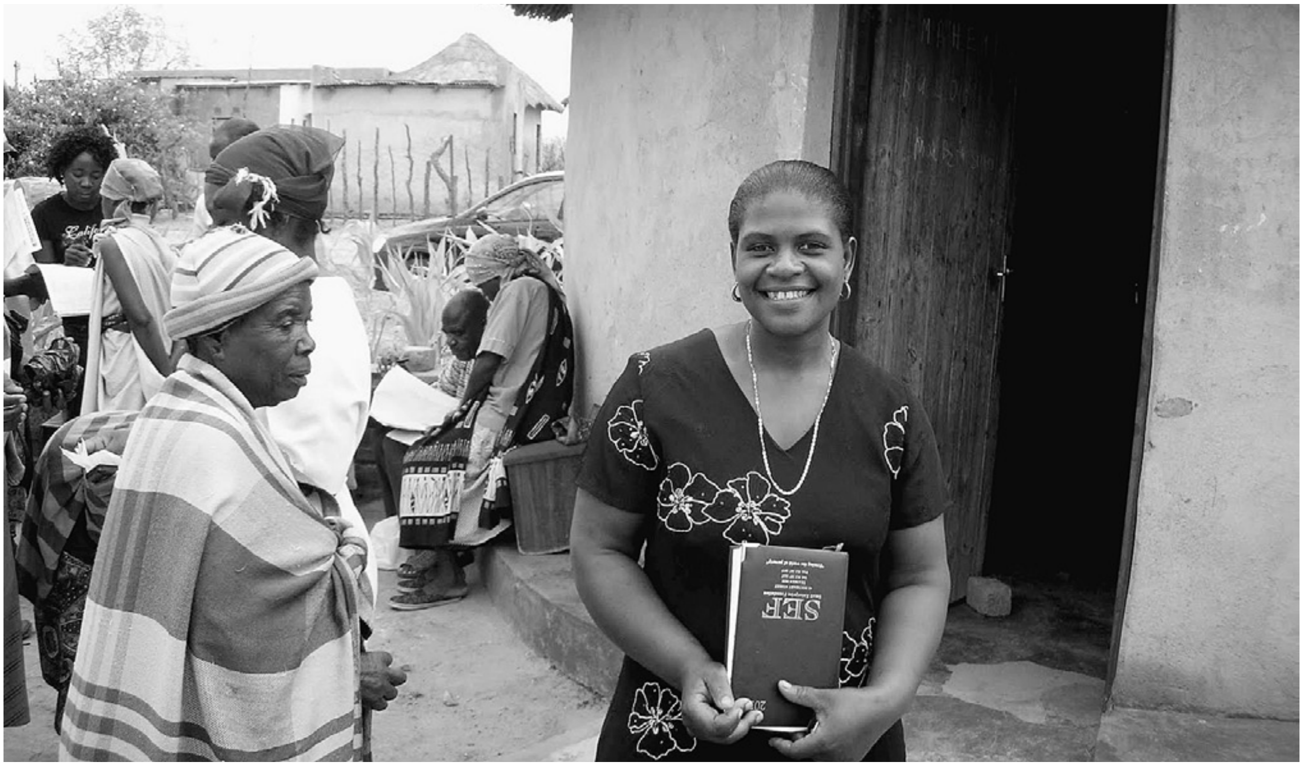
Microlending Programs

Microlending programs are one form of microfinance that includes savings, insurance, and other financial services for people considered too enmeshed in poverty to be served by traditional banking systems. Most microlending programs began as nongovernmental organizations in developing nations that relied on government grants and charitable support to sustain operations, and accordingly, the goals of microlending programs go beyond the financial. Advocates of these programs consider microlending to be a new way of looking at poverty alleviation and social change. By providing access to small loans at modest interest rates, microlending programs intend to unlock the entrepreneurial energies of the poor to increase human capital among the poor and improve civic engagement by the poor.

The contemporary form of microlending is attributed to the pioneering efforts of the 2006 Nobel Prize-winning Muhammad Yunus and the institution he founded in Bangladesh, Grameen Bank. Microlending programs have grown exponentially since the first personal loans Yunus offered to local villagers in the 1970s. The Microfinance Information Exchange, Inc. (MIX), a U.S. nonprofit organization that collects and analyzes global microfinance data, claims to collect data from 80 percent of microfinance institutions in the world. In 2011, MIX reported 95.1 million borrowers at 1,365 microfinance institutions. The outstanding loans totaled $87 billion with significant regional variation from a low average of $153 per borrower in south Asia to a high average of $1,862 per borrower in eastern Europe and central Asia.

Group Lending

Conventional bank lending to low income individuals without stable incomes or assets to use for collateral are rarely available to the clientele who



A loan officer from the GiveWell visits the nongovernmental organization the Small Enterprise Foundation in Tzaneen, South Africa, in 2010. The financial empowerment of women in poverty is perceived by many microlenders as the best means of achieving the social objectives associated with microfinance.

are the focus of microlending programs. The classical method of overcoming individual credit risk deficiencies in microlending is group lending. In the Grameen Bank approach, five individuals self-organize into a group in which individual loans are staged over time. Repayments are scheduled at frequent intervals and processed in public meetings. Using this methodology has been highly effective, with more than 98 percent of loans being repaid in a timely manner in many countries. Economists note that self-organizing into groups makes use of local knowledge about borrower intent to repay; that modest degrees of joint liability among group members promote peer monitoring that helps prevent default; and that public repayment enhances social cohesion and can lead to effective social sanctions that promote repayment.

Gender Diversity

Women are overrepresented among the poorest of the poor in almost every nation, are frequently more focused on within-household financial needs than their male counterparts, and are generally considered to be exceptionally committed to the health and education of their children. The financial empowerment of women in poverty is perceived by many microlenders as the best means of achieving the social objectives associated with microfinance. No organization more strongly demonstrates the focus on gender diversity than the Microcredit Summit Campaign, with the goal of extending credit to 175 million of the world's poorest households by 2015. More than 78 percent of the loans reported through 2011 by the 720 cooperating microfinance institutions were made to women borrowers.

Future Challenges for Microlending

The goals of microlending—poverty alleviation and social change—require evidence of efficacious outcomes to sustain the governmental and charitable funding streams upon which the expansion of microlending has relied. To date, the more rigorous outcomes suggest mixed results, with the majority of borrowers experiencing little economic improvement. In many national studies, those who find the loans an additional financial burden match those who gained. Measuring outcomes has become more complex as nonbank financial institutions and even commercial banks have entered the microfinance marketplace and siphoned off the more profitable borrowers.

As microlending has expanded, classical group lending has proven inadequate to address lending in sparsely settled rural areas and highly mobile and socially disconnected urban centers. Many borrowers who succeed financially chafe at the limitations of group lending, and the proliferation of microlending programs creates more competition among lenders. Accordingly, micro lenders have experimented with traditional forms of individual lending, have expanded financial services to enable savings, and have provided access to insurance. Some have questioned the degree of mission drift that is associated with the expansion as microlenders seek to achieve financial sustainability without governmental or charitable subsidies.

To cope with the escalating costs associated with these new services and the increased risk of individual loans, some microlending programs increase interest rates and pursue commercial capital access. When microlending programs charge interest rates as high as 100 percent and begin to prescreen loan applicants so that the poorest of the poor no longer qualify, it becomes difficult to distinguish these programs from the predatory alternative financial services available in developed countries that include payday loans, rent-to-own stores, and pawn shops.

Sustainability of microlending programs as originally focused on poverty and social change depends primarily on how well these programs navigate the inherent contradictions between profitability and mission. Subsidies to support microlending programs may elevate the focus on mission but do so at the cost of enabling management inefficiencies. Management inefficiencies will not be sustainable by programs that forsake subsidies, but these programs may be unable to continue serving the poorest of the poor. The future of microlending programs is most likely to be determined one program at a time.

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See Also: Economic Support and Services; Financial Literacy Programs; Social and Economic Justice; Social Capital, Role of.

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Midwifery

Unlike modern medical approaches to child care and childbirth, rooted in scientific and technological framework, the early traditions of midwifery have their origins in familial and societal realms. Historically, midwives were celebrated in their communities and relied upon to deliver the next generation. In the late 18th and early 19th centuries, most midwives learned their trade by apprenticing with other midwives; thus, their skills varied considerably from those who were highly competent to others with limited expertise.

In the latter part of the 1800s, the choice of male physicians to orchestrate the birthing process was made increasingly by middle-income women, particularly in metropolitan areas, in response to growing critiques of midwifery and an emerging emphasis in science and medicine as a safer way to give birth. Although midwifery continued to play a vital role in reassuring women through the birth process and in the mechanics of delivering the baby, cutting the cord, and delivering the placenta, the role of male physicians began to occupy more of a central position in the process by the end of the 19th century. By the early 20th century, the use of midwives was associated more often with women

In the 21st century, CNMs (certified nurse midwives), CPMs (certified professional midwives), and CMs (certified midwives) are increasingly functioning as independent health and welfare managers of women and focusing on pregnancy, the childbirth process, and women's reproductive health. By 2010, 1,828 midwives had earned CPM certification.

who were impoverished, immigrants, or living in rural areas, which enhanced the status of physician-assisted births for women who could afford this standard of care.

Major Changes in the American Profession

A significant change in the public acknowledgement and professionalization of midwives occurred in 1925, when the concept of nurse-midwives was introduced, thus attaching more formalized training as well as an official nomenclature to the occupation. The concept of nurse-midwives was developed in the United States in an effort to create subspecialties in nursing that focused on maternal care and childbirth. During this same period (1925–30), however, births attended to solely by midwives dropped from approximately 50 percent in the early 20th century to roughly 15 percent. Significant efforts were made on the part of physicians, nurses, and other public health reformers to medicalize women's health care. For many involved in the public efforts to eliminate traditional midwifery and replace convention with science, their objectives were to decrease maternal and infant mortality, according to Katy Dawley, by providing training and education for nurse-midwives who could better attend to the needs of patients. Women leading this campaign included Carolyn Conant van Blarcom, Lillian Wald, Mary Beard, and Mary Breckinridge, who founded the Frontier Nursing Service (FNS) in Kentucky for the purpose of caring for mothers and their newborns in rural areas with limited access to health care. Unlike traditional midwives who learned their professions as apprentices or through trial and error, and who operated unsupervised in their duties, nurse-midwives were trained and then presided over by physicians.

The mid to late 1950s marked important changes for nurse-midwifery. For example, the national move toward hospital births found nurse-midwives increasingly in hospital settings and focused on "the physical and emotional aspects of a new mother's birth experience," found Laura Ettinger, also showcasing the "first demonstrations in natural childbirth." Educational programs were inaugurated in medical centers connected to teaching hospitals at Columbia, Johns Hopkins, and Yale. In 1954, the Committee on Organization offered definitions of nurse-midwifery that enhanced the role of fathers and put the family unit at the center of labor and childbirth; in 1955, they founded the American College of Nurse-Midwifery (ACNM). Education of both parents became paramount.

By 1970, the Accreditation Commission for Midwifery Education (ACME) was created and a national certification exam was constructed and overseen by the American Midwifery Certification Board (AMCB). A shortage in obstetrical physicians in the 1970s prompted some nurse-midwives to form private practices, offering their services to women who could afford them. Some women sought alternatives to medicalized births through the natural assistance of nurse-midwives. In the 1980s, although the number of obstetricians increased substantially, nurse-midwives continued to practice in clinics, federally funded programs, health maintenance organizations (HMOs), and hospitals even though doctors did not always see their value, reports Laura Ettinger. During this period, nurse-midwives expanded their purview by including menopause as an area of specialty. Over the next couple of decades, this trend continued, resulting in almost doubling nationwide educational programs from 28 to 50 in a 12-year period in the development of programs such as the Frontier Nursing Service's distance learning program, which allowed more women to train for the profession and more women to avail themselves of the service.

Practicing Midwifery in the 21st Century

At the start of the 21st century, three different paths for the midwifery profession are clear: (1) certified nurse-midwifery (CNM)—more closely tied to the nursing profession, (2) certified midwife (CM), and (3) certified professional midwife (CPM). The primary distinctions among the three professional tracks include education, certification requirements, and affiliating associations. According to ACMN, both CNMs and CMs are required to complete a graduate degree, whereas CPMs must graduate from a midwifery education program but do not need to obtain a graduate degree. In addition to the graduate degree, the AMCB requires CNMs to have an active registered nurse (RN) license. In contrast, CMs do not need the RN license. The American Midwifery Certification Board (AMCB) serves as the certifying organization for CNMs and CMs, and the North American Registry of Midwives (NARM) serves as the certifying organization for CPMs. As of 2008, Peter Johnson found "nearly 6,000 certified nurse-midwives in practices throughout the nation." As of 2010, 1,828 midwives had earned CPM certification. While both CNMs and CMs can practice in medical and nonmedical settings, most practice occurs in a hospital setting. In contrast, CPMs typically practice outside of a hospital setting.

Conclusion

In the 21st century, CNMs, CPMs, and CMs continue to function as independent managers of women's health care and focus on pregnancy, the childbirth process, and women's reproductive health. Once considered an anachronism is an increasingly medicalized world, midwives continue to make meaningful contributions to women's health both independently and in cooperation with the established medical community.

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See Also: Continuum of Care; Family Services; Health Promotion Services; aternal/Infant Health Services; Nursing, Public Health; Parenting Skills Training; Prenatal Care; Pregnancy and Parenting Services.

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Migrant Workers

Migrant workers are a globalized species existing in many cultures across the world in developed and developing countries. These workers differ not only by the tasks they perform, but they are cut from a common fabric having to endure the same kind of social injustices in regard to services encompassing compensation, health issues, substandard living conditions, limited access to the legal and health care systems, and underrepresentation by migrant worker advocate groups. The bulk of migrant workers in the Western Hemisphere are seasonal farmworkers in the United States, which include both internal and foreign migrant workers. It is estimated that there are more than 3 million migrant (42 percent) and seasonal (58 percent) farmworkers in the United States, and 72 percent are foreign-born, with the greater portion, 68 percent, from Mexico, followed by Latin America and the Caribbean. These workers are identified as a tremendous national resource, yet they may not be receiving the services they need to improve and sustain quality of life. Much of the dialogue here will refer to the plight of the United States farmworkers who are underserved with respect to the infrastructure and organizational framework needed to adequately address the aforementioned adversities faced by its vast migrant worker population.

Compensation and the Law

Compensation for migrant workers, most of whom do mundane jobs, has seldom reached parity with the society in which they work and at best may reach minimum wage status. They face many obstacles that prevent them from obtaining needed compensation benefits. These include but are not limited to lack of coverage, a growing trend for states to deny benefits to undocumented workers, and workers reluctance to file claims for fear of employer retaliation. In many societies, migrant workers are required to pay taxes even though many states do not require employers to provide them with workers' compensation. Evidently, while they are eligible for programs such as Medicaid, Aid to Families With Dependent Children, and Social Security insurance, the majority cannot obtain these benefits. For example, only about 27 percent of farmworkers receive Social Security payments. They may fail eligibility standards because their income is not stable and because of the need for them to move frequently to find jobs. The American farmworker is a typical example of underpaid migrant workers whose annual income reflects an average of $12,000 to $13,999, and 23 percent of farmworker families are generally below the American poverty line.

American labor laws have not adequately addressed the economic plight of their migrant

Migrant workers weed sugar beets from dawn to dusk for $2.00 an hour in 1972. The bulk of migrant workers in the Western Hemisphere are seasonal farmworkers in the United States and include both internal and foreign migrant workers. It is estimated that there are more than 3 million migrant and seasonal farmworkers in the United States.

farmworkers who are rooted to the base of the economic pyramid. Some labor and immigration laws have served to erode the rights of the migrant workers. This existed under the Bracero Program established in 1942 and continues under the present H2A program created by the Immigration and Nationality Act of 1952, which allowed contractual arrangements with foreign countries, thereby excluding the United States from worker liabilities incurred in that country.

Legal temporary foreign workers who are hired under the H2A visa program must be provided with workers' compensation insurance or equivalent benefits by their employers. However, it should be noted that migrant workers in the H2A program are excluded from the benefits of the Migrant and Seasonal Agricultural Worker Protection Act of 1983, which is designated to the regulation of American farm workers. The nonexistence of the right to unionize and collectively bargain are believed to be drivers for the perceived expansion of the H2A program. It is safe to say that until effective implementation of legislation to address migrant worker compensation is universally negotiated, the exploitation of these individuals will continue.

Heath Coverage and Care

Migrant farmworkers work under hazardous conditions in the United States. They are more likely to die from job-related illnesses and typically have shorter-than-the-average American life expectancy. The very nature of the tasks of migrant workers exposes them to various types of occupational hazards. Overexposure to various adverse health situations accompanied by long working hours to maximize earnings have led to accidents, physical breakdowns, stress, exposure to various social diseases, and mental breakdowns. The Migrant Health Act of 1962 authorized delivery of primary and supplemental health services to migrant farmworkers. Also, the United States Public Health Service provides funding for health centers in a number of states to help provide care to farmworkers. A 2011 report shows that health center programs provided services to approximately 804,000 farmworkers through 156 migrant health centers. These centers serve as models for creative delivery to a hard-to-reach population. However, while migrant workers may have access to primary and supplemental care, including health insurance, these are generally lacking in coverage. Likewise, the difficulty they face in obtaining sick leave often leads to injured farmworkers not seeking needed treatment. Additionally, American hospitals have been known to deport patients (migrants) from whom they are unable to collect fees for services rendered. This cannot be the solution to health problems incurred as a result of the tasks one performs in the development of a society in which they chose to work.

Housing and Living Conditions and Education

Housing solutions for migrant are inadequate. They live in substandard housing conditions including structural defects, close proximity to pesticides, and poor sanitation. The inadequately maintained facilities predispose the migrant worker to adverse social health issues. Common and often overcrowded sleeping and showering quarters for both males and females are the order of the day in certain migrant professions, most notably farmworkers. They face additional risks from exposure to chemicals and other social diseases associated with communal living. Still other migrant workers face issues of sexual harassment and discrimination at varying levels including general state failure to effectively implement federal legislation governing these conditions. It should be noted that those who seek to live in private housing are barred because they cannot provide deposits, do not qualify for credit checks, and cannot make long-term commitments. The generally low education level (on average eighth-grade completion) of migrant workers in America is manifested in their apparent lack of knowledge about and the ability to successfully access these services where they exist. Migrant workers therefore are unaware of the provisions for their compensation, safety, and health. These ignorances are exploited to the benefit of the farmers in many cases.

Human Services for Migrant Workers

Human services are those services designed to enhance the quality of life of humans all over. In the United States, professionals working with agencies and organizations with interest in health, education, employment, and other social services work together to build service networks to improve the quality of life for migrant workers. For example, the National Center for Farmworkers Health focuses on providing services, information, and technical assistance for the population it serves. However, migrant workers have challenges with compensation, health and living conditions, and access to social amenities. In many instances, these are provided but are not reachable or denied for various reasons.

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See Also: Boarder Babies; Caribbean Immigrants; Internal Revenue Service's Migration Data Files.

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Military Families

Military are a unique population with distinctive and diverse requirements for social services. Since the implementation of an all-volunteer force (AFV) 40 years ago, the requirements for social services to meet the needs of military members expanded dramatically. As the AFV force continued, the need for family services continued to grow and become more diverse. With the advent of conflicts during the previous decade, reliance on these services increased, and the services provided expanded and transformed based upon need. Many of these services should continue into the foreseeable future but may be the victim of necessary reductions of military spending. Overall, these services provide a resilient and ready force and continue to help integrate military families into almost all of our communities.

Through the enormous drawdown following the end of the Cold War and since the first Gulf War, the number social services provided to military members evolved. Larger numbers of military members came with families, and more were stationed in the continental United States. Another military demographic change is that more families were composed of dual military members. These changes occurred along with the advent of two major conflicts after the attacks of 9/11.

Military families require unique social services based upon issues of separation, time away from home, and reunions, all of which increase possible negative short-term and long-term effects for the family. The United States military provides an extensive social services menu of military family-oriented services. These services are unique to the specific living and moving conditions families are exposed to during military service. Military service, especially over the past 12 years, provides significant stressors that families are required to endure and mitigate. More and more military members are married. There are also increases in the number of dual-family members, single-parent households, and more women in combat roles within the military. The breadth and depth of social services were tested extensively over the past decade due to the two conflicts in Iraq and Afghanistan and the deployments to other points around the globe.

Community-Based Social Services

Since the inception of the AVF within the U.S. military some 40 years ago, military communities slowly changed from homogenous societies on bases into being included in almost all local communities. With the operational usage of the National Guard, more and more rural communities experienced the difficulties and challenges associated with deployments and casualties. More than two-thirds of military families reside in civilian communities and the remainder on military bases. This parallels the increased use of local resources to provide services to military families. Communities provide resources and services for supporting military families and helping them cope with adversity and positive challenges. Community-based capacity building strategy provides a number of opportunities for military families. Relationships with community organizations can be formal or informal in nature. Examples include the Family Readiness and Ombudsman Groups and Family and Community Support Centers. In 1995, the Army Child and Youth Services began working with the National 4-H Headquarters in improving youth development at all Army installations. Later in 2004, 4-H/Army Youth Development Project started Operation: Military Kids (OMK). OMK focuses on supporting military-affiliated children, youth, and families wherever they may live, both on military installations and off. They concentrate on community connections to promote formal and informal networks for National Guard and Reserve families experiencing deployments.

Family support is a very small percentage of the overall defense budget. The reliance on local resources is not only a function of lower fiscal resources but the merging of military families into local communities. However, other federal organizations are involved in providing military families essential social services. Under a grant from the U.S. Department of Health and Human Services and the Administration for Children and Families, new curriculum specifically focuses on strengthening the needs of Reserve Component families. This instruction is titled "Essential Life Skills for Military Families (ELSMF)." This instruction provides relational and practical skills that families of Reserve Component service members may need to help cope with the uncertainties and challenges related to military life. The ELSMF program intends to create a unique local partnership between key community support organization (cooperative extension) and military families who may come from a variety of military branches within the National Guard and Military Reserve. This program offers military families social services on learned skills but also how to connect to other services they may need in the future. These services are provided hands-on, but a number of other services are provided through the Internet.

Expanded Online Resources

Online services for dealing with suicides, sexual harassment, and homelessness are increasingly provided through initial contact with online resources. Active, reserve, veteran populations and their families continue to be provided a number of additional counseling services and crisis hotlines. Based upon the need for these online resources, the military leveraged the Internet to supplement face-to-face services and counseling. Military One Source (www.militaryonesource.mil) provides a variety of services both online and to schedule for face-to-face meetings. Counseling services include financial, health and wellness, spouse education, and career opportunities (SECO). There are a myriad of products that are also available, from Adobe brochures to CDs covering a range of topics including casualty assistance, deployment, management, and transition assistance. The Web site also has a rotating monthly list of educational topics that include cyberbullying, peer pressure for children, recognizing the signs of combat stress, special needs children, and relationships and family wellness. This resource provides wide-ranging types of services delivered through a variety of modes.

Recently, the U.S. Army Comprehensive Soldier and Family Fitness (CSF2) Program was changed to include family fitness. This program provides resources for emotional, social, physical, spiritual, and family fitness through a variety of assessment and educational tools. This program is designed to enhance overall soldier and family resilience.

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See Also: Family Services; Home and Community Services; Mental Health Services, Adult.

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Military Personnel

"To care for him (or her) who shall have borne the battle and for his widow and his orphan." With these words, President Abraham Lincoln, in his second inaugural address in March 1865, affirmed the government's obligations to care for those wounded while in military service and to provide for their families. Lincoln's words became the motto of the Veterans Health Administration (VA) in 1959. The Department of Defense (DoD), in collaboration with the VA, is the federal agency responsible for serving the diverse needs of veterans and active duty service members (a generic term referring to all who serve in the military regardless of division, i.e., Army, Air Force, Navy, or Marines) by providing health care, disability compensation and rehabilitation, education assistance, home loans, burial in a national cemetery, and other benefits and services to our service member population. The system consists of more than 1,700 sites, serving 8.3 million veterans each year. The DoD and VA operate one of the largest health care organizations in the nation serving active duty military, retirees, survivors, and their dependents. The care system is divided into several integrated components designed to address a broad range of needs. Services are provided to all who have served irrespective of race, gender, ethnicity, or rank.

For Those Wounded in Battle or Active Duty Service

The initiation of combat in Iraq and Afghanistan has resulted in a cohort of service members who have sustained serious injury and requiring long-term care through the DoD and VA system. If injured in Iraq or Afghanistan, typically, the service member is airlifted to a government medical facility in Germany and returned to the United States, where, depending on the type and severity of injury, he or she may be sent to one of four poly-trauma clinics or a military treatment facility in the United States that provides specialized levels of rehabilitation. If this level of care is not required, the service members may be treated at a DoD medical facility and, if able, return to active duty when care is completed. If the service member's injuries are such that he or she cannot return to active duty, care will be transitioned to the VA system.

The DoD system also cares for military retirees who have not qualified for VA care. In order to be treated in the VA, one has to qualify for care by having served in the military and been honorably discharged, received an injury, or have an illness that is service related and the service member is unable to perform in an active duty role. For veterans who have not received a disabling injury, a means test and financial assessment are necessary to receive VA benefits. At each level of care, a multidisciplinary medical, social work, and behavioral health care team works with the patient and family to address the multiplicity of needs that might occur during treatment.

All severely ill or injured service members receiving care at a VA facility are provided with a case manager, with the patient and family as integral partners in the assessment and treatment care plan. For those cared for at the VA who do not have complex medical needs, case managers are assigned as needed.

Beyond Injury and Illness

Numerous other behavioral health services are offered through the VA system including caregiver support, suicide prevention programs, family counseling, military sexual assault counseling, substance abuse counseling, services of homeless veterans, and Vet Center support.

Caregiver support: In recognition of the emotional and physical toll that caring for an injured service member may extract, there are a range of services that support family caregivers including respite care, in-home care, specialized education and training, equipment, home and auto modification, and financial assistance. In 2010, President Barack Obama signed the Veterans Omnibus Health Services Act enhancing current benefits and developing more comprehensive support offerings for caregivers.

- *Suicide prevention programs*: Numerous outreach and behavioral health programs are in place to address the needs of the suicidal service member. Every VA facility has trained behavioral health professionals (social workers and psychologists) in suicide care and prevention. In 2007, the Veterans Crisis Line was launched, which is a 24/7 toll-free confidential hotline staffed by specially trained and experienced professionals. Veterans and family members can access the crisis line by calling 1-800-273-8255 and pressing 1.
- *Military sexual assault counseling*: The DoD's Sexual Assault Prevention and Response Office has established victim advocacy programs that provide support and information to sexual assault survivors. The DoD allows sexual assault victims seeking help to file restricted or unrestricted reports. The restricted reports are designed to protect victims' confidentiality. Victims can receive treatment and counseling for the assault.
- *Substance abuse services*: The VA offers a variety of counseling and rehabilitation services for substance abusers including outpatient counseling, inpatient hospitalization and rehabilitation, continuing care, relapse prevention, and self-help groups.
- *Services for homeless veterans*: Through the Supportive Services for Veteran Families (SSVF) program, homeless vets receive help obtaining temporary housing, health care benefits, transportation services, legal services, and housing counseling services. Homeless vets can call 1-877-424-3838 for 24/7 support and direction.
- *Vet centers*: The Vet Center program began in 1979 to address the needs of Vietnam veterans. Vet Centers are located in local communities, not in the VA hospital facility. There are 282 community Vet Centers across the United States. The Vet Centers are venues where veterans and veterans' families can socialize with other vets and receive individual and group counseling service in a safe and confidential setting. In 2009, the mobile Vet Center program was established. The mobile center, literally a mobile vehicle, provides counseling services to veterans in rural areas. The Vet Center programs also have a 24/7 phone system so members can access a counselor or other veteran in times of need.

The needs of our veterans and their family members may be extensive. The DoD and VA systems of care are designed to address as many of these needs as they can. New programming is constantly being developed for "those who shall have borne the battle."

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See Also: Military Families; Military Veterans; Veterans Services.

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Military Veterans

Service members, even in the best of circumstances, can face multiple challenges as they navigate their transition into civilian life. Social services can facilitate veterans' successful reintegration with their communities and, in the case of overseas deployments, with their families as well. Approximately 2.4 million U.S. service members have deployed to Iraq and Afghanistan since 2001, and many have experienced multiple deployments. As we focus on successful integration of these veterans, we must also assure that veterans of prior conflicts are equally supported.

The U.S. Department of Veteran's Affairs (VA) is the primary organization whose mission is to meet veteran's needs by fulfilling President Abraham Lincoln's promise "to care for him who shall have borne the battle, and for his widow, and his orphan." One of the limitations of the VA is that it is not designed to serve veterans' families. Readjustment Counseling Services or Vet Centers are a part of the VA and were established after the Vietnam War to provide readjustment services for both veterans and their families. Eligible veterans and their families can receive individual and group counseling, family counseling, bereavement counseling, military sexual trauma (MST) counseling, outreach, substance abuse assessment and referral, employment referral, and referral to other VA services, including more specialized treatment and interventions offered by the VA.

Veterans with special needs can benefit from targeted social services to address their unique concerns. Some of these special needs veterans include catastrophically and severely disabled veterans; veterans with posttraumatic stress disorder (PTSD) who are at risk for suicide and may experience other mental health concerns, women veterans, veterans who are at risk of being homeless or are homeless, those who are involved with the justice system, and veterans who are unemployed or underemployed.

Veterans who are catastrophically and severely disabled, including those who have experienced multiple traumas, injuries involving amputations of one or more limbs, severe traumatic brain injuries, or pelvic, abdominal, or uro-genital wounding will require a lifetime of care. Veterans who have experienced poly-trauma can benefit from care coordination, ongoing case management, accredited residential living programs to meet their housing needs, transportation, and social support of their families and caregivers. Caregivers can also benefit from education training, health coverage, and a living stipend when caring for a family member precludes employment outside the home.

Call services, crisis lines, outreach, peer support, tele-health, mobile vans, and mobile apps for smart phones are all useful approaches to increase veterans' access to mental health and social services. These services are being increasingly provided by the VA, Vet Centers, and community agencies alike.

Programs to meet veterans' housing, employment, and sense of community are important social services and support that can facilitate reintegration and reduce some of the more debilitating effects of PTSD and other mental health concerns. In addition to low-cost loans, the VA offers a range of housing and employment programs. Some federal housing programs are for the most vulnerable veterans including women veterans, those recently returning from combat zones, and veterans with disabilities.

Women veterans are more likely than their male counterparts to feel out of sync with their families and their communities. Female veterans are also more likely to experience domestic violence, have difficulties reestablishing bonds with partners and children upon redeployment, have increased difficulties overall in readjustment, and are more likely to experience depression. Women are also more likely to experience military sexual trauma than men. Gender-specific programs such as targeted outreach, transitional housing for female veterans and their families, women's retreats, and support programs for victims of MST can be useful in addressing the unique needs of women veterans.

As a result of combat-related trauma and other service-related experiences, some veterans may turn to alcohol or drugs and may become entangled with the justice system. About 60 percent of the 140,000 veterans in federal and state prisons were struggling with a substance use disorder, while approximately 25 percent reported being under the influence of drugs at the time of their offenses. In response, some jurisdictions have established veterans' treatment courts, designed to treat veterans suffering from a substance abuse or mental health disorder while helping to ensure public safety. These courts promote sobriety, recovery, and stability through a coordinated response involving community partners.

Recognizing the importance of the Serviceman's Readjustment Act, or the G.I. Bill, in promoting reintegration through education, Congress recently approved an expansion of benefits beyond the current G.I. Bill program for veterans serving since September 11, 2001. Known as the Post-9/11 G.I. Bill, this program provides financial support for veterans to receive a college degree as well as support for noncollege degrees, apprenticeships, and on-the-job training. For those attending college, veterans may receive payments for tuition and fees, housing, books and supplies, and relocation or transportation support for those living in rural areas to attend school. Under certain circumstances, benefits may be passed on to dependents.

Many organizations offer supportive, recreational, social, and athletic activities to strengthen social connections. The VA offers a fairly comprehensive directory of these organizations as an information service. Online social support is also available, such as the Make the Connection Web site, where veterans can connect with other veterans, get resources and support to manage the issues they may be facing, and find solutions for improving their lives. Of note, veterans can meet their needs for social support through participation in commemoration events such as those celebrated on Memorial Day and Veterans Day. Through such ceremonies, veterans can experience a sense of kinship with other veterans, living and dead, acting to reaffirm veterans as honored people in American life.

In summary, while many social services resources are available, veterans can still find themselves feeling isolated and not knowing how to connect. At times, the sheer volume of resources may feel overwhelming, especially in crisis situations. The plethora of social services available can suggest that there are unlimited resources to meet the needs of all veterans, for example, that there is a home for every homeless veteran.

In actuality, veterans' social services needs continue to go unmet as many programs are filled to capacity. Though the number of women veterans has increased, not every Vet Center has female counselors.

There are also limited services for veterans with severe and complex problems including inpatient programs for veterans diagnosed with PTSD, substance abuse, and severe mental health concerns. Thus, more needs to be done to increase access to services for all veterans across the life span.

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See Also: Military Families; Military Personnel; Veterans Services.

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Missionary Work and Workers

A plethora of organizations throughout the world deliver human services. Among these organizations are both nongovernmental and governmental associations. Nongovernmental organizations can be in both the profit-making sector and the noprofit sector. Among these are both faith-based and secular institutions. Within the realm of faith-based agencies are those with a Christian worldview. Some of these Christian institutions are nonprofit missionary agencies. The goal of these agencies is to bring Christianity to the world, with some focusing solely on the spiritual needs of people and others being concerned with a mix of the spiritual, physical, and emotional needs. Having a concern for a variety of needs, missionaries find themselves delivering human services to the people with whom they are sharing Christ.

History of Human Services Delivery in the Church

Human services delivery started with the church. Historically, church members served the less financially stable and ill members of their congregations and communities by providing food, medical supplies, child care, and prayer. In the 1800s, faith-based organizations such as the Salvation Army and the YMCA formed in England to meet both the human and spiritual needs of people, some of whom did not feel welcome in church. Missionaries aware of the Salvation Army and the YMCA developed affiliates in the United States and eventually in other countries.

In the early 1900s, after these affiliates were organized, a theological view called the social gospel started to infiltrate the churches. The social gospel placed an emphasis on meeting human needs as a way of expressing Christianity. Not all of Christendom agreed with this perspective, and a group of conservative theologians calling themselves fundamentalists formed. The fundamentalists were concerned that the social gospel view neglected spiritual needs such as regeneration in favor of social concerns. These points of view were antithetical to one another.

Recognizing the divisive nature of the two views, seeing a need for the church to emphasize evangelism and regeneration while meeting human needs and addressing social concerns, a group of theologians started the evangelical movement. The leaders of this movement were concerned with the individual's relationship with God as well as the individual's relationship to others and society.

With this understanding of church history, it is clear that the majority of missionary work including human services delivery comes from missionaries that are from either the social gospel view or the evangelical view. However, some fundamentalist missionaries find themselves involved with social and physical concerns. With a holistic view of humanity, it is difficult to separate the physical from the spiritual.

Examples of Specialized Human Services Delivery by Missionaries

Today missionaries deliver human services throughout the world. There are medical missionaries providing preventative, curative, and palliative care. The preventative health care takes the form of vaccinations, education on topics such as hygiene and sexuality, and exercise programs, just to name a few. Curative health care is treatment for existing conditions including the administering of antibiotics, surgery, and wound care. Palliative care can be in the form of pain reduction. Additionally, medical missionaries may provide wheelchairs and eyeglasses to help people cope more effectively with medical conditions.

In addition to medical missionaries, there are missionaries serving food and providing shelter to the under-resourced populations. There are gospel missions throughout the United States and other areas of the world. Some missions provide sermons for the population they serve prior to meals. In addition to food, shelter, and spiritual guidance, some provide other services such as education and job training.

Missionaries who manage orphanages also provide food, shelter, and often education to children.

As orphanages do not formally exist in the United States, these are located in other countries. Missionaries in war-torn or acquired immune deficiency syndrome (AIDS)-invested countries find many children without homes, food, or clothing. These orphanages form in response to an obvious need. Some missionaries are administrators, nurses, and child-care providers in these settings.

In these countries devastated by war and disease, other needs arise that are both spiritual and emotional in nature. As a response to these needs, missionaries who are trained social workers and counselors help people adjust to life after trauma through counseling. Additionally in these countries, when the infrastructure and industry is destroyed, missionaries help with community organization and building sustainable businesses. These businesses come in many forms, but most are agricultural in nature. However, missionaries have started to give microloans to individuals, families, and communities as a way of helping them start sustainable businesses.

The social aspects of missionary work also continue today. Many faith-based missionary organizations have after-school programs helping children with homework and social skills and providing a safe place to gather. These organizations, staffed by both volunteers and professionals, often have gymnasiums and provide organized activities. These programs often offer snacks or meals.

Missionaries also help those with disabilities. In some countries, a disability such as blindness or deafness is viewed as a curse, so those with these impairments are marginalized. Missionaries develop programs to help people with disabilities develop marketable skills while providing food and shelter. In other countries, people with learning disabilities or people from a nondominate culture are ostracized. Missionaries in these countries develop programs and offer human services to these populations.

Examples of Missionary Agencies Delivering Human Services

A Mennonite agency provides mediation, peace and justice advocacy, community development, and health care in various continents throughout the world. Mediation services are provided in conflict-laden areas such as Columbia and Ireland to encourage peace and reconciliation without violence. Community development may come in the form of leadership development, education, program development, and so on. This development may be comprehensive, providing food, clothing, education, and health care, or it may be specific to one particular area of human services.

An international sports ministry based in Slovakia and Hungary emphasizes human services for the body, mind, and spirit. They provide recreational activities such as baseball and softball, with Christian coaches encouraging under-resourced youth, specifically the Roma population, in their physical development. For the mind, they provide English classes for those marginalized by society, with low incomes, free of charge. For the spirit, they provide spiritual guidance and discipleship.

A Baptist mission agency provides holistic ministry in the Dominican Republic. There is a traditional Hispanic church with numerous ministries. They have a home for young girls managed by an indigenous couple providing nurturing, food, clothing, and education. They have a Christian school focusing on education including teaching English and Christian values, a youth baseball ministry focusing on physical and spiritual well-being, and a youth ministry with a focus on spiritual and social development.

In recent years, this agency has started to do prevention work with children at risk and intervention work with women who are in the sex trade. This intervention includes health care, alternative vocational training, and a safe house for women and children who would like to change vocations. The vocational training offered is in jewelry design, tailoring, sales, or hairdressing. They also offer microloans to women with other creative, sustainable ideas.

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See Also: After School Services; AIDS/HIV Programs; At-Risk Youth Services; Blindness and Low Vision; Childhood Trauma; Children and War; Community Organizing; Deaf/Hard of Hearing; Disability Services; Disabled Clients; Food Insecurity; Human Trafficking; Microlending Programs; Spirituality/Religion and Diversity.

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Mobility-Impaired Individuals

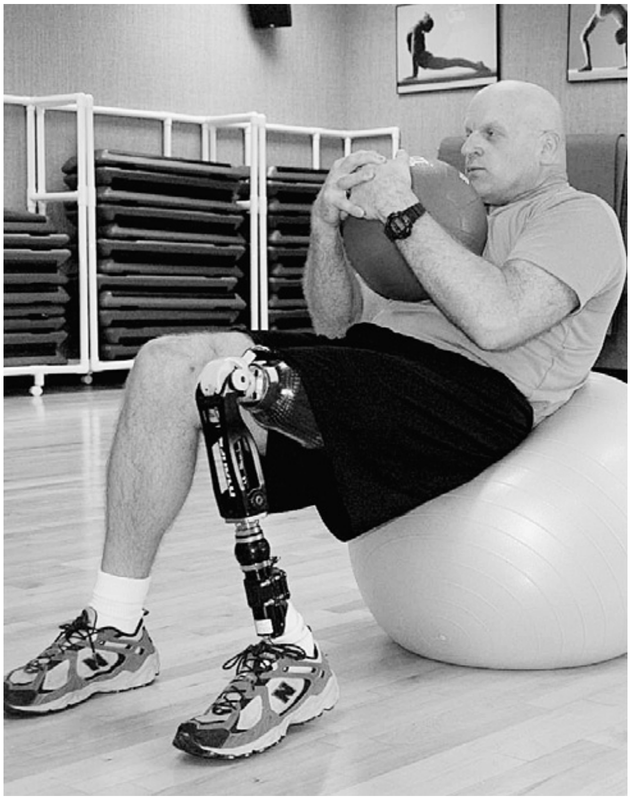
The terms *impairment* and *disability* are synonymously used. However, these terms are different. *Impairment* is used to define a deviation from normal, such as not being able to make a muscle movement or not being able to control an unwanted movement. Disability is the term used to define a restriction in the ability to perform a normal activity of daily living that others of the same age are able to perform. This entry explains mobility impairment, its types and causes, and the human services needs of mobility-impaired individuals**.** The theme is more relevant in the context of human services and diversity.

Mobility-impaired individual means any person, regardless of age, who is subject to a physiological defect or deficiency regardless of its cause, nature, or extent that renders the person unable to move about without the aid of crutches, a wheelchair, or any other form of support, or that limits the person's functional ability to ambulate, climb, descend, sit, or rise, or to perform any related function. Mobility impairments are physical limitations that limit mobility. There are many types of orthopedic or neuromuscular impairments that can restrict mobility. Cerebral palsy, multiple sclerosis, muscular dystrophy, hemiplegia, polio, arthritis, and spinal cord injury are some of the causes of mobility impairments. Multiple sclerosis is a disorder of the nervous system that attacks the brain and spinal cord and causes deterioration of the nerve tissue. Hemiplegia is caused as a result of a stroke or traumatic brain injury. In polio, the muscles in arms and legs become weak and do not function normally to help a person move freely. Mobility impairments can stem from neurological causes, like paralysis and palsy, or physical causes like amputation or birth defects. A mobility-impaired individual may also have audio, cognitive, and visual impairments. The impairment can also be caused either by lack of coordination, weakness, or poor circulation. Due to increase in lifestyle diseases such as, for example, diabetes or cardiovascular diseases, the incidence of mobility impairments are on the rise.

Human Services Needs

Mobility-impaired individuals become disabled by a lack of resources to meet their needs. They have various service needs: physical, human, social, and economic. Individuals with mobility disabilities often experience stigma concerning their physical competence and bodily appearance, leading to impairment in social interactions. They also demonstrate a wide range of physical abilities and need assistive technology devices. They require assistive devices such as a wheelchair, crutches, a cane (auxiliary, T-shaped, or Lofstrand), walker or braces to help them overcome mobility obstacles and become mobile. Slopes, stairs, and steps are some navigation barriers that wheelchair users may face. They therefore need assistive technologies such as ramps, power or automatic door openers, and wheelchair button doors. The impairment varies widely from individual to individual with the part of the body affected. The needs of mobility-impaired individuals vary widely. They may need clean and dry floor surface areas, wide pathways, and environments free of hazards.

Case management is performed by health professionals such as a nurse, social worker, counselor, or support worker. The support workers, known as direct support professionals (DSP) in the United States, assist the impaired individuals. Individuals need therapeutic services such as physical therapy, massage, and movement therapy. Case managers are intimately connected to their clients and provide them emotional support. Individuals with mobility impairments also need an array of software to facilitate computer access and information technology. They may encounter a variety of access barriers. Time-limited actions, such as timed tests and time-responsive Web sites, are particularly problematic for individuals who have little control over their arms or hands. Larger icons and hypertext links can



Mobility impairments are physical limitations that limit mobility. There are many variations of orthopedic or neuromuscular impairments that can restrict mobility.

assist individuals who have difficulty controlling their hand movements. Mobility-impaired students have special needs that vary widely by individual and academic activity.

Residential and Independent Living Services

Some mobility-impaired individuals need residential services and quality care. Adult day services are required for supporting individual needs. Many impaired individuals are unable to maintain themselves at their homes and thus need adult placement services. These services are needed when their health and safety can no longer be maintained at home. Many are vulnerable to abuse, neglect, and exploitation and thus need protective services. Risk management services need to be provided. Family and informal care are also needed by mobility-impaired individuals. Personal care such as, for example, bathing, dressing, toileting, and feeding, are most essential. In-home aide services help assist impaired individuals. Independent living services are required to assist them in developing skills to manage their daily living activities. These services maximize independence of impaired persons in their daily living such as meal preparation, laundry, banking, physical therapy, and transportation. Social workers provide a variety of independent living services. Vocational rehabilitation services are also needed for employment. Employment services support individuals to find work and train in specific job skills.

Emergency Services

Safe evacuation of mobility-impaired individuals during emergency is of critical importance. Mobility-impaired persons need coworkers who will accompany and assist in their evacuation during an emergency. A guide dog or assistance dog provides support to an orthopedic- or mobility-impaired person. Human services are required to provide proper training for the assistance dogs. The mobility-impaired individual needs recognition, moral support, collaborative initiatives, and human services from every individual in the society.

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See Also: Americans with Disabilities Act; Convention on the Rights of Persons with Disabilities, United Nations; Developmental Disabilities, Attitudes and Myths in Services for; Developmental Disabled Individuals; Disabilities, International Variation in Attitudes Toward; Disability Services; Disabled Clients; Service Providers and Diversity.

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Model Minority Stereotype

The model minority stereotype is a socially constructed image of a minority group in what may be perceived as a positive light but that has negative consequences. The stereotype, when applied to members of a minority group that has achieved what appears to be high levels of success within a society, suggests that each individual member of the group should excel academically or financially or have other positive cultural attributes based on his or her group membership. The model minority, as opposed to other minority groups, typically is seen as possessing more cultural capital, thus propelling them to success. Comparatively, other minority groups who face disproportionate struggles are often seen as culturally deficient, with assimilation to white American culture sometimes offered as a solution.

Origin

The first known mention of the model minority stereotype was in a *New York Times* article in 1966 by sociologist William Petersen. Although the model minority stereotype can be applied to other groups in other countries, its most common affiliation is with the Asian American community in the United States. The model minority stereotype grew in popularity in the United States in the 1980s. Specifically, Asian Americans are pointed to in comparison to Latin American immigrants and African Americans as academically inclined (with high levels of educational attainment overall), socioeconomically stable, and with comparatively lower crime rates. In the realm of education, Asian Americans are often expected to have an aptitude toward math, science, and technology-related fields. The Asian American community is credited with possessing greater cultural capital than other minority groups in the United States.

There are several potential causes of the stereotype for Asian Americans. Immigration policies that restrict entry to the United States to only more affluent Asian immigrants or those possessing more highly valued skills would certainly impact Asian American economic well-being. Cultural differences are often cited when comparing Asian Americans to other minority communities and could indeed play a role. Finally, government policies like affirmative action could benefit some Asian Americans in education and employment, providing them opportunities to succeed.

Impacts

The diverse group that constitutes the construct of Asian American is recognized for having a (homogeneous) culture that values education. Some speculate that this becomes a self-fulfilling prophecy in some instances (e.g., an expectation of high performance in mathematics and technological fields is responsible for the propensity of many Asian Americans to choose those fields). Some Asian Americans internalize the model minority stereotype and believe themselves to be better performers than whites and other minority groups as well. So the impact of the stereotype on the identity of Asian Americans and their performance in the United States can be positive.

On the other hand, the impacts of the model minority stereotype can be quite harmful. Expectations on Asian Americans include being hardworking, docile, submissive, and obedient, not complaining, not needing assistance, and possessing both intelligence and wealth.

The model minority stereotype generates resentment from other minority groups. By attributing the perceived success of the Asian American conglomerate to culture, inferiority in the cultures of other minority groups is implied. African Americans and Latino and Latina Americans, whose academic and financial achievement on average is substantially lower than Asian Americans, are compared unfavorably by those who would attribute racial inequality to cultural deficiencies. Even if one understands that this view neglects the unique histories and social positions of members of the differing racial groups, the resentment that the model minority stereotype generates is not surprising. By stereotyping Asian Americans as not needing assistance, other groups with different experiences and challenges who seek assistance are looked down upon. The stereotype generates a sense of satisfaction in the current function of the U.S. meritocracy, which in actuality is more mythical than real. Reinforcing the idea of the correctly operating meritocracy in the United States works against other minority groups, suggesting that they are getting what they deserve and ignoring inequalities produced by social structures.

Thus, the model minority stereotype can be used to argue against social welfare and human service policies, affirmative action, or other governmental policies meant to address issues disproportionately faced by communities of color. In fact, only recently have institutions serving Asian American Pacific Islander been federally designated minority-serving institutions and afforded federal funding.

Interestingly, the model minority stereotype in the United States incorporates attributes of submissiveness and obedience. Model minorities, thus, do not challenge the status quo operation of society. In this way, and through the justification of color-blind social policies, the current racial hierarchy is preserved, with white Americans on top.

Even within the amalgamation that constitutes the U.S. census category Asian American, the model minority stereotype can be harmful. The stereotype neglects to differentiate between Asian immigrant groups that have come to the United States and thrived and those who have faced notable obstacles and may require different human services. The Asian American community is diverse, and the problems faced by its members reflect that level of diversity. While some communities are doing well overall, others are faring much more poorly. In fact, even within Asian communities that have achieved academic and financial "success" in the United States, there are individuals and geographic communities that have been devastated by poverty, crime, and other issues. The faith in the meritocracy that the stereotype engenders and the additional pressure of being a member of the model minority (and thus not requiring human services or needing assistance) puts Asian Americans who struggle in the United States in a strange, often-overlooked position.

Conclusion

In summary, the model minority stereotype applies positive perceived cultural attributes of a minority group to its success in a given nation. As a result, it leads one to question why other minority groups do not achieve the same levels of success as the model minority. In the United States, it is an overgeneralization based on a socially constructed category that is used to advocate color-blind policies and victim-blaming for non-Asian American people of color, generating resentment for Asian Americans as well as neglecting those Asian American communities that disproportionately face social problems not reflected in the stereotype.

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See Also: Asian Americans; Assimilation; Cultural Capital, Role of; Ethnic Diversity and Values; Immigrant Populations; Pacific Islanders; Power, Race, Ethnicity and; Racial Identity Development, Models of.

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Monitoring the Future

Monitoring the Future (MTF) is an ongoing study that measures longitudinal changes in the beliefs, attitudes, and behaviors of secondary school students, college students, and young adults in the United States. Since 1975, the study has been conducted annually by the University of Michigan's Institute for Social Research. With financial support from the National Institute on Drug Abuse, the study has addressed a range of topics related to substance use among young people. Substance use among youth is a rapidly changing phenomenon, and the study was designed to understand shifts in the patterns of drug and alcohol use among youth. The study also monitors attitudes toward drugs and alcohol held by this population as that data can be significant in mapping current and future substance use trends.

A core feature of MTF is an annual survey of the senior class for high schools in the United States, which began in 1975. In 1991, the school-based surveys were expanded to also include nationally representative samples of students in the eighth and 10th grades. The most recent MTF sample (2012) included about 45,400 students from grades eight, 10, or 12 in nearly 400 public or private schools. Schools are selected to provide an accurate, representative cross-section of high school students within the contiguous United States. Within each school, 350 students are randomly selected for participation. For schools with enrollment under this threshold, all students are included in the sample. Data are collected in the classroom using standardized procedures (e.g., closed-ended surveys administered by university staff). To track changes over time, follow-up surveys are mailed to a randomly selected subset of each graduating class for several years.

MTF data can be used to examine trends in the overall proportions of students at each grade level (1) using a particular drug, (2) seeing a great risk associated with its use, (3) disapproving of its use, and (4) saying they could get it fairly easily or very easily if they wanted to. Surveys contain questions on a range of substances including cigarettes, smokeless tobacco, alcohol, marijuana, inhalants, LSD, ecstasy, cocaine (powder and crack cocaine), heroin, other narcotics (e.g., codeine, Vicodin, or OxyContin), amphetamines (e.g., Ritalin, Adderall, or methamphetamine), sedatives (e.g., phenobarbital or Ambien), tranquilizers (e.g., Valium or Xanax), and other emerging drugs. More recently, the survey has provided some of the earliest national estimates on the emerging use of other drugs such as synthetic marijuana (commonly referred to as Spice or K-2) and synthetic stimulants (bath salts). Since its inception, MTF has periodically addressed other topics relevant to youth, including delinquency and victimization, changing roles for women, confidence in social institutions, concerns about the environment, and general social and ethical attitudes.

The longitudinal nature of the data allows users to examine changes in substance-use trends related to age, time period, and birth cohort. Age effects relate behaviors to the particular developmental time period of the participant, while period effects include changes in particular years that show up consistently in all age groups. Cohort or birth group effects are lasting differences between different cohorts entering secondary school. Such cohort effects, for example, have been found for cigarette smoking throughout most of the MTF study. The follow-up data also allow researchers to examine how changes in substance use are linked to different environments (e.g., high school, college, or employment) and developmental transitions (e.g., leaving the parental home, marriage, or parenthood).

MTF data can be used to separately examine attitudes and patterns of drug use in different demographic groups based on gender, race or ethnicity, region of the country, community size, parent's level of education (an indicator of socioeconomic status), and plans following high school graduation. Since MTF began, for example, rates of substance use have varied by race, ethnicity, and gender. Substantial differences have been found among the three largest racial and ethnic groups in the survey: whites, African Americans, and Hispanics. Across all three grade levels, African Americans have generally had lower rates of use for most licit and illicit drugs (e.g., alcohol, cigarettes, prescription drugs, hallucinogens, and ecstasy). Although there are some discrepancies among older youth, Hispanic students generally have rates of drug use that fall in the middle between the rates for whites and African Americans. While the gender gap is narrowing, MTF data have also generally shown that males have higher rates of illicit drug use, and particularly frequent use, compared to females. Understanding these types of subgroup variations in substance use among youth is important for understanding and addressing problems related to drug and alcohol use among young people.

Although MTF provides valuable information on substance use among youth, notable limitations of the survey are that it relies on self-report data and uses a school-based sample. The extent to which youth will answer honestly is a concern for MTF and other self-report surveys addressing sensitive behaviors that are often illegal as well. Another limitation to the school-based sampling approach is that MTF does not include higher-risk youth who are no longer enrolled in school (e.g., high school dropouts) and those whose school attendance is sporadic. Because relatively fewer adolescents drop out before the end of 10th grade, this bias is likely to be smaller for the eighth- and 10th-grade samples.

Data from MTF have been used to inform policy discussions and has helped inform the work of organizations and agencies providing drug and alcohol prevention and treatment services. Reports detailing the annual and cumulative findings from the MTF survey, including those that examine trends by gender, age, and race or ethnicity, are readily available online through the MTF Web site, www.monitoringthefuture.org, listed under Publications.

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See Also: Adolescent/Youth Services: Overview; At-Risk Youth Services; Child and Adolescent Needs and Strengths; Substance Abuse Treatment for Children and Adolescents; Youth Risk Behavior Surveillance System.

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Monoculturalism

Monoculturalism refers to the circumstance in which the defining features and views of one group dominate the other groups within the culture to the point of mass homogeneity.

Five key concepts underpin the practice of monoculturalism. First, there must be a strong belief in the superiority of one group's cultural heritage, including its history, traditions, and values. At the same time, there must be a parallel belief in the inferiority of the cultural heritage of other groups. While both may be true in any culture, in order for monoculturalism to become a reality, it is also essential that the group perceived as the dominant cultural force have the power to impose its beliefs or will on the groups perceived to be culturally inferior. In so doing, the dominant group's values then become institutionalized within the culture, influencing everything from policies and practices to recreation and architectural design. Finally, all of the preceding factors must occur outside of concerted effort and awareness in order for the phenomenon of true monoculturalism to take root.

Bias and Marginalization

In monoculturalism there tends to be a feeling of entitlement among the dominating group based on its perceived superiority. This belief often leads to conflict and exploitation of the submissive groups. In the United States, for example, consider how the early British colonists looked upon the Native American populations as culturally inferior to their own civilized society because the native reality was so different from their own mainstream culture. With that mind-set, the European settlers embarked on a vigorous campaign of fighting and mistreatment designed to rid their new world of the inferior culture through destruction and forced assimilation.

In contemporary times, monoculturalism is illustrated in the form of institutionalized bias that serves to reinforce the dominant culture's values by imposing and perpetuating uniformity across all aspects of society. Individuals who function according to the institutionally biased values are often rewarded with greater success than those who operate outside the monocultural mainstream. Their success reinforces their belief that the dominant cultural values shaping their society are the right ones, creating a cycle of cultural imposition and validation. Individuals generally are not aware of this cyclical cultural conditioning, which emerges as a result of a subconscious reality in which events are interpreted and prejudices are formed based on a singular worldview—that held by the dominant culture.

Those who do not fully subscribe to the monoculture's paradigm tend to find themselves marginalized in society or forced to distance themselves from their true beliefs and character in order to function in a world of someone else's making.

Implications in Human Services

Monoculturalism within human services involves viewing policy making and the implementation of services from the perspective of a single set of dominant ideas about the way things should be, how to get things done, and who should lead the way. That means that human services programs, practices, and interactions are approached from a common, one-size-fits-all point of view—to the detriment or outright exclusion of those whose beliefs and notions fall outside of the established norm. This is especially true in melting pot cultures such as the United States and many western European nations, where immigration policies are more open and resident populations are more ethnically and culturally diverse.

In these types of diverse environments, social services professionals tend to focus narrowly on the standards set by the dominant monoculture and fail to adequately take into account the beliefs, customs, and goals held by individuals who are deeply rooted in their home cultures. In other words, social services professionals are themselves a product of the institutionalization of bias inherent in creating a monoculture environment in the first place. As an institutionalized force, social services practitioners in a monoculture society are accustomed to using the same theories, tools, and approaches to address the same types of situations, regardless of factors such as the ethnicity and social customs of the recipient of the service. While the tactic provides a degree of consistency in service delivery, it may not provide the best approach toward solutions for the party in need.

One reason for this type of potential shortcoming in human services care is that, despite living in a monoculture, most ethnically diverse societies retain some deeply embedded elements of their own culture within their daily lives. Those cultural elements may conflict with the dominant culture's ideas about how to approach a given situation, such as asking for help outside of the family, for instance. In many cases, the disparity in values means the individual's tightly held beliefs are ignored in favor of tradition and the presumed greater good. Individuals in this circumstance have two main options: to give up one's personal beliefs to fit the dominant norm or to become marginalized by failing to conform. It is unlikely that either outcome would be the conscious intent of social services professionals, but the reality should be a conscious consideration for those involved in human services fields.

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See Also: Acculturation; Association for Multicultural Counseling and Development; Bias in Service Delivery; Biculturalism; Communication Styles, Ethnic and Cultural Differences in; Cross-Cultural Service Models; Cultural Appropriation; Cultural Paradigms; Ethnic Diversity and Values; Immigrant Populations, Human Services Needs of; Implicit Bias; Multiculturalism; United States, Demographics of; Values and Ethics, Ethnic Diversity and; White Privilege.

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Mormons

When clients are culturally different, in order to be successful, the health professional should approach these differences with respect. They should educate themselves on the differences and ask respectful questions to clarify and reduce misconceptions.

The Church of Jesus Christ of Latter-day Saints

The Church of Jesus Christ of Latter-day Saints (LDS or Mormon) was founded by Joseph Smith (known as the Prophet Joseph Smith), who received a vision from God at the age of 14 upon petitioning God for an answer as to which church to become a member. Smith believed he was divinely chosen to restore the Church of Jesus Christ to the Earth as he felt the heavenly host had spoken this plan for him. He was given revelations by a host of heavenly messengers and wrote the Book of Mormon. The LDS church was born in 1830 under Smith's leadership. It is reported there are more than 80,000 missionaries in the church and more than 12 million members worldwide.

Family

To understand Mormons as culturally different clients, it is important to have a basic knowledge of the LDS. For family counseling, knowing the LDS's view of the family is critical. David O. McKay, the ninth president of LDS, is quoted as saying, "No other success can compensate for failure in the home." LDS members derive strength from family—believing that children who are raised in loving, supportive homes are given a clear advantage in life. Life lessons are best learned at home with the backing of a united parental unit—consisting of a married father and mother. Families are intended to be guideposts and safe harbors for one another. LDS members hold in great reverence families and their ability to teach love so that each family member may learn to love others outside the family just as their Heavenly Father loves them. LDS members exist to serve God and one day go to live with Him in heaven along with their families. This is their purpose for following Him—to know this eternal blessing.

The Salt Lake Temple in Salt Lake City, Utah. The temple is considered sacred by the church and its members, and a "temple recommend" is required to enter. There are no public tours.

Marriage and Divorce

The church officially disapproves of divorce but does permit divorce, annulment, and the cancellation of sealing of a marriage made in the temple. The belief is that marriages are intended by God to be an eternal union between a man and a woman. Mental health professionals need to understand the church's view on marriage and divorce and allow those guidelines to be used. A civil marriage is one that is for "a time," meaning that it ends with divorce or death. A temple marriage is sealed, and the two will remain married for all eternity—husband and wife in heaven. Second marriages are for a time only, unless the sealing is approved by the first president. The promise of celestial marriage is held sacred by the church.

Misconceptions

Brothers and sisters of the church feel and know that the amount of misinformation about the church is vast, and clients may be put on the defensive quickly if the counselor conveys misconceptions. The church understands these misconceptions—ignorance is fine; wrong is a problem. Primary among these misconceptions is the idea that members of LDS are not Christian. This misconception is extremely offensive to members of the church, as a belief in Christ as their savior and redeemer is central to their faith.

LDS members believe in the Bible and also use the Book of Mormon. If the counselor is not a member of the LDS, odds are high that the counselor has at least some misconceptions about the church. Counselors need to be open to this idea—they probably have misconceptions.

Free Agency

The church embraces the idea that people can control their circumstances. This is called the doctrine of agency (also known as the free agency), and it is central to the faith. The belief that each person has the freedom to choose for themselves is foundational because it is a choice to belong to the church, it is a choice to follow commandments, and it is a choice to break these commandments. Understanding free agency helps health care professionals put issues into perspective for members of the church who are seeking treatment. If a therapist is seeing a member of the church that is in an abusive relationship, the client will understand if the therapist alludes to the fact that the controlling partner is depriving him or her of free agency.

Family and Social Services

In the church, there is no paid clergy, so the ecclesiastical leader may not be well versed in marriage and family issues. The church has a social services department called family services that offers limited services to members. These services include counseling, adoption, and addiction recovery. Services of professionals in the family and social services community may be sought out for their expertise and therefore should take the time to familiarize themselves with the doctrine and rules of the church.

Articles of Faith

The church has 13 Articles of Faith that summarize the fundamental beliefs of the church. The Prophet Joseph Smith gave these to John Wentworth, editor of the *Chicago Democrat*, for printing. These 13 are a succinct summarization of the church's beliefs. Health care professionals would do well to read and familiarize themselves with these before seeing any LDS members. The 13 Articles of Faith are as follows:

1. Mormons believe in the Father, the Son, and in the Holy Ghost.
2. They believe that each human will be punished for his or her own sins and no one else's.
3. It is believed that Christ atoned for all humankind's sins and requires obedience to all laws of the Bible.
4. It is believed that faith in the Lord Jesus Christ comes first; repentance second; baptism by immersion for the remission of sins third; and the laying on of hands for the gift of the Holy Ghost fourth.
5. Being given the gift of prophecy comes by calling and the laying on of hands to go forth and preach.
6. Those positions in the early church exist in the church today—for example, apostles, prophets, pastors, and so on.
7. The same gifts of the early church continue in the church today—gifts of prophecy, revelation, visions, healing, and so on.
8. The Bible and the Book of Mormon are the word of God and are followed as such.
9. The church believes all the revelations past, present, and future of God.
10. The church believes in restoration of Israel and of the 10 tribes, the New Jerusalem being built in America, and Christ's return to reign on the renewed earth.
11. Mormons and all of humankind have the right to worship God as they see fit.
12. The church believes in being subject to those in power and obeying the laws of the land.
13. The church believes in following the admonitions of the Apostle Paul, such as those in Philippians 4:8.

Homosexuality

The church regards homosexuality as a sinful inclination. The church upholds a moral standard, and homosexuality is a violation of this moral standard. The church loves everyone and treats everyone as children of God. The church believes most people have sinful inclinations they must work to control—alcoholism, gambling, and so on. Mental health professionals need to understand the moral standards of the church and gear their treatment accordingly. Encouraging a Mormon to embrace his or her homosexual inclinations would be against his or her beliefs if he or she follows the LDS doctrine.

Acts of Service

The church is not one of self-centeredness. Their philosophy is one of daily service—at home, at work, at school, in the community, and globally. The Prophet Joseph Smith wrote in *Times and Seasons* in 1842 that the church is "to feed the hungry, to clothe the naked, to provide for the widow, to dry up the tear of the orphan, to comfort the afflicted, whether in this church, or in any other, or in no church at all, wherever he finds them." The impact of the church's acts of service, including monetary, can be seen at http://mormon.org/values/humanitarian-aid. The best source for accurate information regarding LDS can be found at http://mormon.org.

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See Also: Religion and Clients; Spirituality/Religion and Diversity.

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Multicultural Education

Multicultural education is a body of knowledge, pedagogies, and polices that emerged during the 1960s in the United States in response to concerns about engaging with differences of culture, race, nationality, and ethnicity. Through curricular, extracurricular, as well as teacher education programs and approaches, multicultural education seeks to enhance the appreciation of cultural diversity in students and teachers. It sees formal and informal educational institutions, at all levels, as its site of operation.

Over the past couple of decades, the theoretical complexity and nuance of multicultural education has increased significantly. While earlier formulations of multicultural education were concerned with demonstrating to students the contribution of people from different cultures to the American social and public life, in its current formulations, it endeavors to achieve a more complicated engagement with difference.

The critical strands of multicultural education, for instance, direct attention to the social construction of difference, highlight the interplay of knowledge and power, center the positionality of students and teachers, and analyze the ways in which differences of race and ethnicity intersect with other differences such as those based on gender, sexuality, religion, and ability. Drawing on critical, poststructuralist, affect, and feminist theories, these recent approaches attempt to make apparent the institutional, communal, and individual practices that naturalize and normalize particular differences, marking others as deviations.

Historical Development

While the concerns, values, and ideals that inform multicultural education have been emphasized by educational movements across the world, as a formal movement, multicultural education traces its origins in the United States.

During the early decades of the 20th century, increased migration from southern, central, and eastern European countries to the United States, and later the migration of African Americans from the south to north during the mid-20th century, heightened concerns about the integration of those who had different races, religions, and socioeconomic backgrounds. The earliest educational efforts to engage with these differences are found in the work of the intercultural and intergroup educational movements. These movements advocated for and designed curricular interventions, models of schooling, and teacher training programs that sought to engender an appreciation and understanding of incoming cultures as well as produce a sense of pride in the immigrants about their own heritage. Their approaches, however, were later criticized for advocating an assimilationist approach. It was argued that the normative, middle-class, white American culture formed the invisible background against which all incoming cultures were tolerated or appreciated and that these movements simply sought to integrate the immigrants into a predefined norm, thereby reproducing power asymmetries.

The passing of the Immigration Reform Act and the Civil Rights Act during the 1960s created another impetus for migration to the United States. Large numbers of immigrants from Asia, Africa, and South America provoked similar fears around racial purity and normative American values. This time around, however, a different movement called multicultural education sought to address these issues through a multidimensional and multidisciplinary perspective.

Dimensions of Multicultural Education

Multicultural education emerged in response to the limited engagement of earlier educational movements with a difference. It was positioned, according to James Banks, as a more complex and nuanced approach to difference and proposed at least five distinct dimensions: a critical analysis of how knowledge is constructed to investigate implicit cultural and racial assumptions and biases; an evaluation of students' own attitudes toward those of other races and cultures; an effort to integrate examples from various cultural groups across all subject areas; a commitment by teachers to employ a pedagogy that facilitates learning and achievement of students from diverse backgrounds; and establishment of a school culture that empowers diverse students. Multicultural education, thus, sought to transform not only the experiences of students and teachers but the entire schooling environment.

The movement, however, was not unified. Banks has identified at least three strands of knowledge within the movement: the Western traditionalists, the multiculturalists, and the Afrocentrists. These groups differ in their understanding of what constitutes knowledge and the purpose of schooling. The Western traditionalists seek to maintain the dominance of Western civilization in the curriculum; the multiculturalists emphasize the inclusion of the cultures and experiences of people of color and women in the curricula; and the Afrocentrists propose a centering of African culture and history. Instead of viewing these as distinct spheres of knowledge, however, it would be more appropriate to conceive of them as overlapping areas of focus, which influence educational institutions to varying degrees across different contexts.

In addition to highlighting their own approaches and pedagogies, proponents of multicultural education have also undertaken significant analysis of the different ways in which educational institutions in the United States engage with difference. Banks has highlighted four approaches that seem to be dominant: the contributions approach, which focuses on culture as an object to be displayed during one-time events such as international days or a celebration of national heroes; the additive approach, which incorporates themes and examples from diverse cultures into the curricula but does not seek to promote any structural change; the transformative approach, which changes the paradigms that students employ to engage with the present, with an emphasis on understanding how others might view the same present from a different perspective; and finally, the social action approach, which seeks to enhance not only knowledge about different cultures but also provides students with the skills to take personal and social actions to address issues of social injustice. Advocates hope that a larger number of schools will adopt the transformative and social action approaches toward multicultural education.

Like the intercultural and intergroup movements, multicultural education too has been criticized, especially for the ways in which it is implemented in schools. It is argued that, in practice, multicultural education models often follow the contributions and additive approaches, which simply affirm diversity by including representations of marginalized groups in the curricula but do not engage with the structural and ideological factors that lead to marginalization or oppression in the first place. In addition, it is also argued that multicultural education's focus on issues of race sometimes leads to a de-prioritization of considerations of gender, sexuality, religion, nationality, and to some extent also social class. Educators and theorists have, therefore, attempted to reconceptualize the field to produce a deeper engagement with difference. Two recent approaches attempt to address some of these concerns: multicultural social reconstructionist education and critical multicultural education.

Emerging Theoretical Dimensions

Grounded in critical and feminist theories, multicultural social reconstructionist education pays particular attention to power relations, conceptualizes identities as fluid, promotes curricula that incorporate students' cultures and experiences, and emphasizes building advocacy and coalition-building skills. It explicitly addresses issues of social oppression and stratification, including gender and sexual injustice, by foregrounding an analysis of the different ways in which race, class, gender, and sexuality intersect to constitute students' and teachers' subjectivities and inform the formal and hidden curricula at schools. Significantly, it sees systems of racial, gender, sexual, and religious oppression as interconnected and reinforcing structures. More broadly, this approach encourages a reconstruction of cultural and societal institutions to promote democratic values and a sense of shared responsibility for societal inequities.

Critical multicultural education shares several dimensions with multicultural social reconstructionist education but extends the analysis by positioning itself as an orientation toward difference that seeks to interrogate the status quo through a historical, social, economic, and ideological investigation. Some of its key features, according to Sonia Nieto, include an emphasis on understanding cultures without essentializing them; making apparent the politics of knowledge production and transmission; encouraging discourses that challenge the status quo; problematizing a simplistic focus on empowering students of color; redefining immigration as a complicated process; and promoting a constant interrogation of teaching pedagogies and models of technocratic public education. In addition, critical multicultural education does not identify schools as the only site where learning takes place. Instead, it views schools as one of the several pedagogical sites and includes other societal institutions such as the family, community centers, neighborhoods, online media spaces, and so on, in its analysis as well. Furthermore, critical multicultural education has a global orientation, which often means that issues of social oppression are seen as intricately connected to broader global imbalances between countries in the North and south. The approach, therefore, seeks to excavate not only local but also global mechanisms that reproduce and sustain cultural differences. Scholars from a range of theoretical perspectives such as neo-Marxist, poststructuralist, feminist, queer, as well as affect theorists locate themselves within critical multicultural education.

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See Also: Association for Multicultural Counseling and Development; Multicultural Education; Multiculturalism.

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Multicultural Education Journals

Multicultural education is a curriculum field that emerged in the 1960s as a result of many factors, including the civil rights movement and the lack of balanced representation in U.S. curricula and textbooks. Christine Bennett asserts that multicultural education is a teaching and learning approach that emphasizes cultural diversity within pluralistic societies and empowers students to gain a full understanding of individuals culturally different from themselves. Leading scholars, including James Banks, Christine Bennett, Geneva Gay, Christine Sleeter, and Carl Grant, have developed various multicultural education approaches that are documented and applied in many scholarly outlets and journals. To date, there are five multicultural education journals and magazines with diversity in their focus, content, and targeted audience. These publications include *Multicultural Perspectives*, *Journal of Praxis in Multicultural Education*, *International Journal of Multicultural Education*, *The Journal of Multiculturalism in Education*, and *Multicultural Education*.

Multicultural Perspectives

This is the quarterly journal of the premier association for multicultural education, the National Association for Multicultural Education (NAME). *Multicultural Perspectives* is a peer-reviewed journal created in the summer of 1993 and is published by Taylor and Francis. It publishes articles featuring best practices in P through 16 (preschool through college completion), the nonprofit sector, and museum organizations. The journal features the following sections: Advancing the Conversations, Multicultural Windows, Creating Multicultural Classrooms, The Multicultural Library, Technology, Guide to New Resources, and NAME Regional News.

Journal of Praxis in Multicultural Education

This is a peer-reviewed journal housed in the University of Las Vegas, Nevada. It accepts manuscripts from the P through 16 community with an emphasis on the definition of praxis. This journal's manuscripts focus on research studies that show effective academic achievement practices of diverse learners from preschool through higher education. Since its inaugural issue in 2006, the journal has produced seven volumes. Manuscripts are published once or twice a year.

International Journal of Multicultural Education (IJME)

This open-access, peer-reviewed e-journal is for individuals interested in promoting cross-cultural understanding, equity, and global awareness in all education tiers. Their writings are centered around four areas, including (1) qualitative research; (2) literature-reviewed research that promotes and advances multicultural education theory and scholarship; (3) scholarship in multicultural education instructional strategies and ideas that are practical and have proven to be successful; and (4) reviews of online, professional, and children's books and visual arts resources. Beginning in 2013, *IJME* began publishing three times annually: April, August, and December. *IJME* is the successor of the electronic magazine of *Multicultural Education*, which published issues between 1999 and 2006 and transitioned into the current *IJME* in 2007. It is published out of Eastern University in St. Davids, Pennsylvania.

The Journal of Multiculturalism in Education

This scholarly journal disseminates peer-reviewed articles that integrate theory and praxis on P through 16-related multicultural areas around the world. It is an online publication housed at West Texas A & M University. To date, it has published eight volumes since its inauguration in 2005.

Multicultural Education

This magazine is an independent quarterly magazine published by Caddo Gap Press. It features articles on promising strategies, art, music, literature, personal perspectives, and resources in the field of multicultural education. It also includes book reviews and announcements on future events. Their audiences are P through 16 educators. The publication celebrated its 20th anniversary in the 2012 to 2013 academic year.

All of these journals are prominent in their own right in the P through 16 community, especially among teachers, teacher educators, and future teachers. The journals have disseminated articles that integrate theory and practices and have used these articles to advance conversations in the field.

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See Also: Cultural Competence, Model of; Multicultural Education; Multiculturalism; People of Color: Service Delivery, Psychological Assessment, Cultural Issues; Pluralism.

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Multiculturalism

Multiculturalism is an important subject that has been discussed and highlighted recently in many areas from education to politics. The reason for this fact is that many societies have now understood that some problems have arisen in different dimensions as people live together, namely from multiculturalism, and they intend to solve these problems by overcoming the problems among countries. Multiculturalism is defined in the literature as the legal and political coherence of ethnical diversity, coexistence of several cultures, modern societies covering different cultural groups, and ensuring that these different cultural groups have equal statutes. Although multiculturalism means several points of view or several dimensions, it could also be defined as the pluralism and diversity of cultures. For example, Canada, which has legalized the multicultural structure, was the first country to use this term in 1971, and although Pierre Trudeau, who was the prime minister of Canada, frequently mentioned the term *multiculturalism*, Canada continued with the double culturalism principle for some period. Despite this, multiculturalists defend that multiculturalism arose in the 1960s due to the cultural needs of groups that immigrated to Europe.

The word *culture* was a word used in its singular culture meaning until the 18th century, and today, culture addresses differentiation in characteristics such as religion, language, race, ethnical origin, class, gender, or lifestyle. In addition to that, the anthropologist Franz Boas defines culture as the patterns of belief, value, tradition, and behavior that people use in regulating their worlds and relationships with each other and are transferred from generation to generation. Consequently, multiculturalism means the coexistence of different cultures in a society. Moreover, multiculturalism means people having different religions, languages, races, and traditions living together.

Whereas multiculturalism does not consider it appropriate from the point of view of the conditions of the country to become prototypes in culture, language, ethnical origin, lifestyle, and religion, it perceives the differences that a society has as a richness and tries to establish a sociability on the grounds created by these differences. For that reason, as it is taken as a purpose by each social ideology, the main purpose of multiculturalism is to establish and survive the good society. A good society is a society that acknowledges cultural diversity as a richness and determines its policies in this direction.

There are various ways to handle the multiculturalism and its impacts at local, national, and global levels. Each different point of angle related to the subject gives a new dimension to our understanding about this complex and changing fact. Multiculturalism means the coming together, living, working, trading, and participating in the political life of people from different races, ethnical origins, religious and cultural groups on a piece of earth, as well as their social and cultural interaction and participation in political life, expressing a social diversity. Multiculturalists believe that multiculturalism teaches giving value to the citizens, diversity, and differences of a democratic society and assisting in integration with the society without breaking different cultures from their pasts. From the point of view of education, the concept of cultural diversity is as important as the concepts of identity and diversity. Furthermore, the culture is the whole of beliefs and actions that a group of people understand as the world they have constructed along with their individual and social lives. Thus, multiculturalism relates to cultural diversity and cultural differences and associates identity and diversity with multiculturalism. We are all connected to culture from physical, social, psychological, and spiritual aspects; therefore, we can change a culture, but we cannot break off from the culture. Whereas there is no escape from multiculturalism, which is defined by scholars as the celebration of diversity in daily life, there is also no escape from culture.

For example, Will Kymlicka underlines that countries that adopt the policy of multiculturalism have some responsibilities, and he states that the most widespread symbolic forms of the policy of multiculturalism comprise eight practices:

1. Ratification of multiculturalism by the constitution, regulations, and the parliament at central or regional level and at municipality level
2. Adoption of multiculturalism by school curricula
3. Inclusion of ethnical representation and sensitivity while obtaining license for public media
4. Granting of exception in clothing, regulations, laws, or lawsuits
5. Permitting double citizenship
6. Providing support to ethnical group organizations for cultural activities
7. Providing financing for education in two languages or courses in a mother tongue
8. Applying positive discrimination for migrant groups that are in disadvantageous (hard) conditions

The purpose of these eight policies specified is to catch the policy dimension that liberal, democratic countries encountered with the issues of whether to return to multiculturalism and developing multicultural citizenship models related to immigrants. It is highly significant to put multiculturalism to a historical context. In this regard, multiculturalism is a concept as old as humanity. Different cultures have always found a way to live together. For example, respecting diversity was a customary condition for many empires including the Ottoman Empire.

For that reason, multiculturalism is a concept that has different histories and origins in different countries. For instance, Canada was the first country to adopt multiculturalism as an official policy in the world together with diversity.

The government of Canada defines multiculturalism as follows: Canada considers its opinion of equality of all citizens as one of the building stones of multiculturalism. Multiculturalism ensures that all citizens are proud of protecting their own identities and of their feeling of loyalty. The feeling of acceptance gives Canadians the feeling of self-trust, ensuring them to be more open to various cultures and to easily adopt these cultures. The example of Canada demonstrates that multiculturalism encourages racial and ethnical coherence and understanding among cultures, and prohibits ghettos, hatred, discrimination, and violence.

This definition theoretically expresses a more comprehensive cultural and social significance. Recognition of diversities by laws and prohibition of discrimination and racism are a must in every country that believes in the equality of citizens. The conceptual discussions related to multiculturalism that developed in Canada brought into agenda the subjects of ghettos and violence as well as equality and human rights.

Whereas Canada is the first migration country that is registered as multicultural, it hosts groups who are ethnically diverse. In the country, multiculturalism is directed toward cultural differences, is focused on the integration of migrant populations, and is the framework of cultural identities. Racism, religion, and lingual differences are included in the concept of multiculturalism in Canada. Multiculturalism has been a part of the discussions of the identity of Canadian and of Canadian politics starting from the establishment of Canada in 1867. In the beginning, multiculturalism was directed toward bringing together the French and the English, who were two building elements, and subsequently assimilating other ethnical groups and migrants, thus organizing the relationship between the state and local people. However, it was understood that this mechanism did not operate, and the country politics was changed, taking into account the cultural, linguistic, and religious structures of individuals of different ethnical identities hosted by the country. Education has always played a key role in ensuring cultural differences. Over time, Canadian society has further adopted multiculturalism, emphasizing cultural differences and highlighting this issue more.

In this regard, Canada had an important place in the world on the issue of multiculturalism, paving the way for collective life of individuals of different ethnical origins in peace. The reason for high importance attached to multiculturalism is that it created a culture of respect in the country, integrating individuals of different ethnical origins and accelerating the process. In this regard, educational policies and state organizations put emphasis on diversity directed toward educating people having different ethnical structures and maintaining different cultures. The learning and teaching approaches in education were shaped around constructivism, respect, and multiculturalism.

The multicultural social structure of Canada is also enjoyed by many countries like the United States. In particular, the concept of multiculturalism in the United States is as old as that in Canada. The deprivation of black people of some rights that white men enjoyed accelerated the development of multiculturalism and multilingual policies in the country as well as multicultural and multilingual education that depended on these policies. Multiculturalists explain multiculturalism in the United States as follows:

> Multiculturalism is a social and political movement that considers the differences among individuals and groups not as a source of conflict but a potential source of power and renewal. It gives value to the effect that people continue their diverse experiences and backgrounds originating from racial, ethnical origin, gender, sexual orientation, and class differences and develop various viewpoints.

It tries to keep standing the ideals of equality, justice, and freedom that are at the root of the United States and adopt the respect for individuals and groups as a principle for the success and growth of the country. Many European countries have adopted multiculturalism as a state policy. For example, Bhikhu Parekh considers multiculturalism in the UK with a point of view that provides significant projections about human life and how we will create our social life.

Initially, people are embedded in the culture because they grow and live in a culturally structured world. They design their lives and social relationships according to the meaning system and importance of the culture and attach high importance to their cultural identities. Secondly, different cultures have different meanings and represent good life visions. A single culture could recognize human capacity and feeling in a limited framework and grasp only a part of human existence. Yet people need others and other cultures in order to understand themselves better and extend their intellectual and ethical horizons. Third, all cultures other than the most primitive are pluralistic and represent a dialogue that continues between different traditions and ways of thinking. These do not mean that they are deprived of internal harmony; on the contrary, the identity is pluralistic and flexible.

The multiculturalism indicated in the national policies and state policies in Australia responds to policies and programs of Australia, which entail cultural diversity, human relationships, social justice, equal opportunities, and antiracism. This order requires that all groups live together in harmony, participate in the society in a complete and effective manner, and use their skills and competencies for the goodness of economic, social, and cultural life.

In addition to this, the Australian government has emphasized the three dimensions of the policy of multiculturalism as follows: (1) cultural identity—it means the expressing and sharing by all Australians their cultural heritages including language and religion; (2) social justice—it expresses all Australians' right to be treated equally and have equality of opportunity while removing the obstacles arising from race, ethnical origin, culture, religion, language, gender, and the region of birth; and (3) manufacturer diversity—it expresses the need of all Australians to develop, use, and continue effective skills and competencies.

While defining multiculturalism, the concept of cultural diversity, which is frequently encountered, is a point that should be highlighted. In addition, the Declaration on Cultural Diversity adopted by the Ministerial Committee of the Council of Europe in its December 7, 2000, meeting, states that cultural diversity is the coexistence and exchange of different practices from cultural aspects. In the same council, various decisions were made for the maintenance and implementation of cultural diversity, such as inviting the member states to continue and encourage cultural and linguistic diversity in the new global framework inviting the Council of Europe to adopt obligations under relevant documents, and also inviting them to pay attention to sustain and encourage cultural diversity in other international areas. Today, compliance by Turkey, which is striving toward entering the European Union, with the decision to be made by the European Council within the context of cultural diversity, will accelerate the process of membership in this union.

Different from the definitions of multiculturalism that is specified, it is defined as an alternative to the understanding of assimilation, which has been widespread in the past. Multiculturalism accepts the existence of various cultures in a country. This situation does not mean the existence of numerous different cultures in the society. On the contrary, it expresses a society that creates, guarantees, and encourages the areas where different cultures may grow themselves. Meanwhile, multiculturalism expresses the formation of a public area where these societies can interact, enrich the culture that exists, and establish new reconciliation systems reflecting their own identities. As a social philosophy and policy, multiculturalism expresses the effort to create a coherent society from different ethnical and cultural groups. Accepting and valuing the diversity and not ignoring diversity or not trying to put all groups in a single basket are more accurate descriptions.

As multiculturalism has principally arisen for demolishing the understanding of assimilation, the term *assimilation* should be emphasized. Assimilation could be defined as the simulation of a culture that is different from the prevailing culture of the society and participated or was forced to participate in that society for any reason. Multiculturalism is an alternative for preventing the clash of cultural differences and demolishes the assimilation in question. As a matter of fact, when near history is examined, it is possible to see many country examples where the issue of multiculturalism was used to solve problems that have arisen due to cultural differences.

Many countries and researchers believe that at the core of all conflicts in multicultural societies lie misunderstandings, doubt, or lack of trust. Many people coming from different backgrounds tend to misinterpret and fail to understand the core of foreign customs, religious beliefs, or different attitudes. A quote from James Banks brings out the importance of multiculturalism as "we live in a dangerous, complex, and depressed world where there is a need for leaders, educators, and teachers who will exceed the unsurpassable cultural, ethnical, and religious borders, imagine new possibilities, find new paradigms, and perform personal transformation and visionary actions." Thus, multiculturalism, beside all, relates to developing new democratic citizenship models built on human rights ideals. This is a part of a wider revolution of human rights covering ethnical and racial diversity. Multiculturalism and training are two interconnected concepts. In addition to being up-to-date, these two concepts host issues such as cultural diversity, difference, equality, and racism. For that reason, it is misleading to think that these two concepts are different from each other. For example, students from various cultures are being trained in a school.

The basic thesis at the root of the discussion on multiculturalism and education is that multiculturalism creates new, healthy generations as social tolerance increases as a result of cultural change for both the products and ideas, thus providing for the wellness of the society and accelerating progress, thus being a successful policy. The opinion asserted by those who think otherwise is that discrimination problems or language obstacles of multiculturalism constitute the basic obstacles before creating such a policy. When the core of multiculturalism is in focus, this policy aims at decreasing discrimination and expressing the ideas openly.

In addition, multiculturalism has three different, interrelated categorical uses by researchers: (1) demographic—identifies use—it is used for expressing the existence of citizens of different ethnical origins of a multicultural society or a state; the structural differentiation in the state in fact represents the cultural diversity; (2) ideological—normative use—this is the use where the different cultural identities in the society are discussed from sociologic theory and ethical or philosophical perspectives; (3) programmed—political use—this means some types of programs and political initiatives are designed for managing ethnical diversity.

In addition to the foregoing definitions, scholars accepted the existence of ethnical diversity and that individuals guarantee to protect their own cultures by guarding their rights and keeping their values high.

Another concept that comes to mind when one speaks about multiculturalism is the concept of otherization. Otherization means the personalization of one who is not us or the exclusion of the person from his or her own group or culture. As it could be understood from the definition, in societies where such a situation occurs, persons who are included in the group "other" and have a culture different from the dominant culture are considered as victims. These persons experience big problems in using their mother tongue in particular. It is well known that the ability of one to learn his or her own language, to use and develop the language, provides for more development in the ability of a person to know and learn new things.

Multiculturalism is a concept that is included among the general principles of various religions. For example, a verse in the Qur'an, the holy book of the religion of Islam, states that "the superior of you is the one who is more afraid of God." It means that the superiority is not in color, race, or generation; it suggests that people should not be discriminated against in the shapes and values they have but be valued according to the value they have before God. It is also stated in the Bible, the holy book of Christians, that "If the first dough is divine, then the whole dough is divine. If the root is divine, branches are also divine. However, if some branches of an olive tree of good species are pruned, and you have got a share from the core of the tree that gives live after it is inoculated among a wild olive, do not be proud against the previous branches." This verse indicates that people should not use the values they have as means to claim superiority over others. Also in a verse of the Torah, the divine book of Jews, it states, "How good, how beautiful it is to live brotherly in union." It emphasizes that the brotherly life enjoyed by people constitutes a good example of a good society. As it could be seen, the divine books of three religions order that no discrimination should be made among people due to different cultural characteristics, as it has been recommended in the teachings of multiculturalism, and that brotherly living enjoyed by all people will bring them peace, happiness, and tranquility.

When the opinions of thinkers who wrote on multiculturalism and the statements in the divine books of three religions are interpreted, it could be concluded that the concept of multiculturalism is among the common beliefs of religions because the purpose of religions is to ensure that people live in peace through spiritual sanctions. Multiculturalism claims that the diversity of people and the values they have do not constitute advantages or disadvantages or targets but rather creates a society where everyone lives in peace enjoying equal rights. It could be said in this regard that, as it is in the teachings of divine religions, multiculturalism also rejects discrimination with a strict language.

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See Also: Association for Multicultural Counseling and Development; Cross-Cultural Knowledge; Multicultural Education.

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Multiethnic Placement Act of 1994

The Multiethnic Placement Act (MEPA), first adopted by Congress in 1994, was a legislative action written with the goal of reducing the number of children who linger in foster care while waiting for adoption. The practice of racial matching of foster children to adoptive parents was seen by legislators as one of the factors increasing the length of stay for these children in foster care and, by extension, swelling the already unwieldy rolls of children in state custody. Proponents of MEPA sought not to eliminate but to relegate the priority of race and ethnicity considerations in adoptive placement decisions by child welfare workers. Although MEPA has been law for nearly 20 years, child advocates still struggle over its specific provisions, interpretation, and application in daily child welfare practice.

In the history of legal adoption in the United States, the practice of racial matching has stirred great controversy among advocates mutually motivated by the well-being of foster children. On one side of the issue are those who believe that it is always in the best interest of children of one racial or ethnic background to be permanently adopted into families of the same background. On the opposite side are those who've argued that it is never in the best interest of children to linger without the sense of permanency that legal adoption brings when there are caring families willing to adopt them, even if that family does not match their own racial or ethnic heritage.

Complicating this controversy is the complex history of institutionalized racism in the United States. In fact, there is well-documented history of the government encouraging the adoption of nonwhite children into the homes of white families with the intention of forcing cultural assimilation and acculturation, particularly with Native American and African American children. Over time, these practices have resulted in significant losses to the maintenance and perpetuation of the diverse cultures of American minorities.

Likely motivated by information from a Congressional study that revealed that the foster child population had reached more than 500,000 children and that African American children waited longer to be adopted, Ohio Senator Howard Metzenbaum introduced the bill that became MEPA, and President Bill Clinton signed it into law in 1994. Despite the lack of consensus among child advocates and researchers on racial matching, the bill essentially came down on the side of accelerating adoption over the practice of racial matching. However, compromises were incorporated into the bill that continue to allow race and ethnicity to be considered in placement decisions. However, it is today's law that also includes additional provisions known as interethnic provisions (IEPs).

Major Provisions

Specifically, MEPA/IEP make the following provisions: Government and federally funded adoption and foster care agencies are allowed to consider the cultural, ethnic, or racial background of a child and the capacity of an adoptive or foster parent to meet the needs of a child with that background when making a placement. However, these agencies are prohibited from delaying, denying, or otherwise discriminating when placing children on the basis of the parent or child's race, color, or national origin or categorically denying any person the opportunity to become a foster or adoptive parent solely on the basis of race, color, or national origin of the parent or the child. In addition, state agencies must develop plans for the recruitment of foster and adoptive families that reflect the ethnic and racial diversity of children in the state for whom families are needed. And finally, failure to comply with MEPA is considered a violation of Title VI of the Civil Rights Act and enforceable as such.

Criticism

Immediately upon the adoption of MEPA and IEP into law, child welfare workers criticized it for its lack of clarity and procedural guidance. Therefore, in 1995, the Department of Health and Human Services published *Policy Guidance on the Use of Race, Color or National Origin as Considerations in Adoption and Fostering* in the *Federal Register*, which was designed to help agencies comply with the law. Yet still in 1998, the Government Accounting Office issued a report to the House of Representatives validating the ongoing difficulty of agencies in consistently implementing the policy.

One problem with the interpretation of the law is that its restrictions on the practice of racial matching may seem to some child welfare workers to be inconsistent with the other federal laws and state policies related to ethnicity and placement, like the Indian Child Welfare Act of 1978, which encourages the practice for particular groups.

Human services scholars have also been critical of MEPA because of its lack of implementation resources and funding. In particular, while the bill encourages transracial and interethnic adoptions, no additional training or support is provided through the legislation assisting adoptive families with the unique challenges they face.

One of the strongest criticisms of MEPA stems from the research that shows that, in the two decades since the legislation has been in place, the overrepresentation of minority children in foster care in the United States has continued. Such statistics bring light to the idea that other child welfare practices, not racial matching in adoption alone, contribute significantly to disproportionality.

Finally, research has been largely inconclusive about the impact of either racial matching or transracial placement in terms of the overall well-being of children in substitute care. While evidence supports the idea that having children remain connected to their cultural heritage can serve to promote positive identity development and self-esteem, evidence also supports that children who are raised by parents of different cultural heritage can still develop a positive sense of self. And as child welfare workers continue to face the reality of high rates of abuse and neglect, large numbers of children continuing to come into state custody, disproportionate numbers of minority children filling the foster care rolls, an overall lack of available foster and adoptive parents of all racial and ethnic backgrounds, and a specific gap in numbers of available minority foster and adoptive parents, the struggle for clarity in how to best help these children achieve permanency continues.

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See Also: Abuse and Neglect; Acculturation; Adoption Agencies and Services; Assimilation; Child Welfare Services; Discrimination and Institutional Racism; Foster Care Agencies; Indian Child Welfare Act; Interethnic Adoption Provision.

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Multiracial Children

It is crucial to preface this discussion of race and the issue of being multiracial with the acknowledgement that race is socially constructed. Because race is a human construct whose boundaries are mediated by history, legislation, and other social order aspects, it is crucial to recognize the importance of its definition. Race is not a biological fact but rather a socially constructed concept. It is this social aspect that is of interest and influences the identity and psychological well-being of multiracial individuals. Multiracial is defined as someone with socially and phenotypically distinct racial heritages. The term *multiracial* includes individuals who are biracial, as well as individuals with more than two distinct racial heritages.

Growing Population of Multiracial Children

The multiracial child population is the fastest-growing population in America. Ever since the 2000 census, which marked the first time individuals were able to mark off more than one race, individuals identifying as multiracial has steadily increased to a total of 9 million people, approximately 3 percent of the population. In fact, the percentage of people identifying as multiracial grew three times faster during the last decade than the number of Americans reporting a single race. Additionally, this is a young population with more than half under the age of 24. Estimations state that, by 2060, approximately one in five individuals will identify as multiracial. The growing prominence of multiracial individuals, such as President Barack Obama, Tiger Woods, Derek Jeter, and Ann Curry, has also led to more positive attitudes, more acceptance, and less discrimination toward multiracial individuals and mixed-raced marriages. This is particularly true in areas where interracial marriage and multiracial individuals are high such as in California, New York, and Hawai'i. Hawai'i has the largest multiracial population, with almost one-quarter of the state identifying with two or more races.

Ethnic Identity

The concept of ethnic identity measures how much individuals identify with their own ascribed ethnic group and the extent to which that identification is salient and significant to them.

A positive and strong ethnic identity is related to many mental health-related outcomes, including self-esteem, self-efficacy, and depression. Difficulty in forming this stable identity can be expressed through a range of psychological symptoms. At the milder end of the spectrum, individuals may suffer from identity confusion, with mild symptoms of sadness, while those with more severe symptoms, such as antisocial and depressive behaviors, may exhibit behavioral problems such as delinquency and substance abuse. The normative stressors to forming a stable identity prevalent during adolescence may be heightened for the multiracial adolescent. Ethnic identification in multiracial adolescents is complex. For instance, the identity may be shaped by physical appearance and is in response not only to how multiracial individuals identify themselves but also by how others may identify them. Moreover, this identification is not static, but rather, it may change over time and according to situation. The environment also plays a role; for example, the number of ethnic minorities in the community may determine whether the multiracial individual identifies with the minority group.

There are different beliefs about what is considered a healthy identity for multiracial individuals. Some argue that multiracial individuals may identify with one, both, or neither of their biological parents' heritages. Others believe it is important to integrate the multiple racial identifications into one healthy multiracial identity. As noted by the bicultural competency theory, multiracial adolescents do benefit from exposure to multiple racial groups and often learn to function in multiple cultural environments. Multiracial adolescents who acquire this flexibility often exhibit a cognitive style that gives them stronger problem-solving skills; they are adept at interpreting and responding to the demands of varying social situations and various cultural orientations. Multiracial individuals are often well versed in understanding and following the rules and norms of numerous cultural contexts; therefore, they are more proficient at interacting with various cultural groups. Furthermore, competent multiracial individuals have a broader base of social support and a strong sense of personal identity and efficacy.

Peer Groups

Conformity is often not only valued but also expected during adolescence. Multiracial adolescents are at risk for rejection by both the majority and minority groups due to differences in physical appearance and family background. The process of forming a healthy identity can be disturbed by peer rejection. Multiracial children may find it difficult to get support from peers. Some multiracial children report teasing and staring. Peer groups (cliques) are inherently dependent on inclusion and exclusion, and this is especially pronounced in junior high and high school. This potential lack of friends has important implications because not only does having friends serve as an indication of social ability, but it helps influence social, emotional, and intellectual competencies.

These additional complications may often place multiracial individuals at greater risk for delinquency and peer conflicts. Multiracial adolescents may withdraw socially and not have any friends for fear of social rejection. Or, in a desperate attempt to be part of a group, they are more vulnerable to peer pressure from delinquent groups. On the other hand, multiracial adolescents may feel more welcomed by different groups and be more capable of using their multiracial background to navigate among groups. Multiracial individuals may be more likely to have racially diverse friends and continue doing so as they get older.

Parents

Multiracial families also face unique challenges compared to monoracial families. For example, there may be disapproval and rejection from extended family, neighbors, and the community. Multiracial children may face additional conflict within the families due to differences in language, religion, and child-rearing practices. There may be conflict among siblings with respect to identity as not all siblings within a family may identify similarly. Multiracial children of divorced families may face greater difficulties in accepting and valuing the culture of both parents. Not having parents that are multiracial may affect the amount of support and understanding parents can offer their children about the multiracial experience; this is in contrast to monoracial families whose parents can draw on their personal experiences. Parents in mixed-race marriages may not have the appropriate tools to discuss multiracial identity. This may cause children to feel a sense of loneliness, confusion, and frustration. Therefore, helping their children develop a clear identity and understand potential challenges of a multiracial identity, including discrimination and questioning, is an important task for parents of multiracial youth.

Tailoring Intervention and Prevention Needs

Mental health professionals and educators need to be prepared to meet the unique needs of multiracial children and their families. To begin with, individuals need to be trained to understand the identity development process for multiracial youth and the problems that may occur. A common question asked of multiracial individuals is this: “So, what are you anyway?” This can be viewed as benign, or it may be seen as an uncomfortable and harassing question. This is a good opportunity for mental health professionals and educators to help multiracial children developing coping skills to address questions and respond to bias, discuss mixed-race heritages, and point out diversity that may exist within everyone’s families.

For example, some families may have individuals who speak different languages, have different religions, and look different. Also recognizing issues that may be unique to multiracial families and incorporating techniques when working with these families are both important; this may include resources and curriculum around multiracial individuals and families. Offering parents education about the unique challenges for their children and also tools to discuss these challenges is important. It is key to recognize that parents may feel helpless and ineffective in supporting and teaching their children about the multiracial experience. Thus, creating or being aware of support groups for multiracial individuals and families is helpful. Discussing these issues may normalize potential difficulties and help provide support not only for the multiracial individuals but their parents as well. There are also numerous online support groups and resources that can be introduced to families.

Future Directions

The process of ethnic identification in multiracial youth is scant and has not kept up to speed with the growing multiracial population. In addition to understanding the formation of ethnic identity in multiracial youth, future considerations include the within-group diversity that exists. Also important is studying the different environmental contexts such as communities of varying levels of ethnic composition and ethnic socialization within families and peers. Moreover, recognizing additional factors that intersect with identity development, such as gender, sexuality, and religion, to name a few, is crucial.

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See Also: Biracial Children; Cross-Cultural Knowledge; Multiethnic Placement Act of 1994; Multiracial Individuals and Families.

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Multiracial Individuals and Families

Multiracial individuals and families have more than two racial heritages. Multiracial families may consist of interracially married couples and their children or monoracial couples and racially different adopted children. Some may become multiracial families via remarriage. Multiracial families are formulated in various ways, but they have many cultural needs in common. They have been exposed to cultural stereotypes such as that multiracial families tend to easily break up, that multiracial individuals are mentally confused, and so on. This entry discusses how cultural stereotypes toward multiracial individuals and families have formed in the United States and what kinds of cultural needs multiracial individuals and families have.

Stigmatization of Multiracial Individuals and Families

Multiracial individuals and families were stigmatized as socially perverted in the past. Many factors contributed to this negative view. One of them was the hybrid degeneracy theory. In the late 19th and the early 20th centuries, some scientists examined multiracial individuals' physical traits, such as the size of the skulls, skin color, and mental attribute, and so on, and they concluded that multiracial individuals were mentally, physically, and morally weak and could not function well in society. This idea was called the hybrid degeneracy theory. The theory is now found to be unscientific, but it fabricated and rooted the negative stereotypes of multiracial individuals in the United States.

In addition to the hybrid degeneracy theory, other factors that stigmatized multiracial individuals and families were the antimiscegenation laws. Virginia first enacted a law in 1662, and many other states enacted similar laws. The law banned any marriage between a Caucasian and non-Caucasian. Some states banned marriages between different non-Caucasian groups such as a marriage between Mexican Americans and Chinese Americans, but these marriages were usually tolerated because it did not threaten the purity of the Caucasian race. It is therefore pointed out that the purpose of the antimiscegenation law was to keep the Caucasian race from being mixed with other races and to maintain the white supremacy. A famous court case that denied interracial marriage by appropriating the hybrid degeneracy theory was 1869 *Scott v. Georgia*. In this ruling, a judge noted that interracial marriage was against nature and God, and its offspring were destined to be dysfunctional. The judge concluded that multiracial individuals and families degraded the Caucasian race, and therefore, they had to be illegal.

Law and science together contributed to stigmatizing multiracial individuals and families. There are many reports on how multiracial individuals and families were discriminated against in the United States. For example, many interracially married couples could not find a place to have their marriages officially approved because of the antimiscegenation law. If they lived in Virginia where interracial marriages were prohibited, they had to go to another state that allowed interracial marriage. Some families were harassed by neighbors by being stared at and called names, having their property vandalized and having their children bullied at school, and undergoing physical violence. Even some educational institutions such as high schools and universities prohibited students from interracial dating.

Multiracial individuals and families had difficult times in the United States because law and science did not allow their existence, and society uncritically accepted the negative views. The environment surrounding multiracial individuals and families changed when an interracial couple challenged the antimiscegenation law. The antimiscegenation law banned biracial marriages for a long time and functioned to justify the discrimination against multiracial individuals and families. However, the law was challenged by an interracial couple, Mildred and Perry Loving, in 1963. Mildred was part African American and Native American. Perry was Caucasian. They were brought up in the same neighborhood in Virginia and came to love each other when they grew up.

Because Virginia practiced the anti-miscegenation law, they went to Washington, D.C., to have their marriage approved officially and lived there for a while. They wanted to live in their hometown in Virginia and moved back. When they were back, the Virginia police arrested them late at night because they violated the antimiscegenation law. The state mandated the couple not to come back to Virginia for 25 years, but they wanted to live in their own community and started a lawsuit against Virginia. On June 12, 1967, the U.S. Supreme Court ruled the antimiscegenation as unconstitutional, and Virginia had to approve of the couple's marriage. After the ruling, multiracial individuals and families were no longer an illegal existence in the United States, and the social environment toward them has become lenient. Nevertheless, stereotypes toward multiracial individuals and families still continue today.

Cultural Stereotypes of Multiracial Individuals and Families

Multiracial individuals used to be regarded as mentally, physically, and morally weak. Multiracial families were thought to be destined to fall apart because they transgressed a social norm that families should be formed along the same racial lines. Today, people having this kind of negative view toward multiracial individuals as well as families are rare, but different types of stereotypes are made. For example, multiracial individuals, especially multiracial female individuals, are thought to be exotic, beautiful, and sexy. Multiracial individuals are an answer to the racial conflicts in the United States. The U.S. mainstream media utilize these stereotypes of multiracial individuals for their advertisements, films, TV productions, and so on. We can quite often see racially ambiguous models on flyers and actors on TV and in films now. When we consider the past that multiracial individuals were thought to be social misfits, some may think that the emergence of multiracial individuals in the mainstream media might be a favorable change.

Some researchers on multiracial individuals and families contend that having more and more multiracial individuals in the mainstream media empowers once-ostracized multiracial individuals because it increases their visibility. They also contend that multiracial stars can function as role models for multiracial individuals. They point out that multiracial individuals find it hard to find a role model in their lives. Their parents are usually monoracial, and they cannot fully function as role models for multiracial individuals. Yet multiracial stars who share similar racial heritages could be role models for multiracial individuals.

On the other hand, some researchers question if multiracial stars really function as role models of multiracial individuals. They examine multiracial individuals in the mainstream media and argue that many of these multiracial individuals have Caucasian features. This means that multiracial individuals are accepted in the mainstream media as long as they do not threaten the Caucasian standard of beauty. In addition, there are many multiracial actors in the 21st-century film industry, but the roles they play are very limited. They either play monoracial roles or superhuman roles. They rarely play multiracial roles that reflect their own racial heritages. If this is the case, multiracial individuals in the mainstream media are far from appealing to the reality of the diverse population of multiracial individuals. They fail to be role models. Researchers also criticize that the stereotypes of multiracial individuals as someone overcoming race problems are appropriated by transnational corporations. These corporations use multiracial models to appeal to the world market by delivering a message that they are against racism and embrace racial diversity. Yet researchers contend that the corporations' seemingly liberal messages through the usage of multiracial models actually disguise their capitalist desire to maximize their profits. In short, multiracial individuals in the mainstream media only strengthen the stereotypes of multiracial individuals.

Some multiracial individuals find stereotypes of multiracial individuals such as beautiful or exotic, and the solution to racism acceptable, because these stereotypes sound positive, but others find that these stereotypes do not reflect their own reality. They have their own cultural needs to resist the stereotypes society has forced on them and claim who they really are. Some multiracial individuals have started challenging the stereotypes by representing their own selves through various medium.

Cultural Production on the Lives of Multiracial Individuals and Families

Multiracial individuals and families problematize the stereotypical representations of multiracial individuals and families created by the mainstream media, and they have started representing themselves in many media such as films, books, magazines, photography, arts, theater, comedy, Internet sites, and so on. These cultural productions deal with various issues multiracial individuals and families confront every day.

Films created by multiracial individuals take up many issues. Some films interview multiracial families and show what kind of problems they have gone through. These films illustrate the experience that, when the couples marry, their relatives or friends sometimes do not accept their marriage. They also show conflicts between parents and children when the children grow up. These are common experiences multiracial families share, but they are not narrated in the mainstream media. Some films interview multiracial university students. Students tell their unique experiences growing up in multiracial families and everyday experiences at schools. Some films are animated and tell the shared experiences of multiracial families such as how they are stared at in public places and how people do not associate the family as a family.

There are many books written by multiracial individuals too. Authors talk about many issues such as sexuality, identity conflicts, problems, and resilience of multiracial families, oscillating feelings between a mother's and father's racial groups, curiosity about their ancestors' countries, war experiences, and so on. In the United States, as dating partners are usually decided along the same racial groups, it is sometimes difficult for some multiracial individuals to decide on a dating partner because they do not belong to one racial group. Some writers recount their search for cultural roots by visiting their ancestors' homeland. Some authors narrate their autobiographies as war orphans born to American military servicemen and foreign women in whose countries American military servicemen were stationed. Their narratives reveal the diversity of multiracial individuals. Some books are dedicated to children. These children's books tell stories of multiracial families in which interracial couples love each other, they are loved by relatives and friends, and of course, everyone loves their children too. The loving atmosphere of the multiracial families in books can deliver the message to children that they are an important asset to the family as well as to society and give them confidence in who they are.

There are magazines specially edited for multiracial individuals and families. These magazines take up issues pertaining to the cultural needs of multiracial individuals and families. They provide information on conferences, get-togethers, cultural events, and so on, all of which may interest multiracial individuals and families. They feature stories of multiracial celebrities, individuals, and families, and readers can experience right along with them. These magazines function not only to give information on multiracial individuals and families but also to network multiracial individuals and families. People meet other multiracial individuals and families through the information provided by the magazines. Internet sites for multiracial individuals and families have a similar function. They provide various information on multiracial individuals and families. Some Internet sites introduce history, people, and books on multiracial individuals and families to their users. Some sites offer opportunities for multiracial individuals and families to talk to one another online. The number of Internet sites on multiracial individuals and families is innumerable, and they have become useful sources for multiracial individuals and families.

Multiracial photographers are working on unique ideas. Multiracial individuals in the mainstream media tend to have Caucasian features, but multiracial individuals and families in reality are racially and ethnically very diverse. A multiracial photographer takes pictures of hundreds of multiracial individuals and shows how diverse the population is. A monoracial photographer who is a father of a multiracial family may develop an interesting idea too. He takes photos of multiracial families, some of which are made through blood relation and others through adoption and remarriage. By showing a variety of multiracial families, the photographer introduces the diversity of multiracial families. Some multiracial artists also challenge the mainstream representation of multiracial individuals and families. They incorporate their multicultural family backgrounds and racially ambiguous figures into their paintings. In this way, they demonstrate a multiracial identity that is irreducible to any racial group.

Multiracial comedians subvert the rigid racial categories in the United States by addressing their identities and families to audiences. Some multiracial comedians recount their experiences as being never identified as multiracial individuals by others. Some make fun of their parents' interracial marriage, but others find it a positive step to change race relations in the United States. Some criticize parents' racial groups that do not accept multiracial individuals. They take up seemingly taboo issues on multiracial individuals and families and make these issues something funny. They make various issues of multiracial individuals and families laughable and accessible to wide audiences.

Toward a More Tolerant Society for Multiracial Individuals and Families

Various cultural productions by multiracial individuals and families respond to the cultural needs of multiracial individuals and families. As discussed, they are still exposed to problematic stereotypes society has made of them. They have a strong necessity to represent themselves and to tell who they are to society. These cultural activities tell us the diverse experiences of multiracial individuals and families. Some multiracial families have problems in maintaining their unity, but many are stable, happy families. Some multiracial individuals have gone through difficult times vis-à-vis their identity, family, and sexuality, but they eventually overcome the problems and are confident in who they are. These cultural productions are especially valuable to the growing number of young multiracial families.

According to the 2010 census, approximately 10 percent of households are multiracial families. The number seems to be small, but it was 7 percent in 2000. The number of multiracial families grew 28 percent in just 10 years. The 2000 census also reveals that the multiracial population is larger than the monoracial population under the age of 14 in the United States. More and more young Americans interracially marry and make multiracial families. They need cultural representations that fit their own reality. The productions of cultural representations of multiracial individuals and families that are not distorted by stereotypes can empower multiracial individuals and families because they can know the pain and resilience of other multiracial individuals and families through these productions. They are also valuable as Americans in general. Without cultural productions on multiracial individuals and families, Americans would only know of them through the stereotypes the mainstream media make, and they would rarely know what multiracial individuals and families really are. The challenge of multiracial individuals and families to the stereotypes is thus to prompt the understanding of the cultural needs of multiracial individuals and families and contribute to making a more racially informed and tolerant American society.

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See Also: Biracial Children; Biracial Couples; Family Structure, Diversity of; Multiracial Children; Race, Social Definitions of; Racial and Ethnic Categories, U.S. Census.

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Multisystemic Therapy

Multisystemic Therapy (MST) is an intensive, family-centered, community-based practice model successfully applied and tested with diverse racial, ethnic, and socioeconomic groups. MST initially focused on eliminating the antisocial behaviors of juvenile offenders aged 12 to 17. After 30 years and over 18 experimental studies, MST demonstrated that it can reduce costly, less effective out-of-home placements by as much as 50 percent, and rearrest rates by as much as 70 percent. It improves school attendance and performance, as well as psychiatric symptoms, and diminishes or eliminates substance use. Because frequent family, school, and community contacts and activities are required, clinicians work with four to seven families at a time. Model-pertinent case-specific assessment and planning documents from these efforts are updated weekly and shared with the MST supervisor, who uses these data to plan weekly coaching of a team of clinicians. This structured quality assurance greatly contributes to MST's ability to achieve targeted outcomes, usually within four to six months.

MST assessment and interventions are specifically anchored in ecological systems theory. Interactions within and between the family, school, the youth's peers, and the community may support or constrain prosocial behavior, or may maintain antisocial behaviors. With the youth and family caregivers, MST clinicians identify proximal contributing factors in multiple systems that maintain behaviors of concern. Together, they draw fit circle assessments. At the center of the circle is a well-defined (including frequency, duration, and intensity) behavior of concern. Thorough consideration of interactions within and between the family, school, the youth's peers, and the community identifies contributing factors that may maintain that behavior. These factors are drawn outside the circle with directional arrows, indicating if they shape other contributing factors and the behavior of concern. Problem fit circles serve as a map for designing interventions to eliminate specific contributing factors. Assessment and interventions are carefully designed and closely monitored by MST supervisors and consultants for fidelity to theory-based principles.

An assessment is made to understand the "fit" between identified problems and key factors from other systems shaping youth behavior. A similar assessment of the fit of the youth's successes also helps guide the treatment process. MST therapists use strengths from the youth's environment as levers for positive change. Focusing on family strengths has numerous advantages such as building on strategies that the family already knows how to use, creating a sense of hope, identifying protective factors, decreasing frustration by emphasizing problem solving, and enhancing caregivers' confidence. Interventions are designed to promote responsible behavior and decrease irresponsible actions by family members. Interventions address what's happening now in the delinquent's life. Therapists look for action that can be immediately taken, targeting specific, well-defined problems. Such interventions enable participants to track the progress of treatment and provide clear criteria to measure success. Family members are expected to actively work toward goals by focusing on present-oriented solutions versus gaining insight or focusing on the past. When the goals are met, the treatment can end.

Interventions target sequences of behavior within and between the various interacting elements of the adolescent's life—family, teachers, friends, home, school and community—that sustain the identified problems. Interventions are designed to be appropriate to the youth's age and to fit their developmental needs. A developmental emphasis stresses building the adolescent's ability to get along well with peers and to acquire academic and vocational skills that will promote a successful transition to adulthood. Interventions require daily or weekly effort by family. Intensive, multifaceted change efforts support more rapid problem resolution, earlier identification of when interventions need fine-tuning, continuous evaluation of outcomes, more frequent corrective interventions, and more opportunities for family members to experience the success that they orchestrated. Intervention effectiveness is continuously evaluated from multiple perspectives with MST team members held accountable for overcoming barriers to successful outcomes. MST does not label families as "resistant, not ready for change or unmotivated." This approach avoids blaming the family and places the responsibility for positive treatment outcomes on the MST team. Interventions are designed to invest the caregivers with the ability to address the family's needs after the intervention is over. The caregiver is viewed as the key to long-term success. Family members drive the change process in collaboration with the MST therapist.

MST is now provided in 34 states and 15 countries. There are over 500 MST teams serving more than 23,000 youth per year. These numbers continue to grow as MST is proven effective with new populations, including psychiatric disorders, problem sexual behavior of youth, and child abuse and neglect. A four-year clinical trial of youth displaying bipolar affective, thought, anxiety, depressive, and destructive impulsive behavior disorders found MST-psychiatric to be significantly more effective than emergency psychiatric hospitalization in decreasing attempted suicides. These youth spent more days in school and in their communities with improved family relations and diminished antisocial behavior.

MST-PSB (problem sexual behavior) works with youth who engage in criminal sexual behaviors, including sexual assault, rape, and molesting younger children. In three studies, MST-PSB was compared with individual therapy and community clinic treatment. With MST-PSB, only 12.5 percent reoffended, in contrast to 75 percent recidivism of youth treated by a therapist and at a cost one-fifth that of more traditional services. MST-CAN (child abuse and neglect) has been similarly studied in longitudinal, randomly assigned clinical trials. Children ages 6 to 17 showed significant reductions in anxiety, disassociation, PTSD, and behavior problems, with fewer out-of-home placements and changes of placement. Parents demonstrated significant reductions in psychological distress, child abuse and neglect, and use of physical discipline, with significant increases in social support and treatment satisfaction.

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See Also: Child Abuse/Neglect, Victims of; Family Therapy; Gangs in Schools.

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Muslim Americans

An individual who identifies as Muslim practices the religion of Islam. The practice of Islam and application of its principles to life is commonly core to the experience of anyone who identifies as Muslim. It is considered a way of life. A Muslim American practices Islam and has either been born in the United States to a Muslim family, has converted to Islam, or has emigrated from a Muslim-majority nation and continues to practice the religion in the United States. It is estimated that 3.5 million Muslims live in the United States as of 2013. Muslim Americans have experienced a significant degree of discrimination in the United States, particularly since the terrorist attacks by the militant Islamic group al-Qaeda on September 11, 2001. Following is a description of core religious constructs that often guide behavior, an overview of common experiences shared by Muslim Americans in the United States, the consequences of discrimination, and suggested human services practices for meeting the needs of Muslim American clients.

The Practice of Islam

Perceptions of the Islamic religion by Americans who do not identify as Muslim are often distorted and incorrect. It is common for non-Muslim Americans to view the religion as Middle Eastern, violent, oppressive, and rigid. This is not surprising considering the leaders of some nations have supported the abuse of their citizens and the justification of violence against other nations in the name of Islam. Additionally, U.S. media has promoted this view through the portrayal of angry-looking Middle Eastern Muslim men and fully shrouded, submissive-looking Muslim women. However, it is documented that these are cultural and political practices of some in these nations with whom we've experienced great conflict and are not, in reality, associated with the religion of Islam. Muslim Americans are in fact from locations all over the world, and the majority practice Islam peacefully.

The American Muslim population can be disaggregated as follows: Approximately 33 percent are of South Asian descent, from Pakistan, India, Bangladesh, and Afghanistan; 30 percent are African American; and 25 percent are of Arab descent. As such, it is important for human services professionals to explore the intersecting variables of culture and religion when working with Muslim American clients. Additionally, the majority of Muslim Americans practice the Sunni tradition of Islam (85 percent), while the remaining adhere to Shi'ite, Sufi, or Nation of Islam traditions. Despite the various traditions, human services professionals can assume that there are some foundational values and beliefs shared by those who identify as Muslim American.

All Muslims believe in one God—Allah. To be Muslim means to find peace through complete submission to Allah. A primary goal for those practicing Islam is to achieve reward in the afterlife through belief in the principles and practices of Islam and through doing good deeds. Those able to maintain their beliefs and engage in good deeds throughout all of the tests and challenges of life will be received in the hereafter with reward. To guide this process, Muslims turn to prophets, including Adam, Abraham, Jesus, and Muhammad, as well as the Qur'an, which is the holy book of Muslims, and the Hadith, which contains specific details of life as recorded from the sayings of Muhammad. Found in the Hadith are the Five Pillars of Islam, which include the following: (1) Shahadah—belief in only one God, (2) Salat—commitment to praying five times per day, (3) Sawm—fasting during the month of Ramadan, (4) Zakat—service to others, and (5) Hajj—pilgrimage to Mecca.

Experience in America

Unfortunately, a lack of understanding of the culture and religion of Muslim Americans results in disproportionate levels of discrimination as compared to other religiously defined groups in the United States. Communities have been noted to block the building of mosques; mosques are vandalized and bombed more so than other places of worship; workplace discrimination against ritual dress and prayer has risen drastically; and rhetoric among some politicians feeds the false fear of Muslim Americans among non-Muslim citizens in the United States. It is challenging to elicit understanding and support of Muslim Americans when those in positions of power and decision making for our nation propagandize negativity about this culture.

Women who choose to fully cover themselves with a hijab out of respect for Allah are frequently judged as being submissive and abused. Couples in arranged marriages are assumed to be miserable despite research indicating that most in this country are quite happy due to the collectivistic nature of most Muslim American families, resulting in greater levels of support and assistance as compared to non-Muslim American families that may feel isolated within their partnerships. Muslim American men also experience discrimination. Those with long beards are frequently assumed to be terrorists and, as such, get singled out for special screening at airports. Virtually every non-Muslim American is aware of Osama bin Laden and his terrorist actions, yet very few can name antiterrorist Muslim Americans who have fought and died in the United States military. The consequences to this discrimination and misunderstanding are great.

Consequences to Discrimination and Human Services Response

The experience of incessantly being treated with contempt has led to heightened levels of depression, anxiety, posttraumatic stress, lowered self-worth, and substance abuse. For those who have immigrated to the United States, additional variables may contribute to socioemotional discord

The Islamic Center of America, the largest mosque in the United States, is located in Warrendale, Michigan. A Muslim American practices Islam and has either been born in the United States to a Muslim family, has converted to Islam, or has emigrated from a Muslim-majority nation and continues to practice the religion in the United States.

including acculturation stress, language barriers, intergenerational conflict, socioeconomic status, and marital and family conflicts. A human services professional must recognize the complexity of the Muslim American identity and explore the unique history and identity of each client. Essentially, the helper must refrain from assumptions.

Key to effective services for any diverse culture, it is imperative that the human services professional develop self-awareness of one's own biases toward Muslim Americans. Additionally, common cultural values and practices of Muslim Americans should be known. These include variables such as the important role that religion plays in their lives, the value placed on family cohesion and loyalty, participation in arranged marriages, paternalism for affairs external to the family, and maternalism for affairs within the home.

Awareness and knowledge of the values and beliefs of Muslim Americans can contribute to the application of appropriate and skillful techniques for addressing concerns. Most important is the integration of Islamic principles into human services practices with Muslim Americans. For example, reminding a client of the peace one can obtain through remembering Allah can be a useful strategy for de-escalation.

Familiarity with the Qur'an and Hadith allows for the inclusion of the written words from these books in the resolution of problems. Asking clients how they think Allah would want them to address their situations can lead to problem-solving approaches that are acceptable to the clients. Presenting problems as tests to bring them closer to Allah as opposed to punishments can be used to reframe negative perspectives. Including family members as much as possible in the helping process honors Muslim Americans' collectivistic perspective. Connecting Muslim Americans to community and national resources such as local mosques allows for additional supports. Finally, it is necessary to move beyond the individual Muslim American client and work to advocate for systemic change in which Muslim Americans are honored, respected, and protected in U.S. society.

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See Also: Discrimination and Institutional Racism; Immigrant Populations, Human Services Needs of; Religion and Clients.

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National Alliance for Hispanic Health

The National Alliance for Hispanic Health (NAHH) is a not-for-profit 501(3) organization that has, as its mission, the improvement of the health and wellness of Latinos in the United States. The organization describes itself as the nation's oldest and largest network of Hispanic health and human services providers.

The organization was founded in 1973 in Los Angeles as the Coalition of Spanish Speaking Mental Health Organizations (COSSMHO). Two years later, following the opening of a national office in Washington, D.C., the group changed its name to the National Coalition of Hispanic Mental Health and Human Services Organizations (COSSMHO). Another name change took place in 1986, with the organization broadening its mission and rebranding itself as the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO). The present name was adopted in 2000.

The NAHH conducts research, operates demonstration programs, provides health-related information, and advocates with governmental decision makers on behalf of health-related issues, especially as they impact the Hispanic American community. The NAHH board of directors, in 2010, adopted the following health care principles: All persons in the United States should have affordable and comprehensive quality health care throughout their life; achieving the best outcomes for all is critical to quality health care; long-term care should be adequately addressed; mental health and physical health are both central to well-being; and health care delivery should be patient centric.

Among the organization's earliest accomplishments were mounting the first National Hispanic Conference on Health and Human Services (1976), forming the National Hispanic Committee to advise the President's Commission on Mental Health (1977), and convening the first National Hispanic Conference on Families (1978). In 1987, the NAHH played a leading role in persuading the U.S. Department of Health and Human Services (HHS) to improve its health data research for Hispanic populations in the United States.

Today, the NAHH operates education programs supporting diagnosis and treatment of rheumatoid arthritis; cancers of the cervix, skin, and ovaries; depression; diabetes; arteriosclerosis; and hypertension. The alliance, through Nuestras Familias, works in seven states (Arizona, California, Florida, Georgia, Illinois, New Jersey, and Texas) to increase and retain enrollment in Medicaid and the Children's Health Insurance Programs (CHIP).

Proyecto Informar Capacity Development, is a six-year project funded by the Office of Minority Health and Health Disparities of the Centers for Disease Control and Prevention (CDC). This project provides training and technical assistance in the area of cultural competence to agencies that provide health services in Hispanic communities. Under this contract, the NAHH has conducted cultural proficiency training with the staff of state and local health departments in 23 states.

Under the Proyecto Informar FDA Hispanic Outreach Initiative, established in 2005, the Alliance adapts Food and Drug Administration (FDA) materials for use in Hispanic communities. The objective of the grant was the communication of risk and emergency public health information to Spanish-speaking consumers. In 2013, the FDA and NAHH expanded their collaboration through the establishment of a Drug Safety Communication Initiative. The program provides Hispanic consumers and health care providers with drug safety information.

The alliance also maintains two bilingual help lines. Established in 1994, the National Hispanic Prenatal Helpline/La Linea Nacional Prenatal Hispana (1-800-504-7081) answers questions about prenatal care. In 2003, the alliance started the National Hispanic Family Health Helpline/Su Familia (1-866-783-2645), which provides free health information and referral services in Spanish and English. The help lines are funded by the Centers for Disease Control.

In addition to its educational and information services, the alliance engages in research. In 1986, the Hispanic Health Research Consortium was established to coordinate university research. The consortium produced a supplement to the December 1990 issue of the *American Journal on Public Health* on the Hispanic Health and Nutrition Examination Survey. This nationwide survey of approximately 16,000 persons, 6 months to 74 years of age, provided data on Puerto Ricans, Mexican Americans, and Cuban Americans, groups for which sufficient data had been lacking. In 1999, the NAHH published "The State of Hispanic Girls." The study, which was funded by the Carnegie Corporation, the Ford Foundation, and the HHS, found that cultural protective factors played a critical role in buffering Hispanic girls from risky and damaging behaviors such as delinquency, depression, pregnancy, and substance abuse. More recently, in 2007, NAHH joined with Research!America to administer the first national public opinion survey of Hispanics on health and research issues. The poll found that Hispanics believed that the United States should make a higher commitment to health and science research and that they were willing to pay additional taxes to subsidize additional medical research.

In 2008, with the support of the Merck Company Foundation, the alliance initiated the Alliance/Merck Ciencia Hispanic Scholars Program. The program, which is open to high school students in Brownsville, Texas; Elizabeth, New Jersey; and Los Angeles, California, awards scholarships to students pursuing science, technology, engineering, and math (STEM fields) college degrees. Students from these communities receive four-year scholarships worth $42,500. A second program, open to Hispanic STEM majors throughout the United States, awards one-time, $2,000 scholarships.

The organization has become an advocate in Washington on a number of health-related issues. Its advocacy efforts include support for the passage of the Disadvantaged Minority Health Improvement Act of 1990 (Public Law 101-57); advocating for expansion of the Children's Health Insurance Program, and through the Health and Environment Action Network (established in 2006); being a proponent of clean air and water in Hispanic communities; and highlighting the connections between the environment and good health. In 2010, the alliance endorsed "Reducing Environmental Cancer Risk," a report prepared by President Barack Obama's Cancer Panel.

NAHH is governed by a 10-member board of directors, which was chaired in November 2013 by Augustine C. Baca. The president and chief executive officer was Dr. Jane L. Delgado, who has led the organization since 1985. Prior to joining what was then COSSMHO, Dr. Delgado had been with the HHS (1979–1985) and the Children's Television Workshop (1973–1979). A clinical psychologist, Dr. Delgado is the author of *The Latina Guide to Health* (Newmarket Press, 2010). The alliance, which is headquartered in Washington, D.C., operates programs in 20 states, the District of Columbia, and Puerto Rico.

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See Also: Border Communities; Central American Immigrants; Community Health, Racial and Ethnic

Approaches to; Community-Based Participatory Research; Cross-Cultural Knowledge; Cross-Cultural Service Models; Cross-Cultural Skills; Cuban Americans; Cultural and Linguistically Appropriate Services Standards; Cultural Competence, Human Service Providers and; Cultural Competence, Measuring and Assessing; Cultural Competence, Model of; Cultural Competence, Professional Standards of; Cultural Competence, Training in; Cultural Literacy; Cultural Services; Culturally Specific Services; Dominican Americans; Hispanic Americans; Hispanic Health and Nutrition Examination Survey; Hispanic Immigrants; Language Assistance; Mexican Americans; Puerto Ricans; South American Immigrants.

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National Assessment Governing Board

The U.S. population is becoming increasingly diverse, with 57 percent of the population expected to represent a nonwhite majority by 2060. The heterogeneous nature of the U.S. population is reflected in the U.S. education system, which includes increasing numbers of African American, Hispanic, and Asian students. Acculturation and nonnative English speakers are additional considerations, with up to 10 percent of students designated as English language learners (ELLs). Evaluating the academic progress of such a diverse population of students in a way that is fair, reliable, valid, and inclusive of all students is a priority of the U.S. government. To meet this need, Congress established the independent, bipartisan National Assessment Governing Board (NAGB) in 1988. The NAGB is responsible for setting policies related to the National Assessment of Educational Progress (NAEP), which consists of national and state evaluations of the educational achievement of U.S. students.

National Assessment Governing Board

The NAGB consists of 26 members, each of whom can serve up to two four-year terms. Individuals are nominated to fill open positions and are subsequently appointed by the U.S. secretary of education. In an effort to represent relevant stakeholders in NAEP decision making and to minimize political influence, the board is required by law to include individuals with a range of backgrounds. Specifically, the board must include bipartisan representatives of government (e.g., governors and legislators), education-related public policy (e.g., school board members), education (e.g., teachers, principals, testing and measurement experts, and curriculum experts), and the general public (e.g., parents). Members span local, state, and federal levels. Though difficult to achieve due to the limited number of positions, the demographic diversity represented in the U.S. education system should be reflected in the characteristics of board members.

The board is responsible for making federal policy related to the NAEP, commonly referred to as the Nation's Report Card, which is a national continuing assessment of American students' academic achievement. The NAGB works closely with the National Center for Education Statistics within the U.S. Department of Education, which administers the NAEP, and the test contractors, who develop the NAEP. The board determines what will be tested on the NAEP, including which subject areas and what specific content will be evaluated. The NAGB also decides how the NAEP will be implemented, with the goal of designing tests that are reliable and valid. Incorporating experts in this process is critical to ensure that the evaluation is fair for children of diverse cultural backgrounds. Once the results of the NAEP have been gathered and analyzed, the board is responsible for providing objective information on the performance of U.S. students to elected officials, policy makers, educators, and the public. One of the NAGB's related goals is to ensure that the NAEP results reach a diverse U.S. public, and their recent efforts have included interactive reporting via their Web site and information sharing via social media outlets.

National Assessment of Educational Progress

The NAEP has provided an account of academic progress since 1969 and has been permanently instituted since 1996. National assessments, conducted in fourth, eighth, and 12th grades, assess student achievement in math, reading, writing, science, geography, U.S. history, civics, economics, art, and technological literacy (which began in 2014). State-specific assessments, conducted in fourth and eighth grades, evaluate achievement in reading, math, writing, and science. The NAEP is a nationally representative evaluation of U.S. education. As such, for each NAEP assessment, students within participating schools are randomly selected to participate. For example, the national NAEP assessments include about 10,000 students per subject per grade from about 525 schools.

Students with disabilities generally receive the same accommodations that they normally would in a standardized testing situation. Though the NAEP does not allow for all accommodations (e.g., reading passages aloud to a student), students who are allowed that accommodation in the context of their individual education plan (IEP) under the Individuals With Disabilities Education Act (IDEA) can be excused from the NAEP assessment. Native Spanish speakers are allowed to complete the math and science NAEP assessments in Spanish as long as their state typically offers Spanish language exams. ELL students are also typically allowed to use bilingual dictionaries. ELL status is not a valid reason for exclusion from the NAEP assessments. These regulations result in the NAEP mirroring the educational system as students generally interact with it. However, failing to fully evaluate students in special education and ELL students results in test scores that incompletely describe the academic ability of the entire U.S. population.

In 2002, a selection of large urban school districts participated in the state-level assessments on reading, mathematics, science, and writing. Today, 18 urban school districts voluntarily participate in this aspect of the NAEP, called the Trial Urban District Assessment (TUDA). Urban school districts serve a unique subset of the U.S. population characterized by low family income and racial or ethnic minority status. These demographics are represented in the public school experience of urban children and youth, who are more likely to attend schools that have large class sizes, are under-resourced, and are underachieving. Especially given the NAGB and U.S. government's commitment to closing the achievement gap for low-income, ethnic minority youth, the inclusion of TUDA in the NAEP is critical.

In an effort to make the reporting of the NAEP clear and easy to understand, the NAGB established three achievement levels: basic, proficient, and advanced. The basic level designates partial mastery of fundamental prerequisite knowledge and skills. Proficient level designation requires that students demonstrate solid academic competency in challenging subject matter. The advanced level denotes superior performance. These achievement levels, which were originally adopted by the board in 1990, were revised in 1993 based on public comments and representative stakeholder feedback, highlighting the importance of diversity among stakeholders. In addition to informing the public generally about how America's students perform in various academic subject areas, the NAEP also compares achievement data among states and provides data by student demographic group, including gender, socioeconomic status, and race or ethnicity.

Relation Between the NAEP and Other State and National Educational Evaluations

The NAEP is distinct from several related state and national evaluations. The NAEP differs from state-specific standardized tests, which are based on states' curricula and academic standards and reported at the school and individual child levels. In contrast, the NAEP provides reports at the aggregate level (i.e., no student, classroom, or school-level results are provided). Additionally, NAEP assessments are independent of those that are currently being developed for the common core curriculum. Lastly, among other requirements, the No Child Left Behind (NCLB) Act requires states to develop and administer annual standardized tests to all students in certain grades. The NCLB also requires a sample of fourth- and eighth-graders in each state to participate in the NAEP reading and mathematics assessment every other year, with the goal of providing a second, aggregate-level data set for regional and national comparisons.

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See Also: Department of Education, U.S.; Educational Status and Service Delivery; Individuals with Disabilities Education Act; No Child Left Behind Act.

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National Center for Children in Poverty

The goal of the National Center for Children in Poverty (NCCP) is the overall well-being of low-income families and children in the United States. The center focuses on public policy designed to ensure overall health and family economic security. The NCCP is a recognized and respected leader in pioneering both state and national improvements.

Founded in 1989 and housed at Columbia University's Mailman School of Public Health, the NCCP has a three-pronged vision. The organization works to promote (1) the economic security of families; (2) resilient, nurturing families; and (3) the healthy development of children. Undergirding the efforts of this nonpartisan, nonprofit organization is the belief that more equitable and effective public policies and practices will create a more positive future for low-income children and families for both current and upcoming generations.

The NCCP develops policies and supports practices based on research findings. Building policy and practice from sound research increases the likelihood of achieving positive outcomes and making a real difference in the lives of individuals and the nation's poor and low income as a whole. Specific initiatives focus on supporting the organization's vision by (1) improving work support and pay; (2) nurturing the cognitive and emotional growth of children, especially young children; and (3) ensuring access to health care, including mental health care, for children and families. The organization's motto, "Putting Research to Work for Children and Families," underlies these goals and guides action.

Despite worldwide perceptions of economic prosperity in the United States, the reality is that many children and families live in poverty. Nearly half of the nation's children are raised in families living on the economic edge. Despite parents who work to try to support the family, struggles ensue on paying basic bills and covering living expenses such as food and health care. This lack of economic security exacts a heavy toll on families and children. The NCCP advances the belief that supporting these families and children ultimately supports the nation. That is, nurturing today's children promises a better future for the country.

The research efforts of the NCCP contribute in several ways, including policy making, service provision, and public awareness. First, sound research is needed to develop good policies. Providing such information to policy makers increases the likelihood of well-formulated decisions and subsequent policies. Second, research foregrounds existing challenges as well as provides insights into how to address them. Translating research into practice is useful to both practitioners providing services and advocates addressing social justice and social change. Third, from across multiple research endeavors and their outcomes, the NCCP can analyze trends and compare policies as well as provide compilations of statistics and facts. Such reports provide the media and other groups with information useful in educating the public about the living conditions of low-income families and children as well as their day-to-day hardships.

The NCCP's Web site houses numerous fact sheets, research reports, and useful tools. This information includes state profiles, which furnish information on policies related to early childhood welfare as well as specific information on poor and low-income children. An example of a useful tool is the family resource simulator, employed by some state agencies for planning and policy making. This simulator depicts the effects of policies on families. The Web site's Young Child Risk Calculator determines the number of young children at risk in terms of general development as well as school readiness by state. The Basic Needs Budget Calculator illustrates the amount of money necessary to cover essential needs. Users can change parameters by adjusting family specifics such as whether the family is a single-parent or two-parent one and the number and ages of children. Research Connections provides a compilation of numerous sources with information on the well-being of children. Publications can be accessed in a variety of ways, such as by topic or date, and fact sheets cover an array of areas. Research foci include a variety of topics ranging from healthy development to immigrant families and from work support to mental health.

At its inception and in its early stages, the NCCP was supported by philanthropic organizations. Today, center funding primarily comes from foundation and federal grants. A link on the Web site allows individuals to contribute to the annual fund.

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See Also: Administration on Children, Youth and Families; Child and Adolescent Needs and Strengths; ChildStats; Early Childhood Development; Infant/Toddler Development; Poverty; Public Health.

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National Center for Cultural Competence

The National Center for Cultural Competence (NCCC) emphasizes an evidence-based approach to policy and practice in the fields of health and mental health care delivery, administration, education, and advocacy to ensure that health care systems are culturally competent. NCCC's goals are to (1) respond to the growing population diversity in the United States, (2) address health and mental health care disparities and inequities, and (3) design services and supports that take culture and language into consideration as health (including mental health) programs are structured. As defined by experts, cultural competence requires that organizations demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally and that they incorporate these policies and practices in all aspects of policy making, administration, and service delivery.

Working through a group of national experts and consultants, NCCC provides training and technical assistance, creates tools and resources that health and mental health care providers and systems can readily use, supports organizational leaders to promote and sustain cultural and linguistic competency, and collaborates with a network of private and public entities to advance the implementation of these concepts. NCCC provides its services to local, state, federal, and international governmental agencies, family advocacy and support organizations, local hospitals and health centers, health care systems, health plans, mental health systems, universities, quality improvement organizations, national professional associations, and foundations. In addition, NCCC's online training, publications, and products reach tens of thousands of individuals each year.

NCCC, founded in the late 1990s, is part of the Georgetown University Center for Child and Human Development and is housed within the Department of Pediatrics of the Georgetown University Medical Center in Washington, D.C. NCCC's work is funded by a variety of federal government agencies (including the U.S. Department of Health and Human Services, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Environmental Protection Agency) as well as foundations, pharmaceutical companies, and international organizations.

NCCC's Philosophy

NCCC's approach is based on the importance of understanding the dynamic demographic changes in the population of the United States and the impacts these changes are having on the provision of quality, effective health care services. As a result of immigration patterns and significant increases among racially, ethnically, culturally, and linguistically diverse populations, the composition of the U.S. population has become more diverse and complex. For example, according to recent census data, there has been a marked increase in the number of persons who speak a language other than English at home, and many of them indicate they have trouble speaking English.

Accordingly, NCCC believes that the delivery of high-quality, accessible, effective, and cost-efficient primary health care requires health care practitioners to have a deeper understanding of the sociocultural background of patients, their families, and the environments in which they live. NCCC believes that this understanding is critical to the elimination of the continuing disparities in the incidence of illness and death among African Americans, Latino and Hispanic Americans, Native Americans, Asian Americans, Alaska Natives, and Pacific Islanders as compared with the U.S. population as a whole.

Further, culturally competent primary health services can lead to more favorable health outcomes and increase the satisfaction of individuals receiving health care services. The ability of practitioners, as well as health care systems, to address these issues can lead not only to better care but also to a competitive advantage in the crowded health care marketplace and can also decrease the likelihood of malpractice and liability claims.

NCCC's Work

NCCC works in a broad and diverse set of arenas to meet its goals and mission and maintains a pool of expert consultants with relevant expertise to provide organizations with training, technical assistance, or consultation. Consultants have experience at the local, state, regional, national, and international levels. NCCC's work falls into five major categories.

Measuring and assessing cultural and linguistic competency. NCCC has developed self-assessment tools, instruments, and processes for organizations and individuals to identify their strengths and challenges in implementing cultural and linguistic competency. As requested, NCCC works with organizations that request help in self-assessment and has worked with local health centers, foundations, and national organizations to tailor tools and processes for their needs.

Influencing policy. Strong policies help guide organizations and ensure that there is consistency. The need for culturally and linguistically competent health and mental health systems has been strongly reaffirmed at the highest levels of the U.S. government, the National Academy of Science, independent commissions, and professional associations and accreditation organizations. In addition, NCCC has documented that there is a need to develop stronger policies around cultural competence in health care systems.

As a result, NCCC supports practitioners in their implementation of cultural and linguistic policies and practice and helps measure the success of practitioners and the organization in serving diverse families. A number of NCCC efforts address the role of policy in implementing and sustaining systemic cultural and linguistic competency, including a series of policy briefs, organizational assessment tools, and a process for organizations to conduct a policy audit related to cultural and linguistic competency. NCCC also collects examples of best practices that advance and sustain cultural and linguistic competency.

Contributing to the evidence base. NCCC faculty produces articles and monographs that identify and advance the evidence base about the importance of cultural and linguistic competency in the provision of health care services as well as the factors leading to successful implementation of practices. In addition, NCCC shares promising practices for implementing cultural and linguistic competency within the health and mental health fields.

Training and staff development. NCCC provides customized on-site training and professional development and assists other U.S. and international organizations to develop their own customized training materials and processes. NCCC has also developed a series of content-based modules on cultural and linguistic competency that can be placed into existing courses and curricula and has created online education, including continuing medical education for credit.

Influencing academia. NCCC publications and products are utilized in university courses targeted at health, mental health, public health, and social services professionals. In addition, NCCC faculty consult with a variety of university-based programs and departments on how to address cultural and linguistic competency in teaching, research, faculty development, community outreach and engagement, and recruitment and retention.

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See Also: Cultural and Linguistically Appropriate Services Standards; Health Care, Disparities in; Mental Health Service Delivery, Cultural Characteristics of; Cultural Competence, Professional Standards of.

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National Center for Hate Crime Prevention

Within the United States, special legal considerations have been enacted targeting the prosecution and sentencing of crimes that meet the qualification to be legally labeled as a hate crime. Hate crime or bias-motivated crime laws provide further punishment and sanctions for crimes motivated by prejudice targeting social groups. However, these laws do not solve the societal problem of why hate crime occurs and how it can be addressed. Hate crimes continue to be a threat to society, as illustrated by crime statistics showing more than 7,000 cases each year in the United States. While the United States at its core embraces its diversity, extreme portions of our society continue to misunderstand, blame, or support views that contribute to hate crimes. Over the years, organizations have developed with the mission to stop or reduce hate crime by litigation, education, and public awareness.

The National Center for Hate Crime Prevention (NCHCP) is an organization dedicated to educating and training people about the causes, costs, and solutions to hate crime. The NCHCP works in cooperation with the Education Development Center, Inc. (EDC), an education and research not-for-profit organization based in Waltham, Massachusetts. As part of the EDC's Health and Human Development Division, the NCHCP represents a part of a vast resource that can help law enforcement, hospitals, workplaces, schools, and all levels of government deal with issues related to all types of violence.

As of 2010, the EDC maintains approximately 300 projects in more than 30 countries worldwide. Through the EDC Web site, the NCHCP offers several different curriculums that deal with hate crime on a law enforcement level and an educational level. These curriculums offer interactive and comprehensive approaches that lead the participants to become part of the interaction and learn by experiencing what hate crime is through examples and presentations.

The NCHCP's law enforcement curriculum, titled "Responding to Hate Crime," can be utilized on many different levels. Designed as a multidisciplinary curriculum, it was developed to provide law enforcement officials with current strategies and data on identifying hate crimes and developing strategies to investigate and reduce its incidence. It also provides strategies and data for victim assistance professionals. The curriculum is designed to increase the efficiency and resources of both law enforcement and victim assistance by helping develop methods that change the norms of the community that allow hate crime to

The Overpass Light Brigade holding a message at the Sikh temple shooting memorial in Oak Creek, Wisconsin, August 7, 2012. One of the most serious challenges that hate crime prevention experts have is in educating those prone to committing hate crime. In America, young people are especially susceptible to becoming victims of hate crimes..

persist, decreasing public indifference and increasing awareness. Finally, this curriculum allows law enforcement and victim assistance personnel to interact with each other, exposing both to different perspectives on hate crime and how each side deals with the ramifications of bias-based crimes.

Broken into six individual lessons, the instructor, preferably a law enforcement official, instructs and aids participants through a series of exercises and challenges. "Responding to Hate Crime" provides a comprehensive approach to hate crime, highlighting many different aspects of it but allowing instructors a modular approach that allows class structure to be specifically designed to hone in on areas of concern to the audience being instructed as well as for limited time constraints.

Lessons are broken down with a summary page highlighting approximately how much time a lesson plan will take, what the objectives are, if there are any videos in the lesson, and instructor's notes that give quick fact access to the instructor. These lesson plans are also interactive, providing multiple facets of explanation that are built for professionals and volunteers, young and old alike. The lesson plans are versatile enough that they allow for adaptation to different types of bias crime, assuring a learning environment that reduces stereotyping.

One of the most serious challenges that hate crime prevention experts have is in educating those prone to committing hate crime. In America, young people are especially susceptible to becoming victims of hate crimes. Educators have been challenged to bring awareness and understanding to the youth of America, while at the same time dealing with the regular educational needs already required. The NCHCP, with assistance from other organizations, helped develop a program designed to assist in educating youth in hate crime awareness and deterrence.

Titled "Healing the Hate: Innovations in Hate Crime Prevention," it was developed to be used at the middle school educational level for students and teachers who are trying to bring awareness to hate crimes and how to stop them. The lessons begin by giving statistics and basic definitions of what hate or bias crimes are and what their prevalence is in school society. It breaks this down by race, ethnicity, sexual orientation, gender, and religion. It educates teachers on various types of graffiti, organized hate groups, and gestures that are linked to hate crime.

One particular aspect of hate crime that this curriculum goes into detail on is how it affects the school community at large and just how damaging hate crime can be. It instructs teachers on the concepts of secondary victimization, where members of the same group as the person who was the victim of a hate crime also suffer some of the effects associated with it, including insecurity, breakdown of trust to authority, and group identity loss.

The curriculum is also designed to provide understanding to the motivations of the perpetrators of hate crime. Breaking down offenders into typologies, the authors define them by thrill seeker, retaliatory, reactive, and mission-orientated offenders. This breakdown educates teachers and provides them with cues to watch for among students who could assist them in finding the real cause of the violence and how to prevent it.

Finally in prevention, the curriculum addresses different methods of prevention, including policy changes, developing educational programs for students, increasing the knowledge of administrators and teachers, and changing school practices. The NCHCP is a valuable resource for educating both human services professionals and providing learning modules that can be utilized to educate the public.

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See Also: Department of Education, U.S.; Discrimination and Institutional Racism; Equal Opportunity and Civil Rights.

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National Center for Missing and Exploited Children

The establishment of the National Center for Missing and Exploited Children (NCMEC) is the story of how parents of lost children were able to move government authorities into action based on common concerns for children's welfare. The social problem of missing children became the most recognized problem of children's welfare through horror stories of lost children and the mobilization of support to monitor and resolve the problem.

Concerns for lost and exploited children grew in response to industrialization and child labor. In Great Britain, they were the basis for Charles Dickens's writings. In the United States, they became the child saver movement, the anticruelty movement, and the new social work profession from the famed Mary Ellen case that appears in social work textbooks. There is a natural parenting response to save a lost child. Hundreds of community volunteers will help search for a missing child. It is not as easy to help through policies and laws, especially if the lost child is an adolescent. Police have responsibility for runaways, while social workers service neglectful parents. But in practice, the police officers find runaways blame their parents for being thrown-away children. Caseworkers find the same adolescents are welcome at home as long as they follow the rules and refer the runaways back to the police. Officials often dodge the problem and expose the difficulty of defining what a missing child is in practice.

The late 20th century produced conditions supporting heightened concerns for children's welfare. Mothers moved into the labor force, leaving child care to others, including teachers in schools and day-care centers. The discovery of the battered child syndrome in 1962 was followed by new fears of child abuse, child sexual abuse, satanic ritual abuse, and missing children. Sociologists, such as Joel Best, studied each of these claims of threats to children as social problem construction. In this theory, a claims maker or advocate stakes a claim in reporting a troubling social condition. Through a rhetoric of social problems, the condition is linked to a horror or atrocity story that is highly emotional and mobilizes public support. The roles of the story's victims are central. The victims must be innocent, their suffering great (best for the claims if they are lifelong and debilitating), and their numbers huge. The missing child problem is presented as large, threatening, and growing, with an annual 2 million victims. These social problem claims fit the theory with numerous innocent victims. Suffering parents became leaders and spokespersons for social movements. They mobilized and organized others' fears for children into many local social movement organizations, and as the organizations' spokespeople, they influenced public policy and laws, all as the theory predicts.

By 1981, advocates pressed the federal government to create a national system to register and report missing children. The atrocity stories of murdered missing children were developed from stranger abductions. Although 50,000 such abductions were repeatedly cited in congressional testimony leading to the NCMEC, the U.S. Federal Bureau of Investigation (FBI) reports only 105 cases of stranger murder annually. But the members of those families have high social visibility, first leading searches for their missing children, then advocating for child victim memorial laws, advocating legislation carrying the child's name such as Billy's Law and AMBER alerts. A *USA Today* article cited three Jacob's laws, three or more Laura's, plus Kendra's, Leandra's, Lauren's, and so on. Over the years, missing children appeared on milk cartons, were printed on government forms, were named on dozens of pieces of legislation and in news media headlines, and became America's most-recognized child social problem. Advocates urged parents to have their children tattooed or implanted with computer chips for recovery when gone missing. The emergency warning system was marshaled into giving emergency alerts for reports of a kidnapped child.

But studies have consistently demonstrated that the problem is far less significant than claimed. Most missing children are runaways or lost for a short time. Almost all abductions are by a parent or other family member in a child custody dispute. A 1988 government study provided estimated types of missing children: runaways (450,200), thrown-aways (127,100), parent abductions (163,200), stranger abductions (4,000), and abducted child murders (105). Other categories (from small lost children to older adolescents not contacting parents) were 139,100, for a total of 883,705. This disconfirmation

First Lady Laura Bush with Rae Leigh Bradbury in 2007 at the announcement of the future opening of the Texas Regional Office of the NCMEC. Rae Leigh was the first child to be recovered as a result of an AMBER alert.

of the claims was unexpected, and the discriminated count has not been repeated to date.

Central for these claims makers was the atrocity story. When a legislator questioned the need for a mandated, formal report to the national system when a child had been missing for only two hours, the advocate responded with a hypothetical account of the legislator's daughter going missing and returning bloody and raped. The two-hour reporting law was enacted. The 1984 result was the NCMEC, a hybrid system: an umbrella organization for thousands of local groups, links with policing agencies, the U.S. Department of Justice, and the new reporting and registry system. Since 1984, the system has grown and adapted to its mandate to reach as many missing children as possible.

Eventually, the age range for missing children was raised from 17 to 21 years old, and a new category was created to include adult children from 21 to 24 as missing. Advocates argue for the greatest possible inclusion of cases, with similar horror stories about adolescents forced into prostitution, crime, and drugs.

Pressures to skirt rules of privacy have come from claims makers in the name of missing children. Some laws serve to increase the numbers of cases. Police departments and social agencies responsible for children are mandated to report within two hours any suspicion that a child has gone missing. This causes such results as one adolescent being reported 10 times over a two-week period by both police and social services workers from the youth's group home. The secret files of the Internal Revenue Service (IRS) are potential sources to locate parent abductors through tax returns with the Social Security numbers of missing children as dependents. In recent years, resistance to these claims has been growing. Despite the inclusion of older children and cases presumed to be missing after two hours, the numbers have been falling. A 1999 Department of Justice study found that almost all runaway children were soon reunited with their parents. Child memorial laws have run into resistance due to their cost and poorly articulated consequences. The future of the missing children problem is uncertain, although the efforts to define the problem and pass laws have led to public awareness and strengthening of child protection.

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See Also: Abduction; Abuse and Neglect; AMBER Alert; Child Welfare Services; Homelessness; Human Trafficking; Protective Services for Children; Runaway Youth/Human Trafficking.

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National Center on Minority Health and Health Disparities

The National Center on Minority Health and Health Disparities (NCMHD) is a division of the National Institutes of Health (NIH), which in turn is part of the Department of Health and Human Services (HHS). The focus of NCMHD has always been on mitigating the burdens associated with major illnesses and death among racial and ethnic minorities and among rural and poor populations in the United States. It has long been understood that certain diseases and conditions hit minority, poor, and rural populations harder than all other populations, but understanding the way that minority health is impacted by those disparities has only been the subject of intensive research since 1990.

Since that time, a good deal of progress has been made in identifying disparities, but much remains to be done before disparities are eliminated entirely. The goals of NCMHD have been carried out through research, training, and information dissemination. This is done in large part through loan repayment awards that provide for government repayment of educational loans for each year a recipient spends in disparities research and in the Centers of Excellence, which carry out projects according to the needs of particular communities. The center has traditionally served as the liaison on issues related to minority health and health disparities among offices within the NIH and with other federal agencies.

The NCMHD was transformed into the National Institute on Minority Health and Health Disparities (NIMHD) by the Obama Administration's Patient Protection and Affordable Care Act (P.L. 111-148), which was signed into law on March 23, 2010. NIMHD operates in all 50 states and in the American territories. Student interns extend that reach by serving in foreign countries. The institute also sponsors training programs and conferences that bring together experts from all over the world as a means of improving understanding of minority health and health disparities and identifying ongoing research and projects among the states and territories.

Understanding the impact that poverty, race, and ethnicity can have on health issues has led NIMHD to closely examine the Appalachian Mountain area of the United States, where poverty is widespread. Other research areas focus on the fact that minority and poor populations are disparately affected by human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), cancer, diabetes, infant mortality, and cardiovascular disease.

Another area of concern deals with the fact that there are major differences in health conditions experienced by white Americans and those experienced by African Americans, Hispanics, Native Americans, Alaska Natives, and Pacific Islanders. At the same time disparities continue to exist, minority populations are rapidly increasing in the United States.

Background

The NIMHD is headed by a director who plans and coordinates all activities and research. Dr. John Ruffin, the first director of the center, continued to serve as director when the center was transformed into an institute. He began his career in the field of minority health and health disparities in 1990, when he accepted a position as the associate director of the minority health program at the NIH.

The work of the center proved to be so significant that, within two years, the Office of Research on Minority Health (ORMH) had been allotted a budget of $45 million and began working on the Minority Health Initiative. In 1993, the Health Revitalization Act (P.L. 103-43) created the ORMH within the office of the director of the NIH, and Ruffin was named to head the new department. He had an initial budget of $211 million and a staff of 35.

In 1994, the ORMH sponsored the National Conference on Minority Health Research and Research Training in Chicago. Three years later,

Capt. Cynthia Macri, Chief of Naval Operations Special Advisor for Minority Affairs, speaks with college-bound high school students about preparing for careers in science and medicine, particularly in health-related career paths. Much remains to be done before disparities in health care are eliminated entirely. The goals of NCMHD have been carried out through research, training, and information dissemination.

the Advisory Committee on Research on Minority Health was created to provide advice to the directors of both NCMHD and NIH on issues related to minority health and health disparities.

In 1999, Senator Ted Kennedy (D–MA) and Representative Jesse L. Jackson Jr. (D–IL) introduced legislation designed to turn the ORMH into the NCMHD, arguing that the office needed to have more authority to carry out its mandates than was possible at the time. By the following year, the effort had gained the support of Senator Bill Frist (R–TN), and bipartisan support proved to be crucial to passage of the bill.

That same year, President Bill Clinton signed the bill into law, creating the NCMHD. The ultimate goal of the act was to eliminate major health disparities over the course of the following decade, focusing chiefly on disparities such as higher infant mortality rates among minorities and incidences of diabetes that were twice as common among Hispanics as among whites.

Activity in the 2000s

In 2000, the Centers of Excellence were created by the Minority Health and Health Disparities Research Act (P.L. 106-525), and the program, which was then known as the Centers of Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training (Project EXPORT), began operations. In 2007, the name was officially changed to the NCMHD Centers of Excellence. Within the United States, Puerto Rico, and the Virgin Islands, the centers provide ways of dealing with disparities in underserved populations. Projects involving research and training are often carried out in cooperation with academic and private institutions, focusing on issues such as breast, prostate, and pancreatic cancers; human papillomavirus (HPV); HIV/AIDS; and cardiovascular disease. Through these efforts, the number of minority groups participating in clinical trials has increased. By 2002, NCMHD had established 88 Centers of Excellence.

In 2000, the National Advisory Council of NCMHD met for the first time. That same year, NCMHD took on responsibility for the Research Infrastructure in Minority Institutions Program. The first NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities was announced in 2003. Two years later, NCMHD was placed in charge of the Minority International Research Training Program, which then became the Minority Health and Health Disparities International Research Training Program. In 2005, the center established the NCMHD Community-Based Participatory Research Program.

On December 16 through 18, 2008, the NCMHD sponsored the National Summit on the Science of Eliminating Health Disparities. More than 3,000 attendees came to hear more than 300 experts speak about the efforts of NIH in the disparities field, learn about the Increase Awareness and Understanding initiative, discuss successful research models, and identify gaps in current disparities research. The summit also provided a means of establishing networks among the experts in the field. Those experts included domestic and international researchers, clinicians, policy makers, community leaders, and academics in fields that encompassed psychology, nursing, psychiatry, sociology, anthropology, medicine, and government.

Current Status

For his dedication to the field of minority health and health disparities, Dr. John Ruffin was awarded the Martin Luther King Legacy Award for National Service in 2007. In 2008, NIMHD sponsored NIH Science of Eliminating Health Disparities in order to examine state actions in the health disparities field. The following year, the institute initiated the Intramural Research Program and Career Transition Program as a means of retaining those individuals who had been trained through the loan recipient program within NIMHD. The institute also formed partnerships with the National Heart, Lung, and Blood Institute's Jackson Heart Study; the National Institute of Environmental Health's Sister Study; the National Institute of Arthritis and Musculoskeletal and Skin Diseases' Osteoarthritis Initiative; the National Institute of Dental and Craniofacial Research's Oral Health Disparities Research Center; the National Institute of General Medicine's Bridges to the Future Program; the Research Centers on Minority Aging Research; and the National Institute of Diabetes and Digestive and Kidney Diseases' ASSK Study.

On September 27, 2010, the NCMHD announced that it had officially become the NIMHD. The change clarified NIMHD's role in the field of minority health and gave the institute additional authority to carry out its assigned functions. One of the major responsibilities of officials at NIMHD is recruiting new talent and retaining talented individuals who have been trained through the NIMHD Loan Repayment Program, which provides up to $35,000 a year to pay off education loans for qualified recipients. The loans are earmarked for health professionals with medical degrees or doctorates who conduct research in the field of health disparities or who are engaged in clinical research in nonfederal academic settings. Concentrated efforts are being directed toward encouraging these talented individuals to remain in the field of health disparities research. Through the loan repayment program, some 1,700 individuals have been trained to conduct disparities research in medicine, epidemiology, psychology, biochemistry, and health policy. Seventy percent of loan recipients come from racial and ethnic minorities or from other populations that experience significant health disparities.

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See Also: Health Care, Disparities in; National Healthcare Disparities Reports; Racial and Ethnic Approaches to Community Health.

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National Child Abuse and Neglect Data System

The foundation for the National Child Abuse and Neglect Data System (NCANDS) was established in 1974 in the federal reporting system responding to Child Abuse and Neglect (CAN). Along with funds supporting the investigation of CAN, Congress required a state central registry for all cases accepted for intake. NCANDS then began to compile U.S. state statistics. These statistics are public and can be easily accessed on the Web site of the U.S. Children's Bureau. Statistical files are available for research at the National Data Archive on Child Abuse and Neglect (NDACAN). The annual report *Child Maltreatment* is a summary of these statistics. Over the years, the number and scope of NCANDS' statistics has grown, and they are used as indicators of child welfare. However, the validity of the data and their use as outcome measures has not been demonstrated.

When national statistics are compiled, regional- and state-level diversity must be considered and taken into account. The collection of national CAN statistics is much more difficult than it appears in the tables of these reports. When Karen Michaelis studied state CAN laws, she found that no two states had the same definition of child abuse. In fact, there were no categories that could be used to group similar definitions. This problem of definition continues. Some states register a single family; in others, each child is considered a separate case. If a child or family is reported multiple times, their case may be registered multiple times. The staff at NCANDS manipulates states' data to identify unique cases. These are children who have been reported during a year, and CAN has either been substantiated or services given. In 2011, 681,000 unique victims nationally were estimated.

The problem of defining CAN is even greater with other NCANDS data. The 42.7 percent of CAN cases classified as psychological maltreatment in Delaware lacks meaning without inquiring into the state's procedures, court systems, and how cases are reported and investigated. It is worrisome to find that psychological maltreatment in North Dakota affects 37 percent of CAN cases, while in neighboring South Dakota, only 1 percent suffer psychological abuse. In Illinois, Rhode Island, and Massachusetts, only one in 1,000 cases is so classified. We can't add up the cases from these highly diverse reporting and investigative systems for an average level of psychological maltreatment. But NCANDS does just that for a meaningless "national average" of 9 percent.

In Pennsylvania, 65 percent of child CAN victims suffer from sexual abuse, while in New York, fewer than 3 percent are so classified. Some states, including Kentucky, Massachusetts, and Nebraska, report that more than 97 percent of their cases include allegations of child neglect. Yet other sates report very low percentages; Vermont and Pennsylvania have 5 percent or less. Such enormous statistical disparities among states indicate operating differences at all levels of reporting, investigating, and servicing families. Data are only as useful as the processes developing them, and those processes remain obscure. Nonetheless, NCANDS data are analyzed to assess child well-being and how well states' child welfare and protection systems are working. These data are published periodically as Child Welfare Outcomes reports. The validity of this work and its application is doubtful.

A second form of extreme variation lies within the casework itself. When Jane Waldfogel gained access to 200 CAN case files, she found that there was no way to categorize them into simple categories. Top-down categories designed by administrators and researchers miss most information in these cases.

A complementary source of data on CAN comes from surveys of caseworkers and others in the field who report cases known to them. These National Incidence Studies (NIS) of Child Abuse and Neglect provide estimates of actual child maltreatment rates in the United States and helpfully distinguish alleged actual child harm from potential harm (endangerment), which NCANDS doesn't. Neither source inquires into the root cause of CAN reports, such as poverty and inequality. Both show similar racial disparities, with African American children the most overrepresented. But social class, education, and poverty are not included in these data, and they cannot support research into the causes of CAN.

Hidden within the statistics are administrative decisions that could reveal racial, cultural, and social class disparities. New laws create new categories of CAN that are added to the state statistics. For example, laws made failure to provide a car seat for a child a CAN case. So classifications vary from state to state and from year to year within states. Variations come from publicity when a child is killed or when laws and policies are changed, and small differences in local interpretation can loom large in the resulting numbers.

These hidden differences in policies and procedures create great interstate disparities. The administrative meaning of physical abuse may be quite different from its apparent meaning, hidden even to researchers analyzing NCANDS data. Thus, in one state, physical abuse may only mean child injury; in another, it may include risk of harm or concern that the child might be hurt. This caution applies to any administrative CAN measure.

The social meaning of CAN statistics is a product of work taking place at many levels, from the frontline worker's investigations to the state legislature passing laws. When money is allocated to help combat CAN, frontline workers will strive to locate CAN in a needy family so services and financial help can be provided. CAN is many times more likely to be found in poor families than middle-class families, probably as a result of responses to family needs other than actual CAN. Definitions will be stretched and loopholes created to help families and careers.

The validity problems of CAN statistics are not unusual for administrative data. Numbers are created to make sure that the work is being done and money is being properly spent. When accounting for expenditures, there is no particular interest in adhering to logical classifications for doing research. The responsibility is NCANDS's to demand consistent definitions from the states in return for federal grants. To its credit, NCANDS is steadily improving its coverage and the detail of its data, and we can anticipate further improvement. With more detailed and consistent data, research into the causes of maltreatment and differences among our diverse population could be achieved. So far, NCANDS has fallen short of achieving coverage of families' diversity; data it does collect is inconsistent and must be treated with caution.

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See Also: Abuse and Neglect; Child Abuse Prevention and Treatment Act; ChildStats; Child Welfare Services; National Center for Missing and Exploited Children; Protective Services for Children.

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National Congress of American Indians

Native American history is wrought with atrocity and abuse from the earliest days of Columbian exploration in America, from the forward attempts of physical and cultural genocide to the indirect microbial plagues brought to the shores of the continent. For five centuries, the American Indian population has faced a life of despair and near extinction. Beyond the perverse loss of life associated with the European contact, the loss of land, human rights violations, and control of natural resources robbed the American Indians of their way of life through forced assimilation practices, denial of religious freedoms, and English-only boarding schools for native children, to name a few. In the words of Jefferson Keel, the current president of the National Congress of American Indians: "We were a people before 'We the People.'" Native Americans were a self-sufficient, thriving diversity of cultures, societies, and independent governments. There are more than 560 tribes today, and to understand the current social conditions, we must understand the historical effects of Indian removal, displacement, and the assertion of reservationist logic on the Native American population that ultimately left them institutionally isolated and dependent upon governmental support and assistance.

The National Congress of American Indians (NCAI) is a nonprofit organization representing the American Indian and Alaska Native populations. The organization, founded in 1944, is both the oldest and the largest pan-ethnic or pan-Indian advocacy group joining this extremely heterogeneous population, with the goal of representing the interests of tribal governments and tribal communities and securing the future for Native American people and the country. The purpose of the NCAI is to serve as a forum for unified policy development among tribal governments in order to: (1) protect and advance tribal governance and treaty rights; (2) promote the economic development and health and welfare in Indian and Alaska Native communities; and (3) educate the public toward a better understanding of Indian and Alaska Native tribes.

NCAI founding principles include the following: (1) to secure and preserve American Indian and Alaska Native sovereign rights under treaties and agreements with the United States as well as under federal statutes, case law, and administration decisions and rulings; (2) to protect American Indian and Alaska Native traditional, cultural, and religious rights; (3) to seek appropriate, equitable, and beneficial services and programs for American Indian and Alaska Native governments and people; (4) to promote the common welfare and enhance the quality of life of American Indian and Alaska Native people; and (5) to educate the general public regarding American Indian and Alaska Native governments, people, and rights.

The NCAI is member based, and the governments of American Indian and Alaska Native tribes petition and delegate representatives that deliberate in committee their tribal goals. The attempt of the NCAI is to unify their diverse interests and determine an ultimate direction that is beneficial to the membership. Due to the fact that NCAI represents an extremely diverse group of nations, the NCAI Standing Rules of Order, Section XII, states, "Resolutions must be of a general nature to advocate the best interests of all American Indians and Alaska

American Indian children from southeastern Idaho dressed in European clothing, circa 1897. American Indians lost their way of life through forced assimilation practices, denial of religious freedoms, and English-only boarding schools for native children.

Natives. Resolutions that take one side between two conflicting tribes are not in order." Simply, the goal is "to speak with one voice to protect tribal sovereignty."

The State of Indian Nations

In the 11th annual State of Indian Nations address in 2013, the president of the NCAI, Jefferson Keel, sustained that there continues the need to protect and strengthen tribal sovereignty, emphasizing that "Indian nations are best governed by Indian people." The relationship between tribal nations and government should be a partnership based on mutual respect, mutual obligation, and mutual trust. He urges Congress to honor their constitutional responsibility, quoting the words of President Barack Obama in the 2013 State of the Union Address: "The federal government must keep the promises they have already made"; these trust responsibilities are the support of education, housing and highway infrastructure, law enforcement, and energy development. Native Americans wish to be proactive stewards of their own future.

Related Native American Issues and History

The Lakota have a word, *wasi'chu/wasichu*, meaning "takes the fat or greedy person." It does not refer to the white man or white race in particular but represents the motivation of individuals, corporations, and government to take and profit from Indian Country. The recent and highly controversial Cobell Settlement, formally known as *Cobell v. Salazar*, was finally settled after 16 years of court battle for $3.4 billion. It was one of the largest class action suits filed against the United States serving to both reclaim Native American land and reacquire mismanaged assets that were in trust with the U.S. government. The federal government is supposed to make decisions and dealings that are in the best interest of Indian Country; however, this has rarely if ever been the case, driving many tribes to revisit treaties and decisions for bias and impropriety. Many individuals and groups feel the decision represents only slight reparations for the historic wrongdoing and cumulative economic loss in this situation.

Continuing today, the profit motive puts Native American land in the crosshairs for development and natural resource extraction. For example, in South Dakota, the Oglala Sioux are attempting to defend their land against the mining of uranium in the southern Black Hills that borders their Pine Ridge Indian Reservation. The main concern is the potential pollution of their water supply; at the end of 2013, they had been unsuccessful and were continuing to protest. As well, on many Native American reservations, the presence and prospect of oil and gas deposits have urged companies to begin securing leases and drilling rights. Similarly, in North Dakota, it has been claimed that the Bureau of Indian Affairs facilitated the lease of tribal land that cost three affiliated tribes—the Mandan, Hidatsa, and Arikara—an estimated $1 billion; lawsuits are currently pending in this case.

Institutionalized racism in sports has a long history that has only been seriously addressed in the past decade. The American Civil Liberties Union reiterated the voice of many civil rights groups, including the National Association for the Advancement of Colored People (NAACP), proclaiming that the use of Indian mascots is in no way honoring the Native American population and continues to produce and reproduce negative images, racism, and bigotry. The Washington Redskins, a team of the National Football League, was the topic of the recent controversy, this bearing significant irony as it is the team "representing" this nation's capital. The term *redskin* has been redefined and deemed in reference materials as an ethnophaulism, a racial slur and derogatory toward Native Americans. Many teams have transitioned out their names and mascots with less-offensive alternatives, but the use of these mascots do continue for many professional and college sports teams. The controversy and petition continues even after civil rights organizations, governmental commissions, and the social scientific communities deem their use as insensitive, inflammatory, and offensive.

The first Thanksgiving was proclaimed by George Washington on November 26, 1789; however, it was only for that year. It was 74 years later in 1863 that Abraham Lincoln initiated the formal annual holiday. The holiday's origin was to acknowledge the nation's blessings; however, over the course of time, it became conflated with Native American imagery, stereotypes, and a hallmark example of institutionalized racism. There has been progress toward racial decompression, as 2013 marked the fifth year of Native American inclusion in the 87-year history of the Macy's Thanksgiving Day Parade. It was the fifth year for the Oneida Indian Nation, and they were for the first time joined by the Native Pride Dance troupe and the Cherokee Youth Choir.

John F. Kennedy wrote, "It seems a basic requirement to study the history of Indian people. Only through this study can we as a nation do what must be done if our treatment of the American Indian is not to be marked down for all time as a national disgrace."

In 2012, the United Nations (UN) for the first time initiated investigations of reservations, exploring the plight of contemporary indigenous peoples and forwarding visibility of the widespread poverty, homelessness, substance abuse, crime, and violence that plague the estimated 2.5 million Native Americans in the United States. Furthermore, the UN has endorsed Native American self-determination as a way to restore and uphold human, political, social, and property rights of indigenous people in the United States and beyond. Native Americans experience homelessness, poverty, and unemployment more than two times the national average, with thousands of households living without basic telephone service and indoor plumbing. Native American tribal nations are experiencing greater visibility and have made substantial economic and political inroads, but there is a long road toward the desired complete sovereign authority of Indian Country. The NCAI continues this mission as Indian nations diversify economically, continue to strengthen tribes internally, and lobby to gain tribal sovereignty across both national and international boundaries.

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See Also: American Indian Movement; Antilocution; Indian Boarding Schools; Indian Child Welfare Act; Indian Civil Rights Act of 1968; Indian Health Service; Poverty; Racism, Long-Term Effects of; Reparations; Tribal Social Services; Tribal Sovereignty; United Nations Declaration on the Rights of Indigenous Peoples; Values and Ethics, Ethnic Diversity and; Voting Rights Act of 1965; White Privilege.

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National Database for Autism Research

The National Database for Autism Research (NDAR) is a secure biomedical informatics system and research data repository developed by the National Institutes of Health (NIH) for the autism spectrum disorders (ASD) research community. In an attempt to address the differing needs of its multiple stakeholders, the NDAR leadership team aims to be inclusive in its composition, having included three parents of children with autism as well as an adult with autism.

Background

In response to intensified social concern about ASD, the U.S. Congress passed the Combatting Autism Act (CAA) of 2006 (P.L. 109-416), legislation designed to rapidly increase and improve the coordination of scientific discoveries in the area of autism research. The CAA authorized the creation of the Interagency Autism Coordinating Committee (IACC), a federal government advisory panel responsible for developing and annually updating a strategic plan for ASD research. The IACC strategic plan was originally designed to specify research opportunities that focus on the six most-pressing questions facing those affected by ASD with the aim of linking them to specific research endeavors. The first plan was finalized in 2009, and a seventh question, which mentions the need for the creation of mechanisms to encourage data contribution to NDAR (whose work originally began in 2007), was added to the IACC strategic plan in 2010.

NDAR was originally developed by the NIH with support from five institutes and centers at the NIH: the National Institute of Mental Health (NIMH), the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute for Environmental Health Sciences (NIEHS), and the Center for Information Technology (CIT). The database contains a full range of data collected by investigators of ASD and provides researchers with the infrastructure to store, search across, and analyze various types of data. Still in its early stages, NDAR interacts with data submitters to improve the submission process and works with institutional review boards (IRBs) to clarify questions or concerns. NDAR also continuously reviews access policies and procedures to make sure that research participants' privacy and confidentiality are protected.

Purpose and Funding

NDAR was developed to support and accelerate the advancement of autism research through the creation of an infrastructure that integrates heterogeneous data sets, thus giving researchers access to more quality data than they would be able to collect on their own. It was also set up to help define standard tools and policies to integrate the computational resources developed by scientific research institutions, private foundations, and other federal and state agencies that support ASD research.

To that end, it allows the longitudinal storage of all of a research participant's information generated by one or more research studies. NDAR is also currently in the process of connecting relevant repositories together through data federation, a structure that allows data to be kept in their respective locations while enabling users to search in all databases at the same time. Both NDAR and the federated repositories all use the NDAR global unique identifier (GUID) system as well as common data definitions to increase data accuracy across each individual laboratory and project. NDAR is cofunded and receives resource contributions from several institutes and centers at the NIH, including the NIMH, NINDS, NIEHS, NICHD, and the CIT.

Sources of Data

The Autism Centers of Excellence (ACE) Program was created in 2007 to foster collaboration among teams of specialists working together to address particular research problems concerning ASD in an in-depth manner. Initial data in NDAR were provided by 11 of these ACE research centers; other autism researchers then provided additional data. NDAR currently accepts high-quality research data from a number of other projects, regardless of their funding sources and locations, and is working to connect with additional relevant research repositories. Several investigators with research grants, investigators who had autism research projects funded through the American Recovery and Reinvestment Act of 2009, as well as more than 120 grantees funded by the NIH are also expected to share their data with NDAR.

In May 2012, NDAR contained more than 170,000 data records from more than 25,000 subjects; as of September 2012, the number of research participants in the database had expanded to 35,000. Data in NDAR includes demographic information, clinical assessments, imaging data, and genomics information. (The database began to receive genomics/sequencing data in 2012.) A large portion of NDAR is comprised of behavioral, intelligence quotient (IQ), and cognitive data, but the database also contains significant information concerning the impacts of environmental exposures.

Who Can Submit Data

Any researcher with research data related to ASD may apply for approval to submit data to NDAR as long as they follow the protocol outlined on the data contribution page of their Web site (http://ndar.nih.gov/ndarpublicweb/contributing.html). To contribute data to NDAR, investigators are required to format their data in line with an existing NDAR data definition or provide a new data definition that will be available for use by others. Researchers must confirm that data conforms to existing definitions by employing the validation tool, a program that ensures that naming conventions are defined, all GUIDs are properly registered, and that the reported data is consistent with the value ranges defined in the system's dictionary. All data contributed and shared with NDAR have to pass validation before being accepted for submission.

Access to Data

Although summary information on the data in NDAR is available on their home page for public use, qualified researchers can request access to data stored in NDAR and data stored at federated repositories when the data are made public. To gain access to this data, an investigator must obtain NDAR data access privileges. In order to protect the privacy of research participants, only researchers who have completed data use certification and received approval from the NDAR Data Access Committee (DAC) may access the broadly shared data in the NDAR Central Repository.

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See Also: Children With Special Needs; Neurodiversity; Sociology of Disability.

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National Health and Nutrition Examination Survey

The National Health and Nutrition Examination Survey (NHANES) is administered annually by the National Center for Health Statistics, a sector of the Centers for Disease Control and Prevention (CDC). The survey provides a comprehensive snapshot of the health and nutrition status of the U.S. population. NHANES is used to identify the prevalence of disease in the U.S. population, as well as risk factors for disease. Data is also used to determine national measurement standards for weight, height, and blood pressure.

NHANES began as a result of the 1956 U.S. National Health Survey Act. The act prioritized research aimed at collecting accurate and timely information on the amount, distribution, and effects of illness and disability in the United States. The CDC conducted surveys periodically from 1974 to 1994 (NHANES I, 1974–1975; NHANES II, 1976–1980; and NHANES III, 1988–1994). Annual data collections have been conducted continually since 1999.

A nationally representative sample of approximately 5,000 people is recruited each year. Since 1974, more than 140,000 people have been surveyed. Survey participants are selected to reflect current U.S. demographics using census information. The NHANES team divides the United States into geographic communities and then further divides those communities into neighborhoods. Neighborhoods are then randomly selected. From the neighborhoods, individual households are randomly selected. Residents of selected households are then contacted and asked to participate. To achieve adequate sample sizes for data analysis, NHANES oversamples individuals in the U.S. population who are over age 60, as well as African Americans, Asian Americans, and Hispanic Americans.

Study Design and Content

The study includes both physical examinations and in-depth interviews. The research team includes physicians, dentists, and medical technicians. Physical examinations are conducted using mobile examination centers to make data collection convenient for the participants. The physical examination includes tests of blood pressure, bone density, condition of teeth, vision test, hearing test, height, weight, and other body measures, an ophthalmology exam for eye diseases, and breathing tests. Urine samples, blood samples, and vaginal swabs are taken. Researchers also take water samples from the participants' homes to test for the presence of environmental chemicals. The interview component of the study takes place in the participants' homes. Survey questions ask participants demographic questions in addition to questions about their health status, drug and alcohol use, nutrition, reproductive health, disease history, and diet. All participants receive a cash payment in exchange for participation and are reimbursed for any transportation or child-care expenses.

Results of the NHANES Survey

All of the data collected annually for the NHANES is publically available on the CDC's Web site. Interested researchers can join the NHANES LISTSERV (listserv.cdc.gov) to receive timely information about NHANES activities, products, and release dates. The NHANES is a rich source of data that enables researchers and organizations to study the nutrition-related behavior and health status of the U.S. population. For example, NHANES data have been used to examine the prevalence of hypertension among adults in the United States. The data allowed for a longitudinal study of awareness, treatment, and control of hypertension to be carried out. Data from this survey have also been used to examine milk consumption by children over time, the effects of 100 percent fruit juice consumption by children and adolescents, the prevalence of nonalcoholic fatty liver disease in the United States, alcoholic beverage consumption by adults, and the relationship between pesticide use and breast and prostate cancer risk.

The data collected are used by government and nongovernment organizations to create health and nutrition programs. Results have been used to design health interventions to improve health outcomes. NHANES data have also been used by researchers to influence policy and improve the health of the U.S. population. In recent years, the data have been used as evidence for the creation of pediatric growth charts and as evidence for the establishment of national baseline estimates for cholesterol levels and hepatitis.

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See Also: Drug and Alcohol Screening; Eating Disorders, Cultural Aspects of; Food Desert; Food Insecurity; Food Support; Health and Sickness, Differing Attitudes Toward; Hispanic Health and Nutrition Examination Survey; National Survey of Family Growth; Nutritional Services and Assessment; Overweight and Obese Adults and Children; Public Health; Socioeconomic Status.

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National Healthcare Disparities Reports

The Agency for Healthcare Research and Quality (AHRQ), an agency of the U.S. Department of Health and Human Services (HHS), publishes the annual National Healthcare Disparities Report (NHDR). Under a 1999 Congressional mandate, this report was first released in 2003 in conjunction with the National Healthcare Quality Report (NHQR). Together, these reports summarize health care measures to evaluate the state of health care quality, access, and disparities. Because these reports work in tandem, the NHDR cannot be presented without also discussing the NHQR. Whereas the NHQR is a comprehensive overview of U.S. health issues, the NHDR examines the same key measures but within the context of priority populations. This includes racial and ethnic minorities, low-income populations, and others with special health care needs such as the elderly and persons with disabilities or chronic illnesses. The content of the reports informs policy makers and aims to improve the overall quality of health care received by the U.S. population. Currently, the health care system distributes services inefficiently and unevenly across populations, resulting in inequalities and disparities. To improve equity, the NHDR examines these disparities to help us better understand the impact of racial, ethnic, and socioeconomic differences in health care provision and outcomes.

Measuring and Reporting Quality

The ultimate goal of these reports is to address critical issues within the health care system and give guidance in providing optimal care for all persons in the United States. In order to examine equitability of service delivery and outcomes, measures had to be established and then applied to all population groups. In addition to performance measures, an interagency work group was tasked with selecting core measures. Through the application of these measures, trends are monitored to identify areas for which health care is improving or getting worse. This group continues to work closely with AHRQ to amend the measures list according to areas where additional health care performance information is needed. Based on data analysis and trends, new measures might be added, while others might be retired. In 2012, the AHRQ made a major evaluative change. Specifically, they analyzed disparities using the full set of measures tracked in each report rather than just the core measures.

The measures are essential for tracking as well as identifying the data to be used for examining the status of health care quality. Establishing effective measures is complicated by the fact that data must be culled from three dozen different databases. This is necessary in order to obtain estimates for different population subgroups and years. Despite the data challenges, changes in health care quality and access can be tracked over time and used to inform policy makers, researchers, providers, and other segments of the care continuum of areas that are improving or declining. It is noted that data collection has improved as a result of the 1999 federal initiative, although data on underserved population are still often incomplete and inadequate. Assuming that the Affordable Care Act remains law, all federally funded health programs and population surveys will be required to collect data on race, ethnicity, sex, primary language, and disability. This data collection improvement will allow for more thorough data sets for evaluation and reporting, and ultimately, identifying priority needs for improvement.

Organization of the Reports and Priority Populations

The NHQR and the NHDR follow the same table of contents. Each report begins with and identically highlights sections that incorporate findings from both the NHQR and the NHDR. This introduction is followed by a chapter providing an overview of the methods used to generate estimates, measure trends, and examine disparities. The next chapter covers effectiveness of care in several clinical areas. These are cancer, cardiovascular disease, chronic kidney disease, diabetes, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), maternal and child health, mental health and substance abuse, musculoskeletal disease, and respiratory disease. These services are examined with data associated with lifestyle modification, functional status preservation and rehabilitation, and supportive and palliative care. Subsequent chapters address patient safety, timeliness (of care), patient centeredness, care coordination, efficiency, health system infrastructure, and access to health care.

While the highlights sections are identical in the NHQR and NHDR, the remaining chapters contain starkly different analyses. Specifically, the NHQR tracks performance for different groups by age, gender, and geographic location. By comparison, the NHDR evaluates performance by race, ethnicity, income, education, activity limitations, and geographic location. Additionally, the NHDR contains a unique chapter on priority populations. These priority populations were specified by Congress in the Healthcare Research and Quality Act of 1999 (Public Law 106-129) and are part of a legislative mandate to collect and report data for nationwide improvement of health care. The priority populations are racial and ethnic minority groups, low-income groups, women, children (under age 18), older adults (65 and over), residents of rural areas, and individuals with special health care. This last group includes people with disabilities and people in need of chronic care or end-of-life care. While not mandated, the lesbian, gay, bisexual, and transgender (LGBT) segment is also included as is subpopulation data for Asians and Hispanics where data are available.

Findings

The ultimate goal of all HHS initiatives is to improve the lives of Americans through better health care and health. Released in 2013, the 2012 NHDR is the 10th annual report allowing for a decade of tracking and data comparison. The evaluation shows that, despite concentrated efforts, health care quality and access remain suboptimal for minority and low-income groups. Findings also demonstrate that, while overall quality is improving, access issues have worsened. While these reports do not directly address social determinants of disease, the data show that racial and ethnic minorities, as well as those living in poverty, often face more barriers to receiving care. Even after gaining entry into the system, they often receive poorer quality of care. This is the result of multiple factors such as service distribution, language, and cultural divides between patient and provider. While these findings are alarming, health care researchers focused on social determinants of health are making progress at identifying problems, targeting resources, and designing interventions for better outcomes. Informed by data, these interventions can focus on specific types of services, at-risk subpopulations, and smaller-scale geographic interventions that national and state level policies cannot.

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See Also: Department of Health and Human Services, U.S.; Health as a Human Right; Health Care, Disparities in; Health Care Delivery, Models of; Health Disparities, Role of; Racial and Ethnic Approaches to Community Health; Social Determinants of Health.

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National Institute of Mental Health

The National Institute of Mental Health (NIMH) is a federally funded agency with a mission to increase the understanding and treatment of mental illness. It is funded to provide clinical research with which to advance mental illness prevention, recovery, and cures. Mental health began to receive a great deal of attention during the recruitment of soldiers for World War II.

At that time, upon examination, approximately one in four draftees were found to be unable to perform military service because of psychiatric or neurological problems. In response, Congress established the Mental Health Act in 1946 to study the mental health needs of the country. This act established the National Institute of Mental Health, in the United States.

In 1961, the NIMH released a groundbreaking report, "Action for Mental Health," which transformed various services provided for the mentally ill. The report made recommendations to improve mental health care in the United States. The report was released at a time when there was a surplus of money in the domestic budget, and President John F. Kennedy was very supportive of improving mental health care because of his experience with a family member. This report was the beginning of an increase in the federal government's involvement in mental health care and the beginning of several federally funded federal mental health initiatives. The report resulted in the passage of the Community Mental Health Center Acts of 1963 and 1965. This legislation provided funding for the NIMH to work on the prevention, treatment, and cure of mental illness.

The NIMH receives its funding through an annual appropriations bill that is passed through the House of Representatives and the Senate and then signed by the president. For the past three decades, achieving diversity in the workforce and adding diversity to their advisory committees and in their grantee population has been a core value of the NIMH. They are interested in getting input from diverse individuals who have overcome difficult challenges because of their ability to work on complex problems with different perspectives.

Importance of NIMH

It is estimated that one in five Americans has a diagnosable mental illness and that 53 percent of adults have a condition that interferes with attendance at work or performing daily activities for several days per year. Currently, the NIMH funds are used for more than 2,000 research grants throughout the country and overseas. The NIMH has seven divisions simultaneously working on many projects, including advances in biological and neuroscience, treatment interventions, and acquired immune deficiency syndrome (AIDS).

An important component of the NIMH is its extensive outreach program, which according to their Web site is working to "increase the public's access to science-based mental health information through partnerships with national and state nonprofit organizations" and "has a particular emphasis on reaching historically underserved populations." One of its objectives is to provide our nation with a better understanding of mental disorders and behaviors as a way of reducing misperceptions and negative attitudes toward mental illness. Advances in treatment cannot occur if misconceptions regarding mental health prevent individuals from accessing available services. The NIMH Web site contains information on many mental health conditions for the public to access free of charge.

The NIMH has numerous research training and career development programs. Its program to Enhance Diversity in Institutional Training promotes diversity in the biomedical, behavioral, clinical, and social sciences research workforce. The program is designed to provide a balanced perspective in the determination of research priorities, improve the recruitment of subjects from diverse

Patient in a magnetoencephalography (MEG) scanner, from the National Institute of Mental Health (NIMH). It is estimated that one in five Americans has a diagnosable mental illness. NIMH funds are used for more than 2,000 research grants throughout the country and overseas.

backgrounds into clinical research protocols, and work toward addressing and eliminating health disparities. It is committed to increasing the quality of the educational and training environment for talented researchers from all racial and ethnic groups.

Current NIMH research initiatives include the following: (1) Fast-Fail Trials (FAST) are clinical trials to study compounds for use as psychiatric medications targeted for specific areas in the brain; (2) Rapidly Acting Treatments for Treatment-Resistant Depression (RAPID) are interventions to develop therapies to lift treatment-resistant depression that will be effective in a few days instead of weeks or months; (3) Army Study to Assess Risk and Resilience in Service Members (Army STARRS) is the largest study on military personnel to identify mental health risks and resilience in an effort to assist the army to develop effective strategies to reduce rising suicide rates and to address mental health problems among soldiers; and (4) Recovery After an Initial Schizophrenia Episode (RAISE) studies treatments that will reduce symptoms and prevent the deterioration of functioning in chronic schizophrenics.

Mental illness has a significant impact on the lives of approximately one in five Americans. The NIMH has a significant role in prioritizing and continuing research for the prevention, treatment, and quality of life of children, adults, and the elderly in the United States. They are currently involved in three initiatives designed to encourage increased diversity in the scientific workforce. One of these is providing funds to institutions, so they can plan and create an infrastructure to mentor individuals from diverse backgrounds to provide new ideas for improving mental health in the United States.

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See Also: International Mental Health Research Organization; Mental Health Service Delivery, Cultural Characteristics of; Mental Health Services, Adult; Mental Health Services, Children.

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National Institute on Aging

The U.S. network of 27 medical research institutes is known as the National Institutes of Health (NIH). These institutes are part of the U.S. Department of Health and Human Services (HHS), whose mission is to protect the physical and mental health of U.S. citizens. As such, the agencies within the NIH vary in their purposes and range from aiming to cure cancer, to researching alcoholism, to finding new ways to treat allergies.

The National Institute on Aging (NIA) is one of the research agencies within this network. It was founded in 1974 and is the main center for government-funded aging research in the United States. It focuses on how to provide older adults with a happy, healthy life. It also investigates common diseases and disabilities associated with growing older. Additionally, the NIA seeks to encourage healthy aging and promotes both basic and clinical research. The main campus of the NIA is located in Bethesda, Maryland; however, the NIA provides funding for research at institutions across the United States. The NIA and its affiliates publish valuable research and resources for the general public to help benefit older adults and their families.

Types of Research in the NIA

The NIA conducts research on many topics related to aging. It has both intramural and extramural research programs. The intramural research program includes both laboratory and clinical research. Among other research, gene studies using mice are conducted to examine genome sequencing, which can inform human biomedical research. It is also the starting point for two large-scale studies, the Baltimore Longitudinal Study of Aging (started in 1958) and the Healthy Aging in Neighborhoods of Diversity Across the Life Span study.

The extramural research program is made up of four divisions of research as well as the collection of partnerships between the NIA and other researchers who receive NIA funding to further health-related research relevant to older adults. The four divisions of research in the extramural research program are the Division of Aging Biology, which focuses on aging processes and age-related disease at a molecular or genetic level; the Division of Behavioral and Social Research, which focuses on research regarding social, behavioral, and economic issues as they relate to aging individuals and society; the Division of Geriatrics and Clinical Gerontology, which focuses on the relationship between disease and health outcomes during aging; and the Division of Neuroscience, which investigates the brain bases behind aging-related diseases.

Alzheimer's Disease and the NIA

The NIA is the primary research center in the United States for the study of Alzheimer's disease. It also partners with centers for Alzheimer's disease drug development around the United States and provides funding for such research. Alzheimer's disease is the most common cause of dementia in older adults, making it an extremely widespread issue for older adults' health. The NIA provides resources for older adults and their families regarding the causes, symptoms, and treatment of Alzheimer's disease. It provides videos, information sheets, and commonly asked questions regarding the progression of Alzheimer's disease.

The NIA also provides information about the funding of Alzheimer's research in the United States. It highlights economic outcomes associated with Alzheimer's disease such as how much care for individuals with the disease costs. Policy or funding changes regarding Alzheimer's disease and related diseases are immediately provided to the public by the NIA. The NIA also provides research progress reports in a reader-friendly manner, characterized by main findings associated with Alzheimer's and related diseases.

Cultural Diversity Initiatives in the NIA

The NIA has actively increased the information provided to the public and health care providers regarding diverse populations of older adults. The Minority Aging and Health Disparities initiative is a multifaceted branch of the NIA that supports research projects specifically aimed at addressing health issues associated with minorities. It also disseminates research findings related to minority aging and health. Recent articles and resources produced by the NIA have focused on cultural differences in medical care and understanding for American Indians, Latino and Latina individuals, individuals from Middle Eastern cultures, and other cultural minorities. These resources have showcased some of the common cultural differences that can have a significant impact on patient–provider interactions. The NIA has also published information regarding specific religious practices that may affect how some older adults approach health care situations. The NIA's public newsletter to increase cultural diversity and awareness of minority aging and health is *LINKS: Minority Research and Training.*

Research and information reported in *LINKS* has addressed areas of health for a variety of issues. For example, in 2007, cancer disparities in Latino communities were reported. The research provided smoking cessation information to Latino individuals. Differences in hospice care for African American and Caucasian older adults were reported in 2010. The research found that African Americans have less exposure to hospice care information than Caucasians. Alzheimer's disease research associated with the NIA has also focused on the low prevalence of Native Americans reporting symptoms of the disease, including investigation of health literacy and genetic factors. Health implications for these findings are important for carrying out the mission of the NIA to provide health care information to all older adults.

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See Also: Aging and Adult Services; Death and Dying, Cultural Attitudes Toward; Elder Care/Geriatric Services; Health Care, Disparities in; National Institute of Mental Health; Public Health.

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National Mental Health Association

Until 2006, Mental Health America (MHA) was named the National Mental Health Association (NMHA). The mission of this leading nonprofit national organization is to promote mental health, prevent mental disorders, and achieve progress to eliminate mental illness through advocacy, education, service delivery, and research initiatives. These endeavors are accomplished through a national organization and state and local nonprofit organizational affiliates that engage in similar functions to advance statewide and local mental health policies, service provision, and an improved quality of life.

There are 240 MHA affiliates organized according to several different operational models. The first is a local MHA organization that is linked to a statewide organization and the national entity. A second alternative allows local organizations to link with the national level without connection to a statewide organization. In a few states, there is a single statewide association without local affiliates linked to the national organization. All affiliates are expected to meet and apply national standards through different staffing and volunteer supports that enhance MHA network participation, undertake consumer advocacy, support organizations, participate in public policy and research, offer public education, and engage with media to support mental health. One of the greatest benefits of this 501(c)(3) affiliate structure is the flexibility to respond to diverse community needs and priorities based on sociodemographic characteristics, local service resource gaps, public mental health financing, and shifting service eligibility regulations driven through Medicaid mental health service policy coverage.

History of Organizational Advocacy

The historical roots of MHA are integrally connected to the late 19th- and early 20th-century American social reform movements in education, public health, juvenile justice services, and state asylum and local almshouse improvements. The mental hygiene reform movement of this era was greatly advanced by the remarkable efforts of Clifford W. Beers. As an educated and rising young Wall Street financier, he encountered an initial bipolar episode involving an attempted suicide that resulted in three years of private and public mental hospitalizations. During his period of institutionalization, he wrote a personal diary that chronicled the abusive and inhumane experiences he shared with other patients. Following his hospitalizations in 1908, Beers published his biographical account in *A Mind That Found Itself*. The book received considerable attention and gained attention of other reformers such as the renowned philosopher William James and well-known psychiatrist Adolf Meyers. These men and other contemporaries joined with Beers in the mental hygiene reform campaign and championed the formation of the National Committee for Mental Hygiene in order to advance institutional settings and patient treatment conditions.

These efforts led to state-by-state legislative reform and improved financing for state-run psychiatric hospitals, promoted interest in psychiatry as an emerging medical specialty, and unified U.S. and European reform efforts. The long mental health advocacy of MHA was a catalyst for more recent psychiatric care reforms that unfolded after World War II in part related to the development of new psychotropic medications that proved effective for major long-term psychiatric disorders. The organization advocated for the federal government's establishment of the National Institute of Mental Health (NIMH) in 1949 to promote research on the cause of major mental disorders and their treatment. MHA lobbied for the congressional passage of the 1963 Community Mental Health Centers Act that facilitated the creation of local, community-based facilities supporting the deinstitutionalization of mental health patients and advanced the foundation of outpatient care. It engaged in nationwide advocacy partnerships that mobilized passage of the 1990 Americans With Disabilities Act and the 2008 Mental Health Parity Act and more recently lobbied successfully for inclusion of significant mandated mental health insurance coverage within the 2010 Affordable Care Act.

State and Local Affiliates

The activities of state and local MHA affiliates are in part guided by national MHA initiatives. These initiatives are presented in the form of mental health position statements that necessitate ongoing and new directions of advocacy and mental health promotion. As nonprofit organizations, the affiliates operate with various amounts and types of professional staffing, but all rely heavily on citizen and consumer volunteer participation. Regional multistate mental health policy advocacy forums are facilitated by efforts of the national MHA in order to disseminate innovative program models, organizational resource acquisition strategies, and legislative advocacy approaches. These organizations strongly support the mental health recovery goals of consumer-driven programs and services. They are committed to the establishment of programs that reflect the cultural and linguistic diversity in response to the local diversification of mental health care needs among the high-risk community populations.

The national organization strongly promotes local models of cultural diversity that increase accessibility for diverse, underserved groups. Model programs such as mental health outreach to the migrant farmer worker network and mental health respite care for African American caregivers have helped promote cultural diversity program transfer. Many of the organizations are engaged in the creation and management of supportive housing adapted as residential alternatives for the chronically mentally ill homeless. Improvement of mental health care within correctional facilities is a goal shared by many organizations. Statewide legislative advocacy focused on governmental mental health department budgetary priorities and care access for the lowest-income consumers remains a continuous focus as state legislatures perpetually erode public mental health care expenditures.

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See Also: Homelessness; Housing Services; National Institute of Mental Health.

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National Minority AIDS Council

The National Minority AIDS Council (NMAC) is a nonprofit organization founded in 1987 for the purpose of developing awareness about the disproportionate impact of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) on people of color in the nation. Two years later, NMAC partnered with the Centers for Disease Control and Prevention (CDC) to assist in building the capacity of community- and faith-based organizations in their efforts to provide HIV/AIDS services. NMAC subsequently changed its mission from raising awareness to building leadership in communities of color to address the challenges posed by HIV/AIDS. Due to recent advances in biomedical interventions for HIV/AIDS (i.e., microbicides and preexposure prophylaxis [PrEP]), the NMAC adjusted its mission again in 2011, from addressing the challenges of HIV/AIDS to ending the HIV/AIDS epidemic.

One of the nation's leading HIV/AIDS organizations, NMAC does not work alone but in partnership with a coalition of other community, faith-based, and AIDS service-providing organizations in delivering health care and support to individuals and families infected and affected by this epidemic.

Programs of the NMAC

The work of the NMAC is carried out through four programmatic divisions:

1. The Division of Community Advancement and Leadership Strategies (D-CALS) lends capacity-building assistance to community-based organizations, planning groups, and health departments in formulating or implementing HIV/AIDS initiatives.
2. Conferences and Meeting Services (CMS) is designed to bring together leaders in the fight against HIV/AIDS to exchange information, network, and provide education and training. One example is the annual U.S. Conference on AIDS, the largest gathering of AIDS activists in the country.
3. Legislative and Public Affairs (LPA) focuses on advocacy and promoting health care policies pertaining to HIV/AIDS that are aimed at social justice and access to care for people of color. This division also engages in grassroots education and mobilization.
4. The Treatment Education, Adherence, and Mobilization (TEAM) works to ensure that minorities of color have access to HIV testing and counseling as well as newer biomedical interventions and provides the means necessary to eliminate or contain new HIV infections and related comorbidities.

Funding comes from membership dues, private donors, the United Way, and federal grants such as those from CDC for capacity-building assistance provided to community agencies.

Advocacy Positions Taken by the NMAC

NMAC has made HIV/AIDS issues more visible to all sectors of the American public, including lawmakers at state and national levels. It has been quite active in testifying on Capitol Hill and in state legislatures, recommending policy and program reforms to benefit minorities living with HIV/AIDS and addressing social and economic conditions that help drive the epidemic in communities of color. As such, NMAC has made the following recommendations: (1) increase the number of drug prevention and treatment programs, including a needle exchange program instituted for current drug users. In the opinion of NMAC, this initiative would not encourage individuals to use drugs but would greatly curtail the transmission of HIV through the sharing of contaminated needles; (2) reduce the impact of incarceration on new infections by distributing condoms to inmates in state and federal prisons, and provide HIV testing upon entry and release. In the opinion of some knowledgeable HIV activists and educators, this initiative would decrease the rate of transmission of HIV in prisons and in the communities to which inmates return; (3) develop a program at the federal level that would provide stable, affordable housing in the African American community for those infected by HIV; (4) provide more culturally relevant HIV education to minority youths in school settings; (5) increase funding for HIV research, critical to further development of biomedical, social, and behavioral interventions; (6) encourage and expand HIV testing that would lead to early identification of the virus; and (7) reduce stigma and marginalization of men who have sex with other men. The NMAC also supports the Patient Protection and Affordable Care Act (ACA) and the National HIV/AIDS Strategy (NHAS) and believes that the full implementation of these two initiatives will provide a pathway to ending the nation's HIV/AIDS epidemic.

Challenges Faced by the Organization

The first challenge of the NMAC is to continue getting its HIV/AIDS messages of education, prevention, treatment, community mobilization, and leadership development across to communities of color—in other words, keeping them involved in the battle. Second is to work toward getting the ACA fully implemented so that it has the intended impact on those living with HIV/AIDS as well as those at risk for transmission.

This will require educating communities of color at the grassroots level so that they are aware of ACA's benefits. NMAC will also need to advocate for fair and effective regulations to govern implementation of ACA. Third is advocacy for additional funding for HIV/AIDS research and capacity-building activities. Compared to 2010, NMAC's income and net assets dropped in 2011, resulting in a loss of grants to various HIV organizations. Funding for capacity building will be significant as health organizations become involved in implementing the ACA.

Legislative Agenda for 2013 and Beyond

In addition to issues identified under advocacy and challenges, some of the organization's other priorities include the following: (1) the reauthorization of the Ryan White CARE Act, providing last-resort access to care for many uninsured and underinsured persons living with HIV/AIDS; (2) passage of the Employment Non-Disclosure Act (ENDA), providing legal protection against employment discrimination based on sexual orientation, gender identity, or gender expression; and (3) reauthorization of the Violence Against Women Act (VAWA), providing protections for Native American women, immigrants, and lesbian, gay, bisexual, and transgender (LGBT) individuals.

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See Also: AIDS/HIV Programs; Health Care Delivery, Models of; LGBT Clients.

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National Organization for Human Services

In 1975, the National Organization for Human Services Education (NOHSE) was founded at the Fifth Annual Faculty Development Conference of the Southern Regional Education Board. The mission of the organization was to unite educators in preparing effective human services professionals. In 2005, the organization removed the word *education* from its name and became the National Organization for Human Services (NOHS), with a greater focus on the overall community of human services. In addition to educators, membership now includes students and practitioners.

The mission of NOHS is to strengthen the community of human services by expanding professional development opportunities, enhancing internal and external communications, nurturing the financial sustainability and growth of the organization, promoting professional and organizational identity through certification, and advocating and implementing a social policy and agenda.

NOHS promotes collaboration of all members in the human services community and advocates for social justice. The guiding principles include the beliefs in the capacity of human growth and change while recognizing and utilizing people's strengths and abilities. NOHS supports a holistic approach to wellness including physical, mental, emotional, and spiritual health.

The national organization includes six regional associations. The Mid-Atlantic Consortium of Human Services (MACHS) includes Delaware, New Jersey, New York, Maryland, Pennsylvania, and Washington, D.C. The Midwest Organization for Human Services (MWOHS) serves Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

The New England Organization for Human Services (NEOHS) covers Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Northwest Human Services Association (NWHSA) comprises Alaska, Colorado, Guam, Idaho, Montana, Oregon, Utah, Washington, and Wyoming. The Southern Organization for Human Services (SOHS) contains Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. Finally, the Western Region of Human Service Professionals (WEST) incorporates Arizona, California, Hawaii, Nevada, New Mexico, Oklahoma, and Texas.

Each of these regional organizations operates independently while maintaining an affiliation with the national organization. When members join the national organization, they also become a member of their designated regional association.

In addition to regional associations, the NOHS board of directors approved the establishment of Tau Upsilon Alpha (TUA), the Human Services Honor Society in 2006. Members include students, faculty, alumni, at-large members, and honorary members who are invited to join when they meet the required criteria. For example, students must demonstrate at least a 3.25 GPA for a designated period of time in their human services program. The mission of TUA is to honor academic excellence; to foster lifelong learning, leadership and development; and to promote excellence in service to humanity.

Once a year, NOHS also publishes a national peer-reviewed journal. *The Journal of Human Services*, formerly known as *Human Services Education*, is the leading source of research in the profession and includes articles, brief notes, and critical reviews of scholarly books.

NOHS also provides Ethical Standards for Human Service Professionals to enhance professional decision making. Finally, NOHS collaborates with the Council for Standards in Human Service Education (CSHSE) as the council determines accreditation standards for human services education programs.

Membership to the national organization includes the benefits of a quarterly newsletter, an annual peer-reviewed journal, access to online discussions and job postings, discounts on national conferences, and eligibility for member-only scholarships and grants. Discounted rates are given to student members.

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See Also: *Code of Ethics* of the National Association of Social Workers; Education for Diversity in Human Services; *Journal of Human Services*; National Mental Health Association; Social Workers.

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National Survey of Family Growth

The National Survey of Family Growth is an interview tool conducted seven times since 1973 to gather information on health topics from fertility and family size to cohabitation and contraceptive use. Sponsored by the National Center for Health Statistics, a branch of the U.S. Department of Health and Human Services (HHS), the National Survey of Family Growth is used in the public and private sectors to identify patterns of population growth, inform policy-making discussions, and guide the development of health programs and social services.

History and Uses of the National Survey of Family Growth

The National Center for Health Statistics lists several topic areas that the National Survey of Family Growth addresses, including the efficacy of existing planning, medical, and infertility services, and historical and biological influences on marriage, divorce, and cohabitation. It measures adoption and nonbiological parenting rates as well as sexual health behaviors across categories of race, geography, education level, and socioeconomic status. Social and behavioral scientists use the data from the National Survey of Family Growth to calculate the circulation of health-related goods and services, to detect patterns in human reproductive behavior, and to increase the efficacy of health messages—from fear appeals to food advertisements.

The National Survey of Family Growth was established in 1971 at the National Center for Health Statistics to standardize less-expansive fertility surveys. The survey was conducted five times between 1973 and 1995, each with a national sample of women. The first survey to include samples of both men and women was conducted in 2002, and the survey was in continuous use from 2006 to 2010, with samples of both men and women. The 2006 to 2010 cycle marked the first time the survey was fielded using a continuous design, in which interviews were conducted 48 weeks per year for four years, instead of completing the entire set of interviews in eight to 12 months. In 2011, interviews began for the next continuous four-year cycle from 2011 to 2015. The next public use data file, including data from interviews conducted from September 2011 to September 2013, was planned for release in fall 2014.

Cycles of the National Survey of Family Growth

Each cycle consists of several years of planning and organization. The first two cycles, in 1973 and 1976, conducted an average of 9,500 interviews with married women between the ages of 15 and 44. The next three cycles, in 1982, 1988, and 1995, included all women between the ages of 15 and 44. The sixth cycle, in 1995, again expanded the survey to 12,571 interviews with men and women between the ages of 15 and 44. The continuous survey, begun in 2006, divided the sample into groups and conducted more concentrated and cost-effective interviews with 5,000 men and women between the ages of 15 and 44 each year from 2006 to 2010.

The National Center for Health Statistics produces a researchers' user guide that describes the procedures used by the survey designers and participants in this most recent survey cycle. Using a computer-assisted personal interviewing technique that allows for in-person interviews with laptop computers, researchers conducted 60- to 80-minute interviews in English and Spanish with more than 12,000 women and 10,000 men between the ages of 15 and 44.

The initial cycles, in 1973 and 1976, collected information on a number of topics, including the habits of working pregnant women and the percentage of the labor force made up of pregnant women. Also, they included numbers of wanted and unwanted or unplanned births, expectations of family size at different periods during the childbearing period, and the longitudinal use of family-planning services among married women of various races and socioeconomic statuses. Additionally, the project collected some of the first data on the efficacy of contraceptive use among married women, the habits of breast-feeding mothers for first and subsequent children, and the employment practices of women before, during, and after pregnancy.

The 1976 cycle included some additive contributions to the 1973 cycle, including data on fecundity impairment or unintentional conditions preventing childbirth among married couples. It also allowed for comparisons with the 1973 data for contraceptive use among married, widowed, divorced, and separated mothers, and updated the figures on wanted and unwanted births and subsequent use of family planning services. Last, it developed an extensive demographic profile of teenage wives and mothers.

The 1982 and 1988 cycles of the National Survey of Family Growth again compared findings with the 1973 and 1976 cycles to more longitudinally define pregnancy and family growth patterns. These cycles collected additional data on the timing of first and subsequent prenatal visits as well as acquired immune deficiency syndrome (AIDS)-related behaviors and smoking and alcohol use before, during, and after pregnancy. Results from the subsequent 1995 and 2002 cycles included trends in teenage sexual behavior and condom use among cohabitating men and women.

Finally, the 2006 to 2010 cycles continued to refine the data-collection, interviewing, and survey-administration techniques of the project. Using data collected from these continuous trials, researchers were able to assess the prevalence and efficacy of sex education programs and detect trends in sexual health, most notably a sharp decline in the percentage of never-married teenagers who have had sexual intercourse.

The seven cycles of the National Survey of Family Growth have been influential in the public and private sectors. The National Center for Health Statistics lists 91 journal articles and book chapters that emerged from the 1972 and 1976 cycles, close to 200 journal articles and book chapters from the 1982 and 1988 cycles, and more than 350 journal articles and book chapters from the 1995 and 2002 cycles.

In addition to more than 20 reports issued by the National Center for Health Statistics, there have been 93 journal articles, books and book chapters, and other papers and reports in medical, communication, economics, and sociology journals for the 2006 to 2010 continuous cycles.

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See Also: Family Pregnancy Planning; Family Services; Pregnancy and Parenting Services; Profile of Parenting Study.

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National Urban League

Founded in New York City in 1910, the National Urban League is one of the oldest and largest civil rights organizations in the United States. At the core of its mission is a goal of full economic, education, and political equality for African Americans by facilitating access to housing, health care, employment, and financial management services. Unique among civil rights organizations in the United States, since its founding, the league has been both nonpartisan and biracial. By 2013, the league had chapters in 35 states, and its services directly reach more than 2 million Americans.

Early History

The origins of the National Urban League date back to the first decade of the 20th century, with the founding of the Committee on Urban Conditions among Negroes on September 29, 1910, by Ruth Standish Baldwin, a wealthy widow who was known as a champion of the poor, and George Edmund Haynes, a social worker and the first African American to earn a doctorate at Columbia University. The organization was founded to assist African Americans who had migrated recently from the agrarian south to the industrial north in adjusting to challenging urban conditions. The group's focus was the amelioration of social, economic, housing, and educational conditions for blacks new to living in northern cities.

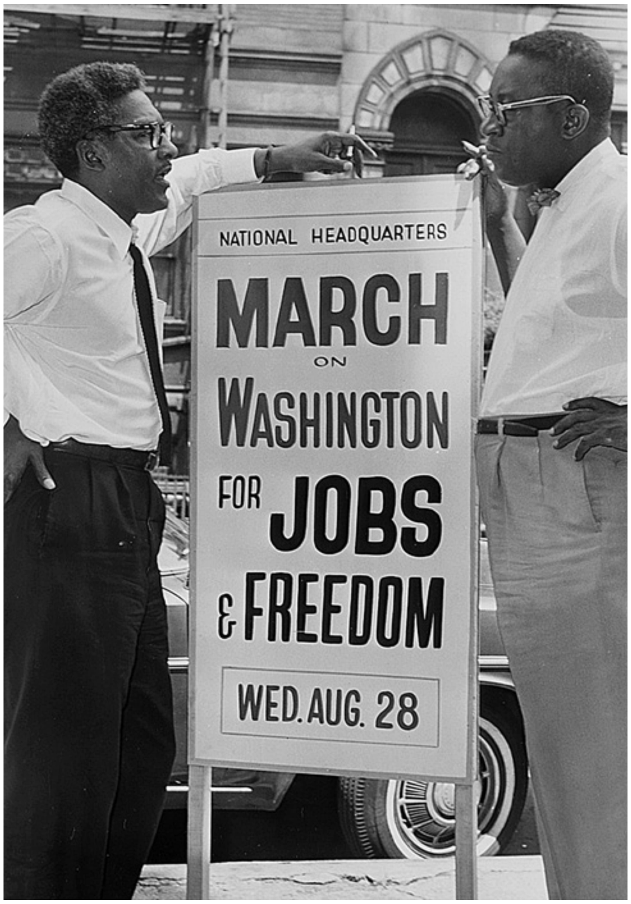
The organization's reach expanded considerably in 1911 when it merged with two grassroots advocacy groups, the National League for the Protection of Colored Women and the Committee for the Improvement of Industrial Conditions Among Negroes in New York; the committee was rechristened the National League on Urban Conditions Among Negroes, which was truncated to the National Urban League in 1920. Its campaigning to improve the living and working conditions of African Americans during World War I allowed the league to grow in size and influence.

During the 1920s and 1930s, under the leadership of Eugene Kinckle Jones, the league led boycotts against businesses that were unwilling to hire African Americans, worked to integrate labor unions, and even lobbied President Franklin D. Roosevelt to include African Americans in New Deal initiatives. The league continued fighting against segregation at the workplace in the 1940s by supporting A. Philip Randolph and Bayard Rustin's March on Washington Movement, which led to the end of racially discriminatory practices in the military with Executive Order 9981 in 1948.

The League and the Civil Rights Movement

Whitney M. Young Jr., a trained social worker and human services provider, took the helm of the league in 1961 and became even more active in the Civil Rights Movement, from facilitating Randolph and Martin Luther King, Jr.'s, planning of the March on Washington in 1963 to engaging community leaders to address local-level issues affecting black Americans to influencing President Johnson's Great Society legislation. Young launched the league's congressional lobbying arm, the National Urban League Policy Institute (NULPI) in Washington, D.C., in 1962. In addition, he instituted a set of apparatus, under which the league's fund-raising capabilities flourished; during his 10 years as executive director, the annual budget increased almost 900 percent, from $625,000 to $6,100,000.

Vernon Jordan, who later would become a close adviser to President Bill Clinton, served as the president from 1971 to 1981, expanding the scope of the league's services to new areas that included conservation and the environment, voter turnout, and expanding professional opportunities for African American women. Jordan also developed the "State of Black America" report, an annual commentary on the economic status of the black community, culled from interviews with scholars, activists, civic leaders, and everyday citizens.



The National Urban League continued fighting segregation in the workplace in the 1940s by supporting the March on Washington Movement. Here, Bayard Rustin and Cleveland Robinson are shown at the March on Washington in 1963.

As urban areas changed over time, so did the agenda of the National Urban League. Addressing the increase in single-parent homes, reducing the rates of teenage pregnancies, eradicating high levels of drug use and drug-related crime, and supporting affirmative action policies were among the top priorities of the league during the 1980s. In 1989, the league partnered with the Coalition to Stop Gun Violence in order to address rising crime rates in

African American communities. All proceeds from the hip-hop single "Self-Destruction," which featured noted rappers Public Enemy, Heavy D, Doug E. Fresh, MC Lyte, Ms. Melodie, KRS-One, and Kool Moe Dee, were donated to support National Urban League efforts in this area. Assuming the mantle of president in 1994, Hugh Bernard Price, an attorney with a background in philanthropy, made education and urban youth empowerment the focal points of his time in office. He also established the Institute of Opportunity and Equality, which conducted research and policy analysis in support of the league's initiatives.

In 2003, Marc H. Morial, a popular former mayor from New Orleans, was selected as the eighth president of the National Urban League. Among Morial's most significant contributions to the National Urban League was the creation of a business incubator, with more than $125 million earmarked for services and resources to support African American entrepreneurs. Mature workers, foreclosure prevention, community health, and financial literacy programs comprised other major league initiatives during the 2000s. By way of NULPI, the league publicly supported a number of policy positions that were considered progressive in their time, including universal health care, reform of government-sponsored enterprise regulations, and the extension of unemployment insurance for all Americans.

Print Media as a Means of Outreach

Beginning with the founding of its scholarly periodical, *Opportunity Journal*, in 1923, the National Urban League utilized a number of printed materials to appeal to its constituents. In addition to the aforementioned "State of Black America" report, the league published *Urban Influence*, an instructional magazine targeted at entrepreneurs of color, and "To Be Equal," a nationally syndicated newspaper column written each week by the organization's president.

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See Also: African Americans; Business Incubator; Equal Opportunity and Civil Rights; Office for Civil Rights; Racial and Ethnic Approaches to Community Health; Voting Rights Act of 1965.

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National Youth in Transition Database

The National Youth in Transition Database (NYTD) is a nationwide data collection system in the United States developed to help gather and track information about independent living services (ILS) provided by states to youth in or transitioned out of foster care. The aims of NYTD are to facilitate the tracking of ILS provided to youth currently or formerly in foster care and to measure the collective outcomes of youth who age out of care. Similar to how data collected for the Adoption and Foster Care Analysis Reporting System (AFCARS) are used to assess young people's status and outcomes while in state foster care, data collected for the NYTD is used to monitor states' performance in preparing youth for transitioning out of foster care into adulthood.

For purposes of the NYTD, states are required to collect and report four types of data on a semiannual (twice a year) basis: (1) information regarding ILS provided to youth previously or currently in foster care; (2) basic demographic characteristics of all youth who received ILS during the reporting period; (3) early adulthood outcomes of selected youth surveyed at ages 17, 19, and 21; and (4) basic demographic characteristics of youth for whom outcome data are reported.

The population of young people in foster care is both racially and socioeconomically diverse. Although child maltreatment is prevalent across all social groups, children of minority race and ethnic groups, particularly children of black or Native American descent, are especially overrepresented in the U.S. foster care system. Supporting young people transitioning out of foster care thus works to promote the safety and well-being of vulnerable young people from predominately minority race and ethnic backgrounds.

Legislative Background

In 1986, the Title IV-E Independent Living Initiative (Public Law 99-272, ILI) was signed into law by President Ronald Reagan, providing federal funding that allowed states to make available ILS for youth in foster care, age 16 to 21. The Foster Care Independence Act (FCIA) of 1999 (Public Law 106-169) improved upon the ILI by establishing the John H. Chafee Foster Care Independence Program (CFCIP) and increasing states' flexibility in serving and supporting youth in their transition out of foster care into adulthood. FCIA redefined eligibility to receive ILS to include any youth likely to remain in foster care until at least age 18, thus removing age restrictions for receiving or participating in ILS programs.

FCIA also required that the Administration for Children and Families (ACF) develop and implement a system for collecting data related to ILS provided by states to youth in foster care. Namely, FCIA requires that the ACF collect data to (1) track the ILS states provide to youth and (2) develop outcome measures that may be used to assess state performance in the operation of their ILS programs. Final rules and regulations regarding NYTD were finalized in 2008. States began implementing data collection on October 1, 2010, and submitted their first reports for the NYTD in May 2011.

ILS Data

In late 2010, states began collecting data regarding the types and extent of ILS provided to youth who are or were previously in foster care. Specifications regarding the type, frequency, and delivery of services provided to youth are left to the jurisdiction of the states. Thus, in an effort to collect more standardized data that may be used to compare across locales, states are asked to report information regarding ILS provided to youth according to the following 11 categories: independent living needs assessments, academic support, postsecondary educational support, career preparation, employment or vocational training programs, budget and financial management, housing education and home management training, health education and risk prevention, family support and health and marriage education, mentorship, and supervised independent living.

Categories were purposely left broad to allow states flexibility in developing and providing their ILS programs. In addition to reporting on services provided, states are also required to identify demographic characteristics of each youth who received ILS during the reporting period, including educational level, sex, and race or ethnicity.

Early Adulthood Outcome Data

Unlike ILS data, states are not required to report NYTD outcome data for all youth in foster care, only youth in foster care who turned age 17 during the reporting period. The first data reporting period began with federal fiscal year 2011, and all 17-year-old youth in foster care who were surveyed during this period will be followed until their 21st birthdays. Outcome data will be reported at ages 17, 19, and 21. States will be required to select a new baseline population of 17-year-olds to survey every three years, with the second group of 17-year-old youth in foster care to be selected for survey in federal fiscal year 2014. Outcome data are to be reported for all youth in the baseline population, regardless of whether they received any ILS during the reporting period.

Similar to the broad categories identified for ILS, states are asked to provide data on youth outcomes according to the following six categories: financial self-sufficiency, educational (including academic or vocational) attainment, connections with adults, housing, engagement in high-risk behavior, and health insurance.

Why Collect Data on Older Youth Transitioning Out of Foster Care?

Decades of research highlight the difficulty that adults with child maltreatment and foster care histories have had in becoming self-sufficient adults. Low levels of educational attainment, unstable and low-wage employment, homelessness, and limited networks of support are well documented, particularly among youth who age out of foster care. One of the most recent and comprehensive studies of youth aging out of care, known as the Midwest Study, began in 2002 and followed youth from age 17 through their mid-20s. Study findings indicated low educational attainment, housing instability, and difficulty in finding and maintaining gainful employment among many study participants.

The John H. Chafee Foster Care Independence Program was established to confront the growing evidence of young people out of foster care faring poorly in adulthood, especially upon aging out of care. The NYTD is one strategy that aims to increase more positive outcomes among youth who age out of foster care by helping document existing supports and services provided to youth in care and highlight areas where additional services are needed.

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See Also: Adoption and Foster Care Analysis and Reporting System; Children in Foster Care; Fostering Connections to Success and Increasing Adoptions Act of 2008; John H. Chafee Foster Care Independence Program.

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Native Americans

Historically, behavioral and mental health providers, counselors, and psychological services practitioners working with Native American populations in the United States have been apt to impose predominant Western values. Often met with resistance and seen as ineffective, mainstream methods and therapies have largely been Eurocentric and monocultural. Simply put, standard methods of treatment and intervention for the culturally different have been viewed as insensitive, alienating, and disparaging—if not altogether harmful—to minority groupings.

Given that there are more than 500 federally recognized tribes in the Unites States, blatant disregard for the differentness of the American Indian experience has led the varying helping professions to better recognize the need for culturally proficient and competent professionals. That is, the respective fields have begun to better recognize the diversity and variation of both lived and generational experiences that may negatively impact Native Americans. These include group psychological trauma from forced migration, discrimination and cultural isolation, as well as racism and societal oppression—each of which may perpetuate and contribute toward individual anguish, grief, and psychological distress as well as indigenous collective community suffering.

Indigenous Healing Versus Eurocentric Helping

Over hundreds of years, many American Indians grew wary and distrustful of government interference due to historical experiences largely stemming from forced migration from sovereign homelands in the Indian Removal Act of 1830. In one well-documented event, government-sanctioned troops forcibly removed thousands of Cherokee Indian families from their homes in the middle of winter without warning and no time to gather belongings—many with just the clothes on their backs. These tribes left belongings, livestock, and family treasures, all of which were left for white looters from the Deep South ready to occupy their fertile lands. This forced removal cost Indians thousands of lives lost due to exposure, disease, and starvation along the months-long journey to government-sanctioned settlements west of the Mississippi. Along the way, children were born, and the displaced who perished were buried in makeshift graves without time for either tribe or family members to pay respects or grieve, as they were forced to keep moving toward new tribal settlements in Oklahoma in what has been called the Trail of Tears. Though this was the plight of the Cherokee tribe, other so-called civilized tribes also experienced similar events of forced migration and subsequent loss of lives, property, and native lands—as well as emotional trauma inflicted.

After many months up to a year of treacherous travel, as tribes settled in new lands, Westerners attempted to acculturate indigenous tribes with Western values and ways of living. American Indians strongly resisted all Western influence as interference. As a people, many American Indians, still reeling from loss of homeland and family, were dealing with deep pain and experiencing feelings of loss, grief, depression, and a sense of helplessness. Though many Westerners were sincerely pained and sympathetic to the plights of the tribes' forced removal and subsequent mental anguish and genuinely desired to assist, their Westernized attempts at healing American Indians' psychic pain were often in stark contrast with American Indians' traditional ways of healing.

Native American storytelling is believed to heal through the native storyteller making peace and meaning through the revealing and telling of his or her story. Here, Dia Molnar, a Navajo woman, tells the history of the Navajo nation.

Spiritual Wellness Versus Mental-Illness Approach

From the outset, well-intentioned nonnative treatment methods of healing and Native American ways of dealing with trauma were often in direct opposition. Western methods included diagnosing and treating symptoms and maladies with talk therapies and prescribed antidepressants. American Indians' ways of healing were centered primarily on herbal remedies, deep meditation, and narrative storytelling. Many American Indians were also deeply suspect and spurned Western practices and treatment as they did not want to be diagnosed altogether or were distrustful of Western medicinal therapies. Generally speaking, American Indians were more apt to rely upon each other within the tribe and trusted their own tribally distinctive indigenous methods (e.g., talking circles or healing ceremonies) to address the ailments that plagued them.

As Native Americans settled into new tribal territories, some American Indians yielded more readily to Western influences and vices such as alcohol and illicit drugs—perhaps finding temporary solace and relief from emotional pain. However, many were also soon mired in the throes of addiction, notwithstanding their pain, grief, and loss itself were both unresolved and at times intensified through self-aggression, violence toward others, and criminal acts perpetrated upon their own native peoples. Addiction and related negative consequences such as domestic violence and an increase in suicides and posttraumatic stress disorder (PTSD) among the Native American population were seen by some as direct evidence of intrapsychic pain unaddressed altogether or spiritually unhealed.

Storytelling Versus Talk Therapy

Western ways of healing through psychological services often include talk therapy, which typically involves an ongoing dialogue between therapist and client and is often therapist directed. The therapist leads the session by asking questions of the client, whose answers may bring follow-up questions and so forth. In contrast, Native American storytelling is narrative in nature, and it is believed to heal the afflicted through the native storyteller him- or herself making peace and meaning through the revealing and telling of their story. Traditional Western therapies were often viewed in direct contradiction to narrative storytelling. By way of generalization, many clients access traditional therapies through insurance and are bound to the counseling parameters established. Additionally, cost and accessibility issues often deter Native Americans from seeking services. Furthermore, some insurers will reimburse only for certain types of therapies; for example, cognitive behavioral therapy or solution-focused brief therapy, which often begin and conclude in six to eight weeks' duration. Thus, traditional Westernized therapeutic techniques may at times be seen in conflict with narrative storytelling because storytelling is client centered, allowing the client storyteller to reveal the story at his or her own pace and time or place so as to derive meaning, clarity, and healing from the recounting of the story.

Modern Practices to Address Group Psychological Trauma

Familial accounts and stories of relatives' forced removal and acculturation have been passed down through the generations to present-day Native American families, along with resultant residual anger, resentment, and pain and grief. In an attempt to gain a deeper understanding of the Native American experience, it is necessary for those working with Native American clients to acknowledge lived personal, familial, and collective trauma experienced. Feelings of shame, governmental distrust, and helplessness may emerge and linger as American Indian ancestors attempt to make sense of the injustices experienced by elder generations. Furthermore, practitioners should not lose sight of ongoing and continuing discrimination and cultural isolation as well as racism and societal oppression that may be ever present for Native Americans who seek psychological help. Simply put, novel methods of treatment and intervention for Native Americans as culturally different clients include utilization of Historical Trauma Theory as well as the practitioner being sensitive to and aware of the need to view each client as expert about his or her own family and culture, generationally transmitted attitudes and beliefs, and lenses from which they see and experience the world—so as to weave indigenous healing, spiritual, and storytelling methods should they be welcomed by Native American clients with whom they come into contact.

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See Also: Acculturation; American Indian Movement; Cultural Competence, Model of; Ethnocentrism and Ethnorelativism; Help-Seeking Behavior, Cultural Differences in; Tribal Social Services.

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Native Americans, Suicide Among

Native Americans, sometimes identified as American Indian or Alaska Natives, are a racial group that contains people having origins in any of the original peoples of North America, South America, and Central America, maintaining tribal affiliation or some level of community attachment. According to the 2010 U.S. Census, approximately 3 million people reported their sole race as Native Americans, and 2.3 million people reported their race as combined Native American and one or more other races.

These current numbers indicate a shift from the census in 2000, where 2.5 million people reported their sole race as Native American and 4.1 million people reported their race as combined Native American and one or more other races. With a combined total of approximately more than 6 million people, Native Americans make up about 2 percent of the U.S. population. There are currently 566 federally recognized Native American tribes in the United States and more than 100 state-recognized tribes. There are also active tribes that exist without any state or federal recognition. Although many perceive Native Americans as residents of remote reservations, separated from the rest of America, the majority live in urban areas; only about one-third live on reservations and tribal trust lands.

Suicide Statistics in the United States

There are more than 38,000 deaths by suicide each year, averaging about 100 per day in the United States. Within the general U.S. population, suicide is the tenth-leading cause of death. However, among Native Americans age 15 to 34 years, suicide is the second-leading cause of death. Native Americans within this age group are 2.5 times higher than the national average to commit suicide. Young Native American males have the highest rates of suicide compared to other Caucasian, African American, and Asian or Pacific Islander males of the same age group. The suicide rate among Native American adults grew 65.2 percent in the beginning of the 21st century. The rate of suicide grew overall to 18.5 percent in 2010, which is the largest increase of any racial or ethnic group in the United States.

Contributing Factors

The percentage of Native American adults living in poverty was among the largest compared with other racial or ethnic groups. Native American youth age 12 to 17 years and adults age 18 years or older had the highest prevalence of smoking compared with other racial or ethnic groups in the United States. Native American mothers had the second-highest infant death rate compared with all other mothers. Native American adults who owned or rented housing more often lived in inadequate and unhealthy housing compared with white adult householders. Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes mellitus are leading causes of deaths in Native American communities. Overall, Natives Americans who are born today have a life expectancy that is 4.1 years less than all races in the U.S. population. The overall health (physical and mental) of Native American communities has improved over the last few decades with advances in health care practices, medical advancements, and increased healthy behaviors. However, when compared to the nonminority population in the United States or with other racial and ethnic minority groups, Native Americans' health still remains poor compared to the rest of the United States population. For many health indicators, Native Americans have the poorest health and greatest health disparity of any population in the nation.

As with other populations, contributing factors that lead to suicide among Native Americans are previous suicide attempts, history of mental disorders, history of alcohol and substance abuse, family history of suicide, family history of child maltreatment, feelings of hopelessness, impulsive or aggressive tendencies, barriers to accessing mental health treatment, and loss (relational, social, work, or financial). For Native Americans, loss also includes loss of land and cultural practices. In addition, Native Americans also experience higher rates of exposure to traumatic events coupled with the overarching cultural, historical, and intergenerational traumas, which make this population more vulnerable to post-traumatic stress disorder (PTSD) resulting in suicide.

"Historical trauma" is the term used for the idea of the collective emotional and psychological harm over a person's life span and throughout generations. It is the result of systematic internalized oppression. Historical trauma can be experienced as a prolonged experience (as in removal or relocation), as a cumulative effect (individual or community violence), or as a personal event that continues its impact over several generations (denial of education or boarding school). Some researchers distinguish historical trauma from multigenerational trauma, which is unresolved trauma that has been passed from previous generations to the next.

Suicide Prevention and Treatment Efforts

The most effective way to generally prevent suicide is to recognize risk factors and know how to respond to warning signs. All warning signs of suicide should be taken seriously, and professional help should be sought when warning signs are present. In the United States and other countries, suicide is usually viewed as a reaction to an individual's psychological pain, such as depression.

The prevention and treatment process under this approach is to psychologically or medically intervene using traditional Western models. For instance, Western practices treat depression with psychological counseling or pharmaceuticals, trusting that such interventions will lower the risks associated with suicidal behaviors. Unfortunately, these types of interventions might have limited impact in Native American communities. Local customs and historical viewpoints may view suicide as the result of historical traumas, oppression, social injustices, or the loss of Native American sacred ways of life and living.

While there are differences of opinion regarding best suicide prevention practices within Native American communities, established practices require some kind of adaptation process prior to implementation with Native American clients. For instance, some Native American communities may view the problems of alcohol, drugs, smoking, suicide, and overall poor health as the result of their community losing their traditional, sacred ways and being forced into European lifestyles.

Using a standard medical model to treat a psychological problem rather than approaching this as a historical problem would seem an illogical best practice. Partnering with community members to better understand local worldviews and traditions paves a way to best practices when working with Native American clients. Practitioners could adapt evidence-based therapies, such as trauma-focused cognitive-based therapy, to the specific community as well as integrate traditional ways of knowing and language into their practice. Professional practices should be grounded and offered in the social context of each unique community.

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See Also: Alaska Natives; American Indian Movement; United Nations Declaration on the Rights of Indigenous Peoples.

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Natural Disasters, Services for

Natural disasters occur frequently and impact significant portions of the population each year. When these disasters occur where people live, there is a human toll leading to emergency needs. Disasters often place people in a situation where they are unable to provide for their necessities, or where they have such significant needs that, without help, they are going to experience physical, emotional, or economic decline. In the United States, an impressive network of service providers has been developed to help individuals recover from, and adjust to, the losses they have experienced in disasters. There is often overlap between those who provide services after a natural disaster and those who are there to help after man-made disasters. The service needs of individuals will depend on the scope of the natural disaster and the time frame after the disaster.

The array of natural disasters is broad and can include weather-related hazards and events, wildfires, earthquakes, tsunamis, landslides, sinkholes, and nonweather floods such as from a dam break. Loss of life, physical injury, emotional injury, damage to property, and loss of income are among the kinds of losses that can result from a natural disaster. The human services provider network available to meet the needs of those impacted by natural disasters is extensive, and many parts of this network respond to the needs of individuals, depending on the response phase to the natural disaster.

The first phase is the period when there is the opportunity to save lives and deliver emergency medical care. Those often referred to as first responders are the initial human services providers on the scene of the natural disaster. The need for medical care due to injuries or from ongoing medical issues is one of the most urgent issues following a natural disaster. This may follow rescues from the midst of the disaster. Police, firefighters, and emergency medical technicians (EMTs) are the first responders often first to arrive on the scene. They assess the situation and call for the kinds of additional help needed. People might have to be plucked from flood waters or from the roof of a building partially submerged in water. Earthquakes give rise to attempts to rescue those who may be caught in rubble. If specialized rescue crews are needed, those making early assessments will call for additional help.

The images from the aftermath of Hurricane Katrina are still vividly in the minds of those who viewed the countless scenes of those being plucked from roofs or from the flood waters. Individuals had put together different kinds of calls for help on their roofs and when rescued showed how much they appreciated those who had themselves risked their lives to come and rescue them. National guard troops often respond during this phase as

With its vast network of volunteers, partnerships, and resources, the American Red Cross (ARC) is positioned to offer almost immediate help when victims of natural disasters are present. Here, U.S. Navy, Royal Dutch, and Mexican sailors work alongside ARC personnel to hand out water, food, and relief supplies to residents in Biloxi, Mississippi, following Hurricane Katrina in 2005.

well. Nonemergency medical professionals also make themselves available in disaster settings. They are able to provide medical triage services and supplement the work of EMTs. All of these first responders provide service that is essential to save lives. People impacted by the disaster also begin to receive from these first responders the first emotional support that is so critical for survivors of natural disasters.

The second stage of recovery from a natural disaster can be described as disaster relief. In this phase, survivors begin to reorient themselves. Survivors will need to know that the necessities of life will be available for them. These individuals may have to travel great distances to find help, depending on how geographically widespread the disaster is and what resources are available in the vicinity. They will often need help finding a place to live. This may involve temporary shelters. Food will be an issue. It is in this phase of recovery that the human services provider network begins to exhibit its strength.

When the term *natural disaster* comes up, we often think immediately of the role of the American Red Cross (ARC). With its vast network of volunteers, partnerships, and resources, the ARC is positioned to offer almost immediate help when victims of natural disasters are present. This organization is known for setting up temporary shelters to aid those who have permanently or temporarily lost their homes. The ARC has preexisting agreements with many organizations that have buildings capable of housing people. The Red Cross is able to go into these buildings and set up shelters when there is a need. These shelters become avenues for a vast array of services available to survivors of natural disasters. In addition to a place to sleep, food is provided. The ARC also has agreements with organizations like Southern Baptist Disaster Relief to provide meals for its shelters and for distribution in disaster settings. Red Cross emergency response vehicles (ERVs) deliver meals into areas where people may still be in their homes but are left with no way to prepare food.

ARC shelters, as well as other kinds of shelters, also provide emotional support for survivors. Trained counselors and social workers are made available to help those who have faced the trauma of a natural disaster. These trained professionals are able to engage those who may be experiencing grief, post traumatic stress, and other emotional issues. In addition to professionals, ARC volunteers are often trained to be able to give basic emotional support. This is important because there may not be enough professional counselors available. Referral services are made available to those staying at these shelters. Information is made available so that people know where they can go to apply for food stamps, help from the Federal Emergency Management Agency (FEMA), and other assistance.

Hundreds of religious and nonprofit organizations around the country will make their presence known in the wake of natural disasters. These groups provide a wide variety of service to individuals and families. Among the help provided is food distribution, cutting and removal of downed trees, removal of mud and ruined household items from homes, emotional and religious support, assessment of damaged homes, and child care for residents who may need help with their children in a disaster setting.

After the initial rescue phase and when the immediate necessities of life have been arranged, individuals are ready to begin the recovery phase. During this phase, people begin to make decisions about how they will put their lives back together. One of the major concerns is the necessity for permanent housing, but there are other important issues as well. Many organizations will provide case management services to individuals and families. Case managers are trained to help people address the issues they face and to be able to find resources that may help them deal with these issues. This may mean referral for counseling, government benefits, volunteer help, or a myriad of other kinds of aid. Some organizations specialize in rebuilding homes. Some of these rebuilding entities provide the volunteer labor and some provide materials and labor. Case managers help survivors find the help they need.

Those offering services must be sensitive to the culture of those in need of help after a natural disaster. Care should be taken to respect the sensibilities that may characterize a group impacted. In addition to providing language-appropriate guidance, helpers should familiarize themselves with cultural norms, taboos, and food traditions.

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See Also: Case Management Services; Childhood Trauma; Crisis Services; Displaced Persons; Information and Referral; Legal Services; Temporary Aid to Needy Families; Trauma-Focused Services.

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Naturalized Citizens

The United States is a nation of immigrants. As a result of the immigration reforms since 1965, immigration to the United States has continued to rise. According to the U.S. Bureau of the Census, the foreign-born population in 2010 stood at nearly 40 million or accounted for 13 percent of the total U.S. population. About 83 percent of the foreign born hailed from Latin America and Asia. The majority (roughly 56 percent) of the foreign-born had not become U.S. citizens at that time. Over time, most immigrants will go through the naturalization process to become naturalized citizens. The decision of immigrants on naturalization can have significant impact on their lives, their family members, their communities, and society as a whole. This entry defines naturalized citizens, outlines requirements for naturalization, discusses the benefits and costs of naturalization, and highlights the determinants of naturalization. The information provided here could be very useful for those who plan to become a naturalized citizen and anyone who wants to understand the naturalization process. The emphasis is on the United States, but with some modifications, the information may be pertinent to some other nations as well.

Who Are Naturalized Citizens?

There are two ways to become citizens of a nation: by birth or through naturalization. In the United States, one can automatically acquire U.S. citizenship by birth within the jurisdiction of the United States or in the territories or outlying possessions of the United States, including Puerto Rico, the Panama Canal Zone or Republic of Panama, the U.S. Virgin Islands, and Guam. This is referred to as birthright citizenship. Birthright citizenship can be acquired by *jus soli* (i.e., born in the United States) or *jus sanguinis* (i.e., born to one or both parents who are American citizens on foreign soil).

One can also become a citizen of a country via naturalization. Naturalization is the process through which a foreign citizen or national acquires the citizenship of a host country. Thus, naturalized citizens are citizens who were born in foreign countries but acquire the citizenship and nationality of the host country through the process of naturalization.

Requirements for Naturalization

Certain conditions must be met before immigrants can become citizens of a host society. In the United States, there are five general requirements for naturalization. One is the age requirement. Naturalization law generally requires an immigrant to be 18 years of age or older. However, minor children of naturalized U.S. citizens can derive U.S. citizenship through their parents. Another is the residence requirement. Normally, a permanent resident must have resided continuously in the United States for at least five years after admission to permanent resident status in order to be eligible for naturalization. Out of the five years, the applicant must be physically present in the United States for at least 30 months. The length of continuous residence can be shortened to three years for a spouse of a U.S. citizen. The periods of residence and physical presence may not apply to military members and certain military family members.

The third general requirement is good moral character or character that measures up to the standards of average citizens of the community in which the naturalization applicant resides. The English and civics requirement is another requirement. In general, the applicant must be able to read, write, speak, and understand English and have knowledge and an understanding of U.S. history and government. Finally, the attachment to the U.S. Constitution requirement requires an applicant to attach to the principles of the U.S. Constitution and be well disposed to the good order and happiness of the United States during all relevant periods under the law.

Benefits and Costs of Naturalization

Citizenship grants immigrants certain political, civic, and social rights and privileges to which permanent residents are not entitled. One of the most important privileges of citizens is political rights, namely, the rights to vote and run for public office. Only U.S. citizens are able to vote in all elections and therefore to influence political decisions and outcomes at the national, state, and local levels, which may have bearings on their lives. As naturalized citizens, immigrants can run for any public office except that of president and vice president.

It is a widely held belief that many immigrants primarily pursue naturalization not for political rights but for immigration benefits accompanying U.S. citizenship—easier and faster immigration of their relatives to the United States. Under the U.S. immigration system operating from 1965 to 1991 and the current immigration system created by the Immigration Act of 1990, permanent residents can only sponsor their spouses and unmarried children as immigrants within a numerically limited category (the second preference or the second preference of family-sponsored immigrants). On the other hand, citizens can sponsor not only their immediate relatives with no numerical restriction but also their unmarried or married adult children and their siblings. The earlier the immigrants become citizens, the shorter the waiting time for their relatives to immigrate.

A third significant advantage of acquiring U.S. citizenship is the qualification for a U.S. passport. A U.S. passport is often considered the most desirable to possess. It confers U.S. citizens worldwide protection of the United States, and it makes travel abroad easier. For immigrants who want to travel abroad, U.S. citizenship is certainly attractive.

Access to broader life opportunities is another naturalization benefit. Although citizens and permanent residents now enjoy similar opportunities in employment and education, certain restrictions do apply to noncitizens. For instance, certain government jobs (e.g., some jobs in federal government agencies, bureaus, think tanks, and many public safety positions with state and local governments) and certain private sector jobs, such as defense contractors, require U.S. citizenship. As a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, most legal immigrants are no longer eligible for publicly funded services such as Medicaid for the first five years of residence, supplemental security income, and food stamps, but U.S. citizens can still enjoy those benefits of welfare assistance. Noncitizens who retire abroad are denied full Social Security benefits. Some educational opportunities, loans, and fellowships (e.g., Rhodes Scholarships, Fulbright Graduate Study Abroad Program and Fulbright Teacher Exchange Program, White House Fellowship Program, all National Science Foundation Fellowships, and all Ford Foundation Fellowships) also require citizenship. Naturalization qualifies immigrants for those jobs, programs, and fellowships for which citizenship is a prerequisite. It offers immigrants important avenues of economic and social mobility.

There are other kinds of convenience provided by citizenship. For example, immigrants will no longer have to carry their alien registration cards or notify the United States Citizen and Immigration Services (USCIS) of their addresses. Citizens can also participate in a jury. It should be noted that, while the value of citizenship in political rights, immigration benefits, and international travel has remained stable over the past several decades, the specific marginal value of citizenship in the sphere of civic and social rights has changed over time.

Citizenship also entails costs. These costs include at least four types: (1) increased citizen obligations in the host country, which, in addition to universal obligations of all residents such as paying taxes and obeying laws, include the responsibilities to participate in the political process, to uphold the Constitution, to serve in the military if necessary, and to remain loyal to their adopted country during wartime; (2) lost or reduced political, civic, and social rights previously enjoyed as nationals in the country of origin; (3) voluntary renunciation of their former nationality and of allegiance to their native land through oath, which in some sense can be considered as a psychological cost; and (4) the actual input in a long, complicated application process. As mentioned earlier, to obtain U.S. citizenship, a minimum of five years of continuous residence in the United States is required, and applicants must also have resided for six months in the state where

Once the residence requirements are met, applicants have to file their applications; do fingerprinting; go through an interview in order to meet the language, civic, and other requirements; and attend a ceremony. Candidates for U.S. citizenship recite the oath of citizenship during a naturalization ceremony at Naval Air Station, Sigonella, Sicily, Italy.

they file their petitions. Once the residence requirements are met, applicants have to file their applications; do fingerprinting; go through an interview in order to meet the language, civic, and other requirements; and attend a ceremony. Applicants are also charged a fee. Some immigrants do not bother to apply for citizenship because they either find the naturalization procedures too complex or are afraid of the examination.

Determinants of Naturalization

Why do immigrants become naturalized citizens of the host country? Or what factors determine or explain immigrant naturalization? Built on previous works, in 1994 Philip Yang put forward a comprehensive framework called contextual perspective, which incorporates immigrants' individual characteristics and larger social contexts in the country of origin and the country of destination to explain the likelihood of citizenship acquisition. A number of hypotheses derived from this framework were proposed for testing. Specifically, poorer economic conditions and lower standards of living in the home country, tighter political control in the home country, an origin from a refugee-sending country, cultural similarity between the home and host country (e.g., use of the same language, common history, or similar traditions), and recognition of dual citizenship by the country of origin encourage immigrants to take root and become naturalized citizens of the host country, while proximity of the home country to the host country reduces the likelihood of naturalization.

A larger immigrant community from the same country of origin and greater urban concentration of an immigrant population in the country of destination also facilitate the naturalization of immigrants. The better the immigrants' cultural and economic adaptation to the host society, the more likely the immigrants are to naturalize. In addition, several demographic variables such as age at immigration, gender, marital status, presence of minor children, and service in the U.S. Armed Forces also influence the likelihood of naturalization.

The framework and hypotheses were tested for a cohort of immigrants using the Public Use Microdata Sample data from the 1980 U.S. Census with appended records of the countries of origin. The results show that economic, political, social, cultural, and geographical conditions in the country of origin, and immigrants' ethnic communities and urban concentration in the country of destination, to a large extent influence immigrants' propensity for naturalization and that, net of the contextual factors, many of the immigrants' adaptation and demographic characteristics are also significant predictors of citizenship acquisition. Notwithstanding some refinements later, Yang's analytical framework has remained to this date the most influential model that predicts immigrant citizenship acquisition.

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See Also: Immigrant Population, Human Service Needs of; Immigration Law, History of U.S.; Immigration, Human Services Issues; U.S. Citizenship and Immigration Services.

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Neighborhood Reinvestment Corporation

The Neighborhood Reinvestment Corporation (NRC) is affiliated with the National Housing System (NHS) and was established by Congress in 1978 to carry out the work of the Urban Reinvestment Taskforce. The organization focuses on promoting reinvestment in older neighborhoods by working with financial institutions, residents of the community, and the local government.

However, this initiative by Congress was not a new one but can be traced back to a campaign by residents for better housing in Pittsburgh, Pennsylvania's, Central North Side neighborhood. NeighborWorks, an affiliation of NRC, was created when the Ad Council joined with Neighborhood Reinvestment to build a new face for NHS. Today, NRC works in conjunction with NeighborWorks to revitalize communities through residential leadership initiatives that focus on organizing communities, strengthening neighborhood associations, developing resident leaders, and building capacity in communities. It targets not only populations of need such as first-time homeowners and minorities and low-income households, but also geographic areas of need. Private investments, practitioner training and innovation, and homeownership creation are trademarks of NRC.

History and Development

The groundwork for NRC began in 1968 and is tied to the work of Dorothy Mae Richardson, a community activist who worked with her block club to improve her neighborhood. Their efforts garnered revolving loans from financial institutions and resulted in the birth of the NHS. The Federal Home Loan Bank (FHLB) also provided training to savings-and-loan officers across the country and evolved into workshops for the starting of other neighborhood housing services organizations.

The Development of NHS can also be linked to President Richard Nixon and the Department of Housing and Urban Development (HUD). In order to soften an impending moratorium on federal housing programs, an agreement was made with FHLB to expand NeighborWorks in the United States. This initiative was coordinated by a specially created Urban Reinvestment Taskforce; funding and staff were provided by HUD and FLHB, respectively. Later, the partnership was expanded to include the Federal Reserve, the Comptroller of Currency, and the Federal Deposit Insurance Corporation (FDIC). However, despite combined efforts of these agencies, the network's effectiveness and further expansion was threatened by limited access to funding. This triggered the enactment of the Community Development Block Grant (CDGB) by Congress.

Home Ownership Creation: Private Investment and Practitioner Training

In the early years, much of the work of NRC was centered on perfecting core services for owner-occupied housing in the initially targeted neighborhood. This included helping residents with referrals to reputable contractors, with follow-up inspections to assure work quality; providing counseling and assistance in work-related financing; and referrals to participating financial institutions for credit-worthy clients. Local organizations were forced to reorganize their strategies through expansions in other neighborhoods and through adaptation of new programs. For example, NRC staff worked to promote home ownership and revitalize apartment buildings and shopping areas that were run down. They also provided training in home construction for youths without jobs. NRC was beginning to look like a formidable organization with long-term goals that focused on neighborhoods in need.

However, in the 1980s, the network organizations were threatened by inflation and a sharp decline in state and federal resources. Fewer residents were able to participate in banking, loan funds were exhausted, and even raising operating funds became a challenge. This led to the incorporation of private investment, practitioner training, and other innovative measures. For example, NRC partnered with selected insurance companies, testing out new insurance products and marketing strategies and securing millions of dollars to expand lending through the network. Local organizations garnered public support in areas such as major in-fill housing and owner-built homes. The organization's efforts did not go unnoticed; in 1984, they were recognized as a part of a national network in the first Congressional proclaimed NeighborWorks week.

In an effort to stay afloat, some local organizations looked at the practicality of adapting the European concept of mutual housing to American neighborhoods. Mutual housing is a variation of the cooperative housing model. It provides reliable affordable housing for a community's long-term renters. Single-room occupancy and transitional housing projects were also used to help ease the problem of the country's growing homeless population. Training institutes provided professional training opportunities and helped executive directors, board members, and key staff members to keep abreast of the challenges of revitalizing neighborhoods. Another aspect of achievement was the network organization confirming its financial stability as it partnered with residents, government officials, and businesses. NRC also attracts investments from national financial partners. In order to harness the investment, NRC developed new strategies in areas such as homeownership, asset management, community organizing, resident leadership, and access to affordable financing and insurance products. NRC is also responsible for the launching of RNA Community Builders, Inc., an alliance of NeighborWorks organizations. These corporations focus on identifying creative ways of addressing rural housing concerns, with special attention being given to garnering resources for rural development.

In the 1990s, NeighborWorks launched a campaign for homeownership, a need that is evident in high poverty areas. This venture grew to evolve into a network of organizations assisting thousands of families into homeownership and attracting more than a billion dollars in total investments. Strategies focusing on full-cycle lending, a comprehensive system of pre- and post-purchase buyer education and flexible financing products, were developed. Customers were also offered services and training in regards to locating, purchasing, rehabilitating, insuring, and maintaining a home. While the NeighborWorks system is viewed as an innovative and effective force in revitalizing America's urban, suburban, and rural communities, it is believed that it lacks measures that focus on changes or outcomes in the lives of those it assists.

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See Also: Community Development Block Grants; Fair Lending Practices; Neighborhood Watch Programs; Primacy of Place.

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Neighborhood Watch Programs

In 1972, the National Sheriff's Association started the Neighborhood Watch program to promote citizen involvement in preventing crime in their respective neighborhoods. Although a similar Town Watch program was active when night watchmen patrolled the streets during the Colonial period, the concept was revitalized in the late 1960s in response to an increase in reported burglaries in suburban communities and rural areas of America.

Initially, the program focused on educating people about how to secure their homes to make them less vulnerable to burglary. In the coming years, the scope of the program grew to include engaging and empowering citizens to report suspicious or criminal activity to law enforcement as a way to prevent crimes. As a volunteer neighborhood organization, Neighborhood Watch encouraged communication with neighbors and law enforcement to prevent crime and to increase community safety but discouraged direct confrontation or action against a person thought to be committing a crime. Today, volunteers are still instructed not to directly intervene to stop criminal activity but to immediately call the local law enforcement agency and report their concerns.

In 2002, when USAonWatch was established by President George W. Bush, it resulted in the further expansion of Neighborhood Watch programs to one that supported Homeland Security endeavors to detect and prevent acts of terrorism. Three years later, after a series of devastating hurricanes struck the Gulf Coast in 2005, the program again grew to include emergency response and disaster preparedness activities. The success of these local ventures has resulted in an increase in the number of Neighborhood Watch programs nationwide. At present, there are a number of watch initiatives, such as business watch, crime watch, and block watch, that are recognized by USAonWatch and considered integral in preparing communities to use an all-hazards approach in preparing for all types of human-made and natural disasters.

Starting a Neighborhood Watch Program

Neighborhood Watch programs are typically started by people who are interested in improving or maintaining the safety and security of their neighborhood. Initial meetings usually include educating people about the mission of watch programs; prioritizing issues of concern; describing possible activities; identifying the geographical reach of the designated watch area, such as a residential subdivision, an apartment complex, or homes governed by a homeowners association; and developing a telephone calling tree and e-mail contact list. These methods of contact are used to enhance and expedite communication among watch members and law enforcement. To provide program support and begin an ongoing dialogue, a local law enforcement officer is assigned to serve as a liaison to the group.

Structure of Neighborhood Watch Programs

Most law enforcement agencies have a sworn officer who is designated as a crime prevention officer. The role of the crime prevention officer liaison is to facilitate the education process, assist in watch program organizational efforts, and work closely with the watch coordinator and block captains. The watch coordinator is responsible for ongoing communication with the law enforcement liaison and keeps the block captains of the group advised of new information pertaining to neighborhood crime, safety, and quality of life.

Block captains assume responsibility for interacting with the neighbors on their respective streets, blocks, or buildings. They provide information and organize meetings with the block residents to address concerns, implement watch activities, and set up a telephone, e-mail or personal chain of contact for use in an emergency to keep people informed of critical information in a timely manner.

Block watchers work closely with captains to maintain up-to-date contact information for residents and to foster involvement of block residents in the Neighborhood Watch program. Leadership teams that are comprised of active watch coordinators, block captains, and block watchers are necessary for initiating and sustaining successful Neighborhood Watch programs.

Neighborhood Watch Program Activities

All citizens are encouraged to establish or join a local Neighborhood Watch program. In partnership with local law enforcement, programs are formed with the goal of increasing the safety and security of home and community. The diverse activities carried out by watch groups vary significantly from neighborhood to neighborhood. For example, a rural community located in a flood zone may elect to focus on disaster preparation and response as well as home safety, while an urban program might work to educate residents about common crimes and empower residents to take appropriate action. Neighborhood Watch activities are selected that reflect the desires of the participants and the needs of the community.

Many states have statutes in place to protect citizens who participate in Neighborhood Watch programs. Neighborhood Watch volunteers do not have police powers; any action on their part is considered an act of a private citizen, and the appropriate state laws apply to their actions. The local law enforcement liaison covers the types of protection offered by the state and describes appropriate responses to suspicious or criminal activity. Suspicious activity is anything that appears abnormal or uncommon to the neighborhood. This may include illegal activities, unusual persons or vehicles, or dangerous incidents.

An emphasis of the Neighborhood Watch program is to increase interaction between neighbors as a way to keep property and communities safe and secure. Effective Neighborhood Watch programs are valuable allies for local law enforcement agencies in preventing crime. Most agencies have limited resources that make it impossible to have a constant physical presence in all neighborhoods. Neighborhood Watch programs provide eyes, ears,

Community members review information about the Citizens Corps Neighborhood Watch program after a community meeting. All citizens are encouraged to establish or join a local Neighborhood Watch program. In partnership with local law enforcement, programs are formed with the goal of increasing the safety and security of home and community.

and boots on the ground by the people who know the neighborhood best.

Over the years, Neighborhood Watch programs have developed into an effective, proactive crime prevention tool for communities of all types. In recent years, activities have expanded to include an all-hazards approach for preparing and responding to natural and human-made disasters. The program provides guidance for people who want to work with neighbors, law enforcement, and other community organizations to plan and implement a range of activities that enhance the safety, security, and quality of their neighborhoods and communities.

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See Also: Abduction; AMBER Alert; Community Organizing; Gangs: Social Issues and Intervention; Homelessness: Interpersonal Violence; Natural Disasters, Service for; Volunteer Services.

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NeighborWorks America

The primary goal of NeighborWorks America is safe, affordable housing for low-income people. The organization works to create sustainable community development that fosters healthy environments for children and families. Through the organizational motto, "Working Together for Strong Communities," NeighborWorks America conveys its team-oriented, community-based orientation. Toward its goal of safe, healthy, sustainable communities, NeighborWorks America offers several forms of assistance, including financial, educational and training, and technical.

NeighborWorks America sponsors a diverse set of national programs, each of which seeks to develop and strengthen the nation's communities. These national programs assist affiliates with shared resources useful in community development.

The national network of affiliates includes more than 200 entities and provides assistance to more than 4,000 communities. Approximately two-thirds of these communities are urban, and the other one-third are rural. Examples of national programs include HomeOwnership, Real Estate, Awards, Center for Foreclosure Solutions, Center for Homeownership Education and Counseling, Community Building and Organizing, Green Organization, Financial Capacity, and Stable Communities, among others.

Because NeighborWorks America and its affiliates in the NeighborWorks network are interested in providing assistance to struggling communities, there also is keen interest in federal and state policy making, especially policies related to housing and community revitalization. The organization's Public Policy and Legislative Affairs Division handles communication with governmental bodies and offices and collaborates with partner organizations advancing similar goals.

Organizational History

NeighborWorks was born from activist efforts. In 1968, Dorothy Mae Richardson led a campaign to improve housing in her neighborhood, the Central North Side of Pittsburgh. With the assistance of local bankers and government officials, Richardson secured commitments from several financial institutions to approve conventional loans for housing in the neighborhood. Resulting from these efforts was an organization named Neighborhood Housing Services (NHS).

Shortly thereafter in 1970, the accomplishments of NHS were noted by the Federal Home Loan Bank (FHLB) as good examples and potential training models for loan officers lending to older neighborhoods in urban areas. As FHLB training expanded, the approach increasingly relied on NHS tenets, with the focus shifting to creation of other NHS entities. Thus, within a relatively short period of time, this Pittsburgh model had become nationwide for community-centered housing development.

In 1978, Congress established the Neighborhood Reinvestment Corporation (NRC), charging it with the goal of expanding the NHS's work in urban communities across the nation. Key priorities were to assist with reinvestment in older communities through partnerships among public, community, and private groups. The focus expanded beyond one-family housing to include multiple-party dwelling and retail shops and beyond urban areas to rural communities. This expansion necessitated the creation of new programming as well. For example, educational and training programs were developed on responsible home ownership and home building.

The 1980s presented considerable challenges to the NRC. Inflation and funding cutbacks called for new innovations in order to continue work toward organizational goals. Public support was gleaned through several high-profile projects, such as neighbors voluntarily painting in neighborhoods and owners' building homes as well as the first congressionally created Neighborhood Housing Services Week, which is now called NeighborWorks Week. Additionally, NRC provided assistance to homeless individuals through transitional housing and single-room arrangements. During this period, the entity also was rebranded as NeighborWorks.

The 1990s held many changes for the organization and its affiliates. New strategic initiatives, underwritten by several financial partners, focused on owning homes, managing resources, procuring affordable financing, and leading and organizing within communities. For example, educational and training programs on home purchasing and maintenance, coupled with affordable financial packaging, were developed. Two of these programs, Full-Cycle Lending and NeighborWorks HomeOwnership Centers, received acclaim as model programs incorporating several best practices. By the end of the decade, direct investment into targeted neighborhoods and distressed communities reached $1 billion, a reinvestment milestone.

In the new century, the NeighborWorks focus has been on capacity development throughout the network of interlinked organizations and their sites and on overall community development. To address the foreclosure crisis, the NeighborWorks Center for Foreclosure Solutions was created. This center takes a multipronged approach to foreclosure solutions and involves multiagency collaborations, including involvement from nonprofits, governmental organizations, and financial institutions. Based on its successes, NeighborWorks America was selected to manage the National Foreclosure Mitigation Counseling program. Further, the Emergency Homeowners' Loan Program, with $1 billion in funding, is coordinated through collaborative efforts between the organization and the U.S. Department of Housing and Urban Development (HUD). Although the official organizational name is still the NRC, NeighborWorks America has become the name typically employed.

The growth from a grassroots effort in one area within a city to a nationwide network of sites and a history of successful programming characterizes the success of the organization. Now more than 35 years old, NeighborWorks America has made positive strides in many communities across the nation.

Structure and Oversight

NeighborWorks America is headquartered in Washington, D.C., overseen by a board of directors, and managed by several officers. Board members, as specified by statute, hold key positions in several financial agencies as well as HUD. Organizational funding comes from corporations, private entities, and the government.

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See Also: Economic Support and Services; Home and Community Services; Homelessness; Housing Services; Housing Support and Homeless Services; Low-Income Housing Tax Credits; Supported Housing.

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Neonatal Care

Newborn babies in need of intensive medical care are treated in neonatal intensive care units (NICUs), where trained doctors and nurses have access to specialized, advanced technology. NICUs are usually directed by a small number of neurologists and staffed by resident physicians, nurses, nurse practitioners, respiratory therapists, pharmacists, physician assistants, and medical social workers. Together, these health care professionals provide intermediate or continuing care for babies who require specialized nursing as well as counsel and support for parents. Hospitals without NICUs must transfer critical patients to hospitals better equipped to care for premature or sick infants. Babies admitted to NICUs are born prematurely, before 37 weeks of pregnancy, have low birth weight (5.5 pounds or less), or have a medical condition requiring special care. Approximately 13 percent of U.S.-born babies are preterm, many of whom have low birth weights. Multiples (e.g., twins or triplets) are often admitted to NICUs because they tend to be smaller than single birth babies.

History of Neonatal Care

Treating preterm or ill babies was a point of interest as early as the 17th and 18th centuries, when scholarly papers were published, attempting to share interventions. Prior to the industrial revolution, premature or sick babies were born and cared for at home, living or dying without medical intervention. The infant incubator was first developed in the mid-19th century by Stéphane Tarnier (1828–97) as a way to keep premature infants in Paris warm in the maternity ward. Other methods were used before; however, the incubator was the first closed model; Dr. Tarnier also advocated this treatment to other physicians. The modern incubator is designed to measure temperature, respiration, cardiac function, oxygenation, and brain activity. It protects infants from cold temperatures, infection, noise, drafts, and excess handling. It also provides nutrition through an intravenous catheter, or NG tube, and is a way of administering medicine.

France became an early forerunner in assisting premature infants as a result of concern about falling birth rates. Pierre Budin followed in Dr. Tarnier’s footsteps but noted the importance of breast milk and mother’s attachment. Dr. Budin is known as the father of modern perintology—the branch of obstetrics that focuses on maternal–fetal medicine. Budin’s *The Nursing* was the first major publication on neonatal care. Hospitals started grouping newborns into one area in 1922. The first intensive care unit for neonates was established at Vanderbilt University in 1961. Professor Mildred Stahlman was the first to use a ventilator to assist a baby with breathing problems. By the 1970s, NICUs were part of hospitals in the industrialized world. Technological monitoring and therapy increased as babies were born in hospitals more often than at home. Moving a baby from home to the NICU in an emergency

A respiratory therapist takes a blood sample from a 3-day-old infant. Newborn babies in need of intensive medical care are treated in neonatal intensive care units, where trained doctors and nurses have access to specialized, advanced technology.

was nearly over, though babies still were moved in an incubator occasionally.

Reasons for Neonatal Care

New techniques and instruments assisted careful nursing for preterm or ill newborn babies. Not unlike adult intensive-care units, monitoring and life support are part of neonatal treatment, and adjustments are made for tiny and immature bodies. Smaller ventilators were created that would not damage babies' lungs, requiring gentler techniques and smaller pressure changes. Despite these new ways of treating and saving low-birth-weight babies, premature labor remains a key issue that has yet to be resolved.

Common diseases requiring NICU treatment include perinatal asphyxia, major birth defects, sepsis, jaundice, and infant respiratory distress syndrome; the most common cause of NICU death is necrotizing enterocolitis. Infants spend anywhere from a day to several months in neonatal units. While units are designed to bring infants around to health, the environment can be challenging due to continual light, high levels of noise, separation from the mother, reduced physical contact, procedures that are frequent or painful, and interference with breast-feeding. Having a child in the NICU is also extremely stressful for parents, particularly because, while birth problems might be resolved, an infant can still suffer severe brain damage or have long-lasting health problems.

There are three levels of neonatal care in the United States. Level 1, the well-newborn nursery, where basic care is administered, has the capacity to provide neonatal resuscitation at every delivery, evaluates and stabilizes infants born at 35 to 37 weeks' gestation and are physiologically stable, and stabilizes infants born at 35 weeks' gestation until transferred to the appropriate level of neonatal care. Level 2A resuscitates and stabilizes preterm or ill infants, including continuous positive airway pressure for infants born at 32 weeks suffering from physiologic immaturity, inability to maintain body temperature, or inability to take oral feedings. Level 2B builds on 2A and can provide mechanical ventilation for 24 hours or continuous positive airway pressure. Level 3A, the advanced specialty unit, provides comprehensive care for infants born at 28 weeks, sustains life support, and performs minor surgical procedures such as placement of a central venous catheter. Level 3B provides advanced respiratory support, advanced imaging with urgent interpretation, pediatric surgical specialists, and pediatric anesthesiologists on site for major surgery. Level 3C is located with an institution that provides extracorporeal membrane oxygenation (ECMO) and surgical repair of complex lung and heart problems. At any level, neonatal care is important to the welfare of babies who otherwise would not survive, in addition to prenatal care of mothers, all of whom are vulnerable despite ethnicity, class, religious affiliation, or ability.

Neonatal Care and Community Health Centers

Community health centers (CHCs), which provide accessible, affordable, comprehensive health care services to those who are medically underserved, provide pre- and postnatal care. Prevalent in the United States since the 1960s, CHCs are a safe haven for marginalized populations in both urban and rural areas. Their mission is to increase access for care within communities and to serve vulnerable populations, including women and children of marginalized racial, ethnic, and socioeconomic groups. These groups, funded by the government if they adhere to particular community requirements, also provide enabling services such as case management, transportation, health education, translation, and child care. These services, primarily for racial and ethnic minorities, low-income families, and uninsured or Medicaid-enrolled patients, are vital to continuing care to mothers and newborns who are vulnerable and marginalized.

CHCs providing translation services for non-English speakers and health care professionals knowledgeable about cultural perspectives on breast-feeding, childbirth, and child rearing, for example, greatly contribute to culturally competent care. About 60 percent of mothers in CHCs receive first-trimester prenatal care, while more than 70 percent receive postpartum and newborn care. At the turn of the 21st century, Asian mothers were most likely to receive both postpartum (81.7 percent) and newborn (80.3 percent) care; Latinas (75 percent and 76.3 percent, respectively), blacks (70.8 percent and 69.6 percent, respectively), and whites (70.7 percent and 66.7 percent, respectively) followed. African American newborns had higher rates of low birth weight (10.4 percent), though the disparity between blacks and whites was smaller in CHCs (3.3 percent) as compared to national disparities for low-income mothers (5.8 percent). Such racial and ethnic disparities in certain prenatal and birth outcomes were lower in CHCs despite patients' high-risk status. Within CHCs, first-trimester prenatal care increases could lead to greater improvement overall in birth outcomes for minority groups.

Cultural Diversity and Neonatal Care

Cultural competence in neonatal care is vital to the health and continued well-being of premature babies and postpartum mothers. Research underscores the importance of attending to needs of culturally and linguistically diverse (CALD) mothers. Swedish researchers reported increased rates of prenatal mortality among women giving birth at Swedish hospitals who were born outside Sweden compared with Swedish-born women. Among women born outside Sweden, sub-Saharan Africans had significantly increased frequency of adverse prenatal, neonatal, and postnatal outcomes.

CALD parameters—including birth nation, ethnicity, refugee status, primary language spoken, and need for an interpreter—can impact health and obstetric or neonatal outcomes. Researchers in Australia report that, because women belonging to CALD groups often have lower incomes and less-established social networks, and due to language, cultural transportation, other barriers, and less ability or willingness to seek health care or understand advice, their health and pregnancy outcomes can be negatively impacted.

The importance of breast-feeding promotion for CALD mothers in neonatal care units has also been researched. A UK study highlighted close, continuing, skin-to-skin contact between mother and infant, effective breast milk expression, peer support in the NICU and community, and staff training. Researchers argue breast-feeding in neonatal units must be included in public health surveillance and policy development. The United Nations Children's Fund (UNICEF) UK Baby Friendly Initiative standards for neonatal units encourage best practices for breast-feeding and relationship building when babies are preterm or ill in NCIUs. Mothers giving birth in UK hospitals where Baby Friendly policies are fully implemented are more likely to initiate breast-feeding and to continue to breast-feed exclusively at 4 weeks of age, compared to mothers in other hospitals. The impact of breast-feeding promotion is stronger for less-educated and more economically disadvantaged mothers.

Organizations such as the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) underscore the need for culturally and ethnically diverse neonatal care. AWHONN and others acknowledge the serious detriments that can result from disparities in neonatal care. Not recognizing the importance of health care equality leads to prolonged and unnecessary inequality within the health care system that can be perceived as racist, ethnocentric, classist, or sexist.

Privilege for members of culturally and socioeconomically dominant groups could be more likely to be given prompt and comprehensive prenatal care because of their socioeconomic status and the health care that privilege affords them. It is important that culturally and linguistically diverse mothers and their newborns are given care by health care professionals who understand and respect their values and beliefs.

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See Also: Early Childhood Development; Fetal Alcohol Syndrome and Drug-Exposed Infants; Hispanic Health and Nutrition Examination Survey; Immunization Campaigns; Infant Mortality/Sudden Infant Death Syndrome; Infant/Toddler Development; KIDS COUNT; Maternal/Infant Health Services; Maternity Homes; Midwifery; National Center for Children in Poverty; Parenting Skills Training; Parenting Styles, Cultural Differences in; Postpartum Depression; Pregnancy and Parenting Services; Prenatal Care; Women, Minorities.

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Neurodiversity

Neurodiversity is a concept that refers to the idea that people experience the world differently due to their neurological attributes. An idea promoted primarily online throughout the world by the autistic self-advocacy movement, *neurodiversity* is a term usually associated with people on the autism spectrum. However, it is sometimes also used to describe certain mental illnesses, learning disabilities, and other forms of neurological difference. Parallel to biodiversity or cultural diversity, neurodiversity as a concept generally recognizes neurological disorders as a form of natural variation in the human genome. Thus, instead of focusing on "cures," neurodiversity advocates emphasize valuing and supporting neurological differences.

Advocates for neurodiversity look for ways to promote social support systems (inclusion-focused services, accommodations, communication and assistive technologies, occupational training, and independent living support) for the neurologically diverse. This way, rather than being forced to embody and enact accepted ideas of normalcy in an unthinking manner, they can live their lives as they are and as they wish. Many advocates place an emphasis on subjective well-being, along with adaptive rather than typical functioning. For example, some advocates believe that verbal communication in itself is not as important as having some form of communication that is reliable and understandable. They also usually oppose any interventions that seek to eliminate unusual but harmless behaviors such as the avoidance of eye contact or repetitive body movements without any regard for the coping mechanisms that they often are.

Consequently, many self-advocates are quite critical of intensive behavioral interventions such as applied behavioral analysis (ABA) because they believe there is too much of a focus on normalization for its own sake rather than an emphasis on the health and happiness of the individual being treated. Envisioning a world in which autistic people enjoy the same access, rights, and opportunities as others, proponents of neurodiversity believe that the acceptance of such differences is an essential condition that will allow all people to live up to their potential and contribute to society on their own terms according to their specific gifts and strengths.

According to philosophers Andrew Fenton and Tim Krahn, advocates for neurodiversity strive to have society reconceptualize autism and other related conditions in concrete ways through (1) recognizing that neurodiversity does not need to be cured; (2) replacing current medical terms such as *condition*, *disease*, *disorder*, or *illness* with more neutral or positive descriptions of neurodiverse individuals; (3) acknowledging new types of autonomy for those classified as neurodiverse; and (4) providing neurodiverse people with more control over their treatments or with decisions about whether they should even be treated at all.

In his own efforts to inform a larger segment of the public about this concept and the potential benefits to societies that embrace this perspective, Thomas Armstrong, an educational psychologist and well-known proponent of neurodiversity, has additionally articulated eight core principles around this concept. These principles can be summarized in the following manner:

Neurodiversity refers to the idea that people experience the world differently due to their neurological attributes. Here, Christopher Adams holds his 3-year-old son, diagnosed with severe autism spectrum disorder, while board-certified behavior analyst (BCBA) Kenna Nelson coaches the child to touch his father's nose during an in-house therapy session.

1. The human brain is more like an ecosystem than a machine; consequently, we need to come up with language that better reflects more recent understandings of the architecture of the brain.
2. Instead of conceiving of disability categories as discrete entities, it is more appropriate to think in terms of spectrums or continuums of competence when talking about the differing gradations of social competence and other abilities enacted by individuals.
3. It is very important to remember that notions of human competence are strongly determined by the values of the culture to which one belongs; consequently, there needs to be an acknowledgment that diagnostic categories are never simply scientifically based but also reflect deeper social biases about certain competencies or abilities within a particular culture.
4. When and where you were born determines whether you are seen as disabled or gifted; thus, diagnostic labels should never be conceived of as absolute realities but as relative terms that only exist in particular social settings.
5. In order to be successful in life, you need to adapt your brain to the needs of the surrounding environment; thus, the use of tools such as psychoactive medication or intensive remediation programs can be very useful and beneficial in helping people adjust to their particular environments.
6. You need to modify your surrounding environment to meet the needs of your unique brain (what Armstrong terms "niche construction").
7. You need to use diverse tools, resources, and strategies to alter the environment in ways that will serve the needs of the neurodiverse brain (essential steps that

must be taken in the process of niche construction).

8. Through positive niche construction, the brain is directly modified and a more complex network of neuronal connections form in the brain, thereby enhancing individuals' abilities to adapt to their particular environments.

History of the Concept

In the 1990s, an autistic civil rights movement led by many autistic writers and activists came into being. During this time, people such as Jim Sinclair, a Canadian autistic advocate, began to assert that neurological differences should be recognized and respected as a social category on a par with gender, ethnicity, sexual orientation, and disability statuses. A principal and early organizer of the international online autism community, Sinclair is generally credited with coining the word *neurotypical*, a term that originally denoted nonautistic people but is now used to refer to typically developing people and the cultures built by and around such people. Other people such as Judy Singer, an Australian social scientist on the autism spectrum, and Kathleen Seidel, an American and creator of the Web site Neurodiversity.com (a site that indexes material from a vast number of Web sites on autism that reflect a diverse range of information and perspectives), were also quite active in efforts to educate and inform the public about the personal and societal implications of these wide-ranging neurological differences.

The term *neurodiversity* itself was coined to challenge prevailing views that conceived of certain forms of neurological diversity as inherently pathological. According to most sources, the word *neurodiversity* first appeared in print on September 30, 1998, in an article in *The Atlantic* titled "Neurodiversity: On the Neurological Underpinnings of Geekdom." In this article, journalist Harvey Blume reflects upon the social and political ramifications of geekdom and speculates about what he describes as the possible neurological underpinnings of the rise of self-described geeks in the computer industry and other related fields. After analyzing the content of a satirical Web site titled the "Institute for the Study of the Neurologically Typical: The Diagnostic and Statistical Manual of 'Normal' Disorders" (a parody of the institutes and journals dedicated to the study of autism and a tongue-in-cheek critique of their so-called quest to make everyone "normal" at http://isnt.autistics.org/dsn.html), he puts forth the idea that neurodiversity is an attribute as essential for the evolution of humans as biodiversity is for all life forms. Furthermore, he advances the notion that cybernetics and computer culture may favor what he calls a more autistic cast of mind. This particular article is also notable for accurately predicting the role the Internet would play in furthering the international neurodiversity movement.

The concept gained broader exposure in 2004 when it appeared in a *New York Times* piece written by Amy Harmon. Titled "Neurodiversity Forever: The Disability Movement Turns to Brains," this article examined the rise of a new kind of disability movement calling for greater tolerance for different neurological constitutions. Since that time, the term has been progressively applied to other conditions and has taken on a more general meaning; in the United Kingdom, for example, the Developmental Adult Neurodiversity Association (DANDA) uses the concept when talking about developmental coordination disorder, attention deficit hyperactivity disorder (ADHD), Asperger's syndrome, and related conditions. In the meantime, other people such as Adam Larsen (a documentary filmmaker) have attempted to make the concept of neurodiversity more familiar to the general public through media vehicles such as *Neurotypical*, a 2012 point-of-view (POV) documentary that features autistic people as narrators of their own experiences.

Controversies and Critics

Neurodiversity as a concept is still quite controversial to many for varying reasons. For example, those who endorse the medical model still believe that such differences are actually medical conditions that can and should be corrected. Such adherents of this view include self-identified and diagnosed autistics such as Jonathan Mitchell (http://www.jonathans-stories.com/non-fiction/neurodiv.html), who has explicitly expressed the desire for a cure for his autism.

Other critics of the neurodiversity movement do not have as much of a problem with the concept itself but do express concerns that broadening the definitions of neurological disorders might lead those with serious physical and psychological needs to be overlooked, thereby precipitating the loss of essential government support services for those who depend upon them to function successfully in their daily lives.

On a more philosophical level, there are people who believe that there really is no such thing as a neurodiverse individual. For example, educator Nick Walker argues that one can conceive of all people being neurodiverse in one way or another. Thus, as an alternative, he proposes the use of the term *neurominority* as a nonjudgmental and nondiscriminatory way of referring to all individuals who cannot be classified as neurotypical.

Yet another point of view can be found in the views of people such as Pier Jaarsma and Stellan Welin, who find no problem in applying the concept of neurodiversity to so-called high-functioning autistics. They believe that individuals in the "high-functioning" group might be more harmed than helped by having medical labels applied to them. On the other hand, they also express the opinion that endorsing a broader definition of neurodiversity that includes so-called low-functioning autistics is problematic due to considerable differences in their ability to engage in self-care and other independent living behaviors.

Neurodiversity advocates respond to critiques of the concept by countering that the notion of neurodiversity does not in any way imply the trivialization or dismissal of the mental, emotional, and physical needs of neurodiverse individuals who require personal assistance or health-related services for their well-being. To the contrary, many readily agree that autism is indeed a disability and are often quite frank about the challenges they have faced and continue to face due to their own neurological constitutions. At the same time, however, they also assert that there is a need for a term such as *neurodiversity* to encapsulate the real needs and desires of the autism community. They also stress the importance of having a say in their own treatment, along with continuing access to the appropriate educational, governmental, and private supports to help them successfully lead satisfying and independent lives.

Neurodiversity and Research Studies

In recent years, some researchers have conducted studies that have looked at the impacts of reframing autism within more positive paradigms such as neurodiversity. In one such study, conducted by Edward Griffin and David Pollak in 2009, 27 students with autism, dyslexia, developmental coordination disorder, ADHD, and stroke were separated into two categories according to how they saw their particular neurological conditions. The first group consisted of those who adopted a difference view, that is, those who saw neurodiversity as a form of difference composed of a set of strengths and weaknesses. The second group was made up of those who took the medical or deficit view; that is, they saw neurodiversity as a disadvantageous medical condition. While all of the students in the study reported problematic schooling histories that included exclusion, abuse, and bullying, those who identified with the difference view exhibited higher levels of academic self-esteem and confidence in their abilities. Additionally, many of the students who expressed the difference view articulated substantial career ambitions with specific, constructive goals.

In another study published in 2013 by Steven K. Kapp and several other investigators, researchers found that parents of children on the autism spectrum and people on the autism spectrum who were able to reframe autism in terms of a neurodiversity perspective exhibited higher levels of coping behavior in their own daily lives. On a related note, the authors of the study concluded that parent education programs using ABA that focus on strengths rather than deficits also appear to strengthen parent–child interaction and help make use of a person's interests and strengths to address such challenges in a positive manner. Consequently, they concluded that a shift to a neurodiversity perspective and a positive emphasis on the restricted interests of individuals on the autism spectrum (a core characteristic of autism) greatly enhance the social-communicative development of autistic people and provides them with selective advantages when it comes to certain job skills and independent living behaviors.

Advocacy

The Autistic Self-Advocacy Network (ASAN, http://autisticadvocacy.org) is arguably the most well-known neurodiversity advocacy group today. Founded as a national nonprofit in 2006 by Ari Ne'eman and Scott Michael Robertson, both autistic adults, ASAN seeks to increase the representation of autistic people across society. Another prominent advocacy group in this area is Autism Network International (http://www.autreat.com), an autistic-run self-help and advocacy organization for autistic people.

Conclusion

Advocates find the concept of neurodiversity to be a very important tool in the fight against the ableism and discrimination experienced by those not viewed as neurotypical. For those who don't see themselves or who are not perceived of as neurotypical, the notion of neurodiversity offers the hope that they will be extended the same rights and privileges extended to other human beings and that they will ultimately be recognized and rewarded for possessing specific talents crucial to the functioning of society. For many proponents, concrete evidence of the utility of embracing neurodiversity as a concept can be found in the examples of software firms that have acknowledged the programming talents of a number of people on the autism spectrum and have hired an appreciable number of neurodiverse people to boost productivity in their workplaces. In their view, companies and individuals who employ neurologically diverse people can experience the satisfaction of providing people who have traditionally been marginalized in the workforce with the means for independent living while also benefiting from the substantial talents of such individuals, a win-win situation for everyone.

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See Also: National Database for Autism Research; Office for Civil Rights; Partial Care Services for Adults, Mental Health; Partial Care Services for Children, Mental Health; Social Services, Disabled Children and; Sociology of Disability; Values and Ethics, Ethnic Diversity and; Western Communities and Cultural Competence.

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No Child Left Behind Act

Melting pot is a remarkably meaningful phrase often used to characterize American society. Due to historical facts forming the country with the contribution of several nations even at the beginning, the United States seems to have started out as a quite diverse country. Among other reasons, what is called the American Dream is likely to be an important reason as to why the United States has one of the most, if not the most, diverse societies in the world. Several people from all around the world seek ways to find a better life in this country, bringing their cultures, unique contributions, and differences.

The current demographics of U.S. society show a clear picture of diversity with a rich mixture of several vivid heritages of different cultures. Diversity seems to have a certain impact on shaping the American educational system as well as several other aspects of modern life in the United States. The comprehensive law aimed to deliver education of higher quality by fixing the problems particularly stemming from this diversity is called the No Child Left Behind Act (NCLB). This entry examines the basic definition, brief history, goals, components, as well as criticisms of the NCLB, particularly as it relates to the diversity of the American society.

History, Definition, and Goals of NCLB

The historical background of the NCLB goes back to the Elementary and Secondary Education Act (ESEA) of 1965, which aimed to provide federal funds for the betterment of economically disadvantaged students through education. The ESEA is revised every five years. The act was reauthorized and revised in 1994 and served as the predecessor of the NCLB. The NCLB was originally proposed in 2001 and signed into federal law in the following year. In President George W. Bush's own words, the NCLB is summarized as "[a]n act to close the achievement gap with accountability, flexibility, and choice, so that no child is left behind." The act aims to improve individual outcomes of education through two fundamental elements: setting high standards by the state and establishing measurable goals. It is intended to compensate for the disadvantages in education caused by social and economic status.

The NCLB can be considered a comprehensive move in the U.S. educational system that requires schools to direct more focus to students with various disadvantages due to their backgrounds. These groups of students include minorities like African Americans and Latinos, children of low-income families, nonnative speakers of English, and students with disabilities.

Its primary goal is to close the achievement gap so that every student has fair and equal learning opportunities in terms of social and economic status. Initially, mathematics and reading were included in testing requirement, then later in 2007, science and social studies were also covered. This change is believed to bring potential changes in curriculums of relevant subject matters, which accordingly has had certain impacts on the way courses are taught.

Some of the major titles of the act covered the following issues: improving the academic achievement of the disadvantaged; preparing, training, and recruiting high-quality teachers and principals; language instruction for limited English proficient and immigrant students; 21st-century schools; promoting informed parental choice and innovative programs; flexibility and accountability; and Indian, Native Hawaiian, and Alaska Native education.

The NCLB allocated considerable amounts of financial support on the one hand, and it placed strict performance standards. According to these standards, all students were supposed to be proficient in mathematics and English by the 2013 to 2014 school year. The Obama administration, however, softened this provision, leaving a door open for waivers for willing states.

Officially, there is no standard K through 12 curriculum in the United States. Instead, each state has its own curriculum, mostly different from others. With the introduction of nationwide standardized tests after the NCLB, states started to adjust curriculum in a way so that students can succeed in nationwide tests and the schools can keep receiving federal funds. In other words, the NCLB paved the way toward standardizing the curriculum and assessments nationwide.

The NCLB also aimed to enhance teacher quality nationwide, requiring higher standards for employment such as holding a bachelor's degree at least, state certification, and proof of competency in the subject area taught. Requirements slightly vary for different groups like elementary or secondary teachers.

The NCLB and Diversity

The United States is possibly the most diverse country in the world, with people from many different cultural and ethnical backgrounds. As a result, problems with English and resulting language barriers are issues of concern, especially for the people of immigrant and migrant minorities. The NCLB required language instruction in schools in order to compensate the disadvantages of immigrant students with limited English proficiency. One of the specific goals of the NCLB was that all students, including those with limited English proficiency, be proficient in English by the 2013 to 2014 school year. The NCLB demonstrated real concern for academic achievement of those who make the American society a diverse one. The law reserved no exemption for short-term residents who had language barriers. English language learners (ELL) are granted extra time in standardized tests and allowed to use bilingual dictionaries. Additionally, school administrations are required to follow up the academic success of ELLs and report to the authorities to make sure that they do not fall behind the native speakers of English due to their disadvantages with language.

Students with disabilities are also taken into account within the comprehensive perspective of the NCLB. Students who need special accommodations due to their cognitive disabilities are subjected to alternative achievement standards. Schools are allowed to use alternative assessment standards for such students with a percentage limitation of 1 percent. Nevertheless, schools that have students with cognitive disabilities more than 1 percent seem to be disadvantaged.

Criticism of NCLB

The NCLB started out with idealistic goals and statements, which also theoretically sounded reasonable. When a huge change is being made on a nationwide scale, theory and practice may differ as in many fields. Unanticipated impediments, delays, side effects, and similar factors may cause unexpected results or falling behind the planned goals. Critics of the NCLB focused on such drawbacks and voiced their concerns publicly. They contend that the law has not improved the quality of education, particularly in high schools. They refer to the results of standardized test results since 2002. Standardized tests are also criticized as the sole means of assessment of academic success. According to critics, standardized tests are given priority over other methods of assessment, and it is not reasonable to use such a shallow tool, as compared to other methods, to measure student performance.

Another aspect of this is the use of arbitrary cut scores, which means a kind of threshold determining whether a test is passed or not regardless of the number of correct answers. This threshold is determined by the government, and it can be changed by the government any time, opponents contend. The strict policy of NCLB on teacher qualification is also criticized by opponents. They argue that such policies worsen the already existing problem of teacher shortage nationwide.

Possibly the most notable of these criticisms comes from teachers, who are an important part of the general picture. Some teachers complain that the course of teaching moves toward being a test-oriented process rather than a real, idealistic process of knowledge transfer.

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See Also: Americans With Disabilities Act; Asian Immigrants; Association for Multicultural Counseling and Development; At-Risk Youth Services; Behavior Support and Management; Bullying; Children With Special Needs; Disability Services; Early Childhood Literacy; Education for Diversity in Human Services; Educational Services; Educational Support Services; Individuals With Disabilities Education Act; Language Assistance; Multicultural Education; Office of Special Education and Rehabilitative Services; School Counselors; Social Services, Disabled Children and; Special Education; Yale Center for Dyslexia and Creativity; Zero Tolerance Approach in Schools.

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Nursing, Public Health

Public health nurses promote health behavior change and maintenance and work to prevent disease. Sometimes referred to as community health nurses, public health nurses are responsible for integrating their nursing expertise and skills into the theory and practice of public health. They are focused on reducing health disparities among at-risk populations; providing timely, evidence-based health care to individuals in need; and staying abreast of the changing face of health systems and their effects on diverse communities. Public health nurses practice in a variety of settings that are quite different from a traditional hospital or outpatient care center. They provide care in local, state, and federal health agencies; home-based settings; community and religious centers; and mobile health units. Nurses in public health consider themselves in community-oriented practice and must perform their duties with limited resources and time. They often work collaboratively with professionals representing public health, health policy and advocacy, governmental agencies, medicine, social work, and even local religious and community leaders to accomplish goals.

Public Health Nursing as a Subset of Professional Nursing

Public health nurses provide care to individuals in diverse community populations. The populations they interact with are diverse with regard to age, race, gender, family structure, religion, and socioeconomic status. Public health nursing is a unique subset of the nursing profession because care begins with an assessment of the community the nurse has identified as a potential population with need. This is distinctive from other forms of nursing, such as hospital-based care, in that the health needs of the population may not be completely known.

A hospital-based nurse is often assigned a patient who has a diagnosis with specific care goals that must be assessed and addressed. Comparatively, the public health nurse must first identify the need of the community and then move into the process of discovering the best ways to address the identified issues. Public health nurses treat individuals as members of communities. Many public health nurses in the United States manage family cases, and the acuity from one family or patient to the next can be quite variable.

Most positions in public health nursing require a nurse to obtain a bachelors of science in nursing (BSN) and complete the registered nurse (RN) licensure process. Public health nurses can also obtain a masters of science in nursing and specialize in public health as a focus of practice. Nurse practitioners in public health possess additional skills in examining, treating, and managing community health issues. During education and training, public health nurses and nurse practitioners learn disease treatment and prevention and how to motivate individuals situated in complex and diverse cultures to make knowledgeable health behavior decisions, thereby effecting more lifelong behavior changes. The ability to evaluate and assess public health situations; communicate with diverse individuals, families, and communities; collaborate with other professionals; and devise plans of care are often identified as the core competencies of public health nurses.

Public health nurses assess groups or communities struggling with health disparities. Examples of public health nursing initiatives include preventing and ending intimate partner abuse, promoting diabetes self-management, substance use prevention and treatment, exercise and weight management, and teen pregnancy assistance. The nurse (or nurses working collaboratively in a small group) evaluates the community's resources, what processes are in place to address health issues, and the scope of the disease or health condition of concern. Public health nurses must implement only evidence-based practice to ensure the efficacy of public health interventions. Following the community evaluation, the public health nurse plans an intervention, develops a plan, acquires necessary resources, and then executes his or her plan.

Education and behavior change motivation are significant components of the intervention, and the interventions are designed for individuals, families, population subgroups, and larger populations. The public health nurse must execute his or her plan in a timely fashion and allocate resources such that the population or population subset feels enhanced. Close formative evaluation is necessary to ensure the population takes ownership of their stake in the intervention and the intervention reaches and affects those identified as having disparities. The public health nurse evaluates the intervention implementation and assesses for issues needing correction or if further resources are needed.

A Day in the Life of the Public Health Nurse

Public health nurses' daily duties are as diverse as the populations they serve, and they travel often. For example, a public health nurse may identify a high-risk and underserved Latino population in the inner city that may have health needs to be addressed. The nurse conducts a windshield survey noting the community does not have safe play environments and many of the children are obese. The nurse then meets with community and religious leaders to discuss concerns, assess past and current obesity-prevention programs in place, and evaluate the community's readiness for change.

Upon building relationships with key stakeholders in this Latino population, the public health nurse creates an intervention strategy to create organic community garden space and employ limited grant funds for playground equipment. The public health nurse then implements the intervention and evaluates outcomes.

The Past, Present, and Future of Public Health Nursing

Beginning in the 19th century, public health nurses dedicated themselves to treating physical, economic, and social ills. Public health nurses once primarily focused on case management, including providing access to services; home care; and community-level prevention measures such as vaccinations. Members of this profession focus on these concerns today but are now better situated to collaborate with other health and governmental officials and emphasize health promotion and behavior change as opposed to merely treating individuals with poor health.

As the health care system in the United States continues to evolve and expand, public health nurses will become more and more in demand. Public health nurses can provide high-quality care at a lower premium and to more diverse populations given their training in cultural diversity and foreign languages.

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See Also: Cultural Competence, Human Service Providers and; Health Promotion Services; Medical Social Workers, Racial and Ethnic Issues for; Midwifery; Public Health.

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Nursing Home Care

Advances in health care and medical technology have increased longevity, and the older adult population in the United States is increasing. As a result of this growing population, the need for nursing home care is a distinct possibility for many older adults. Nursing homes provide long-term care for chronic conditions and assistance with the activities of daily living. Nursing homes offer medical and personal care for the frail elderly with health needs. Round-the-clock physician and nursing services are also available during nursing home care.

A nursing home is an institution with three or more beds that provides personal and medical care for older adults and those with chronic illness in privately owned settings. Three levels of care are provided: Skilled nursing care includes the management and treatment of chronic conditions. Rehabilitation, another level of care, includes short-term medical care and other rehabilitative services (physical therapy, occupational therapy, or speech therapy) after an injury or illness. Long-term care involves medical and nursing care offered over a long period of time. Nursing home placement decisions are made with the patient, family, and physician. Placement can occur after hospitalization, or the patient can be transferred directly from his or her home.

Before a patient can be placed in a nursing home, an assessment is conducted to determine health care status, current level of function, and ability to perform activities of daily living (ADLs). "ADLs" is a term used to describe daily self-care activities such as bathing, dressing, toileting, walking, eating, and continence. Ability to perform ADLs is an indication of the level of nursing home care that is required. Assessment involves independent measures of functioning. An assessment instrument, such as the Katz Index of ADLs, may be used to evaluate health status. Assessment results that indicate impairment in daily functioning form the basis of decisions that determine care needs. Assessments, care plans, and treatment activities are documented in the medical record. Nursing homes are required by law to provide care plans and maintain medical records for all residents.

Prior to the 20th century, the elderly who could afford it were maintained in their own homes or in homes established by religious or charity groups for the care of the aged. Those elderly who were impoverished or isolated from family landed in almshouses. In 1935, President Franklin D. Roosevelt signed the Social Security Act into law. The Social Security Act made it possible for payments to be made to privately owned nursing care facilities. During the 1950s, the Social Security Act was amended to requirw that states license and regulate these nursing facilities. In 1986, a study commissioned by Congress found widespread incidents of nursing home abuse, neglect, and inadequate care.

After the study findings were published, reforms to the nursing home industry were proposed. In 1987, these reforms were passed into law as part of the Omnibus Budget Reconciliation Act of 1987. New standards were established, and more effective regulation measures were implemented. These licensing regulations provided a new level of oversight that ensured the safety and well-being of nursing home residents and offered better protection against abuse and neglect.

Nursing Home Services

Twenty-four-hour skilled nursing care is provided in nursing homes. Skilled nursing refers to care that is provided by a licensed nurse, including wound care, tube feedings, intravenous medication therapy, medication management, and ongoing nursing assessment (blood pressure, pulse, respiratory assessment, and blood sugar screening), along with ongoing physician communication and consultation. The primary care physician is responsible for medical oversight of the patient. In addition to physician and skilled nursing services, nursing home patients may require other services as well.

Physical therapy is provided after an illness or injury and helps improve mobility, strength, endurance, flexibility, and coordination, and aids in pain reduction. Physical therapy helps increase or maintain overall physical functioning and is also an important tool that can be used to prevent injury or accident in the nursing home. Along with physical therapy, some patients may require occupational therapy, a type of therapy that helps restore or enhance ADLs.

Occupational therapy may include teaching residents to use equipment to assist with these activities or making modifications to the environment to increase the possibility that the resident can maintain a higher level of independence. For example, a bar may be installed in a bathroom to allow a nursing home patient to use the toilet on his or her own. Another service is recreation therapy, a service that helps improve functioning and independence. Recreation therapy is usually time limited and, as is the case with other forms of therapy, is physician ordered and used to achieve the objectives of the care plan. Recreation therapy may include activities to promote physical functioning such as exercise and stretching. Activities that promote cognitive functioning may include card or other games that require concentration. To decrease issues such as depression or anxiety, recreation therapy may involve increasing social participation by including nursing home residents in activities such as support groups. Nursing home care also includes pharmacy services, dental care, podiatry, and optical care.

Oversight and Certification

All skilled nursing homes must meet both federal and state regulations that guarantee that they operate within established guidelines. Skilled nursing homes are required by law to maintain compliance with federal requirements to be eligible to receive Medicare and Medicaid payments. A site-based survey is completed to determine compliance and eligibility. Each state is responsible for conducting nursing home certifications. The nursing home does not know when the certification visit will take place as they are not announced in advance. The certification visit may be conducted 24 hours a day, during the week, or on weekends. Nursing homes must meet federal requirements that include having a sufficiently staffed facility and conducting initial assessments of all residents to determine their functional capability. After an assessment is conducted, each resident must have a comprehensive care plan. Certification also involves a review of protocols that ensure that residents do not develop pressure sores (bed sores). If pressure sores develop, the nursing home must provide necessary treatment to heal existing sores and prevent infection and development of new sores. The nursing home must also have procedures that ensure residents receive any necessary assistive devices that may be needed to maintain vision and hearing.

According to federal guidelines, nursing homes must provide services that ensure that ADLs can be carried out. Appropriate provisions must be made to ensure that residents have the right to determine their schedules, activities, and health care. To receive federal certification, nursing homes must have protocols in place for assistance to incontinent residents. Fluid intake must also be monitored so that dehydration can be prevented. Compliance with federal guidelines is necessary to safeguard nursing home residents against injury, abuse, or neglect. Nursing home residents, whether they are elderly or recovering from an illness or injury, are vulnerable and may not have the capacity to look out for their own best interests; therefore, oversight must be in place to guarantee that the highest-quality services are provided and the potential for abuse and neglect is mitigated.

Diversity Issues in Nursing Home Care

Nursing homes are highly diverse organizations, reflecting the diverse society in which we live. Diversity exists in the backgrounds of residents and staff and may include ethnicity, gender, race, religion, sexual orientation, and socioeconomic status. Diversity may also exist in education level and language. The provision of quality nursing home care involves acknowledging and addressing these differences in a responsive and respectful manner. Organizational policies and staff training should highlight the importance of delivering culturally competent nursing home services. Cultural competence involves valuing diversity, making a conscious effort to understand cultural beliefs and values, and incorporating this understanding into the care that nursing home residents receive. Responding to nursing home care needs of economically disadvantaged groups is also an important diversity issue, which involves increasing access to quality nursing home care for these groups.

Abuse and Neglect in Nursing Home Care

Abuse involves intentional physical or emotional harm caused by one person to another. In nursing home settings, the abuse victim is a patient, although agitated nursing home patients have been known to strike out against staff and other residents. Physical abuse includes hitting, slapping, kicking, shaking, or sexual contact that is not consensual. Emotional abuse may involve threats, intimidation, criticizing, name calling, or other acts that belittle and humiliate.

Nursing home neglect may be physical or medical. Neglect involves failure to adequately provide for the needs of the resident. Failure to maintain proper hygiene and provide adequate medical treatment and services also constitute neglect. Inadequate staff training and facility resources and indifference among staff and administrators are risk factors for abuse and neglect.

Benefits of Nursing Home Care

The frail elderly and those recovering from injury and illness have many needs that nursing home care can provide. The provision of personalized health care is a significant benefit to the safety and well-being of patients. Twenty-four-hour monitoring of residents also facilitates health and well-being. Receiving balanced, nutritious meals provides a degree of certainty that the patients are getting the right amounts and types of food that are necessary for better health outcomes. Nursing home care can maximize safety and security and decrease isolation that some older adults experience because a built-in social network is available. Nursing home care is an important resource when the care needs of older adults are beyond what family members can provide. Caregiver burnout is a serious issue for family members who care for elderly relatives. Nursing homes strive to maintain the dignity of all residents and ensure their rights are protected. Human services professionals are an integral component in the provision of nursing home care services. From the time the decision is made for nursing home placement to service coordination during the nursing home stay, human services professionals provide an array of services that contribute to the quality of life for patients.

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See Also: Abuse and Neglect; Adult Day Care; Aging and Adult Services; Elder Care/Geriatric Services; Longitudinal Studies of Aging; Long-Term Residential Care; Medicare; National Institute on Aging; Respite Care; Social Security Administration.

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Nutritional Services and Assessment

Nutritional services in a society imply specific measures aiming to give meals or subsidies for the purchase of food to different groups in a population. These measures can mean providing meals to preschool or school children and elderly people, or providing food to women, infants, and children in low-income groups as in the Special Supplemental Nutrition Program for Women, Infants, and Children, the WIC program in the United States. It can also mean providing economically vulnerable groups economic subsidies to buy food. These services can be provided with or without the ambition to meet the special nutritional needs for the respective group.

From a public health perspective, it is important to enhance and promote healthy eating habits and encourage physical activities in order to prevent obesity. Nutritional services should reflect dietary recommendations in order to enable promotion of a healthy population. The Dietary Guidelines for Americans are based on recommended nutrient intake. Recommended nutrient intake in turn is the daily intake, which meets the nutrient requirements of almost all (97.5 percent) apparently healthy individuals in an age and sex-specific population group. Daily intake corresponds to the average over a period of time. The nutrient requirement aims to cover prevention of deficiency while avoiding toxicity.

Breast milk is the recommended food for infants; its composition is optimal for infant growth and not only represents the nutritional needs of the growing infant but also includes the infant's need for immunological components. Breast milk has been the benchmark for creating replacement diets. Breastfeeding is important from a public health perspective. Suboptimal breast-feeding rates were estimated to cost the U.S. economy at least $8.7 billion in 2011 for pediatric health costs and premature death.

The WIC program is an example of a program with a multisided approach that includes providing nutritious foods and nutrition education (including breast-feeding promotion and support). WIC serves to safeguard the health of low-income pregnant, postpartum, and breast-feeding women and infants and children up to age 5 who are at nutritional risk.

The Supplemental Nutrition Assistance Program (SNAP), the former food stamp program, provides financial assistance for purchasing food to low- and no-income people living in the United States. This program can be used to purchase any prepackaged edible foods, regardless of nutritional value.

Nutritional Assessment

Nutritional assessment can be defined as the interpretation of the information from dietary, laboratory, anthropometric, and clinical studies. The purpose of nutritional assessment is to identify individuals or population groups at risk of becoming malnourished, and to identify individuals or population groups that are malnourished. The nutritional status of an individual is often the result of many interrelated factors. Nutritional status is the balance between the intake of nutrients by an organism and the expenditure of these in the processes of growth, reproduction, and health maintenance. It is influenced by food intake (in terms of both quantity and quality) and physical health. The spectrum of nutritional status is spread from obesity to severe malnutrition. The obtained data on nutritional status must be compared with reference data to produce an indicator of nutritional status. Nutritional assessment gives information to form the basis for developing health care programs that meet the community needs. It can also be used to measure the effectiveness of nutritional programs and interventions. Nutrition can be assessed by direct and indirect methods. The direct methods deal with the individual and measure objective criteria, while indirect methods use community health indices that reflect nutritional influences.

Direct and Indirect Methods

Direct methods can be anthropometric methods, biochemical and laboratory methods, clinical methods, and dietary evaluation methods. Anthropometry is the measurement of body height, weight, and body proportions. It is an essential component of clinical examination of infants, children, and pregnant women. The measurements can be performed relatively quickly, easily, and reliably provided standardized methods and calibrated equipment are used. To interpret anthropometric data, they must be compared with reference data. To aid the interpretation of the anthropometric data, the raw measurements are generally expressed as an index, like height for age. In infants and children, growth charts have been developed to allow assessment of their growth. This is used to evaluate both under- and overnutrition. The measured values reflect the current nutritional status and do not differentiate between acute and chronic changes.

Obesity has become an overriding public health problem in the Western world. A useful nutritional measure to identify the extent of obesity is the body mass index (BMI) measured in kilograms per meter squared. BMI greater than 30 is assumed to be due to excessive adiposity. There are exceptions where completely healthy and muscular people may have a BMI over both 25 and 30 without being considered overweight or obese. This is because muscle weighs more than fat. BMI does not say anything about the proportions of fat and muscle tissue within an individual. Waist circumference has shown to be a useful measure on an individual level to identify obesity. Research studies have given support to define abdominal obesity as a waist circumference over 88 centimeters in women and 102 centimeters for men.

Dietary assessment—that is, to measure the nutritional intake of humans—can be performed by different methods like a 24-hour dietary recall, food frequency questionnaire, food dairy record, dietary history since early life, and observed food consumption. Data on dietary intake in combination with data on nutritional status for different population groups will provide data to form national policy for nutritional interventions or programs and monitor progress of nutritional programs. Data on dietary intake form a base in epidemiological studies aiming to investigate the relationship between dietary intake and development of disease.

Indirect methods can be ecological variables including crop production, socioeconomic factors, population density, social habits, vital health statistics, age-specific mortality rates, and fertility index.

Conclusion

In a society where diversity is growing, nutritional assessment can serve to identify vulnerable groups and create interventions and programs to promote health in these groups.

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See Also: Food Support; Hispanic Health and Nutrition Examination Survey; National Health and Nutrition Examination Survey; Overweight and Obese Adults and Children.

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Occupational Therapy

Occupational therapy is a person-centered, nondirective intervention aimed at maintaining, recovering, or developing the client's health and well-being through occupation.

Occupation is a broad term that encompasses all the activities in which people participate in life, including self-care, productivity, leisure, interacting with their environment and socializing. Occupational therapy is useful and effective in acute treatment, rehabilitation, and secondary and tertiary prevention programs.

Historical Background

Throughout history, many scholars believed that exercise, work, recreation, and amusements could positively influence physical and mental health and well-being. Among them was Galen, a physician living in the 2nd century, and some physicians working in psychiatric institutions at the beginning of the 19th century: Philippe Pinel, Johann Christian Reil, William Hallaran, William Ellis, and W. A. F. Browne. Following their prescriptions, many patients structured their time in a balanced, productive, and gratifying manner, doing leisure activities and working in the kitchen, laundry, and garden of the psychiatric institutions they lived in. In the first part of the 20th century, occupational therapy was used to improve the daily life of the victims of epidemics and people suffering from physical disabilities caused by war.

Although the concept of occupational therapy was known for centuries, the term *occupational therapy* was coined at the beginning of the 20th century: The founders of this rehabilitation technique, the physicians Adolph Meyer, Herbert Hall, and William Dunton, believed that creative and manual work could help people with a physical, mental, or developmental condition to improve their skills, contributing to their physical and psychosocial rehabilitation. In 1917, the National Society for the Promotion of Occupational Therapy was founded in the United States.

Candidates for Intervention

Occupational therapy may be helpful for people who have impairment in their mental, sensory, or movement functions; damage to their skin or neuromusculoskeletal systems; or disabilities concerning mobility, communication, memory, learning, and applying knowledge. The intervention may be beneficial also to those who demonstrate an imbalance among self-care, productivity, and leisure; lose initiative spending a large amount of time in passive activities or rest; cannot define occupations they consider interesting or meaningful; or experience distress or limited enjoyment in activity. Candidates for the intervention are not only those who suffer from disorders that cause significant

Wounded soldiers from World War I practice their knitting skills. In the first part of the 20th century, occupational therapy was used to improve the daily life of the victims of epidemics and people suffering from physical disabilities caused by war. The physicans who founded this therapeutic technique believed that creative and manual work could help people with a physical, mental, or developmental condition to improve their skills, contributing to their rehabilitation.

disability and are of long-standing duration, such as dementia, traumatic brain injury, stroke, schizophrenia, developmental disorders, serious cardiovascular complaints, and severe panic and anxiety disorders, but also children with learning disorders, refugees, and homeless persons.

Purpose and Objectives

The fundamental mission of occupational therapy is to promote the clients' personal autonomy and their participation in social life, fostering their health and wellness. This includes helping clients adapt to their condition, learning or relearning activities whose performance they wish to master, adopting healthier lifestyles, preventing disease and trauma, and providing environmental adjustments suitable to promoting the effectiveness of performance skills, maintaining daily occupations, and keeping or obtaining paid employment. In order to fulfill these goals, occupational therapists (OTs) implement strategies that help their clients to acquire skills in the management of self-care, housework, medication, time, and stress—in this way, enhancing their assertiveness, cognition, self-awareness, and self-sufficiency. Specific objectives connected to the general purpose are set by OTs basing on the assessment of their client's gender, ethnicity, cultural background, socioeconomic status, individual strengths, and weaknesses.

An important part of the assessment process is taking into account the client's age group. In treating toddlers and children, the OT assesses whether the clients' physical, cognitive, emotional, and social skills and abilities correspond to their age; rest and activity phases are balanced; and regular leisure activities promote proper development. In treating adults, the OT determines whether the clients can attend to their self-care without assistance, organize their time in a meaningful way, use the available space in a proper manner, manipulate objects with both hands, pursue leisure activities that are meaningful for them, and promote their participation in a social community. In treating elderly people, the OT determines whether the clients use adequate self-care techniques, can handle and use everyday items properly, and are able to pursue their usual leisure activities and actually wish to. Once specific areas of weakness are determined, the therapist identifies appropriate goals in order to convert weaknesses to strengths.

To set specific objectives, the OT takes into consideration also the prognosis of the client's condition. If recovery is possible (i.e., after a knee replacement), the goal may be to restore the client's functional ability; if the client's condition is a permanent state (e.g., in hemiplegia), the goal may be to help the client to maintain the current occupational performance. If a decrease in functional status is expected (such as in degenerative disorders), the goals may be to compensate for the client's lost abilities and prevent risks for his or her health by adapting occupations and environment.

The Role of the Occupational Therapist

Because of their theoretical knowledge and professional skills, OTs conduct interventions performing different roles: They act as promoters of health, teachers of functioning, managers of adaptations, consultants, and coaches.

As promoters of health, they build trust with clients and their families, determine the clients' levels of functioning, organize the sessions and select appropriate activities, and conduct individual interventions. As teachers of functioning, they teach new ways of approaching tasks—for instance, breaking down a complex activity into achievable components and placing them in a logical sequence. As managers of adaptation, they evaluate the clients' homes and job sites, suggesting adaptations to remove obstacles or make them manageable, recommending the use of adaptive equipment, and training their clients on how to use them. As consultants and coaches, they cooperate with those who interact with the clients, providing expert advice and guidance to the clients' families, friends, coworkers, and caregivers.

In order to help the client to achieve his or her aims, OTs design and implement a specific program, making a baseline assessment, setting outcome goals, monitoring progress, and determining if the client's needs are being met; if not, the goals will be reviewed and the intervention strategy modified.

As each client is unique in how his or her physical, psychological, emotional, relational, and spiritual health are intertwined and interrelated, OTs have a deep responsibility to respect people's differences such as the values rooted in different cultures. Research has highlighted that OTs relying on a single approach may be not representative of most of the populations they serve. Indeed, already in 2004, the Sullivan Commission on Diversity in the Healthcare Workforce pointed out that increasing diversity in the health care professions can improve health care access and quality for all patients, strengthening health care delivery systems at multiple levels and promoting forward-looking research. Therefore, some scholars claimed that an OT's age, gender, ethnicity, and social, cultural, and linguistic background should correspond as much as possible to those of his or her clients; in this way, the clients' deeper needs would be more easily understood and answered in a professional way. Moreover, in order to provide a high level of service to their clients, OTs should embrace a wide diversity of approaches and techniques and keep abreast of the latest developments in their discipline.

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See Also: Adult Day Care; Disability Services; Elder Care/Geriatric Services; Rehabilitative Services; Senior Services.

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Office for Civil Rights

The Office for Civil Rights is an agency of the U.S. Department of Education, which was founded on October 19, 1979. Part of the executive branch of government, the Office for Civil Rights is headed by the U.S. assistant secretary of education for civil rights. He or she reports to the U.S. secretary of education and is appointed by the president of the United States. The primary mission of the Office for Civil Rights is the protection of students' civil rights by ensuring equal educational opportunities and access. Civil rights are a broad range of rights and privileges for individuals that are upheld by the government. They guarantee fundamental liberties and include but are not limited to freedom of speech and expression, the right to own property, and the right to have opportunities in education. The agency enforces civil rights laws in programs or activities that are federally funded by the Department of Education.

These programs and activities include but are not limited to elementary and secondary schools, colleges, universities, vocational schools, and many others. The agency is primarily concerned with students facing discrimination on the basis of their race, ethnicity, sex, disability, and age. They resolve discrimination complaints and work to create strategies to help prevent discrimination. Headquartered in Washington, D.C., the Office for Civil Rights has 12 offices throughout the nation, and each office has a territory that it oversees. These offices are also organized into four separate divisions. The divisions are preventing, identifying, ending, and remedying occurrences of discrimination. These are the core areas of work for the Office of Civil Rights.

Civil Rights Laws Enforced by the Office for Civil Rights

In order to protect students against discrimination, the Office for Civil Rights enforces several civil rights laws. These laws protect against forms of discrimination such as race, national origin, color, sex, disability, and age. To protect students against discrimination on the basis of race, national origin, and color, the agency enforces Title VI of the Civil Rights Act of 1964. Title VI specifically protects against segregation in schools, racial harassment, and refutation of language services for those who do not have English as their primary language. Another important aspect of Title VI is that it protects those who file an Office for Civil Rights complaint. This means that, when one files an Office for Civil Rights complaint, he or she is legally protected from retaliation coming from the institution or individuals involved in the claim.

Another civil rights law enforced by the Office for Civil Rights is Title IX of the Education Amendments of 1972. Title IX prohibits discrimination based on sex, such as sexual harassment, in athletics and against pregnant women. Title IX provides legal protection from retaliation for those making a claim. Discrimination against those with disabilities is enforced by the Office of Civil Rights following Section 504 of the Rehabilitation Act of 1973. Examples of discrimination of those with disabilities prohibited under Section 504 are not providing accessible entries into buildings and not making accommodations for the disabled in higher education settings. Section 504 also protects those who file a discrimination complaint from retaliatory acts.

Finally, discrimination on the basis of age is prohibited by the Age Discrimination Act of 1975. The Age Discrimination Act does not protect against employment discrimination, which is covered under the Equal Employment Opportunity Commission. The Age Discrimination Act of 1975 protects against discrimination in federally funded programs.

Institutions Adhering to and Areas Covered by the Office for Civil Rights

Institutions that are subject to laws enforced by the Office for Civil Rights are those that receive federal funding from the U.S. Department of Education. These include state education agencies such as elementary and secondary school systems, vocational schools, proprietary schools, colleges and universities, and even libraries and museums. Areas covered by the Office for Civil Rights are many and diverse because discrimination comes in many forms and can take place in many areas. A few examples include the admission and recruitment processes, student services such as counseling and financial aid, physical education, housing, and classroom-specific occurrences such as disciplining and grading. All of these situations have the potential for discrimination to take place, but the Office for Civil Rights is aware of this potential and can take necessary action to prevent or remedy any problem.

Resolving Discrimination Complaints and Prevention Efforts

The Office for Civil Rights handles the numerous educational complaints concerning discrimination made each year and has to deal with and attempt to resolve each claim. The agency is one of the largest federal civil rights agencies in the United States and had a budget for 2013 of $105,318,000. Also in 2013, there were approximately 650 people working for the Office for Civil Rights, many of whom are attorneys and investigators whose jobs are dedicated to resolving and investigating discrimination complaints. These complaints can be made by the victim but can also be made on the behalf of the victim or victims by anyone who suspects or witnesses discrimination. Implementing effective procedures for addressing complaints is crucial. These procedures are first attempted at the local level, and if they cannot be resolved there, they then have the chance to move up to the federal level.

However, recently the Office for Civil Rights has been actively shifting its focus to proactive prevention of discrimination compared to reactive investigation of complaints. The agency has been focusing resources aimed at developing strategies and programs to prevent discrimination from happening in the first place as compared to remedying the prob-

Workshop attendees from the Oregon Department of Transportation participate in a discussion group at the 2013 Diversity Conference. The Office for Civil Rights has been actively shifting its focus to proactive prevention of discrimination. It does so by concentrating at the local level, providing schools and other institutions with materials to evaluate and improve their approaches to discrimination.

lem after it has already occurred. The agency does so by concentrating on the local level. They aim to assist parents, students, schools, and universities specifically by providing them with the resources, tools, and knowledge to prevent discrimination. The initial starting point for discrimination prevention is to have comprehensive policies put into place at the local level within individual educational locations. These policies should have clear expectations and consequences laid out for actions of discrimination. These policies can also lay out actions that will be taken when specific acts of discrimination are committed such as sexual harassment or racial discrimination.

The Office for Civil Rights has also created self-evaluation materials for schools and other institutions to use in order to evaluate and improve their approaches to discrimination. The agency offers many self-evaluation materials for many different areas. These areas include different forms of harassment, students who are learning English as their second language, athletics, and science, technology, engineering, and math (STEM). These self-evaluations are used not just by the federally funded institutions but also by parents, the surrounding community, and the students themselves in order to better prevent and remedy any issues. These systems were developed from past experience working in school systems and have been shown to be effective.

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See Also: Department of Education, U.S.; Discrimination and Institutional Racism; Equal Opportunity and Civil Rights.

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Office for Faith-Based and Neighborhood Partnerships, White House

The White House Office for Faith-Based and Neighborhood Partnerships is an entity created to ensure equal government funding for faith-based service organizations. Congregations and other diverse houses of worship have acted as service providers to millions of people for many years. Often, they provide more services than secular organizations. The federal government has gotten involved to make sure these groups receive an adequate and equal amount of federal funding in order to continue to provide services. The three main world religions, Christianity, Judaism, and Islam, are actively involved in social services provision. Christianity is based on the teachings of Jesus Christ. Judaism is the monotheistic religion of the Jewish people. Islam is a monotheistic faith based on the belief that the prophet Muhammad is Allah (God)'s chosen messenger. Often, people are connected with these free services through their places of worship, word of mouth, and news advertisements.

History of Faith-Based Organizations

Faith-based organizations can be dated back to the 19th century, when leaders of Christian churches created service organizations that carried forward their Christian values. A historical example of a faith-based organization is the Salvation Army, which is a Christian-based service organization founded in 1865. Faith-based organizations are service providers that have a distinct religious component. Services provided include but are not limited to education, child services, housing, and elderly care. These organizations may or may not integrate their religious beliefs and practices with the provided services. The three main world religions (Christianity, Judaism, and Islam) all have several organizations within each group that provide services across the world. Organizations in these faith traditions tend to name accountability to God as the reason for service provision. Examples of these initiatives include Catholic Charities USA, the Hebrew Immigrant Aid Society, and Islamic Relief Worldwide.

Natasha Falle, herself a survivor of sexual abuse, a former sex worker, and now an activist and professor, has teamed with a variety of organizations opposing human trafficking, including the Salvation Army. The Salvation Army is a Christian-based service organization that was founded in England in1865 and now operates internationally.

Government and Faith-Based Organizations

President Bill Clinton's administration created Charitable Choice in 1996 to allow government funding for religious organizations that provide social services. In 2001, President George W. Bush issued an executive order that created the White House Office of Faith-Based and Neighborhood Partnerships. A second executive order created equality in regards to funding among faith-based and other community organizations. Several government agencies have centers specifically to execute this order, including the Departments of Health and Human Services, Education, and Veterans Affairs. The Task Force for Faith-Based and Community Initiatives is the center for the Department of Justice. President Bush issued a third executive order in 2002 compelling the federal government to treat all faith-based and other social organizations equally in regards to social services funding. This order prohibited discrimination on the basis of religion and mandated how federal money could and could not be used to comply with constitutional requirements. In 2004, the Department of Justice's Equal Treatment Regulations made sure that faith-based organizations were able to apply for federal grants and contracts from the Department of Justice on an equal level with non-government organizations.

Recently, Secretary of State John Kerry appointed a special advisor to be in charge of the State Department's new Office of Faith-Based Community Initiatives. This office's goal is to ensure that faith communities will be heard in foreign policy and will work with other government officials regarding diplomacy and religious issues.

Faith-Based Organizations as Service Providers

Faith-based organizations provide a plethora of services. Most often, faith-based groups provide specialized services such as rehabilitation of criminals, substance and alcohol abuse counseling, health services, food, clothing, and shelter for the poor, partnerships with neighborhood schools, educational resources, employment assistance, and voter registration. Communities in which the majority of its residents have a low socioeconomic status rely heavily on faith-based organizations to provide essential social services. Services such as Alcoholics Anonymous are faith-based, as are many homeless shelters, food banks, and clothing services.

Faith-based organizations use volunteers to provide services through a variety of roles within the respective groups. Volunteers fill in the gaps when there is a high staff turnover within an organization. The religious component of faith-based organizations is the most common reason why volunteers offer their time and services. Those who volunteer most often in a faith-based organization do so because of a religious obligation to help those in need and as a way to concretely express their religious faith.

For many years, the government has provided funding for faith-based organizations that provide social services, which raises questions about the separation of church and state. Temporary Aid to Needy Families, Welfare to Work, and Community Services Block Grant funds have provided the majority of financial assistance for these organizations. At no time can the funds be used for specific religious practices such as worship and evangelism. Many faith-based organizations rely on funding from volunteers and donors, but government funding has led to better organization of the faith-based groups.

Small faith-based organizations often have trouble applying for and being awarded government grants and funding because they do not know the protocols and process. Currently, the staff of the Department of Justice Task Force for Faith-Based and Community Initiatives provides workshops for instruction on how to properly apply for government funding and contracts. Lutheran Services, Catholic Charities, and Jewish Federations are some of the funding groups that raise and disseminate financial assistance to faith-based organizations.

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See Also: Community-Based Services; Equal Opportunity and Civil Rights; Religion and Clients; Temporary Aid to Needy Families

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Office of Juvenile Justice and Delinquency Prevention

Although there were a series of acts pertaining to juvenile justice and prevention in fragmented forms beginning in 1912, the Juvenile Justice and Delinquency Prevention (JJDP) Act (Pub. L. No. 93-415, 42 U.S.C. § 5601 *et seq.*) of 1974 was the first to introduce a comprehensive, nationwide approach at the federal level. Consequently, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) was established under the same act to provide organizational infrastructure to this approach. Even though the OJJDP does not actively enforce laws, oversee trials, or conduct interventions, they provide comprehensive information regarding policies, programs, and grants for all activities involving youth and violence prevention. Staff serve on various committees and partner with myriad organizations locally and nationally to ensure standardized procedures for violence prevention programs, procedural aspects of the juvenile justice system, and rehabilitation programs. Their involvement can be as intensive as providing oversight and funding to specific prevention programs or as general as providing an online

A Lewis Wicks Hine photograph, one of a series documenting the issue of child labor in 1912. Although laws were in place to prevent young children from working, some families had no choice but to force their children into work, where they were often arrested and put on probation (the two older boys pictured were on probation at the juvenile court). Although a series of acts pertaining to juvenile justice and delinquency prevention began in 1912, the Juvenile Justice and Delinquency Prevention (JJDP) Act of 1974 was the first to introduce a comprehensive, nationwide approach at the federal level.

programming framework and a support network for local and national organizations.

History

Until the mid-1900s, the criminal courts were primarily concerned with adult crimes and treated children in a paternalistic manner. Policy makers pushed for youth to have the same rights as adults, even if being tried within a juvenile court, by mandating due process in the judicial procedure. Further, the term *delinquent* was used arbitrarily by law enforcement officers, judges, or lawyers without any evidence of precriminal behavior, thereby introducing a bias in the process. Further, the separation of children and adults during the incarceration period became a concern secondary to negative outcomes for youth in nondivided environments. The need for uniformity and standardization of such procedures and preventive measures resulted in the establishment of the JJDP Act and consequently the OJJDP. This act ensured that the OJJDP worked in coordination with law enforcement and the criminal justice system to improve all aspects of youth violence issues and services.

Partnerships and Collaboration

The administrator of this office spearheads the support of local and state programs in their efforts to prevent delinquency and improve the juvenile justice system, with a particular focus on youth. The office has expanded its scope by focusing on prevention programs and rehabilitation resources. The OJJDP is also involved with the Coordinating Council on Juvenile Justice and Delinquency prevention, an independent body within the executive branch of the federal government, and the Federal Advisory Committee on Juvenile Justice, a consultative body composed of appointed representatives of state advisory groups. The OJJDP releases annual reports documenting the office's efforts in strengthening the juvenile justice system, combating delinquency, preventing victimization, and enhancing public safety. As an organization, it consists of the Office of the Administrator, the Office of Policy Development (including the communications unit), three program divisions (child protection, demonstration programs, and state relations and assistance), and the Grants Management Unit.

Purpose

As stated in their mission statement, the focus of the OJJDP is to prevent and respond to juvenile victimization and delinquency by providing leadership, coordination, and resources at a national level. They also work with states and local communities to develop and implement prevention and intervention programs. The OJJDP partners with stakeholders to improve the juvenile justice system by providing treatment and rehabilitative services for juvenile offenders and their families, protecting public safety, and holding offenders accountable.

Current Programs

The programs that OJJDP has provided resources for include the following: Children's Advocacy Centers, which work on child abuse cases; Crimes Against Children Research Center; Disproportionate Minority Contact; Enforcing Underage Drinking Laws; Formula Grants Program, for state and local delinquency prevention programs; Gang Reduction Program; Information Sharing to Prevent Juvenile Delinquency; Juvenile Information Sharing (JIS), a training and technical assistance project; Internet Crimes Against Children Task Force Program; Juvenile Accountability Block Grants Program; Juvenile Drug Courts and Reclaiming Futures Program; Model Dependency Courts Initiative; National Center for Missing and Exploited Children; National Gang Center; Program of Research on the Causes and Correlates of Delinquency; Programs for Tribal Youth; Safe Start, for young children and their families living in particularly violent circumstances; and the Truancy Reduction Demonstration Program.

The OJJDP as a whole contributes to human services and diversity by ensuring that racial minorities are given a special interest through purposeful integration into research and intervention programs. It provides a plethora of resources for organizations involved in youth violence prevention, families of delinquent youth, and the youth themselves, while simultaneously conducting research and advocating policy pertaining to juvenile justice issues. The Disproportionate Minority Contact (DMC) and Programs for Tribal Youth (PTY) in particular focus on ensuring that all racial and ethnic differences in the juvenile justice system are addressed. The DMC takes into consideration the number of youths from each minority group and advocates for legislative and systematic improvement efforts that reduce the identified disproportion. It also works with intervention programs to ensure that there are evidence-based objectives targeted at this disproportion. The PTY hosts a wide range of services, resources, and initiatives specifically for youth from the tribal population or living under the tribal government. It has also conducted leadership conferences and mentoring programs for at-risk Alaskan and other Native American youth as a part of the prevention and advocacy efforts.

Grants and Information Dissemination

OJJDP provides a variety of grants and assistance in the grant proposal process through their performance measures and grant management system. The focus of these initiatives has been on evidence-based intervention and innovative research methods. In conjunction with grant funding, the OJJDP provides substantial data and statistics in this field through the judicial system records and the National Research Council. They continue to disseminate programming guidelines, evaluation methods, and critical statistical information to states, as well as individual prevention organizations through their reports, newsletters, and publications.

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See Also: American Correctional Association; Association of Juvenile Compact Administrators; At-Risk Youth Services; Community Development Block

Grants; Disposition of Juvenile Records; Gangs: Social Issues and Intervention; Incarceration and Sentencing, Racial Disparities in; Jail Diversion Programs for Children and Adolescents; Juvenile Delinquents; Juvenile Detention Centers; Juvenile Justice System; Youth Risk Behavior Surveillance System.

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Office of Refugee Resettlement

The Office of Refugee Resettlement (ORR) is a federal agency of the U.S. government that aids refugees after their entry into the United States. The United Stated admits scores of thousands of individuals who meet the definition of refugee status agreed upon by the international community and a treaty dealing with refugee issues. A yearly quota is set for the number of refugees that will be admitted into the country.

The Department of Homeland Security grants refugee status to those people the agency approves before they enter the country. The U.S. State Department is responsible for moving the refugees to the United States. Once refugees arrive in the United States, the ORR, along with partnering organizations, begins to provide them with many kinds of aid and resources as they begin the process of resettling.

Definition of a Refugee

The accepted definition of a refugee includes the fact that a person is away from his or her home country and, due to persecution or substantial fear of persecution due to race, religion, nationality, being a member of a certain group, or having certain political opinions, cannot return to his or her home country. The United States passed its first refugee laws after World War II, when there was a large influx of refugees from Europe. Further legislation was passed after other refugee crises that led to influxes over succeeding years. After the end of the Vietnam War, a heavy burden was place upon the country with the large number of refugees created by that war. Various temporary measures were enacted to provide relief to these refugees. In 1980, permanent legislation was passed to provide a more constant source of aid to those coming in as refugees.

Establishing Laws and Procedures

The Refugee Act of 1980 established U.S. policy toward refugees and provided concrete aid for those resettling in the country. As a direct result of this legislation and later statutes, the ORR was formed as an agency under the U.S. Department of Health and Human Services (HHS) to provide essential aid to those refugees seeking a new start in the United States. The Administration for Children and Families is the section of HHS under which the ORR is housed.

In the years after the establishment of the ORR, laws were enacted that broadened the scope of help provided by the ORR to include others beside refugees. One class of people to which help was extended was immigrants from Cuba and Haiti. In many ways, people from these countries were treated as refugees. Cuba was a special case as a result of our country's long-standing conflict with Fidel Castro and the repression in that country. Haiti received special status because of the political oppression faced by many Haitians and the sheer number of those from Haiti reaching our shores in any way possible. Many Amerasians in southeast Asia left because, being of mixed parentage and often with American fathers, they were looked down upon in places like Vietnam. Congress passed legislation allowing many of these individuals and their families to immigrate to the United States, and they were given the right to claim many of the same benefits offered by the ORR to refugees. Three other classes of those who could receive refugee benefits were asylees, those entering the country and then claiming the same kind of persecution or fear of persecution as refugees and then given approval for asylum, certain torture victims, and victims of human trafficking.

The ORR and Its Partners

Although the ORR does not work directly with most refugees and others beneficiaries, the agency works with a variety of partners, both governmental and private. The ORR partners with a wide array of departments and agencies of the federal government. Being an agency under HHS, it naturally works with other agencies in the same department. Some of the issues dealt with by partner HHS offices are civil rights, drug abuse, mental health, the Head Start program, and aging. The ORR works with the departments of State, Justice, and Homeland Security. The ORR also partners with Mutual Assistance associations, community-based organizations whose leadership boards are made up of a majority of refugees or former refugees. These organizations are often better equipped to help refugees resettle, because those who lead the group have been where newer refugees are. The ORR also partners with the 50 states; each state has a refugee coordinator. States rely, in large part, on federal funds to carry out programs to help refugees.

An important class of partners for the ORR are resettlement voluntary agencies (VOLAGs). VOLAGs contract with other federal agencies to provide immediate reception into the United States. Many VOLAGs also contract with the ORR to provide ongoing help for refugees in the resettlement process once initial settlement has begun. A small handful of these VOLAGs provide a significant portion of refugee services in the United States. These VOLAGs are crucial lynchpins to the process of the ORR, giving help to refugees. Among the larger VOLAGs are the Church World Service, World Relief, U.S. Committee for Refugees and Immigrants, and United States Conference of Catholic Bishops.

A number of benefits are available to refugees and to those who are eligible for help from the ORR. One of the biggest benefits is direct cash assistance. The ORR provides the funds so that refugees can apply in their states of residence for this help. Those who meet certain qualifications can receive these payments for up to eight months. During the same time period, these individuals are eligible for refugee health insurance and often other health benefits. The ORR also arranges for those eligible under its programs to be able to receive certain social services. These services include assistance that would help a refugee get gainful employment such as social adjustment, child care, citizenship and naturalization efforts, and language issues.

With many of these services, priority is given to those who have been in the country for less than five years. The goal is that through these kinds of social services, refugees will be able to gain employment within one year. The ORR has also contracted with a number of entities to provide those who have survived torture or other abuse with emotional, medical, legal, social, and psychological help to facilitate recovery. The ORR has also developed a Refugee Agricultural Partnership program. This program supports and encourages rural and urban farming efforts of refugees and provides some income, food, and mental and physical health support. The ORR furthermore provides funding to school districts to enable better care and integration in schools for school-age children of refugees. Through the ORR, every effort is made to successfully integrate into their new home country those who have been through difficult circumstances.

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See Also: Case Management Service; Family Reunification; Immigration, Human Service Issues; Information and Referral; Legal Services; Refugee Assistance; United Nations High Commissioner for Refugees; U.S. Citizenship and Immigration Services; Vietnamese Americans; War and Terrorism, Survivors of.

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Office of Safe and Drug-Free Schools

The Office of Safe and Drug-Free Schools (OSDFS) was created in September 2002 to unite several programs concerned with the safety, health, and citizenship of the nation's schools that had previously operated under the direction of a number of different federal offices. Functioning under the auspices of the U.S. Department of Education, the OSDFS provided financial assistance for drug and violence prevention activities and activities that promoted the health and well-being of students in elementary and secondary schools and institutions of higher education; participated in interagency committees, groups, and partnerships related to drug and violence prevention; participated in the formulation and development of Department of Education program policy and legislative proposals and in overall administration policies related to violence and drug prevention; cooperated with other federal agencies in the development of a national research agenda for drug and violence prevention; and administered the programs of the Department of Education relating to character and civics education. After seven years of operations, sometimes marked by controversy, OSDFS faced congressional budget cuts of several programs that it had administered. In the wake of these cuts, on September 26, 2011, OSDFS's name was replaced by the Office of Safe and Healthy Students.

The Predecessors of OSDFS

In 1986, Congress passed the Drug-Free Schools and Communities Act. From 1987 to 1994, an increasing number of elementary and high school teachers reported physical conflict and weapons possession as a moderate to serious problem in their schools. In 1994, about 3 million violent crimes and thefts occurred each year in or near schools. In response to the concerns raised by this increase, on October 20, 1994, President Bill Clinton signed the Improving America's Schools Act. The act reauthorized the Elementary and Secondary Education Act and created the Safe and Drug-Free Schools Act as Title IV. This legislation extended, amended, and renamed the Safe and Drug-Free Schools and Communities Act and added violence prevention to the original drug prevention purpose. It authorized funding for federal, state, and local programs to assist schools in establishing an academic environment free of violence and drug use (including alcohol and tobacco).

The No Child Left Behind Act (NCLB), sponsored by powerful congressional leaders such as Representative John Boehner (R–OH) and Senator Edward Kennedy (D–MA), passed both houses of Congress with broad bipartisan support and was signed into law by President George W. Bush on January 8, 2002. Although NCLB is best known for its accountability and standardized testing components, it also reauthorized the Safe and Drug-Free Communities Act as Part A of Title IV and created the OSDFS under the Department of Education.

The Work of OSDFS

Operating under the supervision of the assistant deputy secretary of the Department of Education, who reported to the secretary and the deputy secretary on policy and program administration matters, the OSDFS provided leadership and coordinated programs in five areas: health, mental health, environmental health, and physical education; drug violence prevention—state programs; drug violence prevention—national programs; character and civic education; and policy and cross-cutting programs. The office distributed discretionary grants to local educational agencies and community-based organizations to promote health and prevent violence at the primary, secondary, and higher education levels.

Specific programs were varied in purpose and design. The Carol M. White Physical Education Program provided grants to initiate, expand, or enhance physical education programs, including after-school programs for students in kindergarten through 12th grade, which included activities such as development of and instruction in cogni-

The Gay, Lesbian, and Straight Education Network (GLSEN) marching in the 38th annual Capital Pride parade on June 8, 2013. GLSEN was founded by Kevin Jennings, who made antibullying the focus of his controversial tenure from 2009 to 2011 as assistant deputy secretary in charge of the Office of Safe and Drug-Free Schools (OSDFS). The GLSEN works on improving the climate in schools for students who may face problems because of their sexual orientation.

tive concepts about motor skills and physical fitness that support a lifelong healthy lifestyle; opportunities to develop positive social and cooperative skills through physical activity participation; and opportunities for professional development for teachers of physical education to stay abreast of the latest research, issues, and trends in the field of physical education. Governors' grants gave priority to programs targeting unreached or inadequately reached student populations such as youths in juvenile detention facilities, runaway or homeless youth, pregnant and parenting teenagers, and school dropouts. One national project supported school-based mentoring programs and activities to serve children with the greatest need in grades four through eight who lived in rural areas, high-crime areas, or troubled-home environments or who attended schools with violence problems.

Controversy at OSDFS

Department of Education Secretary Arne Duncan appointed Kevin Jennings as assistant deputy secretary in charge of the OSDFS in 2009. Almost immediately, conservatives began attacking the appointment of Jennings, a gay man and founder of the Gay, Lesbian, and Straight Education Network, which works on improving the climate in schools for students who may face problems because of their sexual orientation. A group of 53 Republican members of Congress wrote President Barack Obama charging that Jennings would promote a pro-homosexual agenda in America's schools in violation of the values of many parents and requesting that the president remove Jennings from his position at OSDFS.

Jennings, who took office at a time when the media had reported a rash of suicides by gay students, made antibullying a particular focus of his tenure. He worked with groups such as the National Association for Pupil Transportation to create the first federal antibullying intervention program for bus drivers, and his office helped convene the first White House Conference on Bullying Prevention. Some in the school safety field felt that his focus was too narrow and that other areas suffered during the period of bullying emphasis, citing cuts in funding for emergency school grants that could be used to train staff members as one example. Jennings resigned in 2011, acknowledging the difficulty of enduring the firestorm of attacks but expressing his satisfaction that the national momentum to control bullying and make schools safer places for all students would continue.

Also in 2011, after cutting almost $80 million from the OSDFS budget, Congress eliminated a number of the programs administered by the office including the mentoring programs, charter education and state grants, mental health integration in schools, foundations for learning, grants to reduce alcohol abuse, and civic education. OSDFS announced that, while their commitment to their mission remained unchanged, it was necessary to maximize their newly limited resources. On September 26, 2011, the OSDFS ceased to exist. It was replaced by the Office of Safe and Healthy Students within the Office of Elementary and Secondary Education.

The Office of Safe and Healthy Students

The Office of Safe and Healthy Students is divided into three subordinate units: the Safe and Supportive Schools Group, the Healthy Students Group, and the Center for School Preparedness.

The Safe and Supportive Schools Group administers the safe and supportive schools grant program and coordinates interagency focuses on bullying, school recovery research, data collection, and drug and violence prevention activities. In addition, this group provides leadership character and civic education. The Healthy Students Group administers programs that provide financial assistance for activities that promote the health and well-being of students in elementary and secondary schools and institutions of higher education. The Carol M. White Physical Education Program is the responsibility of this group. Finally, the Center for School Preparedness is in charge of programs that improve the ability of schools to prepare for and respond to crises and disasters (natural and human-made). The center also oversees issues related to homeland security and maintains contact with school security police chiefs, school resource officers, and emergency first responders.

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See Also: Department of Education, U.S.; Educational Services; Education Support Services; School Health Services; School Mental Health Project.

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Office of Special Education and Rehabilitative Services

The U.S. Department of Education operates the Office of Special Education and Rehabilitative Services (OSERS) to provide programs and support that assists those with special needs. With a dual focus on programs and research, OSERS works to implement some of the key legislation dealing with disabilities. OSERS is composed of the Office of the Assistant Secretary for Special Education and Rehabilitative Services, one of four offices reporting to the deputy secretary of education. To serve its intended mission, OSERS operates three programs. These three programs are the Office of Special Education Programs, the National Institute on Disability and Rehabilitation Research, and the

Rehabilitation Services Administration. Together, these three programs serve as the U.S. government's primary policy supports for individuals with disabilities.

Background

Although the Department of Education was first created in 1979, various offices and agencies of the U.S. government had worked to support individuals with disabilities before this. Previously a part of the Department of Health, Education, and Welfare, itself formed in 1953, the Department of Education was made independent in an effort to collect better data from U.S. schools as well as to establish policy for and administer federal aid to schools. The Department of Education also enforces federal civil rights laws and the privacy rights of students and families. This oversight has been especially significant with regard to the rights of individuals with special needs, as many of these are grounded in federal laws and regulations.

Beginning in the 1960s, more attention and funding were directed at the education of individuals with special needs. Prior to this, many children with special needs were provided with no education or housed in institutions that separated them from the general education programs in most schools. In 1967, however, James Gallagher, formerly a professor at the University of Illinois, became the director for the Bureau for the Education of the Handicapped, later the Office of Special Education Programs (OSEP).

Although the federal government has begun OSEP, many states and local school districts made few changes to provide educational services to children with special needs until 1975, when Congress passed the Education for All Handicapped Children Act (later the Individuals With Disabilities Education Act [IDEA]). This act required all schools accepting federal funds to provide children with cognitive or physical disabilities equal access to education. To this end, school districts were required to assess children who might have a disability. If a child was found to have a cognitive or physical disability, the school was required to form an individualized education program for him or her, and to monitor the child's progress over time. This change in law created many new opportunities for children with disabilities, many of which were monitored by the OSERS.

Operations and Responsibilities

OSERS is responsible for administering programs and monitoring compliance with a variety of federal laws. These laws include IDEA, the Rehabilitation Act of 1973, the Education of the Deaf Act, the Act to Promote Education of the Blind Act, the Assistive Technology Act of 2004, the Randolph–Sheppard Act, and the Helen Keller National Center Act. To that end, OSERS is organized so that it provides programs in three areas, OSEP: the National Institute on Disability and Rehabilitation Research (NIDRR), and the Rehabilitation Services Administration (RSA). Each of these programs is responsible for formulating and disseminating policy, monitoring compliance, and supporting research and programming that benefits individuals with disabilities.

OSEP provides support for school personnel and others who work with children with disabilities. Specifically, OSEP helps ensure that children with disabilities are provided with a free and appropriate public education in the least-restrictive environment possible. To do this, OSEP works to formulate and promote policies related to early intervention programs, preschools, elementary schools, middle schools, and high schools so that children with disabilities are provided with the educational services they need. Because of the importance of skilled personnel to work with children with disabilities, OSEP promotes the training of professionals as well as volunteers, parents, and others. OSEP monitors compliance with federal rules and regulations regarding special education services, and it also coordinates the review of its own activities by relevant stakeholders. To ensure the continued evolution and improvement of services provided to children with disabilities, OSEP also provides competitive and state-administered program grants to promote discretionary programs and funds research and innovative services that show promise.

NIDRR works to improve the lives of individuals with disabilities regardless of their age. As the primary federal agency that supports applied research regarding as well as the training and development for individuals with disabilities, NIDRR seeks to improve available rehabilitative services. This is done in two ways. First, NIDRR seeks to generate new knowledge regarding disabilities and rehabilitative services and then to promote its effective use to permit individuals with disabilities to perform activities of their choice within their own communities. Second, NIDRR works to expand society's capacity to support individuals with disabilities and to provide them with full opportunities and accommodations necessary to live and thrive. NIDRR funds and monitors a series of grants that supports these goals and disseminates the findings to appropriate stakeholders.

The RSA was specifically established to monitor grant programs that were established pursuant to the Rehabilitation Act of 1973. As that act prohibits discrimination based on a person's disability, the RSA works to fund programs that allow individuals with cognitive or physical disabilities to live as independently as possible and to obtain suitable employment. To ensure this, the RSA provides funding for supports that will make these outcomes more likely, such as counseling, job training, and other individualized vocational services, along with medical and psychological care. State programs that provide these supports are funded by the RSA through a formula-based program. The RSA monitors these programs to ensure that individuals between the ages of 14 and 24 receive services in a timely and adequate manner. The RSA also audits financial records of the programs it funds to ensure compliance with financial requirements of various statutes and regulations. Results of the Title I funds that RSA provides to state vocational rehabilitation agencies are maximized through publicity that is shared with other groups.

OSERS works to coordinate efforts devoted to special education, vocational rehabilitation, and research devoted to support these programs. These efforts are intended to allow children and adults with disabilities to be, as much as possible, fully included in school, employment, and life. Through rigorous analysis of the various programs it funds, OSERS is able to identify those approaches that work best to foster success in schools for children and employment opportunities and independent living options for adults. As a result, the opportunities for individuals with disabilities have grown dramatically over the past five decades.

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See Also: ADHD, Services for Individuals With; Administration on Developmental Disabilities; Children With Special Needs; Department of Education, U.S.; Head Start and Prekindergarten Programs; School Psychologists.

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Outpatient Medical Care

Outpatient medical care is care that is not provided in an inpatient (acute care, subacute care, or residential) setting. Outpatient medical care takes place in physician's offices, clinics, testing centers, and in designated areas of most hospitals. Outpatient services are utilized by everyone, creating a very diverse clientele for service providers. Physicians, nurses, therapists, mental health professionals, and others all provide services regularly to an ethnically and racially diverse population.

Cost constraints and resource limitations in the United States have caused a shift in recent decades related to the delivery of many medical services. Procedures and treatments that were once typically inpatient hospital services are now provided on an outpatient basis or with limited inpatient treatments. In the early 1980s, Medicare changed the way it provided payment to hospitals. Prior to this time, if a person was hospitalized, his or her care, treatment, and procedures would be itemized, and insurance would have paid the bill—a process that made it very difficult to contain costs. Policymakers changed this to a system of diagnosis-related groups (DRGs), which categorized reasons for hospitalizations and paid the hospitals a set rate for delivering the services. Every admitting diagnosis, from heart failure to pneumonia to vaginal delivery, has a set price attached to it. If a patient is hospitalized for one of these diagnoses, the hospital receives the set rate for the diagnosis regardless of how long the patient actually stays in the hospital. The longer a patient stays in the hospital under the DRG payment system, the more money the hospital loses.

Costly inpatient treatment, combined with DRGs limiting the amount of money the hospitals can get paid, have created the implementation of increased outpatient services. Unless a person is hospitalized for an acute illness or acute symptom management, most tests and treatments are completed in outpatient settings. Inpatient acute and subacute care is much more costly than outpatient treatments and is reserved for medical management of illnesses and conditions that cannot be addressed in outpatient settings.

One of the drawbacks to increased delivery of care in outpatient settings is reduced access to care. Patients who do not have health insurance or have limited funds will have difficulty accessing care on an outpatient basis. These services are often administered in office-like settings, with a check-in point that requires payment prior to the service being completed. If a patient does not have the money to pay for the service, it can be difficult to have the service performed. The facility may have a payment plan or charity care application or may require either health insurance coverage or payment in full as the only options. Inpatient care or emergent care is, in this case, the only way a person is able to meet his or her medical needs. There are also outpatient health clinics and health departments that serve patients who are uninsured or have limited resources, but they may not provide all necessary services, and they also may exclude patients who make too much money to qualify for their services but not enough money to afford to pay for their care.

Medical Services

There are many types of outpatient medical care services. Radiological services including X-rays and other scans are typically performed on an outpatient basis. Laboratories used for blood draws and testing provide services that are generally for outpatients. Therapy services, including physical, occupational, and speech, are often performed in outpatient offices or clinics as opposed to during lengthy inpatient hospitalizations.

When determining the need for inpatient services, it is useful to ask the question: Is there something being done in the hospital that cannot be done anywhere else? In cases of acute illness or severe medical instability, 24-hour monitoring may be a necessity and thus require acute hospitalization. In subacute or acute rehabilitation settings, patients may be receiving such a large amount of therapy services during the day that keeping them in the facility where the services are being provided is most beneficial to their care and well-being. There are other times when this question yields a different answer, as in the case of a patient who has a wound that needs dressing. If the wound can be cared for either by the patient at home or with medical assistance at home or in the doctor's office, the patient will not meet the criteria to receive further inpatient care.

Cancer is one medical condition that has seen a shift in the way the treatment is provided. Many cancer treatments are now performed on an outpatient basis. In the past, chemotherapy was administered in the hospital during an inpatient stay. This has changed as now chemotherapy is provided on an outpatient basis except for special circumstances. Not only is it more cost-effective to administer chemotherapy to outpatients, but it is also proven to be safer. Chemotherapy patients can be highly susceptible to infections, making a hospital that houses hundreds of ill people a potentially very dangerous place to be.

Childbirth is another condition that has seen a shift in inpatient care. While there are not yet standards in place for complete outpatient deliveries, the amount of inpatient care is steadily shrinking. Gone are the days when a woman could stay in the hospital for four or five days after giving birth to a child. Currently, the average length of stay for a vaginal birth is 24 to 48 hours and three to four days for a cesarean birth. Other pregnancy-related care is administered as outpatient, including ultrasounds, glucose testing, and exams.

Psychological and Psychiatric Services

Most psychiatric and mental health services are also provided on an outpatient basis. Chronic mental illness is treated by outpatient psychiatry appointments, regular therapy, and sometimes even an intensive outpatient program (IOP). These programs provide more intensive care than weekly or biweekly hourly sessions but less than full-time residential care. Inpatient psychiatric treatment is provided on a very limited basis. If a patient is deemed appropriate for an outpatient level of care, then inpatient services will not be covered by insurance. In cases of substance abuse treatment, there are inpatient and outpatient services as well. Severity is not the only factor used in determining whether substance abuse treatment is inpatient or outpatient. If a patient has had multiple inpatient and outpatient treatments, insurance companies are often less likely to authorize additional costly inpatient services.

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See Also: Community Health, Racial and Ethnic Approaches to; Diversity and Quality in Health Care; Health and Sickness, Differing Attitudes Toward; Health as a Human Right; Health Care Delivery, Models of; Health Care, Disparities in; Health Disparities, Role of; Health Insurance; Health Insurance Portability and Accountability Act of 1996; Public Health.

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Overweight and Obese Adults and Children

Weight management has become an increasingly pervasive issue among Americans. Education on and intervention upon obesity are critical because the steady increase in obesity among adults and children has resulted in serious health consequences for the overall health and welfare of American citizens. To date, a variety of campaign and intervention initiatives have been developed and implemented to combat obesity among target populations.

Individuals who are categorized as overweight or obese have a body mass index (BMI) that falls above that of an individual who is within a healthy weight range. One's BMI is calculated using height and weight. The Centers for Disease Control and Prevention categorizes an individual with a BMI between 25 and 29.9 as overweight. If a person has a BMI that falls above 30, he or she is considered to be obese.

It is important to note that BMI should not be the only indicator used in determining whether or not an individual is at a healthy weight. In certain cases, athletes who have a substantial amount of muscle mass may fall above the recommended BMI because their muscle mass places them at a much higher weight than a nonathlete. Given this, additional tests may need to be taken into consideration, such as body fat measurement, when determining whether an individual can be categorized as overweight.

Prevalence of Obesity

Weight problems are an increasingly common issue among American citizens. The Centers for Disease Control and Prevention has tracked the progression of obesity throughout the last two decades. Through this practice, it has been found that the average adult obesity rate has drastically increased from around 10 percent in the 1990s to nearly 33 percent in 2010. The Robert Woods Johnson Foundation has also projected that this rate will increase to nearly 50 percent or 60 percent in most U.S. states by 2030. Given this, it is imperative for new health interventions and campaign initiatives to focus on how to reduce obesity and prevent future incidences of this problem.

Obesity Among Children

Adults are not the only individuals suffering from obesity problems in the United States. The Centers for Disease Control and Prevention has reported that nearly 13 percent of American children were categorized as obese in 2011. To receive a categorization of obese, a child must be at or above the 95th percentile for BMI. As a result, these children are likely to suffer from detrimental health outcomes such as sleep apnea, type 2 diabetes, high cholesterol, anxiety, breathing problems, and joint problems. Many children who suffer from obesity issues have overweight or obese family members as well.

Obesity Implications

Obesity is a focal issue for public health practitioners because it can have serious negative consequences on the overall health of adults as well as children. Adults who experience obesity are likely to develop issues such as coronary heart disease, type 2 diabetes, cancer, hypertension, stoke, liver disease, gallbladder disease, sleep apnea, osteoarthritis, and infertility. These negative health outcomes can impede upon one's personal quality of life and the quality of life of his or her close family members. Additionally, these severe health issues are extremely costly for patients, health care systems, and taxpayers.

Factors Contributing to Obesity

Several different factors have been identified by the Mayo Clinic as contributors to obesity. One of the most basic contributors to this problem is an inactive lifestyle. People who lead sedentary lifestyles do not burn many calories. Many Americans who have sedentary jobs and drive vehicles to work do not take time out of their day to ensure that they are getting extra physical activity. This is why many obesity campaigns attempt to persuade target audience members to engage in small behavior changes that can easily be integrated into one's daily life. These behaviors include climbing the stairs instead of taking the elevator or going for short walks over one's lunch hour.

Another primary contributor to obesity is unhealthy dietary practices. Adults and children who consume diets that consist of foods with very high caloric value are more inclined to gain weight. These foods can include but are not limited to fast food, fried food, candy, and alcoholic beverages. Scaling back the amount of high-calorie foods an individual consumes can help that person lose weight over time.

Family history and genetics can also influence one's risk for obesity. Genetics can impact how fast an individual's metabolism runs and how quickly one's body can change calories into energy. Furthermore, genetics can influence where the body stores fat and how evenly it is distributed. Given this, it is important for people to consider familial history when developing a weight loss plan.

Household income and environmental factors have also been linked to obesity. This link is partially related to environmental issues such as the limited availability of nutritious food in lower-income communities. Low-income communities tend to have limited options in terms of stores and markets that offer fresh fruits and vegetables. Oftentimes, members of these communities are forced to make do with less-than-nutritious options provided at corner stores rather than full-fledged grocers. As a result, these individuals are not provided with a wide array of nutritious options that people have access to in middle- and higher-income communities.

Another risk factor for obesity is ethnicity. The Centers for Disease Control and Prevention reports that, in most U.S. states, blacks have the highest prevalence of obesity, followed by Hispanics and whites. The disparities in obesity levels among ethnicities may be the result of a couple of different factors. Specifically, different cultural groups may engage in different behaviors that contribute to weight gain. Alternatively, some cultural groups differ in what is deemed acceptable in terms of body weight and norms.

Media use is also a risk factor for obesity among children. Specifically, children who spend more time using media such as television, movies, the Internet, and video games are more likely to have weight problems than children who do not. This is likely due to the sedentary nature of consuming media. It is also important to note that televised content may impact weight issues among children as well. During children's programming, kids are exposed to advertisements for many different sugary snacks and beverages. Many of these children, in turn, request sugary snacks and beverages from their parents and subsequently gain unneeded weight.

Obesity Campaigns and Interventions

Given that weight issues can negatively influence one's health and welfare, it is unsurprising that numerous health initiatives have been undertaken in an attempt to curb this problem. Many health communication campaigns have focused on decreasing obesity levels among American adults. Oftentimes, these new and mass media initiatives attempt to persuade consumers to change their nutrition and exercise habits through messages disseminated via print materials, commercials, and radio spots.

In recent years, various campaign endeavors have attempted to curb obesity among children through messages disseminated via traditional mass media outlets (e.g., television, radio, and billboards) and new media channels (e.g., Web sites, social networks, and so on). One of the most notable recent campaigns has been the Let's Move campaign spearheaded by First Lady Michelle Obama. This campaign has disseminated messages promoting healthy consumption and physical activity through various means such as social networking Web sites, print materials, and television commercials. This initiative has also used entertainment–education to weave relevant health messages into children's entertainment television programs such as *Sesame Street.*

In addition to mass media campaigns, small group and face-to-face interventions have been implemented around the country in an effort to promote healthy lifestyles. Among adult populations, many interventions have been implemented at worksites. Some successful worksite interventions have focused on solving problems through individual and group counseling, skill-building activities, building social support networks for workers, and focusing on both diet and physical activity modifications.

To conclude, weight management issues have become an increasingly pervasive problem for American adults and children. The steady rise in obesity has had a detrimental impact on the overall well-being of U.S. citizens. Given the various factors contributing to weight management issues and obesity, it is critical for campaigns and interventions to be targeted toward and tailored to the needs of focal populations.

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See Also: Department of Health and Human Services, U.S.; Ethnic Diversity and Values; Public Health; Racial and Ethnic Approaches to Community Health; Social Determinants of Health; Workplace Health Services.

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Pacific Islanders

Individuals who identify themselves as Pacific Islanders belong to a unique group of ethnic minorities. Pacific Islander Americans are also known as Oceanian Americans, with ethnic origins belonging to native populations of Oceania. The words *Pacific Islander* represent people whose heritage belongs to either Polynesia, Melanesia, or Micronesia; these represent subregions of Oceania. The northern Mariana Islands and American Samoa are regions, Guam is a U.S. territory, whereas Hawai‘i is a state. They are still seen as perpetual foreigners even if they are either natural-born citizens or native to Hawai‘i. Provided is an overview of the diversity within the ethnic group, demographic information, cultural values and social problems, mental health concerns, and implications for human service professionals as service providers meeting the needs of these clients.

Diversity Within the Group

The fact that there are at least 50 or more ethnic groups with subgroups and more than 100 languages makes it extremely difficult to sum up this group as a whole. In the past, the U.S. Census Bureau has also made it challenging for practitioners and researchers working with this ethnic group in providing culturally relevant services due in part to the changing definition on the census survey to help define this group. The concept of ambiguity in naming this group has had an impact on research and information disseminated about Pacific Islanders. The last U.S. Census in 2010 had a somewhat clearer description of Pacific Islander, yet most literature found still lumps Asian American and Pacific Islanders together. New terms added to Native Hawai‘ian and Other Pacific Islander include check boxes for Guamanian or Chamorro, Samoan, and Other Pacific Islander, with an area to write in other entries, which can include but are not limited to Polynesian (Tahitian, Tongan, or Tokelauan), Micronesian (Marshallese, Palauan, or Chuukese), and Melanesian (Fijian, Guinean, or Solomon Islander). This could have an overall impact on both studies and research.

Demographics

According to the National Education Association, Pacific Islanders or Asian American Pacific Islanders are one of the fastest-growing groups in the nation. In the 2010 census, the approximate total of single-race Asian Americans was reported as 14,674,252. The Native Hawai‘ians and Pacific Islander population was recorded as 540,013. American Asians as a single race account for 4.8 percent of the U.S. population, and Native Hawai‘ian and Pacific Islanders account for 0.1 percent. Yet the overall population total from 2000 to 2010 jumped from 281.4 million to 308.7 million, and that includes all other Pacific

Islanders and subcategories that identified with this race, so this population has grown significantly by 9.7 percent since 2000. Pacific Islanders consist of an extremely diverse population who differ in all areas to include cultural norms, traditions, values, and languages. The growth for this ethnic population by the U.S. census is projected at a rate of 200 percent by 2050; this further implies that human service professionals may see an increase in clients seeking services. Large portions of Pacific Islanders are geographically located in the western-most states, with southern, northern, and midwest states gaining popularity.

Cultural Values

Cultural values differ from each group or ethnic subgroup; however, there have been some identified values that might be considered as useful knowledge for practitioners. For Pacific Islanders, family can take on several different meanings to include nuclear family, extended family, and members of a household. Extended families are still the primary structure of the family unit when possible, which is an essential component of collectivism within their culture. A sense of family obligation is a strong tie for families of the Pacific. Age and intelligence are honored due to wisdom gained and more life experience; therefore, elders should be more respected than youth. Educated individuals command respect, and in some Pacific Islander subgroups, educational achievement is a priority.

Filial piety is associated with deep respect for parents, and children are to love and obey parents. Shame is connected to filial piety and used by family members to disrupt inappropriate behaviors as well as diminish an unwanted reputation, which may highlight the family or individual. Self-control in emotional situations and calmness help maintain a sense of dignity. Modest behaviors and unassuming attitudes are expected in individuals, which are representative of their collectivistic nature. Individuals' needs are often repressed in order to satisfy group needs and goals.

Social Problems Encountered by Pacific Islanders

Westernization has had an impact on Pacific Islanders and contributed to forms of oppression and racism. Most Pacific Islanders are original inhabitants of the United States and share the experience of other natives whose lives changed as a result of European explorers. Historically, these events and circumstances have shaped the mental health status of this ethnic group. One of the features of the traditional Pacific Islander family was the clearly defined roles of the individual within the family system. Pacific Islanders who migrate to the United States may find roles being disrupted depending on acculturation or assimilation. For those who migrated and those who are U.S. residents, forms of assimilation can impact the family and lead to stress with the acceptance of family violence as a way to cope. Disruption of communication between parents and children lead to breakdown of family structures. Changes in the status of women and children may be a source of tension for the family. The loss of culture or traditions such as breaking patterns in collectivism and having to reshape identities if migration occurred has affected families.

Urbanization as a whole on Pacific Islanders has included drug and alcohol abuse, issues regarding low educational achievement with a prevalence in poor housing and overcrowding, and a significant decrease in health status. Low levels of income among Pacific Islanders contribute to the high rates of poverty; almost 20 percent of Pacific Islanders live in impoverished conditions. Inadequate coverage of health care for Pacific Islanders is an obstacle in receiving proper medical care and mental health services. Close to 16 percent of all Pacific Islanders lack health insurance, and financial stressors may contribute to this problem. Pacific Islanders face the model minority myth, which stereotypes all Asian Americans and Pacific Islanders as doing exceedingly well in terms of education and income. There is an expectation that they are equally intelligent and that average income is relatively high, yet the educational achievement and economic attainment varies greatly within this complex group. Additionally, compared to any other group, Pacific Islanders are overrepresented in the military at an alarming rate of 249 percent. Military families have unique hardships, and with the high rate of service members, this is a stressor of modern-day family life for enlisted Pacific Islanders.

Mental Health

For many cultures of the Pacific, there is no direct translation for mental illness because emotional and psychological problems are often integrated

Compared to any other group, Pacific Islanders are overrepresented in the military at an alarming rate. Military families have unique hardships, and with the high rate of service members, this is a stressor of modern-day family life for enlisted Pacific Islanders. Here, dancers and performers prepare for the Asian American and Pacific Islander Heritage Month Celebration at Contingency Operating Base Adder, Iraq, honoring the soldier diversity of Asian/Pacific Americans in the U.S. Army.

holistically with biological, cognitive, and spiritual functions. Not only are there many family alterations due to social structures changing that cause stress, but the alarming statistic on the rate of military service from this ethnic group suggests that veterans of this population could be at greater risk for many mental health problems, which could include post-traumatic stress disorder (PTSD), substance abuse, increased suicide rate, and homelessness. Rates of depression and anxiety are reported as high, but this varies among the subgroups within Pacific Islanders.

Implications for Human Services

Human service professionals should be aware of the differences that exist for each client within the Pacific Islander ethnic group and subgroups. Knowledge about assimilation and acculturation levels for the client may be helpful for human services professionals within this group and may be helpful in determining appropriate services. Barriers to seeking services include lack of trust, not recognizing mental health issues as problems, cultural values placed on self-disclosure, language barriers, and family conflict, lack of insurance or finances are also significant.

Human service professionals should have a basic understanding of barriers and look for ways to improve or change how services are provided. Cultural sensitivity should be displayed by acknowledging an awareness about how the client identifies him- or herself in terms of ethnic identity. Human service professionals should also be aware of any biases held about this group.

As depression, anxiety, PTSD, family violence, substance abuse, low academic achievement, and stressors related to poverty and housing conditions are current issues, human service professionals should be skilled at finding resources and providing necessary services.

Community-based preventative programs could reach a larger segment of this population. Pacific Islanders are more likely to see health care providers than seek mental health services; it may be necessary for human service professionals to provide insight to medical practitioners about Pacific Islanders and inform them of services or resources available to this population. Family and extended family members are important to this ethnic group; when providing services it may be helpful to suggest that all family members are welcome. Human service professionals should understand the impact the family has on a Pacific Islander client.

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See Also: Behavioral Health Disparities for Racial and Ethnic Minority Populations; Cultural Competence, Human Service Providers and; Ethnic Diversity and Values.

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Pain Management

More than one-third of Americans suffer from chronic pain. Their medical care, lost work, and disability benefits cost about $100 billion annually. Chronic pain is associated with illness and injury, and patients often develop co-occurring disorders of depression, anxiety, and addiction. As 76 million baby boomers approach old age, issues associated with chronic pain and its management will increase the demand on human service providers.

The Nature of Pain

Pain is an unpleasant sensory experience associated with actual or potential tissue damage. Acute pain usually subsides when the site of a trauma heals. Persistent pain is associated with medical conditions such as cancer, neuropathy, and arthritis. Pain can also be associated with treatments such as chemotherapy and physical therapy. The assessment of pain relies heavily on the report of the patient. Pain can be perceived as pressure, aching, or burning. A pain assessment includes evaluation of the etiology of the pain, its location in the body, the physiological system that is affected, the frequency and duration of painful episodes, and the patient's rating of its intensity.

How pain is experienced, expressed, and treated differs among races, ethnicities, and cultures, placing some minorities at risk for inadequate treatment. Generally, African Americans, Native Americans, and Asians receive less-intensive pain treatment than Caucasians. African Americans use prayer to cope with pain, while Caucasians are more likely to ignore the pain. It is difficult to determine if the discrepancy in treatment is caused by a difference in how the patient perceives and reports the pain or if it is a result of misattributions by health care providers. Some research suggests that health care providers who speak the same language as the pain patient are more likely to match their objective assessment of a patient's pain to the patient's subjective report.

Treatment of Chronic Pain

Since the 1980s, when the use of opioids to treat pain came into question, pain management has emerged as a medical specialty. Advances in medical technology have increased treatment options for patients who enter pain management programs when physicians fail to treat conditions underlying the pain, do not believe the pain is as great as the patient is reporting, or suspect that the patient is drug seeking.

Interdisciplinary pain management teams may include physicians, counselors, nurse practitioners, physical and occupational therapists, and providers of massotherapy and acupuncture. Effective pain management is individualized and multimodal to include medication, physical therapy, exercise, and application of ice or heat. Procedures associated with pain reduction include injections to block the perception of pain, massage, and acupuncture.

Massotherapy helps to manage pain by decreasing inflammation. Eastern cultures use acupuncture, a method of placing small pins in the patient's skin, to regulate the flow of energy. Physical therapy builds strength and mobility. Psychological treatments include biofeedback, cognitive therapy, life management training, and support groups.

The World Health Organization (WHO) has developed guidelines to determine the appropriate medications for each type of pain and the correct dosages for the intensity of pain. Opioids are effective in managing pain but are highly addicting and can impair cognitive and motor functions. If the patient states that a medication relieves pain but the physician does not assess improvement in functioning, assessment for substance abuse is indicated. Some aging baby boomers were recreational drug users in their youth, putting them at high risk for abuse and addiction as they age.

In almost half of the United States, cannabis is legal for pain management. Most medical marijuana comes in pill form. In some states, it is legal to grow and smoke marijuana for medical use. Advocates for legalizing medical marijuana argue that it is effective in managing pain with a reduced risk of addiction. Opponents caution that extended use of marijuana causes amotivational disorder, which has the potential to interfere with the patient's participation in other therapies that support treatment goals of better physical, cognitive, and social functioning. In most people, marijuana increases appetite. The subsequent weight gain has the potential to burden the musculoskeletal system and ultimately worsen the pain.

An effective pain management program incorporates psychological services that address issues of loss, grief, depression, anxiety, stress, family dynamics, and coping with the pain itself. Biofeedback is a method by which a patient gains awareness of the body and control of his or her pain. The therapist teaches the patient techniques to decrease the perception of pain using a connection to a biofeedback machine that provides auditory or visual feedback. Hypnosis is a pain management method that alters consciousness to change the perception of pain. Relaxation training can assist a patient in decreasing muscle tension that is often associated with headaches and backaches.

Because pain interferes with serotonin production, even localized pain can diminish a patient's sense of well-being. Pain patients often lose the ability to work, play sports, do household tasks, or be intimate because of limitations in bending, lifting, or mobility. Counseling can assist these patients in identifying and grieving the losses associated with pain. Pain is invisible to others. Some families and friends are not supportive. Others overaccommodate the pain patient, creating secondary gains and inadvertently creating learned helplessness. Family therapy can help families to rework their roles. Addiction counseling addresses dependence upon pain medications. Self-help groups are a strong adjunct to pain management programs. Groups may be dedicated to pain management or to an underlying condition such as cancer, lupus, fibromyalgia, or arthritis. Cognitive-behavioral therapy can empower a chronic pain patient to redistribute time and energy, mobilize resources, and reestablish a sense of self-worth.

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See Also: Assistive Technology; Disabled Clients; Quality of Life, Measurement of.

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Palliative Care

Palliative care is a universally available approach to health care that addresses both the needs of patients and families experiencing serious, progressive, or life-threatening illnesses and also the costs of delivering such needed services. Different from a traditional disease-model approach to medicine, palliative care is a paradigm of care focused on anticipating, preventing, and alleviating the suffering of serious, progressive, or life-threatening illness. The goal of palliative care is to improve quality of life by holistically addressing the physical, emotional, social, and spiritual needs of patients and their families. By emphasizing clear communication among medical professionals, patients, and their families, palliative care enhances the coordination of health care services, which usually results in reduced costs.

The Benefits of Palliative Care

There are several benefits of palliative care. From a medical perspective, patients receiving palliative care usually show physical improvement, as their symptoms are addressed early, leading to longer survival as well as higher quality of life. A specific emphasis of palliative care is addressing pain levels. By focusing on reducing pain levels, palliative care increases the comfort of patients and gives them peace of mind. Moreover, numerous studies show that palliative care can help control fatigue, anxiety, breathlessness, nausea, depression, constipation, and other sources of symptom distress, leading to improved medical outcomes.

When patients receive palliative care, their psychosocial, emotional, and spiritual well-being are just as important to caregivers as their physical well-being. Likewise, the concerns and wellness of families and friends is important in palliative care. The financial benefits of palliative care are also significant. The costs of palliative care, when compared to usual methods of treatment, are lower at every juncture of the health care process. For example, when individuals received palliative care, their costs of treatment per day were usually lowered by almost $300, as costs for hospital admissions, laboratory tests, medications, and treatment in intensive care units (ICUs) were all reduced. By reducing reactive medical decisions and emphasizing patient-informed treatment, medical care is tailored to the specific needs of patients while minimizing costs incurred from expensive procedures that may be ordered indiscriminately in emergency situations.

Palliative Care and Diversity

Cultural, racial, and ethnic differences exist in how different groups of people experience palliative care. For instance, although the benefits are clear, significant differences exist between African Americans and whites in the use of palliative care. African Americans hold less-favorable views of palliative care than whites, hold greater distrust of the health care system, and are more likely to seek aggressive treatment at the end of life. Cultural differences also shape patient and family views of receiving palliative care. For example, the belief that people are individual free agents with the right to make their own decisions about accepting or receiving treatment is a Western-held assumption that does not always translate to other cultures. Patients and families from Asian, Middle Eastern, or African cultures may view individuals as part of a unit, extended family, or tribe where family members are always involved and have a major say in all important personal decisions. Competent human service providers must, therefore, remember to assess and value the role of diversity in working with patients receiving palliative care.

Palliative Care and Hospice Care

Palliative care is sometimes considered the same as hospice care. While both forms of care are based on similar principles of patient-centered holistic care, there are two important distinctions between the approaches to medical treatment. Hospice care is offered to patients and families during the last few weeks or months of life. Physicians refer patients to hospice care when all other efforts to find a cure are exhausted. Palliative care, in comparison, is provided at any time during the trajectory of treating patients. Patients, therefore, can receive curative medical treatment while receiving palliative care. Perhaps the best way to think about palliative and hospice care is to consider both approaches as part of a continuum of care. Palliative care is a broader approach for anyone, while hospice focuses on minimizing pain and enhancing the quality of life for patients expected to live less than a few months.

Roles for Human Service Professionals in Palliative Care

There are important direct and indirect roles for human service professionals in palliative care. Palliative care is usually provided by an interdisciplinary staff. Physicians, nurses, social workers, chaplains, nutritionists, rehabilitation counselors, and occupational therapists normally work together as a team to coordinate care. Human service professionals are also needed as advocates and educators of palliative care. There is an increased need for community education about the benefits of palliative care. Hospitals and health care clinics need professionals with the communication skills necessary to engage patients and families in conversations about palliative care. They also need to educate more physicians to understand the medical, psychosocial, emotional, spiritual, and fiscal benefits of referring patients for palliative care sooner rather than later. In summary, as the population ages and health care spending escalate, human service professionals need to bring palliative care to the forefront of health care discussions as a viable approach to cost-effective, high-quality care.

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See Also: Adult Day Care; Aging and Adult Services; Alternative Medical Systems; Case Management Services; Community-Based Services; Continuum of Care; Health Care Delivery, Models of; Hospice Services.

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Pandemics

The roles of the human service professional include promoting the welfare of humanity and mobilizing efforts to meet individuals' needs. As such, they are uniquely positioned to impact efforts at addressing societal epidemics and global pandemics. This entry will define epidemics and pandemics, examine the impact of such crises, and address various roles the human services professional can take in preparation and response at the individual and systemic levels.

Defining Epidemics and Pandemics

Public health issues that are simultaneously experienced by a disproportionately large number of individuals can be defined as an epidemic or a pandemic. They differ by geographical coverage. An epidemic is focused to a particular city, region, or nation, while a pandemic is global. When both local regions and international communities are concurrently experiencing a crisis, the terms *pandemic* and *epidemic* may be used interchangeably. When a health issue is contained to no more than a single area, the crisis is specified as an epidemic. Efforts to address community needs are very similar for both pandemics and epidemics. However, because they are experienced by such a large number of people, pandemics result in far greater costs to society both economically and socially. Epidemics and pandemics can be infectious diseases transmitted from human to human or noninfectious conditions that result in health consequences.

Types of Epidemics and Pandemics

Infectious disease epidemics and pandemics include influenza, cholera, HIV/AIDS, dengue fever, and measles. The most common include strains of influenza. Of these, in recent years, avian flu (or bird flu) and swine flu have been most prevalent. Currently, cholera and HIV/AIDS are deemed examples of pandemics while the others are examples of present epidemics in various countries. Consequences of infectious disease epidemics and pandemics include social phobias, mandatory vaccinations, overtaxed health care systems, high rates of mortality, and prejudice and discrimination against specific individuals and/or regions affected by the disease.

Pandemics and epidemics that are noninfectious conditions resulting in health consequences include bioterrorist attacks, *salmonellosis* outbreaks, hurricanes, obesity, and nonmedical use of prescription drugs. Health consequences of these pandemics and epidemics can be both physical and mental. They include but are not limited to heart disease, diabetes, debilitating levels of stress and anxiety, increased prevalence of social phobias, substantial economic loss, malnutrition, displaced populations, fraudulence and criminal behavior, social stigma, and death.

The World Health Organization developed a scale for identifying stages of influenza pandemics. However, its phases are applicable to categorizing virtually any type of epidemic or pandemic. In general, the scale ranges from phase 1 in which there is no infectious or noninfectious condition to phase 6 in which there is a full-blown pandemic. Specifically, in phase 1, while animals may be experiencing a particular condition, no human cases would have been reported. In phase 2, human cases have been noted and thus an epidemic and/or pandemic threat exists. Phase 3 consists of clusters of individuals experiencing the condition yet a community outbreak has not yet occurred. In Phase 4, the condition is epidemic; entire communities, regions or a nation is affected. Phase 5 is identified by the condition existing in two countries and indicates that a pandemic is inevitable. Finally, phase 6 is characterized by the condition existing in multiple countries and is indicative of a global pandemic. These phases can be used to guide the development of appropriate prevention and response efforts at each level.

Human Service Professionals' Roles

The primary goal of efforts aimed at addressing epidemics and pandemics is to minimize the number of individuals affected by an infectious or noninfectious condition and ultimately prevent mortality. Many of these efforts are nonpharmaceutical community mitigation strategies. With training in advocacy, prevention programming, collaboration, systems theory, brokering, and cultural competence, human service professionals are well equipped to positively address community needs with regard to these societal crises. They may play an important role in providing interventions at pre-epidemic, epidemic, and post-epidemic stages.

In particular, the human service professional is capable of developing strategies that prevent health conditions and death and ultimately attempt to mitigate the impact of an impending epidemic. These may include efforts to disseminate information through the media, in academic institutions, and in various health care settings. This information may be psychoeducational in nature and include physical health-related topics such as reminding individuals to obtain annual vaccinations, cover their mouth when coughing and sneezing, engage in frequent hand washing, routinely clean their surroundings, stay home when ill, engage in safe sex practices, and eat nutritionally. Human service professionals may also engage in advocacy efforts to prevent stigmatization of those who become afflicted by a condition. They may also advocate for policy development in agencies to address mobilization of resources and personnel as well as coping strategies for addressing the consequences of epidemics. This may include flexibility around absences due to either experiencing the condition or preventing exposure to the condition, as well as allowing employees to work from home during epidemic crises.

Once a health condition has reached epidemic proportions, a human service professional can continue psychoeducational efforts to minimize the spread of the condition, correct misinformation, and prevent discrimination of those with the condition. In general, psychoeducation expands to promoting the wearing of facemasks, encouraging household isolation upon exposure to the condition, and early accessing of health care. Human service professionals may also work collaboratively with other health professionals to establish continuum of care plans for those directly impacted by the condition. Direct service initiatives include support to those affected, including family members and caregivers. For those experiencing the condition directly, human service professionals can assist in accessing and navigating health care systems, addressing employers, and coping with the psychosocial consequences of affliction, including isolation, discrimination, and failing health. Families and caretakers may also benefit from psychosocial support to assist in coping with fears associated with losing a loved one and/or becoming afflicted with the condition oneself.

They may also need coping skills to manage the stigma encountered as a result of being associated with an afflicted individual. Skills associated with crisis counseling may be employed. Human service professionals may advocate for company follow-through with policies related to sick leave and working from home. Ultimately, efforts are aimed at minimizing social disruption, mitigating economic consequences, and curtailing mortality. These efforts should be maintained until population immunity is achieved.

In the post-epidemic/pandemic stage, recovery becomes the focus. Prevention and intervention strategies and policies should be reviewed for effectiveness. Economic recovery efforts should be taken due to disruptions to both production and consumption during the epidemic. Individuals may also need assistance recovering financial losses through insurance agencies or covering expenses through social service agencies. Mental health services for individuals will be particularly important during the post-pandemic/epidemic stage. Addressing post-traumatic stress symptoms, developed phobias, and persisting anxiety may be necessary.

Finally, being skilled in grief counseling to address individuals struggling with losses associated with the epidemic are paramount. In addition to addressing the obvious grief associated with the loss of a loved one due to death from an epidemic condition, individuals may need assistance in coping with factors such as the loss of physical abilities due to exposure to the epidemic condition, loss of economic stability due to prolonged absenteeism from work, and/or loss of a sense of safety and security in society.

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See Also: AIDS/HIV Programs; Community Health Centers; Crisis Services; Department of Health and Human Services, U.S.; Health Care Delivery, Models of.

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Parenting Skills Training

Parents have a major influence on their children's development. Good parent–child interactions have a positive influence, while poor parent–child interactions may yield negative outcomes. Parenting styles—that is, the typical ways parents think, feel, and behave in terms of child rearing—matter, and optimal parenting can be taught. Furthermore, what is optimal in one culture may vary in another culture or ethnic group. Parenting skills training programs are designed to help parents become better parents through skill development and education; these programs focus on developing appropriate and positive parenting practices. Parent training programs allow families to break negative cycles, and parents learn improved family management skills and positive parenting skills and are given information about child development and how that influences their interactions with their children.

Programs

Parenting skills programs emerged in the late 1960s and have grown in popularity since that time. These programs developed with a shift in focus from changing the behavior of the child to changing the behavior of the parents. Evidence had emerged suggesting that parents could help their children change their behavior as well as therapists could. Parent training programs are only one type of intervention, but they appear to be the treatment of choice, especially for young children.

Originally, parenting programs focused on correcting problem behaviors in children, but programs have expanded to include improving the cognitive development of children, treating internalizing problems such as anxiety disorders, and treating or managing physical health issues, and have been used for parents and families with children who are at risk for maltreatment. Parenting programs vary in focus, but they tend to cover similar material and teach similar skills. Programs may be active, passive, or both. While both active and passive parent training programs appear effective, active programs, especially programs that require parents to practice learned skills with their own children and those that include coaching, yield better outcomes.

There are many different parent training programs that have been developed. Some, such as the ones described, have been identified as evidence based for the treatment of disruptive behaviors in pre- and school-aged children. Helping the Non-Compliant Child is a program designed for children ages 3 to 8 years and involves parent training aimed at teaching skills to stop or reduce the negative parent–child interactions. The Incredible Years involves both a parent training program and a child training program. The parent training component uses small groups in which parents view videos that demonstrate desired parenting skills and parents are taught how to teach their children problem-solving skills. In parent–child interaction therapy (PCIT), parents are taught specific skills and techniques to improve interactions with their children. PCIT includes two phases: the first is child-directed interactions, and the second is parent-directed interactions. The Parent Management Training Oregon Model (PMTO) teaches parents to encourage and monitor their children's behaviors as well as teaching parents about how to use behavior modification programs with their children.

The Triple P-Positive Parenting Program is a multilevel and multidisciplinary, evidence-based system. It provides different levels of treatment intensity depending on the expressed need. These levels range from public access to intense mental health care. Parents are taught skills and are guided by therapists through live coaching during interactions with their children. Support strategies are designed to prevent or reverse behavioral, emotional, and developmental problems in children. Currently, the Triple P program is receiving much attention and has been implemented in a number of countries with much success. In general, there is a lot of evidence supporting the use of behavioral parent training programs for many different types of problems.

One of the major challenges facing mental health practitioners is getting help to all individuals who need it, including those in rural or remote areas. Health care services are expanding with the advent of telehealth and telerehabiliation technologies. Parenting skills training programs are usually time limited but are intensive, requiring multiple hours of commitment each week. Families in rural areas are at a significant disadvantage when it comes to accessing evidence-based treatments. Parenting training programs have been developed to require only minimal therapist involvement. Research has shown that programs can be delivered over vast distances and can result in a decrease in negative child behaviors and an increase in positive parenting skills. Parents were also supportive of the help received even though it was done over a distance. The ability to provide treatment even to families who live in isolated areas will only continue to get better. This potential is especially salient for smartphone technologies. The potential associated with these devices is large and may increase program adherence and participation.

Although it is universal that good child and parent outcomes are dependent on good family interactions, different cultures may have different views as to what constitutes good parent–child interactions and what contributes to good emotional and physical outcomes. Cultural differences can influence whether parents are willing to participate in a parenting program, whether they view a particular behavior as a problem, and whether a particular intervention strategy would be acceptable. Because most parent skills training programs have been developed to reflect European American child-rearing beliefs, minority parents may not benefit as much from these parent skills training programs.

There is considerable debate as to whether culture-specific adaptations to parent skills training programs are needed. Several studies have examined the differences between PCIT and culturally adapted versions of the program. Both PCIT and the adapted programs were found to decrease symptoms better than traditional therapies, but there was no difference among the versions. The effectiveness of the Incredible Years program has also been examined for African American, Asian American, Caucasian, and Hispanic mothers, and significant improvements were found across all groups. These results suggest that culture-specific parent skills training is not needed; however, the design of the Incredible Years program may allow parents to incorporate skills learned into their own belief systems, which may account for why the program was beneficial across groups. The Triple P program acknowledges and respects the diversity of family types and cultural backgrounds and aims to empower families by building on existing parenting strengths and focusing on self-regulation of parental skill in order to enhance parental self-sufficiency and preparedness for future problem solving. By focusing on self-regulation, it allows parents to choose meaningful and culturally relevant personal goals. It has been found to be an effective and acceptable program in a number of countries.

In sum, culturally adapted versions of parent skills training programs have been found to be as good as traditional programs. It remains unclear, however, as to whether there is a need for these culturally adapted versions of parent skills training programs. There is a lot of research that does recommend that clinicians take an individual’s culture into consideration during treatment. Because this may be particularly important when looking at parent–child interactions due to the influence culture may have on these interactions, future research will determine if culture-adapted parent training versions are necessary or whether generic versions work as well. When evidence-based training programs are adapted to reflect the culture of participants, families may be more drawn to participate. Adaptations, if used, must ensure the core principles of the programs remain. Using local language and visual materials that reflect the culture are important considerations. There is, however, a need to do further research to compare results from culturally adapted parent training programs to standard versions. What does seem clear is that parent skills training programs have been shown to be beneficial for improving interactions between parents and children.

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See Also: Child Support Agencies and Services; Children, International Variations in Attitudes Toward; Parenting Styles, Cultural Differences in.

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Parenting Styles, Cultural Differences in

Parenting is defined as the process of caring for, raising, and supporting a child from the time of birth to adulthood. The parenting process affects a child's emotional, cognitive, physical, and social well-being. The age at which parenting involvement declines or stops depends upon the culture in which the children are raised. Traditionally, the parenting role has been viewed as a cooperative relationship by both parents. Individuals in the nuclear family may also take part in the parenting role if the biological parents are unable or incapable of doing so. In some cultures, the family elders have a significant role in the caring and support provided to the family.

Family is a primary source of support and serves multiple functions, but the definition of family can vary across cultures. There are four types of parenting styles, and each style can differ within cultures whether or not one conforms into the mainstream culture. The four general parenting styles are authoritative, authoritarian, permissive, and neglectful. While there are many factors that can affect the degree of parenting style, economic status tends to hold the greatest impact.

Types of Parenting Styles

Authoritative parents set rules and expect them to be followed at all times. While holding high expectations of their children, authoritative parents encourage independence while being balanced and actively responsive in their parenting. In cases of discipline, the authoritative parent will punish the child while sharing the reasons for doing so. These parents are attentive to the well-being and needs of their children and share explanations for the parenting style. In this parenting style, the voice of the child is not silenced but encouraged.

Similar to authoritative parenting, authoritarian parenting styles emphasize high expectations. Where the two begin to differ is that authoritarian parents are not necessarily as responsive to their children's behaviors and needs. Authoritarian parenting does not leave room for open discussion with the children about their relationship or how they are being parented. Explanations from parents are not usually common in authoritarian parenting styles. Obedience is always expected, and strict rules are created to be followed by the children of authoritarian parents. This parenting style does not openly leave room for the child to question or discuss the parent's actions.

In the permissive parenting style, the parent is very much responsive and involved in the life of the child either directly or indirectly. The parent is available and takes an active position in the relationship with the child. While the child is continually provided for, the permissive parent does not hold any expectations on the child. The parent does not provide limits on the child's behavior, and behavior tends to be unregulated. This approach can lead to acting out, involvement in risky behaviors, and the development of an attitude of entitlement. By growing up in an environment without expectations, the child may not learn about concepts related to hard work, responsibility, gratitude, and socially acceptable behavior. Lack of these understandings may impede upon the child's future adult relationships.

With a neglectful parenting style, parents are neither actively involved in the life of their children nor have any expectations. Here, parents do not take part in being an active member of their children's lives due to circumstances surrounding financial strain, outside pressures, and the prioritizing of others. A negative parenting style includes dismissing the behaviors, attitudes, and emotions of the child. In this parenting style, children do not have clear boundaries or a support system. The child is left alone to understand and navigate through the social world.

Factors Affecting Parenting Style

In order to fully understand each parenting style, it is important to take into account the culture of the family. Cultures can vary in attitudes, behaviors, expectations, and values—and is not limited to the customs, language, religion, beliefs, and support systems held by the family. Considering all the differences in culture, it is important to acknowledge different cultures to understand the parenting style of an individual. Overgeneralizing and stereotyping should be avoided when trying to get an accurate understanding of how each culture impacts an individual's parenting style. For example, the same behavior can hold a different meaning across cultures.

Culture is highly correlated with parenting styles. How close or far one chooses to embrace his or her culture has an impact on children. Individuals may choose either parenting styles similar to those they experienced in their own upbringing or those styles that are the opposite. With the experience of a particular parenting style, individuals have two choices: participate in a parenting style that is familiar to them or differ from it slightly or even entirely. It is very common for a parent to select a parenting style that is most beneficial for him or her. Oftentimes, the parenting style is adjusted to the age level and lifestyle of the parent and child. Factors that influence a change in parenting styles are those such as time, money, ethnicity, and lack of support.

Religious beliefs can also affect a parent's decision in selecting a suitable parenting style. Religion that is practiced and actively shared within the culture will have much say in the parenting style. Religious elders, figures, and customs all can be factored in the decision of parenting. More demands may be put on the parents and child to follow a prescribed attitude, behavior, identity, and life role. Even if religion is not strictly practiced, understanding the meaning and value it has in a parent's life is important. Oftentimes, families share that they are more spiritual than religious, and that is also helpful in developing a clearer understanding of the parenting style.

Now—more than ever—we are witnessing diversity in parenting. There are less traditional family units and more family lifestyles that adopt beliefs from different family systems. There are new groups of single parents in all ethnic, cultural, social, and age groups. Gay, lesbian, and transgender parents also add to the varying degrees of culturally followed parenting styles. The definitions, beliefs, and customs each parent values continue to vary among and within groups of these subpopulations.

Culturally understanding parenting styles includes the acknowledgement of multiple factors. There is not a superior model of parenting style to follow or a superior culture. Keep in mind that culture defines both strengths and weakness. What is considered acceptable and normal depends highly on the social context. One cannot attempt to separate from all cultural aspects because, as you attempt to leave one, you can just as easily find yourself in another.

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See Also: Acculturation; Administration on Children, Youth and Families; Alloparenting, Cultural Aspects of; Cross-Cultural Knowledge; Parenting Skills Training.

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Partial Care Services for Adults, Mental Health

Partial care services for adults with mental health needs in the United States encompass the Partial Hospitalization and Intensive Outpatient Programs and can be provided in either a hospital setting or by a free-standing community mental health center (CMHC). In partial hospitalization, the patient continues to reside at home but commutes to a treatment center up to seven days a week. Partial care services are run by relatively egalitarian multidisciplinary teams, with treatment programs focusing on the overall treatment of the individual, and are intended to avert or reduce inpatient hospitalization. The partial care programs for adults catering for those with substance abuse problems and various mental disorders ranging from Alzheimer's disease or schizophrenia to eating disorders have individualized care plans and include group therapy and psycho-education modules. These services have state funding and legislative support.

The day hospitals concept emerged during the deinstitutionalization and community mental health (CMH) movements in the 1960s, heralding the beginning of partial care mental health services. In 1988, the U.S. Congress approved a major benefit change for the Title XVIII Medicare program by including reimbursement for partial hospital programs that meet a strict definition and provide a series of treatment services. In 1990, Congress expanded the partial hospitalization benefit to allow CMHCs to deliver this benefit. Partial care services are historically known as the partial hospitalization programs (PHP). More recently with the inclusion of intensive community programs, they are frequently referred to as the Ambulatory Behavioral Health Services. In this entry, all three terms are used interchangeably.

The U.S. Congress defined partial hospitalization as a community treatment program specifically designed for the diagnosis or active treatment of a serious mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse or full hospitalization. That definition and the service components are endorsed by the National Association of Private Psychiatric Hospitals (NAPPH) and the American Association for Partial Hospitalization (renamed as the Association of Ambulatory Behavioral Healthcare [AABH] in 1995).

The partial care programs' cost-effectiveness and better client-related outcomes with reduced need for full hospitalization was established by a body of research worldwide by the late 1980s. The major benefits for clients include having tailored care plans meeting the individual needs, maintaining important community ties, and less disruption to living arrangements. While the names, shape, and funding arrangements of the services vary, services with similar objectives of providing treatment in the community for those needing more than an outpatient consultation and averting or reducing the need for hospitalization were developed in different countries worldwide. The shape of the services changed over time to include persons with more acute needs and continues to evolve in keeping with the contemporary sociopolitical and financial pressures between consumer groups and taxpayers alongside the medical advances.

Drawing upon the experience from partial hospitalization programs, the AABH identified a set of unifying principles to differentiate the ambulatory services from inpatient and traditional outpatient services. The first and foremost of them is that the person accessing the service have a psychiatric or chemical dependency diagnosis with a need for treatment that is more intensive than outpatient office visits and less restrictive than 24-hour care. The ambulatory services are required to coordinate an array of active treatment components, which are determined by an individualized treatment plan based upon a comprehensive evaluation of the patient needs and strengths. The service should be provided in a manner that simulates real-life experience and with the least amount of disruption to the person's normal daily functioning in the most appropriate, least-restrictive environment.

Levels of Care

Placing the ambulatory health care programs on a continuum of care between inpatient and traditional outpatient services, AABH separates three distinct levels of care as categorized on critical patient and service variables. The first level of services caters to those with maximum needs, and the services at the third level cater to those whose functional level is only moderately impaired. The patient variables that determine the level of care needed include the functional ability of the patient for undertaking tasks of daily living, their social supports, psychiatric signs and symptoms, and the risk to self or others, along with the ability to commit to the treatment and follow through with the program. The service variables that are specific to the service functioning are the specified care function of the service, including planned hours of the treatment, mechanisms by which a new patient makes contact and begins treatment, intake and admission procedures, and the routines, scheduled activities, expectations, and special treatment procedures integral to nonhospital-based services. The factors that influence the level of care offered from the point of safety of providing service are the availability of the crisis intervention and emergency services, the blanket protective services that cover the patient during nontreatment hours, degree of responsibility and participation assumed by medical and nursing personnel, and overall role of treating professionals in providing a safety net for the patient.

Providers of the services are required to pass comprehensive reviews from national, state, and insurance bodies that specify the guidelines for assessment, treatment, and facility maintenance. For instance, the providers need to specify a minimum number of hours or days of treatment offered and demonstrate the process of making the clients aware of the process of accessing emergency services. The criteria the programs need to meet may, for instance, be specifying the inclusion of appropriate individual or systemic treatment modalities in the program. The performance improvement and client outcome studies are integral to approval of partial hospitalization programs.

Partial care services are funded in the United States by insurance companies, Medicare, the U.S. national social insurance program, and in some states, Medicaid, the U.S. health program for families and individuals with low income and resources. Part B (medical insurance) of Medicare that covers certain doctor services, outpatient care, medical supplies, and preventive services covers the partial care services in addition to hospital-based and CMH service-based programs, the Medicare funds free-standing partial hospitalization programs, and the storefront operations. The storefront operations are usually family-run businesses and have attracted criticism for poor quality care and misuse of funds. Clients get Medicare funding support for joining the program only if a duly qualified physician certifies that the person would otherwise need inpatient treatment. The clients need to co-pay a certain percentage of the costs, and the number of days one can access the services may be limited. Some of the limitations imposed by Medicare were criticized as discriminatory by the National Alliance on Mental Illness (NAMI). This situation for those in need of accessing the partial care services is expected to improve with the implementation of the Affordability Care Act as the law requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of preexisting conditions.

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See Also: Alcohol and Substance Abuse Services; Day Treatment Centers; Deinstitutionalization; Medicare; Mental Health Services, Adult; Partial Care Services for Children, Mental Health.

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Partial Care Services for Children, Mental Health

Partial care is intensive therapeutic mental health treatment that, unlike other intensive mental health treatments, is outpatient rather than residential. It is sometimes, but not always, offered through a hospital, and when it is, it is sometimes called partial hospitalization. Partial care services for children and youth naturally involve their own challenges and special considerations, as is always the case when the mental health or well-being of children is involved. Partial care treatment is characterized by its high degree of structure and reliance on multiple modalities of treatment.

Treatment involves sessions of several hours, sometimes as long as five or six hours, at least twice a week and sometimes every weekday. Some programs for adolescents run daily during school holiday periods and in the summer. Partial care is typically recommended for patients who face the risk of their conditions worsening to the point that inpatient care will be necessary and who are experiencing conditions that interfere with their day-to-day existence in concrete ways.

Goals and Services

Partial care may also be a step down from inpatient or residential treatment as a way to keep the patient stable while transitioning from an inpatient situation to the end goal of the end of treatment or tapering off to less-intensive treatment, depending on the patient and the nature of the problems being addressed. For young people especially, partial care is outcome driven and centered around clinical treatment under the supervision of a medical doctor. Partial care is not a long-term treatment strategy but rather is intended to stabilize the patient. Treatment targets specific needs through a variety of means including individual and group counseling and support group activities, organized recreation, family therapy and supportive counseling, parenting skills development, as well as traditional psychiatric treatment and medication management.

Partial care services, particularly when the patient is transitioning from inpatient care, include time spent teaching *activities of daily living* (ADLs), a term of art in the health care field. ADL skills constitute the ability to tend to daily self care both at home and in outdoor environments and are a measure of a patient's functional status. ADLs include washing and bathing, toilet use, dressing, cooking, feeding oneself and eating, personal hygiene and grooming, functional mobility, the ability to perform housework or to do homework, managing prescribed and over-the-counter medication, money management, shopping, telephone and technology use, the use of transportation (whether driving oneself or not), and others. Occupational therapists, for example, use a list of 12 instrumental ADLs—those that most healthy people have but that are not necessary to fundamental functioning: care of others, care of pets, child rearing, communication management, community mobility, financial management, health management, home maintenance, meal preparation, religious observances, safety and emergency procedures, and shopping. With young patients, the evaluation of ADLs is informed by developmental psychology: 6-year-olds and 12-year-olds are expected to have very different skill sets. There are specific tools that have been developed for evaluating ADL skills, usually tailored toward a patient type such as patients in physical therapy, elderly patients, or young patients.

Typically, partial care services need to be coordinated with the underage patient's school hours, but in some cases, some school hours may be sacrificed in favor of a course of treatment that seeks to curtail the necessity of inpatient treatment or as a measure taken while transitioning out from inpatient treatment. In the latter case, this is especially true if it is expected that being in school will be an emotional challenge for the patient. Evaluating whether or not a patient is suited to partial care typically encompasses multiple criteria, including the patient's need for clinical and social support, a patient transitioning from a restrictive residential or inpatient treatment situation, the patient's DSM-IV diagnosis or the presence of some other behavioral and emotional disturbance, and the need for multimodal comprehensive treatment.

There are also important exclusion criteria to consider, such as the possibility that the patient is a risk to self or others or any other condition that would support the recommendation of round-the-clock inpatient supervision. Patients also will be refused partial care if their parent or legal guardian does not consent (absent a court order), if a psychiatric assessment indicates that more- or less-intensive therapeutic treatment is recommended, or if an underlying medical condition requiring treatment in a hospital setting is the cause of behavioral or emotional problems. In some cases, comparisons will be made to previous case studies and the effectiveness therein of partial care. This is particularly true when advocating for partial care as an alternative to inpatient treatment because inpatient treatment is an older modality and may be the default measure for some institutions or professionals. Some professionals also do not recommend partial care services for youths who have a particular sole diagnosis—for instance, substance abuse, autism, or developmental impairment—without accompanying symptoms consisting with a DSM-IV diagnosis.

Partial care services for children are more likely to incorporate play, group, and recreational activities than services for adults do, though neither generalization here is universally true. Treatment sessions provide safe spaces, whether individually with counselors or in groups. For various reasons, many partial care services programs have a minimum age under which they will not admit patients (often 6 or 8), and some specialize in preadolescent patients, admitting only those under 13 or 14. Groups will usually be put together according to age proximity as well. Some programs handle specific types of problems, including substance abuse or dual-diagnosis adolescents (those with both addiction and mental health problems), anxiety and mood disorders, trauma survivors, and eating disorders.

The question of how long to continue partial care is not one that is easily answered, though in some cases, the answer is determined by external forces such as the wishes of parents or the amount of coverage provided by an insurance provider. Absent those factors, the decision is informed by the severity of the patient's disturbance and the evidence supporting belief that partial care rather than more-intensive inpatient treatment is what is likely to be helpful. Ideally, discharge comes when treatment managers are convinced that treatment goals have been met.

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See Also: Hospitals; Mental Health Services, Children; Partial Care Services for Adults, Mental Health.

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Partner Notification Programs in HIV/AIDS

Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) partner notification programs assist HIV-positive individuals in notifying high-risk sexual or injection drug partners of their HIV exposure. Often, it is too difficult to do this on one's own. Accepting an HIV-positive diagnosis can be challenging; having trained service providers available to assist with an anonymous notification process can be very helpful. Notified partners are not given the HIV-positive individual's name; only testing recommendations and service referrals are provided. If the informed individual had only one high-risk behavior, it is likely he or she will correctly guess the exposure source and HIV-positive status of that person. In such cases, it is possible the exposed person might disclose the HIV-positive person's identity and status.

Identifying exposed partners is key in the fight against HIV, so treatment can begin and cases of new infections can be reduced. High-risk contact information must be given voluntarily, absent of coercion or deception, to ensure comprehensiveness and accuracy. Once informed of exposure, HIV-positive partners can be careful to avoid infecting others as they might have done unintentionally prior to learning their own status.

Partner notification services should be client centered, confidential, free, and evidence based. Services and disseminated information should be comprehensive, integrative, accessible, and available to everyone while being culturally, linguistically, and developmentally appropriate. The history of HIV has included many different groups that have suffered from stigma and discrimination on the basis of race, ethnicity, or sexual orientation. Informed individuals are encouraged to be tested and to receive HIV education and treatment as needed.

Partner Notification Efficacy

Partner notification programs have become widely accepted and have demonstrated new infection reductions. In New York, for example, The Centers for Disease Control and Prevention (CDC) found notification and referral services for gonorrhea to be most effective by targeting geographic areas instead of interviewing, in person, all infected individuals and their partners.

In the United States, according to the CDC, approximately 25 percent of HIV-positive individuals do not know their infection status. Partner notification provides an opportunity for outreach to persons known to be at risk. The CDC found that one in eight notified individuals was newly diagnosed as HIV positive. The Task Force on Community Prevention Services' review of studies found that 14 to 26 percent of notified partners were diagnosed as HIV positive. Overall, partner notification services have been found to be cost-effective but greatly underused.

Diversity Implications

Anyone can become HIV infected regardless of age, sexual orientation, culture, ethnicity, race, and more. Culturally sensitive protocols should be provided to each respective group; one size will not fit all, and the goal of partner notification is to identify individuals who can benefit from diagnosis and treatment. Trained service providers, knowledgeable about the special needs of a population as well as relevant laws and regulations, are integral to the success of this process. Stigma, cultural rights and wrongs, religious beliefs, as well as racial and language differences and implications must be considered in any partner notification program.

Men Who Have Sex With Men

Men who have sex with men (MSM) represent a diverse community across race, ethnic, and socioeconomic groups. The CDC reported a 34 percent increase in HIV infections among young gay and bisexual men between 2006 and 2009. In 2010, 63 percent of all new AIDS cases were among MSMs. MSMs accounted for 51 percent of the new cases within the African American population and 68 percent among Latinos. These groups have been affected by stigma and discrimination based on sexual orientation, ethnic and racial identity, and high rates of HIV. Many MSMs do not self-identify as homosexual, wishing to avoid that stigma; they may resist disclosing their HIV status to at-risk partners.

African Americans

According to the CDC, African Americans are the racial or ethnic group most affected by HIV despite representing only 12 to 14 percent of the U.S. population. The new infection rate among African Americans (68.9 percent) was 7.9 times as high as the rate in whites (8.7 percent). Sexually active African Americans are therefore at an increased risk of having sex with an HIV-positive partner. The high poverty rate among African Americans both directly and indirectly affects HIV infection risks. The CDC estimates many are unaware of their HIV status.

Latinos

HIV disproportionately affects the Latino community. While Latinos comprise 16 percent of the U.S. population, in 2009, they accounted for 20 percent of the reported HIV cases. The rate of new infections for Latino men was 1.5 times that of white men, and the rate for Latina women was four times the rate of white women. Cultural factors increase the risk of HIV infection. The fear of discrimination, stigmatization, or immigration status may impact an individual's motivation to be tested and treated. Traditional gender roles may increase women's and MSMs' risks and fears of notification and accessing services. Language barriers can inhibit HIV prevention, testing, and notification.

Immigrants and Migrants

There is limited data about HIV infection prevalence among U.S. immigrants and migrant populations. This is partly due to the vulnerabilities of a population that does not have adequate information about HIV/AIDS or access to health care, which delays HIV testing, education, and treatment. The economic disparities, as well as cultural role differences between men and women, make women more vulnerable to domestic violence and sexual abuse, reducing their abilities to protect themselves from harm, including HIV exposure. Partner notification programs can provide a unique opportunity to reach at-risk individuals who may not seek services themselves due to feelings of disempowerment and language differences. Stigma related to disclosure of one's HIV status and assumed infection methods create many concerns and fear of partner violence, particularly among women.

Conclusion

Partner notification programs and services exist throughout the country and are underutilized. Having an HIV/AIDS test is often an overwhelming experience. Add to that the requirement to disclose names and contact details of individuals who may be at risk due to shared transmission behaviors, and a simple HIV test can become traumatic.

Service providers must share information and options in culturally competent ways using relevant languages and other effective tools in order to optimize notifications, testing, education, and treatment if needed; informed partners can prevent further transmission of HIV. The best program in the world will not be fully utilized if clients do not feel safe and well attended to; many may prefer to die with their HIV status kept secret, leaving at-risk partners absent of exposure notification. Language, age, literacy, cultural competence, and more regarding available services must all be taken into consideration under the umbrella of federal, state, and local laws and regulations.

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See Also: AIDS/HIV Programs; Community Health, Racial and Ethnic Approaches to; Discrimination and Institutional Racism; Ethnic Groups and Drug and Alcohol Use; Health Promotion Services; National Minority AIDS Council.

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Paternity, Establishing

Human services is the field that has the responsibility of caring for individuals in different settings and situations depending on their needs. Some individuals have more needs than others. Some individuals have the resources to meet their needs without the assistance of society, while others do not. Single mothers have always been in a position of need. Their situations put them in a position of disadvantage. Having to care for children's physical, mental, financial, and emotional needs alone can be difficult. Historically, single mothers have had to rely on many social systems to assist them in meeting the needs of their children. These women make up a large portion of the population that utilizes entitlement programs. Many policies have recently been created to minimize the use of such programs. Policies such as child support enforcement and paternity establishment exist to minimize the use of entitlement programs and hold the absentee parent accountable.

Defining Paternity

Paternity is a legal term referring to the man recognized by the law as a child's father for economic support purposes. When a child is born outside of marriage, although the child has a biological father, the child is considered illegitimate and has no legal father. In such a case, paternity is not assumed, and it has to be legally established.

Establishing paternity is important because it allows children born outside of marriage the same or similar rights and privileges of children born within a marriage. Paternity provides children the rights to financial support from parents, access to family medical history and records, and access to the noncustodial parent's medical benefits. Historically, the U.S. government and individual states would assume the financial responsibility for children without

A father holds his 7-month-old son for only the second time following his unit's welcome home ceremony. Soldiers on deployment when their children are born are allotted up to 10 days of paternity leave. Paternity also provides fathers with rights. Parents who are not legally united or in a civil partnership to another are faced with the challenges of establishing custodial rights and, possibly, coparenting. Paternity can minimize some of the conflict involved with visitation and other noncustodial dilemmas that fathers often face.

paternity for the purpose of providing medical care. Paternity does not exclude or exempt the federal or state government from any financial duty. However, it does obligate the legal father to care for the child or children born outside of marriage.

Paternity also provides fathers with rights. Parents who are not legally united or in a civil partnership to another are faced with the challenges of establishing custodial rights and, possibly, coparenting. Paternity can minimize some of the conflict involved with visitation and other noncustodial dilemmas that fathers often face. Interparental conflict and continued hostility between ex-spouses or never-married parents has been problematic in deciding custody, child support, and visitation arrangements. Through court administrative hearings or default custodial arrangement (if the man is served with notice of hearing and does not appear), visitation rights are defined and guaranteed to the legal father.

The Role of Paternity in Child Support Policy

In 1968, the U.S. Supreme Court negotiated several cases where children were being denied the right to parental support, inheritance, surnames, and even benefits from worker's compensation programs. This led to state-regulated, statutory procedures that mandated the identification of the biological father of children born out of wedlock for the purpose of establishing child support. The determination of paternity was thus initially established as an action to obtain financial support from an absent father.

Since the Great Depression, the United States has made great efforts to fund and support domestic economic welfare programs. Aid to Families with Dependent Children (AFDC) operated from 1935 after the Depression until 1996, when welfare was reformed, and AFDC inspired the passage of child support policy around 1968. In cases where the custodial parent is receiving AFDC, the government has leverage to adjudicate (pronounced by judicial sentence) economic support from the legal father.

In 1975, Congress passed the Child Support Enforcement Act, Part D, Title IV, of the Social Security Act, which mandated states to initiate paternity suits on absentee fathers of children that were receiving AFDC if the state was seeking reimbursement from the federal government.

In 1996, Temporary Assistance for Needy Families (TANF) replaced AFDC. Nevertheless, many Americans continue to refer to TANF as welfare or AFDC. This change in welfare system, which some describe as reform, expanded the use of technology to ensure that children receive more financial support from the noncustodial parent or legal father. The use of computers allows the government to track the Social Security numbers (SSNs) of legal fathers who are working and paying into Social Security through employment. The purpose of the changes was to reduce the government economic responsibility for children from unmarried individuals or broken homes, thereby elevating the importance of establishing paternity.

Acknowledgment of Paternity

Most adults expect fathers to acknowledge and support their children, regardless of the circumstance or situation. However, a substantial number of fathers do not take responsibility for their children where biological and legal fatherhood applies unless a court order is issued for them to do so. Failure to claim paternity may be the result of the child being born out of wedlock or because the father has separated or divorced from the child's mother, trouble securing work, or involvement with another partner. Regardless, these are all examples of situations where a child support order may be necessary. Typically, children born as a result of an illicit or dissolved relationship are less likely to receive voluntary financial support from the legal father.

When a child is born, the biological father may sign an Acknowledgment of Paternity (AOP) or a Declaration of Paternity (DOP). This document is usually part of the birth certificate (or birthing documents) in most states and is filed with the Bureau of Vital Statistics to ensure that the biological father becomes the legal father. In more complex situations where paternity is being questioned by the father or mother, DNA testing must be conducted to determine biological fatherhood before legal fatherhood is conferred and child support enforced through a court order.

In situations where two individuals are married or living together in any other type of legally affirmed relationship and the relationship is dissolved, paternity of any children who were part of the relationship is implied in most cases unless disputed. When a man is married to a woman and children were born into the marriage, the husband is assumed to be the biological and legal father and is financially responsible for those children. The husband (or his attorney) can file a written response disputing biological fatherhood to the divorce petition with the court if he is divorcing a woman who already had children and legal fatherhood (paternity) was not already established for the child or children before the marriage.

Compliance

A large proportion of absent fathers make enough money to financially support their children. Whether or not absent fathers conform to child support policies needs to be explored. Effective economic sanctions that ensure child support payments are received once paternity has been established are employer or payroll deductions and state or federal internal revenue refund deductions of a predetermined amount based on income. The current legal actors that regulate and invoke financial responsibility are family courts, social service agencies, and prosecutors. Failure to comply can result in legal sanctions of fines, court costs, and jail time.

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See Also: Child Support Agencies and Services; Child Welfare Services; Families, Nontraditional; Single Parents.

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Peer Pressure

Health behavior is influenced by many factors. Behavior change theories initially focused on individual biological factors as main determinants of behavior, but as theories have evolved over time, environmental factors have been incorporated into behavioral theories. The socioecological model, a widely utilized theory in behavior change programs, indicates that there are various levels that influence individual behavior, including individual-level factors, community factors, and policy-level factors. Specifically, at the interpersonal level, peer pressure, a form of social influence, has been identified as an important factor that affects individual behaviors.

Peer pressure is defined as any influence on individual feelings, thoughts, or behaviors exerted by the real or imagined presence or actions of others. From a health behavior perspective, an individual's attitudes, beliefs, and behaviors are primarily shaped through the prevailing norms of a group; as in any given society, individuals engage in certain behaviors based on what norms are prevalent. Norms are social phenomena and refer to conforming to the expectations of another person or group. Norms provide guidelines for behavior, and two norms are particularly relevant to behavior. According to R. Cialdini and B. Kallgren, injunctive norms are an individual's perception of what other people approve or disapprove of with regard to behavior. For example, if teenagers are deciding whether or not to drink alcohol, they may be influenced by what they think they ought to do by others in their social group, as injunctive norms represent the perceived moral rules of one's peer group. According to M. Fishbein, another type of norm, the descriptive norm, reflects individuals' perception of the behaviors other people are doing. The teenager who is deciding whether to drink alcohol may be influenced by what others in his or her social group are doing with regard to engaging in alcohol consumption.

Peer pressure informed by norms is particularly important when studying the influence of peers in relation to deviant behavior. Norms define which behaviors are tolerable and which are not and provide information about what behavior is expected. The major reason why people conform to group norms is fear of sanctions for nonconformity. For example, in studies examining alcohol consumption among students at U.S. colleges and universities, students overwhelmingly perceived higher permissive norms and higher levels of alcohol abuse among their peers than what was actually reported. Studies have shown a consistent relationship between individual alcohol consumption and perceived social norms; perceived norms of higher alcohol consumption acceptability are linked with greater personal use.

Peer pressure is often thought to be more salient among young people; however, norms can influence the behaviors of children, adolescents, and adults alike. The influence of peer pressure can be as straightforward as influencing likes and dislikes, such as fashion and music, but often has a significant effect on the way individuals behave. Peer pressure can exert positive influence through the encouragement of academic achievement, good nutrition, and exercise, and participation in clubs, sports, and civic causes. However, peer pressure is often understood to be a negative influence presenting itself in the form of coercion, teasing, bullying, and rejection from social groups if the individual does not capitulate to the pressure to behave in a certain way. At younger ages, peer pressure can influence behaviors including rule breaking, lying, and shoplifting. As individuals get older, the negative behavior stemming from peer pressure can get riskier and escalate into those with significant health impacts, including reckless driving, cigarette smoking, alcohol consumption, substance abuse, sexual initiation, and risk taking.

Various programs have utilized peer pressure to influence health behavior. One of the most widely used substance abuse prevention programs targeted at school-age youths is Project DARE (Drug Abuse Resistance Education). The original Project DARE curriculum utilized police officers to educate

The original Project DARE curriculum used police officers to educate students about the dangers of drugs and used videos employing scare tactics to encourage students to reject peer pressure to use drugs. Here, fifth-grade students take the DARE pledge after learning about the harmful effects of drugs, alcohol, and tobacco and how to avoid peer pressure.

students about the dangers of drugs and used videos employing scare tactics in order to encourage students to reject peer pressure to use drugs. Meta-analyses by S. L. West and colleagues have shown that this approach has not been effective in preventing negative behaviors. Project DARE implemented a new curriculum "Keepin' it REAL," which was culturally grounded and kid-centric, with a series of videos made by children themselves teaching and demonstrating the key principles of the refuse, explain, avoid, and leave strategies focusing on risks, consequences, decision making, and communication skills. This approach has been more effective in helping students avoid negative peer pressure.

Understanding peer pressure may prove helpful in strengthening health programs because, if peer pressure through norms influence behavior, then changing normative beliefs should lead to behavior change. Additionally, various researchers have indicated the effects of peer pressure across gender, race, and ethnic groups, and although effects vary based on behavior type, the idea—that peer pressure is critical in influencing behavior in various settings—should be acknowledged when seeking to improve health outcomes. With regards to risk behavior generally, various studies have found that individuals view risk as a value and do not want to appear less risky than their peers. In essence, peer pressure is powerful because individuals want to be liked and accepted by those around them, which requires the avoidance of appearing dissimilar from the group norm. However, this could mean that an individual will engage in a risky behavior because of peer pressure. Therefore, when designing a health program that is susceptible to the influence of peer pressure, program designers must address the power of peer pressure in order to increase the chances of program success.

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See Also: Adolescent/Youth Services: Overview; Health Promotion Services; Peer Support and Counseling Services; Substance Abuse Treatment for Children and Adolescents.

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Peer Support and Counseling Services

Peer support services are important for human services and diversity because they merge cost-effective mental health and addiction treatment practices (i.e., group and individual supportive counseling in wellness) within a culturally and spiritually responsive relationship. This mentoring relationship is designed to be the vehicle that guides people with mental health and addiction issues in their personal recoveries. Providers of these services, referred to variously as consumer-providers, peer-providers, sponsors, and peer-specialists, are individuals who are in recovery from a mental illness or addiction and use their experiences to help others struggling with similar issues by providing an array of services and support.

Peer support providers rely on their shared lived experiences with mental illness or addiction to engage with other mental health or substance abuse service users authentically and act as role models and mentors in the recovery process. Overall, peer support services have shown to be effective in improving psychiatric symptoms, social functioning, the ability to manage one’s illness, and perceived quality of life while decreasing the frequency of inpatient hospitalizations and the utilization of crisis services. Persons with mental illness or addiction who receive peer support services in addition to other professionally provided services have reported higher rates of personal empowerment and hope for the future.

In the field of addictions, mutual aid groups such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, and Gamblers Anonymous have been in existence since the 1930s. Persons who struggled with alcoholism and other addictions formed these fellowship groups as a means to support one another in sobriety. These groups are structured around 12 common steps and traditions. These groups have no formal leadership structure and do not partner with outside organizations. They are solely member driven. All persons seeking sobriety are welcome to attend open meetings that consist of persons sharing their experiences and offering support to one another. More-structured step meetings are designed for persons at a particular stage of recovery. These groups have grown and diversified extensively. For instance, Alcoholics Anonymous has grown to more than 100,000 groups in 170 countries with approximately 2 million members.

In the United States, peer support services in the mental health sphere emerged in the 1970s from the work of grassroots activist groups consisting of current and former psychiatric patients and their allies. These groups strongly advocated for the rights of other mental health service users and formed informal self-help groups where psychiatric ex-patients used their experiences to help one another. Today, mental health peer support services and consumer-operated service programs advocate for consumers’ rights and provide a range of services delivered within the context of respect, camaraderie, dignity, and choice. These services have become a common component of traditional, professional-based mental health service delivery systems.

In 2001, Georgia became the first state to approve the peer support services provided by specially trained and certified peer specialists for Medicaid reimbursement. Since 2001, more than 30 states have implemented certification programs for peer specialists. These certified peer specialists (CPSs) provide a variety of services in a wide range of settings. These settings can include informal, voluntary self-help groups, consumer-operated service programs that are run and controlled solely by people with histories of mental illness or addiction, as well as traditional mental health or substance use treatment agencies. In these latter settings, they work alongside other mental health and addiction service providers and supervisors such as licensed clinical social workers, nurses, professional counselors, psychologists, and psychiatrists. In these more-traditional human services settings, they often provide consumers with services that can include advocacy, education about addiction, mental illness and recovery, case management, wellness programs, interpersonal support, and social skills training.

Research is emerging that shows that the combination of peer support services with clinical services such as medication and psychotherapy can assist persons with mental illnesses and addictions in achieving a more holistic sense of recovery. This recovery is defined as not only the amelioration of symptoms but also the achievement of a more-balanced and holistic sense of well-being in the domains of daily living, self-efficacy, relationships, health, and meaningful pursuits.

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See Also: Alcohol and Substance Abuse Services; Counseling and Psychotherapy Services; Mental Health Services, Adult; Substance Abuse and Mental Health Services Administration.

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People of Color: Service Delivery, Psychological Assessment, Cultural Issues

There are numerous cultural issues that can enhance or impede the psychological assessment and service delivery of people of color in the United States (e.g., African American or black, Hispanic, Asian American or Pacific Islander, Native American, and mixed racial or ethnic groups). These cultural issues may be understood broadly by examining three main cultural factors that affect an assessment and treatment setting: (1) individual characteristics and cultural beliefs of the person of color; (2) cultural beliefs of the clinician or service provider, including cultural assumptions and theoretical orientation; and (3) the type and standardization of the psychological assessment instruments chosen for use in psychological evaluation.

According to the American Psychological Association, race and ethnicity are dynamic constructs that impact all aspects of psychological practice and interactions. Thus, while noting the large heterogeneity among the many individuals that identify within the racial or ethnic groups noted here, it is nonetheless important to be aware of cultural issues that can significantly impact optimal assessment, diagnosis, and service delivery.

Individual Characteristics of People of Color

Societal institutions often operate within a dominant cultural framework in which one's behavior, appearance, communication style, and mannerisms are expected to conform to the behavioral norms of the majority. If the cultural characteristics of people of color deviate significantly from the behavioral expectations of the institution in which they operate, they may be judged as less competent or capable than their peers. An example of the pervasive effects of this form of stereotyping can be found within U.S. schools, where historically, students of color have been referred for psychological assessment of cognitive, learning, or emotional problems in disproportionately greater numbers than their white European American peers. As a result, there are a disproportionate number of students of color identified as having emotional disturbance (ED), attention deficit hyperactivity disorder (ADHD), or an intellectual disability (ID, formerly mental retardation [MR]) within the American educational system. Research studies that have examined this racial and ethnic disproportionality have found a number of contributing factors, including an association between referral for psychological assessment and differences in learning styles and mannerisms between students of color and white students.

Cultural Beliefs of People of Color

For people of color, cultural beliefs of what constitutes a sign and symptom of mental illness, the meanings attributed to them, and where their origins lie also impact the psychological assessment and services they receive. In general, people tend to communicate or report mental health symptoms to service providers in ways that are culturally acceptable and meaningful to them. A person of Native American descent, for example, may believe that certain mental health symptoms are caused or correlated with a spiritual deity; as such, they may be less likely to seek out treatment and, if they do, may be more likely to use traditional healers than the mental health services found in U.S. professional settings.

Among many people of color, the degree of interpersonal connectedness, the focus on family over and above the individual, the belief in the origins of mental illness (whether from the mind, body, or both), and the stigma of mental illness factor significantly in the interpretation and communication of psychological symptoms. For example, according to Gayle Iwamasa of the Asian American Psychological Association, in some Asian cultural groups, the experience of psychological distress is not only a reflection on the individual in distress but also on the entire family. Thus, shame, humiliation, and loss of face contribute to whether an individual in this population will admit to experiencing psychological problems.

Cultural Beliefs of the Clinician or Service Provider

Cultural issues for people of color seeking psychological assessment and treatment also arise from the individual characteristics and cultural beliefs of the mental health service provider. Among these cultural beliefs are the clinician's expectations for how to treat mental health symptoms, the terminology and framework used to discuss mental health issues with the person of color seeking psychological treatment, and the theoretical orientation under which the service provider operates.

Historically, service providers who treat mental illness in the United States have been trained to practice traditional Western medicine, which emphasizes scientific inquiry and the use of prescription drugs and clinical therapy to lead to a possible cure of mental illness. The dominant Western cultural belief in the viability of psychopharmacological medication to manage mental health symptoms currently shares wide acceptability within the United States, and this can influence the assessment and treatment options that people of color are given within the treatment setting. Moreover, clinicians operating within a dominant European American perspective who work with people of color may also seek to appear color-blind—that is, they may operate under the cultural belief that people should all be treated the same regardless of race or ethnicity, and that by ignoring cultural differences they will improve relations with the people of color whom they serve. In this effort to appear nonprejudicial to their clients, however, clinicians may disregard cultural interpretations of their clients' mental health symptoms. In favor of a universal approach, they may avoid recognizing racial or ethnic differences that may help assist in treating the person of color in a culturally relevant way.

In 2003, in an effort to address the cultural issues inherent in the training and practice of psychological service providers, the American Psychological Association endorsed a set of multicultural guidelines for psychologists. These guidelines provide an overview of six main areas to address when working with culturally diverse populations; two of these areas relate specifically to psychologists becoming self-aware of unconscious biases and racial and cultural stereotypes that impact their assessment, diagnosis, and treatment of persons of color.

Type and Standardization of Psychological Assessment Instruments

Psychological assessment is defined as an evaluation of an individual's mental health by a mental health services professional for the purposes of providing data that can aid in diagnostic decision making. Psychological assessments often use a battery of assessment instruments to examine cognitive and emotional functioning and the degree of psychological distress present in an individual. In order to provide objective data, these assessment instruments are standardized, enabling the mental health professional to compare assessment scores from an individual with those of the larger population.

However, cultural issues can arise in the standardization of psychological assessment instruments for people of color as assessment instruments that are not normed on a population that represents the person of color assessed may lack adequate statistical validity for minority populations. Moreover, psychological assessments often assume a set of shared cultural understandings of mental health, and these cultural meanings may or may not be held by the person of color assessed.

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See Also: Cross-Cultural Knowledge; Cross-Cultural Service Models; Cross-Cultural Skills; Mental Health Service Delivery, Cultural Characteristics of; Mental Health Services, Ethnic Models and Multicultural Service.

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Personal Practice, Model of

While a model of personal practice is generally used by mental health professionals, it is an important part of any human service professional's tool box. The field of human services broadly encompasses any form of health care—from mental health to physical health and education to social services. It would be an asset to each practitioner if he or she incorporated a model of personal practice into his or her professional life. Included in the model are the values, principles, and practices of the practitioner. The significance and implications of this model of personal practice includes the promotion of racial, ethnic, and socioeconomic diversity in human services. This framework promotes positive interactions between health services and those being served by breaking the model into the subcategories on which the model of personal practice is based.

Values

During the process of preparing for practice, all health professionals have to determine how their own personal values relate to the values being taught in their fields of choice. Mental health professionals, whether consciously or unconsciously, have models of personal practice. Developing a tangible personal practice model helps the practitioner realize his or her pattern of thoughts, behaviors, and practices and allows the practitioner to see a multifaceted approach to mental health practice. The health professional's own values (personal and professional) are part of his or her identity—so many facets play a part in this identity.

Ethics

Each facet of the mental health profession has ethical standards set forth by a governing board, which must be followed—a code of ethics. Issues involving social justice, human value and dignity, integrity, and so forth will arise, and no hard and fast rules for solving these issues exist. By having a model of personal practice, the mental health professional can grow a living, breathing model banking on prior decisions to aid in future decisions. This helps the practitioner to solidify his or her professional identity and keep it strong and expanding in knowledge.

Knowledge of Self

The desire to be well versed in all therapeutic genres related to one's personal practice is an integral part of serving human needs and diversity. Part and parcel of being a mental health professional is incorporating diversity into a knowledge base and treatment plans. This is part of one's professional identity. Each person should be treated with respect and consideration given to each facet of his or her identity: ethnicity, culture, regional cultural, level of education, religious beliefs, gender identity, age, marital status, employment, illnesses, work history, work field, family of origin—and the list goes on from macro to micro.

After initial contact, the health services professional may need to research any areas where his or her knowledge is lacking to be able to fully address issues from a learned position. Frequent consultation with other experts in the field, including staying abreast of current cultural research and published resources, attending cultural diversity conferences, and so forth are a must.

The human services professional needs to recognize his or her own biases, preconceived ideas, and limitations to help prevent one from judging or overwhelming the identity of the client. Practitioners need to understand themselves and how they approach treatment. Are they more psychodynamic in nature or behavioristic? Do they see themselves more as my way or the highway, or are they open to trying different modalities to find the best fit for the client? The model of personal practice is an exemplary tool to address and map these areas.

Population Age

To highlight a few factors that need inclusion, let us start with age. With the population living longer, generational differences must be considered. In the United States, generational differences are presumed to be precipitated by critical events that happened during their formative years. The greatest generation refers to those who grew up during the Great Depression and World War II. The baby boomers are the post–World War II and Vietnam era. Generation X is heavily influenced by the leaps and bounds experienced in the rise of technology. The critical event for the millennials is 9/11. Mental health professionals may need to include in their considerations a question regarding where in time is this person coming from.

Technology

Technology has increased to the extent that Earth has become a global community wherein treatment may no longer be geographically restrained. It is no longer enough to have a regional thought or treatment process. Treatment is now taking place via Skype, FaceTime, even e-mail and text. If internationally recognized, then diversity plays a much larger role in treatment and personal practice. Again the model of personal practice allows the mental health professional to build a personal encyclopedia of information for future reference.

Discrimination

Self-culture is as much a part of the mental health professional's practice model as the ability to treat diverse cultures. Self-awareness and the ability to separate oneself from preconceived notions lie deep in the heart of recognizing that, through our diversity, we can create deep and meaningful relationships that may not be congruent, but many still coexist with synergy and acceptance of each perspective. When those who were mistreated become the mistreaters, progress is stymied.

Self-Health

Along with all their tools to help others, health services professionals also need tools to keep themselves both mentally and physically healthy. Self-care includes a support system—at a minimum, another professional with whom one may confide, present dilemmas in a confidential setting, and get feedback. This individual becomes basically a therapist for the therapist, one who values the colleague and meets his or her human services and diversity needs. There is a richness in diversity. Valuing human diversity and possessing cultural competence breaks down barriers and allows healing to begin.

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See Also: Communication Styles, Ethnic and Cultural Differences in; Health Care Delivery, Model of; Mental Health Service Delivery, Cultural Characteristics of; Mental Health Services, Adult; Peer Support and Counseling Services; Social Work, Diversity Practice in.

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Personal Responsibility and Work Opportunity Reconciliation Act

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was signed on August 22, 1996. Also known as Public Law 104–193, it was reauthorized in 2002 with revisions granting states greater flexibility to design their own programs. Overall, the act reduced federal welfare spending by eliminating and reorganizing cash and food welfare programs. Most significantly, it terminated entitlement to cash welfare under title IV–A of the Social Security Act and replaced the Aid to Families With Dependent Children (AFDC), which was passed during the Depression era. In place of the entitlement concept, the law created two block grants that provided funds necessary to assist states in supporting families by reducing out-of-marriage pregnancy, encouraging two-parent families and parental or adult employment, and subsidizing child care and nutrition. Specifically, the act offered annual grants to states for Temporary Assistance for Needy Families (TANF).

The grant limited the receipt of cash benefits to five years, though the law allowed states to exempt up to 20 percent of their caseload from this provision. Furthermore, the law limited the provision of welfare benefits to most noncitizens, families on welfare for more than five years, children who are judged to be disabled based on age-inappropriate behavior standards, and drug addicts and alcoholics. In 1997, Congress created Welfare-to-Work (WtW) grants to help states move TANF recipients into jobs.

A fundamental stipulation of PRWORA law was that all able-bodied adults on welfare for two years would be required to participate in activities to help them become self-supporting, requiring states to have one-half of their recipients in work programs for 30 hours per week. Medicaid could be provided to eligible families. The purpose of the Social Services Block Grant (SSBG) was to support social services directed toward achieving economic self-sufficiency and to prevent the neglect, abuse, or the exploitation of children and adults.

Child care was provided for by a mandatory block grant to low-income families, and states had flexibility in designing child care policies. Mandatory child care and abstinence education included provisions designed to reduce nonmarital births in general and teen nonmarital births in particular. Child support enforcement required the federal and state governments to establish automated registries as a means for locating and tracking absent parents and to operate automated, centralized units for collection, disbursement, and restriction purposes. The PRWORA law required each state to have developed a unit for collecting and distributing child support payments. According to the Office of Child Support Enforcement, almost two out of every three dollars collected by child support agencies came from income withholding. This amounted to more than $6 billion in 1995.

The PRWORA law significantly affected other programs. For example, the Individual Functional Assessment (IFA) for children was eliminated, and children could only qualify through a more restrictive medical listing. Among the children most likely to lose benefits were those suffering from multiple impairments, none of which was severe enough to meet the disability criteria established by the law. Twenty to 30 percent of children with mood disorders, pulmonary tuberculosis, mental retardation, burns, intracranial injuries, schizophrenia, and arthritis were at risk to be impacted by the legislation. Additionally, alien eligibility for welfare was not granted during the first five years of residency unless there was a substantial work history or military or veteran connection. This changed in 1998, and food stamp eligibility was restored for children, elderly persons, and disability benefit recipients who were in the United States at enactment.

Notably, the PRWORA was implemented during the longest boom in postwar history and culminated out of bipartisan debate. Both political parties relied on research to argue their points. Some researchers argued that 40 to 80 percent of the reduction of caseloads was attributable to the economic boom rather than the policy reforms. Strong labor demand played an important role in creating jobs for welfare recipients to move into, while weakened labor demand in the future would make it more difficult for former welfare recipients to find or maintain employment.

While the overall health of the U.S. economy in the 1990s was a positive background factor contributing to a reduction in welfare dependence, other researchers argued that the economy was neither a sufficient nor a primary factor in that reduction. The huge state variations in the rates of caseload decline were not attributed to differences in state economic factors but were explained by differences in the rigor of work-related welfare reforms. Policy reform, not economics, was considered the principal engine driving the decline in dependence. It was, however, not that the effects of inflation, increases in populations, and economic recessions may lead to fewer opportunities for work and welfare independence, but that allocated governmental funds may be insufficient to meet the needs of adults, children, and families living below the poverty line.

In 2002, the Bush Administration amended the law by passing a bill increasing the number of working hours per week required for welfare recipients under TANF from 30 to 40 (citing issues of responsibility), and PRWORA was reauthorized in the Deficit Reduction Act of 2005. In response to the Great Recession of 2007 to 2009, the Obama Administration passed the American Recovery and Reinvestment Act of 2009 (ARRA) to stimulate the economy and provide temporary relief to those in need. A $5 million emergency fund was created to help with increasing caseloads, but this funding expired in 2010. Because of persisting low employment rates and joblessness, in 2012, the Department of Health and Human Services (HHS) released a memo allowing states greater flexibility in how they operate their welfare programs, stating that they could apply for a waiver for the work requirements of the TANF program. Other changes stipulated that welfare recipients could qualify by participating in work preparation activities, such as vocational training. Because of such changes, Republicans have accused the Obama Administration of gutting welfare reform. However, according to the Center on Budget and Policy Priorities, because of rising inflation and persisting economic difficulties, in 2013, TANF benefit levels were insufficient to provide family income above half of the poverty line in any state.

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See Also: Aid to Families With Dependent Children, Historical Role of; Temporary Aid to Needy Families; Welfare Reform, Role of.

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Pharmaceuticals, Access to

Limited access to pharmaceuticals, or prescription drugs, is a problem that can have dire health consequences. The poor, minorities, and rural populations already suffering health disparities are more likely to face limited access. Using lower-cost generic medicines, when available, helps offset costs for under- and uninsured. Government programs like Medicare and Medicaid, as well as prescription assistance programs (PAPs), improve access for many.

More than 2 billion people lack access to medicines worldwide, and millions die every year from diseases that are treatable. While manufacturing, infrastructure, and distribution inadequacies limit access in developing nations, the high cost of prescription medicines is an obstacle for patients everywhere. Prescription drug prices have more than doubled over the last decade. In the United States, where drug prices are the highest in the world, costs approach $280 billion a year.

Even for those with prescription drug coverage, access can be difficult given high copayments coupled with prior authorization and restrictive refill policies. Studies show that about one-quarter of Americans routinely skip doses or split pills because of high costs. More than one-third of all prescriptions written are never filled. Not taking medicines as prescribed is associated with adverse health outcomes: Studies link poor management of high blood pressure, diabetes, and cholesterol with medication noncompliance. Inadequate access is also associated with more emergency room visits and longer hospital stays, diminishing quality of life and increasing overall health care costs in the process.

The availability and utilization of generic medicines merits discussion. There are generic medicines to treat diseases with high morbidity, like heart disease, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and diabetes, but generics are underutilized. Several studies show that generic medicines are just as effective as their more-expensive counterparts; nonetheless, patients often request brand-name drugs instead. Critics claim pharmaceutical advertising clouds consumer judgment by promoting brand loyalty, but physicians also play a role. A 2004 study found inappropriate prescribing of brand-name medicines to treat high blood pressure, while clinical guidelines recommended a cheaper generic alternative. The practice added $1 billion to Medicare costs that year alone. Many physicians may not know generic alternatives exist. They may not know how much their patients spend on medicines either and so fail to suggest cheaper alternatives. Pharmaceutical companies also impede widespread access and use; pay-for-delay deals or reverse payments to generic drug manufacturers push back production and delay access to cheaper medicines for years.

People with the most difficulty accessing medicines are often those with the greatest need. The National Institutes of Health (NIH) Health Disparities Strategic Plan identifies racial and ethnic minorities, as well as those living in rural communities, at increased risk for early death due to health disparities. These groups suffer a disproportionate number of health-related problems made worse by inadequate access to prescription medicines. Studies show that Hispanics, blacks, and the poor are less likely to take medicines to treat high blood pressure and cholesterol than whites; in addition to an increased risk for heart disease, they also experience diabetes in greater numbers. The risk of diabetes is 66 percent higher among Hispanics and 77 percent higher among blacks compared with whites.

Chronic conditions like diabetes can be effectively managed with medication; when unchecked, complications can include blindness, nerve and kidney damage, stroke, loss of lower extremities, and death. Heart disease, if untreated, can also cause premature death. Research shows that people with heart disease living in the south have higher mortality, and the death rate is strongly correlated with the number of prescriptions filled. Rural and underserved populations in the south are less likely to have employer-provided health care or prescription drug coverage. They are also less likely to receive Medicaid or Medicare benefits, further limiting access to life-saving medicines.

Government programs, like Medicaid and Medicare, can improve medication access and offset costs for the poor and elderly. Medicaid is a means-tested program providing health care and drug coverage for the poor. Jointly funded by federal and state governments, Medicaid is administered at the state level. Although the Affordable Care Act (ACA) expanded eligibility and services, programs vary widely by state. For most Medicaid enrollees, prescriptions are free due in large part to the Medicaid Drug Rebate Program. Enacted in 1991, this is a partnership between federal and state governments and pharmaceutical manufacturers that offsets the cost of drugs administered to Medicaid patients.

Medicare, however, does not provide universal drug coverage. Medicare Parts A and B cover 80 percent of hospital and outpatient care for adults 65 and older, but optional drug plans vary considerably in levels of coverage, copayments, deductibles, and formularies (number and types of prescriptions covered). The 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) established Part D, which covers prescription drug plans regulated by Medicare but administered by private companies. Part D plans are not standardized, and formularies vary, often making it difficult for seniors to choose the plan that best meets their prescription drug needs. Half of Medicare enrollees have three or more chronic conditions requiring many medications to manage, so choosing the right Part D plan is important. The MMA has a clause prohibiting Medicare from negotiating better prices for enrollees, so out-of-pocket costs (deductibles and copayments) are high. Although the ACA helps offset this by reducing deductibles and coverage gaps, many seniors still lack adequate access to medicines.

There are PAPs available to help cover the cost of medicines for the uninsured. Most PAPs are partnerships between drug makers, care providers, and patient advocacy groups, but they are generally administered by pharmaceutical companies. In many instances, access is limited because patients and physicians do not know about PAPs or how to enroll. Most PAPs can only be found online, limiting participation to those with computer access (according to the Federal Communication Commission, 66 million Americans lack basic skills needed to use computers and access the Internet).

Application processes vary, but most PAPs require documented proof of need and details from prescribing physicians. The complexity of the application process is a barrier for many who qualify. Agencies can help match patients with PAPs and assist with the applications, but patients are ultimately responsible for submitting and tracking all of the forms themselves. The approval process can take up to six weeks and programs can be discontinued without notice. The Partnership for Prescription Assistance offers free help and maintains a database of more than 475 PAPs offering 2,500 medicines for reduced or no cost to qualified applicants (www.pparx.org).

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See Also: Department of Health and Human Services, U.S.; Health Insurance; Medicaid; Medicare.

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Pluralism

The precise meaning of pluralism, like many other theoretical concepts, has proved rather elusive because the term embraces multiple variants. However, there is a compelling degree of consensus that at the core of theorizing regarding pluralism is an attempt to explain, understand, or address how intergroup relations work. Pluralism is a model whereby power is centered in a range of places. Under pluralism, power is diffused in such a way that no one group or section of society can have the ability to exercise its power so as to consistently influence policy or decision making. This cultural pluralism manifests itself by way of attention to intergroup relations by developing a common core set of values to underpin the approach. Further, it is important to note, though, that the meaning of pluralism is not exclusively associated with immigrants–host community relations.

In an attempt to appreciate pluralism, it is important to discuss briefly the concept of assimilation, which was historically a forerunner to much of the pluralism discourse and led to the emergence of subsequent concepts and practice around modes of intergroup relations. Assimilation theory is grounded in the academic work of an American sociologist, Robert Park, in the 1920s. Robert Park stated that ethnic minority groups underwent phases of changing relationships with the host (dominant) communities from the point of first contact to the point whereby they were fully integrated. These phases were referred to by Park as the race relations cycle. According to Park, when groups first come into contact with each other, a kind of competition develops between them. Park further stated that migrants inevitably and gradually surrendered their home cultural traditions and embraced the values and culture of the host nation—America, in this case.

A Precursor to Pluralism

Against a tide of significant migration into America, by and large, America has historically approached cultural and ethnic difference from an assimilationist perspective. The expectation was that migrants would over time encounter a melting pot—that is, they would blend into existing American cultural, social, and political values. These expectations can, for example, be strikingly captured through speeches made by American presidents and leading politicians, particularly in the 18th, 19th, and early parts of the 20th centuries. Speeches made by President Theodore Roosevelt of the United States after leaving office with reference to the time-significant migration between 1904 and 1908 underline this point.

Although assimilation has largely been associated with the United States, such an approach to migration is often compared to the French government's assimilationist policy. Some studies focusing on identity and ethnocultural differences suggest that comparisons between what may be called assimilationist approaches in America, Canada, and France can be too simplistic in that the modes of assimilation have emerged from somewhat dissimilar contexts.

As can be observed from the preceding discussion, underlying the assimilationist practice was an aspiration by the host society to foster a state that was truly American. Thus, the American state was conceptualized in terms of immigrants learning and embracing American language, education, and political and cultural values. It is important to note though that, at times, migrants themselves deemed it beneficial to learn the host nation's language and embrace American values, religion, and education with the aim and expectation of improving their chances for employment and acceptance within social circles. However, from as early as 1915, critics of assimilationist policies such as Horace Kallen argued that Anglo-conformist policies that demanded migrants abandon their culture, religion, and language were incompatible with American democratic ideals. During the 18th, 19th, and 20th centuries and indeed the first part of the 21st century, the concept of assimilation and its dominant ideologies were seldom challenged, explored, or discussed in depth. Against this background, hardly any other options were considered for dealing with cultural difference or identity.

The Rise of Pluralism as a Concept

Much of the previous three centuries had been marked by power imbalances brought about by conquest and colonialism. Issues around rights, governance, and intergroup relations were rarely discussed as long as the dominant ethnic group was comfortable with what tended to be a predominantly assimilationist model. Thus, ideologies that governed relations between groups were primarily viewed through the prism of conquerors or dominant groups.

From the early part of the 20th century and most certainly from the 1960s, migration and globalization singularly or together reconfigured the nature and quality of discussions around intergroup relations, whether from a sociological, political, geographical, or international development perspective. The nature and quality of social, economic, and cultural intergroup relations were increasingly being deemed central to effective functioning of states, and this was consistent with democratic values. Thus, attempts to grapple with historic norms, practices, and their effects on intergroup relations gave currency for seeking viable alternatives for dealing with issues of identity and difference. These developments therefore led to the discussion about pluralism.

At a superficial level, the term *pluralism* may erroneously be viewed as synonymous with *multiculturalism*. Yet the two concepts offer distinct perspectives from each other in regards to the discourse around identity and difference. While some researchers may suggest that pluralism is closer to multiculturalism, this position is somewhat misleading. By definition, pluralists are neither multiculturalists nor cultural relativists in ideology.

In an attempt to shed more light on the term *pluralism*, it is important to compare this term with *multiculturalism* with which it is often associated. The differences between multiculturalism and pluralism mainly revolve around the following areas: the nature of cultural diversity, the values promoted by the respective ideologies, and the role of public space. Pluralists will argue for a public space that is neutral for equality of opportunity and freedoms of association to be made available where people can exercise their freedoms. Multiculturalists are likely to dismiss the idea and claims of a public space being neutral enough. Multiculturalists would argue that this public space, in spite of being branded neutral, is incapable of catering for the specific needs of cultural groups and their unique identities. Thus, multiculturalists would see the position they advocate as providing a satisfying sanctuary for cultural affiliation and ethnic visibility and, from that position, gain due recognition from the other groups. Pluralists tend to accept cultures and their respective forms of expression while being opposed to the state actively resourcing alternative cultural endeavors specific to a group.

Perspectives of Pluralism

As has perhaps been observed from this discussion, pluralism is often discussed from two dimensions: the political philosophy and the sociological perspectives. From the political philosophy perspective, pluralism advocates that power must be diffused among a range of interest groups within society, including religious groups, education institutions, and professional and cultural groups, thus acknowledging the range of interests. The political philosophy perspective to pluralism advances the argument that no one single institution should dominate another in a society. This was a view principally developed by British liberals in the early part of the 20th century. At the core of the pluralism philosophy is the belief that effective defense of people's rights firmly belongs at the small group level.

Perhaps a typical pluralistic perspective may be encapsulated best in an example of a state education system as explained within this paragraph. Pluralists would, for example, not be in support of the state resourcing schools that develop or choose to be governed along specific ethnic, religious, and cultural orientations. Pluralists would argue that, while recognition and acceptance of diversity can be tolerated, schools are a public space within which citizens from all backgrounds can meet in neutral ways. Further to this, while pluralists recognize the validity and existence of other identities and cultures, they would argue that society must not have the obligation to support alternative modes of expression. Pluralists, for example, would view schools as arenas for providing neutral space for equality of opportunity and freedoms of association. Pluralists would argue that merit is rewarded through the provision of equality of opportunity; in this case, a school system that is not culturally specific in its approach.

Pluralism and Multiculturalism

In spite of liberal forms of dealing with difference, there have been other perspectives that have emerged over the past 50 years. These have been promoted as viable perspectives for dealing with increasing transnational movements and globalization. It has been suggested that the rise of multiculturalism had been influenced by liberal thinking about new forms of living with ethnic diversity. Large numbers of migrants moving into America and Europe had now been significant enough to have an impact on host populations away from the assimilationist perspective. In the middle of the 20th century, there was increasing acknowledgment that traditional connotations of assimilation with superiority of either host or conquest community's social and cultural values ran counter to democratic values.

Further to this, pluralists will view multiculturalism as contingent on cultural values and therefore not likely to accommodate or be accepting of other forms of cultural persuasions. Accordingly, pluralists will consider the predominance of cultural dimensions among multiculturalists as placing some constraints on common democratic values and, as such, not always compatible with the open values of a liberal society.

Pluralism as an issue has increasingly become a point of discussion in the United Kingdom. Leicester is a city in the United Kingdom with a population of about 320,000 residents. The city of Leicester lies about 85 miles north of London in central England. For centuries, all of its residents have been people of European descent until after World War I and World War II and certainly after the independence of India and Pakistan in 1948. People from the Caribbean, through what was known as the Windrush, and some people from India migrated to the motherland (Britain) as a matter of right as citizens of the Commonwealth. By and large, it was expected that new migrants would assimilate. Considering that most migrants into Leicester came from former colonies, it would have been expected that they would assimilate. In the 1960s, Afro Caribbean migrants settled in St. Peters, while East African Indians and Pakistanis settled in the Belgrave Road and Spinney Hill parts of the city of Leicester. The first decade was characterized by migrants establishing worship places and clubs and identifying specific places for welcoming new arrivals, shopping, and socializing. Further to the initial wave of migrants, during the 1960s when most countries in Africa were attaining independence from colonial powers, Leicester experienced the beginning of East African Asian migration. Indeed, soon there was an exodus of East Asians from Kenya, bringing the population of Indian migrants in Leicester to about 20,000 by 1971.

Considering cultural and religious differences between host and migrants, there was a growing feeling in some natives against migration. This disquiet is evidenced by low voting patterns in 1974 and 1976, rising to about 18 percent of the host community voting against immigration, and this only declined in about 1979.

The history of Leicester in the United Kingdom provides within it lessons around intergroup relations and dealing with difference. Previous to the 1970s, some migrants had settled in Leicester. The comparatively insignificant number of migrants over the period leading to the 1970s had not given rise to much tension. Migrants coming into the city previous to the 1970s melted into the community and became anglicized.

Early migrants into the city of Leicester were not perceived as in competition for resources by the majority population. Migration of East African Asians into the city during the period leading to the 1970s had evidently impacted on sections of host communities. Parallel to protests and antimigrant sentiments were new liberals and socialists who had pluralistic leanings and who became instrumental in influencing the votes, resulting in a popular acceptance of cultural diversity. Leicester occupies a unique place in the United Kingdom as one of the country's most diverse cities, with minorities accounting for about half of the residents. Despite somewhat uncertain tensions in the city of Leicester in early migrant history, few would doubt that the city had inherited a pluralistic position.

In many respects, political leaders in Leicester, like the United Kingdom as a whole, will almost never explicitly identify themselves with assimilationist policies. In the same way, both researchers and politicians would rarely align themselves with integration because of its perceived link with assimilation. However, politicians would be reasonably comfortable to claim the multicultural composition of their cities.

Within the city of Leicester, multiculturalism was highly embraced in the first decade of the 21st century. Every year, residents and the city have worked closely to organize cultural events. Residents from diverse cultural backgrounds share in celebrations. At some point, Leicester, like many cities in the United Kingdom, would translate official documents into key minority ethnic languages. In recent years, in the aftermath of Europeans acceding, states have increased the level of migration. During this time, there has been a significant increase in the number of migrants from Somalia, Iraq, Afghanistan, and Zimbabwe.

However, looked at from another political, philosophical perspective, Leicester pursues a pluralistic model of dealing with identity and difference. While initially ethnic events would have been exclusively designed with specific groups in mind, the city of Leicester has in recent years promoted inclusive events with more subtle cultural dimensions. Against an environment of disquiet against multiculturalism due to migration and largely misguided associations with terrorism, there is recently a general trend for local authorities to actively support pluralistic initiatives and projects. Decision making is diffused in many other ways, indicating more of a pluralistic dimension to policies.

Examined from a theoretical point of view and intergroup sociological and development theory, there are a few important points that can be made. Over decades of migration into Leicester, two perspectives would have provided avenues for dealing with ethnic, cultural, and racial difference. Either accept a multicultural approach to dealing with difference, or have a critical mass within the city who subscribed to a pluralist ideology, thereby minimizing tensions that may arise in acceptance and denial of difference within the range of interest groups.

As can be seen, the rise of pluralism, although attributed to liberals, may be an inevitable step in the development of intergroup relations. Globalization, good governance, associated rights, and diversity of groups with a range of interests, needs, and vulnerabilities within a range of contexts present challenges that may not be well served within assimilationist or multiculturalist modes of dealing with difference. Increases in migration resulting from disasters and voluntary migration for better prospects, employment, and personal choice, some would argue, seem to point to pluralism as an inevitable direction.

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See Also: Assimilation; Immigrant Populations, Human Services Needs of; Immigration, Human Services Issues; Multiculturalism.

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Policing and Safety

The police are an organ of the executive arm of government that is constitutionally established and responsible for the enforcement of law and order, protection of life and property, and protection from any form of antisocial behavior. The cosmopolitan nature of most cities makes the work of policing more complex. For effective policing, the United Nation (UN) recommends one police officer to 400 people. Many countries of the world cannot meet this recommendation because of the huge finance and logistics that effective policing demands. Human diversity as a result of multiculturalism and neoliberalism contribute to diverse services required to provide safety for the community in modern times. The responsibility for policing and public safety rests across a number of different agencies.

The complex nature of policing made societies come up with the idea of dividing policing into public and private policing. Private policing is a personal arrangement to secure personal safety and to protect personal property. This type of policing is financed by the individual and has limited function, duty, and power under the Constitution. It involves door supervision, closed-circuit television (CCTV) monitoring, bodyguards, and supervision of money and important goods in transit.

Public policing is financed and controlled by the nation's authorities. Modern policing issues must consider public safety from crime prevention and victim support to planning. Policing and community safety partnerships are new statutory bodies established under the justice act to help make

The responsibility for policing and public safety rests across a number of different agencies. New York Army National Guard soldiers along with New York state police troopers assist local residents arriving by military vehicle at the Long Beach City Hall for evacuation to shelters supervised by Nassau County Office of Emergency Management following subtropical storm Sandy.

communities safer. This includes community and district policing partnerships to consult and engage in crime monitoring, identify and prioritize the safety needs of the community, and monitor performance of the police to deliver a reduction in crime and enhance community safety in the district. Effective policing requires huge financial support and cooperation of members of society to have a safe and secure society.

Police Names

The names given to the police are different from country to country; they depend on the origin of police formation in different countries. Police could also be referred to as gendarmerie, constabulary, police department, police service, crime prevention, protective services, police authority, law enforcement agency, civil guard, or civic guard. These are synonyms based on human diversities and identities. Members of the police rank and file could also be referred to as police officers, troopers, sheriffs, garda, constables, rangers, peace officers, militsiya, or civic or civil guards.

Policing and Safe Communities

The task of making a community safe is the duty of every citizen. Historically, in America, policing is provided by the elected members of the community. In ancient Britain, every citizen participated in policing by providing security through hue and cry. The New York Sheriff Office was founded in 1826, and Albany County had elected sheriffs and local militias. The U.S. Secret Service was founded in 1865. Making society safe involves activities such as control of antisocial behaviors, which include hate crimes, excessive noise nuisances, intimidating groups in public spaces, graffiti, dumping rubbish, stray dogs, street prostitution, street drinking, and drug or alcohol misuse.

Prevention of violence against women and girls is another method of making a community safe. This includes domestic violence, rape and sexual violence, female genital mutilation, forced marriage, crimes in the name of "honor," sexual harassment, stalking, trafficking, prostitution, sexual exploitation, and drug and alcohol abuse.

To have a safe community, hate crimes must be well policed by the community. Hate crimes include physical attacks, harassment, threats, disputes with neighbors' abusive remarks, intimidation, distress, fighting, bullying at school and workplaces, arson, spitting, or making insulting gestures. If anybody feels insecure and experiences any of these antisocial behaviors, he or she can contact the police or a victim support organization. In most countries, for instance, in the United States and the United Kingdom, 911 and 999, respectively, are the designated numbers for a victim of crime.

Effective Policing

For effective policing of communities, police authorities are divided into different units based on the security needs of a particular country. There are uniformed police known as administrative, order, or patrol police; they are always in uniform and readily available for the protection of life and property. Police detectives are always in civilian clothes and hide their identities. They provide secret services and information that could aid investigation and detection of criminal plans. Detective police are also referred to as investigation police, judiciary or judicial police, and criminal police. In the United Kingdom, detective police work is in the Criminal Investigation Department. They also work in the Federal Bureau of Investigation (FBI) in the United States.

Specialized police are those who work where specialized or high-tech know-how is needed such as traffic law enforcement, crash investigation, homicide, fraud, underwater issues, aviation, explosive device disposal (bomb squad), computer crime, light infantry, police field forces, peacekeeping, antiterrorism, hostage taking, armed robbery, and assault. Military police carry out the same duties as civilian officers but within military circles. Many Islamic nations have religious police who carry out the implementation of Sharia law. Interpol forms global webs of policing to curb internationally connected crime. There is an auxiliary police unit that provides administrative duties such as issuing fire arms licenses.

Police, as gatekeepers in the criminal justice system, are the first point of contact for the community. Police arrest, detain, investigate, grant bail, and arraign offenders in (criminal) courts. There are other policing units that provide safety measures in air and water such as air and marine police. Policing and safety are everybody's business because the police depend on intelligent reports from the general public to combat crime and criminals.

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See Also: Juvenile Detention Centers; Juvenile Justice System; Neighborhood Watch Programs; Social Security Administration.

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Postpartum Depression

The birth of a child is an exciting time for a family and produces a range of emotions from joy to fear to exhaustion. However, for some mothers, the birth of a child can trigger postpartum depression. Experiencing depression following the birth of a child is a common occurrence and can be managed through psychiatric and therapeutic treatment. This entry explains the types of postpartum depression including the baby blues, postpartum depression, and postpartum psychosis. Furthermore, this entry discusses the risk and protective factors, screening, and treatment of postpartum depression.

Types of Postpartum Depression

The baby blues are a transient state of heightened emotional reactivity that include depressive symptoms such as mood swings, anxiety, sadness, irritability, crying, decreased concentration, and trouble sleeping. The baby blues occur in approximately 50 percent of women postpartum, according to L. J. Miller. Postpartum blues peak three to five days after delivery and can last anywhere from a few hours to 10 days. The symptoms of the baby blues may be distressing; however, they do not reflect psychopathology, and they typically do not affect the mother's ability to function and care for her child.

Postpartum depression has similar symptoms to the baby blues except that the symptoms are more intense and longer lasting. Postpartum depression symptoms interfere with the mother's ability to care for her baby and handle everyday tasks. Postpartum depression symptoms may also include loss of appetite; insomnia; intense irritability and anger; overwhelming fatigue; loss of interest in sex; a lack of joy in life; feelings of shame, guilt, or inadequacy; severe mood swings; difficulty bonding with the baby; withdrawal from family and friends; and thoughts of harming self or the baby. Postpartum depression occurs in approximately 10 to 20 percent of women within six months after delivery. Risk factors in developing postpartum depression include a history of depressive disorders, psychosocial stress, and inadequate social support. If postpartum depression goes untreated, the symptoms can last for months.

In addition to postpartum depression, some mothers also experience postpartum psychosis. Postpartum psychosis is a rare condition that typically develops within the first two weeks after delivery and includes symptoms such as confusion and disorientation, hallucinations and delusions, paranoia, and attempts to harm self or the baby. It is important to note that many mothers with postpartum depression have thoughts of harming their infants. These thoughts are often obsessional in quality and rarely acted upon. However, when a mother with severe postpartum depression becomes suicidal, she may also consider killing her children, not typically out of anger or a desire to harm her children but rather due to a desire not to abandon her children. Episodes of postpartum psychosis can be successfully treated; however, postpartum psychotic depressions have a high likelihood of recurrence, both during and outside of the postpartum period, without maintenance treatment.

Screening

With 10 to 20 percent of mothers developing postpartum depression following the birth of a child, it is imperative that screening efforts occur by primary care physicians, obstetricians and gynecologists, maternity nurses, and pediatricians. The Edinburgh Postnatal Depression Scale (EPDS) is a commonly used 10-item measure assessing a mother's risk for postpartum depression. At a minimum, while in the maternity ward post-delivery and at the baby's well visits, doctors and medical staff should monitor and assess for potential depressive symptoms.

Screening is imperative for the early detection and treatment of postpartum depression for the mother but is also important to the support of the entire family. Partners are more likely to develop depressive symptoms in the postpartum period if the mother has developed postpartum depression. The marital relationship is significantly strained by the occurrence of postpartum depression. In addition, multiple studies have indicated the strain the mother–child relationship experiences if the mother develops postpartum depression.

Treatment

Postpartum depression is often treated with medication or therapy. It is important to know that, if a mother is breast-feeding, any medication taken by the mother will enter into her breast milk. However, there are some antidepressants that can be used during breast-feeding with little risk of side effects for the baby. Antidepressants are a proven treatment for postpartum depression, and a doctor can help the mother understand the benefits and potential risks of taking antidepressants while breast-feeding. In addition, estrogen replacement treatment may help counteract the rapid drop in estrogen that accompanies childbirth. However, research on estrogen replacement treatment is limited.

Individual and group counseling for postpartum depression focuses on helping the mother find ways to cope with depressive symptoms, utilize problem-solving skills, and set realistic goals. Cognitive-behavioral therapy is a commonly utilized therapy for the treatment of postpartum depression. Cognitive-behavioral therapy focuses on helping the mother identify distorted perceptions, change these perceptions, and discover new patterns of actions and behaviors to improve mood. The following three steps are the main focus of cognitive behavioral therapy: (1) the mother must learn to recognize depressive reactions and thoughts as they occur, usually by keeping a journal of feelings about daily events; (2) the mother is given homework to practice identifying and challenging old negative thoughts and assumptions by replacing the old thoughts with new realistic and helpful thoughts; and (3) the mother works with the therapist to identify behaviors the mother can utilize to improve her mood on a daily basis.

Cognitive-behavioral therapy has been demonstrated to be as effective as psychiatric medications in the treatment of depression. Treatment typically lasts for a period of 12 to 14 weeks and may include individual or group therapy modalities. With appropriate treatment, the symptoms of postpartum depression generally go away within a few months. For additional education and support visit Postpartum Support International (www.postpartum.net).

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See Also: Family Services; Maternal/Infant Health Services; Mental Health Services, Adult.

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Poverty

Poverty in the United States differs from the degree and forms of material deprivation found in less-industrialized nations, many of whose citizens barely survive on $1 or $2 a day. In the United States, there are varying opinions about the nature and extent of material hardship that poor persons experience. Those on the political left, such as economist Barbara Ehrenreich, political scientist Stephen Pimpare, and sociologist Kathryn Edin, stress the struggles poor families have to put sufficient food on the table, to put a roof over their heads, and to educate their children.

Those on the political right, such as Senior Research Fellow Robert Rector and Research Associate Rachel Sheffield at the Heritage Foundation, argue that official poverty thresholds provide a misleading indication of material deprivation or hardships—they cite things such as the presence of cable or satellite TV (two-thirds of poor families), wide-screen or plasma TV (one-third), air-conditioning in the home (80 percent), car or truck ownership (75 percent), and the like. Invariably, both portraits contain some grain of truth, in part reflecting that the poverty population in the United States is not of one piece—that is, it varies along sociodemographic characteristics, with some groups such as children, female-headed families, and black persons more likely than others to be classified officially as poor or to experience deep poverty at any given time and for longer periods of time.

How Poverty Is Determined

The U.S. Census Bureau uses a set of dollar-value thresholds that vary by family size and composition to determine who is poor. The poverty thresholds are used primarily for statistical purposes; for example, estimating the number of persons in poverty and tabulating them by type of residence, race, and other social, economic, and demographic characteristics. Relying on several official estimates of low-budget food plans, economist Mollie Orshansky, working for the Social Security Administration, developed the poverty thresholds in 1963 and 1964. The poverty thresholds became official in August 1969 when the Bureau of the Budget issued a memorandum that directed all federal branch agencies to use revised estimates as issued by the U.S. Census Bureau for statistical purposes.

Poverty thresholds are distinguished from poverty guidelines, which are issued by the Department of Health and Human Services (HHS) for administrative purposes such as determining whether a person or family is financially eligible for assistance or services under certain federal programs; for example, Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program (SNAP).

Based on family size and number of children under 18 years of age, in 2011, the lowest U.S. Census Bureau poverty threshold was set at $10,788 for a family of one person 65 years and older, with the highest threshold at $50,059 for a family of nine or more people with only one related child under 18 years of age. If a family's total income is less than the applicable threshold, then that family and every individual in it are considered in poverty. To account for inflation, the consumer price index (CPI-U) is used to update these thresholds annually. The official poverty definition uses money income before taxes and tax credits; it excludes capital gains and noncash benefits such as those from SNAP, formerly known as food stamps, and housing assistance. For example, imagine two families, A and B, each of which has five people living at home: three children (two under 18 years of age and the third 20 years of age with a part-time job while earning a degree), their mother, and their grandmother with income from cleaning other people's homes. Family A's and Family B's poverty threshold in 2011 was $27,517. Because their total family income, $29,000, was higher than their threshold ($27,517), Family A would not be considered in poverty; however, because their total family income, $27,000, fell below the same threshold, Family B would be considered in poverty.

Characteristics of the Poverty Population

According to the demographic makeup of the U.S. population at varying degrees of poverty in 2011, of all persons whose family incomes fell between 50 and 99 percent of their poverty threshold, more than one-third (34.3 percent) were children under 18 years of age, more than half (55.3 percent) were between the ages of 18 and 65, and the remainder (10.4 percent) were 65 years of age or older. Of all persons whose family incomes fell below 50 percent of the poverty threshold, considered extreme poverty, more than one-third (35.6 percent) were children under 18 years of age, more than half (59.8 percent) were between the ages of 18 and 65, and the remainder (4.6 percent) were 65 years of age or older.

In 2011, the official poverty rate in the United States, based on the U.S. Census Bureau poverty thresholds, was 15.0 percent: 46.2 million people were poor; 13.6 percent of males (20.5 million persons) and 16.3 percent of females (25.7 million persons) were poor. The poverty rate and the number of families in poverty in 2011 were 11.8 percent and 9.5 million. For married-couple families, the poverty rate was 6.2 percent (3.6 million); for families with a female householder and no husband present, 31.2 percent (4.8 million); and for families with a male householder, 16.1 percent (1 million).

Trends in the Poverty Population

Poverty rates are affected by the economy: Generally, as the economy grows, poverty rates decline; as economic growth slows, as is the case during recessions, poverty rates tend to increase. The poverty rate declined for all persons throughout the 1960s as the economy emerged from the 1960 to 1961 recession and leveled off in the 1970s, which had three recessions, so that the highs and lows on average evened out.

In the early 1980s, the poverty rate was about 15 percent, declined gradually throughout the remainder of the decade, but rose again in the later part of the decade, showing a gradual rise on average throughout the decade. Coming off the 1990 and 1991 recession, the poverty rate dropped precipitously throughout the 1990s, reaching historical lows at the turn of the century, before increasing again in the early 2000s in light of the Great Recession of 2007 to 2009. However, poverty rates differed markedly for non-Hispanic whites and blacks between 1959 and 2011.

Although the poverty rate declined for both non-Hispanic whites and blacks during the 1960s, at no time were more than 20 percent of non-Hispanic white persons living in poverty, hovering between 9 and 11 percent throughout most of the period. Poverty rates were about three times higher for black persons until the mid-1990s, when the gap narrowed to about twice the rates for non-Hispanic whites. The two recessions of the 2000s produced increased poverty rates for non-Hispanic whites and for blacks, with the gap between them remaining about twice as high for blacks. The U.S. Census Bureau issued poverty statistics for Hispanic persons of any race beginning in 1972. At no time were less than 20 percent of Hispanic persons living in poverty, hovering in the mid-20s in the 1970s and high-20s in the 1980s, peaking at 30.7 percent in 1994, fluctuating thereafter, and standing at 25.3 percent in 2011. The U.S. Census Bureau issued poverty statistics for Asian persons of any race beginning in 1987, when 16.1 percent of such persons were classified as in poverty.

Trends in poverty rates between 1959 and 2011 also varied by age. Those 65 years of age and older experienced the greatest decline, particularly in the 1960s through the mid-1970s. The poverty rates for children under 18 years of age also declined in the 1960s through the mid-1970s, but unlike those 65 years of age and older, their rates climbed in the late 1970s and early 1980s and again in the early 1990s and throughout the 2000s.

Paralleling the increasing poverty rates of children less than 18 years of age are the trends in the poverty rates of female-headed families, particularly those with no husband present. Whether for non-Hispanic whites, blacks, or those of Hispanic origin, for these parents and their children, poverty rates never dipped below 20 percent between 1972 and 2011.

Major Public Programs Affecting Low-Income Persons and Families

Aside from the war on poverty during the administration of President Lyndon Johnson in the mid- to late 1960s, the United States has no comprehensive antipoverty strategy per se—at least at the national level of government beyond that of growing the economy. Nonetheless, there are three major cash-related programs that directly affect poverty rates, namely, Social Security, the Earned Income Tax Credit (EITC), and Supplemental Security Income (SSI), which will be highlighted here. Other programs that provide benefits to low-income persons and their families include TANF, SNAP, Medicaid, State Children's Health Insurance Program (SCHIP), and Head Start.

Established by the Social Security Act of 1935 for retirees and their dependents, Social Security is the pay-as-you-go retirement program funded by payroll taxes—that is, current employees pay into the trust fund that supports the current generation of retirees and their dependents. Individual workers and their employers each pay 6.2 percent of an employee's wage up to a specified maximum dollar amount ($113,700 in 2013), with self-employed persons contributing 12.4 percent. Every month, Social Security checks lift about 20 million or so persons above official poverty thresholds, including 1.1 million children under 18 years of age, 5.3 million adults between the ages of 18 and 64, and 13.4 million persons 65 years of age or older.

The mayor of Duluth, Minnesota, Herb Bergson (center), attends an antipoverty rally in 2005. Poverty varies along sociodemographic lines, with some groups more likely than others to officially be classified as poor.

Created in 1972 and launched in 1974, Supplemental Security Income (SSI) is a federal income supplement program funded by general tax revenues and designed to provide cash assistance to people who are disabled, aged, or both, and who have low income and few assets. About 60 percent of SSI recipients are disabled adults (18–64 years of age), about 15 percent are disabled children (under age 18), and about 25 percent are older adults (age 65 and over) with or without disabilities. SSI recipients are generally eligible for Medicaid and other programs available for low-income persons and families. According to the trends in the SSI population, the increase in the number of disabled adults since the 1990s is the most pronounced. By contrast, the share of the aged who participate in SSI steadily declined in the past few decades as more women qualified for Social Security benefits and as average Social Security benefits have increased. Overall, the number of SSI recipients has increased faster than the overall population over the past few decades. SSI has been estimated to reduce poverty among recipients; for example, from a pretransfer poverty rate of 80.2 percent in 2004 to 72.2 percent.

The EITC was enacted provisionally in 1975 as part of the Tax Reduction Act during the Gerald Ford administration to offset the burden of the Social Security payroll tax on low-income working parents. Low-income, full-time workers whose annual income falls below official poverty guidelines are eligible for the tax credit, and they must file tax returns to obtain a tax refund just as any other taxpayer.

The EITC generally equals a specified percentage of wages up to a maximum dollar amount. For 2012, for example, earned income and adjusted gross income (AGI) for a single adult must have been less than $45,060 ($50,270 married filing jointly) with three or more qualifying children; $41,952 ($47,162 married filing jointly) with two qualifying children; $36,920 ($42,130 married filing jointly) with one qualifying child; and $13,980 ($19,190 married filing jointly) with no qualifying children. Maximum credits were $5,891 with three or more qualifying children, $5,236 with two qualifying children, $3,169 with one qualifying child, and $475 with no qualifying children. Additionally, investment income must be $3,200 or less for the year.

From 1975 through 1987, the number of EITC claimants ranged between 6,000 and 9,000; in 1988, more than 11,100 individuals claimed the credit. By 2010, nearly 27.8 million returns were filed claiming the credit, representing nearly 19.5 percent of all tax returns filed for that tax year and $60.9 billion in revenue lost to the U.S. Treasury Department. By contrast, for fiscal year 2006, net federal expenditures for TANF, which replaced the Aid to Families With Dependent Children (AFDC) program in 1996, amounted to $13.6 billion, less than one-third of revenue lost in the calendar year 2006 because of the EITC.

Total claimants climbed to 27.4 million in 2009, surpassing the 24.8 million in 2008, with total costs increasing from $50.7 billion to $60.4 billion, respectively. In 2011, EITC kept 5.7 million low-income workers and their families out of poverty, including 3.1 million children. Had the SNAP or food stamp voucher been counted as cash income in 2011, it would have lifted 3.9 million persons above poverty thresholds, including 1.7 million children.

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See Also: Aid to Families With Dependent Children, Historical Role of; Homelessness; Social and Economic Justice; Temporary Aid to Needy Families; War on Poverty Programs; Welfare Reform, Role of.

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Power, Race/Ethnicity and

Race, ethnicity, and culture are often translated in one meaning for many characteristics. Each of the three terms are used widely to label a group or individual; however, lack of understanding of the distinction often leads to confusion, misrepresentation, or unintentional bias. The literature reveals that there are multidimensional approaches to referencing race, ethnicity, and culture.

Early research studies characterize race in terms of reference groups based on an individual's identity to physical image, social values, and individual perceptions. Ethnicity, while different from race, is often used interchangeably. The distinction of the two are defined by the construct associated with skin color and the practices and cultures associated with one's ethnic background.

Race Defined

For centuries, race has defined differences among humans to create distinctions among groups. The categorization of race has been used widely across the United States and is accepted as a blanket form of identification in government documents, personnel profiles, health care, and human services. Race is a social construct used in systems to define or categorize humans based on distinct characteristics associated with outer appearances such as the color of one's skin and facial structure; however, the literature presents multiple points related to research that this classification alone is not based on anthropological ideas centered on race.

Since the late 1700s when the first United States decennial census collected data, the white population has been enumerated. Not until the 2000 census poll did individuals have options to self-identify with more than one race. Based on the Office of Management and Budget, the U.S. Census adheres to the five racial categories. Individuals now have the ability to choose from more than 57 possible multiple race combinations. The U.S. Census Bureau in 2010 defined race and ethnicity by classification in five categories: white, black or African American, American Indian or Alaska Native, Asian, and Native Hawai'ian or other Pacific Islander.

The U.S. Census Bureau in 2010 offered an understanding of the race category questions and states: "The race categories included in the census questionnaire generally reflect a social definition of race recognized in this country and are not an attempt to define race biologically, anthropologically, or genetically. In addition, it is recognized that the categories of the race question include racial and national origin or sociocultural groups."

Historically, there have been detrimental research studies that propagated race as an inferior or superior determination of intelligence. The 1924 Immigration Act prevented groups of people from entering the United States based on quotas and limited annual immigration from particular countries. The Immigration Act allowed for a 2 percent or less admittance into the country and provided priority to specific persons, including those who who were married or related to a U.S. citizen, or had agricultural skills. In more recent years, psychologists published controversial research on the bell curve and used race as the construct to make the claim that, based on race, people were inferior or superior in intelligence and ability to achieve.

Ethnicity Defined

Researchers define ethnicity much different than race or culture. The literature reveals ethnicity is the part of an individual that identifies similar beliefs and practices. It consists of characteristics that make up the smaller groups within the larger cultural group or society. Culture and ethnicity are both important within various groups, and the traditions and practices are passed down for generations. Ethnicity looks different even within racial classifications because ethnicity comprises culture and practice. Ethnic diversity is shared commonly by people who have similar historical backgrounds and cultures. Additionally, the ethnic group may also have similar values, beliefs, and practices. In some instances, a person with a different racial background may practice more ethnic traditions of another group, and conversely, someone connected within an ethnicity may not adhere or practice their ethnic traditions.

In the development of the Smith Ethnic Identity Model, author and researcher Elise Smith defines ethnicity through identification: The ethnic identification process can be measured by observing the degree to which an individual's ethnic membership group is a salient reference group and by observing the extent to which the individual uses the signs, symbols, and language of the culture associated with the ethnic membership group.

Ethnicity is often associated with race because of the origin of the group associated with race. This labeling and identification can also lead to a power struggle or resistance within Western culture. The U.S. Census characterizes the white race with origins from European, Middle Eastern, or North African descent. Based on the size of the white population in the United States, all other races have been characterized as minority races.

Power in the United States

The U.S. system of power was developed largely to maintain control among society and provide rules and laws to adhere to in daily living. These laws govern the United States and the empirical power that the Constitution embodies yet, some would argue, separates power among various races in society. The nature of U.S. culture is identified through the historical power displayed in the forming of the nation as a democracy. Acknowledging the accomplishment of the country and the laws that govern is notable, while ignoring the differentiation among racial groups is negligent. Politics, economics, and the societal norms of this country are part of the power dynamic. Identifying how race is also a part of this construct and recognizing the disparity in power among races provides a clear indication for moving into informed thought surrounding power as a construct.

Balance of power and equity through predominate cultures can shape integration of all levels of diversity. Understanding the theoretical basis for power and norms that often do not inherently include relevance for culturally or linguistically diverse populations will also eliminate the possibility of achieving a balance of power. To achieve this balance in organizations or systemic operations, researchers on cultural proficiency suggest integrating culture within the organization, identifying biases of stakeholders and those in power, and integrating a positive approach to achieving equity, which includes community stakeholders.

Minority Versus Majority as a Classification

The racial and ethnic classifications in the United States have led to unfortunate stereotypes that have shaped our society. There are several race-related issues tied to negative occurrences in U.S. culture. Racial profiling in the criminal justice system has become a reality, and there are services put in place to mitigate such occurrences. The American Civil Liberties Union (ACLU) defines racial profiling as, "law enforcement and private security practices that disproportionately target people of color for investigation and enforcement." The ACLU works on behalf of individuals who have been victims of such profiling.

Race-based initiatives to assist in equalizing the level of access in economic, educational, and human services have been implemented in efforts to achieve equal opportunities. One example of such an initiative is in an executive order signed by President Barack Obama titled the White House Initiative of Educational Excellence for African Americans.

This executive order promotes the implementation of innovative education reform strategies and practices in American public schools and ensures that all African American students have comparable access to the resources necessary to obtain a high-quality education, including effective teachers and school leaders, in part by supporting efforts to improve the recruitment, preparation, development, and retention of successful African American teachers and school leaders and other effective teachers and school leaders responsible for the education of African American students.

Additionally, affirmative action set out through Executive Order 10925, signed by President John F. Kennedy in 1961, to "not discriminate against any employee or applicant for employment because of race, creed, color or national origin" and "take affirmative action to ensure that applicants are employed and that employees are treated during employment, without regard to their race, creed, color or national origin."

Some race-based initiatives are scrutinized by the predominate race, and they ridicule such initiatives for providing unfair opportunities for everyone. This led to several states banning affirmative action because of its opposition from some groups in American society related to questions of intent.

Critical Race Theory

Critical race theory (CRT) began to bring attention to inequitable practices in the United States at many levels of society. The emergence of CRT came almost a decade after the Civil Rights Act of 1964, when Derrick Bell, an African American Harvard professor, and Alan Freeman, a fellow advocate, fought intellectually to right the wrongs of race-based injustice.

While the Civil Rights Movement was a catalyst to begin setting the stage for racial equity, the level of integration and social changes were rarely occurring at best. CRT seeks to identify practices of inequity while oftentimes giving voice to those affected by providing a lens to explain true happenings in the work environment and social settings. Additionally, CRT exposes contextual factors of race by identifying historical and systemic effects on race and class in American culture. CRT is widely cited in research publications, legal briefs, and scholarly books reaching thousands of cross references and citations.

White Privilege

CRT and similar theories on the study of whiteness introduce the academic perspective of white privilege. However, the issues surrounding white privilege have historically been a part of academic discovery as early as the civil rights era. White privilege is the social construct experienced by individuals who identify within the white race based on skin color. White privilege asserts that the racialization of American culture allows whites advantage in social, economic, and cultural advancement. White privilege also identifies the biases and sometimes unintentional superiority upheld by the white race against other races that are of color. White privilege is often associated with personal self-worth, uninhibited freedom of speech, and social nonjudgmental norms that are not provided

Veiled demonstrators at a march against racially disproportionate policing in New York City. Racial profiling in the criminal justice system has become a reality, and there are services put in place to mitigate such occurrences. The American Civil Liberties Union (ACLU) works on behalf of individuals who have been victims of such profiling.

or acceptable from people of color. While white privilege is widely used in sociological studies, it is important to note that some consider it reverse discrimination. Understanding white privilege allows for the understanding of problems surrounding inequality and injustice as well as more prolific issues in race, ethnicity, and power.

Inequality

Race and power are controlled by the subconstruct of inequality. Inequality characterized in this discussion refers to the societal, economic, and educational disadvantage tied to a racial group or classification of race. Income distribution along with poverty comparison by race as a construct indicates disproportionate results from race to race. A number of historical factors contribute to racial inequality in the United States. The disparity among races in America and the unequal distribution of wealth attainment can be tied to slavery, immigration, and Jim Crow. Each of these historical accounts eliminated equality in wage earnings and fair hiring practices. These detriments put a bridge between wealth and poverty that has been very difficult to close.

Higher-paying jobs are given to a better-educated, highly skilled workforce, while labor demands are less attractive for less-educated workers. Initiatives implemented to increase the education level in the workforce could decrease the labor gap in the future if careful consideration is also given to culturally proficient education and job training.

The U.S. Census Bureau data shows black or African American and Hispanic families are 22.7 percent below the poverty level, while whites and Asians are 9.3 and 9.4 percent below the poverty level, respectively, and all total races are 11.1 percent below. The double in percentage increase of black and Hispanic families is daunting, especially when considering the population increase in both races.

Educational inequality is also a major challenge in U.S. communities. Surveying states and cities within states that have financial inequality and limited educational access within blocks or miles of privileged areas create a faulty system for those in poverty to overcome. Other additional barriers are placed on students within these school settings because they often have not been provided the same resources as students in upper-middle class or suburban schools. Programs such as Title I are put in place in schools with extreme poverty to equalize the access in the classroom. Far too often, though, the resources provided by the district and standard curriculum are so below par that Title I funding goes to supply critical educational resources or to implement allowable support staff to mitigate the effects of oversized classes.

There are ways in which to bridge the gap among schools regardless of economic disadvantage by providing integration in broad communities, increasing funding for schools, and eliminating the educational divide. This notion of inclusiveness to reach equality will not occur until we heal and grow from the aforementioned discussion on race and power in the United States.

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See Also: Critical Race Theory; Ethnicity, Definitions of; Race, Social Definition of; Racial Microaggression; White Privilege.

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Pregnancy and Parenting Services

Many services are provided to parents to assist them in their parental roles. Susanna Rautio contends that parenting can be a challenging task, especially for first time parents; they often need support and information. Services are offered during pregnancy and extend into the teenage years of the child to provide support and information to parents. These services are geared toward fostering healthy parental relationships through educational and support services. Community agencies, governmental agencies, and religious entities work to support parents by providing everything from education, counseling, and support to nutrition, medical, and career services.

Pregnancy Services

Pregnancy services are geared toward preparation of the birth of the infant. Community agencies including hospitals offer medical services including prenatal care. Many community agencies provide pregnancy testing, ultrasounds, counseling, and abortion services. These agencies are often referred to as pregnancy centers or pregnancy clinics. They are often nonprofit agencies that usually provide immediate temporary services and will provide clients with medical referrals for prenatal care. Community agencies also offer educational services. Clients are educated on the symptoms of pregnancy, alternatives to pregnancy, and the use of contraceptives. Pregnancy centers can be found in all of the United States but are often located in inner cities to service low-income populations. There are controversies over abortions being conducted at these centers. Antiabortion critics often protest near these centers.

Religious entities such as local churches provide various services to those who are pregnant. Services include shelter, food, and clothing. Many churches have food and clothing pantries. Some have clothing pantries that are geared toward providing clothing for babies. These services are typically run by volunteers. Participants must show some proof of pregnancy.

Governmental agencies such as local health departments offer a number of services for pregnant clients. These services include pregnancy testing, communicable disease testing and education, prenatal care, infant development education, and nutritional programs such as Women, Infants, and Children (WIC), services that are often free to those who qualify. Qualifying may include income level for services such as WIC. However, most pregnancy services are free to the public such as testing and prenatal vitamins.

Crisis centers are agencies that provide emergency services to pregnant teens. Crisis centers offer teen parents shelter and educational services. The services provided include temporary housing for those who have been kicked out of their homes due to pregnancy, interventions for abortions, motherhood education, and skills trainings. These agencies focus on providing teens with education and skills needed to live on their own. They assist teens in finding housing and employment. These agencies often do not endorse abortion procedures.

Hospitals offer a variety of services during pregnancy. Doctors care for patients and provide prenatal care. Specialty doctors provide care for at-risk pregnancies. These are generally patients with higher risk of loss of the infant during the pregnancy. Hospitals also offer educational courses on breast-feeding, childbirth, and delivery options. Many hospitals offer midwives for those who want home births as well as other alternative birthing locations for those who do not want to be in traditional hospital settings. Child safety seat distribution and education are offered by most hospitals. This program educates parents on proper usage of child car seats. It is a requirement that an infant have a child car seat before leaving the hospital and must leave in one. Hospitals will distribute free car seats and diaper bags to those who meet the requirements.

Parenting Services

Many programs have been designed to assist parents in their parenting skills. Much research has been dedicated to understanding parenting styles and dimensions of parenting. Research has provided the foundation of how society can support parents and encourage parenting that is healthy to the development of children. Amy Romagnoli and Glenda Wall contend that there is an expansion in parenting expectations that includes protecting children from various risks. Parents are considered a risk factor that can negatively impact the development of children. It is further found that parents are expected to meet the needs of their children, which includes physical, emotional, psychological, and cognitive needs. Services have been designed to support parenting in meeting these needs.

Parenting support groups were developed out of the need for parents to receive peer support. Parenting support groups focus on parent-to-parent communication on effective parenting strategies and dealing with some of the challenges in parenting. Support groups have increasingly been developed by parents for parents in addressing parenting of developmentally delayed children, autistic children, and loss. Support groups provide an outlet for parents and support from those who are dealing

A policeman stands guard near the front door when pro-life and pro-choice supporters turned out to this Planned Parenthood location in Saint Paul, Minnesota, to oppose and support the organization. Many community agencies provide pregnancy testing, ultrasounds, counseling, and abortion services. They also offer educational services; clients are educated on the symptoms of pregnancy, alternatives to pregnancy, and the use of contraceptives. Anti-abortion critics often protest near these centers.

with similar issues. These groups can be directed by a parent or an industry professional but are often run by members within the group. Relationships are developed within support groups that extend outside of the group and lead to play dates. Support groups also assist in sharing community resources with participants.

Community agencies have focused on supporting parents during many life transitions. Programs provide educational courses, community resource referrals, and on-site support services. Educational courses focus on discipline, dealing with difficult behaviors, parental roles in child development, as well as various other resource parents can target for additional support. Programs within the community include play groups, prenatal and infant toddler education, early childhood support, school-age parenting education, divorce and mediation, grandparent parenting support, teen parent support, and parenting of developmentally delayed children. These programs offer support in a variety of ways to parents. Some offer case management assistance to assist parents in removing barriers and obtaining resources for which they qualify. Parents are often unaware of resources within their communities. Many community programs offer in-house services in which professionals come in and educate as well as provide a number of services. Dental care, medical shots, testing, tutoring, and physicals can all be done within community agencies. Supports to special populations are also provided through community agencies. There are supports for ex-offenders and substance abusers and specific supports for fathers that encourage involvement.

Government agencies also provide supportive services to parents. Parents can receive child-care assistance, temporary financial assistance, food assistance, and medical care if they qualify. Government agencies also offer parents assistance in obtaining employment and nutritional programs that provide food to needy families. These resources are often temporary and come with many restraints. Parents often look to community agencies for guidance as they go through government processes.

Pregnancy and parenting services often overlap due to the ultimate focus being on the healthy development of children. Support programs and services are offered to parents during pregnancy and extend until the child reaches the age of 18 in many cases. It is believed that supporting parents creates stronger parental bonds and provides opportunities for positive physical and psychological growth in children.

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See Also: Family Services; Parenting Skills Training; Parenting Styles, Cultural Differences in; Prenatal Care.

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Prejudice, Theories of

In daily life, every man and woman has to deal with prejudice, whether prejudice is used by them unconsciously or they are hurt by it. These incorrect or unjustified attitudes against individuals of another social, racial, or gender background, which build a phenomenon of interhuman relations and human diversity, can be explained through different theoretical approaches. The authoritarian personality theory, the exploitation theory, the normative theory, the scapegoating theory, and the social identity theory are able to explain different forms of prejudice that are visible in human societies and definitely as a consequence of human diversities in the numerous societies around the globe.

Regarding the roots of these prejudices, different factors can determine their establishment, in individual cases or as a part of the whole society, which are responsible for the negative overemphasis of human diversities. All the mentioned theories determine different reasons for the development and existence of prejudice in our society, and the people who are confronted with prejudices will consequently always need a specially determined kind of human services too.

Authoritarian Personality Theory

Following Theodor W. Adorno (1903–69), the well-known German philosopher and sociologist, authoritarian personalities especially tend to use prejudices because these people tend to be hostile toward another person of inferior rank. In the same way, they are more servile in the presence of a superior authority. As a consequence, the authoritarian personality theory determines a particular personality as the root for prejudice, which tends to regard the world following dichotomous terms like *right or wrong, good or bad,* and so on. Influenced by a harsh childhood, these people can adopt prejudicial attitudes about people or things, following their own suitable lines of argumentation.

Exploitation Theory

The exploitation theory determines economic conflicts as a source of prejudice. Especially in competitive situations that force people to compete against each other to get a good job or new business clients, prejudices are used to justify their own actions, which could be directed against individuals of another racial or ethnic background, who are the competitors. A well-known and researched phenomenon that was and still is an expression of this theory is antisemitism. Because of their religious beliefs and inequality during the Middle Ages, European Jews began to specialize in trade and banking. As a consequence, many of them became rich and successful and, over the course of history, became competitors with non-Jews in modern Europe, where antisemitism became a visible expression of envy.

Normative Theory

All people live their lives following norms. These could be defined by parents, friends, social groups, or the media. Because of this, the normative theory tries to explain the development of prejudices from the experiences people have during socialization. *The father hated these people, so the son hates them too* could be a suitable expression for this theory. Parents, relatives, friends, colleagues, and the media are able to influence our own attitudes day by day, and with regard to the normative surroundings, people begin to adopt these norms. Following this course of events, the prejudices finally become part of an individual's thoughts. This process doesn't have to be a fast one. Ethnic communities who have bad experiences with another ethnic group will convey these experiences to the next generation, and by giving this core experience of socialization, they will lay the basis for the prejudice that follows.

Scapegoating Theory

The scapegoating theory is derived from Sigmund Freud's (1856–1939) psychological works, in which he was able to determine that some people were trying to displace their own aggression onto other people when they were not able to place their aggression on the original cause of their frustration. A subordinate who is angry about his or her superior may tend to direct those aggressions against his or her own subordinate instead of confronting the superior with his or her anger. By doing this, the personal misfortunes are displaced onto other people, who belong to a relatively weak group. As a result, this negativity will be projected on this target group. During the Middle Ages, a collective act of violence against the Jewish minorities in larger cities or small villages or witch hunts, which experienced a climax in these early modern times, could be the consequence of droughts or the deaths of animals in a town because these groups or persons were used as scapegoats for causing misfortune. The collective violence followed stereotypes and prejudices, which labeled these minorities as the cause for these evil occurrences.

Social Identity Theory

Henry Tajfel (1919–82), a British social psychologist, developed another theory for the causes of prejudice: the social identity theory. By separating people into in-groups and out-groups, the given individual is trying to generate a positive self-image. As a consequence, the need for a positive social identity is the reason for the formation of a prejudice, which helps to underline the positive image of the individual's group. Only this group can be right or positive, while any nonmember is considered worse than members, who—following the individual definition—must be friends.

Tajfel provided a proof for his theory by analyzing an experiment with young boys from Bristol. The boys were separated into two groups and were allowed to award points to either their own group or the other group. In almost all cases, the in-group members were awarded first because, due to the established social identity, the known members were favored. Despite the fact that giving points to the other group would have increased the total reward for all participants, the other group members remained discriminated against, which was a sole result of the existing categorization or classification of an in-group and an out-group. As part of the in-group, people have two aims. They first want to create a positive self-image and, second, a positive group image. By awarding points to the group, they achieved the second aim, and with the appraisal of their group members, they were able to achieve the first aim as well.

Theories Combined

Not every prejudice can be explained by using just one of these theories. Many prejudices are the consequence of different reasoning, and two or more theories could be taken into consideration to explain the causes. Despite this, prejudices are a fundamental part of modern societies, used by everyone, mainly subconsciously. The things we buy, the things we eat, the things we do—all are influenced by existing prejudices, which could be transferred through generations and be a consequence of our own social situation or negative feelings. However, not every prejudice is as bad as another, especially concerning social, racial, ethnic, and gender-related prejudice. It is the task of laws and states to protect the people who become victims of prejudices in many aspects of daily life.

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See Also: Administration for Native Americans; Arab Americans; Asian Americans; Assimilation; Bullying; Diaspora; Discrimination and Institutional Racism; Diversity in the Workplace; Early Childhood Development; Ethnic Diversity and Values; Hate Groups; Power, Race/Ethnicity and; Racism, Self-Assessment of.

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Prenatal Care

Prenatal, or antenatal, care encompasses both preventative and treatment-based medical care that a woman receives during her pregnancy. The goal of prenatal care is to educate expecting mothers about proper health care during pregnancy in addition to implementing treatment and preventative care to help ensure that the baby receives proper nutrients and medical attention. Prenatal care is the primary method through which potential problems or risks are identified and treated during pregnancy. Two common and potentially fatal threats are preterm labor, defined as birth prior to 37 weeks, and low birth weight. Research suggests that consistent prenatal care can aid in diagnosing and treating many signs of preterm birth and low birth weight and ultimately improve quality of life for mothers and babies. These positive outcomes have spurred changes in public policy geared at increasing access to prenatal care for all pregnant women regardless of socioeconomic status, age, location, and race and ethnicity.

Prenatal Care Providers and Services

Prenatal care can be administered and overseen by a variety of health care professionals such as family physicians, midwives, or obstetricians. These professionals see a pregnant woman throughout her gestation period at regular intervals. Typically, appointments are scheduled once per month during week four to week 28, twice monthly between weeks 28 and 36, and weekly from week 36 until the birth of the baby. Expecting mothers deemed high risk, such as those over age 35, may have more frequent visits.

Prenatal doctors' visits assess risks to the health of the expecting mother and baby, track the growth and development of the baby, and educate the expecting mother on labor expectations, nutrition, and overall physical and mental wellness. Initial visits generally include a comprehensive physical exam, a review of the patient's and family's health histories, blood and urine tests, measurements of height, weight, and vitals, and determination of the due date. Visits occurring later in the pregnancy focus on growth of the baby and checking the baby's heart rate. Though the content of each appointment depends on the individual needs of the woman, each visit is imperative for thorough prenatal care.

History and Effectiveness of Prenatal Care

Although midwives throughout the world have practiced rudimentary forms of prenatal care for hundreds of years, modern conceptions of prenatal care were suggested in the early 1900s by Dr. John William Ballantyne as a means to prevent fetal abnormalities and to reduce maternal mortality rates. Shortly thereafter, the notion that prenatal care could reduce infant mortality gained support. However, the effectiveness of prenatal care was questioned in the 1960s, and connections were drawn between positive outcomes of prenatal care and initiation of prenatal care during the first trimester.

In order to assess the utilization of prenatal care, the Kessner Institute Adequacy of Prenatal Care Index was published by the Institute of Medicine in 1973. According to the Kessner Index, prenatal care adequacy is determined based on the month during pregnancy when care began and the number of prenatal visits, taking into consideration the length of the gestation period. It is rated as adequate, intermediate, or inadequate. Though this index fails to consider how routinely visits occur after care began, it became the standard measurement in public health research and planning.

The shortcomings of the Kessner Index prompted the creation of the Adequacy of Prenatal Care Utilization (APNCU) or Kotelchuck Index. The APNCU measures both the adequacy of initiation of care and of routineness of visits once prenatal care begins on two distinctive scales that then provide an overall rating. Both the Kessner Index and the APNCU examine the utilization of prenatal care rather than the quality of care. Although the Kessner Index is still used, the APNCU is generally accepted as the standard measurement for utilization of prenatal care in public health research.

The effectiveness of prenatal care has been widely studied and debated. Prenatal care is effective in diagnosing and treating preeclampsia and eclampsia, managing pregestational diabetes and human immunodeficiency virus (HIV), and reducing birth defects and maternal morbidity and mortality. Many challenges face researchers attempting to measure the efficacy of prenatal care—namely, as prenatal care has become the standard practice, research is not able to sufficiently evaluate women who receive no or little prenatal care. Although some research suggests that prenatal care may not be as efficacious as presumed, it is widely utilized and continues to be highly recommended by health care professionals.

Access to Prenatal Care

Women are strongly advised to obtain early prenatal care when pregnant and even while attempting to conceive. In 2006, the Centers for Disease Control and Prevention (CDC) reported that about 84 percent of U.S. women reported receiving prenatal care in their first trimesters. Though the number of women seeking first trimester prenatal care is steadily increasing in the United States, differences exist within this population.

The Child Health USA study published by the Department of Health and Human Services (HHS) reported prenatal care utilization for 27 states and territories in the United States in 2008. Non-Hispanic white (76.6 percent) and non-Hispanic Asian and Pacific Islander (77.9 percent) women reported the highest rates of first-trimester prenatal care utilization. The lowest rates of early prenatal care were reported by non-Hispanic American Indian and Alaska Native (53.3 percent) and non-Hispanic Native Hawai‘ian and other Pacific Islander (54.8 percent) women.

Additionally, results demonstrate that young mothers are much less likely to utilize early prenatal care than older women. Only 32.9 percent of teenaged mothers under 15 years old reported use of first trimester prenatal care, while 54.3 percent of women aged 15 to 19 received early care. These results suggest the need for services that increase knowledge of and access to early prenatal care for diverse groups of women, including teenage mothers and women of all racial and ethnic backgrounds.

Prenatal care can be administered and overseen by a variety of health care professionals such as family physicians, midwives, or obstetricians. These professionals see a pregnant woman throughout her gestation period at regular intervals. Here, a midwife measures the height of the top of the mother's uterus at about 26 weeks to determine the probable gestational age of the fetus.

To increase access to prenatal care, all states in the United States have programs through which women can obtain financial assistance to help pay for prenatal care. Despite these efforts, many barriers exist that limit access such as lack of transportation to medical facilities, lack of financial resources or health insurance, difficulties scheduling appointments early in pregnancy, and language barriers. Additionally, women with unplanned pregnancies or those who believe that prenatal care is unnecessary are less likely to seek medical care. Minority women and those of low socioeconomic status are less likely to obtain prenatal care, as these groups often have additional barriers to overcome. Prenatal care providers will need to improve outreach and services to better meet the needs of this diverse population of women.

Though not all women have access to prenatal care in the United States, it continues to be one of the most widely utilized health services. Research on ways to improve the utilization and content of prenatal care continues to expand with the goal of improving the quality of life for women and infants.

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See Also: Family Pregnancy Planning; Infant/Toddler Development; Maternal/Infant Health Services; Women Minorities.

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Primacy of Place

Primacy of Place is a trademarked program established as part of the Building Better Communities initiative at Ball State University (BSU) in Muncie, Indiana. The program was established according to the premise that communities can make a difference by choosing to dedicate significant resources to improving the quality of community life for residents, businesses, and visitors in areas such as wellness, cultural growth, community and economic renewal, happiness, and prosperity. The goals of the program are carried out by BSU faculty, staff, and students in partnership with businesses and private organizations across the state. Determining that human beings and the talents they possess are the greatest resources available to any state, Primacy of Place focuses on attracting new talents to communities while continuing to maximize the talents of current residents and businesses. Since it was established in the late 1980s, the Primacy of Place program has hosted an annual conference, bringing together individuals from various fields who are dedicated to improving community life. In 2013, communities across Indiana began competing for Primacy of Place awards. The Primacy of Place program also maintains the Primacy of Place practices database to provide resources to Indiana's communities.

Students interested in becoming actively involved in the Primacy of Place program can apply to enroll in Primacy of Place classes. Exceptional Me allows BSU students to study both gifted and special education students while designing a phone application that maximizes potential for specific individuals. Seniors and graduate students can enroll in the Global Reporting Initiative Sustainability Report for the Indianapolis Airport, in which teams gather data and learn about report writing and design as they study the aspects of sustainability. Igniting Indiana's Film Industry brings teams of students together with Film Indiana and the Indiana Media Production Alliance to shoot, direct, and produce their own short films. Battle of Perryville Phone App gives students the opportunity to create a phone application featuring a famous Indiana Civil War battle site. Students enrolled in the Centennial Park Tour create 12 driving and walking tours in partnership with the Indiana Department of Natural Resources.

Each year, at the Primacy of Place Conference, interested parties meet in knowledge groups to learn more about improving community life. Knowledge groups examine subjects such as arts integration in community economic development, community design, community collaboration for educational excellence, community well-being, municipal governance, and community readiness for change.

2013 Awards

In 2013, Primacy of Place awards were awarded for the first time. Out of 22 communities in 18 Indiana counties, awards went to the City of Columbus (population 44,061), the City of Valparaiso (population 31,730), and the Town of Walkerton (population 2,144). While there were similarities in the efforts of the three communities, each area tailored its program to meet the needs of the individual community.

Recognition for Columbus was the result of the creation of the Columbus Art District, which expanded both business opportunities and diversity within the community and led developers to erect 240 new apartments. The art district was the result of numerous town hall meetings, surveys, and workshops that allowed residents to work together to improve community life through promoting economic prosperity. By integrating the city's modern architecture with its historic district, Columbus officials created a downtown environment that allows residents and visitors to enjoy what the city has to offer as they walk through downtown. The total financial impact of the establishment of the art district was estimated at $214.5 million.

Valparaiso also focused on the arts, but its Primacy of Place efforts were devoted to integrating the arts with programs designed to revitalize

Valparaiso. Under the leadership of the Valparaiso Redevelopment Commission and the Parks and Recreation Department, the city revitalized a five-block downtown area and two key corridors into the city. Valparaiso also promoted wellness through its Fit City Program, which created interactive recreation areas while establishing hundreds of acres of protected parklands. Outdoor art sculptures were strategically placed along the Art Walk at Cumberland.

Efforts to attract residents and visitors to the downtown area continue through the monthly Eat Up, Wine Down program in which seven local residents provide samples of their food for a charge of $5 per person. Valparaiso officials also commissioned sculptor Lou Cella, who won the commission through a web-based competition, to erect a bronze statue of popcorn icon Orville Redenbacher, who called the town home. Funds for the statue were offset by donations from Indiana Dune Tourism and the local Rotary Club. Town officials created a Twitter account for the statue in 2012 to promote the statue's presence on a park bench in Central Park Plaza. The statue's 200 followers are mostly local residents. The Orville Redenbacher statue was named Best in Show in 2012 at the Social Media Summit.

The inclusion of Walkerton in the Primacy of Place awards was in recognition of the town's renovation efforts, which resulted in the rebuilding of 80 homes that were transformed into residences that are both affordable and of good quality. In 2009, work began on transforming the blighted neighborhood of West York, which had been thrown together in the 1940s to house veterans returning from World War II. Since the houses had no insulation, utility bills averaged more than $500 each month, a charge that was beyond the means of the poor residents who lived there. The streets were so narrow that it was almost impossible for emergency vehicles to navigate them.

Using federal grant money from the Neighborhood Stabilization Program and partnering with the Indiana Housing and Community Development Authority, Walkerton officials began revitalization efforts in 2009. Financing for creating the area that became Dogwood Estates was provided by the Neighborhood Development Association, Great Lakes Bank, Granite Ridge Builders, West York LLC, and First Source Bank. The fact that the transformation slashed utility bills by one-half has helped to make it possible for residents to become homeowners because rental payments give them ownership credits. The Primacy of Place program stands as a role model for communities throughout the United States.

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See Also: Community Action Agencies; Community Development Block Grants; Community Development Corporations; Community Organizing.

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Prisoner Reentry Programs

Reentry, according to Ram Cnaan and Jill Sinha, is defined as the process of leaving prison and returning to family, the labor force, the community, and the greater society. The process of reentry represents crucial points in the corrections system from several different perspectives. How successfully an individual fares post-release is, in part, a reflection of the effectiveness of the larger criminal justice system and may have significant consequences for the community to which a prisoner returns.

For the individual prisoner, being released may present new and sometimes daunting challenges such as finding adequate housing and employment and reconnecting with loved ones. For certain populations, these challenges are arguably more salient, making the process of assimilating back into society even more difficult. Requirements for prisoners released after serving sentences for sexual offenses, for example, including restrictions on where they can live, present these prisoners with further practical limitations. Although there may not exist the same explicit challenges to reentry as is seen with sexual offenders, prisoners released from long-term solitary confinement may also experience a great deal of difficulty adjusting back into the general population.

In addition, the diversity of the demographic profile of the released inmates deserves careful consideration. The higher incarceration rate of African American males, states E. A. Carson and D. Golinelli, inevitably yields higher numbers of African American men returning to their communities. Traditionally, men have been incarcerated at rates far greater than women. As a result, an integral part of the justice system is designed for men's needs. However, the number of women in prison has been rising faster than the number of males, report William Sabol, Todd Minton, and Paige Harrison. Approximately two out of every three people released are rearrested in three years, estimate P. A. Langan and D. J. Levin; 58 percent of women released from state prison are rearrested within three years, and 40 percent are reconvicted. The diverse nature of released people requires human services to be compatible with their needs. If the common goal is to prevent future arrest after release, transitional and reentry services to ease the burden on diverse reentering populations shall be delivered through culturally competent social service providers. Considering these conditions, it is not difficult to imagine that this segment of the prison population also experiences unique barriers to the reentry process.

Most people know that there will come a time where prisoners are released from the correctional system and will reenter back to their respective communities. What they do not know is the difficulties that the now ex-prisoners are faced with once they are out of the system. Many come out of prison and are immediately faced with obstacles that may prevent them from successfully reintegrating back to society. Chuck Colson, an ex-prisoner and former Nixon administration member, once said, "The road home is possibly the most difficult journey an ex-prisoner will ever make." When most inmates leave prison, they are already confronted with an assortment of problems such as looking for housing, good employment, and as Eugene Williams mentioned, the success or failure regarding substance abuse. Offenders are generally unprepared for reentry; they are not provided with adequate support to effectively transition back into their communities upon release.

As mentioned earlier, individuals who are released are, according to Bridgette Bassford, "forced to secure housing, obtain employment, establish a legal identity, receive treatment for substance abuse or mental health, reestablish relationships, find transportation," and "procure basic necessities such as food and clothing." These tasks seem virtually impossible and make it hard for successful reentry.

When it comes to housing and finding work, released offenders are faced with discrimination. Their criminal backgrounds, absence of legal identification (the majority of prisoners are released without proper identifications from the state), and their lack of job training allows for landowners and employers to dismiss or reject them. In addition to all this, most ex-prisoners have limited human capital; a good number of them are illiterate or have an 11th-grade education, and according to Bassford, 11 percent of the population are generally expected to enter homeless shelters within two years of their release. These issues serve to highlight the importance of developing effective release and reentry policies designed specifically to address the unique challenges that face the prison population.

Principles

Researchers formulated the principles of risk, need, and responsivity as those that have to guide rehabilitation programs in order to be effective. These principles mean that the programs that target higher-risk populations tend to be more effective because high-risk populations will have a greater need of the treatment, and there is more room for improvement. The programs must target criminogenic needs, and they have to be able to generate some improvement in those needs. According to these principles, in-prison rehabilitation programs with risk-based approaches have shown to be effective in reducing recidivism. In 2003, researchers conducted a meta-analysis of prisoner reentry. They found that vocational training, work release programs, halfway houses, and prerelease programs did reduce the risk of recidivism upon release. Other authors have also pointed out that prison-based therapeutic communities or cognitive-behavioral treatment also work in reducing recidivism. On the other hand, programs that increase surveillance or monitoring upon release are not effective. One of the reasons is that increased monitoring tends to increase the number of technical violations, which result in increased recidivism. Some of the programs that were found to be promising were educational programs (which do increase the skills of the individuals but don't seem to reduce their recidivism) and prison-based treatment for sex offenders.

One of the scholars who has studied more in depth the issue of reentry is Joan Petersilia, who analyzed the requirements for successful reentry in her work *When Prisoners Come Home*. She suggested four general initiatives to reduce the recidivism rates of ex-offenders. The first one is to restore discretionary parole because, as we have already seen, those released through discretionary parole tend to recidivate less than those who are released through mandatory parole. The second initiative is to start working in reentry programs, while the inmate is still in prison, and follow up upon release. These types of programs have shown some success in reducing recidivism when targeting criminogenic needs (e.g., drug abuse treatment). The third initiative is to provide post-release services, like housing, job, or substance abuse treatment referrals, at least during the first six months after being released into the community. Research shows that most of the people who recidivate tend to do so within the first months after leaving prison, so providing support during those months is critical to help the individual succeed in the process of reentry. Finally, Petersilia recommends the removal of the obstacles to reentry.

New Developments

Within the last decades, a whole array of measures has been implemented, which make it more and more difficult for ex-offenders to reintegrate successfully into the community. People who are released from prison face a large number of obstacles that, by making the process of reentry especially difficult, have as a result the increase in the likelihood of recidivism. For example, some ex-offenders are not allowed to live in public housing (e.g., drug offenders), or they are not allowed to live within a certain distance of places frequented by children. This last measure is applied fundamentally to sex and drug offenders.

Another restriction is the types of jobs that they can get. Most ex-offenders are barred from working as beauticians or hairdressers, and some offenses lead to more-restrictive obstacles in this area (like in the case of sex offenders). States are required to revoke the driver's licenses of drug offenders, without which it is much more difficult to look for or to maintain a job. The Welfare Reform Act of 1996 (PRWORA) established that people convicted for drug-related offenses (possession, use, sale, or distribution) are barred from receiving welfare benefits like food stamps or Temporary Assistance for Needy Families (TANF). Furthermore, ex-felons lose their voting rights. Many states make criminal records publicly available, which makes it more difficult getting a job or reintegrating successfully in the society. All those obstacles make it extremely difficult for somebody who has been imprisoned to turn to a prosaic type of life and establish meaningful social bonds that help them to desist from crime.

Some correction systems, however, have implemented prerelease programs in an effort to help prisoners better transition from isolation into society, writes T. Kupers. For example, in Oregon, prior to being released, prisoners held in solitary confinement rejoin the general prison population to work and attend classes, L. Sullivan reports. Correctional facilities in Oregon also provide anger management therapy for solitary confinement inmates before they are released. The importance of such prerelease programs has been highlighted by recent research. For example, D. Lovell and C. Johnson found that individuals who participated in a prerelease program after leaving solitary confinement were less likely to commit a felony once released than those who did not.

Postprison supervision and parole policies also vary by state. Although information regarding postprison supervision for this specific segment of the prison population is scarce, it may be possible to extrapolate to a certain degree from the facts available regarding more standard procedures. For example, with a shift toward determinate sentencing, there has been a decline in the use of parole boards. These parole boards have traditionally been responsible not only for determining release dates but also for playing a major role in the prisoner's reentry process, J. Travis describes.

One of the most frequent criticisms that reentry programs have to face is the enormous cost that the provision of all those services would generate. Although this is true in some cases, there are some other courses of action that could also improve the process of reentry and therefore reduce the risk of recidivism while not generating additional costs such as the removal of some of the obstacles cited previously. For instance, returning a driver's license to those individuals who have lost it as a result of a drug conviction would help them to find and maintain jobs. The cost of this measure would be minimal, and the taxes paid by those individuals would generate benefits for the state.

Despite the advantages that these programs have, it is important to take into account that, after so many years of get-tough discourse in which offenders have been demonized, it is foreseeable that the public would oppose this kind of change as they could be interpreted as a turn toward a more lenient criminal justice system.

Conclusion

The first step in making any type of policy change regarding release and reentry procedures requires a shift in how we conceptualize these steps. In fact, in his article "But They All Come Back: Rethinking Prison Reentry," Travis suggests that, instead of thinking of reentry as an isolated step in the process of incarceration, we should begin to regard it as an overarching theme. In order to most effectively facilitate a prisoner's transition into society, Travis proposes that reentry be the continual focus of the criminal justice system from the beginning at sentencing throughout incarceration and again at the time of one's release. This more-comprehensive, long-term perspective can then help to inform important decisions that will later affect the reentry transition such as whether or not an individual requires substance abuse counseling during incarceration. Though it may appear more complicated, this type of individualized approach to incarceration appears to hold the most promise for facilitating successful reentry.

Fortunately, a number of programs have been implemented over the years to help manage the difficult readjustment period that ex-prisoners must go through in order to transition back to society. These programs provide guidance and help to those who are willing to change and maintain a positive lifestyle. The problem about evidence of efficacy of offender reentry programs is that the evidence is still weak; more research is needed.

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See Also: Families of Prisoners and Ex-Prisoners; Prisoners and Ex-Prisoners; Probation and Parole Officers.

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Prisoners and Ex-Prisoners

People enter jails and prisons with an overwhelming amount of need. These needs include health, dental, and mental health care; financial assistance; legal assistance; education and job training; addiction treatment; and parenting support. Upon release, they must secure employment and housing; reconnect with family and community; readjust to the outside world; contend with the stigma and psychological scars of incarceration; maintain substance abuse, mental health, and health treatment; and develop crime-free lifestyles to avoid rearrest. Given the large numbers of people entering and leaving jails and prisons today, increasing services to this population has the potential to reduce disparities and prevent crime in society at large.

Incarcerated Populations

With more than 2 million people in jails and prisons, the United States has the highest incarceration rate in the world. Each year, more than half a million are released, of which around 70 percent will be rearrested within a year. Prisoners and ex-prisoners are more likely than the general public to have been unemployed or homeless, to not have finished high school, to have grown up in poverty or experienced trauma, to have had an incarcerated parent, to be diagnosed with mental illness, to commit suicide, to suffer from chronic and infectious disease, and to have untreated dental problems.

A small but growing number of prisoners (7 percent) and parolees (12 percent) in the United States are women with gender-specific service needs. Prisoners in U.S. jails and prisons are disproportionately black (40 percent), Latino or Latina (15 percent), and Native American (3 percent), and services must be culturally sensitive in design and delivery.

Service needs, and the challenges of providing services, differ depending on the type of institution. Jails are county or city facilities that house people awaiting adjudication or who are serving a sentence of less than one year (or in some states two years). Prisons are state facilities where people serve sentences of one year (or two years) or more. The federal system also has prisons and detention facilities.

A majority of arrestees are released from jail within 72 hours, with an average stay of 10 to 20 days. In prisons, the average length of stay is about three years, while nearly 10 percent of prisoners are serving life sentences (30 percent of which have no possibility of parole). The service needs of and the opportunities for someone in jail for a 24-hour period will differ from those of someone in jail for one year, in prison for two years, or in prison for the rest of his or her life.

Education and Health Care

Around 80 percent of incarcerated people have not attended college, and a majority of them do not have a high school diploma. All correctional institutions offer some form of basic education (GED) and many offer vocational training, but due to the elimination of Pell grants for prisoners in 1994, college programs are scarce. GED, college, and vocational certificate programs have all been shown to reduce recidivism.

Incarcerated people have higher rates of infectious disease including human immunodeficiency virus (HIV), tuberculosis, methicillin-resistant *Staphylococcus aureus* (MRSA), and hepatitis. Correctional facilities are therefore an ideal place to target interventions aimed at reducing infectious diseases. Incarcerated people also have higher rates of chronic disease, including hypertension, asthma, and arthritis. Due to longer sentence lengths, including life without parole, more prisoners require care for geriatric conditions as well as end-of-life and hospice care. Given funding and security challenges, health care services in jails and prisons are often inadequate.

Mental Health Care and Substance Abuse Treatment

More than half of all prisoners have a mental health problem; rates of mental illness in county jails are slightly higher than in state prisons, which in turn are higher than in federal prisons. Inmates are two to four times more likely than the general public to have serious mental disorders including schizophrenia, bipolar disorder, and depression. As with physical health, there are many challenges to providing quality mental health care in jails and prisons including funding constraints, the stressful and unpleasant environment, high caseloads, and correctional paradigms that do not recognize the importance of mental health care.

One of the biggest service needs in jails and prisons is substance abuse treatment. A staggering 85 percent of U.S. prisoners either meet the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) diagnosis of substance abuse disorder, were intoxicated at the time of their crime, committed their crime to get money to buy drugs, or were arrested for a drug-related offense. Despite this need, only about 10 percent receive any sort of substance abuse treatment.

Parenting and Family Connections

A little over half of incarcerated men and nearly two-thirds of incarcerated women are parents. Prisoners may need support to improve their parenting skills and maintain connections to spouses, children, and other family members. Depending on the institution, visits with family members may be limited in terms of frequency, length, and whether contact is allowed. Only six states allow conjugal visits, now called extended family visits. Inmates who receive frequent visits from family members are less likely to recidivate upon release.

Spirituality, Support, Autonomy, and Self-Expression

Due to the emphasis in jails and prisons on security, opportunities for privacy, autonomy, and personal expression are limited. Within this artificial social world, inmates must keep a constant eye out for threats to their physical and emotional well-being. In addition to stress, inmates must contend with intense boredom, monotonous routine, and countless rules. To reconnect with their humanity, incarcerated people can benefit from participating in spiritual enrichment programs; support groups; art, music, and creative writing classes; and prisoner-led clubs and organizations.

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See Also: Families of Prisoners and Ex-Prisoners; Incarceration and Sentencing, Racial Disparities in; Jail Diversion Programs for Children and Adolescents; Prisoner Reentry Programs.

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Probation and Parole Officers

Probation and parole officers are responsible for nearly three-quarters of adults under court supervision (e.g., those in jail, prison, probation, or parole). Probation and parole officers perform similar duties as they monitor convicted criminals who live in the community and prepare presentence investigation reports (PSIs) for the courts. The community-monitoring duties of probation and parole officers include meeting with the offender in the office and in community settings such as at the offender's home or workplace. Probation and parole officers must make sure that their probationers or parolees are paying restitution, attending support meetings, passing drug tests, not affiliating with other known criminals, staying within certain geographic boundaries, and obeying the law.

U.S. History of Probation and Parole

The history of American probation and parole dates back to the 1840s in Boston, Massachusetts. John Augustus began his career as the first American probation officer, albeit unofficial, when he agreed to supervise an alcoholic who appeared in court. Augustus was successful and, in subsequent years, would come to supervise boys and girls as well. By 1869, the Massachusetts legislature had decided to require that a state agent be present with juveniles if placement into a facility was a possibility. The agent's job was to look for someone to place the child and to protect the child's interest. By the late 1870s, the Massachusetts legislature had created a paid probation officer position. Within the next 50 years, every state, with the exception of Wyoming, had developed a paid probation position.

As of the year 2010, there were nearly 5 million adults in the United States who were on probation or parole. Just over 80 percent (or 4 million) of these people were on probation. Of those on probation, three-quarters were male and one-quarter female. Just over half (55 percent) of all probationers were white, 30 percent black, and 13 percent Hispanic. Just over 850,000 of this group were on parole. For those on parole, 88 percent were male and 12 percent were female. The races of those on parole were 42 percent white, 39 percent black, and 18 percent Hispanic.

Probation and Parole Officer Characteristics and Requirements

According to the Bureau of Labor Statistics, there are 88,000 probation officers and correctional treatment specialists in the United States. Nearly half (47 percent) of these are female, 72.7 percent white, 20.7 percent black, 1.3 percent Asian, and 15.0 percent Hispanic or Latino. Probation and parole officers must generally have at least a bachelor's degree, although a few states may allow experience to substitute for education.

Many probation and parole officers have degrees in criminal justice but also psychology and even graduate-level degrees in counseling. In some states, all officers are authorized to carry firearms, while in other states only those dealing with adults may carry firearms. Some states do not allow firearms at all. Probation and parole officers receive diversity training in their initial trainings and in subsequent in-service trainings. Probation and parole officers are hybrids between police officer (they carry firearms and enforce laws) with counselor (rehabilitation).

Probation and Parole Duties

The roles of probation and parole officers differ from each other because their clients have had different experiences. Those on probation, generally, have never been incarcerated in prison. While they may have spent time in jail, briefly, the general idea of probation is to keep offenders in the community while they are being punished and rehabilitated. Those on probation, then, need help improving their lives in the community but typically not establishing a new life in the community. Parolees, however, have been incarcerated for a year or for several decades. Parolees may need help reintegrating into society. Things that were once familiar may now seem foreign. Technologies such as cell phones or even ATM machines may be new. Work skills may be outdated. In any event, parolees need more help than probationers building a life after incarceration.

Besides general supervisory functions, probation may also include any number of intermediate sanctions that are more severe than simply being monitored and less severe, cheaper, and freer than incarceration. Some states make probationers pay fines. These fines are a condition of the probation, and failure to make timely payments can result in revocation of probation. Restitution is similar in that the probationer has to make timely payment, but in this case, the payments go to the victim to pay for damages done when the crime was committed.

Other intermediate sanction approaches focus on supervision. Intensive supervision provides more supervision and potentially more assistance from the probation officer. Instead of reporting to the probation officer monthly, a person under intensive supervision may report weekly or, more likely, several times a week. While intensive supervision may provide more assistance, it also creates a situation in which the probation officer is more available to notice probation violations.

Substance abuse and mental health treatment are often intermediate sanctions required for offenders. Remember that the original probationer of John

Augustus was a substance abuser. Substance abuse and mental health treatment can range from 12-step groups, to individual counseling, to medication to deal with the problem. In these situations, recovery industry professionals (e.g., social workers, psychiatrists, psychologists, and licensed alcohol and drug counselors) become a part of the criminal justice system as they report back to probation officers and judges. Their reports can potentially cause probationers to have their probations revoked.

Other intermediate sanctions may include electronic monitoring so that the probationer remains only where he or she is allowed. For instance, a probationer may be ordered to stay at home, and the electronic monitoring system will alert authorities when the probationer leaves home. If the probationer is allowed to go to work during certain hours of the day, the monitoring system can detect if the person is at work.

Additional intermediate sanctions can make a person live in a place other than his or her home. Boot camps are modeled after the military. Those who attend them are put through heavily regimented, physically demanding work days. Those who attend them are even provided a graduation ceremony. Finally, halfway houses are used by some on probation. Halfway houses are not prison, but they are places for probationers to sleep and eat. There are rules to the halfway house, and failure to follow those rules can lead to revocation of probation. The halfway house allows the probationer to live and work in the community but is cheaper than sending the person to prison.

Another duty of probation officers is to write the PSI. Prior to sentencing, the probation officer must write a PSI, which covers the convicted person's background and includes information such as mental health or substance abuse problems, past arrests and convictions, personal information, and any other information that is helpful to treating the person.

Conclusion

Probation started in the United States in the 1840s, as John Augustus successfully helped criminals who had problems with alcohol. By the 1920s, nearly every state in the United States had a paid probation position. In 2012 there were nearly 5 million people on probation and parole in the United States. Most of these people were on probation (more than 4 million), and nearly 1 million (850,000) were on parole. These two groups are supervised similarly in that each is required to stay in a certain geographic location, submit to urine tests, seek and receive counseling, to work, stay away from convicted felons, to stay out of trouble, and pay restitution. Probationers and those on parole do differ in some ways in that parolees have spent years in prison and, therefore, may need much more help than probationers when it comes to reintegrating into society.

Probation and parole officers serve roles that can be thought of as a combination of police officers on one hand and counselors on the other. The positions also require that those who occupy them have a bachelor's degree. Probation and parole officers must make sure that their clients are obeying the law and doing what they are supposed to do. Many probation and parole officers are issued firearms along with badges. Probation and parole officers may have to send people to prison. At the same time, the counselor side of the probation and parole officer wants to see clients succeed. They want them to lead law-abiding lives. The roles of probation and parole officers are crucial to the criminal justice system. For every incarcerated person, there are more than two people in the community under court supervision (i.e., probation and parole). Probation and parole officers help to make society safer, to improve the lives of their clients, and to save society money by not having to incarcerate all offenders.

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See Also: Families of Prisoners and Ex-Prisoners; Prisoner Reentry Programs; Prisoners and Ex-Prisoners.

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Profile of Parenting Study

The Profile of Parenting Study (POPS) is a questionnaire designed to assess the suitability and facilitate the decision-making of foster, kinship, or adoptive parent applicants. Developed in Tennessee, the POPS identifies needs and strengths of prospective resource parents. This entry uses the POPS manual and questionnaire to first outline the structure and purposes of the tool and second describe in detail its topics and indices.

Uses of the Profile of Parenting Study

The POPS questionnaire matches children and parents based on self-reported strengths and weaknesses. The questionnaire is not only a preparatory tool but also a record used in the private and public sectors to develop educational programs and professional development services. Prospective parents respond to 57 items within nine topic areas, basing their responses on the action they intend to take in the planning process. Although a high score may change the course of action, the tool is meant only to assess need, not to assign blame or pass judgment. By understanding appropriate principles and practices, prospective parents apply and adapt them according to the experience of both the child and parent. Parents strike a balance among the child's background, accepted parenting principles, and their own experience.

The balance depends on a number of outcomes, including several protective factors of the Strengthening Families approach, a national initiative designed to guide policy decisions and program development for family services. The measures of the POPS are drawn from several other communimetric tools and family services, including the Child and Adolescent Needs and Strengths (CANS) tool, the Family Advocacy and Support Tool (FAST), and the Adult Needs and Strengths Assessment (ANSA). These are open-access tools meant to facilitate the decision making of prospective parents, not measure them according to an etiological standard.

All items listed on the POPS are descriptive, tied to planning, and include child-centered action levels dependent on cultural considerations and situational circumstances. First, the POPS questionnaire measures parental resilience, a barometer of mature and responsible behavior in response to the inevitable adversity of parenting. Second, it asks for strong social connections that ground the child in a real world of supportive friends and family. Third, it tests knowledge of parenting and child development, especially for applicants with difficult upbringings, and ensures that applicants satisfy the child's basic physiological needs and provide concrete support during crises. Fourth, it maximizes the child's social and emotional competence through early detection of problematic behaviors, and finally, it gauges the child's support network beyond the parental dyad and detects risks from other children in the family or surrounding neighborhood.

Structure of the Profile of Parenting Study

The POPS questionnaire consists of nine topic areas, each with its own subset of indices. For each prompt, applicants rate themselves on a scale from zero to three. The scores are assessed along two dimensions, needs and strengths. The needs dimension directs the preparatory plan. A zero on the needs dimension requires no action, and a one suggests possible but not immediate intervention. A two compels some level of preventive action, and a three inhibits the applicant and requires immediate action.

The strength dimension identifies areas of strength and weakness. On this dimension, a zero indicates a well-developed trait, and a one denotes a useful behavior that, with some development, can benefit the applicant's parenting ability. A two requires further development if it is to become a strength, and a three is a nonexistent behavior that requires full development. All responses initiate discussion with and reassessment by the assessment board, during which applicants further explicate their responses with written evidence and examples.

For instance, the first part of the POPS questionnaire assesses the applicant's basic knowledge of child development in 13 items as follows. The first and 10th items, knowledge and expectations of the child's needs, gauge parents' familiarity with physical or psychological conditions of abused or neglected children. Low scores mean that the parent is equipped to handle the child's needs, and high scores mean that the parent is ignorant of or unfamiliar with the child's needs. The third and ninth items, discipline and child's play, test age-appropriate limits on the child's behavior while respecting and engaging in play. Low scores create an environment with disciplined play, and high scores require disciplinary intervention.

Similarly, the fifth and seventh items of the first topic area concern age-appropriate boundaries in a learning environment conducive to intellectual development. Low scores represent an ideal place to learn and mature, and high scores may inhibit the child's intellectual development and social maturation. The 11th and 13th items, birth sibling and birth parent relationships, involve relationships with the child's birth parents and biological kin. Low scores provide support for fruitful relationships with birth siblings, and high scores cannot inculcate such relationships. The second and eighth items, primary care and nutrition management, involve the basic physiological and hygienic needs of the child. Low scores meet these needs, and high scores cannot care for the child for reasons financial or otherwise.

The fourth and sixth items, supervision and demonstration of effective parenting approaches, test proper parenting principles and commitment to supervision. Low scores model appropriate behavior, and high scores indicate an inability or unwillingness to put principles into practice. Finally, the 12th item, child and birth family background, concerns the child's cultural background and medical history. Low scores respect the child's background, and high scores overlook or cannot articulate the child's cultural heritage.

Conclusion

By juxtaposing these self-reported data with the parents' mental and physical health, s financial status, and employment situation, the POPS encourages self-reflection and, in consultation with applicants, guides a plan of action for successful foster, kinship, or adoptive parenting.

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See Also: Family Permanency Planning; Family Services; National Center for Children in Poverty; National Survey of Family Growth; Parenting Skills Training; Pregnancy and Parenting Services.

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Protective Services for Adults

Adult protective services has a short history in the United States but was created to designate a means for reporting abuse of adults. Since the advent of this movement, this service has expanded to include reports of abuse, neglect, emotional abuse, and financial exploitation. This service not only assists elderly adults but includes those vulnerable populations, such as people with disabilities from the age of 18 or 22 in most jurisdictions. In 2004, a survey was conducted on state adult protective services, specifically focusing on abuse of vulnerable adults. This study showed that abuse victims vary in ethnicity. In nine states, just over 65 percent of victims age 18 to 59 were Caucasian, and 32 percent were African American. In 11 states (without age-specific categories), 78.5 percent of victims were Caucasian, while 17.1 percent were African American, according to the National Committee for the Prevention of Elder Abuse and the National Adult Protective Services Association. Given the diversity of the sample of victims, it is incumbent upon service providers to expand their cultural competence in order to best serve the wide range of victims seeking their care and advocacy.

Adults With Disability Abuse and Protection

In 1975, Public Law 93-647, or Title 20 of the Social Security Act, was enacted by Congress. One provision in that legislation required that states protect children, elder adults, and adults with disabilities from abuse, neglect, and/or exploitation. In 1981, an amendment to the law created a funding stream to states through the Title XX Social Services Block Grant Program.

States were given extensive discretion to determine the services to be provided and the groups that may be eligible for services. The law allowed states to use their allotments for staff training, administration, planning, evaluation, and purchasing technical assistance in developing, implementing, or administering the state social service program. Under Title XX, states decide what amount of the federal allotment to spend on services, training, and administration.

Coinciding with the Title XX provisions was an increasing movement toward community-based services for people with intellectual disabilities and mental illness. With that, states had to establish procedures for access to services and how people's rights were to be protected.

Protection of people's rights in many states has become a two-tiered process. A primary emphasis for protection in adult services goes to clarifying people's human rights and due process. This is often managed through the use of independent human rights committees whose function is to provide checks and balances by commenting on agency practices. That can include reviewing agency policy and procedures, any medication and treatment planning, due process concerns, incident reporting, review of protective service investigations, and outcomes and other practices held by state regulation for review. These committees are frequently given advisory status within state and not-for-profit organizations. Training on rights for people receiving services, their families and staff are typically presented at least annually. Also, procedures for involving protective services are reviewed with staff.

Protective service access and investigation is a second tier within the support process. States identify and define what rights and protections are to be monitored and investigated by protective services. For example, that might include fiscal abuse, emotional abuse, physical abuse, sexual abuse, mistreatment by commission or omission, and such. They each will establish a means to contact and report alleged cases of abuse, mistreatment, or exploitation. Frequently, direct care staff, managers, and medical and mental health professionals will be designated mandated reporters, requiring them to report alleged cases of abuse they witness or become privy to. Once reported, protective service personnel will identify how or whether a case is to be investigated. In many states, if the allegation could be classified as criminal behavior, police involvement will be solicited. Investigations proceed through proscribed processes, and again, states determine, at their completion, how to discharge findings for all the involved parties.

Elder Abuse and Protection

During the 1960s, demonstration grants were provided to assist in determining whether adult abuse reporting systems should be creating across the United States. By the early 1980s, 83 percent of members of the U.S. Congress were in favor of creating adult protective services systems, and elder abuse was identified as an epidemic. Though the Prevention, Identification, and Treatment of Adult Abuse Bill of 1980 was introduced in the same year, no action was taken on a federal level, and states were left to tackle this issue on their own. By 1985, 46 states had offices in place to assist with adult protective services. Mandatory reporting laws were on the books in 46 states as of 1991, and at that time, 34 states provided protection services to not only the elderly but to vulnerable adults as well.

Each state is responsible for the creation, implementation, and maintenance of laws regarding the delivery of protective services. The areas of abuse generally covered include physical, sexual, emotional, neglect (both on the part of the elder in question or the caregiver), and financial exploitation. Oftentimes, a second layer of legal protection exists for elders residing in nursing homes, though this may vary state to state.

The services provided in these models include receiving and documenting reports, creating and following a case plan, evaluating risk, evaluating capacity for informed consent, counseling or referral for counseling services, and general case management. In more than two-thirds of states, the Department of Social Services is responsible for these tasks, although State Units on Aging and some Departments of Health and Rehabilitation may be accountable as well.

The basic principles underlying the provision of these services include the right to self-determination, using the least-restrictive alternative, preservation of the family unit where possible, utilizing community-based services as opposed to institutionalizing, avoiding blame, and the idea that inadequate service is a worse scenario than no service at all.

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See Also: Abuse and Neglect; Disabled Clients; Elder Care/Geriatric Services.

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Protective Services for Children

The purpose of protective services for children, often referred to as Child Protective Services (CPS), is to promote the safety and well-being of all children by protecting them from child abuse and neglect. Protective services for children are available in every state in the United States. Although definitions vary by state, the Child Abuse Prevention and Treatment Act (CAPTA) of 1974, amended by the CAPTA Reauthorization Act of 2010, sets national standards on which these definitions are based. Racial, ethnic, and cultural diversity are prevalent in the CPS population. Therefore, CPS workers must be cognizant of their own perceptions and biases and informed on cultural practices different from their own.

Mandated Reporting

Every state has child abuse and neglect reporting laws that require certain individuals to report all suspected child abuse or neglect to the CPS agency. Who is considered a mandated reporter varies by state. The failure to report child abuse and neglect is punishable for mandated reporters according to state statutes. Every state also accepts reports from individuals who are not mandated reporters.

Process of Child Protective Services

In accordance with state statutes, concerns regarding the abuse or neglect of a child are handled by CPS in a specific way. As outlined by Diane DePanfilis and Marsha Salus in *Child Protective Services: A Guide for Caseworkers*, there are seven basic stages to the CPS process. First, cases are received by an intake department. At this point, a CPS worker and supervisor determine if the report meets state guidelines that will allow the child to be assessed for maltreatment.

What qualifies as a report of child maltreatment varies greatly by state. If the report involves an

American Indian child, the CPS agency must work with the family and the American Indian tribe to ensure compliance with the Indian Child Welfare Act (ICWA). Passed in 1978, the goal of the ICWA is to protect the cultural heritage of American Indian children by trying to keep them in American Indian families.

How the ICWA is implemented depends on the specifics of the case and the specific tribe. When CPS accepts a report of maltreatment for further assessment, reports are assigned a CPS investigative caseworker. In states with a dual track system, reports of maltreatment are assigned to one of two types of assessment procedures. Reports that do not indicate children are at immediate risk are assigned into one track. Reports indicating children are unsafe or at higher risk are assigned into a second track.

In the second stage of the CPS process, the CPS investigative caseworker contacts the family and attempts to engage them in an assessment of their strengths and needs. CPS works with the family to evaluate whether or not the reported allegations of child maltreatment are true to assess for the presence of any other needs in the family and to decide if there are services that could be provided to strengthen the family. CPS workers must be fully aware of their own cultural biases and seek guidance from a supervisor when assessing the parenting practices of others.

For example, coining is a common form of Chinese and south Asian folk medicine, which results in red marks on the body that can appear to be bruises. Although the practice is not considered maltreatment, coining can be misidentified as physical abuse. To prevent this, CPS agencies must be informed on the cultural practices of groups in the community and seek guidance when specific cultural practices are reported.

At the conclusion of the second stage, many outcomes are possible. Most reports result in the closure of the investigation without the provision of services to the family. In some situations, CPS recommends that a family receive services to strengthen the family. It may be voluntary for the family to receive these services, or the services may be mandated by the court system. Sometimes, it is not possible for a child or children to remain in the home with the family due to concerns for child safety or well-being. In these situations, CPS may either work with the family to voluntarily place the child outside of the home with an approved caregiver, or CPS may petition the court to legally remove custody of the child from the caregivers. Removal of the child from the home can occur at any point in the CPS process.

For those families whose CPS cases are not closed, the third stage involves further assessing the strengths and needs of a family during an open CPS case. Although this varies greatly at the state and local levels, a new CPS caseworker may be assigned to the family to work with them to either stabilize the family while keeping the children in the home or to reunite the family after case goals have been achieved. At this stage, caregivers may be involved in assessments to determine what services would be useful.

In the fourth stage, interventions and services appropriate to the needs of each family member are identified, and referrals are made to these services. A case plan may be developed with the family to list out the steps necessary to either return the children to the home or to close the CPS case. During the fifth stage, services are provided to the family. These services may be provided by the CPS agency or by agencies contracting with CPS to provide these services. In the sixth stage, the CPS worker and supervisor periodically evaluate the progress of the family toward reaching the goals of their case plan. The seventh stage is the case closure.

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See Also: Child Abuse/Neglect, Victims of; Child Welfare Services; Children in Foster Care; Indian Child Welfare Act.

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Providers, Institutional Racism and

Racism is the support of a belief system that classifies people in the world in terms of the difference in their skin color and promotes the superiority of one race over another. Historically, racism has served to deny certain individuals the same rights, privileges, access, and entitlements that are afforded to other groups, namely white persons in a U.S. context. Racism implies the innate power of one group over another, often by means of a history of domination, regulation, and control. Human services workers receive diversity training that often includes how to understand and work toward eradicating systemic racism, as well as learning about the matters to keep in mind when working with others outside of one's race.

This begins with an understanding of how racism manifests itself on an individual level between persons. Individualized racism is generally the most obvious form of racism, yet other types exist that are more structural than individual. Structural racism is often perpetuated, even if the individuals who make up the structure do not individually hold racist views. Institutional racism, a form of structural racism, is the collapse, preexisting failure, or breakdown within a social interest group or institutional setting that disallows the privilege of equal access or equitable services to individuals because of the color of their skin, ethnic heritage, or cultural origin. Institutional settings include companies, businesses, educational systems, health care organizations, human service agencies, and political parties or movements.

While providers may not knowingly perpetuate institutional racism, they are part of the complex structures that were often configured with the needs of white people in mind. An imbalanced power dynamic is therefore created where the interests of people of color are not equally as paramount as that of whites or elided altogether in a way that perpetuates marginalization within the particular setting. Because the racist structures predate the providers of today, it is essential to examine how issues of institutional racism in human service and health care settings were created in order to break down the barriers to services that still exist for minority populations.

Tuskegee Experiment

One need only look as recently as the middle of the 20th century to the Tuskegee experiment to understand the mistrust that has developed between minority communities and services providers because of a pernicious example of institutionalized racism in health care research. Several hundred black men tested positive for syphilis and were not told that they were infected. They were then recruited to be research subjects under the guise of receiving free health care.

The researchers were actually interested in the effects of untreated syphilis on these men, even well after a treatment had been discovered that cured the condition. This is an often-cited example of institutionalized racism knowingly executed by health care providers, one of many in the course of history.

Though not as overt as Tuskegee, minority populations still face many barriers to accessing services when it comes to seeking health or mental health care. While universal health care is pending in the United States, many minority populations are unemployed or underemployed so they do not qualify for employer subsidized health care plans. Some qualify for Medicaid, but there are often very long waiting lists to see a provider, if the particular clinic is accepting new Medicaid patients at all.

Further, minority groups often live in areas that are medically underserved and without the staffing of minority providers that can provide racial, ethnic, or cultural familiarity to some clients who are also underrepresented in these areas. This underrepresentation can lead to language barriers for patients/clients whose first language is not English. It can be difficult to locate a translator if one is available at all, and treatment or services are unnecessarily delayed. Language barriers and the failure of agencies and providers to meet this need is an obstacle to full and complete access and a form of institutionalized racism because it says to the client that he or she is not important enough to have people on staff that speak his or her language.

There are many shelter environments in U.S. cities that cater to many monolingual Spanish-speaking Latinos, yet they do not have a Spanish-speaking staff member. This problem exists with many subjugated groups that are monolingual to their native language and enforces a sense of rejection or disrespect to the client's heritage. While it

Doctor drawing blood from a patient as part of the Tuskegee Syphilis Study, a pernicious example of institutionalized racism in health care research. Several hundred black men tested positive for syphilis and were not told they were infected. They were then recruited to be research subjects under the guise of receiving free health care. The researchers were actually interested in the effects of untreated syphilis on these men, even well after a treatment had been discovered that cured the condition.

is difficult to manage all these factors in smaller nonprofit organizations that may have minimal funding, it still constructs the client as an outsider or "other" compared to clients who can enter the organization for help and immediately have their needs addressed because no such barriers exist. Because funds are not available on a federal level for these smaller agencies, the racism is embedded and therefore institutionalized within the structure of funding sources.

White Bias

Many individuals from communities of color are overrepresented in pathologizing mental health diagnoses and score lower on standard intelligence test questions. These assessments were developed with white middle-class people as the determinates of normalcy, and are therefore designed around culturally different views of the world that are far more privileged and have not been subjected to a history of domination and control, nor do they have to live in an environment that perpetuates negative stereotypes by nature of institutionalized racism. Race and racism cannot be teased out from their relationships to social class, ability, and gender.

Women of color have a much higher incidence of health care disparities, and they are subjugated by the sexism that affects them for being women and the racism or ethnocentrism that is a consequence of being persons of color. Native American men and women are often blamed for the high rate of alcoholism within their communities, and they are often viewed as intrinsically unable to employ better coping skills. The history, however, is elided in the days of land acquisition by white men; they introduced alcohol to native people through trade when it was not a part of native cultural history and they had no tolerance or experience with the risks of addiction. Often, histories of other subjugated groups are erased, and stigma and blame are perpetuated.

Less experienced providers are often ignorant of the issues of difference that prevent them from being culturally sensitive. For example, some white providers have difficulty understanding the kinship model of childrearing in the African American family (and other communities of color) and question the adequacy of parental attention toward their children, not realizing that the extended community fills in any perceived gap.

Providers can also perpetuate institutionalized racism by not speaking up when hearing or seeing examples of more individualized forms of racism from colleagues in their respective agencies. Many governing bodies or licensing entities that certify workers in human service agencies are examining how institutionalized racism is perpetuated and are taking steps to address it as individual fields. The hope is that deconstructing institutionalized racism in the history of the helping profession will trickle down to the human service providers employed by individual agencies.

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See Also: Race and Clients; Race, Social Definitions of; Racial and Ethnic Approaches to Community Health; Racial Identity Development, Models of; Racial Microaggression; Racism, Long-Term Effects of.

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Psychiatric/Psychological Assessment

There are many aspects of a thorough psychiatric and psychological assessment, with some of the more prominent ones being conducting a clinical interview, conducting a mental status exam, making a diagnosis, and administering and interpreting a wide range of assessment instruments. A thorough psychiatric and psychological assessment may include one or all of these sources of information in an effort to gather enough evidence to make a determination or prediction about a client's status. Usually, the psychiatric and psychological assessment results in some type of evaluation or test report. Although human service professionals tend to have the training to conduct a clinical interview and to administer a mental status exam, they may or may not have training in making a diagnosis. In addition, human service professionals only have the training to give some types of tests. The following offers a brief description of these four important aspects a psychiatric and psychological assessment.

The Clinical Interview

The clinical interview is a broad-based assessment of an individual, which is generally done face-to-face by a mental health professional. Clinical interviews can be structured or unstructured and usually take between one and three hours. With both types of interview, the mental health professional attempts to gather a wide range of information from the client, including the following: demographic information, presenting problem or reason for referral, family background, significant relationship patterns, medical history, prior counseling, substance use and abuse, educational and vocational history, mental status (see next section), and other pertinent information. Human service professionals should have the training in basic counseling skills to be able to effectively conduct a clinical interview.

Whereas structured interviews have a predetermined set of questions or a checklist of items to be covered, the unstructured interview allows the client to drift and discuss items that may feel particularly important to him or her. The advantage of the structured interview is that, because it is focused, one is less likely to miss items that are typically covered in the interview process. The advantage of the unstructured interview is that items that might not be uncovered in a structured interview are discovered as the client drifts into uncharted territory about his or her life. This may reveal intimate details about the client's mental health status. Some mental health professionals will conduct a semistructured interview in an attempt to have the best of both the structured and unstructured interviews. Whether conducting a structured, unstructured, or semistructured interview, it is important to make sure that the depth and breadth of the client's experience is gathered so that an accurate psychiatric or psychological assessment is conducted.

The Mental Status Exam

A major part of the psychiatric and psychological assessment is the mental status exam, which is generally conducted during the clinical interview phase of the assessment process and assesses clients' appearance and behavior, emotional state, thought components, and cognitive functioning. This exam may be done in a deliberate fashion, where the examiner asks specific questions to ensure that he or she gathers all the necessary information, or may be an outgrowth of the clinical interview, as the examiner picks up cues from the client about the areas to be assessed in the mental status exam.

Appearance and behavior. Appearance and behavior include things such as the client's body posture, eye contact, nonverbal behaviors, tics, hygiene, manner of speech, and so forth. Appearance and behaviors give an indication of how the client presents himself or herself to the world.

Emotional state. Here, the examiner assesses the client's affect, which is how the client appears to the examiner, whereas the mood is the client's subjective sense of self, usually appearing over a period of time. A few examples of the dozens of types of affect and mood include depressed, anxious, apathetic, serious, sad, happy, and joyful. In addition, a statement about the type of affect and mood is usually made. A few of the many examples of those include constricted, exaggerated, labile, or flat.

Thought components. A client's thought components include the kinds of things a client is thinking about (content) as well as the process of one's thinking. Some examples of the many kinds of items examiners will look for include whether a client has delusions, distortions of body image, hallucinations, obsessions, suicidal or homicidal ideation, and whether the thinking process is tangential, circumstantial, coherent, flighty, logical, intact, loose, organized, or tangential.

Cognition. Some of the many items assessed when examining cognition include whether the individual knows what time and date it is, where he or she is, and who he or she is (oriented to time, place, and person), as well as a statement about the person's short- and long-term memory, insight, judgment, and intellectual ability.

Making a Diagnosis

One aspect of doing a psychiatric and psychological assessment is making an accurate diagnosis of the client, which includes the use of the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition, or DSM-5). In order to make an accurate diagnosis, most mental health professionals will have conducted a clinical interview and a mental status exam. Sometimes, assessment instruments will be used to help in the diagnostic process. Any mental health professional that is adequately trained in DSM-5 should be able to make a diagnosis.

DSM-5 includes information on a wide range of disorders to help the mental health professional make a diagnosis. There are hundreds of disorders that are listed under the following broad categories: neurodevelopmental disorders; schizophrenia spectrum and other psychotic disorders; bipolar and related disorders; depressive disorders; anxiety disorders; obsessive-compulsive and related disorders; trauma- and stressor-related disorders; dissociative disorders; somatic symptom disorders; feeding and eating disorders; elimination disorders; sleep–wake disorders; sexual dysfunctions; gender dysphoria; disruptive, impulse control, and conduct disorders; substance use and addictive disorders; neurocognitive disorders; personality disorders; paraphilic disorders; other disorders; and co-occurring and substance-induced disorders. DSM-5 uses a dimensional assessment that asks the professional to identify whether the diagnosis is mild, moderate, severe, or very severe. Generally, mental health professionals are also asked to make a statement about a medical condition if it is related to a disorder as well as psychosocial and environmental issues that may have exasperated a disorder.

Conducting Testing and Assessment Procedures

The final aspect of doing a good psychiatric and psychological assessment sometimes includes the use of tests and other assessment instruments. Testing and assessment can be viewed from four broad categories: ability testing, personality testing, and informal assessment.

Ability Testing

Often, a person's cognitive functioning can have a direct impact on his or her psychological functioning. Thus, some examiners like to do an assessment of those aspects of cognitive ability that are seen as important to a particular person's functioning.

There are two types of ability testing: achievement testing, which measures what one has learned, and aptitude testing, which measures what one is capable of learning. Types of achievement testing include survey achievement tests such as tests of what you have learned in school; diagnostic tests, like tests of learning disabilities; and readiness tests such as tests to see if a person is ready to move to the next level of education. Types of aptitude tests include cognitive ability tests such as tests to measure what you are capable of in school or to measure how well you might perform in college (e.g., SATs, ACTs); tests of cognitive functioning such as intelligence tests or tests of neuropsychological assessments (e.g., tests to measure changes in brain function); and tests of special and multiple aptitude, which measure one's ability at different skills and are usually used to predict job performance.

Personality Assessment

Personality assessment has to do with assessment in the affective realm. Three kinds of personality assessment include interest inventories, objective tests of personality, and projective tests of personality. The latter two types are frequently used when conducting a broad-based psychiatric and psychological assessment, although sometimes interest inventories are also used.

Interest inventories assess a person's likes and dislikes and often result in a description of an individual's personality orientation toward the world of work. They are used to help a client in the career counseling process and are fairly predictive of job satisfaction. Objective personality tests are predominantly multiple choice and true–false instruments that provide information about a person's temperament and day-to-day functioning. Every objective test measures different aspects of personality, although the more involved ones tend to provide diagnostic information about the individual. Projective tests present unstructured stimuli, such as a series of inkblots or sentence stems (e.g., My mother was . . .), and asks the individual to respond to them. Then, the examiner interprets the client's responses.

Informal Assessment

Informal assessment techniques are created by the individual who is administering the assessment procedure or conducting the psychiatric and psychological assessment. By their very nature, these instruments are less valid or reliable than ability or personality tests. However, they are useful because they can zero in on a specific aspect of client behavior. Some of the more popular types of informal assessment instruments include observation, rating scales, classification methods (e.g., feeling word checklists), environmental assessment techniques (e.g., observing a child in school or observing a person at his or her home), and records and personal documents (e.g., diaries, autobiographies, or genograms).

Who Can Give Tests

A number of years ago, the American Psychological Association suggested that competency in test administration and interpretation can be categorized among three levels. Those who can give Level A tests should have a minimum of a two- or four-year degree. Some tests they can give include informal assessment procedures and proctoring exams. Those who can administer and interpret Level B tests include those who have a master's degree in psychology or a related field (e.g., human services) and a basic course in testing. Some tests at this level include interest inventories, some objective personality tests, and many ability tests. Those who can give Level C tests should have a master's degree, a basic course in testing, and advanced training on the test. Some tests they can give include intelligence tests, neuropsychological assessment, some learning disabilities tests, and projective tests. Generally, a human service professional can give Level A tests.

Diversity and Assessment

Although there are clearly benefits to conducting assessments with clients, the 100-year history of assessment has not always been kind to a wide range of diverse clients. For instance, two of the first assessment instruments included the Army Alpha and Army Beta tests, which were verbal and nonverbal tests, given in large groups, of what was said to be intelligence. However, a close look at these tests showed that they were filled with cultural and socioeconomic bias. Clearly, those who were white and well-off did better than others as their life experiences had exposed them to the types of questions asked on the test. In addition, the test was a far cry from what we would currently call intelligence.

Despite its faults, the tests were widely given, and the results were used by the U.S. government to prevent emigration to the United States of those who did poorly on the test, such as Jews from eastern Europe, as they were seen as intellectually inferior. One result of this policy was the murder of millions of Jews and others in the Nazi concentration camps. These tests were also used as a justification for the eugenics movement, which suggested that those who were "brighter" should be encouraged to find other bright individuals to have children with, and those who were "dull" would be encouraged to not have children and sometimes given forced sterilization. Other horrific examples of the misuse of tests include culturally biased tests of achievement and aptitude that were used throughout this country during a large part of the second half of the 20th century. These tests clearly were positively biased toward whites and were often used in important decision making such as advancement in school or placement in jobs.

A number of tests and assessment procedures were initially developed to equalize differences among people. For instance, James Conant Bryant, the developer of the SAT, was hoping that the test could identify those who were struggling academically so that they could be given additional help to achieve. Also, Public Law 94-142, the original special education act passed in 1975, was put into place to identify, through assessment, those children who had disabilities so that they could be given special attention and helped to achieve in schools at higher levels. Unfortunately, these good-hearted attempts sometimes did not have their expected results, such as when the SATs were used to prevent minorities from attending college, when tests of special education resulted in a child's label becoming a burden rather than a mechanism of helping the child do better in school, or when bias in testing misidentifies large percentages of individuals from minority groups for special education.

Over the years, as attention to bias in testing became more prevalent, test publishing companies have made a strong effort to include minorities and women in their norm samples and have tried to limit the bias in their test items. The development of the computer has helped in this process as it made the statistical analysis of tests much easier, and many studies have been conducted over the past 20 years attesting to the cultural fairness or unfairness of tests. However, there is still little doubt that many tests continue to have bias today. Test examiners need to ensure that, whenever they give a test, it has been screened for bias. They should also take into account cross-cultural concerns of the examinee such as whether the examinee understands the questions, the motivation of the examinee, and whether or not the examinee has a disability that could interfere with the accuracy of the test score. This is why test administrators need to be well trained in how to give a test and be aware of the subtle signs that an individual's score may not represent his or her true score due to bias in the test or in the testing procedures. Finally, test examiners need to be particularly careful that their own bias toward certain groups does not interfere with their interpretation of test scores.

Cultural bias in assessment is not only a concern in tests but also a concern in diagnosis. For instance, it has been found that, due to mental health professionals' bias, clients from diverse backgrounds are often misdiagnosed, given inappropriate treatment plans, and terminate from helping relationships early because they do not feel a connection with the helper. In addition, clients from diverse backgrounds often do not even seek helping relationships because they do not feel welcomed. Thus, any good helper should be aware of his or her own bias, have knowledge about different cultures, and have the skills necessary to work with a wide variety of clients.

Conclusion

The clinical interview, mental status exam, diagnosis, and assessment results can all be used in psychiatric and psychological assessment of clients.

If conducted well with an eye to potential cultural bias, information from all of these sources can be used by human service professionals and other mental health professionals to develop a broad and in-depth impression of the client.

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See Also: Case Management; *Diagnostic and Statistical Manual of Mental Disorders*, Cultural Responsiveness of; Intelligence Testing.

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Public Health

The concept of public health is best thought of as a practice model within the wider health care system. It is primarily distinguished by focusing on population-level health and disease prevention. This contrasts with the typical practice model of health care, which focuses on patient-level health and addresses acute symptoms of illness. Public health finds its origins in urbanized settings around the world and early public works that removed human waste, decreased rodent infestations, contained outbreaks of diseases, and limited behaviors associated with alcohol and drug use and sexual relationships. Its formulation into a profession and codification in public policy are phenomena that developed in association with industrialization.

Public health draws primarily from three scientific sources: epidemiology, biostatistics, and health services. Two streams of thought have dominated how disease prevention and population health are achieved: environmental and bacterial. Under the large umbrella of public health are numerous subfields that focus on social justice; climate change; vaccination; access to community-based health services; health disparities among Native Americans, Latinos, Asians, and African Americans; public policy in regards to poverty, maternal health, addictions, and occupational safety; the economics of health care; and mental health services.

Basic Activities

Public health is concerned with preventing epidemics, protecting the physical environment (e.g., air and water quality in the home and workplace), monitoring the general health of the population, responding to natural and man-made disasters, assuring quality and accessible health care, linking vulnerable populations to health services, research, and policy advocacy. The most visible manifestations of these ideals in the United States are the system of state, county, and city public health departments, the 1,200 Federally Qualified Community Health Centers (FQHCs), the Centers for Disease Control (CDC), and the United States Public Health Service (USPHS).

A strong commitment to issues of social justice has meant that public health professionals and institutions generally are engaged in serving a variety of diverse and vulnerable populations.

Historical Highlights

The literature concerning public health is mostly Eurocentric, with a strong focus on discoveries and developments in London. Because London was the largest urban center between 1841 and 1914 and the home of industrialization, it provided ample evidence of the impacts of poverty, lack of sanitation, and environmental degradation. These same conditions, not surprisingly, also found themselves prominent in the growing cities of the northeastern United States, particularly in Boston and New York City. As a result, much of the early history of public health arises from public policy and research in

London, New York, and Boston. The two streams of public health, environmental and bacterial, are seen in its early history.

Environmental approaches in public health are demonstrated in Edwin Chadwick's (1800–90) 1842 *Report on the Sanitary Condition of Labouring Population of Great Britain*. Chadwick's seminal report linked together poor health, poverty, and dangerous environmental conditions that included contaminated drinking sources, improperly disposed garbage, and the presence of human waste in public streets. Eight years later in 1850, Lemual Shattuck (1793–1859) authored a similar public health report about the conditions of poverty in Boston. This report identified the public health needs of Massachusetts and made recommendations to create the first state board of health. One of the most famous episodes in public health was linking the London cholera epidemic of 1854 with a contaminated public water source by John Snow (1813–58), considered one of the founders of epidemiology.

Equally important is the work of public health scientists who approached population health and disease prevention from a bacterial perspective. One of the earliest scientific public health manuscripts appeared in 1796 and was written by Edward Jenner (1749–1843). Jenner's paper sketched out the potential for inoculation as a method of preventing disease. This paper led to the development of the smallpox vaccine, which was eventually considered eradicated in 1977 as a result of population-wide inoculation. French microbiologist Louis Pasteur (1822–95) developed a system of inoculation and the first vaccine for rabies. He also created the process of pasteurization, which kills all bacteria and molds in liquids such as milk that are related to disease. German scientist Robert Koch (1843–1910) was one of the founders of bacteriology. He was instrumental in developing methods used in modern epidemiology and won the Nobel Prize in Physiology or Medicine in 1905 for his development of Koch's Postulates, which identify four criteria necessary to establish a causal relationship between a parasite and a disease.

Women in Early Public Health

Women played a significant role in promoting environmental and social justice aspects of public health. Examples include Sara Josephine Baker (1873–1945), a physician in New York City who focused on the role of poverty in infant mortality. In 1917, Baker compared the mortality rate of World War I soldiers to children born in the United States and found that soldiers had a better chance of survival. Her work is believed to have saved the lives of 90,000 children. Baker is also famous for catching Typhoid Mary (twice) and improving the hygiene of New York City's Hell's Kitchen, a highly impoverished immigrant community. Lillian Wald (1867–1940), a nurse, social worker, and feminist, is considered the founder of public health nursing in the United States. In 1895, Wald started the Henry Street Settlement at which she introduced the concept of public health nursing. The idea was to provide basic medical care in the neighborhoods where poor and vulnerable populations lived. Mary Seacole (1805–81), who was known as the black Florence Nightingale, was instrumental in treating cholera and yellow fever outbreaks in Jamaica during


Women played a significant role in promoting public health. Lillian Wald, a nurse, social worker, and feminist, is considered the founder of public health nursing in the United States.

the 1850s. Most famously, she opened the British Hotel with her own resources to serve the wounded and sick soldiers of the Crimea War despite Britain's refusal to financially support her work. Her kind care was remembered by thousands of British soldiers and recognized by Queen Victoria.

Race and Public Health

Early in the history of public health, there is limited evidence of support for the African American community despite extensive engagement with immigrant populations. The 1918 influenza pandemic highlighted the racist theories of blacks' susceptibility to disease, racially constructed public policy, and service barriers to health care. In response to these barriers in the United States, the African American community established separate hospitals and professional organizations to address the influenza epidemic, resulting in lower incidents of the disease among African Americans.

Since the mid-1960s, race, culture, and ethnicity have increasingly been part of the public health discourse. An active discussion within the public health scholarly literature has occurred about several dimensions of race, including the meaning of race as a social determinate of health, its measurement difficulties, and the role of racism in health services. The concept of race in particular and its use in public health policy and research has garnered significant debate in the scholarly literature. Generally, the current operationalization of race is viewed as deeply flawed. This is balanced with the importance of understanding the experiences of minority groups and the health determinant of race.

Notorious Incidents

Although often at odds, public health and the eugenics movement of the early 20th century found some similarities in policy and methods. The common goal held by both movements of protecting population health created a wide range of opportunities to collaborate. One such example is the USPHS examining immigrants for hereditary as well as infectious diseases, both of which were considered threats to population health. The connection between eugenics and public health was further solidified in the 1927 Supreme Court case *Buck v. Bell*, which upheld involuntary sterilization. The case was based upon *Jacobson v. Massachusetts*, a 1905 Supreme Court case mandating smallpox vaccines. The court found in both instances that the state had an obligation to the safety of the general population over the rights of the individual.

In one of the darkest moments in U.S. scientific history, the USPHS, in cooperation with the Tuskegee Institute, began the Tuskegee Study of Untreated Syphilis in the Negro Male in 1932. The study, although intended to justify treatment programs for African Americans with syphilis, was based on racist perceptions codified in the racial epidemiology of the time. A letter from a medical researcher concerning the Tuskegee syphilis study sent to the CDC in 1965 states:

> I am utterly astounded by the fact that physicians allow patients with a potentially fatal disease to remain untreated when effective therapy is available. I assume you feel that the information extracted from observations of this untreated group is worth their sacrifice.

It was not until 1972 that the experiment was discontinued based on an exposé in the *New York Times*. In 1997, President Bill Clinton, on behalf of the United States, apologized to the surviving participants and their families.

The USPHS was also associated with the syphilis experiments in Guatemala that were funded by National Institutes of Health (NIH). This sad chapter in public health was discovered in 2010 during a review of records associated with the Tuskegee syphilis study. The records revealed that, in Guatemala between 1946 and 1948, research was conducted that involved intentionally infecting more than 1,300 subjects including prisoners, soldiers, and orphaned children with venereal diseases to test the efficacy of penicillin.

More recently, there has been concern about the ethical conduct of research studies on the prevention of mother–child transmission of human immunodeficiency virus (HIV) in developing countries. In 1997, Peter Lurie and Sidney Wolf published an article in the *New England Journal of Medicine* accusing the NIH, World Health Organization (WHO), United Nations (UN), and CDC of ethical violations in these studies.

Modern Public Health

The WHO core public health functions provide an understanding of the role of modern public health.

These core functions include providing early warning for imminent public health emergencies, recording the impact of public health interventions, and explaining the epidemiology of health problems in an effort to improve health policies. Surveillance of public health challenges has led to the identification of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), type 2 diabetes and obesity epidemics, zoonotic diseases such as severe acute respiratory syndrome (SARS), and resistance to antibiotics, which is leading to the reemergence of infectious diseases.

The environmental history of public health is not forgotten in modern public health as reflected in the 10 greatest public health accomplishments of the 20th century identified by the CDC. These include immunization, motor vehicle safety, workplace safety, control of infectious diseases, declines in death from heart disease and stroke, safer and healthier foods, healthier mothers and babies, family planning, fluoridation of drinking water, and tobacco as a health hazard.

Immunization is considered one of the most important successes of modern public health. Since 1900, 21 vaccines have been developed to prevent disease in the general population. Of these, 11 vaccines have been recommended for population-wide use in children. These 11 have resulted in remarkable reductions in morbidity associated with smallpox, polio, measles, congenital rubella syndrome, and Hib (leading cause of childhood meningitis). The polio vaccine in particular reduced the 16,316 paralytic polio cases and 1,879 deaths that occurred between 1951 and 1954 to the elimination of wild-type viruses in the United States by 1991.

American Association of Public Health

Founded in 1872, the American Association of Public Health (APHA) is the professional organization for public health. The organization has 53 state affiliates, 29 sections that represent special interests ranging from health disparities to global climate change, and active relationships with public health organizations in 70 countries, WHO, and the Pan American Health Organization. APHA sponsors an annual conference that attracts approximately 12,000 professionals and more than 1,000 scientific sessions. Themes since 2000 that highlight public health's commitment to diverse populations include Eliminating Health Disparities (2000), Public Health and Human Rights (2006), Public Health Without Borders (2007), Social Justice: A Public Health Imperative (2010), and Prevention and Wellness Across the Life Span (2012). As well, the organization produces one of the premier scholarly journals related to public health (*American Journal of Public Health*).

Schools and Programs of Public Health

There are approximately 90 accredited schools of public health that belong to the Association of Schools and Programs of Public Health (ASPPH). The two widely offered degrees are master of public health (MPH) and doctor of public health (Dr.PH). Accreditation is granted by the Council on Education for Public Health (CEPH). CEPH is recognized by the U.S. Department of Education and accredits schools of public health and public health programs to assure that the school or program has been evaluated and has met accepted standards established by and with the public health profession.

Federally Qualified Community Health Centers

There are more than 1,200 federally qualified community health centers (FQHCs) in the United States that serve approximately 19 million patients. Typically, FQHCs serve a highly vulnerable group of people, 27 percent of whom are African American, 35 percent are Hispanic or Latino, and 71 percent live at or below the poverty level. FQHCs grew out of President Lyndon Johnson's War on Poverty. The federally qualified designation was created under the Health Centers Consolidation Act of 1996, which merged health care programs for migrant, homeless, and public housing populations. FQHCs are considered an important part of expanding health care under the 2010 Patient Affordable Care Act.

Centers for Disease Control and Prevention

The CDC was established in 1946. It is a federal agency within the Department of Health and Human Services (DHHS) with the goal of promoting public health and safety through the control and prevention of disease, injury, and disability. In particular, the CDC focuses on infectious disease, food-borne illness, environmental hazards to health, occupational safety, and injury prevention.

The CDC played a leadership role in the HIV/AIDS epidemic when few other health care institutions would in the United States because of the disease's initial connection with male homosexuality.

U.S. Public Health Service

The USPHS links its history back to the 1789 Act for the Relief of Sick and Disabled Seamen. It was officially designated in 1944 and is one of seven uniform services in the United States. It is led by the surgeon general and employs more than 6,000 public health professionals from a variety of professional backgrounds including environmental and occupational health, medicine, nursing, dentistry, pharmacy, psychology, social work, hospital administration, health record administration, nutrition, engineering, science, veterinary, health information technology, and other health-related occupations. The mission of the USPHS is to protect, promote, and advance the health and safety of the United States.

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See Also: Health as a Human Right; Health Care, Disparities in; Health Care Delivery, Models of; Nursing, Public Health; Providers, Institutional Racism and.

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Puerto Ricans

In spite of common values shared by many Hispanics and Latinos (such as Spanish language, the centrality of family, and importance of community), Hispanics and Latinos from diverse regions and countries are not a monolithic culture, and thus, a uniform style of communication does not exist in their cultural spectrum. They often differ across social, political, economic, and symbolic dimensions.

In the case of the Puerto Rican population, as a result of a long historical process of colonialism and massive migrations, they have become what anthropologists, sociodemographers, and migration researchers call a nation on the move, a transnational reality, and a divided nation. According to the 2010 Puerto Rican Diaspora Atlas and the 2010 Pew Research Center's Hispanic Trends Project, "Hispanics of Puerto Rican Origin in the United States" statistical profile report, by 2010, there were approximately 4.6 million people of Puerto Rican origins living in the United States. This group represents about 9.2 percent of the Hispanic population in the United States. In contrast, 3.7 million individuals were living in Puerto Rico, with the United States' population outnumbering Puerto Rico's by nearly 1 million. Both groups manifest a strong sense of cultural identity, different from the American identity, regardless of their ideological, economic, and social differences.

The human services challenges faced by the Puerto Rican community in the United States and Puerto Rico are hardly related to the cultural, symbolic and linguistic communication patterns; their underlying attitudes, values, and belief systems; and socioeconomic, racial, political, and legal conditions. Academic literature on human services oriented toward Puerto Rican clients in the United States suggest that their cultural value system and their expectations for mental health services show that their sociopsychological and cultural orientation to therapy, its use, and expectations are seen as relatively different to that of the typical middle-class American client.

Cultural Identity Traits

Puerto Ricans in the United States and on the island have created eclectic, liminal, or hybrid cultural identity traits, which are manifested in their sociocultural struggles and survivor strategies.

Characteristic of their identity is a constant mode of coping, dealing, and resolving. A strong sense of cultural identity, different from the American identity, unites Puerto Ricans regardless of their ideological, economic, and social differences. The effort to preserve that identity surpasses the limits of political rivalries and the circumstances of socioeconomic migratory movements and demographic transformations.

They have constructed an identity in a social condition in which colonial and countercultural power discourses and practices coexist and are central to their social and cultural transnational contexts. Such identity is rooted in indigenous, African, and Spanish heritage and is often manifested during festivities, which are commonly used as survival strategies to disguise social and material scarcity. Puerto Rican nationalism in the United States displays cultural practices that show that their hybrid identity, including the use of salsa and reggaeton music, and speaking "Spanglish," which is a mixture of Spanish and English languages, as symbolic sociocultural resistance strategies.

Scholars studying Puerto Rican community migration and sociocultural patterns suggest that, in the context of cultural identity traits, Puerto Ricans demonstrate expressiveness to strangers, warmth, and a sense of hospitality in which respect for the family is critical; mothers and elders are venerated, and a strong sense of duty toward the family, including the extended family, is essential. They also show that a one-dimensional manifestation of masculinity expressed as a form of machismo is a critical element of Puerto Rican identity.

Beliefs in the intrinsic merit of humanity may be a protective factor and a source of strength. Individuals may avoid discussing problems that compromise dignity. Dissent may be communicated indirectly (e.g., nod as if in tacit agreement). Elders may not make eye contact, while younger Puerto Ricans and those born in the United States prefer eye contact.

Research on the cultural and moral dimensions of dignity and respect reveal that they are main cultural values that lay emphasis on bonds, mutuality, and faithfulness to family members beyond the limits of the nuclear family. Individuals may place family concerns above individual needs. Individuals may prefer or expect a close relationship once truthful relationships are established. Children and parents may continue a dependent relationship into adulthood. Parents may leave children with grandparents as they establish financial stability in the United States.

A one-dimensional masculinity tendency expressed as a form of machismo acknowledges both negative and positive aspects of culturally sanctioned ideas about masculinity. Privately, decision making tends to be shared by husband and wife, though publicly, men may appear to have the final word. Men may believe strongly in their fiscal and moral duties to their families. They may be judged by their abilities to make sacrifices for their families; they may hesitate to discuss problems that reveal personal weaknesses, perceive a fatalistic acceptance of problems as a courageous attitude, and be vigilant over matters of dignity and respect.

Religion

Caribbean popular religion and spiritualty play an important role as part of the Puerto Rican culture. That type of religiosity and spirituality is rooted in a Roman Catholicism that is dynamically syncretized with religious practice of the indigenous habitants of the Caribbean and the enslaved population of the 16th-century slave trade of black Africans brought to the Americas and the Caribbean Islands. Popular religions and spiritualities play a significant role in the everyday life of Puerto Ricans. Practicing religious rites, praying, keeping religious artifacts, and erecting small home altars are some common religious practices. A more recent emergent Pentecostal faith and spirituality has become a growing manifestation of a popular evangelical religious and spiritual practice between Puerto Ricans of the island and the diaspora.

Puerto Ricans and their diaspora are part of the syncretic or hybrid Caribbean religious and spiritual cultural identity. What is characteristic among this population is a constant mode of coping, dealing, resolving, and surviving, and a shared, constructed identity in a social context in which colonial and countercultural power discourses and practices coexist.

As some Puerto Rican religious studies and social scientists of religions suggest, Caribbean popular religions and spiritualities should be understood as based in a dialectical relationship between the material and spiritual worlds in which one world could affect and shape the other. This understanding provides an alternative style of human-divine relationship, primarily in confrontation with the dominant culture, but is flexible enough to appropriate from that culture the customs and practices that contribute to the nature of healing of diseases and well-being of the community and create a different force for struggle, which sustains at a conscious or unconscious level an attitude of resistance against psychosocial oppression, dysfunctions, and diseases.

Human Services Addressed to Puerto Rican Communities

Academic literature concerning human services aimed toward the Puerto Rican community in the United States and on the island suggests that key cultural Puerto Rican traditions emphasize national identity, collectivism, interdependence, and cooperation. Some manifestation of such customs are the use of their native language when talking about emotional expression to minimize possible defensiveness. These sociocultural behaviors were found to be involved in the differential psychocultural orientation to human health services therapy for Puerto Rican clients.

Other research has found that many of their stressors are related to their traditional roles in the family, role conflicts, marital conflicts, problems associated with raising adolescents rejecting parental values, inexplicable neurological symptoms among adults, and those associated with the acculturation process. The physical symptoms they present are frequently combined with anxiety and depression. Empirical data also show that women are more likely than men to engage as human services clients.

Clinical implications of certain key predicting studies data of child maltreatment among Puerto Rican children from migrant and nonmigrant families suggest that, while rates of child abuse or neglect incidents are similar in both migrant and nonmigrant Puerto Rican families, when compared to general prevalence rates in the United States, predictors of maltreatment, such as poverty, may differ. These data also imply that, given the strong identification with Puerto Rican culture in a highly populated U.S. east coast city, it is recommended that culturally competent prevention and intervention strategies in child maltreatment, such as collaboration with extended family and overcoming language barriers, should be considered in the process of providing human services to those clients.

Most Latino human services studies indicate that this ethnic group expects therapy to be directive and actually prefers family or group therapy. They also suggest that Puerto Ricans often underutilize mental health services and express pain through somatic symptoms. They turn to their families in their neighborhoods for support. Key ethnographic and theoretical research noted that Puerto Ricans may equally seek help from a physician or a religious and spiritual healer.

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See Also: Acculturation; Mental Health Services, Adult; Spirituality/Religion and Diversity.

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Quality of Life, Measurement of

Quality of life is a general term used by health care providers and researchers to refer to satisfaction with everyday life. Although definitions of quality of life vary, they generally involve physical, psychological, and social factors that affect individuals' life satisfaction. Additionally, the concept of quality of life has been applied to different realms of study, and a diverse collection of terminology has been established in the examination of quality of life. Researchers have estimated that there are more than 100 definitions of quality of life in the literature and more than 1,000 assessments of quality of life currently being employed. Quality of life is important to study because it can be informative about how an individual perceives his or her own level of satisfaction. Measurement of quality of life can vary greatly, and different ways of measuring can provide different insights regarding factors affecting an individuals' life satisfaction.

Definitions of Quality of Life

With more than 100 different definitions of quality of life in the literature, the conceptualization of it varies by discipline. For example, psychologists are often concerned with psychological and social factors affecting quality of life, while doctors and nurses tend to place heavy emphasis on physical factors affecting quality of life. However, most definitions of quality of life involve a blend of how to assess physical, psychological, and social factors in order to discover what provides the most informative view of an individual. Some researchers have posited that quality of life is synonymous with an individual's happiness, while others argue that the scope of quality of life delves deeper than happiness level.

A common conceptualization of quality of life is health-related quality of life. Health-related quality of life focuses on how physical (and sometimes mental) factors specifically relate to the health outcomes of an individual. Health outcomes can include physical illness (e.g., heart disease, diabetes, or obesity) or mental illness (e.g., depression or anxiety). Health-related quality of life can also be fine-tuned to examine a group of people with a specific illness or disorder. The definition and assessment of specific populations involves defining health-related quality of life by identifying factors that may be especially important to that population of individuals. For example, there are definitions and assessments of quality of life for individuals who have had a stroke, individuals with multiple sclerosis, and individuals with diabetes. These and other specific individuals by default have different factors affecting quality of life because of their conditions.

Measuring Quality of Life

Despite the multitude of means through which quality of life can be measured, there are several assessments that have been validated and are used throughout the world. For example, the World Health Organization's quality of life scale assesses three categories of an individual's subjective quality of life: general functioning, global functioning, and personal evaluations. General functioning inquiries include straightforward questions about sleep, eating, and other health behaviors. Global functioning questions assess characteristics of health behaviors described in the general functioning questions such as quality of diet or sleep. Personal evaluations tap into the individual's perception of factors affecting his or her quality of life such as satisfaction.

Another popular way to measure quality of life is through the Medical Outcomes Study Short Forms (SF-12 and SF-36). These 12- and 36-question measures rely on a five-point rating scale that individuals use to endorse factors affecting quality of life. Individuals are asked to think about their experiences in the past one to four weeks and answer the questions in these assessments. For example, questions regarding physical or psychological problems may require an individual to rate the degree to which relationships were affected by the problems. Many other measurements of quality of life assess varying factors such as quality of social networks, overall mood, financial and career factors, and community-level functioning as it relates to the individual's life satisfaction.

Measuring Quality of Life in Diverse Populations

Quality of life can vary greatly from person to person, and specialized quality of life measures have been created to investigate experiences of specific groups of individuals. Age group can be a significant factor that affects quality of life. Quality of life scales have been established for infants and toddlers and can assess factors such as how income level, ethnic minority status, and temperament can affect quality of life in very young children. While the caregiver of the child answers the questions in this type of assessment, one can imagine how the life satisfaction of an infant would be measured differently from that of an adult. Similarly, some quality of life measures assess life satisfaction in adolescents. This particular age group is well studied in the quality of life literature, as biological and social changes during adolescence can often have a profound effect on quality of life. Measures targeting college students often include specific questions that are pertinent to college life and could affect life satisfaction such as sleep patterns of the individual, diet, activity level, and academic stress. Quality of life measures aimed at older adults are also plentiful, as this age group experiences health and social issues that are very unique due to physical and cognitive aging.

For persons of ethnic or sexual minority status, some scales may be more effective than others at examining issues pertinent to these groups of individuals. Because much attention has been placed on how being gay, lesbian, bisexual, or transgender can affect the social and emotional status of individuals, a scale in which measurement emphasis is placed on relationships, social support, endorsement of depression or anxiety, or self-esteem level may be the best fit.

Additionally, health or social disparities among people of ethnic minority status may be investigated best through measures that focus on those factors. For example, African American individuals have been shown to have a greater risk for coronary heart disease compared to Caucasian individuals, which is a major factor in health-related quality of life. Specialized measures have been created to target these types of phenomena.

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See Also: Economic Support and Services; Elder Care/Geriatric Services; Equal Opportunity and Civil Rights; Health Care Delivery, Models of; Life Skills Training; Nutritional Services and Assessment; Overweight and Obese Adults and Children; Pharmaceuticals, Access to; Poverty; Prenatal Care; Psychiatric/Psychological Assessment; Public Health; Racism, Self-Assessment of; Social Determinants of Health; Wraparound Services/Systems of Care; Youth Risk Behavior Surveillance System.

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Race, Social Definitions of

The notion that the diversity of the human race can be reliably subdivided into a small number of uniform groups is an invention of the Enlightenment. From its origin as a justification for slavery, the notion that biology has causative effect on an individual's interests, aptitudes, and potential had a long legacy that persisted until the middle of the 1950s. The slow growth of scientific racism from the assertion that races were variations of a single human species through the notion that human races were, in fact, separate species demonstrates the various social purposes that the race concept has been put throughout its history. Nevertheless, an increasing scientific consensus developed in the 20th century that showed there is no reliable way to draw distinct lines among human races. Today, one is inclined to assert that race is a social concept, by which one means that race is defined to serve social purposes. This is by no means to trivialize the concept of race. Race has important political uses, such as seen in the civil rights movement. Furthermore, to assert that race is not a valid biological category is not the same as saying that racism does not exist; to the contrary, the fact that biology is not the source of human differences suggests that racism is all the more pernicious. Overall, the history of scientific definitions of race demonstrates how conceptions of race are more likely to be tied to social imperatives than they are to scientific fact.

Rise and Fall of the Biological Definition of Race

Historians suggest that it was not until the modern era, in the period known as the Enlightenment, that the rigid notion of distinct racial groups took form. Although one sees the word race in classical Greek texts, for instance, the word that is in the original text has a meaning more like *kin, group*, or *type*. Each region was thought to have its own type of population, and there was no thought of dividing the entirety of the human species into a limited number of biological groups with distinct boundaries between them.

Collectively, a group of European natural historians built on each other's work to craft the idea that large swaths of the human population were alike in their aptitudes and attitudes and could be distinguished by superficial characteristics like skin color and hair type. One of the first was François Bernier, writing in 1684, who proposed to divide the human species into four broad types, each distinguished by their facial features and the area of the world in which they lived. The idea that each corner of the known world would excite a different humor in the human body led Carl Linnaeus to distinguish four types of humans in the

18th century: *Homo americanus* (regulated by custom), *Homo europaeus* (regulated by law), *Homo asiaticus* (regulated by opinion), and *Homo afer* (regulated by caprice).

Johann Blumenbach was the first to use the term *Caucasian*, a term he assigned to a small group from the Caucasus Mountains in modern-day Georgia, and suggested that, in the climate of the border region between Europe and Asia, the most beautiful women were found. Blumenbach distinguished four other races—Malay, Ethiopian, [native] American, and Mongolian—and suggested, like Bernier, that each was a degeneration of the ideal type due to environment. Blumenbach, like Bernier and Linnaeus before him, argued for the unity of the human species. "I have desired nothing so much as that the arguments which I have brought forward for the unity of the human species," he writes in 1775. "Innumerable varieties of mankind run into one another by insensible degrees." These authors might be termed *monogenists* due to their belief that there is only one human species.

An undercurrent of opinion that there might, in fact, be more than one human species had been simmering since the exploration of the New World. One of the first to articulate this position in the context of the age of exploration was Theophrastus Paracelsus in 1520, who asserted that the presence of humans on remote islands and continents could never have been the progeny of Adam and Eve. Paracelsus's opinion was that they were born after the Biblical flood, and not being descended from Adam and Eve, they had no souls. This theory was considered variously and, in 1655, this group was given the name *pre-Adamites* by Isaac Peyrere in his book *Prae-Adamitae*.

The monogenists, who focused on the environmental influences on the human body, differed from those who espoused the pre-Adamite position of multiple human species. Historians like Siep Stuurman and Londa Schiebinger, however, point out that both groups were similar in result: Their work was used to support the claim that some humans were natural born slaves. With their assertion that there was something physically different in the bodies of people of color, and that this difference influenced their capacities and interests, one could go so far as to say that slavery was beneficial to the enslaved because it would help the victims quell their supposed savage tendencies, giving them the opportunity to better experience reason and the love of God.

Nineteenth-century notions of evolution were enlisted to support the notion that the separate human species were in fact distinct races. Stephen Jay Gould, in his well-known study *The Mismeasure of Man,* has detailed the founding of this American school of anthropology based on contradictory measurements of individual skulls. In antebellum America, the notion that there were distinct human species, each with its own evolutionary inheritance that led to separate aptitudes and capacities, was an important part of the argument to support slavery as well as to prevent the mixing of the races.

At the end of the 19th century, it was argued that each race, whether it had originated separately or from a common stock, had through successive generations added on features that suited its climate. The minute changes built up over millennia to such an extent that the different races had diverged into separate strands of humanity. The concern over miscegenation, or the mixing of the races, was based on the belief that combining the races would be a disservice to the offspring. Mixing the attributes necessary for survival in a tribal society with the traits needed in a society of law, for instance, was thought to produce an individual who was suited for neither society. The individual would have, it was supposed, the passions necessary for survival in barbarism but none of the idealism needed to submit to the law. Or, perhaps, the individual would have the dexterity needed in a machine age but find him- or herself in an environment when brute force was necessary for survival. This belief in the power of racial physiology led the states to establish antimiscegenation laws in order to prevent what was believed to be an inappropriate mixture of human races that would result in a generation that would become a burden to the states.

This belief in biological determinism saw its high watermark in the United States with the American eugenics movement, led by Charles Davenport. He and his followers attempted to incorporate the work of Gregor Mendel to make a science out of the theory that one's ancestors had an influence on one's abilities. Taking a cue from the British anthropologist who coined the word *eugenics,* Francis Galton, American eugenicists proposed that the tendency of a generation to revert to the range of traits seen in the previous generation, even if only a certain type of parent were allowed to breed, meant that there was a racial type that guided the development of an individual. If one selected offspring only from tall bean plants, for instance, the next generation would nevertheless show the range of heights found in its parents' generation. American eugenics thus supported legislation to keep the races apart and, to ensure that no unwanted mixes would be born, mandated sterilization for individuals it saw as problematic.

The eugenics movement was successful in its agenda as evidenced by the number of states that established laws allowing court-enforced medical sterilization at the start of the 20th century. In addition, Davenport and his colleagues were instrumental in the Immigration Act of 1924, which took a race-based approach to limiting the number of people who could immigrate to the United States based on the relative proportion of nationalities in the country in 1890. This approach, eugenics proponents believed, would help keep the racial influence of immigrants on the overall population. Outside the United States, eugenics was felt in Adolf Hitler's policies, which were based on the research of U.S. practitioners. The Nazi party sought to encourage mating between individuals it saw as providing a positive influence on Germany's racial mix (so-called positive eugenics) and eliminate the progeny of those whose status as a separate, degenerate race could never improve the population through sterilization and murder (negative eugenics).

Development of the Culture Concept

Until the 1920s, it is difficult to find scientists who promoted anything but a biologically determinist viewpoint in their work. Coincident with the development of American eugenics and the German final solution, however, was the work of scientists who sought to undermine the biological determinism of the 19th century. One of the most prominent of these was Franz Boas, an American anthropologist who is most famous for inspiring his students to promote the idea of cultural relativism. What is sometimes less appreciated, however, was the way in which Boas made a systematic investigation of scientific racism in order to overturn the racial ideology of his time.

Some of Boas's earliest published work included reviews of books in the field of physical anthropology, which at the time was concerned with the use of measurement to quantify the differences between human species. Also, in *The Mind of Primitive Man* and other works, Boas sought to support the idea that one culture was not necessarily better than another. The keystone to the scientific racism of the 19th century was the idea that human races passed through successive stages from savagery through barbarism into civilization, each with their antecedent biological changes that allowed the individuals of a society to progress to the next level. For Boas, the idea of culture was transcendent, and so his work sought to demonstrate the powerful way that all humans were cultural creatures.

In addition to his promotion of the culture concept, Boas engaged in important analytical work to disrupt the notion that the different races were distinct biological categories. As early as 1871, Charles Darwin's *Descent of Man* had disputed the notion that mixing races caused infertile and weakened offspring in the same way that donkeys and horses—two distinct species—could produce infertile offspring. Based on this analogy to the natural world, proponents of polygenism had asserted that mixing different races of humans would result in a defective progeny. In order to test this proposition, Boas made a statistical study of mixed-race individuals to determine whether they were weakened and infertile. By looking at the children of Europeans and native Americans, Boas came to the startling conclusion that mixed-race individuals were as vigorous as their supposedly pure-race parents but also that they were even more fertile than the earlier generation. This work, first published in 1894, was one of the first blows against the racialized notions of the 19th century.

Another figure who is worth remembering for his insistence that culture, and not biology, accounted largely for the differences between human aspirations and aptitudes was W. E. B. Du Bois. His sociological study *The Philadelphia Negro*, first published in 1899, sought to determine that it was not biological differences that were to blame for the higher incidence of crime and poverty among the black population. In fact, his study was careful to show that the crime was correlated with poverty and the incidence of crime was not uniformly distributed throughout the black population. In order to account for the presumption that the black population was riddled with crime and, contrawise, that the white population was prejudiced against the blacks, Du Bois made the interesting observation that the higher classes of blacks were segregated from the higher classes of the whites so that the upper classes of the black population were confronted by the lower classes of whites and the upper class white population was in closer proximity to the lower-class blacks. Thus, a situation that seemed uniform was in fact an accident of cultural attitudes.

Du Bois went on to popularize the notions of the talented 10th and the submerged 10ths. In this statistical argument, Du Bois proposed that the way to uplift the black population was to address the highest and lowest 10 percent of the race. The highest group, the most talented, he suggested needed to be enriched through education so that they could become the race leaders, doctors, lawyers, and professors for the next generation. The lowest 10th, he believed, was in need of uplift so that they would not inflict the rest of the population through the ills caused by their poverty. Although this notion is rightfully thought of as elitist today—certainly few would believe that only the top 10 percent of a population is in need of uplift—it is the cultural notion of this program that is notable. Du Bois did not assert that black people were biologically destined to certain abilities and circumstances, and to the contrary, he sought a social program that would use learning and the arts (i.e., culture) to transform the material circumstances of the race.

In addition to literary writers, like Charles W. Chesnutt, it was social scientists like Boas and Du Bois who were the first to convincingly argue that it was culture, and not biology, that accounted for human difference. By 1920, there were a number of eugenicists who began to seek a more nuanced approach to race that reduced the primacy of racial difference. Julian Huxley is a famous example of an individual who started from a racist eugenic outlook in the 1910s but became interested in the diversity of the black "species" in the 1930s, suggesting that there was much variability in the so-called black race as there was among humans at large. This insight led naturally to the conclusion that scientific definitions of a limited and uniform race were motivated by something other than direct observation.

The movement away from racism was aided by what today is known as the modern synthesis, the scientific movement that found support for Darwin's theory of evolution by an interdisciplinary study of human development. Drawing together strands of insight from embryology, endocrinology, Mendelian population genetics, and other fields, scientists were beginning to imagine the way in which Darwin was correct: All life comes from preexisting forms of life, and human beings are not all that different from each other. Whereas scientific racists had asserted that humans recapitulated all of evolution in their development, with people of color and women being left at an earlier stage and white men proceeding through additional stages that resulted in their supposedly superior physiology, after the great synthesis, it became clearer that human beings were made largely from the same material and that superficial differences, such as skin color or the ability to grow a beard, were induced by hormones and not connected to other individual traits.


W. E. B. Du Bois published a sociological study in 1899 that sought to determine that biological differences due to race were not the cause of higher incidences of crime and poverty among the black population.

Theodosius Dobzhansky, one of the population geneticists who was part of the modern synthesis, sought to explain why the 19th-century notion of a race as a distinct group with a clear biological boundary was incompatible with modern knowledge about genetic inheritance. The habit of the 19th century, Dobzhansky writes in 1941, is to think of a particular group as having an average of certain characteristics such as height or weight. However, this convenient fiction is unhelpful when it comes to understanding the mechanism of human variation. Just as Mendel had asserted in the earlier century, Dobzhansky reminds his readers that there is no such thing as a gradual diffusion of traits; it is not as if a child is the average of its mother and father's traits. Traits are not inherited in diffuse particles so that characteristics do not mingle like dye in water. If this were true, then certainly breeding groups would quickly form into uniform races. It is the case, however, that many individuals hold characteristics that are markers of a different race.

Taking this idea further, Dobzhansky reminds his readers that one group may be distinguished from another based on the presence of a particular trait. The task of forming those distinct groups into races, however, is complicated by a number of factors. One is that not all traits are acted upon by natural selection, meaning that an individual contains some traits that have given its group an advantage in an environment, yet there are others that are neutral with regard to natural selection. In this way, it is possible to find similar traits in organisms even over wide geographic areas. He concludes his investigation that the notion of a pure race "is not even a legitimate abstraction," and he goes on to state that the notion of a pure race "is a subterfuge used to cloak one's ignorance of the phenomenon or racial variation."

Insights from the evolutionary synthesis like Dobzhansky's lie behind the 1950 and 1951 United Nations Educational, Scientific and Cultural Organization (UNESCO) statements on race. In their effort, a group of scientists assert that the mental capacities of all humans are similar, there is no biological deterioration from hybridity, and there is no correlation between national or religious groups and race. This reversal of attitudes that were so prevalent in the 1920s is remarkable, but in 1950, there was a considerable support for the idea that reducing human cultural differences to a matter of biology was suspect. Indeed, the scientists asserted that all normal human beings can learn to share in modern life and respect social contracts, and those biological differences that do exist do not have any relevance to social and political organization, morality, or communication.

In the UNESCO statement, scientists asserted an early finding of the growing sentiment against the clear delineations of biological race: When considered as groups, human races did not vary from each other in any remarkable fashion. Each individual in a purported race shares many characteristics with its fellows, but at the same time, due to the independence of inherited characteristics, each individual does not have all of the markers one would consider to be part of the race. What is more, statistical analyses could be used to demonstrate that the degree of difference among the races as a whole was less than the variation among individuals within a purported race. In other words, the variability of the biology of individuals of the same races was higher than between their racial group and another. One of the early proponents of this principle was William C. Boyd, whose work on the nonuniform distribution of blood factors dispelled the notion that people of different races literally had different blood.

Elaborating the Social Definition of Race

The statement that there is no reliable biological definition of race and the failure of the project to limit the diversity of humanity into four or five distinct groups that were akin to species having been established at mid-century had the perhaps unexpected consequence of calling attention to racial disparities. If there is no reliable way to distinguish races by means of their biology, then why is it that there are racial distinctions in health, education, and economics? The removal of the biological underpinning of race thus called attention that there were social and historical, and not physiological, causes of racial differences. Indeed, given that there were no longer biological excuses, differences in achievement and ability among the races were soon seen as more insidious. Race was no longer a reliable concept, so paying attention to racism seemed increasingly important.

One of the first works to appear after the UNESCO statement that elaborated the social construction of race was Frantz Fanon's *Black Skin, White Masks* (published in 1952 as *Peau noire, masques blancs*). His biography of moving from Martinique to France to study medicine provided the groundwork for his study: How can a young person of color be expected to perform well in school when all of a culture's resources are marshaled to signal that blackness is bad and whiteness is good? It is not surprising, he suggests, that students who are quite serious in a black-only environment lose their sense of purpose in a mixed environment. In his 1967 *The Wretched of the Earth*, Fanon goes farther to explore how intrinsic notions of race are a necessary corollary of colonialism. In this way, the definitions of human races are shown to be constructions that solve certain social problems rather than neutral descriptions of scientific fact.

Following on this work, Michael Banton began a series of publications, beginning with his 1968 *Race Relations*, that sought to elaborate the contingent nature of definitions of race. In other ways, Banton's work shows how there are many different ways in which concepts of race are used to divide populations, and so the particular way in which a society chooses to make claims about race tells us about the expectations of the society as a whole. His cross-cultural approach served to illuminate the ways that definitions of race serve social purposes rather than being descriptive arguments about biological facts.

The evidence for the shifting sand in the history of the race concept was studied extensively by Martin Bernal in his three-volume *Black Athena*, published in 1987. This controversial work has inspired several follow-up volumes, but its central thesis is unavoidable: There was a time in antiquity that African societies were seen as the wellsprings of civilization, and classical Latin and ancient Greek authors alike made direct allusion to the esteem in which they held schools and philosophers from the continent. In spite of the many direct assertions of this fact among Greeks and Romans, there was an increasing pressure in the modern period to review this assertion. Certainly, the geographical system asserted by Linnaeus and his contemporaries would have difficulty with the notion that Africa was the source of human civilization, and Bernal demonstrates how new theories of how Greece gained prominence were developed that suggested invaders from the north—what would be asserted were the Aryans in Europe—were what caused Greece to develop civilization. At the same time, the importance of African and Asian civilizations were downplayed so much that, by the 19th century, their reputation had fallen. Bernal's study demonstrates clearly how ideas of race influence even the acceptance of information of the humanities and, in turn, how findings from the humanities were used to support notions of racial hierarchy.

The notion of racial identities being shaped by social imperatives drew significant attention in the 1990s. Noel Ignatiev's 1995 *How the Irish Became White* tells the story of how the once-despised immigrant group rose in the ranks of racial hierarchy. In 1996, Ian Haney Lopez's *White by Law* demonstrates how arguments about who qualified for protection under the nation's immigration and naturalization statutes shaped U.S. conceptions of racial difference. Matthew Frye Jacobson's 1999 *Whiteness of a Different Color* shows how the various strands of European stock at the end of the 19th century—strands that were thought of needing to be kept separate by the American eugenicists—came together at midcentury under the banner of Caucasian as a means to maintain political power.

With the decoding of the human genome, the project's head scientist Craig Venter asserted that race was proved to be an invalid concept. Nevertheless, in the genomic age, race seems to be returning as a biological concept. Ann Morning's research into depictions of essentialist and constructivist notions of race, published in her 2011 The Nature of Race, shows why it is important to detail the process of racialization. In the United States, some students and professors assert that science has overwhelmingly rejected a biological concept of race, and yet others believe that tidy categories of biological race have been largely retained. Her explanation for the resurgence of the essentialized notion of race is notable. Her argument is that it is a reaction to the seeming failure of social programs to make meaningful progress for racial differences. While one could conclude that the lack of progress in alleviating the racial disparities in health, income, and educational achievement is evidence of the strong cultural and structural supports of racism, this answer is unsavory given the many years of effort to change this view. It would seem, Morning suggests, that it is easier to disregard the notion of social constructivism and blame an individual's biology, which cannot be changed, rather than examine the political and economic structures that could be changed with difficulty.

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See Also: Racial and Ethnic Categories, U.S. Census; Racial Identity Development, Models of; Racial Microaggression; Racism, Long-Term Effects of; Racism, Self-Assessment of.

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Race and Clients

Race in the United States has traditionally been seen as an issue involving blacks and whites, but in the 21st century, Americans have been forced to realize that race is more complex than earlier generations realized. The Hispanic population increased to 50.5 million in the first decade of the century, 16.3 percent of the total U.S. population. Approximately 16.6 million Asian Americans and Pacific Islanders, representing over 30 countries, reside in the United States, about 5.4 percent of the population. Experts predict that number will reach 40 million by 2050. Although American Indians and Alaska Natives make up less than 2 percent of the total population, this group grew at almost triple the overall population increase between 2000 and 2010. Additionally, those who identify as more than one race grew dramatically during the same period. Those identifying as white and black or African American increased by 134 percent, and those identifying as both white and Asian increased by 87 percent in the same period.

All of these groups are represented in the client base of human services. Despite advances in civil rights and ethical guidelines of the human service professions that expressly forbid discrimination on the basis of race or ethnicity, personal, institutional, and systemic racism affects human services at all levels. Decades of research have shown that racial minorities in the United States are more likely than non-Hispanic whites to have limited access to employment, educational opportunities, and health services. The same groups are disproportionally represented among Supplemental Nutrition Assistance Program and Temporary Assistance to Needy Families clients and on the rolls of the incarcerated. Human service professionals have stressed "cultural competence" as a means of serving such a diverse population, but proponents add that cultural competence requires informed action as well as greater sensitivity.

Poverty, Race, and Human Sevices

According to the 2007–2011 American Community Survey, 14.3 percent of the U.S. population (42.7 million people) had incomes below the poverty level. American Indians and Alaska Natives had the highest poverty rates (27.0 percent), with the rate for African Americans only slightly lower (25.8 percent). Among Hispanics, national poverty rates ranged from a low of 16.2 percent for Cubans to a high of 26.3 percent for Dominicans. Native Hawai'ians and Other Pacific Islanders also had a high rate at 17.6 percent. Among the Asian population, rates were highest for Vietnamese (14.7 percent) and Koreans (15.0 percent). The rate for non-Hispanic whites was 11.6 percent. One of every three African American children and one of every four Latino children live in poverty—two times higher than the rate for white children.

Given the color of poverty in the United States, it seems only logical that minorities would account for the majority of clients served by human services. However, research reveals that residents of a predominately black or Hispanic neighborhood have access to roughly half as many social services as those in predominately white neighborhoods. Individuals in high-poverty neighborhoods are the least likely to have access to food pantries, child care, transportation, job training, substance abuse treatment, and other services, which are more likely to be located in low-poverty communities and is predominantly white areas. Ninety-three percent of poor families do not use all the resources available to them. Twenty-five percent of the working poor receive no benefits even though they are eligible for them. Only 7 percent of the working poor access all of the four major supports: tax credits, Medicaid, food stamps, and child care subsidies.

Regardless of such statistics, most Americans think of human services primarily as benefits for poor people who are not white. The very word *welfare* is racially charged in the United States. Although, according to the U.S. Department of Health and Human Services, in 2009 recipients of what is informally known as welfare were 31.2 percent white, 33.3 percent black, and 28.8 percent Hispanic, the popular image of those on welfare rolls is an African American mother with several children. This image prevailed in 1996 when Congress passed the Personal Responsibility and Work Opportunity Act, which changed the program that had been known as Aid to Families with Dependent Children to Temporary Assistance to Needy Families (TANF), with a five-year lifetime limit on cash benefits and a requirement that recipients be working or in a job-training program. States with denser populations of African Americans and Hispanics were more likely to impose lifetime limits, family caps on benefits, and stricter sanctions for noncompliance.

With the money allocated to states in block grants, each state decided which clients it would serve and to what degree. The number of people on welfare rolls immediately began to decline. In 1996, 4.4 million families received welfare; in 2008, only 1.6 million did. Eligibility standards and benefits ranged widely. In 2011, benefits ranged from a low of $170 a month for a single-parent family of three in Mississippi to a high of $753 for the same family living in New York. On the national level, TANF funding has been set at $16.6 billion since 1996, with no adjustment for inflation.

The Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, is another component of the national safety net for the poor that has inspired political debate with racial subtexts. The implication is that such assistance overwhelmingly goes to racial minorities, which in popular imagination includes undocumented immigrants, and that abuse of the program is rampant.

In reality, SNAP eligibility is limited to households with gross income of no more than 130 percent of the federal poverty guideline, and 83 percent of SNAP households have gross income at or below 100 percent of the poverty guideline ($19,530 for a family of three in 2013). A majority of families receiving SNAP have gross income at or below 75 percent of the poverty guideline ($14,648 for a family of three in 2013). Although SNAP recipients are no longer required to identify themselves by race, and 20 percent do not, among those who chose to indicate race in 2010, 34 percent were white, 22 percent were African American, 16 percent were Hispanic, 3 percent were Asian, and 4 percent were Native American.

The average SNAP household has a net monthly income of $338 after the standard deduction. Children, the elderly, and the disabled are the most frequent SNAP beneficiaries. Households that include one or more people from these groups make up 76 percent of SNAP households, and these households receive 83 percent of all SNAP benefits. Undocumented immigrants are not (and never have been) eligible for SNAP benefits, and documented immigrants, with few exceptions, are eligible only after five years of residency in the United States. Fraud has actually decreased since the 1990s, when the rate was about 4 percent to about one cent of each SNAP dollar between 2006 and 2008.

The Criminal Justice System and Racial Disparities

People of color make up approximately 30 percent of the U.S. population, but they account for 60 percent of those incarcerated in U.S. prisons. One in 15 African American men and one in 36 Hispanic men are incarcerated, compared to one in 106 non-Hispanic white men. The U.S. Department of Justice projects that if current trends continue, one out of every three black males born in 2010, as well as one out of every six Latino males, will go to prison at some point during his life.

Although women generally constitute a small percentage of the prison population, disparities exist in this group as well. African American women are three times more likely than white women to be jailed, and Hispanic women are 69 percent more likely than white women to receive a prison sentence. One of every 100 African American women who is 35 to 39 years old is in prison or jail, compared with one in 358 white women of the same age group.

Both males and females of color are more likely to be arrested on drug charges than are whites, although, according to Human Rights Watch, they are no more likely to use or sell illegal drugs. In nearly three decades of the War on Drugs, one in three of the 25.4 million adults arrested for drugs was African American. Disparities persist at every level of the system. The Department of Justice reports that African Americans and Hispanics were approximately three times more likely to be searched during a traffic stop than white motorists, and African Americans were twice as likely to be arrested and almost four times as likely to experience the use of force during encounters with the police.

The longer sentences meted out to racial minorities are reflected in the harsher punishments given to students of color for infractions of school rules. Such infractions often lead to incarceration as well. Black and Hispanic students represent more than 70 percent of those involved in school-related arrests or referrals to law enforcement. African Americans make up 40 percent and Hispanics 20 percent of youths who receive prison sentences. The Sentencing Project, a nonprofit organization that advocates for a fair and effective criminal justice system, reports that even though African Americans account for about 16 percent of the youthful offenders, 37 percent of their cases are moved to criminal court and 58 percent of African American youth are sent to adult prisons.

The collateral consequences of a felony conviction include bans on entering certain occupations, voting, serving on juries, and receiving federal college loans and grants. While these bans apply across racial lines, racial disparities exaggerate their effects. Eleven states deny the right to vote to more than 10 percent of their African American population on the ground of felony conviction. Race is a factor for those released from prison who apply for jobs. One study found that employers were not only twice as likely to hire a white applicant as an equally qualified black applicant for an entry-level position, but they were also just as likely to hire a white person recently released from prison as a black applicant with no criminal history. Following release from prison, former black inmates found their wages grew at a 21 percent slower rate than that of white ex-convicts. Some states have bans on people with certain convictions working in domestic health service industries such as nursing, child care, and home health care—areas in which women of color are disproportionately concentrated.

Racial Disparities in Health Services

Despite the medical advances and ever-evolving technologies that have led to an average life expectancy of 78.8 years in 2010, health disparities in access, quality of service, and outcomes persist among races in the United States. Such differences are connected to the social, economic, and environmental disadvantages of racial minorities, with a broad range of factors including poverty, employment, neighborhood violence, community disorganization, underperforming schools, trauma, racism, discrimination, social isolation, and acculturation stress playing a role. Consequently, individuals from racial minorities are more likely than the non-Hispanic white majority to die as infants, have higher rates of diseases and disabilities, and have shorter life spans. A 2009 report, "Economic Burden of Health Inequalities in the United States," commissioned by the Joint Center for Political and Economic Studies, placed the three-year costs of health inequalities and premature death in the United States at $1.24 trillion.

Infant mortality rates, generally considered to be sensitive indicators of a group's health status, reveal the disparities that characterize the health system. African Americans have 2.3 times the infant mortality rate of non-Hispanic whites. They are almost four times as likely to die as infants due to complications related to low birth weight than are non-Hispanic white infants. American Indian/Alaska Natives have 1.6 times the infant mortality rate of non-Hispanic whites, and American Indian/Alaska Native babies are 2.2 times as likely as non-Hispanic white babies to die from sudden infant death syndrome (SIDS).

Among Hispanic Americans, the infant mortality rate ranges from 4.5 per 1,000 live births for Central and South Americans to 7.2 per 1,000 live births for Puerto Ricans. Puerto Rican Americans have a 40 percent higher infant mortality rate than non-Hispanic whites. Although the infant mortality rate among Asian/Pacific Islanders is lower than for other racial minorities, the rate is twice as great for mothers under 20 years old as for those 25 to 29 years old. SIDS is a leading cause of infant mortality in this group. Most racial-minority mothers are also more likely than non-Hispanic white mothers to begin prenatal care in the third trimester or not receive prenatal care at all.

Similar disparities are evident in diseases that affect the quality of life and longevity. The rate of diabetes among African Americans is more than three times that of non-Hispanic whites, and the rate for the same disease among Native Americans is more than twice that of whites. The Pima tribe of Arizona has one of the highest rates of diabetes in the world. The incidence of end-stage renal disease, a known complication of diabetes, is higher among American Indians and Alaska Natives than for both whites and African Americans.

Hispanics are twice as likely as non-Hispanic whites to die from diabetes. African Americans suffer from heart disease at a rate 40 percent higher than that of whites, and the rate for prostate cancer is more than double that of whites. Although American Indians and Alaska Natives are less likely to die from cancer and heart disease, they are five times more likely to die of alcohol-related causes than are whites. Hispanics exceed whites in rates of high blood pressure and obesity. Asian Americans and Pacific Islanders have lower death rates attributable to cancer and heart disease than other minority groups, but Native Hawai‘ian men have higher rates of lung cancer than white men do, and the incidence of cervical cancer among Vietnamese women in the United States is more than five times greater than that among white women.

According to some sources, mental disorders in the United States rank second only to cardiovascular disease in their impact on disability. Minorities are overrepresented among the high-need groups, such as the homeless and incarcerated persons, and these subpopulations typically have higher rates of mental disorders than do people living in the community. Yet, disparities in mental health services are as great as the inequities in physical health care. Racial minorities have less access to mental health services than do non-Hispanic whites. When minorities receive care, it is more likely to be poor in quality. Cost of care, societal stigma, and the fragmented organization of services contribute to the poor quality of mental health care, and limited English proficiency creates an additional barrier for some.

The greatest barrier to health care service generally is the lack of health insurance. Multiple studies over many years have shown that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases. The uninsured are at higher risk for preventable hospitalizations and missed diagnoses of serious health conditions; even after diagnoses of chronic conditions, they are less likely to receive needed care. Not surprisingly, research also suggests a link between the lack of insurance and the presence of depression and debilitating stress.

Racial minorities are significantly less likely than the rest of the population to have health insurance. Individuals living below the poverty line account for 38 percent of all the uninsured, and significant numbers of racial minorities fall in this group. Regionally, individuals in the south and west, areas with large racial minority populations, are more likely to be uninsured. In 2010, three in 10 individuals of Hispanic origin (30.7 percent) were uninsured; by 2011, the number had risen to 40 percent. African Americans were also more likely to be uninsured, with 20.8 percent lacking insurance, and 18.1 percent of Asians were uninsured, compared to 11.7 percent of non-Hispanic whites. The lack of insurance is directly related to unemployment and poverty, and both factors affect racial minorities disproportionately. Although the Affordable Care Act possesses the potential to expand coverage of uninsured people through the expansion of Medicaid eligibility, 24 states have chosen not to accept federal funds for the expansion. Researchers have pointed out that the approximately 8 million uninsured individuals in those 24 states will include women who will not be screened for breast and cervical cancer, diabetics who will go without medication, and people with other diseases that will go undiagnosed and untreated leading to a predicted 7,000 to 17,000 additional deaths. In such conditions, health disparities along racial lines will continue.

Cultural Competence

Cultural competence is a strategy implemented by human service workers to address the racial disparities in the various fields of human services. Sociocultural barriers exist at the organizational, structural, and clinical levels. Training in cultural competence ideally results in human service workers who are knowledgeable about the clients they serve, self-reflective to a degree that enables them to recognize their own biases and the biases within their particular organizations, and skillful in integrating their cultural knowledge and self-awareness with cultural sensitivity and cultural action.

The health professions were among the first to support training in cultural competence because they realized that cultural misunderstandings could have serious, even fatal, consequences. In 2007, New Jersey became the first state to require physicians who practice there to complete cultural competency training. Five other states adopted similar provisions.

Training in cultural competence has also proved invaluable for social workers involved in international or cross-racial adoptions. Culturally competent social workers can assist adoptive parents in understanding their child's cultural heritage and ease the child's transition to a new environment. A culturally competent worker will also understand that Western approaches may violate practices and customs of non-Western cultures with values that are antithetical to the individualistic, analytical method. Cultural competence on an organizational level may also include minority recruitment, interpreter services, and language-appropriate materials.

However, knowing facts about a client's race or ethnicity, social class, religion, acculturation, and other relevant information is inadequate to address racial disparities in human services unless the knowledge is accompanied by the ability to recognize problems or issues of concern that clients face, the understanding of possible consequences of the problems and empathetic responses, and actions that produce an effective outcome for the clients.

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See Also: Bias in Service Delivery; Cultural Competence, Training in; Health Care, Disparities in; Health Insurance.

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Racial and Ethnic Approaches to Community Health

The population in the United States is becoming increasingly diverse along several dimensions, including racial, ethnic, and other forms of diversity (e.g., religious, sexual orientation, or political). With increasing diversity comes a need to address a wider range of health issues that may be linked to distinct populations. This entry is organized to provide the reader with an overview of (1) racial and ethnically based health issues and inequities, (2) social determinants of health among racial and ethnic groups, and (3) strategies to enhance health promotion efforts among racial and ethnic-majority communities.

Extent of Racial and Ethnic Health Inequities

There are large racial and ethnic inequities in health in the United States. This includes health outcomes, access to health care, and systemic factors (e.g., environmental health), all of which impact one's overall health. All this contributes to disparities, and in the United States, minorities typically shoulder the greater burden of adverse health outcomes. Data from the Centers for Disease Control (CDC) indicates that, while the incidence of breast cancer among white women is higher than non-Hispanic black women, the latter's survival rate is significantly lower; 86 percent of white women survive versus 71 percent of non-Hispanic black women. Cervical cancer among Vietnamese American women is five times higher than white women. Prevalence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) prevalence among Hispanics and Latinos is about 585 cases per 100,000 people compared to 224 among whites.

Whites in the United States are not immune from negative outcomes of health issues. According to statistics from the Substance Abuse and Mental Health Services Administration, nearly 20 percent of whites in the United States have used cocaine, compared to approximately 10 percent of non-Hispanic blacks and Hispanics. A CDC-supported study shows that 32 percent of non-Hispanic black and 24 percent of Asian youth (ages 12–17) admit to using illicit substances, compared to 39 percent of white youth. White males from Appalachia and Mississippi Valley areas have lower life expectancies (71.8 years), compared to Asians males (82.8) overall. In all of these examples, whites have adverse health outcomes at a higher rate than minority groups to which they are compared. Clearly, health inequities are not limited to being a minority health issue.

These health inequities appear to be segmented along racial or ethnic bases. However, the situation is much more complicated. Guided by a socio-ecological framework, community health promotion specialists understand that social and behavioral determinants play important roles in how people achieve and maintain health. Communities are one level of the socio-ecological framework and present a unique opportunity to conduct health promotion interventions that will have wide impact on diverse populations. While health inequities impact a wide range of diverse populations, we will focus on community health issues specific to select racial and ethnic groups, as other entries of this volume address human services issues related to other diverse groups.

Race, Ethnicity, Culture, and Other Social Determinants of Health

In order to have a coherent understanding of the complex relationships among race, ethnicity, and health, clear definitions of these terms, as used in health promotion, need to be established. Race is generally defined as a way to group people by ancestry and visible phenotype and as a simple but inaccurate way of determining genotype. It is determined by how a person appears but is often incorrect or unclear. Ethnicity, also unclearly defined, is generally considered a connection among people via shared history or origin. This may include ancestral origins. Culture is defined by the Office of Minority Health (U.S. Department of Health and Human Services) as "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups." It is transmitted socially, meaning that it is shared with people by other members of the culture. Culture influences one's dress, language, foods, customs and traditions, and other behaviors. It is also considered a better way to understand and explain health disparities among minority and ethnic groups compared to race and ethnicity.

In the practice of community health promotion, race and ethnicity are often used as proxy indicators for culture. For example, community health assessment efforts may yield statistics that indicate non-Hispanic blacks residing in inner cities relative to nonblacks residing in urban areas suffer disproportionately from a variety of adverse health conditions. It may appear to be reasonable to identify race as a risk factor. A more accurate explanation could be culture—that is, customs—and income. For example, non-Hispanic blacks in urban areas are more likely to be poor and consequentially have a lifestyle (i.e., culture) that reflects their reality: nutrient-poor diets, substance use to deal with stress, and low levels of physical activity due to dangerous outdoor conditions.

These social and behavioral factors contribute to poor health outcomes for this group. Due to gentrification of inner cities, whites who live in urban areas are likely to be from higher-income backgrounds—in other words, a different culture—and have access to food, gym memberships, and other resources that make positive contributions to health. Geographically, the groups are similar, but culturally, they are worlds apart. In this case, race is readily identifiable and therefore used as a shortcut to determine a population's culture and lifestyle.

Community-Based Participatory Approaches

Health promotion efforts based in racial and ethnic minority communities face several challenges. Historically based distrust of health professionals is one barrier, which leads to difficulties with access to those communities with the critical needs. Sustainability is another challenge, particularly for communities viewed as being low in assets and resources. In such cases, progress is made while program funding is available. Yet maintenance of positive changes becomes problematic when external financial resources are no longer available. These challenges need to be addressed for community health interventions to take hold and be maintained.

Community-based participatory research (CBPR) approaches—also known as participatory action research (PAR)—are designed to involve community members with program and research specialists in a team in which all members are considered equal partners. The aim of CBPR is not research. Rather, the aim is to achieve social justice, which would be reflected by improved community health outcomes, which occurs under the power and direction of community members. Indeed, partnerships between health promotion researchers–practitioners and community members should be formed before a community health issue is identified.

Irrespective of the community health issue being targeted, CBPR or PAR is effective because the outcomes include empowerment of the community members so that they may carry on and take care of problems themselves. In other words, this approach advocates for self-determination. Among the best examples of the success of this type of approach can be seen abroad, such as work in Australia with Aboriginal populations. Barbara Israel provides a clear yet succinct summary of the principles of CBPS.

A key to successful community health programs using CBPR or PAR approaches is to have a mutually respectful and trustful relationship with the community before a health problem is identified. Therefore, it requires establishing a presence in target communities, meeting with key stakeholders, and investing time and resources as a show of good faith. Seeking community partners after a funding or program opportunity has been identified is counter to key CBPR or PAR principles.

Once relationships have been established, then communities (or their representatives) work with members of health organizations to identify and prioritize community health issues of concern. Note that a major benefit of utilizing this approach is that, in this phase, assets and strengths are also identified. No community is absolutely bereft of assets and strengths. They may be difficult to identify from an outsider's perspective, but including community members fully as part of the CBPR or PAR approach will yield information in nontraditional ways.

Program Design, Recruitment and Execution

Like all the other steps, designing and executing any health promotion program will require guidance from the community. Without community buy-in and endorsement, programs will encounter difficulty with protocols being accepted by community members. Similarly, CBPR or PAR approaches will enhance recruitment and improve retention efforts because of the investment by community members. Utilization of CBPR or PAR approaches in developing interventions will improve the cultural sensitivity and relevance of the program. This is important regardless of the efficacy of a particular strategy. If a community refuses to participate, the effectiveness of a given health promotion program will be zero.

Data Analysis, Interpretation, and Dissemination of Results

Consistent with every other step of this process, community members continue to be an integral member of the team and fully participate in the data analysis, interpretation, and dissemination process. Their contributions will be especially important in contextualizing the findings, by bringing a perspective that reflects the relevant culture and beliefs. Health promotion specialists risk misinterpreting statistics (or other results) without information regarding contexts. Among health promotion researchers, dissemination of findings typically occurs via academic venues (e.g., conference presentations or peer-reviewed journals). Similarly, community health practitioners share program results with stakeholders via various venues such as professional development seminars. However, CBPR or PAR approaches require that community members be fully integrated into this process. One example is inclusion as coauthors and presenters at venues where laypeople may typically not be representatives.

Including community members in dissemination activities at all levels sends a powerful message: Their contribution is important enough to recognize at the venues deemed most valuable to our professions (research and practice). It sends a mixed message when they are included as coauthors in an article submitted to a local magazine but excluded as a contributor for a peer-reviewed manuscript.

Summary

Community health promotion must occur from the inside out. That is, ideas, efforts, and accountability must arise from the communities themselves if there is any hope of positive effects and sustainability. Regardless of how many challenges a community may face (e.g., poverty, crime), there will be assets and strengths. These need to be identified, capitalized upon, and utilized to effect change and to further inspire the community's own people. Therefore, one must remember that people are not deficient. Instead, social systems may be deficient and consequently result in unequal access and opportunities. Nevertheless, CBPR or PAR approaches include strategies that reveal and make most of the inherent positives all communities have.

Finally, CBPR or PAR approaches are ideal for minority and other disenfranchised populations because of the egalitarian nature of the process. It ensures that programs are appropriate for the racial and ethnic contexts in which they need to function. A CBPR or PAR approach is designed so that, regardless of the community, culture, racial, or ethnic representation, health promotion programs will be tailored to fit.

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See Also: Community-Based Participatory Research; Empowerment Research; Social and Economic Justice.

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Racial and Ethnic Categories, U.S. Census

The U.S. Census Bureau provides data about the nation's people and economy through a decennial census. The U.S. Census counts every resident in the United States, helps to determine the number of seats each state will have in the U.S. House of Representatives, and is used to define how federal funds will be allocated across the country. All levels of government require information on Hispanic origin and race to implement and evaluate programs or enforce laws such as the Civil Rights Act, Voting Rights Act, Fair Housing Act, and the Equal Employment Opportunity Act.

Every 10 years, households of the United States receive a census form through the U.S. mail, that requests information about those who reside within the household. On the census form, questions are asked: How many people were living in the household? What is the name of each person living in the household? What is the age of each person living in the household? And, what is each person's Hispanic origin and race? An individual's responses to the race and Hispanic origin (ethnicity) question were based upon self-identification. However, some individuals may have experienced difficulty in answering the questions.

Ethnicity and Race Questions Defined

The Hispanic origin and race question was revised for the 2010 U.S. Census. The U.S. Census Bureau collected Hispanic origin and race information following the guidance of the U.S. Office of Management and Budget's (OMB) 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity.* The OMB serves the United States president through the executive branch and, in response to criticisms; the OMB undertook a comprehensive review of the current categories for data on race and ethnicity. Both public and private organizations use Hispanic origin and race information to determine areas where groups may need special services and to plan and implement education, housing, health, and other programs that address these needs. Accurate data of racial and ethnic categories collected by the U.S. Census is critical in the distribution of federal funds to groups that need funding the most.

These federal standards mandate that race and Hispanic origin (ethnicity) are separate and distinct concepts and advised that two different questions must be used. For the 2010 census, a new instruction was added immediately preceding the questions on Hispanic origin and race, which was not used in the 2000 census. The instruction stated that Hispanic origins are not races because, in the federal statistical system, Hispanic origin is considered to be a separate concept from race. However, the new standards were to be used by the Bureau of the Census in the 2000 decennial census. The U.S. Census Bureau reports that it followed the guidelines of the OMB in creating the race and ethnicity questions on the 2010 census, which is used to determine the distribution of federal funding. The OMB requires federal agencies to use a minimum of two ethnicities: Hispanic or Latino and not Hispanic or Latino. It states that Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States.

The Hispanic origin question included five separate response categories and one area where respondents could write in a specific Hispanic origin group. After answering the Hispanic origin question, the respondents would answer the race question next. The OMB required federal agencies to use a minimum of five race categories: (1) white, (2) black or African American, (3) American Indian or Alaska Native, (4) Asian, and (5) Native Hawai'ian or other Pacific Islander. For respondents unable to identify with any of these five race categories, OMB approved the Census Bureau's inclusion of a sixth category: some other race. Those who identified their origin as Hispanic, Latino, or Spanish could have reported to be any race. The U.S. Census defined the race categories as follows: White refers to a person having origins in any of the original peoples of Europe, the Middle East, or north Africa. It includes those who identify as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian. Black or African American refers to a person having origins in any of the black racial groups of Africa. It includes people who indicated their race as black, African American, or Negro as well as those who identified as Kenyan, Nigerian, or Haitian. American Indian or Alaska Native refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation. This category includes people who classified their race as American Indian or Alaska Native or reported their principal tribe, such as Navajo, Blackfeet, Inupiat, Yup'ik, or Central American Indian groups or South American Indian groups.

According to the U.S. Census Bureau, Asian refers to a person having origins in any of the original peoples of the Far East, southeast Asia, or the Indian subcontinent, including, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes people who indicated their race as Asian, Asian Indian, Chinese, Filipino, Korean, Japanese, Vietnamese, and Other Asian. Native Hawai'ian or other Pacific Islander refers to a person having origins in any of the original peoples of Hawai'i, Guam, Samoa, or other Pacific Islands. It includes people who indicated their race as Pacific Islander or Native Hawai'ian, Guamanian or Chamorro, Samoan, and Other Pacific Islander. Some other race includes all other responses not included in the race categories described above. Respondents who identified as multiracial, mixed, interracial, or a Hispanic or Latino group in response to the race question are included in this category.

Responses to the Ethnicity and Race Categories on the 2010 Census

In 2000, Hispanics made up 13 percent of the U.S. population. In 2010, they made up 16 percent of the U.S. population but accounted for half of the population increase over the 10-year period. The U.S. Census revealed that more than half of the Hispanic population identified as white and no other race, while about one-third provided responses that were classified as some other race alone when responding to the question on race. The racial distribution of the non-Hispanic population was mostly white alone (76 percent), black alone (15 percent), and Asian alone (6 percent). Less than 1 percent of non-Hispanics provided responses to the race question that were classified as some other race alone (0.2 percent). In the 2010 census, 97 percent of all respondents reported only one race. The non-Hispanic population grew slowly over the decade, and the number of people who reported their race as white alone grew even slower (1 percent). The responses of the 2010 U.S. Census revealed that the largest group reported white alone (72 percent of all people living in the United States). The black or African American alone population represented 13 percent of the total population. There were 0.9 percent of respondents who indicated American Indian and Alaska Native alone. Approximately 5 percent of all respondents identified their race as Asian alone. The smallest major race group was Native Hawai'ian and other Pacific Islander alone and represented 0.2 percent of the total population. The remainder of respondents who reported only one race (6 percent of all respondents) classified as some other race alone.

Summary

The current standards in OMB's Statistical Policy Directive No. 15 were developed to provide consistent data on race and ethnicity throughout the federal government. The revised standards required five minimum categories for data on race: American Indian or Alaska Native, Asian, black or African American, Native Hawai'ian or other Pacific Islander, white, or some other race. There were to be two categories for data on ethnicity: Hispanic or Latino and not Hispanic or Latino. Those who identified as Hispanic were required to choose one of the racial groups listed above, and most identified as white and no other race.

The OMB reports the racial and ethnic categories of the standards should not be interpreted as being primarily biological or genetic in reference. It adds that race and ethnicity may be thought of in terms of social and cultural characteristics as well as ancestry, but the categories represent a social–political construct designed for collecting data on race and ethnicity and are not anthropologically or scientifically based. However, it also states the concepts and terminology should reflect clear and generally understood definitions that can achieve broad public acceptance and should be developed using appropriate scientific methodologies, including the social sciences.

The results of the census are important in that they are used to allocate federal funding for important programs such as the Civil Rights Act, Voting Rights Act, Fair Housing Act, and the Equal Employment Opportunity Act. One program that could be impacted by the results of the census is the Health and Human Services Office of Minority Health (OMH). The OMH reports its mission is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate disparities. The OMH suggests it builds upon current science and expert consensus about racial and ethnic minority health disparities and systems problems and provides a rationale for efforts funded. The report of ethnic categories from the census could have a direct impact on the funding of health programs, which are designed to improve the health of racial and ethnic minority groups.

Some programs are crucial in supporting marginalized groups, as funding is based on the number of individuals who represent those groups. In addition to impacting health programs, the census data are used to make decisions about what community services to provide and affects how funding is allocated to neighborhood improvement, public health, and education. Failure to accurately complete the 2010 U.S. Census could result in funding that is not distributed to programs equitably.

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See Also: Ethnicity, Definitions of; Race, Social Definition of; United States, Demographics of.

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Racial Identity Development, Models of

Race can be studied from a psychological perspective. For decades, researchers and psychologists, primarily within the United States, have conceptualized, analyzed, interpreted, and produced models of racial identity development. Models of racial identity development offer insight into race-related behaviors, perceptions, attitudes, and emotions.

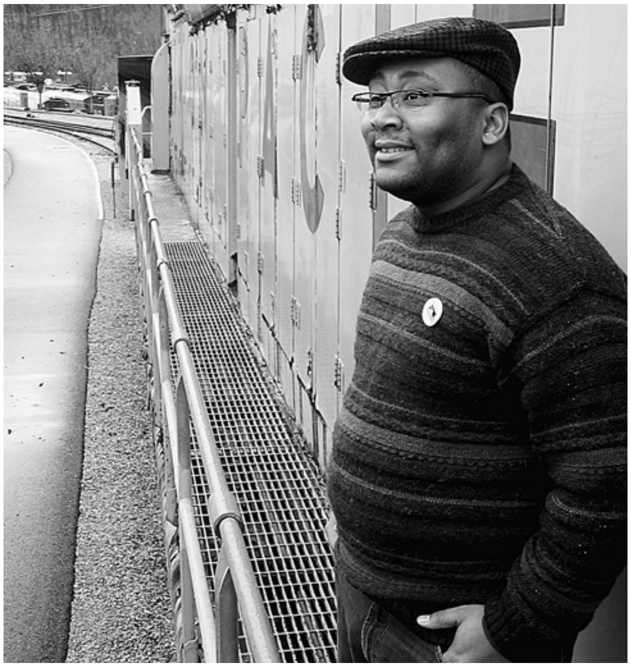
Definitions of Racial Identity

Scholars and researchers are inconsistent in defining race, thus the concept of racial identity is often misunderstood. Some meanings of race are derived from presumed biological dimensions, whereas other meanings are derived from social dimensions. As a biological category, race concerns one's physical features (e.g., skin color) and genetic background, while race as a social construction has to do with one's belief that one has a shared heritage with a specific racial group. Racial identity is both an individual and a collective construction. In societies (such as the United States) where racial group membership is emphasized, it is assumed that members of all racial groups will go through a racial identity development process.

Racial Identity Development

Racial identity development is assumed to differ between racial groups because racial identity development processes occur within a social context, and they are based on how groups are racially classified and socialized. It is a result of differential socialization (based on dominate/subordinate relationships) and differential responses to that socialization. Socialization in the context of racial identity development refers to the acquisition of values, beliefs, attitudes, and behaviors of racial groups. For example, in the United States, individuals who identify with the dominant culture have been socialized in an environment that sends the message that their race is normal or superior to that of nondominant cultures. On the other hand, individuals who do not identify with or are not connected to the dominant culture will likely hold worldviews linked to historical and experiential racial oppression.

A model of racial identity development typically used to describe the African American experience in the United States is William Cross's model of black identity development. According to the Cross model, there are five stages of black racial identity development: pre-encounter, encounter, immersion/emersion, internalization, and internalization-commitment. In the first stage, pre-encounter, black individuals perceive race as unimportant and would prefer to be accepted as "human beings." They tend to accept and adopt the dominant culture's values and beliefs without question. Those in the second stage, encounter, have had a profound event or series of experiences directly linked to their race. Realizing that they are not perceived as equal to white people or those of the dominant culture, they are forced to reexamine their current identity and find or further develop their black identity. The third stage,



A model of racial identity development typically used to describe the African American experience in the United States is William Cross's Model of Black Identity Development.

immersion/emersion, is described as being problack and antiwhite. Externally, individuals immerse themselves in black culture by surrounding themselves with visual symbols of their racial identity; yet internally, they have not made a commitment to support all values and traditions associated with black culture. The fourth stage, internalization, is characterized as individuals having a sense of satisfaction and a feeling of security with being black. The final stage, internalization-commitment, represents those who are comfortable with their race as well as the races of others around them. They are willing to translate their internalized identities into a plan of action that benefits other oppressed groups.

Janet Helms created one of the first and most widely accepted models of white racial identity development. Her model presupposes that all individuals who identify as white begin with racist perspectives. Further, she proposed two phases by which white individuals move from a racist perspective toward a nonracist white identity; they are "abandonment of racism" and "defining a nonracist white identity." Moreover, the Helms model describes six statuses of white racial identity development. The first three statuses, contact, disintegration, and reintegration, outline how a white person abandons a racist identity before moving to the next three statuses, pseudo-independence, immersion/emersion, and autonomy, where he or she discovers a nonracist white identity.

Individuals in the contact status lack an understanding of racism and have had few experiences with people of a different race. During the disintegration status, white individuals begin to have an increased awareness of white privilege and the reality of racism. They start to question inequality and they may experience dissonance. The dissonance associated with this status can lead some white individuals to deny racism and white privilege and avoid future contact with people of a different race. The reintegration status is characterized as a regression when a white individual returns to his or her previously held prejudices, negative stereotypes, and racist beliefs. A person is likely to move into the pseudo-independence status because of a painful or an insightful event or experience that jolts the individual from the reintegration status. This status is marked by a white person's attempt to abandon racism. At the immersion/emersion status, a white individual has a greater understanding of him or herself as a racial being. There is a readiness to challenge one's biases. The individual may question to what extent he or she can be proud of being white without being racist. The autonomy status is characterized as an internalization of a positive white identity. At this status, race is not perceived to be a threat because the white individual begins to make the connections between racism and inequality.

These models of black and white racial identity development present monoracial comparisons between two different racial groups. Whether black or white, racial identity development models or any other model such as Asian American, Latino, American Indian, multiracial, biracial, or multidimensional, there are common themes among all models.

Common Themes Among Models of Racial Identity Development

All models of racial identity development focus on the psychosocial process of defining one's racial identity with regard to the dominant race or culture. Each provides the basis for stages of development in which there is a nonrecognition of the individual's racial identity, a self-examination in which the individual struggles with his or her racial identity with regard to the dominant race or culture, and then a resolution of the conflict where an individual arrives at a better understanding, appreciation, and/or acceptance of his or her race. Models of racial identity development tend to be organized around stages or statuses. The specific content or themes of the stages or statuses, however, are assumed to differ between racial groups because of socially ascribed power dynamics among racial groups. The stages or statuses range from the least developmentally sophisticated to the most developmentally advanced.

There are variations in the processes in different models; however, most tend to follow a general linear or step-wise progression in which one developmental stage needs to be resolved before another can be achieved. Contemporary models recognize that stages or statuses are not fixed; they fluctuate. Individuals move back and forth from stage to stage or status to status, but when they return to a former stage or status, that stage or status will seem different because of new events and experiences.

Models of racial identity development support the notion that individuals will not become receptive to different racial groups unless they develop a positive sense of self, including an understanding and appreciation of their racial group. Achieving higher statuses or stages along the continuum of racial identity development could lead to better acceptance of racial differences, reduced racist behavior, and a greater appreciation for diversity, all of which would contribute to a more humane and socially just world.

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See Also: Race, Social Definitions of; Racism, Long-Term Effects of; Racism, Self-Assessment of.

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Racial Microaggression

Racial microaggressions are daily hostile, derogatory, and negative insults that can be covert or overt and encompass behavioral and verbal slights against a person or racial group. The literature first identified African Americans as a race that is often associated with microaggressions; however, these behavioral and verbal slights can be directed at any racial group. Racial microaggressions are often used as a form of racism and to perpetuate racist views about a specific racial group. Microaggressions reflect the conscious and unconscious worldview that is racist in nature, first used to oppress African Americans.

The understanding of racial microaggressions as racism is important because much of the overt displays of racism have become more unacceptable, thus more covert forms of racism, such as racial microaggressions, have become more common. Racial microaggression is linked to racism in environments and situations that limit opportunities and access to people of color. Racism is the false belief that a person is inferior based on the color of his or her skin, specifically, the darker the skin color, the more inferior. Microaggressions are deliberate and explicit in nature, and the person issuing the aggression is conscious of the impact.

Psychological Impact

Microaggressions serve to perpetuate the belief that people of color are somehow intellectually inferior and hold some inferior status than the dominate culture and that each person of color making up each racial group is monolithic rather than accounting for the wide diversity that occurs within groups. The intent of the microaggressor is to oppress and discriminate against people of color, hence there is a deep psychological impact associated with microaggressions. The psychological harm caused by microaggressions calls into question the integrity and cultural identity of the person of color, while causing increased psychological distress. Because racial microaggressions are daily and can have multiple microaggressors, the psychological distress is constant and is often linked to increased exhaustion, low self-esteem, anxiety, and increased levels of depression in people of color. Experiencing racial microaggressions can foster feelings of not belonging and feeling isolated in people of color.

The psychological consequences and feelings of those experiencing racial microaggressions in their everyday lives encompass a sense of invisibility, powerlessness, and personal sacrifice of culture in order to better conform to United States and dominate culture beliefs and values. Another psychological consequence often expressed by people of color is the feeling of being forced to be responsible for representing the entire racial group. The increased interest in the psychological impact of racial microaggressions on various populations has opened the study of the topic in the field of mental health care.

Professional Training

Historically, there has been a mistrust of the mental health professionals and the medical field due to long-standing racism in the health care field in regards to studying and providing care to people of color. Racial microaggressions have been studied extensively in all fields of human service, often being discussed regarding the relationship between the health professional and those they are helping. The impact of microaggressions on the helping relationship has been linked to fostering a weaker alliance between the helping professional and the patient. Racial microaggressions have also been linked as a predictor of health outcomes for the patient. Additionally, helping professionals that are unaware of their use of microaggressions were linked to demonstrating less awareness of how culture and environment impacted their patients.

People of color are linked to receiving less-sufficient health services and are often less willing to seek mental health care because of high occurrences of mental misdiagnosis, suspicion of health care providers, and feelings of being pathologized by health care providers. In an effort to better train and limit racial microaggressions in the health professions, training programs are paying more attention to the impact of historically promoting only Eurocentric training. More programs are training students to look beyond conforming patient issues and behaviors into the dominant U.S. culture and behavioral changes that are only congruent with the values of American culture. Health care training programs have recently pushed for the inclusion of courses and workshops that specifically discuss moving away from a Eurocentric worldview when accessing people of color for health services and incorporating a multicultural worldview that accounts for the patient's culture and experience as a person of color.

Organizational Impact

Racial microaggressions reflect an invisible worldview that white culture holds supremacy over all other cultures. This viewpoint permeates and is manifested in individuals, institutions, and organizations that all people participate in and in the U.S. culture as a whole. Because microaggressions are embedded in U.S. culture, it serves as a barrier to equality in education, employment, and health care. Racial microaggressions serve to perpetuate injustice for people of color in all aspects of life, thus people of color's access and opportunity to human services is also impacted. The impact on people has been studied as well as long-term consequences at the institutional and organizational level; continued investigation of the impact on professional training and individual psychological impact is needed in mental health care.

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See Also: African Americans; Bias in Service Delivery; Conflict Resolution and Diversity; Conflict Resolution and Diversity Cultural Competence; Cultural Competence, Model of; Culturally Diverse Practice, Definitions of.

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Racism, Long-Term Effects of

Early scholars disseminated research about the long-term effects of racism in historical documents that attempted to explain within-group behaviors among culturally marginalized groups. These works noted the disparities in housing, employment, education, crime, and health. Unfortunately, much of this work was deficit oriented in that it blamed marginalized communities for the outcomes of systemic racism rather than focusing on the contextual factors that created these outcomes. Today, scholars focus on the disparities as an outcome rather than a causal element in the disproportionate effects of racism. Much of this work utilizes the term *traumatic stress* to identify the key outcomes of historical bias and racism and place a greater emphasis on environmental factors and the resulting psychological outcomes, including depression, low self-esteem, and interpersonal problems. Effective human service, personnel are encouraged to enhance their cultural competence.

Traumatic Stress

Scholars have focused on the topic of traumatic stress to highlight the emotional and psychological outcomes of systemic or institutionalized oppression. Systemic oppression refers to structural biases embedded in society that create economic, educational, and health disparities for specific segments of the population. These disparities are often historical in nature and have roots in sociopolitical issues. Thus, marginalized communities can experience multilayered effects of racism in which current acts of oppression can trigger prior experiences with racism. Emotional and psychological outcomes have included depression, hypertension, and anxiety. Secondary effects, such as substance abuse, community violence, familial conflicts, and persistent academic underachievement, have also been cited.

Examples of racism-related traumatic stress can be found in the United States and globally. For example, Native Americans and other indigenous peoples have been historically vulnerable to social and political oppression. Refugees such as southeast Asians, Haitians, Rwandans, South Africans, eastern Europeans, and others who have been forced to flee their homelands due to political oppression have also shown symptoms of traumatic stress. It is also important to remember that children can be affected by traumatic stress and are often overlooked as potential victims of trauma. Racial marginalization may cause their peers to treat them differently or view them as inferior.

Traumatic stress is often contextualized through the lens of structural racism and the subsequent social positioning of groups of individuals in society. Racism can be categorized as individual, cultural, or structural. Individual racism relates to interpersonal interactions in which mainstream individuals enact their internalized privilege when interacting with members of marginalized groups. Cultural racism refers to the socially embedded values and worldviews that are widely held as normative within society and place other value systems and realities as aberrant or nonexistent. Structural racism is evident through systemic unequal distributions and outcomes in society such as in education, employment, housing, health care, and politics. As a result, racially marginalized individuals are left with the message that one's race or culture is inferior to that of the mainstream.

Historically marginalized groups in the United States include African Americans, Latinos, Native Americans, and Asian Americans, among others. Historically, racism in the United States has been based upon physical characteristics creating a race-based social system whereby nonwhite individuals were treated and viewed differently with little or no path to become a mainstream group member. Further, macrosystematic efforts were made to destroy vestiges of nonmainstream cultures, including forms of language, traditions, and customs.

Structural Racism

Today, the outcomes of structural racism can be seen in the persistent underachievement of African American, Latino, southeast Asian, and Native American students. These students, often tracked in low-achievement academic programs, also experience disproportionality in special education placement (e.g., behavior disorder, mild retardation, learning disabled, or attention deficit disorder) and disciplinary action such as expulsion and suspensions. Social-justice-oriented educators have asserted that it is important to differentiate between symptoms of racism-related traumatic stress and actual lower cognitive functioning. Another area in which racism related to stress is evident is in the criminal justice system wherein African Americans and other racially marginalized individuals experience disproportionate convictions compared to their white counterparts. As a result, marginalized group members experience secondary effects of racism that influence their ability to secure jobs, attend postsecondary institutions, and earn livable wages.

Over time, macro- and microaggressive encounters with discrimination and marginalization can cause psychological distress for individuals who are members of racially marginalized groups. Microaggressions or traumatic stress events are often described as experiences that individuals perceive as negative, sudden, and uncontrollable. These events, due to discrimination and racism, are often pervasive and can disrupt individuals' functioning. Responses to traumatic events can depend on several factors such as the severity of the stressful event, the developmental level of the individual, prior history of trauma, intergenerational trauma, or other personal, lived experiences. In addition, interacting factors, like gender, social class, or sexual orientation, can further exacerbate the racial marginalization of individuals.

Some of the psychological reactions to racism-related traumatic stress include depression, anxiety, shame or guilt, decreased self-esteem, negative perceptions of self-identity, social withdrawal, and problems in interpersonal relationships. Additionally, studies investigating hypertension and high blood pressure among racially marginalized individuals have shown a link between traumatic stress and physical health. In addition, researchers are investigating the coping skills used by individuals in response to racism, such as avoidance or withdrawal, combating, and seeking a support system.

It is imperative for human service professionals to be aware of and skilled in working with clients who are suffering from racism-related traumatic stress. Due to the harmful effects of racism and discrimination, individuals might not seek the assistance of human services personnel. Moreover, the consequences of inadequate care, due to the service provider's cultural encapsulation, can lead to mistrust of human service professionals and contribute to individuals' traumatic stress symptoms. An understanding of traumatic stress is important for case conceptualization, treatment planning, intervention, and assessment. It is important to conceptualize these symptoms by considering environmental factors such as racism and other forms of systemic oppression. Furthermore, lack of cultural competence can lead to misdiagnosis and ineffective treatments. This can serve as another systemic barrier for individuals of racially marginalized groups. Awareness of racism-related traumatic stress can assist human service professionals in identifying the environmental barriers in clients' lives. The ability to promote coping skills and highlight resilience is warranted.

Intervention

Human service professionals working in this area utilize racial or cultural identity and traumatic stress assessment tools to address the long-term effects of racism. Studies have shown correlations between racial or cultural identity and the various health, education, relational, and economic outcomes. Assessing for traumatic stress focuses on internalizing (anxiety and depression) and externalizing behaviors (anger and interpersonal problems). At the community-wide level, assessment of the long-term effects of racism might include the use of a needs assessment to gather interview data from community residents about their perspectives on community strengths and challenges as well as archival data from reports on and by the community.

Interventions to address the long-term effects of racism have been multipronged, and those routed within the community's own worldviews are particularly effective. The bulk of the literature has focused on identity development interventions to counter the impact of the cultural dominance of Eurocentric ideals on culturally marginalized groups. Additionally, culture-centered counseling interventions have been shown to assist culturally diverse individuals in resolving clinical issues related to racism-related trauma. Mental health and education professionals have investigated the influence of cultural awareness, rites of passage, and creative arts programs on individuals' racial or cultural identity, and their subsequent self-actualization.

To gain more information about the long-term effects of racism, it is recommended that human service professionals seek out books by behavioral scientists and mental health professionals who discuss the impact of racism and other forms of oppression on individuals, such as Yael Danieli's *International Handbook of Multigenerational Legacies of Trauma*. Other resources include research articles published in professional journals and conferences dedicated to disseminating information about trauma, oppression, and social justice issues.

Human service professionals are also encouraged to seek out information from stakeholders within culturally diverse communities who may have knowledge about significant events and coping strategies that relate to systemic oppression. Museums such as the Smithsonian's National Museum of the American Indian can also be an excellent resource to acquire historical information about sociohistorical oppression. Finally, Web sites can also offer insightful information about the pervasive effects of racism and other forms of oppression on individuals and how to counter institutional racism, including the People's Institute for Survival and Beyond (http://www.pisab.org).

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See Also: African Americans; Cultural Competence, Human Service Providers and; Discrimination and Institutional Racism; Incarceration and Sentencing, Racial Disparities in; Providers, Institutional Racism and; Rites of Passage; White Privilege.

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Racism, Self-Assessment of

The term *self-assessment* is used in social psychology to refer to the process of examining one's thoughts and behaviors in order to uncover values, habits, and biases, especially when they do not accord with one's self-image. In the case of racism, it is not sufficient for a person to ask themselves if they are a racist; many people who commit racist behaviors, harbor racist beliefs, and are burdened with racist biases do not self-identify as a racist. They may adopt a slippery definition of racism in order to absolve themselves or hide behind supposed "facts" that justify racist views, or they may simply harbor unexamined biases that influence their perceptions and decisions without making them "feel" like a racist. Self-assessment of possible racism is useful for human services workers in order to make them best able to deal with their clients.

Racism is the belief that subsets of the human race are substantively or qualitatively different, a definition that is vague because the concept of race is vague, and though referring to groups of hereditary traits is nevertheless socially and culturally constructed. *The Oxford English Dictionary* defines racism as "the belief that all members of each race possess characteristics, abilities, or qualities specific to that race, especially so as to distinguish it as inferior or superior to another race." Racism is often extended to encompass discrimination and racist-like beliefs predicated on differences in ethnicity or religion, as with discrimination against Arabs (who are not recognized as a separate race by the racial classification system used by the U.S. federal government); against the Irish or Italians in the historical United States; or against Jewish people (Jewishness being an ethnicity, a cultural identity, and a religious identity). There is considerable disagreement about how large a tent racism is and which behaviors or beliefs related to racial differences constitute it, which is why legal frameworks specifically focus on discrimination: preferential treatment for one group over another, predicated on racial or ethnic differences. The United Nations, for instance, condemns racism but does not define what it means by racism, while defining racial discrimination in the Convention on the Elimination of All Forms of Racial Discrimination.

Internalized Racism

This focus on the concrete makes sense when it comes to forming policy: The law cannot legislate the heart. However, it can lead to public discourse focusing on discrimination to such an extent that stereotyping, symbolic racism, and institutional racism are given short shrift. This, in turn, leads many people—especially people who are not regularly victimized by racism—to internalize a model of racism that is largely made up of behaviors of which they are not guilty, or in which they do not consciously partake. In popular culture, racists are more often portrayed as malicious and willful, perfectly conscious of their biases and giving voice to an explicit hatred of another race, which presents an image of racism with which few people would relate. And yet it is well understood by sociologists and psychologists that most racist behavior comes from people who are far less overt, and may be thought of as more neglectful or thoughtless than malicious. Sociologists often focus on issues of privilege: Even people who believe that they are actively opposed to racism may have racist beliefs or practices that they are blind to, in part because of the group privilege that they enjoy; as a result of the fact that they are not themselves victimized by racism, their thoughts on racism and racist institutions are not mature or well-formed, and they draw erroneous conclusions about the world by drawing on their privileged experience without making allowances for the effects of that privilege. White people will perceive banks to be fairer lenders than nonwhites, for instance; non-Arabs will have a very different experience of airport security in the post-9/11 world than Arab Americans.

Orthodox Jews, who are often subject to racism in spite of the fact that Jewishness is an ethnicity, a cultural identity, and a religious identity, but not a race.

For instance, a 2004 study found that job applicants were 50 percent less likely to be invited to interview for a job if they had a "black-sounding" name when compared to "white-sounding" applicants with identical credentials. The study did not suggest that this was the result of conscious racism and deliberate exclusion, but of unconscious racist biases, biases that the biased would deny. Several follow-up studies have confirmed these results in multiple cities and industries. This is a small-scale version of a phenomenon that sociologists and historians have long discussed: the economic and social disparity that has arisen as a side effect not only of overt racist institutions like slavery, segregation, and restricted immigration, but also unconscious racist biases. The result of such biases is that between two similar candidates for a given good—a job, loan, act of charity, acceptance to a school or professional organization—in the aggregate, the white candidate is more likely to receive it than the nonwhite candidate. These minor benefits accrete over time, creating more wealthy and middle class white families, more entrenched wealth, more predominantly white social and professional groups, and perpetuating the idea that whites perform well.

Self-Evaluation

Racism self-assessments seek to reveal these hidden biases. They often begin simply by asking individuals to describe their ethnic and racial identity including the racial and ethnic heritages that have played a role in their lives, their family lives and their identities, and to describe events in their lives in which their races or ethnicities were relevant. They are also asked whether there are cultures with which they identify or that have influenced them, whether or not they are a member of such a culture (this may be the result of a spouse's culture, for instance, or of places they have lived). They may then be asked to list everything they know about a particular ethnic or racial group, to identify the sources of their knowledge about that group, to reflect on how that knowledge has influenced their interactions with members of that group, and whether they have had interactions that changed any of the assumptions built on that knowledge. They may also be asked about systemic racism, what they know about its effects, and whether it has affected them.

Self-assessment is one element of self-evaluation, along with self-enhancement, self-verification, and self-improvement. In some ways, it is the simplest: It seeks to create an accurate picture of the self, and self-assessments are often conducted with a professional (e.g., a therapist, social worker, or sociologist) who provides feedback and can help formulate follow-up questions or point out when answers could go into more detail. On the other hand, self-enhancement is rarely objective; it is a tendency to look at the self in the manner that accentuates the positive in one's self-concept, playing up virtues and downplaying faults (or contextualizing them so as to defend or excuse them). Self-verification is perhaps the simplest motive involved in self-evaluation: It reflects the desire of people to find that their self-image is accurate, and to confirm that they are, and act and behave as if they are, the person they seem to be to themselves. Even negative behaviors can be self-verifying when they affirm that a person has correctly assessed his or her faults.

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See Also: Discrimination and Institutional Racism; Race and Clients; Racial Identity Development, Models of; Racial Microaggression; Racism, Long-Term Effects of.

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Rape as an Instrument of War

Rape and war can be more readily defined than understood. Both involve violence against others, and when combined, the effect is devastating. Rape is not a sexual crime; it is one of violence predominately against women. Paul Kirby describes wartime rape as "a social act marked by gendered power."

The impact of war on soldiers and others who live in contested, dangerous regions results in unimaginable trauma. Some participants find justification and opportunities to act on their own violent agendas. However, in the context of this entry, the focus is on evil rape, a deliberate attempt to humiliate, provoke fear in, dominate, and disperse and forcibly relocate communities or ethnic groups. War rape humiliates the victim and respective society.

While atrocities can be motivated by a variety of intentions, the act of rape, independently and in conjunction with the horrors of war, leave permanent, multilayered damage on the victims of any age, sex, race, ethnicity, or gender. Rape has become part of the arsenals of some combatants who have calculated the social, cultural, and ethnic fallout to victims. For example, in cultures or religions requiring women to be virgins before marriage, deliberate campaigns of rape have been launched, making the victimized women unable to marry. They may be received by families and communities as if they had voluntarily participated sexually instead of as survivors of very real violent attacks and permanent trauma.

Intentions and Results

Wartime rape is often perceived as an inevitable consequence and dismissed as such. In wartime, the number of reported rapes seems likely to be more underreported than in nonwar times. This is likely due to survival priorities of those impacted directly and indirectly as well as potentially reduced availability of police jurisdictions during such crises. However, in ethnic wars, rape is often used as a way of shaming and subjugating members of minority ethnic groups. Eva Fogelman describes the rape of Jewish women during the Nazi Holocaust as based on "three motivations (entitlement, sadism, and masculine ego gratification)," which fueled such violence.

Gang rape is more common during war than at any other time. Dara Cohen names ethnic hatred, gender inequality, opportunism and greed, and forced recruitment that human service providers must understand as underlying factors of war rape. The purpose of war rape is to instill as much harm as possible including, but not limited to, sexual violence. Many victims experience serious physical, psychic, and psychological torture. Physical violence including gang rape, stabbings, cuttings, amputations, and rape with foreign objects and substances are all too common. Rape can happen in a woman's home, in the woods, streets, at border checkpoints, within jails and combatant and refugee camps, as well as in displacement settlements. Rape can also be part of abductions.

Raping the women of the enemy humiliates the males, intentionally engendering feelings of impotence of an inability to protect their women. This is part of the larger picture of ethnic cleansing and genocide. There is no specific authority to whom one can report such rapes, so precise data is not available.

Rape as a War Crime

In the context of war, rape was considered to be collateral damage, something that happens, a by-product. It was not considered a violation of humanitarian law until the establishment, in 1994, of the *International Criminal Tribunal for Rwanda*. This resulted in an important understanding of such rapes as crimes against humanity related to the objective of genocide. Instead of viewing rape as something that happens in war, it became identified as a war objective.

Male Rape Victims

Sexual violence in war is mostly perpetrated against women. However, Will Storr shared the experiences of many traumatized survivors in Uganda, including male rape survivors. Seeking help from a counselor, a wife talked of her husband's inability to have sex. Meeting one-on-one, the husband confided his rape experience, three times a day for three years, in the company of other male victims, and the permanent damage and infection he bears; seeking medical assistance would mean admitting what happened, risking a label of homosexuality punishable, in some cases, by family rejection, arrest, or death. During World War II, most rape victims were women but not all. It is likely that men underreport their own victimization; rapes are underreported in general. Thus, the focus of war rape remains on women.

In the 1980s, 76 percent of male political prisoners in El Salvador reported having experienced sexual torture at least once. Sri Lankan males treated at a London torture treatment center reported being sexually abused in 21 percent of cases. Eighty percent of 6,000 male concentration camp inmates in Sarajevo reported having been raped. Cases of male rape have been reported in Chile, the former Soviet Union, Croatia, Kuwait, and Greece.

Relevance to Human Service

Human service providers comprise a broad range of practitioners from paraprofessional and credentialed case workers to mental health and medical professionals. All must be culturally sensitive and competent to understand the physical and unseen wounds as well as the critical challenges to healing necessary to resume fulfilling lives. Practitioners must function within societies holding values and power hierarchies different from their own. Human service providers must be culturally competent to help war rape victims of different ages, sexes, genders, ethnicities, sexual orientations, and opposing war party affiliations.

Conclusion

Rape is an instrument of war that impacts victims in many ways. Societies impacted by rape as an instrument of war are debilitated, families are destroyed, and victims become shells of themselves. Human service providers can assist with concrete services, family reunification, immigration and refugee issues, and family losses. To this end, practitioners must be culturally competent and respectful of individual needs and beliefs. They must understand the magnitude of such violence, treating all victims humanely and with compassion while remaining realistic regarding the limitations of comprehensive healing in the face of values and cultural norms with which they are unfamiliar.

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See Also: Children and War; Mental Health Services, Ethnic Models and Multicultural Service; Refugee Assistance; Sexual Abuse Survivors; Values and Ethics, Ethnic Diversity and.

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Reasonable Accommodations

The Americans with Disabilities Act (ADA) is a civil rights law intending to remove barriers to employment, transportation, public services, and telecommunication for Americans with disabilities. Human service providers can proactively support those with disabilities in accessing legal rights. The ADA prohibits discrimination in all employment practices, and employers must provide reasonable accommodations to all qualified people with disabilities. Under the ADA, a person is considered disabled if he or she is limited in one or more life functions, has a record of disability, or is regarded as having a disability. An applicant or employee is qualified if he or she is capable of performing essential duties of the job.

A reasonable accommodation is any adaptation that enables the individual with a disability to equally apply for a job, perform essential job duties, and be involved in the rights and privileges of the job. A reasonable accommodation must effectually meet the needs of the individual. An accommodation is considered reasonable if it appears feasible on its face or is commonsensical.

Reasonable accommodations commonly implemented include making existing environments accessible; restructuring a job; modifying a work schedule; purchasing or adapting equipment; altering tests, materials, or policies; providing interpreters or readers; or reassignment to a vacant position. The ADA defines what is considered reasonable. An accommodation is unreasonable if it eliminates or substantially alters the fundamental duties of the position or if production standards would be reduced. Also, a reasonable accommodation should not cause undue hardship to the employer, defined as significant difficulty or expense. Employers are also not required to provide personal items used outside the workplace such as glasses or hearing aids.

Unfortunately, terms such as "reasonable," "undue hardship," and "qualified" are vague and have proven difficult to define. Many cases have been litigated, and courts have made progress in clarifying terms, leading to the reauthorized ADA in 2008.

Implementing Reasonable Accommodations

After the 2008 reauthorization, the United States Equal Employment Opportunity Commission (EEOC) put forward a document offering guidance on enforcing reasonable accommodations. Generally, reasonable accommodations are decided on a case-by-case basis, but employers should follow the EEOC's advice. Key elements from the EEOC's guidance explain the following.

Employers should attempt to advertise job opportunities in accessible locations and formats. For instance, if a phone number is listed on a job advertisement, a telecommunication device for the deaf number should also be listed.

During the prehire process of a job interview, disability-related questions should not be asked. Reasonable accommodations must be made at this stage, even if an examination is required. For instance, during an examination, the employer should provide an interpreter for a person who is deaf or a modified test for a person with a learning disability.

During any stage of employment, a person with a disability may request a reasonable accommodation, and requests may come in a variety of formats. A person with a disability may verbally request an accommodation in plain English or in writing. Another individual such as a human service professional or family member may also make a request on an individual's behalf.

An employer has the right to request reasonable documentation proving the individual has an ADA-defined disability. Professionals with expertise about the disability can supply the documentation. If the disability diagnosis has been previously established or is obvious, the employer may not request documentation.

In determining the appropriate accommodation, an interactive process should take place between the employer and the employee. However, the employer may choose from a range of effective accommodations. If multiple available accommodations are equally effectual, the employer should take into consideration the preference of the employee. Ultimately, the employer may choose the cheaper or easier option. For example, a vision-impaired employee requests software that reads text aloud. The employer instead offers a magnifying glass with the hopes it will be as effective. The employee, however, is less productive with the magnifying glass, thus it is determined that the software is the most reasonable accommodation. Once a reasonable accommodation is requested, the employer should respond expeditiously and process the request within 30 business days.

Outside of typical duties of employment, employees with disabilities must be provided access to workplace communication, trainings, services, or social functions. All communicative information must be disseminated in accessible formats. All facilities that nondisabled employees enjoy must be accessible, such as a lunchroom, gymnasium, or work-related transportation. If a social event is held, it should be accessible. For example, an employer assures that all office-wide communications occur through e-mail and that all training videos are captioned so a deaf employee can access all work-related information.

An employer may not make it public knowledge that an individual has requested or received a reasonable accommodation. This violates the employee's right to privacy. If the employee–employer interactive process fails and a lawsuit results, the burden of proof falls on the employer if it is determined that the requested accommodation is reasonable on face value.

Goals and Conclusions

The ADA has helped reduce discrimination and supported people with disabilities to become productive members of their communities. Employers who proactively work with employees with disabilities are successful in reducing discrimination in the workplace and often find that American's with disabilities are productive, creative, and competent employees.

Becoming knowledgeable about the legal rights of people with disabilities is key for employees with disabilities, employers, and human service professionals to ensure the fundamental rights of all Americans.

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See Also: Ableism; Accommodation; Americans with Disabilities Act; Americans with Disabilities Act of 1990; Disability Services; Equal Opportunity and Civil Rights; Individuals With Disabilities Education Act.

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Recreation Services

Recreation services and leisure services are often used interchangeably. By definition, both recreation and leisure play a vital role in promoting individual free time. This means the individual is not obligated to do any form of structured work. Recreational and leisure services were also designed as a resource that benefited everyone in a community and are viewed as a public good. These two emphases were aimed at helping to create higher-quality lives and communities through increased psychological and physical health and eliminate social issues through social reform.

Over the last decades, recreation and leisure services have gone through various transformations. These changes were dependent upon culture, social, and political dynamics. In the late 1800s, commercial recreation services such as a small theater and dance hall services served as a form of entertainment and encouraged wholesome, enriching experiences to counter the negative effects brought on by the Industrial Revolution. In the late 1900s, opportunities for structure and policy implementation to organize recreation and leisure services were developed as a consequence of the settlement houses and playground movements. As a result, many saw leisure and recreation as the perfect solution to the political, economic, and social inequities found in America. For example, the implementation of policies such as juvenile curfew laws, child labor laws, and extended education help to promote positive youth development. Today, recreation services can be found in major cities and communities throughout the United States. In most local neighborhoods with recreation services such as playgrounds, swimming pools, athletic fields, and community facilities are funded through the local tax base by members of that particular community. The benefit of recreation services is to increase the lives of individuals through mental and physical health, family and community relationships, environmental stewardship, arts, entertainment, and sharing of cultural traditions. Most programs are geared toward different age groups, genders, health issues, and cultural beliefs. Other recreation services address social issues such as helping immigrant children with acculturation to their social environments. Another benefit of recreation services is to help youth develop positive attributes and skills, which can expose them to different mechanisms away from the home environment. The overall purpose of recreation services is to address individual and community needs in a holistic fashion.

Training for Recreation Services Providers and Staff

Traditionally, individuals who peruse a career in recreation services focus on programming and management. Professional preparation is offered at major colleges and universities. Today, more than 500 programs are identified across the United States. These programs award associate-level through doctoral-level degrees. The degrees' concentration areas include leisure studies, therapeutic recreation, leisure and recreation administration and management, outdoor and natural resources, commercial recreation, tourism, and recreation leadership. College and university recreation programs are accredited by the National Recreation and Park Association and the National Council of Therapeutic Recreation Certification agencies. These accrediting agencies set criteria for the institutions in order to promote quality standards and ethical practices. Persons who are certified by these institutions must maintain continuous certification through the accrediting boards.

Recreation Services Jobs

Recreation services can be found in government, nonprofit, and for-profit commercial organizations. Individuals who are employed in the government sector usually work at the federal, state, local, and municipal level jobs. These services are funded by taxpayers' dollars and provided to all citizens for participation. Municipal government jobs are available in administration, park management, planning, aquatics, golf course management, facility supervising, cultural arts programming, athletics, and various other support positions. Recreational services jobs in the nonprofit arena are geared toward education, recreation and social services; thus, recreation is not their main purpose. Examples of these facilities are the Salvation Army, local charitable foundations, the Girl Scouts, and the Boy Scouts. The staff in these organizations work as youth leaders, camp and center directors, adventure planners, and recreational therapists. Commercial recreation services offer recreation and leisure for profit. Employees in this segment of recreation and services specialize in the hotel and hospitality management, tourism, travel, sports, arts and culture, and professional event services businesses. All these sectors of recreation and leisure services offer some benefit to humans and society as a whole. The field covers a wide spectrum of employment opportunities and is expected to increase as more individuals devote free time and money to increase their pursuit of leisure and recreation experiences.

The Influence of Recreations

Today, recreation services have influenced our society in many different ways. It strengthens the relationship and interactions between individuals and communities to achieve more positive outcomes. Increased diversity has forced recreation leaders to develop new techniques and management skills such as conceptual and human relations dimension. Also, the concept of leisure has encouraged Americans to take yearly vacations with family or friends to explore new personal, social, and cultural experiences. These efforts have contributed to our society's economic, social, and educational systems and provide an opportunity to enhance the richness of our society.

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See Also: National Assessment Governing Board; Neighborhood Reinvestment Corporation; Primacy of Place; Regional Cultural Competence; Role Flexibility, International Differences in; Tribal Social Services.

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Redlining

Redlining is the practice, currently illegal in the United States, of color-coding different neighborhoods on residential maps based on mortgage default risk (as a proxy for race). While race may not have been explicit, race was a factor in neighborhood ratings and whether lenders would approve mortgages in an area; red was the lowest category in the rating system, and mortgages were rarely (if ever) approved to buy properties in redlined areas.

History

In the 1930s, the U.S. federal government initiated programs to increase the availability of home ownership and simultaneously increase employment in construction and related industries. As a result, the Home Owners' Loan Corporation (HOLC) was birthed in 1933 with the purpose of refinancing urban mortgages and providing those who lost their homes due to foreclosure opportunities to buy them back with low-interest loans. In developing a rating system to evaluate the risk of loans made to specific urban areas, the HOLC institutionalized and formalized redlining.

The ranking system put neighborhoods into one of four categories: type A (green), type B (blue), type C (yellow), and type D (red). These colors were drawn onto residential security maps, which were used to inform lending decisions. The actual term *redlining* was coined by sociologist and activist John McKnight in the 1960s and was in reference to the red lines on residential security maps. Those homes located in yellow or red regions on residential security maps rarely (if ever) were approved for HOLC loans. The ranking systematically undervalued older, more racially and ethnically mixed, central-city neighborhoods, placing a priority on new construction in suburban areas. Additionally, African Americans were almost always redlined, ranked in the lowest rating category. As a result, mortgage funds were channeled away from

African American neighborhoods as well as those suspected to be likely to contain substantial African American populations in the future.

The HOLC residential security maps became somewhat of a standard, and soon, private banks and lenders in the 1930s and 1940s relied on the HOLC maps or created their own similar maps when making lending decisions. The redlining issue was thus not restricted to the HOLC but became a massive disinvestment by private institutions in predominantly African American communities as well.

Redlining was enforced by racially restrictive covenants implemented through neighborhood associations, which were contracts among property owners stating that they would not lease to an African American, sell to an African American, or otherwise let an African American occupy their property. If restrictive covenants were violated, as contracts, they could be taken to court and the violator could be sued for damages. Contract terms were typically 20 years in duration and required 75 percent of neighborhood association property owners' backing to be enforceable. Peer pressure often served as an effective means to gain the necessary backing.

In April of 1968, partly in response to conclusions drawn from the race riots in the 1960s, Congress passed the Fair Housing Act, officially banning discrimination in the sale or rental of housing. Unfortunately, enforcement provisions under the act were relatively weak—these provisions were weakened as the bill passed through Congress—and residential racial integration did not follow after its passing. The act had a short statute of limitations (180 days from the alleged violation) and relied on individual efforts to combat housing discrimination rather than a large-scale institutional effort. Housing testers at local fair housing commission offices continue to be the primary means of prosecuting or uncovering housing discrimination, and no systemic federal government approach to deal with housing discrimination or residential segregation has been established to date.

In a further effort to combat redlining, Congress passed the Community Reinvestment Act in 1977, requiring banks to demonstrate evidence that they were providing credit to low-income areas that had been historically unable to secure capital.

Impact

The impact of redlining is multifaceted and substantial. Redlining has contributed to lower property values in the urban inner city, reducing home ownership in those areas. Additionally, with fewer potential owners of inner-city properties due to the inability to secure mortgages for such properties, redlining increased landlord abandonment. Abandoned buildings often become hotbeds for criminal activity in urban areas. Refusing to provide mortgages for central city areas and instead opting toward suburban or rural communities, redlining has contributed to sprawl, decreasing population density.

An obvious consequence of redlining has been the persistence of racial residential segregation, but another consequence is the social reproduction of racial wealth inequality. With blatant housing discrimination and the discrimination of lenders, African Americans who were able to invest in housing when redlining was legal were unlikely to see the same return on their investments as white Americans. Not only were African Americans more likely to rent than own homes, but those who bought homes often were not approved to buy homes in suburban areas where property values skyrocketed. Instead, loans were approved in urban and inner-city areas, where redlining was a key factor in the decimation of property values and increase in crime. The result, from the perspective of the racial wealth gap, is that, while many white Americans owned homes with values that increased to perhaps 10 times the purchase price, securing some form of inheritance for their children, African American children were much less likely to generate any substantial inheritance from their property and much less likely to own property in the first place.

Current Issues

With redlining prohibited but residential segregation persisting, a number of additional issues have come up. One such issue is known as reverse redlining; this is where the lender or insurer targets minority consumers in order to charge them more. Indeed, rather than ignoring minorities or not considering them for loans, reverse redlining targets minorities for exploitation. Meanwhile, some still practice redlining but get around the letter of the law by using sponsor concentration or rental concentration as an excuse to redline. While this is still technically illegal, there is evidence to suggest that this is practiced as an internal policy. Finally, some recent research has suggested that in the foreclosure crisis that coincided with the Great Recession of 2008, residential segregation made possible a targeted marketing of subprime loans to minorities. As a result, minorities were hit particularly hard when it came to foreclosures.

While redlining is currently prohibited by law, lax enforcement of regulations for fair housing and an absence of a systemic solution has resulted in a perpetuation of residential segregation and numerous multifarious consequences that are particularly detrimental to African Americans and other people of color.

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See Also: African Americans; Community Reinvestment Act (1977); Environmental Racism; Fair Lending Practices; Isolated Communities and Cultural Competence; Socioeconomic Status.

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Refugee Assistance

According to the 1951 convention relating to the status of refugees, a refugee is any person who is being persecuted or has a realistic fear of being persecuted due to his or her race, religion, or nationality, or because he or she is a member of a particular group or hold a particular political opinion. A refugee must also live outside of his or her country and be unwilling or unable to return home because he or she is afraid that he or she will not be protected by the home country. U.S. federal law defines refugees in a similar way, with the added distinction that, in order for someone to be considered a refugee, he or she must either be designated as such by the United Nations High Commission for Refugees (UNHCR) or a U.S. embassy, or be the member of an identified group that has been granted priority status by the U.S. government. Refugees receive their status prior to arriving in the United States, and a political asylum seeker receives his or her status after arriving in the United States (often arriving on visa such as a conference or student visa).

Currently, there are approximately 42 million refugees worldwide. While the number of refugees the United States accepts has ranged in recent years, there were approximately 58,000 refugees resettled in the United States in 2012, and just over 29,000 individuals were granted political asylum. Refugees are processed by the U.S. Department of State through the U.S. Refugee Admissions program in coordination with U.S. embassies around the world. Each year, admissions criteria and admissions limits are established. Refugees are then interviewed to ensure that they meet the established criteria. Once eligibility is confirmed, refugees undergo security and medical screening and are referred to a U.S. resettlement agency approved by the State Department. Then travel arrangements are made. This process can be extended or may occur swiftly depending on a variety of circumstances, including the urgency of the situation in the host country where the refugee is residing. For instance, protracted refugee situations, illness, and security situations may facilitate the resettlement process.

Refugees in the United States are eligible for several legal entitlements such as the right to work, and a fast track to citizenship, as well as a range of services. Refugees are forced to leave their home country for a range of reasons, most of which involve psychological and physical trauma. Many refugees have survived war, torture, rape, and a range of other traumatic experiences. Most refugees have been forced to flee their homes and communities, often with very little notice. They have lost loved ones or have endured illness, often on long treks in search of safety. Prior to refugees being resettled to the United States, many have spent years living in tenuous situations with minimal services. They come to the United States frightened, traumatized, confused, and vulnerable.

Because of the dire conditions and grave situations, refugee services are broad and include language training, vocational assistance, housing assistance, trauma counseling, and family counseling. Many services are provided by the original refugee resettlement agencies, which receive funding (albeit minimal) from the federal government for the resettlement process. Initial services include assistance with housing, medical care, and school registration, with a particular focus on services that encourage economic self-sufficiency such as employment services.

In many respects, the current U.S. Refugee Resettlement program has not kept pace with contemporary refugee dynamics. For instance, many of the world's refugees are now resettled due to violent civil conflict and often remain in protracted situations for decades before being resettled in the United States. This dynamic reflects a significantly different picture than refugee dynamics during the Cold War, when individuals and families were fleeing from communist countries. Not only does this shift have ramifications for refugee services with regard to the type of assistance needed (i.e., most incoming refugees have experienced far greater trauma than in previous decades), but historic programs that were designed to be positive may have a negative effect on many refugees' resettlement experience. For instance, all refugees are provided with a no-interest travel loan to cover the cost of travel, facilitated through the International Organization for Migration (IOM).

While this may have been a helpful program for incoming refugees several decades ago, compelling refugees who have lived much of their lives from UNHCR-facilitated camps located in war-torn regions to pay for their travel seems to be an unreasonable expectation and can set new refugees up for failure. This is particularly a risk for female heads-of-household with numerous children, histories of trauma, limited education, and minimal employment skills. Some families are burdened with thousands of dollars of debt the moment they arrive in the country. They are expected to learn English, gain employment skills, gain employment, find child care, and within a relatively short time, begin making payments on a loan.

Women and children in a refugee camp in Darfur, Sudan. Many of the world's refugees are now resettled due to violent civil conflict and often remain in protracted situations for decades before being resettled in the United States.

One of the greatest challenges in providing services for refugee populations is the complex nature of the challenges they experience—both in their country of origin, as well as in the country of resettlement. As the need for self-sufficiency is so urgent, human services such as employment assistance programs often take precedence over other types of human services such as trauma counseling. Refugees who do not receive adequate psychological counseling often struggle the most with the resettlement process. Many refugees are children, some of whom are unaccompanied and have experienced various types of trauma and loss and have poor or no education, and yet they are expected to adapt quickly and successfully to the U.S. educational system. Many refugees are women who are survivors of gender-based violence. Sometimes, this violence follows them in the form of domestic violence, and they are in need of family counseling as well as women's empowerment counseling and advocacy. Men need counseling as well, not only to deal with the trauma they have likely experienced but because many come from countries that are patriarchal in nature, and adjusting to the egalitarian nature of U.S. society is challenging.

Although initial refugee services are provided primarily by the government-contracted refugee resettlement agencies, longer-term services are provided by a range of human service agencies such as child welfare agencies, domestic violence shelters, counselors at schools, homeless shelters, public health agencies, and churches. In time, many refugees adapt quite well to U.S. society, yet others continue to struggle with poverty, underemployment, domestic violence, and substance abuse and remain marginalized and vulnerable for years.

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See Also: African Immigrants; Displaced Persons; Diaspora.

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Regional Cultural Competence

The term *cultural competence* first emerged in the United States in the 1980s in response to the need for more diversity among providers serving social sector services such as education, social work, and health to better meet the needs of an increasingly diverse immigrant population of the country. This concept is now taken up in many other English-speaking immigrant-receiving countries, like Canada, to respond to the needs of their growing immigrant populations whose English is a second language. In the health sector, there is increasing evidence of inequity experienced by minority populations.

The focus of this entry is to examine the components of cultural competency and its importance in the health system in its entirety within Canada. Although the Aboriginal and First Nations population has a long history of inequities in this country, in this entry, we focus on immigrants and visible minorities only.

Country Context

Canada is a growing multicultural and multiracial country. It attracts more than 200,000 newcomers annually. Immigrants accounted for 20 percent of Canada's population in 2006, and according to Statistics Canada, this proportion is projected to reach between 25 and 28 percent by 2031. The 2006 census reported that nearly 5,068,100 people surveyed belonged to a visible minority group, accounting for about 16.2 percent of the total population. These growing numbers reflect change in Canada's demographic composition since 1971, when the majority of the population were of European heritage.

In recent years, a majority of the immigrants are arriving from countries in Asia, the Middle East, Latin America, and Africa, and now south Asians constitute the largest visible minority group in the country. The 2006 census also reports that about 72.8 percent of the immigrant population have a mother tongue other than English or French. The growing cultural and linguistic diversity indicates the need and the importance of cultural competency within social and health systems.

Canada also receives a substantial number of refugees. Depending on the background circumstances, they may have specific physical and mental health needs and may not have the language abilities or skills common among other types of migrants. Health care providers who do not have training in cultural competency may be inadequately prepared to work with such diverse populations.

Defining Cultural Competency

There is no consensus on a universal definition of cultural competency, and the terms *culture*, *ethnicity*, *diversity*, and *race* are generally used interchangeably in the literature. Some scholars have defined *cultural competency* as a term that synchronizes behaviors, attitudes, and policies to help a system, organization, or profession to work effectively with culturally diverse populations. There is, however, an ongoing discussion as to how this important social construct can be better defined and operationalized. The need for an operational definition has increasingly been sought because of growing ethnocultural diversity in the composition of immigrant population and their children.

In the health sector, the importance of the construct of cultural competence is well recognized and considered an integral component to providing quality and equitable health care services to all. However, the lack of clarity in the definition of the construct has limited its application for practice.

Further complexity occurs because terms like race, ethnicity, and culture are used interchangeably and are interrelated in complex ways that are difficult to disentangle in practical situations. In order to develop an understanding of cultural competence, therefore, the meanings of commonly used interrelated terms need to be clarified. In the following section, these interrelated terms are defined.

Race

Race is a social construct and has no biological and genetic basis. It refers to conferred identities based on gross morphological features such as skin color, hair type, body proportions, and other supposed biological expressions of group inferiority. Many social scientists have replaced the term *race* with the word *ethnicity* to refer to self-identifying groups based on shared beliefs, culture, religion, and history. The term historically signifies stereotyping, exclusion, and other forms of social injustices.

Racism is the force by which superiority and inferiority of a race are characterized, and skin color plays an important role in such classifications. For example, in Western societies where the predominant group in the population is white Caucasian, African Americans and other groups with darker skin pigmentation are viewed as inferior to whites.

In recent years, scholars are increasingly challenging the biological basis of race. Due to globalization and high migration flows, the rates of interracial marriages have increased, and children of mixed-race couples tend to have varying degrees of skin pigmentation, yet they share the same genetic characteristics and social and cultural specifics of their parents.

In the health sector, evidence shows that, in North America, blacks and other minority populations of color are disadvantaged in various aspects of life in addition to socioeconomic disadvantage. For example, African Americans are more likely to receive inadequate treatment for pain as compared to the white population. Similarly, in Canada, visible minority newcomer; women are less likely to undergo screening tests, for example, screening for breast and cervical cancers.

Ethnicity

The term *ethnicity* may mean different things to different people. In multiracial and multicultural societies such as Canada, the term *ethnicity* may incorporate the meaning of both race and culture in a positive sense. Often, the two terms *ethnicity* and *race* are used interchangeably or in combination, such as race and ethnicity. The main difference between race and ethnicity is that race denotes a physical attribute, whereas ethnicity is considered a self-chosen category and reflects culture, religion, language, and ancestry that can help in identifying a group with a particular country or heritage. Although both terms are recognized by people's actual behavioral and physical characteristics, the context in which the two terms are used can have very different meanings. Racial characteristics are described as predetermined that do not change under social pressures, whereas ethnicity is amenable to change under social and other pressures. Ethnic groups, therefore, assimilate over time with other ethnic groups, while racial groups' identifications are kept separately in the mainstream context. When these terms are used interchangeably, it can potentially obscure or narrow the meanings of both the terms. The context in which identification of people in terms of their race or ethnicity is made is important. In racist societies, oftentimes, ethnicity is used to conceal racism.

In the context of health, there is substantial evidence indicating inequities among members of these groups in both the state of health and the accessibility and quality of health services available to them. The social differentiations based on cultural and racial identity may promote discrimination, lead to social isolation, and impose other stresses and deprivations in their lives. To tackle these issues, the existing health system, which was originally developed to address the needs of the majority population, may need to adapt to the needs diverse populations. These changes should expand to all social services and not only to the health sector to help address health disparities.

Culture

Culture is an anthropological term, and its definition is variable. The term signifies more than race, ethnicity, gender, class, religion, disability or ability, or sexual orientation. Culture is often confused with race, mainly because people who are seen as racially different are also conceptualized as having different cultural backgrounds, and the term is generally used to hide racism in society.

In contrast to other terms, culture signifies a dynamic process of developing understanding of other people's backgrounds and experiences that are different from their own. That is to say, culture is not static like race but changes over time as people resettle, adapt, and assimilate in new environments. In the process of this resettlement, members of a particular culture or ethnicity will not always think and act in ways that are consistent with their previous social and cultural practices.

Culture plays an important role in the health care sector, including determining the quality of services and reducing health disparities. The knowledge of culture and training in cultural competency helps service providers in establishing a therapeutic relationship with patients and clients from the very first encounter. Cultural beliefs are well known to shape understandings of and responses to health and illness, and when there is a mismatch between the belief system and the care provided, the outcomes are usually poorer. For example, in cultures where mental health issues are stigmatized, symptoms of depression may be expressed as somatic pain, which is likely to be misdiagnosed if the provider does not have a comprehensive understanding of diversity and other cultures. These issues are of particular importance in an immigrant country like Canada, where health care is designed on the Western biomedical paradigm and may not meet the needs of all client groups.

Visible Minority

About 75 percent of immigrants who have arrived in Canada since 2001 are considered by Statistics Canada to be visible minorities. Visible minorities are identified by Statistics Canada as "persons, other than Aboriginal persons, who are non-Caucasian in race and non-white in colour." The groups included in this category are: "Chinese, South Asians, Blacks, Arabs, West Asians, Filipinos, Southeast Asians, Latin Americans, Japanese, Koreans and other visible minority groups, such as Pacific Islanders."

Some scholars contest the term *visible minorities*. They argue that the term agglomerates diverse groups of people who are historically different, and their experiences as immigrants are different. New immigrants and ethnic minorities, because of their low economic status, tend to occupy a less-favorable social position in a new country. Research indicates that an individual's socioeconomic position is strongly linked to less access to care and greater health problems. Often, the disadvantaged positions held by visible minority groups are confounded by race and ethnicity.

Diversity

Diversity is also a very broad term and not well defined. Diversity can be visible or invisible. Visible diversity refers to individual characteristics that are always evident such as age, gender, race, ethnicity, physical appearance, and speech accents or dialects. Invisible diversity refers to characteristics that are not evident such as sexual orientation, religion, social class, occupation, and religious beliefs.

Visible diversity is always apparent as is the case of visible minority groups in Canada; the risk among this group to encounter discrimination, marginalization, stigmatization, and stereotyping is considerably increased. Thus, visible or invisible characteristics of diversity can have real advantages or disadvantages to the individual.

Intersectionality

More recently, in the Canadian context, race and ethnicity are viewed as intersectional because racial diversity occurs within ethnically defined groups. Intersectionality recognizes that identities (e.g., ethnic, racial, or gender) are fluid and individuals' multiple identities intersect and interact depending on context. Thus, it avoids essentializing identities and further reinforcing stereotypes of difference. Intersectional frameworks also consider power dynamics and its shifting contextual basis. However, application of intersectional frameworks to health care practice is in its earlier phases in Canada.

There is usually contention between supporters of cultural competency approaches in health care and those of antioppressive practitioners in the community. However, research shows that, when knowledge from cultural competency and antioppressive practice are combined, best practices and policies to address health disparities can be developed. These practices can address social determinants such as class, gender, and immigrant status in multicultural society. Understanding these intersections will allow the recognition and the needs of marginalized groups in the society.

Cultural Competence and Health

Changing Canadian demographics, increasing workforce diversity, and disparities in health access and outcomes call for change in the health and social services system as a whole. The Canadian Multicultural Act (1970) and the Canadian Human Rights Act (1981) recognize and promote the understanding that multiculturalism reflects the cultural to racial diversity of Canadian society. The policies stipulate that all individuals have equal opportunity and have their needs accommodated. Under the Human Rights Act, an individual based on his or her particular characteristics such as age, gender, race, culture, and disability can demand service providers to accommodate his or her needs; for example, interpreters for those who do not speak English or French.

Cultural competency refers to the ability of service providers to understand, respond, and provide appropriate care according to the needs of diverse groups of people. An inaccurate diagnosis can be made due to lack of cultural understanding during health communication, which can lead to serious consequences for the patient. In health care, therefore, cultural competency in health care programs are aimed at preventing medical errors and increasing access to quality care for disadvantaged populations such as immigrants.

Research shows that, for health care providers to be culturally competent, they need to value cultural diversity, have the ability to do cultural self-assessment, be conscious of the factors when cultures interact, and be able to apply knowledge and skills to adapt to service delivery that reflect an understanding of cultural diversity. This does not mean that a service provider needs to know about every culture; rather, it means to be able to respect the differences, be willing to adapt to differences, and be able to provide the care the patient requires.

Cultural Competency Continuum

Seminal work on the cultural competency continuum framework was done by researchers. In the literature, cultural competency is described as a dynamic process that evolves over time. Cultural destructiveness is at the bottom and cultural proficiency on the top of the continuum. The framework describes six stages or characteristics through which the continuum establishes over an expanded period of time. The characteristics start from the extreme negative end of the continuum and are described as (1) cultural destructiveness, (2) cultural incapacity, (3) cultural blindness, (4) cultural precompetence, (5) cultural competence, and (6) cultural proficiency. These characteristics were developed to help systems and organizations to self-monitor their work and plan accordingly.

Cultural destructiveness is characterized by attitudes, practices, structures, and policies established in the system or organization that creates distinctions among cultural groups and can be destructive to certain cultural groups.

Cultural incapacity is the weakness in the system or organization to effectively deliver services to diverse clients according to their needs. Characteristics may include institutional practices that may result in discrimination in hiring and promotion or not providing enough allocation to fulfill the needs of certain cultural groups.

Cultural blindness occurs when organizations within a multicultural society treat everyone the same and do not appreciate culture differences. As a result, no value is placed on appropriate training of workforce on cultural competence.

Cultural precompetence refers to systems and organizations that are aware of the changing needs and are prepared to respond effectively to culturally diverse populations.

Cultural competence refers to systems' or organizations' awareness to respond to the needs of culturally and linguistically diverse populations. Characteristics of cultural precompetence include the desire to deliver high-quality and cost-effective services; commitment to civil rights and social justice; community participation; policies for hiring a diverse workforce and training in cultural competence; and inclusiveness of all groups.

Cultural proficiency is the last characteristic of the competency continuum. Organizations that have reached cultural proficiency will reflect their commitment through emphasis in their mission statement and all other documents; the commitment to serve culturally and linguistically diverse populations; adopting good practices; continuously monitoring its progress; policies and structures to recruit and train a diverse workforce; resources for evaluating cultural competence of staff and the organization as a whole; and community participation in planning and governance of the organization.

Good Practices

Some of the strategies suggested in the literature for improving cultural competence within organizations include the following.

Training of workforce—evidence shows that training and refreshment courses are essential for developing cultural competence. However, these trainings should be for all staff, including administrative staff, researchers, managers and policy makers. The purpose of such intervention is to increase institutional capacity for providing appropriate care to diverse populations. Currently, there is no consensus on the content of these courses, and there is paucity of data on the cost-effectiveness of such interventions

Diversification of the workforce—the need for diversification in the health sector workforce is increasingly being sought. Organizational policies and structures need to be in place to ensure that service providers reflect the diversity of the populations they serve.

"Cultural mediator" is a term used in some European countries, such as in the United Kingdom, the Netherlands, Belgium, France, Italy, and Spain, who have experience improving services for the Roma population. For people with English as second language, it can be a major obstacle in accessing services. Providing good-quality interpretation services can help in translating what the patient or client is saying but would not be able to extract the meaning. Proper translation would require the appropriate language skills, considerable medical knowledge, and having knowledge of the care seekers' cultural and social contexts. Experience shows that this is a dual need: Interpretation and understanding the cultural and social contexts could be filled by cultural mediators. These are people from the same minority groups that work as brokers between service providers and patients. Their roles are very varied; for example, some help in connecting the communities with services, while others help in improving health workers' understanding of the community and the community members' understanding of the health system, and yet others may guide people to treatment by guiding them in the initial stages of the intake process. The potentials of using cultural mediators for improving access to services and for reducing access barriers for minority groups is promising; however, legal and training issues are yet to be resolved.

Communication and Cultural Competence

Research indicates that language is one of the most common communication barriers in the multicultural society of Canada. As a result, the need for good communication skills among health care professionals has become important. Both verbal and nonverbal communications skills are required to communicate effectively with diverse communities who have varied needs, language abilities, and literacy. Without proper communication skills, service providers may misdiagnose a patient, not be able to obtain informed consent, have difficulty in explaining the treatment process in nontechnical language to patients, and may fail to build the relationship needed for ongoing health maintenance.

Challenges

The major challenges to the system are lack of commitment at all levels of the health and social system; lack of diversity in leadership and workforce within the health and social system; not enough information and understanding of the needs of diverse groups of population; a health system designed to fulfill the needs of the dominant population but not yet modified to meet the needs of diverse populations; and poor communication between health care providers and clients or patients of different cultural, ethnic, and racial backgrounds whose English is a second language.

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See Also: Communication Styles, Ethnic and Cultural Differences in; Cross-Cultural Knowledge; Cross-Cultural Service Models; Cross-Cultural Skills; Cultural and Linguistically Appropriate Services Standards; Cultural Competence, Professional Standards of; Cultural Competence, Training in; Cultural Competence, Human Service Providers and; Cultural Competence, Measuring and Assessing; Cultural Competence, Model of; Cultural Competence, Professional Standards of; Discrimination and Institutional Racism; Diversity and Quality in Health Care; Ethnicity, Definitions of; Health Care, Disparities in; Immigrant Populations, Human Service Needs of; *Journal of Ethnic and Cultural Diversity*; *Journal of Immigrant and Minority Health*; Medical Social Workers, Racial and Ethnic Issues for; Medicine, Workplace, Diversity in; Racial and Ethnic Approaches to Community Health; Race, Social Definition of; Universal Access/Universal Design.

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Rehabilitation Centers

The goal of rehabilitation centers (rehab centers) is to assist individuals to function effectively within their environments. These environments include major social institutions like religious institutions, families, and educational and occupational institutions. Although individuals may continue to need accommodations, they are able to function as a part of society. For rehab to be effective, it must produce a physical, mental, or social change in the individual. Prison officials believe that prisons achieve this goal, perhaps in part but not fully.

Initially, rehab centers were only for the deviant members of society, such as those with mental illness, cognitive or intellectual disabilities, substance dependence, or physical or sensory limitations until sociologists, psychologists, medical doctors, and mental health advocates recognized that separating these individuals from society further handicapped these populations. Confining individuals to institutions only enabled the individuals to develops a certain mentality that might be described as an institutionalized or prison mentality, where the individuals believe themselves unable to be independent. As these negative effects of institutionalization became apparent, efforts were made to shift care back to the community, thus contributing to what is currently known as rehabilitation.

Rehabilitation has adopted the definition of returning individuals with a physical disability or medical or social impairment to independent functioning. These individuals are expected to adjust normally within society. The criterion of adjustment is crucial to defining rehabilitation, according to R. Wilmot. Adjustment to socially defined norms for behavior also defines rehabilitation. Did the individual relapse or reoffend? As such, rehabilitation is teaching individuals to cope with the stresses and strains of daily living. Stresses and strains can be physical challenges or mental obstacles. Various agencies (rehabilitation centers) respond to the rehabilitative needs of the special populations to address the stress of daily life in an appropriate manner. Additionally, each rehab center offers different resources and therapies to respond to the needs of their population.

Evolution of the Rehabilitation Center

Historically, prisons and psychiatric hospitals were considered rehabilitation centers. Both were used as places of isolation. The assumption consistently made by policy makers, family members, and loved ones was that the socially deviant needed to be separate from the remainder of society in order to protect them or to protect society. Furthermore, there existed the belief, report F. Cullen and P. Gendreau, that offender treatment should be an integral goal of the correctional system and not mainstream society.

Robert Martinson and his Nothing Works doctrine assisted with the separation of correctional facilities from rehab centers. The social and political context associated with prisons was not one associated with rehab but punishment. These ideologies are what separate correctional facilities from rehabilitation centers. Correctional facilities have rehabilitative components and programs; nonetheless, they are still correctional facilities, with the intended goal of retribution. Rehab is not punishment; this distinction is very apparent with facilitates with a focus on physical or sensory limitations.

During the 1970s, prisons and psychiatric wards became crowded with individuals who abused alcohol and drugs or were dependent on these, C. F. Levinthal found, and this forced political ideology and policy changes. Correctional agencies were no longer the sole option, and the rehab center emerged. Various types of rehab centers emerged: drug rehab, alcohol rehab, addiction rehab, and cognitive rehab. These adapted to the needs of the individuals who were once imprisoned.

Much different from prisons, psychiatric hospitals, and alcohol and drug treatment facilities, physical impairment treatment facilities provide treatment to individuals with spinal cord damage or neurological injuries. The Warm Springs Institute, founded by President Roosevelt in 1927 as a post-polio rehabilitation center, was an establishment that emphasized physical health and the sense of social normalcy, describes L. Patterson. However, this institution only serviced whites and had its limitations.

However, this concept has led to what is known today as medical rehabilitation. These rehab centers not only deal with medical and physical problems but also provide psychological assistance. Individuals with major medical problems that have suffered a brain or neurological injury and lost some or all functioning have additional problems. Feelings of hopelessness that may turn into suicidal tendencies need to be addressed. This makes the psychological services rendered a very important component of all rehab centers.

Rehabilitation Policy and Regulation

As prisons were (and some still are) used as rehab centers and the conditions of prison did not resemble a hotel resort (like Warm Springs), prisoners began to complain. Their complaints reached the U.S. Supreme Court, thus inspiring the Prisoners' Rights Movement. Supported by the American Civil Liberties Union (ACLU), prisoners began to advocate for prison reform. This reform addressed the issues that were problematic to incarceration, including medical care. A list of the problems that were the focus of reform included availability of mental health treatment, substance abuse services, restriction of prisoner's rights, and the overreliance of solitary confinement. Conditions of confinement would often exacerbate physical and mental health issues.

Disability activists advocated for what is known today as the Rehabilitation Act of 1973. This movement was in its prime during the 1960s and 1970s. Rehab centers provided individuals with limitations a sense of normalcy while on the grounds of the facilities. However, once the individuals left the walls of these institutions, there were still many barriers to access to overcome, both physical and social. Beyond the walls of rehab centers and summer camps, students began to form organizations that lobbied for barrier-free environments and equality.

There were very many homegrown organizations, but Disabled in Action (DIA) was the first large-scale, cross-disability organization of its kind. This organization's mission is to represent individuals with various disabilities against systemic discrimination. Why would this type of organization be needed if President Richard Nixon already enacted the Rehabilitation Act of 1973? There was still a lot of resistance to the Rehabilitation Act of 1973. School boards were not licensing teachers who were in wheelchairs who passed the written and oral exams. The failure was based on a physical or medical exam. That is just an example of the numerous disability discriminations that were prevalent after the Rehabilitation Act of 1973 was passed. Therefore, DIA worked tirelessly to get the act amended, and Section 504 was added successfully.

Additionally, the Rehabilitation Act of 1973, Section 504, was integral in ensuring that individuals leaving care did not experience discrimination. The Rehabilitation Act lists the qualifying disabilities and clearly states that reasonable accommodations should be made for such an individual. This piece of legislation protects those who meet the disability definition. It also guarantees the individual the opportunity to be a contributing member of society.

Evaluation of Rehabilitation

Guiding interventions of rehab success should be based on best practices and focus on dynamic limitations that can potentially be changed. Multi-analyses reveal that rehab centers should provide meaningful activity for individuals with chronic physical and mental health problems. The prevalence of boredom is a reoccurring issue in many rehab centers. These suggest that the treatment focus should be behavioral in nature. In general, behavioral interventions are effective in changing an array of human behavior.

Successful rehab programs should motivate individuals to participate in rehabilitation activities. Motivation can be measured as minimizing the problem of boredom, according to P. Bracke, K. Bruynooghe, and M. Verhaeghe. Pinpointing organizational causes of boredom in mental health and substance abuse rehabilitation can help to enrich the rehabilitative process. One main purpose of the rehabilitation process is to provide mental health and substance-abusing clients meaningful activities that eliminate idle time.

Because effectiveness in reducing relapse or recidivism is not a perfect indicator of effectiveness and does not apply to organizations that do not handle dependencies or antisocial behavior, programs might consider the program's effectiveness in restoring some greater measure of function as one way of evaluating rehab; possibly, measures of self-care, mobility, attitudes toward self and others, personal motivation, and task completion. This list of measures can be applied to almost all rehab facilities as evaluation measures.

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See Also: Mental Health Services, Adult; Psychiatric/Psychological Assessment; Rehabilitative Services.

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Rehabilitative Services

Rehabilitation services are the comprehensive care of, and recovery from, illness or injury in infants through older adults. Rehabilitation involves a multidisciplinary team approach to develop a treatment plan that addresses a person's physical and cognitive deficits so that the individual can return to functioning at as high of a level as possible—and aligned with the goals he or she wants to achieve.

The role of the social worker in a rehabilitation team setting is both traditional and evolving. This is in response to the seismic changes in health care policy that affect service delivery from the micro level all the way through the macro level. This entry is about the changing role of social workers in the rehabilitation setting and the evolution of these changes.

Due to the fluctuating nature of the health care environment, it is important for social workers to be flexible in fulfilling their team roles. The social worker's primary functions on the team are to (1) advocate for the consumer's wellness goals; (2) ensure that all stakeholders are involved and informed regarding the treatment plan—this could be the family and partners, employers, funding agencies, and possibly durable medical equipment (DME) agencies to help the consumer be as independent as possible in ambulating with or without a wheelchair, using

An injured Marine receives physical therapy as part of his rehabilitative services. Rehabilitation involves a multidisciplinary team approach to develop a treatment plan that addresses a person's physical and cognitive deficits.

shower benches or chairs, raised toilet seats, and so on; and (3) possibly serve as the team leader in coordinating physical, cognitive, and psychosocial treatment goals. A key goal of rehabilitation services is the reintegration of people into the community. This involves all facets of life: vocational services (or return to work or other meaningful activity), speech functioning (for memory, learning, and speech), recreational activities, and occupational therapy (i.e., self-care competency).

The social worker's role in rehabilitative services is changing rapidly as care is increasingly being moved from the hospital or subacute care settings, which are primarily residential, to the home and community, which is likely more preferred for the consumer and much less expensive for the insurance company. The evolution in any allied or primary care roles is due to the influence of several key factors: (1) changes in national health care policy, (2) an aging population that is living longer with chronic conditions that used to be deadly diagnoses (i.e., acquired immune deficiency syndrome [AIDS] and various forms of cancer); (3) the impingement of other health care specialties on what have always been traditional social work domains (i.e., case management increasingly done by nurses and rehabilitation team leadership conducted by psychologists); (4) the rapid cycling of consumers through the various health care acuity levels, who are arriving more acutely ill in the rehabilitation settings than even just five years ago; and (5) a far more expansive scope of practice, requiring a varied skill set, than has traditionally been required of social workers. This expanded scope of practice includes being familiar with medical jargon and procedures. Social workers continuously must also be aware of professional autonomy and the critical importance they play in reintegrating patients back into the community.

Social workers had much work to do to ensure that individuals' dignity and worth were preserved during these rapid change cycles and that programs were developed with consumers' input and goals. Person-centered planning (PCP) became a popular treatment philosophy in the 1980s that is still dominant today when working with individuals with developmental disabilities, mental illness, substance abuse disorders, and general disabilities and chronic conditions. The PCP promotes social inclusion (e.g., community activities, vocational training and placement, and enjoyable recreational activities) through an active, consumer goals-based process. Providers characterize the key constructs behind person-centered methods and approaches four themes: (1) seeing people first rather than diagnostic labels; (2) using ordinary language and images rather than professional jargon; (3) actively searching for a person's gifts and capacities in the context of community life; and (4) strengthening the voice of the person and those who know the person best in accounting for his or her history, evaluating the present conditions in terms of valued experiences, and defining desirable changes in his or her life.

Nowhere is person centeredness more important than in designing health care delivery systems that actively embrace the mosaic of cultures and ethnicities in people requesting services. The information about race and ethnicity has only recently been collected in some major health care systems. Yet training programs that include a diversity component often fail to include content that is relevant to health care delivery. The e-newsletter *Hospitals* *and Health Networks* constructed three case studies that highlight the importance of seeking knowledge about various cultures and ethnicities to promote inclusiveness, and the effectiveness, of care:

1. A Japanese man has a ruptured appendix and needs immediate surgery. Although he was not very anxious about the surgery initially, he started refusing to have the surgery after being taken to his room. Cultural explanation—being aware of some Japanese beliefs about death may help health care providers understand the cause of his anxiety. In Japanese, *four* is pronounced in the same way as the word that means *death*. This makes many Japanese patients uncomfortable in a hospital room with a number four.
2. Following surgery, Mr. Ramirez is reluctant to participate in self-care or to ambulate. His family has complained to the hospital administration that the nurses are not doing their jobs assisting Mr. Ramirez with activities of daily living. Cultural explanation—the American health care system's emphasis on patient self-care to hasten recovery may directly conflict with a Latino belief that a patient should be assisted in daily tasks for the duration of the illness because the patient needs to conserve energy in order to recover. Knowing this, the hospital staff could explain that it is necessary for Mr. Ramirez to get out of bed in order to prevent postoperative complications.
3. A Vietnamese mother was observed by hospital staff to be neglecting her newborn baby. After repeated attempts by hospital staff to engage the mother in conversation by praising the baby, the mother became quite agitated. Cultural explanation—some traditional Vietnamese believe that potentially evil spirits are attracted to infants. In an effort to protect their babies, parents try not to attract attention to them.

As can be seen from these examples, when sociocultural differences between patient and provider aren't appreciated, explored, or communicated, the provider risks patient dissatisfaction, poor adherence to treatment protocols, and poorer health outcomes. Confusion and conflict often can be averted when there is an understanding of cultural differences.

These are just a few, and nowhere near all, of the issues that have impacted social workers in the rehabilitation setting. Amidst these changes, however, social workers must remain true to the values and ethics of the profession as it ensures that consumer goal-directed treatment planning occurs:

"Nothing about me, without me"—this simple phrase, first heard from people with developmental disabilities, clearly states that no goals, interventions, or treatment and discharge planning should occur without the active participation of the consumer.

Least-restrictive environment—the individual should be able to live a life while in rehabilitation or recovery free of restraints, unnecessary seclusion, or exclusion, in a healthy, freedom-based environment.

Lead with education, and end with participation—this means that social workers need to make sure that consumers and their families receive all the information and education they need to make informed decisions on the care and treatment they receive. Community inclusion and full participation are the treatment goals. Culturally competent care should also include a staff training component.

Contemporary social workers who practice in rehabilitation settings often find themselves in these roles: (1) post-acute discharge planners; (2) patient and consumer educators on the nature of a person's illness or condition; (3) interdisciplinary team leaders of clinical specialists in the areas of psychology, speech pathology, vocational planners and job coaches, nursing, occupational therapy, and physical therapy; and 4) family therapists and liaisons to the clinical team. It is incumbent upon every social worker in rehabilitative and medical settings to do as much self-education as possible so that he or she is seen as a competent professional whose knowledge and skill set are critical to the successful treatment goals and outcomes of the family, caregivers, and consumers.

Here is a very brief overview of some of the functions of the interdisciplinary rehabilitation team in which a social worker may find him- or herself in the role of a member or team leader:

1. *Psychology*: The diagnosis and long-term treatment planning of those consumers who have mental health issues.

2. *Speech pathology*: More than just speech production, these professionals often find themselves working with consumers on issues related to memory, organization, and swallowing disorders.
3. *Vocational planners and job coaches.* These professionals often have dual roles. They recruit employers and build sustaining relationships with them as ongoing consumer training placement sites. Job coaches make sure that on-site support is provided to the consumer, if needed, so that vocational goals are on track and the employer is satisfied with the consumer's work. Social engagement with coworkers, in addition to job performance, is often an important goal.
4. *Nurses monitor and oversee the medical management of consumers while in treatment.* There are often comorbid medical conditions that consumer's manage that occurred either before the injury or illness or have resulted as a function of it, as is the case often in many chronic conditions. These conditions could be brittle diabetes, high blood pressure, care and maintenance of stomas or ports, or physical injuries such as broken bones, spinal cord injury, brain injury, or other neuromuscular or cognitive challenges.

Occupational therapist—practitioners are concerned with activities of daily living (ADLs) of their consumers. This involves working on skills and goals related to showering or bathing, dressing, successful completion of tasks such as laundry or cooking, and special skills needed for the consumer to be as independent as possible. To achieve these goals, occupational therapists are also concerned with issues related to vision and visual-perceptual deficits, upper extremity functioning, and grip strength.

Physical therapist—these specialists work on strengthening and conditioning and independent living skills such as balance and coordination, walking, stair climbing, and any needed aids, such as ankle foot orthoses (AFOs), that improve an individual's independence.

The importance of understanding the perspectives of other races and ethnicities has been discussed, but cultural competence also includes knowledge regarding other cultures such as the deaf culture; the lesbian, gay, bisexual, and transgender (LGBT) community; and the influence of gender regarding the care provided. Consider these examples:

1. A 52-year-old lesbian woman becomes critically ill. She and her partner of 11 years have extensively discussed what measures each would like to have should one become ill. Both want to avoid heroic measures and wish to die naturally. The parents of the ill woman are actively involved in their church, known for its conservative theology. The partner is stunned to learn that the belief system of her partner's parents trump her own advocacy on her partner's behalf. Heroic measures have been instituted, such as a respiration tube and a gastrointestinal feeding tube—both measures she knows her partner would detest.
2. A 26-year-old man who uses a wheelchair is in a rehabilitation facility to address decubitus (bedsore) infections. He is his own guardian, has excellent and lively communication skills, and lives independently. He works more than 40 hours a week as a sales representative for a computer company. In a treatment team meeting, his physician turns to his parents and says, "What do you think he would like to do?"

Here are some final thoughts that social workers should keep in mind in the rehabilitation setting. Social work in rehabilitative settings is often very fulfilling work. In acute-care (hospital) settings, the work is fast-paced, and consumer movement out of the hospital setting is quick. In post-acute (home or community-based rehabilitation) settings, the ability to form longer-term relationships with the consumers and their support systems, while working on goals that can often take the consumer years to accomplish, can be very gratifying. In any case, social work in rehabilitative settings has enjoyed a rich history—founded in advocacy and currently based in consumer-directed goal setting.

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See Also: Cultural Competence, Human Service Providers and; Medical Necessity; Outpatient Medical Care; Rehabilitation Centers.

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Religion and Clients

Religion is indicated by a formal system of beliefs, traditions, rituals, and worship that inform a particular worldview. Christianity is the largest monotheistic religion in the world with the majority of adherents in the United States being Protestant. Knowledge about client religious or spiritual issues as well as self-awareness that is developed over time is required to provide human services that are spiritually competent. Human service workers may address client religious or spiritual issues indirectly or directly. Ethical practice sometimes requires a referral to clergy or experienced professional for help.

Definition of Religion

Religion is a system of beliefs that are expressed through the worship of one (monotheistic) or more (polytheistic) deities. A deity is a god or goddess who is believed to have the power to influence life and the afterlife. Religious worship involves the practice of particular rituals such as prayer, meditation, celebration, communion, and offerings made in the name of the god being worshipped. Individuals are socialized to religious dictates through social institutions like family, church, temple, mosque, and government. Hence, religious affiliation helps individuals develop a sense of social identity, gain access to support, and develop behavioral norms for direction in the world.

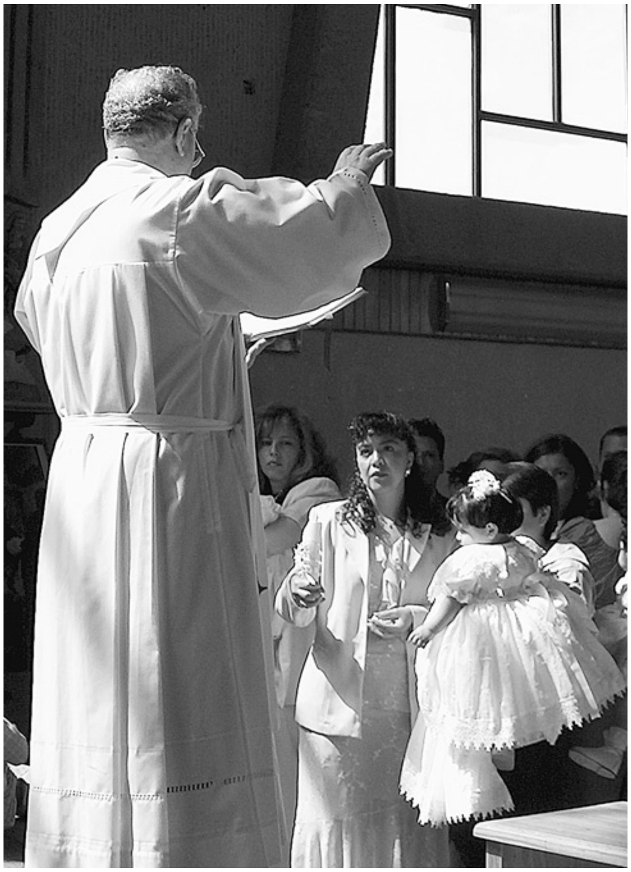
World Religions

There are three major monotheistic religions in the world: Christianity, Judaism, and Islam. Judaism is the oldest of the three major monotheistic religions and the first to focus on the relationship between one God and the Jewish people as documented in the Old Testament of the Holy Bible. Christianity later emerged to include the worship of Jesus Christ, God's son, whose life and teachings are described in the New Testament of the Holy Bible. Islam is also a religious faith that is centered on a belief in God relative to the dictates outlined in the Qur'an (Koran) and the Old Testament of the Holy Bible. The Qur'an is said to be the literal word of God that was dictated as heard from an angel by Mohammad, who became the founder of Islam.

Christianity

Christianity is the most widespread of the three world religions, with the majority of religious adherents in the United States being Christian. Christians believe that God is the creator of humanity. Jesus Christ is believed to be God's son, who was crucified and died on behalf of humanity's sins. His death enabled those who believe in God the opportunity to experience spiritual life after death with God in Heaven. Thus, Jesus Christ is considered the savior of humankind. Separation from God or spiritual damnation is to be avoided through belief in God and adherence to religious dictates. The Holy Spirit is considered to be the breath of life that animates all things. God the Father, Son, and Holy Spirit are believed to represent three dimensions of one God, known as the Trinity.

Christians identify as being Catholic, Eastern Orthodox, or Protestant based on differences in doctrine and tradition. Catholicism is the largest Christian tradition in the world, although in the United States, there are more Protestants than there are Catholics. Unlike Catholics who identify as one universal church starting with the first followers of Jesus Christ, Protestants consist of



Collaboration with clergy, such as this Catholic priest, can be an important resource for human service workers. Clergy are likely to have some training in the provision of pastoral counseling that is provided under the auspices of the clergy's religious institution.

loosely connected denominations that emerged out of efforts to reform the Roman Catholic Church. These denominations can range significantly based on, for example, a literal interpretation of the Bible (fundamental), mission to profess faith and convert others to Christianity (evangelical), and outward expression of the Holy Spirit during worship (charismatic). The most common, mainstream Protestant denominations in the United States are Baptist, Lutheran, Presbyterian, and Methodist.

Catholicism

Catholics recognize the authority of the Pope in Rome and others who take formal religious vows, such as the vow of abstinence and poverty, to serve as official Church leaders. The hierarchical structure consists of the Pope, cardinals, bishops, and clergy. The clergy include priests who must be single males. Priests are assigned to a church by Church authorities. There is an emphasis on liturgical worship that involves a religious rite, called the mass, which is celebrated by a priest in each church. Weekly mass attendance is expected. The mass involves reading the Bible, a sermon by a priest who interprets biblical passages relative to Catholic theology, and sharing of bread and wine.

The elements of bread and wine that are blessed by the priest during communion, called the Eucharist, are believed to transubstantiate into the actual body and blood of Jesus Christ. The Eucharist is one of seven sacraments that include Baptism, Confirmation, Penance (confession), Matrimony, Holy Orders (ordination of clergy), and Anointing of the Sick. Catholics are generally baptized as children and confirmed as adolescents to affirm their Catholic faith. Behaviors that separate one from God are considered sins that require confession to a priest who, representing God's authority, assures the confessor of God's forgiveness and assigns prayers for the confessor to say for spiritual reconciliation.

Catholics believe that they can gain access to Heaven through participation in Church sacraments and sacrifice through charitable works. Upon death, Catholics believe individuals must go to purgatory for spiritual purification before entering Heaven. The Catholic Church formally recognizes certain people who have died as being saints due to their lives of extraordinary faith. The saints and Virgin Mary, the mother of Jesus, are called upon to encourage God to answer the believer's prayer. Divorce, premarital sex, contraception, abortion, and homosexual behavior are forbidden. Catholics are encouraged to use alternatives like annulment, natural family planning, adoption, and abstinence.

Protestantism

Protestants do not recognize the authority of the Pope. Congregations generally hire their own priests who, depending on the church, might be called a minister or a pastor. There is variation in theological training and religious vows required to serve in Protestant churches. Ministers are able to marry, and some churches allow women and sexual minorities to assume ministerial roles. Nonclergy or lay ministers might be employed to facilitate special programming like youth ministry or music ministry. Therefore, Protestant churches have both clergy and lay ministers, including congregational members who play central roles in determining the conduct of congregational life and style of worship.

As a result, the passages of the Bible that are read as well as the manner in which services are conducted are different across denominations and even among congregations within the same denomination. Protestants emphasize a close personal experience with and expression of God that can further result in worship services that are more charismatic than formal in liturgical in style. This might include the incorporation of contemporary Christian worship music and, in some denominations, dancing and speaking in tongues. Speaking in tongues is said to be a manifestation of the Holy Spirit that involves speaking aloud in a manner that cannot be understood by others while in a state of prayer.

A minister generally presides over worship services that involve reading the Bible and a sermon that helps congregants learn how to discern what the Bible is saying for application in daily life relative to church theology and inspiration of the Holy Spirit. Churches may also reenact the Last Supper, but the frequency of Communion depends on the denomination. In general, the elements involved in Communion are not believed to transubstantiate into the actual body and blood of Jesus Christ, but some denominations recognize the spiritual presence of Jesus Christ based on faith known as receptionism. This is just one example of some very complex theological differences between denominations; nevertheless, there are many common beliefs and practices that connect them as well.

Protestants believe that Jesus Christ died for the sins of humanity so that all who believe in God would go to Heaven. Salvation is thus considered a gift from God. As such, it is believed that salvation does not require sacrifice through charitable works or spiritual purification upon death. Neither does salvation require participation in particular sacraments, like Communion, for religious worship does not require church mediation. Some sacraments are used, however, for Protestants to share in congregational life and spiritual growth. Protestants are expected to demonstrate how Christian beliefs have transformed them as reflections of Jesus Christ in the world. For some, this began with a spiritual encounter that led to Christian conversion and formal testimony of salvation.

Given the emphasis on a personal relationship with God, Protestants do not believe that they must confess their sins to a priest for spiritual atonement, nor do they believe in asking the saints or Virgin Mary to ask for God's intervention on their behalf as spiritual intercessors. Christian life is likely to involve membership in a particular church that supports daily adherence to Christian values that inspire others to accept God as one's savior. There are Protestant denominations that believe the Bible is the literal word of God, while others rely on a contextual interpretation along with church tradition and personal discernment to guide behavior. This influences what churches accept as moral behavior.

Broadly speaking, Protestant churches accept divorce and contraception. Premarital sex and abortion are discouraged, although tolerated. The stance on homosexual behavior varies across denominations. Members of the same denomination may also vary in their beliefs given the potential for Protestants to switch denominations based on the composition of a particular church's membership or programming rather than for ideological or theological reasons. In addition, there has been a move away from denominational to nondenominational and interdenominational churches resulting in significant heterogeneity across Protestant churches.

Definition of Spirituality

Another topic that is closely related to religion is spirituality. Spirituality has been defined a variety of ways in academic literature but has often been referred to as the experience of enhanced life meaning, sense of purpose, and transpersonal connection. For people who are affiliated with a religious tradition, church membership and participation may enable a heightened sense of spirituality. Religious adherents may experience spirituality as a transpersonal connection with God through religious practice. Some people consider themselves as being more spiritual than religious, while others identify with being religious rather than spiritual. Such variation makes it even more important for human service workers to assess how clients identify themselves.

Spiritual and Religious Diversity

There is significant diversity within and across adherents of the Christian faith. Even though individuals may ascribe to a particular religious tradition such as Catholic or Protestant, individual views on particular issues may vary within a particular religious denomination as well as across churches within the same denomination. This includes those who have had negative experiences with institutionalized religion. Individuals who have been marginalized based on, for instance, having a minority status will likely require additional sensitivity.

There are some minority groups who rely significantly on religion and spirituality as a resource for coping. For example, the African American Church has been an essential resource for the empowerment of African Americans. The African American hurch is associated with the Baptist tradition. The style of preaching tends to be more interactive with an emphasis on conversion and authority of the Bible. There is significant variation across black Churches, however. Therefore, human service workers need to be sensitive not only to religious diversity but also to issues of race and ethnicity.

It is also important to explore religious beliefs beyond Judaism, Christianity, and Islam. Some of these beliefs are associated with other Christian traditions like the Greek Orthodox faith as well as non-Christian traditions associated with, for example, Native American spirituality and eastern religions of Hinduism, Buddhism, and Confucianism. Although less mainstream, there may be individuals who ascribe to New Age spirituality or Paganism. There are many other people who do not identify with a particular religion although do believe in a higher power and engage in spiritual practices.

Implications for Human Services

Religion can influence clients from birth to death. Religion can influence a client's worldview as well as functioning and problems in living. In particular, Christian beliefs profoundly shape American culture, with Christian values being established as the acceptable norm by social institutions. It is not uncommon for employers to recognize Christian holidays or to see *In God We Trust* inscribed on public property. This is punctuated by ongoing debate over how much the government should allow religion to inform public policy, resulting in political polarization over issues such as contraception, abortion, and homosexual marriage.

The academic literature has reflected this debate where it has been cited that social workers with conservative religious views have been marginalized for questioning dominant support for a more liberal ideology in the social work profession. Questions about the boundary between church and state have further emerged with the institutionalization of federal funding for faith-based organizations. Hence, progress in clarifying how to ethically address religious issues across systems that interface with clients has been slow. Nevertheless, it is important for human service workers to respect a client's religious beliefs, including his or her freedom not to believe.

Such sensitivity is needed because clients might solicit the support of human service workers rather than that of clergy. Understanding client religion is also important to help ensure respectful communication, particularly when clients have religious views that are different from the human service worker. Information about a client's religion can help human service workers be alert to problems that can stem from particular belief systems. This information further enables human service workers to identify appropriate resources or if a specific referral is needed. Advocacy might be required to assure that a client's religious needs are addressed within the client's formal and informal networks.

Spiritual Competence

Spiritual sensitivity starts with a human service worker's willingness to take the time to become spiritually competent. Spiritual competence is driven by a client's desire to experience spiritual well-being and the human service worker's ability to help clients realize this goal through the provision of spiritually sensitive care. Spiritual competence is reflected by a human service worker's understanding of how religion or spirituality influences a client's development and functioning as well as self-awareness and empathy to ensure that services are consistent with a client's religious or spiritual worldview. Like any other professional skill, spiritual competence needs to be cultivated through education.

There are university courses and professional seminars to educate human service workers on client religious or spiritual needs. Practice guidelines and codes of ethics have been developed by professional organizations across disciplines such as the National Association for Human Services and National Association of Social Workers. Accreditation organizations, like the Joint Commission on Accreditation of Healthcare Organizations, require client access to religious or spiritual resources, in particular treatment settings. Therefore, human service workers are expected to be spiritually competent and are given the guidelines and resources to develop this capacity.

Theoretical Models

There are a variety of theories that can help a human service worker understand a client's spiritual, faith, and ethical or moral development. One such model is James Fowler's Theory of Faith Development. According to Fowler, the concept of faith is intended to include religious and nonreligious systems of belief that inform life meaning. Fowler's theory proposes that progressive development of cognitive processing skills enables individuals to move from relying on the faith of others to questioning these beliefs and then integrating knowledge to inform personal faith. The process begins early in life and ends with a faith that gives life coherence by old age.

However, as with any developmental model, people can vary with regard to the ages at which they reach certain stages and the extent to which they achieve developmental tasks in each stage. Additional theories and models have been used to explain how spiritual development is a recursive (back and forth) rather than a linear (straightforward) process. For example, Ken Wilber's spectrum theory suggests that spiritual growth is not confined to milestones based on a particular stage of development but involves the expansion of perceptual consciousness until one is able to consistently operate within a state of awareness of one's innate connection with all things.

Caution should be used when applying these and other theories given the need for research to verify if they accurately reflect how religion and spirituality operate. Nevertheless, there has been considerable research on the health effects of religious affiliation and practice with evidence to suggest significant implications for a client's general well-being. Research has further demonstrated client interest in addressing religious and spiritual issues with trained professionals across treatment settings. These findings support the importance of spiritually competent care that first requires the ability to engage in spiritual assessment.

Spiritual Assessment

A spiritual assessment may not be required in every treatment setting but is likely to be required when clients are receiving medical or behavioral health care services. The type of spiritual assessment and who is responsible for completing it depends on the organization.

A spiritual assessment may start and end with asking if a client has a religious affiliation simply because no more information is needed for service provision. A full assessment may be in order, however, particularly if the client presents with religious or spiritual needs or the experience of spiritual pain.

Information about client beliefs may be collected along with other components of a biopsychosocial history. This process will include a series of questions that result in a narrative description of a client's religious and spiritual background. A spiritual assessment can ultimately inform a personalized understanding of the client's religious and spiritual beliefs and practices, provide an opportunity to communicate respect for the client's religious and spiritual worldview, and clarify potential religious or spiritual needs and resources that may be used throughout the intervention process.

There are assessment tools professionals use to quickly collect client religious and spiritual information identified by acronyms such as FICA (faith, importance or influence, community, and address or action) and HOPE (hope-inspiring resources, organized religious affiliation, personal spirituality and practices, and effects on care). There are also assessment activities that allow a client to visually depict current spiritual resources in the client's environment (a spiritual eco-map), key moments in one's spiritual journey (spiritual life map), and intergenerational spiritual and religious trends (spiritual genogram).

Intervention

The helping relationship provides an excellent opportunity to facilitate a connection that is profoundly nurturing. Human service workers can communicate empathy and compassion while maintaining an unconditional positive regard for clients. This allows for a spiritually sensitive style of engagement that preserves a client's sense of dignity and worth to offset one's experience of hardship, marginalization, and powerlessness. There are times when it may be appropriate to directly address a client's religious or spiritual needs, particularly when a client is in spiritual pain.

When clients present with specific religious or spiritual needs, the intervention must be relative to the client's interests and worker's expertise. More advanced clinical skills are required for spiritually oriented, spiritually integrated, or spiritually modified psychotherapy. The specific name used for this approach depends on the discipline but requires additional accommodation to address client spiritual or religious issues. This may involve the adaptation of psychodynamic, cognitive-behavioral, or transpersonal theories as well as the use of religious or spiritual practices to promote a client's spiritual well-being.

Based on transpersonal psychology, a psychotherapist might help a client expand one's sense of conscious connection to someone or something outside of oneself to experience enhanced life meaning. Spiritually modified cognitive-behavioral therapy could involve reframing cognitive distortions associated with religious beliefs to minimize spiritual distress. A 12-step program might use client prayer to bolster faith in a higher power and meet needs in a healthy way. Such interventions require a mental health evaluation to ensure that client religiosity is not a delusion or hallucination associated with mental illness.

Referral

Collaboration with clergy can be an important resource, especially when a client is involved with a particular religious organization or religious information is needed for client intervention. When clients primarily seek religious counsel or spiritual growth, a referral to clergy or experienced professional would be appropriate. Such a referral would also be warranted if the human services worker does not have the authority, time, or comfort level required to address a client's religious or spiritual needs. In any case, a client's written permission is required before connecting with this resource.

Clergy include priests, pastors, ministers, rabbis, and other religious leaders. These professionals usually have seminary training that provides a theological foundation in a particular religious tradition. Clergy have the expertise and authority to address client interpretation of scripture, teaching how to employ religious dictates in daily life, and facilitate religious rites that can be integral to client spiritual well-being. Clergy are likely to have some training in the provision of pastoral counseling that is provided under the auspices of the clergy's religious institution.

Some religious institutions also provide more comprehensive social services. In faith-based organizations, religious dictates of the sponsoring religious institution are integrated into the organization's mission, employment practices, and service delivery; however, the degree of faith integration in organizational operations can vary and be relative to funding limitations. For example, faith-based organizations that receive federal funding are required to provide services to clients without discrimination, but such organizations can hire staff based on religious affiliation.

For clients who are receiving inpatient hospital services or hospice care, a human services worker might also refer the client to a chaplain. Chaplains do not usually represent a particular religious affiliation but often have theological or other training that enables them to address issues of faith. Human service workers may also work with other professionals such as nurses and social workers to ensure a client's religious or spiritual needs are addressed. Social workers with a clinical license may provide spiritually oriented psychotherapy as well as mobilize other resources that are spiritually sensitive.

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See Also: Social Work, Diversity Practice in; Spirituality/Religion and Diversity; Values and Ethics, Ethnic Diversity and.

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Reparations

As a public recognition of systematic disadvantages imposed on a group, reparations attempt to materially and symbolically correct harms done to marginalized populations through exclusion or mistreatment. When a group of people have been treated unjustly and have no legal recourse, a remedy is sought that acknowledges the wrongdoing and offers some sort of payment to redress the injustice. Reparations serve this purpose. In addition to material compensation, reparations represent atonement for unjust actions. Unlike purely legal settlements such as torts, reparations imply an apology to the victims and an admission of responsibility by (or on behalf of) the perpetrators. Reparations may be directed to individuals or to groups, and they may consist of one-time or ongoing compensation. Although reparations most commonly take the form of monetary payments, they also can consist of rehabilitative services (such as provision of psychiatric or therapeutic programs) or in-kind aid (such as employment or educational opportunities).

Rationale and Functions of Reparations

Philosophically, reparations often have been justified on the basis of corrective justice, which acknowledges and seeks to redress past wrongs. By contrast, advocates of retributive justice treat reparations primarily as a punishment against the offenders. This view underlies many impositions of war reparations, which the victors may impose as deliberately harsh economic penalties.

Reparations can perform several roles. As restitution, reparations can restore material losses. Return of seized possessions or assets can thus serve distributive justice, redistributing resources to their prior conditions. Reparations also signal official disavowal of the regime that authorized the initial wrongdoing. Germany's commitment to meeting its reparation obligations to Holocaust survivors has affirmed the desire to distance the nation from its fascist past.

Symbolically, reparations represent formal legal closure to acknowledged systematic oppression. The sheer act of awarding reparations, regardless of amount or form, may foster reconciliation between victims and perpetrators by recognizing prior suffering and expressing the desire to prevent its recurrence. This legal declaration of wrongdoing generates complicated questions. Heated debates center on whether restitution implies forgiveness of the perpetrators, absolving them and their descendants of further responsibilities toward the oppressed groups. Some researchers have questioned the conciliatory value of reparations, arguing that they refocus attention on past suffering rather than promote reintegration of oppressed groups into a more harmonious social order.

Instances of Reparations

Several examples illustrate the variety and degree of reparations. Germany's payments to compensate victims of the Holocaust constitute the largest and most sustained program of formal reparations. Since World War II, Germany has paid more than $89 billion in reparations for various atrocities and wrongdoings associated with the Holocaust. Payments have continued without interruption since the 1952 Luxembourg Agreement. Funds are distributed as direct payments to victims (most of whom are Jewish survivors), as aid to the nation of Israel, or to support organizations associated with promoting Holocaust education and genocide prevention. There are also ongoing efforts to restore stolen or seized property and assets to their rightful owners.

The United States has mixed experience with reparations. In 1988, Congress issued a formal apology for forcible internment of Japanese Americans during World War II. This apology was accompanied by $1.6 billion in payments to survivors. The issue of reparations for chattel slavery (legally terminated by the Emancipation Proclamation in 1863) remains contentious. Courts have consistently dismissed lawsuits against the federal government and corporations for damages resulting from chattel slavery.

Some individual lawsuits have resulted in formal apologies from private corporations. In 2009, the Senate passed a resolution that formally apologized for slavery and racial segregation but did not offer compensation. A similar congressional apology—without financial reparations—for injustices to Native Americans was issued in 2009.

Other nations have used reparations to respond to different forms of injustice. In 1992, Chile offered monthly pensions to victims and families of those affected by executions, torture, and deportation under the dictatorship of Augusto Pinochet. In 1995 and 1996, Japan agreed to pay an estimated $20 million related to the use of up to 200,000 Korean comfort women as sex slaves in occupied territories during World War II. The Japanese Parliament issued an apology in 2007 despite a denial by the prime minister at the time. In 1998, Canada agreed to pay $350 million (Canadian) to aboriginal families for forcibly assimilating children and removing them from their native cultures. The South African Truth and Reconciliation Commission's reparation recommendations in 1997 emphasized provision of resources for individual and community empowerment as an essential component. To that end, the commission recommended a broad commitment to providing sufficient housing, education, and employment services as integral to making the victims of apartheid full participants in postapartheid society.

Challenges of Making Reparations

Several challenges accompany the determination and implementation of reparations. First, who qualifies as eligible for reparations? This issue complicates cases such as reparations for slavery in the United States because all those who were actually enslaved have since died. It also remains unclear what threshold of harm would justify eligibility for reparations. Would a concentration camp survivor and someone deported from his or her homeland during the Nazi regime both deserve reparations? Second, who bears responsibility for making reparations? For example, several German corporations used slave labor from concentration camps, but those companies may have been acquired by or merged with others or gone out of business entirely. Third, what constitutes an appropriate amount and kind of reparations? This question raises perhaps the most difficult issue surrounding reparations: how to quantify the various forms of physical, psychological, and emotional suffering instigated by oppression.

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See Also: Anti-Semitism; Displaced Persons; Torture, Survivors of; War and Terrorism, Survivors of.

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Respite Care

According to a 2009 survey completed by National Alliance for Caregiving and the American Association of Retired Persons, an estimated 65.7 million people, or 29 percent of the population, had served as unpaid family caregivers to an adult or child with special needs during the previous 12 months. The sample reported providing an average of about 20 hours of care per week. The economic value of their activities has been estimated at $450 billion for unpaid care provision.

In California, for example, it is estimated that family caregivers may annually provide up to $47 billion of unpaid caregiving. The need for respite care to meet culturally and socially diverse American families remains a challenge for service delivery organizations offering caregiver respite supports. Ethnic, religious, family composition, residential locale, and language are but a few of the cultural variations that must be taken into consideration to accommodate the needs of both the caregiver and person for whom respite support is being offered. Matching the respite provider to families being serviced must approach cultural diversity as a priority for effective results.

This unpaid care is often described as family caregiving. However, it is a very broad term that refers to the efforts of family members as well as other persons invested in the care of an adult or child with special needs. The activities of these caregivers are sometimes referred to as informal caregiving because they do not receive payment. The individuals assist care recipients who are at any and every stage of the life span with needs for assistance from family caregivers that may be time limited or continuous. Family caregivers, for example, assist with or complete tasks of daily living, monitor the environment to ensure safety, maintain personal hygiene, participate in medical and health care regimes, interact to reduce social isolation or stimulate sensory acuity for the care recipient. Caregiver assistance is most frequently offered in a home environment, often in the home of the care recipient. Respite care is offered to caregivers as temporary relief from their activities through planned or crisis care provided to a dependent child or adult with special needs such as autism, Down syndrome, multiple sclerosis, traumatic brain injury, and Alzheimer's disease. Formalized respite care resources have increased extensively over the past decade and are recognized as a formal service arrangement included within a long-term service and support system.

Caregiver Burden and Respite Care Need

Irrespective of the type of disability, there are some similar factors influencing the increasing demand for caregiver respite. Most significant is the demographics of the aging population, the ever-increasing longevity of aging persons, and the ethnic and cultural diversity of aging Americans. These factors crosscut needs present in disabilities, acquired brain injury, aging, and mental illness. Both individual caregivers and their families may experience high degrees of burden, consistent stress and anxiety, fatigue, relationship tension, and conflict. Some caregivers have family members and others in their social networks who may assist the primary caregiver. For instance, an elderly wife with a husband severely disabled by a stroke may have a younger widowed brother assume responsibility for financial management beyond the capacity of the wife, who is continuously engaged in spousal care. Another example is an aunt of an autistic child making use of her vacation time to live in the home to allow parents to take their other children on a family holiday. In such situations, the primary caregivers take leave for the day-to-day emotional and physical challenges of caregiving.

Caregivers vary in their desire for and actual willingness to take advantage of informal care assistance and more formal respite services. For some caregivers, their sources of informal respite have dissipated as the result of the intensification of a care recipient's needs. In other situations, individuals who previously relied on relief are no longer available because of changes in personal circumstances. Sometimes provision of respite to the primary caregiver becomes entangled in relationship conflicts, making the option of assistance unacceptable to the caregiver or care recipient. For other caregivers, far too many, they alone are giving 24-hour care to spouses, disabled children, or aging parents with no adequate, informal respite.

Providing caregivers release time from routine, rigorous care demands has been well researched in relation to deferring or eliminating the need for institutional care, enhancing relationships in the family system, and promoting self-care and the well-being of caregivers. Whether or not the respite care is provided from an informal or formal source, caregivers must be able to trust and depend on a knowledgeable respite provider. On the other hand, when respite care is provided in or out of the household, caregivers tend to evaluate service benefits in relation to the needs of the care receiver. While there is an infinite array of caregiving scenarios, there are common areas of need in the lives of a caregiver that demonstrate the necessity of more and approved respite care options.

Significant underdevelopment of respite care service alternatives is of ongoing concern to health and mental health professionals, politicians and policy makers, citizen advocates, and caregivers. National caregiver advocacy organizations, such as the National Family Caregivers Association, Family Caregivers Alliance, Alzheimer's Disease Association, American Association of Retired Persons, national- and state-level developmental disability associations, and national veteran's organizations, have effectively advocated for more respite care through state- and federal-level policy advocacy.

National Efforts to Develop Respite Care Systems

The nationwide availability of quality respite care to meet the special needs of children and adults is being supported through Title XXIX of the Public Health Services Act, the Lifespan Respite Care Act of 2006 (PL109-442). The U.S. Administration on Aging (AoA) within the Department of Health and Human Services (DHHS) is the federal oversight agency designated to competitively award grants to states for respite care system expansion. In 2009 and 2010, AoA funded 21 three-year grants to state aging and disability services departments to create and sustain life-span respite programs. The objectives of these state programs are to ensure respite services are available to families across age and disability spectrums. These programs expand and enhance respite services within the participating state, improve coordination, disseminate respite care information, fill critical respite care gaps, and promote the overall quality of available services. In order to support successful project outcomes, a technical assistance contract was awarded to the ARCH National Respite Network and Resource Center, partnered with the National Family Alliance. These organizations in collaboration with the funded states and AoA have developed respite guidelines based on consensus principles for respite care delivery models and programs.

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See Also: Adult Day Care; Aging and Adult Services; Elder Care/Geriatric Services; Families, Nontraditional; Medicaid.

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Respite Services

Respite services are temporary services designed to provide relief care for families of children or adults with special needs. Respite services can range from a few hours of relief care provided on a one-time basis to overnight or extended sessions. Care might be accessed on a regular or irregular basis and may be provided by family members, friends, community members, skilled care providers, or respite care professionals. Respite services are used by a diversity of communities (race, ethnic, age, sex, religion, etc.), and services often need to be tailored to the needs of each community. The majority of respite services are geared toward children, older adults, and adults with special needs. These services need to be additionally tailored depending on the cultural and linguistic needs of the population being served. With the growing diversity of communities, especially communities comprised of large numbers of immigrants and refugees, respite services have to be increasingly provided in a variety of languages and dialects and take into consideration the traditions, cultures, and beliefs of these communities.

Respite care has the primary goal of assisting families with caretaking responsibilities and needs. The caretakers of children or adults with special needs often experience serious problems or stress as a result of having to balance caretaking with other needs and responsibilities. Respite care provides a much-needed break and allows caretakers to attend to the needs of their children, spouses, or themselves. To this end, respite services provide temporary stress relief, improve family stability, and reduce the likelihood of abuse or neglect. Accessing respite services also helps to improve long-term family stability and reduces the need for out-of-home placements or residential care.

Respite services can be provided in the home or outside of the home in a special facility. For most families, in-home respite services are preferred to out-of-home services. There are several advantages to in-home respite such as (1) the care recipient might feel more comfortable at home and in a familiar setting; (2) the home is already set up to address the special needs of the child or adult; (3) cost is usually lower than out-of-home care, especially if a relative provides care; and (4) transportation is not a barrier to accessing treatment.

Typical Models of In-Home Respite

Model 1: In-home respite. In this model, respite care is provided in the home of the adult or child. The relief caregiver goes to the home of the primary caregiver and becomes familiar with the adult or child in his or her usual environment. The adult or child receiving care is not burdened by having to acclimate to a new environment or navigate transportation.

Model 2: Sitter–companion services. Sitter–companion services are provided by individuals who are trained to care for children or adults with special needs. Such services might be the project of a service organization or specialized nonprofit agency.

Model 3: Consumer-directed respite. This model involves having a friend or relative provide respite services to a care recipient. The difference with this model is that the care provider has been selected by the family and trained by a respite program or the family itself. In this model, the care provider might be paid or unpaid. If they are paid, it is often through a voucher program offered directly to family caregivers to allow them to locate, hire, train, and pay their own providers.

Out-of-home respite provides an opportunity for the care recipients to receive respite services outside of their homes. While out-of-home care may present some obstacles, it does have some benefits. Out-of-home care allows care recipients to experience new surroundings, different expectations, peer relationships, and even cognitive and emotional stimulation. Here are some typical models of out-of-home respite:

Model 4: Family care homes or host family model. In the family care home or host family model, respite services are provided in the care provider's home. Services might be delivered in the home of a staff person from a respite program, a trained volunteer's home, a family day care home, or a licensed foster home. Homes used in this model are often licensed to provide care by regulating agencies.

Model 5: Respite center-based model. In this model, the respite program contracts with existing day care centers to provide respite to children with special needs. This model has been found to be effective in rural areas and allows children and adults to be cared for in a facility that might be close to home. These programs may be located in community centers, after-school programs, or churches.

*Model 6: Respite in corporate foster home settings for children and teen*s. This model of care provides a homelike environment monitored by trained, rotating staff. Care is provided to children and teens as vacancies occur. In particular, some teens adapt well to this model of care because it presents opportunities for semi-independent living.

Model 7: Residential facilities. In this model, long-term residential facilities set aside a specific number of beds to be used for shorter-term respite services. These services might be provided at community residences, nursing homes, state-owned facilities, assisted living homes, and nursing homes. Respite might be offered on an overnight, weekend, or extended-stay basis.

Model 8: Parent or family caregiver cooperative model. Many communities, especially in rural areas, have developed caregiver cooperatives where more formal models of respite are limited. Used primarily with children with special needs or chronic illnesses, families will often trade respite services with one another. This model has been especially helpful with young veterans who have experienced a traumatic brain injury or other disabling condition. In this model, families receive services on a regular and planned basis, and fees are usually not charged.

Model 9: Hospital based. Hospitals can also provide respite services for children and adults with special needs. This model can be especially appropriate for smaller communities where the hospital census may not be very high. Care receivers are able to receive high-quality services in familiar surroundings that might be close to home, offering a sense of security. Veterans' hospitals often provide respite for eligible veterans.

Model 10: Adult day-care centers. For more than 20 years, adult day-care centers have been providing respite services to families in need. In addition to respite services for caregivers, day-care centers also provide health services, therapeutic services, and social activities for adults with severe physical or mental illness. These services have expanded dramatically in the last decade due to new funding sources, such as Medicaid waivers, being available. Care receivers attend day-care centers for several hours a day, usually five days a week. Limited weekend services might also be provided.

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See Also: Children With Special Needs; Elder Care/Geriatric Services; Respite Care.

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Restorative Justice

> "Restorative justice is a compass, not a map."
> —Howard Zehr

There is no overarching or agreed-upon definition of restorative justice. It encompasses a broad set of empowerment-based practices and decisions made in response to crime, inviting an agenda of accountability and rehabilitation strategies for diverse groups including adolescents, adults, and older adults in the criminal justice system. By the mid-1990s, several hundred victim–offender reconciliation programs (the terms *victim* and *offender* are used throughout, acknowledging the stigma associated with this language) emerged in North America and Europe alongside New Zealand-based family group conferencing. Advocates of restorative justice in social work, psychology, criminology, and other professions acknowledge the importance of responsivity to cultural traditions in addressing crime (such as First Nations' healing circles), with promising research-based outcomes. Unifying theory, practice, and research, the principles are intended to be an interface among individual rights and social justice and well-being in communities. Howard Zehr conceptualizes restorative justice as a compass that invites community dialogue regarding a continuum of offenses, including the most severe, and he emphasizes that the Western legal system may exacerbate conflicts rather than fostering healing or peace.

At the heart of restorative justice (RJ) frameworks, also known as transformational justice, are three principles advanced by Zehr: restoration, accountability, and engagement. The practice of restorative conferencing is an alternative to offender-centered sanctions and punishment that attempts to balance the needs of all the stakeholders (victim, offender, and community), which leads to restorative agreements while encouraging accountability for offending behavior and promoting victim healing from traumatic stress. Types of restorations include damaged relationships, physical and mental health, and international peacemaking. In order to effectively respond to crime, victims, offenders, families, and community stakeholders are engaged to identify and repair the harm. Questions restorative justice proponents pose include: What is the nature of the harm resulting from the crime? What needs to be done to repair the harm? Who is responsible for repair? Are all stakeholders involved?

The criminologist John Braithwaite argues for the marriage between responsive regulation and restorative justice and that standards for evaluation of restorative justice processes include how well they are aligned with fundamental human rights and foster democratic participation of stakeholders (e.g., regulation that is not shaped only by powerful legal entrepreneurs). RJ conferences would, for example, not result in imposing unreasonable punishments. Integral to restorative processes are the noncoercive values that facilitators ask of participants directly (such as respectful listening) and indirectly (such as apology and forgiveness). Scholars such as Kathleen Daly do not consider RJ to be the opposite of retributive justice.

RJ discourses have roots in the aboriginal systems of community-based decision making in Australia and New Zealand, with a range of applicability from addressing bullying in schools to healing in child sexual abuse cases, as well as situations of gendered or intimate partner violence, where conferencing and resolving conflict in a community setting can be effective. The formation of modern restorative justice emerged out of the traditions of the Mennonite Community during the 1970s in Canada and Indiana.

In the United States, Vermont, Colorado (the first state mandating that judges notify adjudicated youth of RJ options), California, Minnesota, and other states have been implementing RJ principles through the use of conferencing circles, reparative boards, and family group conferencing, with positive outcomes in restoring victim losses and reducing the likelihood of offender recidivism. In 1982, Fresno County created the Victim Offender Reconciliation Program, adopted in 1995 by the United Nations (UN) for International Restorative Justice. RJ programs such as these are in line with research corroborating the negative effects associated with the reliance on punitive sanctions (e.g., federal risk-based classification systems such as sex offender registration and notification applied to juveniles) as well as the costs and health effects of long-term incarceration on younger and older offenders. In south Australia, for example, conferencing in cases of youthful sexual assault has been shown to be more effective and less victimizing than the court process.

Efficacy

Meta-analyses have identified effectiveness factors associated with restorative justice programs: (1) victim satisfaction, (2) offender satisfaction, (3) increased offender compliance with restitution, and (4) decreased recidivism. RJ proponents emphasize that restorative justice is not focused on reducing recidivism, although that may be the outcome of the process encouraging offender accountability and involvement of those affected by the crime. The effectiveness of human service delivery (e.g., family therapy) and interventions to prevent recidivism among juvenile offenders, compared with punitive strategies, has been well documented.

Core Restorative Practices: Sentencing Circles

A structured method of equal dialogue among stakeholders using a talking piece (e.g., a rock or feather) to facilitate speaking time, designed to illicit the victim's story and foster self-governance and community safety. Examples of circles include Robin Wilson's Circles of Support and Accountability (COSA), enacted in many communities in the United States and Canada in high-risk sex offender cases as a community reintegration model in line with the UN Standards for the Treatment of Prisoners. It involves offender accountability and community safety protocols, with the acknowledgement that traditional public safety measures and notification policies have been inadequate and that accountability combined with support with community integration can prevent recidivism. Additionally, Lorenn Walker's reentry and transition planning circles for incarcerated individuals is a circle model designed to provide a space for offenders to express remorse and understand the impact of their crime, using solution-focused interventions.

Family Group Conferencing

Subsumed under restorative justice practices, family group conferencing (FGC) engages youth and their extended families in democratic decision making in both the child welfare and juvenile justice systems. Historically associated with addressing the overrepresentation of the Maori in the criminal justice system in New Zealand, FGC values family systems of care, partnerships with professionals, and healing from the impact of crime. The process involves four stages facilitated by a coordinator: opening, information sharing, deliberations and consensus, and closing, with the additional consideration of safety planning in cases of child abuse and neglect. Victim involvement can be crucial to ensure the offender's input is not central. Gale Burford pioneered the implementation of FGC in Vermont.

Reparative Boards

Community reparative boards in Vermont were shaped by RJ principles. They include community capacity-building and decision-making processes that involve recruiting and training board members who make recommendations regarding offender compliance with the probation or diversion contract, incorporating victim input (violations can result in renegotiation or a return to court). Offenders are usually considered low risk and may choose traditional sentencing rather than reparative probation. The goals include repairing the harm to victims and offender reintegration in the community, and boards can refer to FGCs or victim–offender mediation.

Other core practices and models include written or verbal apologies to victims, victim–offender dialogues, UN Truth Commissions (on human rights violations), financial restitution to victims, and community justice boards.

Conclusion

Despite evidence that RJ programs can be effective, there remains a popular belief that formal punishment is needed in order to prevent offender recidivism. Community justice boards that engage community members in understanding and addressing offenses, FGC, or sentencing circles provide compelling alternatives to legal pathways that focus solely on individualized risk assessments.

Indeed, despite the international growth of RJ models, there are controversies from a victim advocates' perspective about whether practices such as case conferences are a better option than formal court proceedings in cases involving domestic and sexual violence. One central conclusion is that it is important to implement potentially restorative approaches rather than solely rely on punitive processes. Finally, it should be noted that an ideal justice system does not draw from one approach, whether it be retributive, rehabilitative, or restorative. In fact, the retributive–restorative binary is not defensible from empirical grounds.

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See Also: Adolescent/Youth Services: Overview; Child Welfare Services; Community Corrections; Prisoner Reentry Programs; Victim Services.

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Reverse Discrimination

Treating someone differently (better or worse) based on the person's race, gender, or physical attributes constitutes discrimination. Women and racial minorities were historical targets of discrimination, sanctioned by the legal system. The expression *reverse discrimination* has been used to characterize the "unfair" treatment that men or whites have received in admissions and employment.

Members of the historically disadvantaged (underrepresented) groups (i.e., women and racial minorities) are being admitted into professional or graduate programs, hired, or promoted over members of the majority group (i.e., men and whites). Alleged discrimination against whites or men revolves around a denial of admissions to graduate, law, and medical schools. Alleged discrimination against white males in the labor markets includes but is not limited to hiring, compensation, discipline, discharge, promotion, demotion, and layoffs in law enforcement, firefighting, sanitation, teaching, and civil service. However, reverse discrimination is not frequent.

Affirmative Action: Promoting Equality of Opportunity

In 1965, U.S. President Lyndon Johnson signed an executive order to prohibit discrimination in education and employment based on race and gender. Federal contractors are required to take affirmative action to ensure that applicants are employed without regard to race, creed, color, national origin, or gender. Employers are expected to give members of the historically (economically or educationally) disadvantaged groups (blacks, Hispanics or Latinos, American Indians, and Asians)

A group of white male businessmen, a segment of the population that may be targeted by reverse discrimination, which occurs when members of historically underrepresented groups are hired or promoted over members of the majority group.

special consideration in admissions and in hiring. The purpose of an affirmative action program is to redress past discrimination against women and minorities by pushing employers to try harder—to cast a wider net seeking out blacks among the best and not the best among blacks. The program is aimed at leveling the playing field for all in education and employment.

Critics of affirmative action have argued that the practice is an unwarranted punishment to white males. Giving special consideration to members of underrepresented groups in admissions, hiring, and promotions would give unfair advantages to women and minorities and in turn has adversely affected white males. Some label such governments intervention as positive discrimination and challenge it on legal and moral grounds:

Reverse discrimination undermines the core values of equality and fairness in American society. After outlawing discrimination based on race and gender in the society, everyone should be treated the same way (equality). Giving special consideration to members of the underrepresented groups in admissions and employment is unfair to members of the majority group.

The counterclaim would be that few have raised questions about social justice when applicants receive special consideration if they meet one of the following nonrace, nongender-based affirmative action criteria used in admissions or employment: athletes, specially talented, low-income family, geographical location, religion, disability, war veterans, children of donors (alumni, faculty, or staff), or having personal or professional ties to current (or former) workers.

Reverse discrimination violates the principle of meritocracy and lowers the overall productivity in the society. To get the best-qualified candidates, selection, rewards, and promotions should be based *solely* on merits and not on irrelevant characteristics such as race or gender.

The counterclaim would be that selection for many jobs is seldom based on merits alone. In addition to having the ability to do well on paper or pencil tests (merits), special consideration has been given to qualifications related to job performance such as cultural sensitivity, interpersonal skills, and communication skills.

Reverse discrimination generates a feeling of inferiority in women and minorities and creates a negative stereotype in the mind of white males. Women and minorities may see themselves merely as tokens or quota hires to meet the requirements of an affirmative action program. Others may see all women and minorities as unqualified or less qualified for the positions when compared to white males. Taken together, this can undermine the dignity of women and minorities who have the requisite skills and qualifications to meet the admissions or job requirements.

The counterclaim would be that the evidence of a self-perception of inferiority among women and minorities is anecdotal and speculative. There is no empirical evidence of lower self-esteem among women and minorities. Stigma or negative stereotypes of women and minorities have long existed before the implementation of affirmative action. Additionally, no stigma has been attached to athletes admitted to college or veterans hired for certain jobs.

Reverse discrimination extends (and does not end) gender bias and racial prejudice in the society. If it was wrong for schools and employers to treat women and minorities badly in the past, it is also wrong to start treating men and whites badly when many of them have had nothing to do with historical discriminatory policies or practices against women and blacks.

The counterclaim would be that whites and males are the direct beneficiaries of historical discrimination against women and minorities. An increase of women and minorities in colleges and in the workforce is not because they have suddenly become smarter but because discriminatory policies and practices have been outlawed. They are free to receive education and to participate in jobs that were historically reserved for men or whites only.

Prevalence

There is no evidence of widespread discrimination against whites or males. A majority of high-level positions in both the public and private sectors are still held by white males. It has been suggested that angry white males have simply misdirected anger toward minorities and women as a result of restructuring in the economy.

Incidences of reverse discrimination reported by white males are rare compared to complaints about discrimination by women and minorities. Generally, it is not easy to measure and prove discrimination. To successfully challenge discrimination by schools or employers in courts, it takes resources, organization, and mobilization among the plaintiffs. Litigations are lengthy and costly when outcomes are highly uncertain.

Cuts in government spending, corporate restructuring, and downsizing have eliminated many jobs previously held by white males, especially in middle-level management or administration. It is not easy for middle-age white males who have lost their jobs to find employment commensurate with their experience, due to skills obsolescence or competition with newcomers in their fields. Being self-employed or working as an independent contractor has become a realistic option for white males holding previously high-paying, high-status jobs.

Data reveal that the majority of high-paying jobs or leadership positions are still occupied by white males. Additionally, despite recent gains in educational and occupational attainments, women and racial minorities still trail men and whites in science and engineering education, in earnings, and in gaining promotions to supervisory positions.

The direct evidence for perceived widespread of reverse discrimination is anecdotal. For instance, lucrative job offers from top universities to women or minority scholars to launch a new program or direct a research center typically attract a lot of media attention.

Unlike mass mobilization against racial and gender discrimination, there is no evidence of collective and well-organized efforts among white males against reverse discrimination. Unlike women and racial minorities, the disproportionate control of the United States Congress and the executive branch by white males reflects the lesser importance of the courts as an instrument to protect and promote their interests in schools and workplaces.

Cases

Although cases of reverse discrimination are rare, a few historical and recent cases are particularly noteworthy.

In 1978, Allan Bakke successfully challenged the Medical School of the University of California at Davis at the U.S. Supreme Court for twice denying him admission because he was white.

In 1996, the court struck down the race-conscious admissions program of the University of Texas Law School using lower minimum criteria for blacks and Latinos than for others.

The Fulton County in Georgia was ordered by a judge to pay $300,000 to the county's deputy director of human services for being passed over for a promotion in favor of a black woman in 2007.

In 2009, a group of white firefighters won a reverse discrimination case when the U.S. Supreme Court ruled that the city of New Haven, Connecticut, improperly threw out the promotion test results. City officials claimed that only one but no blacks would qualify for promotion based on the test results.

Implications for Human Services

Due to dramatic demographic changes, the U.S. population has become more culturally diverse than ever. At the same time, demands for goods and services in the global economy have compelled many U.S. companies to seek, retain, and promote talented and skilled workers. Through practices and policies, leadership from the top could make a lasting and positive impact on the trends of diversity in the workplace.

First, government and corporations should take steps to ensure the selection, evaluation, and promotion criteria and processes are clear, fair, and transparent to all of those concerned. Second, employers should take a comprehensive approach in the provision and delivery of human services to a multicultural workforce. Broadening cross-cultural knowledge and skills of the workforce could improve the overall cultural competence of staff when interacting with one another and with the public. Seminars to help workers deal with gender, ethnic, and cultural differences in communication styles could foster intergroup understandings, enhance productivity, and promote job satisfaction. Third, employee assistance programs could benefit from hiring psychologists and social workers who are capable of providing counseling and therapy services, information, and referrals to a culturally diverse workforce.

Unique human services could be targeted to workers who have negative reactions or opposition to peers who look, think, and act differently from themselves or who have failed to move up the organizational ladder. Boot camps run by outside experts (or career coaches) could offer this at-risk group realistic self-assessments and counseling. Female and minority workers would potentially benefit from support and services from career coaches on career development and advancement.

Cosponsoring workshops on employment and career assistance services could improve the career prospects of a diverse workforce. A multicultural workforce could also benefit from learning about the psychological and emotional tolls of microaggressions (i.e., day-to-day behaviors, knowingly or unknowingly) such as slights and put-downs that carry covert negative connotations to the recipients.

A diverse workforce calls for different human services needs and delivery. To meet the needs of different groups, government and corporations are required to devote resources to personnel training and deployment of these services. Thus, the trend of diversifying the workforce has become the locomotive of further changes in the labor market by increasing the demands for human services professionals such as therapists, social workers, counselors, and career coaches.

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See Also: Discrimination and Institutional Racism; Diversity in the Workplace; Prejudice, Theories of; Racism, Long-Term Effects of; White Privilege.

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Rites of Passage

Rites of passage have their roots in anthropology and are generally defined as group processes designed to structure and provide meaning to the various transitional stages in human development, from childhood into adulthood. Research on rite of passage programs began in the early 20th century by anthropologists reflecting programs that included debutante balls for the white upper class. More recent research on rites of passage programs has focused on youth in marginalized schools and communities. Schools are considered to be a place that prepares young people for their roles in society and aids them in transitioning from childhood to adulthood.

Purpose and Structure

Rites of passage programs exist in communities to assist members with any transition from one phase of life to another, such as birth, puberty, or death. N. Warfield-Coppock identified six formats for rites of passage programs: community-based, agency- or organizationally based, school-based, church-based, therapeutic, and family-based rites of passage programs. The rites of passage symbolic rituals of separation, transition, and incorporation assist individuals in gaining skills, values, norms, and morals that prepare them to accept roles in society. Rites of passage rituals are typically composed of (1) separation from the community, (2) preparation from elders, (3) a period of transition, and

(4) reintroduction to the community. Today, rites of passage programs tend to be culturally specific and focus on improving self-concept, ethnic identity development, and self-sufficiency among at-risk youth. The primary aim is to influence youth to be cooperative, understand and respect the sameness of self and of other individuals, and have a high sense of responsibility for the well-being and harmonious interconnection between self and community.

Rites of passage programs are typically designed as after-school, weekend, or summer programs. Components of rites of passage programs can include foreign language acquisition, arts and crafts, history, mathematics and science, martial arts, cultural excursions, and academic tutoring. Rites of passage programs facilitate academic improvement by requiring strict attendance, providing homework assistance, and helping students to develop conflict resolution skills. Structurally, these programs intervene at the school, family, and individual levels. Program staff frequently include administrators, teachers, athletic coaches, human service professionals, and mentors who are often members of the community.

The Role of Human Service Providers

Human service professionals are often involved in rites of passage programs to assist with the developmental needs of the participants. In order to engage in rites of passage programs, it is recommended that human service professionals first strive to become more knowledgeable about the culture of the community served and the sociopolitical realities that the families experience. Cultural understanding enables professionals to work with diverse populations in ways that validate their experiences. For many service providers, this will necessitate leaving the comfort of their workplaces and entering into culturally diverse communities. Activities, such as participating in outreach work, volunteering, and attending cultural events with community stakeholders, are ways to engage in immersion experiences and increase cultural understanding.

As staff members or consultants, human service professionals focus on psychosocial concerns and often provide psychoeducational workshops on identity development (personal, cultural, and social), interpersonal communication and conflict resolution, and decision making and moral judgement. The emphasis on psychosocial development allows for prevention and intervention with social skills, familial interactions and dynamics, educational challenges, and career planning. Service providers can provide services for program participants as well as their parents in the form of individual, group, and family counseling; psychoeducational workshops for participants; parent support groups; crisis intervention; and in-service training for staff. Human service professionals can also develop relationships with school personnel for fluid communication between the school and the program. Additionally, they can provide outreach to family members and social service agencies to connect participants to much-needed services. By partnering with community entities to provide supplemental services and culturally informed interventions, human service professionals can assist marginalized youth in developing the coping skills necessary to combat educational hegemony and social marginalization.

For more information about rites of passage programs, human services professionals can explore Web sites describing single-sex and coeducational programs. Additionally, program Web sites can be found that articulate services for specific cultural groups, such as African Americans and Latinos. Other resources include books that describe how to develop a rites of passage program (e.g., Ron Spears) and explicate the use of rites of passage programs within the human services paradigm (e.g., Jerome Schiele). Peer-reviewed journal articles are also useful in developing evidence-based interventions based upon the outcomes of research studies exploring the benefits of rites of passage programs.

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See Also: African Americans; Cultural Competence, Human Service Providers and; Discrimination and Institutional Racism; Providers, Institutional Racism and; Racism, Long-Term Effects of; White Privilege.

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Role Flexibility, International Differences in

In society, people perform or enact different social roles. A woman may be a corporate executive, mother, and graduate student. A man may be a teacher, the coach of his son's Little League team, and the prayer leader in his local congregation. The ability to move between varied and sometimes conflicting roles is called role flexibility. Roles are socially defined—the ease with which an individual embraces a role is to a large extent determined by personal expectations and the expectations of the community and society. Similarly, the ease with which an individual is able to transition among roles is dependent on the dynamics of the culture in which the individual participates. As such, there are marked international differences in role flexibility.

Loose Versus Tight Culture

Role flexibility is easier to achieve in a loose culture than it is in a tight culture. Loose cultures are cultures with relatively fluid norms, while tight cultures have norms that are more rigid, and there is less room for deviations. Loose cultures include countries such as Brazil, Hungary, the Netherlands, Ukraine, and the United States. Conversely, countries such as Pakistan, India, Japan, Singapore, and South Korea have been identified as tight cultures. In tight cultures, norms are preserved through the application of harsh sanctions such as the death penalty. The fear of sanctions in tight cultures mediates behavior, and people are more unwilling to strain the boundaries of established roles. In addition, people in tight cultures tend to identify with the ideals of the culture and develop self-regulatory beliefs and behaviors that parallel social expectations. As such, people in tight cultures exhibit less flexibility than people in loose cultures.

Gender Role Flexibility

One role that is significantly mediated by culture is gender. Gender role flexibility is the ability to challenge and go beyond social prescriptions of what it means to be masculine or feminine. While there have always been individuals who reject gender stereotyping, historically, masculinity has been associated with strength, dominance, independence, and assertiveness, and femininity has been associated with passiveness, expressiveness, and dependence. These definitions of masculinity and femininity are tied to social roles. In some cultures, there are clear lines of demarcation between the roles, but in other cultures, some lines are blurred. In Western societies, for example, there is a movement toward egalitarianism, and women and men are increasingly enacting roles that were once reserved for the opposite sex. This flexibility is evident in choice of occupation, dress, and domestic responsibilities.

The shift in traditional gender roles is partly a result of social and economic changes that are impacting the structure of families worldwide. An increasing number of women are now accessing education and gaining paid employment. In some instances, women are earning more than their spouses, and their income is necessary for the economic well-being of the family. These realities have influenced changes in attitudes about the roles women and men are expected to carry out.

In spite of the widespread change in gender attitudes, there are some cultures—particularly in rural areas—where gender ideologies remain fixed. In regions of some developing countries in Asia, Africa, Latin America, and the Caribbean, an androgynous or transgendered individual may experience violence for violating social norms. Even a man who carries out domestic chores sometimes receives the ridicule of other men and risks losing the respect of the women. Similarly, women who venture into traditional male roles are criticized for failing to embrace their prescribed roles as wives and mothers. On the other hand, men and women who act according to their stereotypical gender roles receive the approval of their communities. These social sanctions and reinforcements result in inflexible role boundaries, particularly among males. Internationally, men tend to have a deeper aversion to moving between gender roles, and women have greater gender role flexibility. The difference in gender role flexibility between men and women is probably most evident in social attitudes toward lesbians and gays. In general, heterosexual individuals demonstrate more favorable attitudes for lesbians than they do for gays.

Role Flexibility in the Workplace

Similar to the conflict in gender roles, workers often experience difficulty moving between their roles in the workplace and their roles in the family. Long work hours and rigid workplace structures frequently conflict with family responsibilities. Working caregivers of children and aging parents find they are pressured to find time for medical appointments and their children's extracurricular activities while advancing their careers. Also, because women often find it difficult to reenter the job market after taking time off, some working mothers experience tension in deciding whether to return to work and protect their jobs or spend time with their newborn child. In a number of countries, even if mothers decide to return to work part time, they normally do so at the expense of reduced hourly wage and loss of benefits. In the United States, part-time workers earn 21 percent less than full-time workers.

The amount of tension that arises between individuals' responsibility to their families and their responsibility to their jobs varies depending on labor laws and company policies. The United States has fewer labor laws than many European countries, and on average, workers in the United States work longer hours than their European counterparts. The limited legal protection U.S. employees receive makes it more difficult for them to move between their roles as parents and wage earners. In other parts of the world where work hours are shorter and there are more regulations that protect employees, workers may find it easier to navigate both roles. In Sweden, for example, working parents have the right to reduce their work week by up to 25 percent until their child is 8 years old or has completed first grade.

The Benefits of Role Flexibility

Role conflict theory suggests role flexibility reduces conflict between competing roles. When individuals have freedom to act in different—sometimes incompatible—capacities, they experience less anxiety and achieve greater psychological well-being. In the workplace, role flexibility can result in reduced absenteeism, lower stress levels among workers, and an enhanced ability to attract and keep high-quality staff. All of this translates into improved worker satisfaction and productivity and a better quality of life.

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See Also: Ethnic Diversity and Values; LGBTQ Clients; Regional Cultural Competence.

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Runaway Youth

In the United States, there are two distinct yet frequently overlapping populations of transient minors who may be receiving a variety of human services and support: runaway and homeless youth and youth victims of human trafficking. Considering their age and legal status, these minors are highly vulnerable to injustice, oppression, violence, and general lack of access to basic human necessities like food, clothing, and shelter. It is important for human services professionals to understand some of the common characteristics of these groups and to know where and how to access resources to help these potential clients. It is also important to note that many of these youth face additional and intersecting oppressions because of previous and primary socioeconomic, sexual or gender, racial or ethnic, or other minority statuses.

Unaccompanied Homeless Youth

The first group of minors falls into the federally defined category of being runaway or homeless youth. This population has been separated from their family of origin or adults responsible for their care, either by choice via running away from home or by force, when their caregivers kick them out or *throw them away* (an expression used in the federal definition). According to the National Alliance to End Homelessness, it is likely that, in a given three-year period, more than 550,000 youth will fall into this category.

Additional studies conclude that one in seven young people between the ages of 10 and 18 will run away. Youth age 12 to 17 are more at risk of homelessness than adults. Out of all runaways, 75 percent are female. Estimates of the number of pregnant homeless girls are between 6 and 22 percent. Between 20 and 40 percent of homeless youth identify as gay, lesbian, bisexual, transgender, or questioning GLBTQ. Of all runaway and homeless youth, 46 percent reported being physically abused, 38 percent reported being emotionally abused, and 17 percent reported being forced into unwanted sexual activity by a family or household member. And, 75 percent have dropped out or will drop out of school. Reasons cited show that the most common reasons why these youth run away or become homeless are due to family problems, leaving foster care, and poverty.

A subcategory of the unaccompanied homeless youth population is made up of youth who have been forced into physical or sexual labor and essentially into an underground slave trade. Because of their vulnerability, runaway or homeless youth from the first category may become victims of human trafficking; yet another significant number of trafficked youth are illegally transported in and out of the United States by vast international networks of perpetrators. Estimates show that anywhere from less than one-quarter to more than half of the identified human trafficking victims globally are minors under the age of 18.

Programs and Services

A large majority of services for all homeless minors are funded in large part by the federal government through the Runaway and Homeless Youth Act (RHYA), which was first enacted in 1974. This legislation funnels grants through the Department of Health and Human Services' Family and Youth Services Bureau (FYSB) to private, nonprofit agencies as well as state and local governments. Among the FYSB-funded programs are a national hotline service, prevention and outreach services, emergency shelters, and transitional living programs. The Departments of State and Labor make up the largest share of fiscal responsibility for services to victims of human trafficking. If an unaccompanied minor can be certified by the federal government as a victim of human trafficking, a number of services and supports are available to assist them.

Two other important pieces of legislation that significantly impact the availability of services, especially education support, to both groups of minors in the United States are the McKinney-Vento Act of 1987, which mandates that public schools make accommodations to ensure that homeless youth have access to education, and the Chaffee Act, which provides ongoing services and financial support to youth aging out of the foster care system with the goal of preventing homelessness. There have also been important state-level legislative initiatives that have been passed to increase the accessibility of education, shelter, medical and dental care, and transportation to these youth.

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See Also: Adolescent/Youth Services: Overview; At-Risk Youth Services; Children, Youth, and Human Trafficking; Youth Risk Behavior Surveillance System.

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Rural Communities

The practice of human services in rural American communities presents both special challenges and unique opportunities to professionals. The human service profession is committed to meeting human needs, promoting social justice, enhancing quality of life, and developing the full potential of individuals, families, groups, and communities in society. Rural communities usually lack the social and economic resources that exist in most urban communities. The rising unemployment rates and increasing poverty, coupled with rural-life, unique risk factors, such as isolation and scarcity of services, and behavioral problems, such as domestic violence and alcohol and substance abuse, have led to a higher need for human services and safety net programs, including food stamps, job training, and direct financial assistance. Ineluctably, rural life involves a certain amount of economic risks that the individual has no control over, and there is limited capacity to support community-based human services to assist people experiencing serious economic difficulties.

The lack of adequate attention to conditions in rural communities results in a parsimonious range of choices, few opportunities for personal or community development, and living conditions and levels of income that tend to lag behind those in urban areas. Rural communities, based on census classifications, have less than 10,000 people. Usually, they include a small town that might have a grocery store, gas station, and perhaps a tavern. Such communities, however, usually lack substantial human services and resources. Residents of most rural communities often depend on the county and neighboring towns for resources. People in a rural community live under very different accompaniments than those in metropolitan areas. Communities in rural areas are characterized with low population density as residents either live relatively apart or the entire community may be populated by few people.

A rural Appalachian family in the early 20th century. As a stimulus to address rural issues, with rural communities being defined as having less than 10,000 people based on census classifications, the Appalachian Redevelopment Act of 1965 provided considerable funds for the provision of services to the Appalachian Mountain region.

Rural communities also tend to be more geographically distant than urban areas. Although rural communities, like the rest of the United States, are becoming increasingly diverse and multidimensional, they still tend to be more specialized than urban areas, which are more likely to have more room for diverse services. All rural communities, nevertheless, are not necessarily alike. Rural communities can be identified in four distinct types: (1) the farm or ranch trade center, (2) the bedroom community for an urban area, (3) the tourist center, and (4) the mining, energy, or timber company town. Although each type of community experiences unique problems, all are undergoing rapid transition and encounter difficulties in adapting to this change.

Another serious barrier is the stigma attached to having problems and receiving services in rural communities. This negative perception commonly prevents individuals and families from seeking help for their problems, particularly in the area of mental health. Rural community residents are reluctant to use human services for reasons that include concerns about the family's reputation; pride; a family tradition of self-reliance and not asking for help from social agencies; fear of being perceived or labeled as lazy or incapable of taking care of oneself; and mistrust of the social welfare system.

Developmental History of Human Services

The term *human service* is a broad umbrella category that includes many different kinds of work in the helping field. Among the early, prominent human service workers were doctors and nurses, teachers, lawyers, social workers, the clergy, and others. Before the period of industrialization, heavy reliance on the self-help approach remained the major means of providing human needs in rural areas. While the Charity Organization Society (COS) and the settlement house movement had significant impacts in shaping human services demand and delivery in urban settings, they had little effect on rural areas. In the past, rural residents were bound together through their dependence on the land, mostly through faming for their livelihood. For this reason, public welfare has never been as acceptable in rural areas as in urban communities. Historically, the original Social Security Act's social insurance arrangement did not provide coverage to farmers and other self-employed citizens and, as such, offered little protection to rural populations. The human service field in the United States began in the 1950s and since then has grown with the impact of deinstitutionalization, the War on Poverty program, the New Careers movement, and the proliferation of community colleges.

The reemergence of interest in professional human service in rural American communities began in the early 1960s. The unrest of the 1960s influenced human service providers, mainly social workers. Many new types of professional practices and new practice settings were developed. Since the 1960s, the human service movement has experienced tremendous growth. This growth is evidenced by the increase in the number of training programs, the unprecedented expansion in the size of the mental health delivery systems and the establishment of the human service administration at the federal level. As a stimulus to address rural issues, the Appalachian Redevelopment Act of 1965 provided considerable funds for the provision of services to the Appalachian Mountain region. Part of the funds were available to professionals in health and social services and contributed to the creation of different approaches to practice and different human service delivery patterns.

Furthermore, government expenditures on social welfare increased dramatically between 1960 and 1970. With the passage of Title XX legislation in 1975 came another infusion of funds specifically for social services. In the years that followed, a group of practitioners in various rural sectors around the country began to organize special knowledge bases for work in these settings. In 1975, the National Organization for Human Service Education (NOHSE) was founded at the 5th Annual Faculty Development Conference of the Southern Regional Education Board. The National Institute of Mental Health (NIMH), in 1976, appropriated funds to the Southern Regional Education Board (SREB) to establish national standards for training and reviewing human service programs. The efforts of SREB led to the formation of the Council for Standards in Human Service Education (CSHSE) in February 1979.

The CSHSE was established with the mandate to provide guidance and direction to education and training programs in human services by identifying criteria for faculty, curricula, field education, student admission and advisement, and essential resources. As formal organizations, both NOHSE and CSHSE played major roles in the establishment of the human services methodology as an important field of study for the helping professions. Additionally, the term *human service*, as opposed to “welfare,” was given the official stamp of approval in 1980, when the federal Department of Health, Education, and Welfare (HEW) changed its name to HHS. In 1982, the National Commission for Human Service Workers (NCHSW) was formed to provide a national system for voluntary registration and certification of human service workers.

Human Services and Rural Community Practice

Since the 1970s, interest in providing human services in rural areas has increased. Historically, those living in rural areas have been disadvantaged, experiencing steady erosion in population and quality of life. They are more likely to be elderly, be members of disadvantaged minorities, lack the kinds of resources and opportunities available to their urban counterparts, and be in need of the help of human service professionals and agencies. More barriers or difficulties in providing accessible and adequate services include shortages of trained helping professionals, the large distance between clients and providers, the management of confidentiality, and the coordination of care. Overall, the rural population of the United States has lower incomes, higher unemployment levels, higher poverty rates, inadequate educational service, and insufficient health and social services compared with urban and suburban areas.

Although human service practice in rural areas may not require considerably different competencies than those routinely required for the human services worker in urban settings, it must be understood that the application of activities is definitely different. The rural human service worker often is one of a very small number of professionals in a community, and as such, the worker is expected to possess broad knowledge and skills required to improve conditions for the clients of the community. It is imperative that the rural human service worker must be independently resourceful, innovative, and self-motivating and have the ability to function with minimal supervision. They are to be versatile in their practice with clients and willing, sometimes, to engage in unconventional approaches to services provision.

Rural human service practice requires much more than the transfer of an urban worker’s knowledge, skills, and urban-oriented approaches to service delivery to rural settings. A rural human service worker must be prepared to provide counseling to individuals, families, and groups; to establish support networks and engage natural helpers in providing services; and to work with local, county, and other community elites to generate needed resources. The worker recognizes the need to devote adequate attention to working with the community to develop prevention programs and to build linkages among the existing services to maximize their effectiveness. The worker, sometimes, may have to performs the role of the spokesperson for the most vulnerable people in the community.

Practice Perspective in Rural Community Human Services

Human service practice in rural communities challenges the worker to use a range of professional interventions and community skills. Rural community human services call for the worker to have practice potential and experience in broad areas such as clinical and health practice, community organization, administration and management, public welfare, and community-based services. The human service practitioner’s skills that are based on the generalist concept and training are uniquely suited to helping rural people plan their lives, families, groups, organizations, and communities to surmount adversity. Generalist rural service workers look at issues in context with the intention to find solutions within the interactions between client systems and their social environments. Human service generalists possess the knowledge, values, and skills to perform several job functions while moving beyond the confines of individually focused practice to the expansive sphere of intervention at the multiple systems level.

The generalist also works with a rural community client using both the micro and macro systems perspective. The micro system intervention focuses on work with individuals in the client’s environment, including family and small groups, and related others such as friends, teachers, coworkers, and individuals within human service delivery. Using the problem-solving process of engagement, data collection, assessment, intervention, evaluation, and termination, the worker should be able to provide assistance to different client systems. The worker engages in interviewing the client, establishing rapport, and engaging in planning and problem solving. The goal is to foster changes within personal functioning in social relationships and in the part of people's interaction with social and institutional resources. Intervention at the macro systems level addresses social problems in community, organization, agency, neighborhood, institutional, and societal systems. At this level, the generalist practitioner works as a community planner, locality developer, public educator, neighborhood organizer, and policy developer, and also engage in social action. The goal is to work with rural clients to understand the relationship between their problems and the larger environment and, therefore, find change strategies in the process.

Case management is also a viable approach for service delivery in rural communities. This approach provides for a central worker who knows and understands the client's full situation or who is charged with the responsibility for planning and coordinating intervention activities. The goal of case management is to educate those who need assistance to manage their own lives but to support them when professional expertise is needed or a crisis develops. Use of case management as a method of coordinating and delivering service in a rural setting may be suited for long-term care involving work with individuals experiencing problems associated with aging, disability, and mental illness. Essentially, case managers gather information, conduct assessments, arrange services from other agencies, and provide advocacy and direct services. They assume responsibility for the allocation of scarce resources, provide quality assurance, and most importantly, monitor services.

Case management provides a single point of access advantage rather than entry points at each agency. Furthermore, it is important that rural human service practitioners empower members of their communities to appreciate the interconnectedness of their lives in the social fabric and economic and political structures of the country. Empowerment is a process through which individuals, families, organizations, communities, and societies realize and increase their personal, interpersonal, and political power to make and advance improvement in their life situations.

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See Also: Appalachia and Human Services; Department of Health and Human Services, U.S.; Social Welfare Policy, Cultural Competence in.

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Same-Sex Couples/Marriage

Same-sex couples exist in every ethnic, religious, racial, and cultural group. Respective social norms and cultural taboos can often challenge the experience of being welcomed within families or the immediate and broader society of a community or country.

Homosexuality is prevalent in approximately 10 percent of the population. Many gay individuals partner with others and, if available, may choose to have a personal, religious, or civil union or domestic partnership. Increasingly, same-sex marriage is becoming available to a greater number of global citizens. However, legislation still exists in the United States and in other countries that criminalizes such relationships and relevant sexual behaviors. Penalties may range from being completely overlooked to a death sentence.

Human service providers need to understand the needs and expectations of same-sex couples within the context of the clients' relationships and macro systems that may condemn their very existence. Effective service provision is dependent on cultural competence as well as awareness by the provider of their own attitudes toward same-sex couples and marriage. If a practitioner is not able to offer supportive and solution-based services due to personal biases, they must, ethically, refer the clients to others absent such beliefs so that the best possible services can be offered.

Same-Sex Couples: A Historical Overview

Same-sex couples have existed throughout reported history. The Bible presents the story of Ruth and Naomi, and while unclear, some find the suggestion of a lesbian relationship. Evidence suggests the acceptance of homosexual relationships in ancient Egypt in which a pharaoh's tomb was made for a same-sex couple, representing the kingdom's acceptance of that relationship. Similar relationships existed in Mesopotamia; early documents outlined types of relationships including those of male lovers and kings. The Code of Hammurabi, one of the recorded laws of Mesopotamia, contained restrictions against same-sex unions.

Plato described same-sex attractions and homosexual relationships, which were accepted in ancient Greece without condemnation. Greek mythology provided examples of same-sex involvement by the god Zeus. Homer's *Iliad* and *The Odyssey* provided subtle poetic passages discussing homoerotic love. Same-sex unions existed in ancient Rome, even among Roman emperors. Cicero, a Roman statesman, documented legal rights of individuals within same-sex marriages. Such opportunities pertained to men more than women due to the lack of equal freedoms for women economically and socially.

With the rise of Christianity, Rome experienced a change similar to that of Greece in increasing negative attitudes regarding same-sex unions as well as nonprocreative sex. Rome ultimately passed a fourth-century law to punish anyone in a same-sex marriage.

Religious traditions regarding homosexuality have changed over time. Eastern religions presented overall more-tolerant attitudes than those of Western belief systems. The Vedas, the sacred texts of Hindus, view homosexuality as a perversion but do not restrict it. Mixed-race relationships were considered much more offensive. The most-tolerant attitude toward homosexuality was in Japanese Buddhism, which praises its essence due to its mystery. Modern Japan holds no restrictions, religious or political, recognizing homosexual behavior as a private matter between consenting adults; gay unions are not yet legally recognized.

Later Buddhist texts were similarly neutral. Today, same-sex love is counter to the political norms in India; however, Hindu traditions provide community elders with the decision of determining if a marriage is acceptable.

The advent of Christianity and the power of the Church in medieval Europe stigmatized same-sex relationships. Yet some evidence shows such relationships existed freely during the early Middle Ages. There was very limited European sexual law forbidding same-sex behavior, and there is evidence in clergy literature of compassion regarding homosexuality even within its own membership. The Church tolerated such unions and even offered some ceremonies. Gay clerics performed homosexual marriages as far back as the 4th century. The first laws against sodomy appeared in the 13th century. In the West, the next few centuries provided numerous examples of behaviors deemed unnatural or deviant, which shifted the perception of same-sex couples as a threat to society, like witches and Jews. This led to violent reactions by many. Heterosexuality became accepted as the normal sexual orientation by the 19th century, resulting in a rejection of any deviations, viewed as diseases, best served by individual suppression if not treated in another way. Western society came to predominantly forbid same-sex marriage. Missionaries shared these beliefs globally, converting indigenous belief systems and practices. The Nazis classified homosexuals as part of an inferior race, leading to the greatest discrimination of this population by the mass murder of many.

Same-Sex Relationships in Modern Society

The advent of the gay and lesbian rights movement of the 1960s provided a vocal and visual awareness for many of a population that wanted to claim rights equal to the rest of society. Religious interpretations of marriage as only appropriate between one man and one woman prevented the provision and guarantee of equal rights as denoted in the U.S. Constitution. The influence of religion on federal policies and laws was profound in this area. Studies found long-term same-sex couples as similar to heterosexuals regarding stability and longevity. Yet social stigma, prejudice, lack of many entitlements from inheritance and adoption to health care decisions and Social Security spousal qualifications undermined the legitimacy of such relationships within society, delaying legal recognition for decades.

Over time, different countries, and states within the United States, began to provide recognition of unions by domestic partnerships or civil unions and, in some cases, even marriage with full rights granted to heterosexual counterparts.

The United States enacted the Defense of Marriage Act of 1996, which defined marriage as a union between one man and one woman. The United States observes states' rights allowing each to decide jurisdictional laws independently. Many states forbid same-sex marriages and, despite a federal law that requires the recognition of a legally binding marriage in one state to be recognized by every other, federalism allowed states to not recognize same-sex legal unions from other states.

Legal Recognition of Same-Sex Marriages

An increasing number of countries provide same-sex marriage licenses. The Netherlands recognized this freedom to marry in 2001, followed by Belgium (2003); Spain, a Catholic country, and Canada (2005); South Africa (2006); Norway and then Sweden (2009); Portugal, Iceland, and Argentina (2010); Denmark (2012); and Brazil, France, Uruguay, and New Zealand (2013). In Britain, including England and Wales, same-sex couples were able to marry as of 2014.

Other countries, including the United States, have regional freedom for same-sex marriage.

Massachusetts, in 2004, became the first U.S. state to allow same-sex couples to marry. Since then, California, Connecticut, Delaware, Iowa, Maine, Maryland, Minnesota, New Hampshire, New York, Rhode Island, Vermont, Washington, and Washington, D.C., all passed their own state laws. This number of states passing laws either for or against same-sex marriage is changing rapidly. In addition, several Native American nations within the United States recognize same-sex marriages. Other states have domestic partner and civil union options, which provide some states rights.

In 2013, the U.S. Supreme Court struck down the Defense of Marriage Act, which resulted in individual states already performing such marriages adding federal recognitions and benefits to their same-sex, legally married residents. However, states still banning same-sex marriage recognition continue to deny rights now recognized at federal and state levels to same-sex couples legally married in another state. This presents a range of issues that will be debated in the courts as is happening in Pennsylvania, which does not recognize same-sex marriage from any state or offer civil unions or domestic partnerships. One Pennsylvania county offering marriage licenses is being challenged in a lawsuit by the state. New Jersey's legislature voted to allow same-sex marriage; however, Governor Chris Christie vetoed the legislation saying this should be a referendum for the state to determine. However, a state judge ruled that the *civil union* designation illegally prevented same-sex couples from receiving equality guaranteed by the Constitution, becoming the first case applying the U.S. Supreme Court's decisions to state law. The judge ruled on September 27, 2013, that same-sex couples must be permitted to marry in the state of New Jersey; while the governor planned to appeal to the state Supreme Court, he withdrew the appeal the same year.

Several other states are in the process of offering civil unions or domestic partnerships. The majority of states still deny same-sex marriages within their own as well as recognition of those from other states. It is expected that challenges to these state laws will eventually overturn them as was done with the antimiscegenation laws banning interracial marriage in some states. In *Loving v. Virginia* (1967), the Supreme Court invalidated a Virginia antimiscegenation law that violated the equal-protection clause of the Fourteenth Amendment to the U.S. Constitution.

Challenges remain. Divorce laws for couples married in one state but living in another where their marriage is not recognized will not be able to end their marriage. Couples may have difficulty implementing parental and custodial rights if their adoption is not recognized in the state of residence.

Federal legislation has provided U.S. military benefits to same-sex couples married in states that allow same-sex marriage. A quandary arises when such couples relocate to another base in a state that does not recognize same-sex marriage. While such marriages remain recognized on the base, they are not recognized in the state, and rights are lost, at the state level, once off base. An adoptive parent may not be able to advocate for his or her child or attend to vital medical matters for his or her child or spouse. This creates inequities in experiences and rights for military-based families from one state to another. The U.S. government has extended Internal Revenue Service (IRS) federal benefits to all gay married couples regardless of the state laws of residence recognizing their marriage or not. Oklahoma, based on a voter-approved constitutional amendment, has become the fourth state, following Texas, Mississippi, and Louisiana, to stop processing benefits to same-sex legally married couples in its state National Guard despite a federal directive requiring such provisions. These fast-changing and complicated regulations lead to many issues human service providers need to address.

Human Service Providers' Obligations to Consumers

Human service providers range from paraprofessionals to credentialed professionals, all of whom work to provide referrals, services, and other benefits and entitlements to the clients they serve. Absent the issue of same-sex couples and marriage, individuals working in any human service field are likely to have personal values relevant to biases and deservedness of clients. Biases can arise from race, ethnicity, age, any type of physical or mental challenge, religious beliefs, immigration status, and legal histories. It can be challenging to provide services to members of groups with which the service provider feels uncomfortable.

Responsible practice requires such practitioners to refer any individual to whom they cannot provide full and equal support and service to another provider. Knowing one's own practice limitations regarding populations is essential. In addition, competence and knowledge of current legislation is key in providing proper services based on the most up-to-date legal decisions.

Keeping Up With the Law

Changes in legislation regarding same-sex marriage in the United States seem to be occurring almost weekly. While it took an extended period of time for states previously identified to legalize same-sex marriage within their jurisdictions, the U.S. Supreme Court made two groundbreaking decisions in June 2013.

The decision was whether or not to support a California court's decision to overturn Proposition 8, which was a ballot initiative on a California state constitutional amendment restricting marriage as between one man and one woman. The U.S. Supreme Court determined the case should not be before that court. By declining to decide if Proposition 8 was constitutional or not, the Supreme Court left the lower court's decision in place, allowing gay marriage to be the law of the state as it had been prior to Proposition 8. A second decision that same week, in June, *United States v. Windsor,* determined that federal law denied Ms. Windsor, a surviving spouse, inheritance protections afforded heterosexual, married, widowed partners. Married to her late spouse, she faced a tax bill of $360,000 versus no such bill for a heterosexual widow. This case quickly led to the federal government's decision to afford all same-sex married couples these IRS protections.

Same-Sex Couple and Marriage Complexities Faced by Human Service Providers

Not everyone supports same sex marriage. In fact, a number of people find homosexuality incomprehensible or sinful. Human service providers are also members of society, and while many may find ways to fairly address needs of clients of different cultures and belief systems, the ability to address same-sex couples fairly may be an especially challenging task for some. Changes in state and federal laws as well as nonrecognition of legal marriages from another state, while federal benefits like IRS recognition are legal, can become very confusing. In one day, same-sex married partners, legally married in another state, absent any recognition in their current state, might become eligible for federal but not state benefits. Human service providers must keep up with current regulations, benefits, and qualifications; in some cases, laws are being adjusted or written at the same time that clients are seeking assistance.

Challenges to Personal Values of Human Service Providers

Continuing in this vein, human service providers need to untangle available and developing referrals and services. They need to be competent in dealing with immigration issues, which now legally recognize same-sex married couples where one partner might have been previously deported or denied heterosexual citizenship benefits. Families of same-sex partners, now legally married, with children, as well as same-sex couples without children, can need a range of services that human service providers previously did not have to provide. Meeting aging, married, same-sex couples and helping them with IRS and other benefits to which they are entitled may seem distasteful, frivolous, or unimportant to practitioners. Social justice provisions in all professional codes of ethics require professionals to advocate on behalf of individuals who are being categorically denied services freely available to others.

Human service providers work within social service agencies in many cases or with other types of organizations, such as schools and hospitals. These need to address their possibly biased standards and rules regarding service provision. Many social service agencies have religious affiliations; they may not recognize abortion as a pregnancy option or approve of same-sex relationships much less marriages and adoptions. All service agencies will need to provide diversity training to all employees and volunteers, in particular, in this case, regarding issues relevant to marriage in the lesbian, gay, bisexual, and transgender (LGBT) community, and appropriate referrals if they feel unable to provide adequate services.

Same-sex marriage has been a long sought-after equal rights recognition that is slowly making its way across the globe and within the United States. Service providers who work and provide services in states that recognize same-sex marriage but who find same-sex marriage to conflict with their personal beliefs will have to deal with that paradox. Such workers will need to do their best to understand their own personal biases in order to work with individuals to whom they must provide benefits for which they are now legally eligible.

Conclusion

Same-sex couples and their rights to marry have varied throughout history. This century has provided a variety of new challenges globally and within the United States regarding such couples' service needs and the abilities and demands of human service workers to provide appropriate, informed, accurate, unbiased, and nonjudgmental assistance. Too often, opinions are value laden, which is not appropriate in human service practice. Clients must, ideally, receive equal care and attention. This can be immensely challenging for some, and it should be noted that not all biases are based on sexual orientation.

Human service workers are not required to change their personal values, only to be mindful of them and how they might interfere with fair and equitable treatment of their consumers. If they cannot work with a specific population, in this case, same-sex couples, married or not, it is imperative that they excuse themselves from the professional relationship and appropriately refer the case to another practitioner who can better meet the needs of those clients who are seeking services.

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See Also: AIDS/HIV Programs; Domestic Violence, Victims of; Heterosexual Privilege; Marriage and Family Therapy; Transgender Individuals.

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School Counselors

School counselors coordinate and assist students of diverse socioeconomic and demographic backgrounds. Employed in elementary, middle, and high schools, in public and private institutions, this unique population of human service workers engages in academic, social, and emotional counseling. Their jobs may require them to connect students to school and community resources and help students (and often their families) resolve a variety of problems. The field of school counseling (as evidenced in the curriculum of credentialing programs, professional journals, and conferences) acknowledges that working with diverse student bodies shapes counselors' practices and attitudes and that counselors' practices can inequitably impact youth. This entry focuses on public high school counselors (the group most studied by researchers). It first provides an overview of counselors' tasks and interactions then discusses how a focus on diversity and equity characterizes counselor credentialing programs and professional associations. It concludes by identifying some dilemmas facing this field of professionals.

Counseling Activities in Public High Schools

Virtually all public high schools have counselors who are part of the support infrastructure for students. Other members of this infrastructure (aside from teachers and administrators) may include any of the following: social workers, nurses, psychologists, school interns, police officers, intervention counselors, and special education teachers. Any given school is likely to employ a handful of full-time counselors and employ the other service providers on a part-time basis; the latter may work part time in multiple high schools.

The American School Counseling Association National Model of standards identifies three separate yet overlapping domains in counselors' work: academic, career, and social or personal. Academic counseling ranges from advising students on which courses they need to take, which requirements they need to fulfill, how to improve grades, whether they should transfer to an alternative or independent school program, which colleges they should apply to, and how to apply for college and for financial aid. Career counseling orients students to postgraduate work-related opportunities including jobs, careers, the military, or vocational training programs. Because students are closer to the end of the public school pipeline when they reach high school, a good deal of counseling at the high school level (in contrast to middle and elementary school) is devoted to working with students to help them identify and achieve their post-high school goals (broadly defined).

The number of counselors in any given school is determined by district and state budgets; in times of fiscal austerity and budget cutbacks, counseling departments can shrink, adversely impacting students. In the United States, this has led to a very high ratio of students to counselors in public schools who may only be able to meet with each student once a year. However, to manage this ratio, counselors also use a batch processing approach that is typical of people-processing human services organizations: They organize collective events with groups of students (and often parents), enabling counselors to reach a greater number of students and to multiply their effectiveness.

In the areas of social and personal counseling, counselors encounter and manage a broad range of issues. School counselors often are the frontline school representatives who interact one-on-one with students and often their parents for routine transactions. They are on call to take up unanticipated crises as well. Counselors act as intermediaries between students and their parents who need resources (e.g., counselors may obtain referrals for students to visit off-site mental health clinics or for parents to visit housing assistance agencies; they may contact Child Protective Services on behalf of youth; and, on occasion, they must work with a student's probation or truancy officer). They match students with resources within schools (setting up accommodations for special needs students, channeling them into appropriate academic study groups or workshops of relevance to particular students).

Counselors tend to many social-emotional problems that cannot be addressed in the classroom, thus serving an important function in the overall operation of the school. Structurally, teachers are unable to cope with such problems because of demands that they focus on academic content in the classroom. Counselors may engage in one-on-one sessions with students to help them navigate difficult peer dynamics (bullying, turf wars, or peer mediation), assist them in resolving or help them talk through problematic family situations (parental neglect, divorce, pressure, incarceration, homelessness, drug addiction, or joblessness), and help them with painful and destructive personal behaviors or situations (cutting, eating disorders, drug and alcohol abuse, anger and depression, mental illness, suicide ideation, hunger, pregnancy, or being a foster youth).

Counselors may organize and facilitate student groups that address these issues, creating spaces in which peers can share fears and concerns with one another. Many counselors organize groups around particular constituencies, recognizing that some issues are more salient to one group than to another. For example, a group addressing sexual abuse in young couples or a group dedicated to heightening awareness of hurtful body images might be organized for girls. Counselors in some schools also facilitate diversity training workshops for students, appointing student leaders to run the workshops along with guidance from the adult counselor.

Occupationally, counselors can be thought of as emotion managers (managing the emotions of youth, which can range from ecstatic to suicidal; of their parents, who might have lost a job, had a house foreclosed on, or be disappointed or angry over their child's academic performance; and managing their own emotions as they go through unpredictable workdays that may entail school tragedy or the emotional distress of others). They manage others' emotions in the course of interactions and in the way they structure and design their work spaces, creating environments that

A New Jersey high school counselor gives a presentation to students and parents to assist them through the complicated college application process.

communicate norms and values through the use of posters and office artifacts.

Like many other types of human service workers, school counselors' work and the "products" of their activities are hard to quantify, codify, or measure. Much of their work is invisible because it takes place privately due to confidentiality requirements. Measuring effectiveness can be difficult if not impossible when looking at outcomes such as emotional well-being, student prosperity, or problem resolution.

Counselors' impact on student outcomes tends to be indirect: While they are expected to play a role in improving school outcomes across the board, the degree to which their personal or collective interventions into outcomes such as test scores or college attendance is difficult to gauge. This contributes to the perception that counselors are auxiliary or nonessential employees. There are concerted, ongoing efforts to further professionalize the field of school counseling to combat the impression that counselors are marginal to school outcomes and student success.

Professional Training, Diversity, and Serving Students

Historically, the high school counselor was considered to be a gatekeeper, a representative of the school who directly and indirectly created opportunities for some groups of students but limited them for others. In the post-World War II era—until roughly the 1980s—fewer students went to college after high school, and those who did tended to be white, male, and middle class. Research found that counselors played a key role in discouraging other students—girls and students from underrepresented minority groups or working-class families—from taking college preparatory classes or attending four-year colleges. The latter groups were considered noncollege material, an identification that was deepened by counselors' practices. For example, acting on negative assumptions about the aptitudes and aspirations of students they considered noncollege material, counselors tended to guide these students into vocational curricular tracks.

In recent decades, youth from diverse backgrounds planned to attend college in unprecedented numbers, a sea change that has dramatically transformed both the environment in which counselors work and the normative orientation of the field. Counselor training programs caution counseling professionals against blocking students' aspirations and goals for higher education. Training curriculum involves, in part, educating future counselors about their own biases (both explicit and latent) toward students of color, working-class students, and students whose parents are immigrants or whose educational backgrounds are limited. Many professional programs, as do professional journals, encourage counselors to develop inclusive practices. Emphasis on cultural competency—the ability to communicate and interact effectively with people from different cultures and classes—has spread into the field of counseling, just as it has grown in the fields of health care and teaching.

Many people are attracted to the field of school counseling because they consider themselves to be advocates for youth. They seek a professional role that will enable them to serve in that role. Many prospective counselors also see counseling as a field in which they can act as social change advocates, and professional counselor journals publish many articles addressing this goal.

Professional journals and conferences devote extensive space to sensitizing counselors to the unique dilemmas faced by distinct populations of underserved students, including youth who are first-generation students; gay, lesbian, and transgender youth; youth who have experienced substance abuse; youth of distinct demographic groups such as African Americans, Latinos and Latinas, Native Americans, and Asian subgroups. These professional norms inform counselors' practices; an in-depth interview study with high school counselors revealed that the majority of counselors spend some of their time on efforts to give disadvantaged students time and space for discussing these problems.

Studies find that this is significant to students whose parents lack college degrees, who don't understand the process of selecting colleges and applying for financial aid, and who can't provide information and guidance about embarking on the road through higher education. Such students tend to rely more on school representatives such as school counselors to fill in these information gaps and to help them complete college and financial aid applications. Counselors can take a parental role, and many counselors who work with disadvantaged youth see their role as to fill in the gap left by parents who are unable to assist their children with these efforts.

The Future

The field of counseling has much to offer to people who wish to work in the human services sector and to help youth and adults overcome disadvantages. However, in the case of public high school counseling, structural limits to the field make this a difficult choice for young adults who are deciding how they can contribute professionally to this mission. Very high ratios of students to counselors being the norm, regular layoffs of counselors as school districts and states experience declining funding for education, and the difficulty of finding a stable, full-time counseling job will discourage many bright young adults from pursuing this field. In addition, efforts to professionalize school counseling (as seen in the ongoing evolution and advancement of national and state standards for school counselors), with their emphases on results-based practices and counselor accountability, compete with the idealistic goals many applicants have: to work intensively with youth (rather than engage in surveys and paperwork), to help youth from a variety of backgrounds, and to help the disadvantaged. Administrators in state education bureaucracies, districts, and schools would do well to acknowledge the many immeasurable benefits counselors provide to students, their parents, and to schools.

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See Also: Association for Multicultural Counseling and Development; Child and Adolescent Needs and Strengths; Counseling and Psychotherapy Services; Educational Services; Multiracial Individuals and Families; School Social Workers, Racial and Ethnic issues for; Values and Ethics, Ethnic Diversity and.

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School Health Services

Children attend school for many of their waking hours, making these institutions one of the central hubs of many families' lives. While the time children spend in school is increasing, so too is the realization that many children, especially those from diverse backgrounds, do not have the access to health care services that they need. As schools increasingly take responsibility for care of the whole child, school health services are seen as an effective way to address many of the health problems addressing children and their families, especially those who might otherwise not have access to such services. School health services comprise that care or advice provided by medical, education, or social work professionals that are provided in school settings or facilitated through connections with the school. School health services are provided to improve the health and overall well-being of children or their families or both. Focusing upon early detection, correction, prevention, or recovery of diseases, disabilities, or abuse that affects school-age children and their families, school health services seek to address some of the impediments that can influence children's school performance.

Background

During the first half of the 20th century, universal education became more common in the United States. As interest in improving the educational performance of children grew, so too did the realization that children's physical ailments affected their classroom performance. Student health problems also increased the public's expense to provide education. When health issues forced children to repeat a grade, for example, school systems were forced to spend to provide these students with teachers, textbooks, classroom space, and other materials. Some studies of urban school districts found that as many as 70 percent of school children suffered physical ailments that impeded their learning such as problems with their teeth or uncorrected vision. In an effort to decrease these costs and improve children's health, schools began experimenting with providing trained nurses in order to reduce the number of days of instruction lost to illness.

The New York City Department of Education hired the United States' first school nurse in 1902. Lina Rogers, the first school nurse, sought to reduce student absenteeism by working with students and their families to address the problems caused by communicable diseases. After a month in this role, Rogers had dramatically decreased student absences in the schools she served. As a result, New York City schools were able to expand their school nurse program across their facilities. By providing evidence-based nursing care to students in schools, the New York City public school system was able to increase many children's ability to learn. This, coupled with the decrease in absenteeism, caused many other American school districts to become interested in providing nursing services in their buildings.

For much of the 20th century, school nurses served as the major provider of school health services. School nurses initially provided care that addressed the physical maladies affecting students. This soon expanded to include a variety of emotional, mental, and social problems afflicting children enrolled in schools. As the century progressed, schools became aware of other health issues facing children and their families. In an effort to ameliorate these problems, many school districts engaged school psychologists and social workers to work with students and families. Passage of the federal Education for All Handicapped Children Act (later modified as the Individuals with Disabilities Educational Act) dramatically expanded the type of health services schools provided. As the 20th century closed, a growing realization of the health problems facing American families, especially those living in rural or urban settings, led some schools to partner with medical and dental professionals to provide services to children and families who were otherwise without such care. At the advent of the 21st century, schools were seen as a major influence in the battle against childhood obesity. As additional health problems become issues of concern, American schools will undoubtedly continue to play a role in detecting, preventing, and treating diseases and other health problems facing children and their families.

Direct School Services

School nurses, counselors, and psychologists all provide a variety of services that address the health needs of children and their families. Providing school-based nursing services was the first effort that school administrators made to prevent illnesses in and to provide other health-related services for students. While the geographic setting of the school (i.e., rural, urban, or suburban) affects the role played by the school nurse, certain services are almost always provided. School nurses serve as the health care expert who helps to assure normal development and to measure the response to certain interventions offered. In this role, school nurses often assess student health and supervise interventions and administer other care required for children's wellness. School nurses also play a major role in promoting health and safety, often participating in initiatives designed to promote student and community health such as administering antismoking campaigns, monitoring student immunizations, and assessing the learning environment for risks to student well-being. As issues such as bullying, emergency plans, and violence are increasingly of interest to the public, school nurses have found their role in addressing such increasing problems. Many school nurses also interact with families and students to build their capacity for learning, self-management, and behavior modification to reduce the risk of certain health problems.

School psychologists use principles from clinical and educational psychology to diagnose and treat students' behavioral, emotional, and learning problems. School psychologists provide assessment services that identify learning disabilities and other measures of student performance. School psychologists often take a leading role in the identification of children who qualify for special education and gifted services and work with school administrators and teachers to develop appropriate interventions that will best meet a child's individual learning needs. When various crises affect a school, whether death, violence, natural disaster, or other causes, school psychologists often help to develop interventions that assist teachers and students to deal with these.

School counselors work in elementary, middle school, or high school settings to help guide students to make decisions that benefit them. Originally focused chiefly upon exploring career options, school counseling has evolved to also address personal and social issues facing children. Many school counselors today work to identify, ameliorate, and address opportunity and achievement gaps facing children, especially those from diverse backgrounds. Interested in promoting and enhancing student achievement, school counselors work with children, their families, and their teachers to address issues, including those related to health, that might impede student success. In an elementary school setting, guidance counselors assist children and their families in developing personal and social competencies by means of individual and group counseling, collaboration with teachers, and family workshops. In middle schools, school counselors work to help students address social and behavioral issues that might negatively impact their school performance, especially as it impedes their ability to attend college. In high schools, school counselors work with all students to help them make postsecondary school plans, including college and vocational options. As educational attainment has a strong correlational effect on an individual's health, school counselors work to increase college access, which directly affects the physical and mental health of those whom they serve.

Other Health Concerns

The Individuals With Disabilities Education Act (IDEA) provides the framework for how American schools identify children in need of special services and the provision of those services. Children with disabilities are defined as those with autism, hearing or vision impairments (including the deaf and blind), intellectual disabilities, orthopedic impairments, serious emotional disturbances, specific learning disabilities, speech or language impairments, or traumatic brain injuries. IDEA mandates that schools provide special services, including medical, to permit those with disabilities access to a free and appropriate public education in the least-restrictive environment. Since its predecessor legislation's passage in 1975, IDEA has greatly expanded the opportunities available to those with physical or mental impairments. In certain cases, schools must also provide nursing and other health care to the students they serve.

Schools have always played a key role in identifying certain health risks and appropriate treatment for those children for whom this was appropriate. During the 1990s, however, a growing perception of the needs of many children and their families to access medical and dental care led many schools to attempt to provide access to such services on their campuses. Although some schools worked in conjunction with other federal, state, and local agencies, others initiated such programs on their own. Believing that student health problems affected children's performance whether treated or not, these efforts attempted to provide students and their families access to the services they needed to allow them to function at their full capacity.

Although the success of such programs has been difficult to document, schools' access to children and their families will continue to make this an area of interest to many.

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See Also: Administration on Children, Youth and Families; After-School Services; Assistive Technology; Dental Services; Early Childhood Development; Head Start and Prekindergarten Programs; School Social Workers, Racial and Ethnic Issues for; Uninsured Clients.

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School Mental Health Project

The academic performance of students of all ages is dependent on a variety of factors. Although psychological well-being of students is as important as their physical health in affecting academic performance, few coordinated efforts have existed to develop effective programs for monitoring mental health in school settings. To address this issue, the School Mental Health Project was founded in 1986. The primary goals of the project include researching and improving school policies as well as training teachers and mental health professionals about more effective ways to address mental health and psychosocial concerns in schools. To ensure that psychological services are available to the largest number of students, the School Mental Health Project integrates the activities of school districts, governmental agencies, and professional educators on a national and expansive scale. The School Mental Health Project also takes into account the differences that may exist among schools and among students in the same school. Among the mental health population in schools, diversity exists in students' socioeconomic status, access to mental health resources, age, cultural and religious beliefs, and developmental stages. To help meet the varied needs of students, the role of diversity in schools is a focus in the project's initiatives. Specifically, the project strives to increase cultural competence among mental health professionals in order to understand the ways in which a child's unique cultural and ethnic background can affect his or her experiences in school and, relatedly, his or her psychological well-being. By cooperating with local schools, the project also takes into account the local culture in which a particular school may be situated to create the most effective mental health program.

Mental Health Initiatives in Schools

As research has demonstrated that psychological well-being affects academic proficiency, most schools have developed programs to address students' mental health problems. These programs are critical for students with cognitive, emotional, and behavioral concerns that may interfere with their ability to learn. Unfortunately, as a result of their insufficient breadth, scarce resources, and narrow goals, the effectiveness of many of these initiatives has been limited. Collaborative difficulties between schools and existing resources in communities contributed to inadequacies within these programs and prompted the creation of the School Mental Health Project.

The School Mental Health Project was created with the intention of targeting these issues of breadth, resources, and goals. Its mission is to create and coordinate all of the components necessary for effectively addressing the psychological needs of students by developing an overarching conceptualization of school-based mental health. In particular, the project strives to introduce interventions and preventive strategies, expand the use of these resources, and advance the field of school-based mental health. The School Mental Health Project addresses topics such as psychosocial adjustment to school, attendance, truancy, physical abuse, drug and alcohol abuse, dysfunctional relationships, misconduct, criminal activities, and violence.

Center for Mental Health in Schools

The U.S. federal government established the national Center for Mental Health in Schools in 1995 to serve as the primary conduit for the School Mental Health Project. The center operates through the School Mental Health Project at the University of California, Los Angeles (UCLA). The primary mission of the center is to uphold national standards for school-based mental health programs and to work with academic facilities to coordinate more-effective programs. Addressing psychological impediments to learning cannot be accomplished without integrating the project's goals with those of individual schools and regions. Therefore, the center emphasizes reducing inequities and counterproductive competition among particular schools and school districts. It also gives priority to approaching student mental health from an extensive, structural perspective. The overarching goal is to standardize mental health interventions and preventive programs across all schools while simultaneously honoring the unique needs of each student and each school.

As the main switchboard for school-based mental health programs, the center coordinates a number of training initiatives and activities in addition to addressing conceptual and policy issues. The center gathers and develops materials including guidebooks and training curricula as a means to implement innovative prevention and treatment practices. It also delivers direct assistance to professionals in the field in the form of newsletters, electronic networking, and information on support strategies. To encourage collaboration among educators and mental health professionals, the center generates, analyzes, and provides a forum for ongoing discussions regarding the most up-to-date procedures and practices in an effort to hasten new developments without marginalizing schools that may use different approaches. The center endorses the use of evidence-based practices in an effort to ensure that those practices encouraged and taught are the most efficacious.

Perhaps the most valuable and informative resources provided by the center are four national e-mail list management systems. These systems are the primary mechanism for accomplishing the center's work and the work of school-based mental health programs around the country. Each e-mail list management system circulates specific and topical information related to public outreach and to improve collaborative efforts among administrators, educators, parents, and students.

The first is a general e-mail list management system for any person who is interested in receiving information about the field and, specifically, about any of the center's newly developed resources. The second system is designed to share special initiatives such as those that might be of interest to school superintendents and principals. The third is an inter-center system to facilitate correspondence among different program centers and facilities. The fourth is the media and Internet news outlet e-mail list management system that promotes communication with the public at large to raise awareness and garner support.

As a result of utilizing these varied and integrative resources, the Center for Mental Health in Schools within the School Mental Health Project advances the ability of everyone involved to address the mental health needs of students. The center's goal is to insert these potent mental health programs in all schools to meet the needs of students who are suffering psychosocial issues that impede their learning.

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See Also: Adolescent/Youth Services: Overview; Department of Education, U.S.; Learning Disabilities, Services for Individuals With; Mental Health Services, Children; School Counselors; School Health Services; School Psychologists; School Social Workers, Racial and Ethnic Issues for.

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School Psychologists

In the past, the field of school psychology has been associated with the gatekeeping process to special education in school systems. Since the passage of Public Law 94-192 (Education of All Handicapped Children Act) in 1975 to its more recent revisions and amendments, known as the Individuals with Disabilities Education Act (IDEA), the role of school psychologists has evolved. Today, school psychologists play a key role in the prevention of problems associated with learning, such as consultation with parents, teachers, and school administrators prior to a referral for a special education evaluation. This shift in the field of school psychology frees up school psychologists to perform more tasks associated with creating positive and effective school climates and less time testing one student at a time for special education services.

Training in School Psychology

School psychologists are professionals who have obtained a master's, specialist, or doctoral degree that specializes in working with learners of all ages and working with those who intervene with these learners. At the master's and specialist level, the highest standard of accreditation of the training program comes from the National Association of School Psychologists (NASP). Typically, graduates from a master's- or specialist-level program become certified or licensed to practice in a school setting. Doctoral-level programs in school psychology can also be accredited by the American Psychological Association (APA), and graduates from these programs have the option to pursue licensure to practice independently as a health care psychologist.

Each school psychology program has required course work and training components to ensure the graduate student is competent to practice. The course work in school psychology programs allows students to learn the techniques necessary to work effectively in the areas of ethics, prevention, intervention, consultation, assessment, and research. The training aspect of school psychology programs allows the graduate student to apply his or her classroom learning in actual practice settings under supervision, which are typically school based. The final program component of a school psychology graduate student culminates in a yearlong, supervised internship experience that allows him or her to successfully navigate the day-to-day responsibilities of being a school psychologist. A key area addressed in most training programs in school psychology focuses on the global community aspect of training and application. One priority area of training includes an advanced understanding and integration of multicultural diversity that is rapidly changing the sociological and educational landscapes of the world.

Practice in School Psychology

Master's- and specialist-level school psychologists are found mainly in the public school setting, while doctoral-level school psychologists can be found in a variety of work settings, including schools, clinics, hospitals, universities, and private practice. In addition, most school psychologists assist with the development of individual education plans (IEPs) for school-age students and are an integral part of their services in special education. Regardless of practice setting, school psychologists are required to engage in an interdisciplinary team setting, typically made up of parents, school administrators, regular education teachers, special education teachers, school counselors, school nurses, school social workers, speech and language therapists, occupational therapists, physical therapists, and any other professional who is involved in the well-being and welfare of the student. Moreover, the school psychologist is typically the liaison between medical personnel and the school. The successful school psychologist must communicate well in an interdisciplinary team setting and have the ability to work with a variety of individuals from many different training backgrounds.

Besides collaborating with other professionals, a school psychologist's skill set also includes the ability to apply preventative measures to ensure that learning or social problems do not arise. For example, many school districts have a district-wide mental health screening process that is headed by the school psychologist. These screenings can be an early detection indicator for issues such as depression, anxiety, and suicide.

Moreover, school psychologists are trained to consult with teachers concerning the learning environment of their students. For example, school psychologists can collaborate with classroom teachers to address behavior problems or help them adapt to the environment to provide better classroom management. Thus, school psychologists are a resource that can be tapped to assist in averting problems before they must be addressed in a more formal manner.

Even with their skills in prevention, many school psychologists intervene with students or schools for a variety of reasons. School psychologists are trained to provide therapeutic services, such as counseling or behavior planning, to assist students to become successful learners in their environment. The therapeutic services are research based and utilize a variety of modalities such as individual talk therapy, family therapy, or therapeutic groups. Sometimes, however, school psychologists must intervene when a crisis occurs in the school district. School psychologists are typically a key part of a school crisis response team that responds to traumatic incidents in the district such as school violence and suicide. Working with other professionals in the system and within the community, they assist and organize a rapid response to ensure that the necessary staff and services are available to students and their families to help them cope with such incidents.

Finally, school psychologists utilize a wide variety of assessment procedures and instruments to assist with treatment planning for students and learners. School psychologists have been trained to use an assessment as the beginning of the treatment process. School psychologists are often required to assess students for a variety of academic, behavioral, and social conditions that may impact their ability to function well in a school environment. Informal assessments, such as parent and teacher interviews, classroom and environmental observation, and previously gathered information, allow school psychologists to analyze the referral questions and design an assessment procedure to answer these questions. This procedure can include a direct, face-to-face evaluation of the student, using instruments to test intelligence, achievement, and personality. In addition, an indirect evaluation is typically included, which uses checklists and evaluation instruments that tap the parent and teacher perceptions of the student. From this evaluation process, the school psychologist can then offer a diagnostic impression of the student and, using the collected data from the assessment, recommend community services and further treatment options regarding interventions and follow-up information to the school, and the family.

The Future of School Psychology

The field of school psychology continues to evolve as the educational and social culture shifts into being more multicultural and diverse. School psychologists should be culturally competent practitioners to adequately utilize their skill sets with families and children from a variety of backgrounds and languages. Currently, a majority of practicing school psychologists in the United States are Caucasian and female.

However, nearly all of these school psychologists provide services to racial or ethnic minority groups in their practice settings. In addition, many school psychologists are nearing retirement age, with fewer graduates from school psychology training programs available to take their places. This has the effect of increasing the student-to-school psychologist ratio, thus reducing the school psychologist's ability to provide adequate service to their students, to their schools, and to their communities. Many national organizations have made it a mission to increase the visibility of the field of school psychology and educate individuals of the critical need of culturally competent school psychologists.

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See Also: ADHD, Services for Individuals With; Children With Special Needs; Counseling and Psychotherapy Services; Crisis Services; Cultural Competence, Human Service Providers and; Educational Services; Education Support Services; Intelligence Testing; Learning Disabilities, Services for Individuals With; Mental Health Services, Children; Psychiatric/Psychological Assessment; School Mental Health Project; Special Education.

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School Social Workers, Racial and Ethnic Issues for

School social workers collaborate with other school professionals to support the academic achievement of students. Their focus is on enhancing the emotional health and well-being of students and ameliorating factors that put students at risk for poor educational and developmental outcomes. This generally includes providing direct support to students, helping them overcome any barriers to academic success that they may face. The role of school social workers may also include working with parents, agencies, and other segments of the community to prevent discrimination based on race, ethnic background, religion, and culture. The growing diversity of students in the United States makes responding to these concerns more complex.

Race is generally defined as both a biological and social construction. The biological aspect is based on the fact that members of the same race share a common lineage and, as such, are likely to have common physical and genetic characteristics. Notions of race, however, have no real basis in scientific notation. The characteristics by which racial categories are defined are instead socially constructed, as members of a society attach meaning or significance to various aspects of race or racial attributes. Ethnicity, on the other hand, relates to cultural factors such as shared traditions, practices, nationalities, and beliefs of people with a common ancestry.

A substantial problem facing schools in the United States is the long-standing gap in educational achievement and educational attainment between advantaged and disadvantaged groups in the United States. African American students and students of Hispanic origin, for example, continue to have higher rates of school dropouts than do their white counterparts. They also score significantly lower on other measures of academic performance, as do poor students and students with immigrant status. Poor performance in school can leave students at risk of dropping out and have far-reaching effects on their social mobility and economic well-being. Of note is that the achievement gap has gradually narrowed slightly over the past several decades. However, significant gaps in achievement remain.

Discriminatory discipline and harassment also impact achievement. School social workers have an ethical commitment to work toward overcoming problems of inequality and social injustice in schools. This entails the need to assess whether various mechanisms of oppression are at play and taking steps to remedy or counteract concerns when they are present.

Cultural Heterogeneity

In recent years, the population of the United States has become increasingly more diverse. This trend corresponds with the growth of minority populations and with immigration. As schools in the United States are increasingly heterogeneous, issues related to race and ethnicity have also become more complex. The cultural heterogeneity of students enrolled in school, according to U.S. Census Bureau statistics, continues to rise. Populations of school students in the United States increasingly include children of color and of Hispanic origin, and Hispanic students made up nearly 18 percent of nursery school students in 2008, an increase of 13 percent from the late 1980s. At the same time, immigrant populations in the United States continue to grow. Social workers in education settings, in keeping with this upward trend in diversity, must have the knowledge and skills required to meet the needs of diverse students.

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 affirms the equal right of all children in the United States, regardless of their immigration status, race, color, or national origin, to attend public elementary and secondary school. Despite this guarantee, equitable access to education continues to be threatened on a variety of fronts. The promotion of equitable access, according to the Office of Civil Rights, will require substantial efforts be directed toward remedying the following: (1) unequal access to educational opportunities; (2) discriminatory discipline; (3) harassment; (4) barriers to education for students learning English; (5) equal rights for all children to attend school; and (6) racial diversity.

Cultural Competence

According to the National Association of Social Workers (NASW), "Social workers must have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups served." The NASW defines cultural competence as a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enable the system, agency, or professional to work effectively in cross-cultural situations. Practicing in accordance with NASW standards around cultural competence entails attending to the way professional standards may conflict with the needs of diverse clients and being aware of personal values and beliefs. Cultural competence also requires the attainment of cross-cultural knowledge and skills and leadership in communicating with other professionals the importance of diversity.

Achievement Gap

The achievement gap in education refers to the disparity in academic performance among groups of students. These gaps are evident across every measure of academic performanc;, that is, standardized test scores, overall grade point averages, dropout rates, and college enrollment and completion rates. Gaps exist among groups who are less advantaged overall than other groups, including African American students, students of Hispanic origin, and Native American students. Of the 1.3 million students that fail to graduate from high school each year, for example, more than half are students of color. Sixteen- to 24-year-old students with the lowest family incomes are seven times more likely to have dropped out of high school than similar students in higher income brackets. Over the last several decades, gaps in the educational achievement of students have narrowed. However, gaps in educational achievement remain significant. Gaps also exist between low- and high-income students.

A mixed-race group of high school students. Social workers in education settings must have the knowledge and skills required to meet the needs of diverse students.

Immigrant Status

Immigrant children, especially those from Latin America, tend to have poorer school outcomes when compared to other groups. Additionally, recent immigrants tend to fare less well than those who have been in the United States for a longer time period. For children who are learning English, significantly more barriers are present. Evidence suggests that classroom support can level off differences in achievement if provided early on. Improving low levels of enrollment in preschool could also increase achievement. Another area of disadvantage for immigrants stems from policies in the United States that prevent children of undocumented immigrants from accessing postsecondary education. School social workers must practice in ways that are culturally competent and recognize that language and cultural differences can present challenges for school social workers attempting to engage with families.

The Impact of Poverty

Poverty significantly impacts the educational achievement students. According to the United

States Census Bureau statistics, more than one in five children in the United States are living in poverty. These students are more likely to have developmental disabilities or learning disabilities than their more well-off counterparts, and they are less likely overall to be prepared to enter the primary school setting. Students living in poverty are disadvantage in a number of ways. First, poor children may have difficulty getting to school and can suffer from chronic absenteeism. Other responsibilities, such as caring for family members or employment, can also impact attendance and potentially lead to the need to drop out. Dropout rates are greater for students who come from low-income families, who are seven times more likely to drop out than those from families with higher incomes. Compounding these concerns is the fact that students living in poverty are likely to reside in areas where school funding is inadequate.

Harassment

Students of different races and ethnicities may be subjected to bullying and harassment in schools. Harassment can take the form of name calling, the use of racial and ethnic slurs, making racist gestures, and the display of racist materials. Students who are victims of harassment are likely to become isolated and lose trust in school officials if the situation is not remedied. School performance is likely to suffer, placing victims at risk for all of the problems associated with poor academic performance. School social workers must work to remedy harassment when it occurs and work with victims to counteract the effects of harassment. Schools are required to take measures to prevent and respond to harassment. Antiharassment policies and grievance procedures should be in place. Federal law requires schools to have policies against racial and sex discrimination and to notify employees, students, and parents of the policy. School-based harassment is a violation of Title VI and Title VII of the Civil Rights act of 1964 and Title IX of the Education Amendments of 1972. Schools are responsible for illegal acts they know about or should know about.

Discriminatory Discipline

Disproportional discipline of minority students has also raised civil rights concerns. Evidence consistently suggests that students of color are overrepresented among students who are disciplined. Mandatory suspensions and expulsions associated with zero tolerance policies have continued to be disproportionately applied to students of color. Mandatory suspensions or expulsions allow for no discretion and put students on a path toward juvenile delinquency and dropping out. They can also have long-lasting effects in terms of earnings potential across the life span. Additionally, school program or districts with greater rates of suspension and expulsions consistently have lower levels of academic achievement associated with them.

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See Also: School Counselors; School Health Services; School Psychologists; Zero Tolerance Approach in Schools.

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Section 8

Section 8 of the Housing Act of 1937 (created through a 1974 amendment to the act) provides rental assistance in the form of payments to private landlords in order to subsidize the costs of renting low-rent residences to low-income households. More than 3 million American households are served through the various programs funded by Section 8, which are managed by the Department of Housing and Urban Development (HUD).

The Housing Act, or Wagner-Steagall Act (sponsored by Democratic Congressman Henry Steagall of Alabama and Robert Wagner of New York), was the second major housing act of the New Deal period that sought to remedy the problems of the Great Depression and the economic infrastructures that had led to it, following the National Housing Act of 1934, which had provided funding for the construction of residences for low-income families and to slow down the rate of foreclosures. The 1937 act was notable for having the support of Robert A. Taft and Allen Ellender, opponents of the New Deal overall, leaders of the conservative coalition that formed in response to the expansion of the federal government, and ideological forefathers of today's Republican Party. The 1934 act had created the Federal Housing Administration (FHA); the 1937 act created the United States Housing Authority (USHA), an agency within the Department of the Interior, which handled housing matters in the days before HUD. USHA was eventually absorbed into the Housing and Home Finance Agency in 1947, which was itself dissolved and succeeded by HUD when it was formed in 1965 as part of Lyndon B. Johnson's Great Society programs, which were designed as a continuation and maturation of the New Deal policies a generation earlier.

One reason for the support of the conservatives was that elements of the bill were perceived as a compromise between doing nothing and the possibility of a nationalized housing industry—which may seem unrealistic in hindsight but which must have seemed no more radical than some of the other changes wrought to the structure of American business by the previous years of the New Deal. This compromise also limited the extent of public housing legislation, which conscientiously maintained a spacer gap between the upper-income limits that qualified a household for subsidized housing and the lower-income limits of those who could afford the nonsubsidized housing provided by the private sector. Section 8 housing, by design, does not provide housing for all those who can't afford it but only for those least able to afford it. Section 8 housing was also originally racially segregated, then desegregated in the 1950s, though as with many neighborhoods throughout the country, de facto segregation has continued.

Other than the creation of HUD, notable amendments to the Housing Act of 1937 have included the Housing Act of 1949, which came at the economic ebb following the end of World War II and funded urban renewal programs as well as refunding public housing programs; the 1965 Leased Housing Program, which (until superceded in 1974) provided subsidized housing for eligible families by assigning them to a unit from a master list of available eligible housing, setting a rent based on need and income and separately paying the landlord the difference between that adjusted rent and the fair market value; and the Housing and Community Development Act of 1974, which created the Section 8 class of housing, essentially broadening and streamlining the 1965 program while divorcing it from its reliance on a specific list of housing units.

Until 1974, most public housing in the United States was in the form of specific subsidized units of housing—housing projects created as low-income housing, usually abbreviated as the projects and referred to in various euphemistic ways. The creation of such projects acted to concentrate poverty in specific neighborhoods, even to a greater degree than the private sector had done. While dedicated housing projects continue to exist and continue to be built, increasingly since 1974, housing assistance has been in the form of rental vouchers—a sort of housing analogue to food stamps, which are redeemable only for food but may be spent anywhere. Similarly, Section 8 recipients in many cases may live wherever they can afford (given the value of the voucher), not just in specific subsidized housing projects. This has been coupled with a tendency to replace public housing projects, as wear and tear erodes them, with mixed-income housing developments.

The largest program created under Section 8 is the Housing Choice Voucher Program, which is tenant-based rental assistance as opposed to landlord-based rental assistance, such as the creation of specific subsidized housing projects and units. Vouchers have a ceiling of $2200 a month and are based on various factors, including family size and local median rent. Vouchers need not be used toward renting and can instead be put toward home purchase, which in many cases requires less assistance for the same household. Roughly two-thirds of Section 8 aid recipients receive their aid through the Housing Choice program. Another voucher-based Section 8 program is the Veterans Affairs Supportive Housing program (VASH), operated in conjunction with the U.S. Department of Veterans Affairs, to provide housing rental vouchers to armed forces veterans who are in need.

In theory, one of the benefits of housing vouchers is that they do not contribute to de facto segregation the way the construction of housing projects did. While such projects are no longer segregated de jure, separate projects were often constructed in white and black neighborhoods (sometimes with separate Latino projects in areas with large-enough populations to sustain them and with nonwhites who are neither black nor Latino usually, but not always, winding up in the nonwhite projects). Concentrating poverty in one neighborhood is damaging enough in its creation of a ghetto that attracts predatory businesses (convenience stores with marked-up prices, check-cashing and payday advance stores, predatory banks, liquor stores, cigarette stores that sell cigarettes individually when that practice was still legal) and is socially and economically difficult to escape from.

Concentrating poverty in a single-race neighborhood reinforces negative stereotypes as well as laying the groundwork for the class-driven racial tensions such as those that boiled over into riots in New York in the 1980s and Los Angeles in the early 1990s. Housing vouchers allow mobility and also address a problem revealed in studies from the 1970s—that by that point in history, the main housing problem faced by low-income families in the United States wasn't the quality of housing (as it had been during the Great Depression and in most of history) but the percentage of income that they spent on housing, which had long-term ramifications (because of the money available for education, for instance, or the impact on employment choices) that impacted multiple generations.

Most households using rental vouchers pay 30 percent of their adjusted income for rent, which is comparable to what normal households are expected to spend, allowing households the freedom to budget their income and make their own choices. Though the adjusted income allows deductions for dependents (which, in and of itself, might result in a qualified household paying a smaller percentage of its income for rent than an average household), it also counts certain assets as imputed income, including noninterest-bearing bank accounts, which often offset those deductions by artificially inflating the household's on-paper income.

Not all landlords are required to accept Section 8 vouchers, though in some states the law effectively forces them to do so by forbidding them to discriminate on the basis of Section 8 qualification. Landlords in high-rent areas or areas experiencing a housing shortage may be especially reluctant to participate because there is a good chance they will be able to rent the unit for greater than the fair market value the Section 8 program would pay them. On the other hand, the housing authority is a reliable payor, and tenants may be kicked out of the program if they damage their rented properties without compensating their landlord, which makes Section 8 renters attractive tenants for some landlords.

An article by Hanna Rosin, published in *The Atlantic* in 2008, argued that, contrary to the prevailing view of violent crime having steadily decreased since the late 1990s (barring a minor spike in some areas during the onset of the current financial crisis), crime has simply been redistributed to a greater number of suburban and exurban neighborhoods due to Section 8's dispersal of low-income families in a wider area. However, authors of some of the studies she cited later disavowed any connection between housing vouchers and crime increases and accused Rosin of ignoring other factors.

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See Also: Displaced Persons; Housing Services; Housing Support and Homeless Services.

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Self-Determination and Education Assistance Act

The Indian Self-Determination and Education Asistance Act (ISDEAA) of 1975, Public Law 93-638, was designed to give Native American tribes greater control over their own lives by giving tribal governments more control over tribal affairs and obtaining funding for educational assistance. Signed into law on January 4, 1975, this law focused government action on self-determination. It authorized the U.S. government to enter into contracts with and make grants directly to federally recognized tribes. This act created a formal statutory environment for sustaining tribal governments and allowed tribal governments to contract to perform services that had previously been done by the Departments of the Interior and Health and Human Services.

Brutal Past for California Indians

California was home of the most diverse Native American populations, with more than 200 tribes that had distinctive dialects. Indigenous orientations to land and self presented the antipode to American and European sensibilities. Spanish Franciscan established a mission system with the military to contain neophytes in missions. Entire village communities were moved to different missions, breaking down existing cultural structures. Approximately 1,699 Coast Miwok between 1783 and 1817 entered the Mission at San Francisco, but by the end of that time, only 485 survived. During the California gold rush, Indians could legally be indentured—sold into slavery if captured. The U.S. Congress passed legislation during the Civil War terminating titles to Indian land in California, thus stripping California tribes of lands. Congress passed the California Rancheria Act in 1958, terminating all 41 California Rancherias.

Tribal activists with the Coast Miwok worked with California Indian Legal Services (CILS) to obtain federal recognition as members, demonstrating descent from ancestors living in 1852. Passage of the Omnibus Indian Advancement Act (Public Law No. 106-568) in 2000 restored sovereignty to the Coast Miwoks as the Federated Indians of Graton Rancheria (FIRG). However, the legislator that promoted this legislation had a family member that profited from subsequent land deals to open a casino mandated by the act that were inconsistent with original FIGC wishes.

Tribes geographically located crossing state or national borders became physically and psychologically divided when the Bureau of Indian Affairs (BIA) discouraged indigenous travel within Indian country that was considered to be too nomadic. An example is the Kumayyay of southern California, which has traditional tribal lands extending into Baja California in Mexico. The BIA labeled this tribe as Mission Indians so that they could not reassert their tribal name until the agency backed away from its assimilation policies. Tribal members in Mexico may have baptism records but not birth certificates needed for regular visas. It has only been since 2000 that this tribe has been able to negotiate with the United States and Mexican governments to secure laser visas to allow short visits across the border.

Additional Legislation Related to Self-Determination

Congress granted all Native Americans citizenship in 1924 if they abandoned native languages, culture, relations, and values to take on Western culture. Education, land redistributions or allotments, enfranchisement, and economic self-sufficiency within the reservations became the means that the United States and state governments used to foster assimilation. Conversely, the Indian Civil Rights Act of 1968 opened the door for a shift in tribal activism from local, tribally based protest to broader, nationally organized events as Native Americans from a variety of tribes focused on broadly shared concerns to bring attention to the federal government's past and continuing misdeeds that lasted a decade and led to subsequent legislation. Native American activists occupied Alcatraz Island in San

Francisco Bay as well as organized sit-ins at the Bureau of Indian Affairs. This occupation of traditional tribal lands by non-Bay Area tribes between November 20, 1969, and June 11, 1971, not only drew attention to federal Indian policy but also became a landmark for large-scale Native American activism.

The primary goal of this occupation was to create awareness with the American people that Native Americans throughout the land were dealing with serious problems of alcoholism, poverty, and land lost that could only be resolved with Indian self-determination.

Subsequent Legislation to Restore Tribal Knowledge

The underlying theory of ISDEAA was that tribal governments know best how to identify challenges and allocate the right resources to solve problems. The loss of tribal identity in America has led to catastrophic cycles of violence on reservations, where one in three women can expect to be sexually assaulted during their lifetimes. Sexual violence is not traditional or natural to Native American cultural heritage but comes as a result of demolished tribal identities, astronomically high unemployment on reservations, alcohol and drug abuse, and a modern acceptance that crimes against women will go unpunished. Passage of the Native American Graves Protection and Reparation Act (NAGPRA) on November 16, 1990, means that objects related to funerary practices and present-day adherents are protected. In 1999, the National Congress of American Indians (NCAI) met with its Canadian equivalent, the Assembly of First Nations, in order to strengthen the sovereignty and unity of North American Indian nations, share information on the uniqueness of Indian governments, and initiate a Declaration of Kinship and Cooperation in support of tribal sovereignty, spiritual practices, traditional knowledge, economic and social well-being, and the need to protect indigenous rights to travel uninterrupted across the borders between the United States, Canada, and Mexico.

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See Also: Indian Child Welfare Act; Indian Civil Rights Act of 1968; Rape as an Instrument of War.

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Self-Harm, Cultural Aspects of

Self-harm, or parasuicide, encompasses a wide range of behaviors that involve the intentional and deliberate infliction of damage or injury to one’s body. These behaviors include cutting, burning, scratching, scalding, bruising, breaking bones, hair pulling, biting, and poisoning oneself. Cutting is the most prevalent form of self-harming behavior. In Western culture, these acts are generally considered within the purview of psychiatry, psychology, and sociology and are often regarded as deviant or abnormal. However, the acceptability and motivations for self-harming behaviors vary depending on cultural context.

According to the Western psychological perspective, individuals engage in self-harming behaviors as a means to cope with negative emotions, psychological pain, or self-loathing. Many individuals who self-harm report that the inflicted physical pain is comforting because it arouses them from a psychologically numb state and allows them to experience sensations. Although individuals who self-harm typically do not engage in the act with the intent of killing themselves, self-harming is a risk factor for future suicide attempts. It is a common misconception that self-harm is performed mainly as a means for gaining attention. In most cases, self-harmers are embarrassed about their wounds. They restrict their inflictions to parts of the body that cannot be seen and often go to great lengths to hide their injuries. Their attempts to conceal their self-harming activities can interfere with their lives.

There are a number of methods used to treat self-harm. Many therapeutic techniques concentrate on addressing the underlying causes of the behavior as many self-harmers have experienced trauma or abuse. Therapy also may target a client's underlying mental illness, if one is present. Other treatments focus on modifying the self-harming behavior itself through behavioral therapy or by changing the maladaptive thought patterns that may lead to self-injurious behavior. Altering the thought patterns is often accomplished through cognitive therapy. Dialectic behavior therapy (DBT) is particularly effective because it combines a number of approaches including cognitive restructuring, management of emotions associated with self-harming, and mindfulness meditation.

Cultural Definitions of Self-Harm

Evidence of self-harming behaviors across many cultures has existed for thousands of years, and historically, self-harm is known to have been a customary ritual practice. For example, in the ancient Maya civilization, the religious leaders engaged in a number of physically injurious behaviors such as gathering blood by slicing and piercing their bodies. However, these acts of self-harming cannot be interpreted from a Western psychological perspective or characterized as problematic because the cultural context in which they occurred is much different.

In fact, sociologists and anthropologists have generated compelling evidence to suggest that cultural values have significant influence on attitudes toward self-harming acts around the world. Self-harming acts that fit the definition in one social context or region do not necessarily meet the definitional criteria in another, thus sparking debate over whether self-harming behavior should be considered a form of pathology. In most cultures, criteria include the motivation for engaging in the self-harming act. Whether the act has redeeming value for the culture as a whole determines if it is viewed as a sign of illness. If the act is considered socially meaningful or serves a cultural purpose beyond an individual's personal motivations, it is less likely to be considered pathological.

Many common behaviors exist that carry highly discrepant meaning across cultures. For example, body piercing, circumcision, or genital mutilation is acceptable in some societies because it carries cultural value, while in other social contexts, it is highly problematic. Even within the same culture, the same behavior may service to enhance attractiveness or adhere to social ideals by one subcultural group and yet is considered self-harming by another. For example, some people regard extreme dieting, plastic surgery, waxing, or shaving as forms of self-mutilation because these behaviors represent unnecessary deviations from the natural human condition. However, other individuals, influenced by Western and media standards of beauty, may view these activities as normal responses to environmental demands.

To make matters more complex, many mutilating practices that are considered deviant in some cultures are sanctioned in others and are even associated with healing, repentance, spirituality, and the social standing of individuals within that culture. Examples include bloodletting and decorative and commemorative skin mutilation. In some societies, individuals must endure mutilation and suffering to attain positions of prestige within a culture. This is the case with shamans who must self-immolate in order to access special curative powers. Adolescent rites of passage into the adult world often involve mutilative practices. Australian aborigines, for example, use stones to slice the initiate's penis during the ceremony. Furthermore, Buddhist culture condones specific types of self-harm associated with spiritual commitment and political challenge. Altruistically motivated suicide is even accepted, and Buddhist monks may cut off their genitals as penance for sexual temptations. Again, determining whether these acts are considered pathological involves the motivating factors as well as the extent of their effects on the larger cultural context in which they occur.

Although these rituals and cultural activities fall within the definition of self-mutilation in Western cultures, many anthropologists prefer to recognize these rituals and practices as body modification to downplay any suggestion of negative or pathological judgment and to emphasize the significance of cultural relevance. Body modification practices are often apotropaic—they serve to prevent, or even correct, conditions that represent potential social menace.

For example, self-immolation is often associated with rituals to ward off disease, crop failure, or the wrath of an angered god. Although these culturally sanctioned acts may meet the criteria for self-mutilation in Western cultures, they are not regarded as such in these other social frameworks because they serve meaningful and even spiritual purposes. The issue of meaningful symbolism is critical for determining whether a behavior is categorized as culturally sanctioned or deviant, purposive or pathological, divine or in need of therapeutic attention.

Prevalence Rates and Epidemiology of Deviant Self-Harming

Research has demonstrated that the number of documented incidents of acts defined as pathological self-harming differs among cultures and ethnic groups. However, researchers have not determined the reasons for these differences. As with suicide, rates of self-harm vary greatly among countries. Results from studies conducted in Western nations suggest that between 5 and 9 percent of teenagers have engaged in self-harming acts within the previous year. These rates have been increasing in particular in both the United Kingdom and the United States. Using household surveys to measure the incidence of self-injurious behavior across all ages of people, the results of a nine-country investigation revealed significant differences among countries. Although the incident rate is less than 1 percent in Beirut and Taiwan, it approximates 6 percent in Puerto Rico. Native populations of colonized regions have demonstrably higher incidents of self-harm.

Cultural values influence not only the definition and incidence of deviant self-harm but also its causal factors. Factors that decrease the likelihood of self-harming behaviors in some cultures are not clearly evident. It does appear that environments in which suicide is unequivocally disapproved offer some defense against self-harm. Citizens of Catholic and Islamic countries have lower incidents. On the other hand, cultures in which the mass media appears to encourage hedonism, materialism, and impulsivity have higher rates of a wide range of psychosocial problems, including suicide and self-harming, particularly in adolescents. While this is especially true for Western societies, countries in the Eastern Hemisphere are not immune. Often, excessively rapid cultural change appears to be the culprit contributing to familial and community stress. For example, younger women in rural China who have been raised in modern contexts find themselves caught between new customs and old traditions and are more susceptible to self-injury.

Despite the influence of cultural context, there are some relatively predictable societal factors that increase the likelihood of pathological self-harming across social environments. For example, being raised in a smaller nuclear family, as opposed to growing up in a larger family context, seems to be one variable that augments the probability of engaging in self-harming acts. In general, the more socially isolated and deprived of social, financial, health, and mental health resources, the higher the likelihood of destructive self-injury. This is particularly the case for people with a history of abuse and psychiatric disturbance.

The most recent research data suggest that self-harm may occur in countries throughout the world. However, its definitional criteria, incidence rates, and expressions are heavily influenced by social context.

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See Also: Cross-Cultural Skills; Cultural Paradigms; *Diagnostic and Statistical Manual of Mental Disorders*, Cultural Responsiveness of; People of Color: Service Delivery, Psychological Assessment, Cultural Issues; Rites of Passage; Substance Abuse and Mental Health Services Administration; Suicide, Cultural Aspects of; Youth Risk Behavior Surveillance System.

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Senior Services

Senior services are the activities and services offered by social and community programs that offer assistance and support to older adults to enhance or maintain their quality of life, physical health, and well-being. Senior services also support independent living and enhance the dignity and worth of older adults. The Older Adult Act of 1965 marked the emergence of senior centers that provide senior services. With greater attention given to the burgeoning senior adult population, the scope of senior services has increased in recent years. In fact, senior services have become an integral part of our communities and essential in the daily lives of many seniors. The topic of senior services is relevant to the *Encyclopedia of Human Services* because it informs human services professionals of the scope of senior services and how these services significantly impact a growing yet vulnerable segment of society. Additionally, human service professionals will better understand the framework from which human services are provided, who participates, and the benefits received from participating in senior services.

Senior services are provided to promote health and wellness in the lives of all older adults. Senior services are shown to improve the lives of older adults and allow them to age in place rather than opt for traditional, long-term care services. More than ever before, older adults desire to participate in healthy behaviors, function independently, and maintain their community-dwelling status; however, remaining in the community for some is often complicated by chronic or debilitating conditions. To meet the diverse needs of older adults, two primary models provide the framework for providing senior services.

Voluntary Organization Senior Centers provide senior services to healthy senior adults to encourage healthy behaviors and promote optimal living in the community. Senior services for healthy senior adults include services such as recreational programs, arts and crafts, trips, performances, volunteer opportunities, cultural programs, and meals. To some extent, health education and screening services are also offered. While senior services promote continued healthy living in senior adults, additionally, they provide opportunities for social interaction and companionship.

Senior services are also available for older adults who are frailer and more physically challenged to participate in activities. These services are primarily provided at Social Agency Model Senior Centers. The scope of these services is detailed under the Home and Community-Based Service program funded by the Centers for Medicaid and Medicare Services. Home- and community-based senior services vary by state and program but primarily include the following: case management services, homemaker services, home health aide services, personal care, adult day health care services, and respite care and meal services. Case management is a mandatory service where case managers assist consumers with their senior services. Case manager teams consist of a social worker or a nurse who interviews and assesses the older adult, develops an individual service plan, and monitors the services.

Homemaker services consist of assistance with general household management of the consumer's home. Homemaker services may include general housecleaning, meal preparation, grocery shopping and other household chores. Personal assistance may include supervision for safety and assistance with personal care and grooming. Home health aide services are often contracted with home health agencies in the community. Home health aides offer education and training as well as administer skilled nursing care as needed by the consumer. Adult day care centers provide nutritional, recreational, social, or habilitative services for four or more hours on one or more days per week. Ancillary services such as transportation, in-home support, and minor home modifications may be offered with the approval of the Health Care Finance Administration. According to several studies, at least one-third of those residing in institutional long-term care would have been capable of maintaining their independent living with support. Also, senior services have helped to shrink the burgeoning long-term care budget as well as aide in the deinstitutionalization of many residents in traditional long-term care settings.

Funding for home- and community-based senior services is allocated from the federal government Center for Medicare and Medicaid Services and the Older American Act. Funds for senior services are allocated through a process of devolution in which the authority to manage is transferred from a central government system to individual states to provide support to qualified older adults in the community.

Senior citizens at a senior center. Senior services are available for healthy senior adults as well as older adults who are frail and more physically challenged.

Senior Services Utilization

Senior services are offered at more than 12,000 senior centers across the country. The profile of the typical participant of senior services is a white female who lives alone and is approximately 75 years old. Also, individuals with fewer health problems use senior services more. However, given the increase in older adults and the desire to live independently, the use of senior services by diverse populations is becoming more evident. While senior services are primarily used by Caucasian Americans, diversity in the utilization of senior services is growing. African American participants follow closely behind Caucasian American counterparts in utilization of services, while service utilization by Latino and Asian Americans continues to grow at a steady pace. In fact, the first Program of All-Inclusive Care for the Elderly (PACE program), a nursing home alternative, has its roots in the Asian American community. PACE is a programming prototype that has vastly spread across the nation.

Given the diversity of the senior adult population, it is imperative to understand that culture and racial or ethnic factors can affect the utilization of available senior services. For instance, in the Korean American culture, there is low awareness of senior services. Korean Americans are also ambivalent about using these services (despite the need) due to cultural norms. In Korean, Latino, and African American cultures, many attribute conditions such as memory loss to a natural part of growing older, thereby do not see the need for formal services. Other cultural influences in utilization of senior services include the culture's perception of stigmatization, the desired level of acculturation, and the amount of reverence given to elders.

Benefits of Senior Service Use

Senior adults today are enjoying longer and healthier lives. Compared to a life expectancy of 44 years in the early 1900s, today, individuals reaching age 65 have an average life expectancy of an additional 18.8 years. Medical advances and technology have both contributed to the longevity of older adults; however, the impact of senior services in the lives of senior adults has become increasingly significant. Senior services are found to have improved the lives of older adults in many aspects of life. The benefit is evident socially, physically, psychologically, and economically. The economic benefit is extended to society in general as the emergence and use of senior services has helped to shrink the burgeoning health care budget.

Senior adults are likely to experience incidences of grief, loss of a spouse or loved one, and loss of independence, all of which increases the risk of social isolation and depression. The use of senior services is shown to improve the mental health of senior adults and lead to a greater quality of life. Senior services are shown to decrease depression and improve the stress levels in senior adults. In addition to improving the mental health of senior adults, the use of senior services expands the social networks in senior adults and aids in a more positive perception of one's health and well-being.

Aggregately, senior adults are living longer, healthier lives; yet many continue to live with chronic diseases. As participants of senior services, senior adults are educated on the onset of chronic diseases such as diabetes and cardiovascular disease, disease management, and maintenance of chronic disease. Moreover, by participating in the physical activity provided by senior service programs, active senior adults tend to have better mobility and joint function, and their risk for falls is decreased. Finally, participants in senior services have improved dietary intake, nutrition, and healthy eating habits in general.

Senior Services in the Future

Senior services have been instrumental in the improved quality of life in the lives of traditional senior consumers; however, a review of senior centers underscores the need for senior services to be expanded in order to meet the needs of the growing diverse, 21st-century senior adult. Expansive senior service programming will include services that will enhance the use of technology in senior adults, to meet the needs of bilingual seniors and otherwise diverse senior adults. Additionally, senior services in the future will be enhanced to meet the needs of senior adults with chronic mental health disorders. Finally, given the projected growth of the senior adult population, there is a growing need for service employees who are trained to deliver services to meet the unique needs of senior adults.

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See Also: Adult Day Care; Community-Based Services; Home Care Services; Long-Term Residential Care.

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Service Providers and Diversity

Given the diversity of consumers who need health care, mental health care, and other social services, it is vital that service providers are able to provide professional and culturally competent care. Cultural competency is defined by the United States Department of Health and Human Services (HHS) Office of Minority Health (OMH) as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations." Culture refers to "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups." Competence implies "having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

The Importance of Diversity Training

All human service providers (doctors, nurses, social workers, occupational and physical therapists, lab technicians, medical personnel, psychiatrists, psychologists, marriage and family therapists, licensed professional counselors, substance abuse counselors—the list goes on) have a responsibility to be able to assist diverse consumers regardless of their backgrounds. Service providers should be able to provide quality services to a range of persons who represent different races, cultures, genders, religions, sexual orientations, belief systems, customs, and geographic experiences. If service providers are not trained in understanding diversity issues that may impact a consumer's presentation of symptoms, this can lead to faulty assessment or even misdiagnosis on the part of the service provider. This inconsistency can be due to issues based on a continuum, from intentional prejudice to an unintentional lack of knowledge about other cultures.

Stereotyping is an example of one of the pitfalls that can occur if service providers remain untrained in diversity issues. For example, Victor Adebimpe noted stereotypes of black psychopathology such as prejudicial concepts of psychiatric illness in blacks as a possible cause of misdiagnosis. Harold Neighbors and colleagues stated that clinical uncertainty paves the way to the potential influence of stereotypes that service providers link to observable patient characteristics (such as race). Untrained service providers often reflect the attitudes and discriminatory practices of their society. For example, Vickie Mays engaged in a systematic research synthesis of the early psychological research on African Americans and pointed out the history of racism inherent in that early research. She stated that mental health models, patterned after medical models, at times deny that there are fundamental, positive differences (not deficits or pathologies) that contribute to a different state of psychological reality for people of color.

Annelle B. Primm, MD, the director of Minority and National Affairs for the American Psychiatric Association, discussed four common defenses for bias dynamics exhibited by service providers:

(1) Color blindness is the tendency to behave as if patients from other cultural groups are no different from patients of the dominant culture. (2) Color consciousness is the tendency to behave as if the patient's problem stems solely from being a person of color. (3) Racial countertransference is the emotional reactions of a therapist projected onto a patient of another race or culture. (4) Overidentification is attributing behavioral assumptions to patients who are the same race and culture as the therapist. She said, based on this, that service providers need to be conscious (but not overly conscious) of race. Service providers need to carefully consider each patient's symptom presentation, interpretation, social and environmental context, and the input of collateral informants when using their best clinical judgment.

A service provider's lack of diversity training can lead to both faulty assessment and faulty treatment. For instance, Jennifer Abe-Kim and David T. Takeuchi stated in their research that, when services lack cultural responsiveness or cultural sensitivity, sociocultural differences among groups could lead to (1) difficulties in performing valid psychological assessments, (2) differential or discriminatory forms of treatment, and (3) therapist preferences for consumer characteristics that place ethnic minorities at a disadvantage.

Demographics of Service Providers and Consumers

The demographics of health and mental health consumers are becoming increasingly more diverse. Because of the nature of changes in population trends in the United States and beyond, human service providers are more likely to work with persons of different cultures, and they are more likely to encounter clients with racial profiles different from their own. According to the 2010 U.S. Census, minorities (especially Hispanic or Latino populations) are now driving nearly all of the population growth in the United States. Out of the total population, 63 percent self-identify as white (non-Hispanic), which is lower than in previous years.

In comparison to an increasingly diverse consumer base, there is limited data available about the racial profiles of licensed clinicians (medical and mental health professionals), but that which is available show that these demographics remain primarily white. For example, Tina McRee and colleagues admitted that demographic data are extremely limited and difficult to locate in regards to the health and behavioral health workforce. However, they did determine that U.S. estimates suggest that there are fewer minority clinicians licensed nationwide when compared with the nonminority population. National estimates suggest that more than 70 percent of psychologists and social workers are non-Hispanic whites. African Americans, for example, make up less than 4 percent of mental health care providers nationally. According to the 2008 Health Tracking Physician Survey, approximately 74 percent of physicians are white, 17 percent are Asian, 5 percent are Hispanic, and 4 percent are black.

Because the service provider population is not diverse in comparison with the consumer population, it is extremely important that all service providers obtain diversity training to decrease service disparities for nonwhite populations.

Diversity Standards for Service Providers

Service providers who must obtain and maintain professional licensure status are also required to exhibit some level of competence when handling diverse consumers. There are accreditation standards for professional licensure in the fields of medicine, nursing, psychology, social work, marriage and family therapy, and other disciplines. Standards have been written regarding diversity competence within these disciplines. For example, the Association for American Medical Colleges uses the Tool for Assessing Cultural Competence Training (TACCT) in order to determine if health care professionals are educated on how demographic and cultural factors of their consumers influence health, health delivery, and health behaviors.

The American Association of Colleges in Nursing (AACN) has developed a Tool Kit for Culturally Competent Baccalaureate Nursing Education and a Culturally Competency Tool Kit for Graduate Nursing Students. Based on AACN information and standards obtained from several other sources. Marilyn Douglas and colleagues developed a set of universally applicable standards of practice for culturally competent care that nurses around the globe may use to guide clinical practice, research, education, and administration. The 12 standards include the following: (1) social justice, (2) critical reflection, (3) knowledge of cultures, (4) culturally competent practice, (5) cultural competence in health care systems and organizations, (6) patient advocacy and empowerment, (7) multicultural workforce, (8) education and training in culturally competent care, (9) cross-cultural communication, (10) cross-cultural leadership, (11) policy development, and (12) evidence-based practice and research.

The National Association of Social Workers (NASW) has also developed standards for cultural competence in social work practice. The 2001 standards, updated in 2007, were the first attempt by the clinical social work profession to delineate standards for culturally competent social work practice. NASW developed 10 specific standards that social workers are to adhere to when servicing consumers of other cultures. NASW officials mention that, with the establishment of standards for cultural competence in social work practice, there is an equally important need for the profession to provide ongoing training in cultural competence and to establish mechanisms for the evaluation of competence-based practice. NASW's 10 standards of cultural competence include the following domains: (1) ethics and values, (2) self-awareness, (3) cross-cultural knowledge, (4) cross-cultural skills, (5) service delivery, (6) empowerment and advocacy, (7) diverse workforce, (8) professional education, (9) language diversity, and (10) cross-cultural leadership.

In August 2002, the American Psychological Association's (APA) Council of Representatives approved the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. In 2008, the APA Task Force published a report on the success of their implementation of the multicultural guidelines. In contrast, marriage and family therapists had not adopted specific standards on cultural competence as late as the year 2002. An article by Roy Bean, Benjamin Perry, and Tina Bedell urged marriage and family therapists to "begin to develop a level of cultural competence."

Thus, professional standards for service providers serving diverse populations vary widely. In addition, it is unknown to what extent service providers are able to adhere to their own standards of culturally competent practice. Little research exists describing how consistently and successfully diversity guidelines are operationalized in the everyday professional life of the service provider.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) have been developed in order to provide a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. These 15 standards were initially developed by the HHS OMH in 2000 and were implemented for 10 years after development. The standards were developed in response to health and health care disparities, changing demographics, and legal and accreditation requirements. The enhanced National CLAS Standards are structured as follows:

- Principal Standard (Standard 1): Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
- Governance, Leadership, and Workforce (Standards 2–4)
- Communication and Language Assistance (Standards 5–8)
- Engagement, Continuous Improvement, and Accountability (Standards 9–15)

A Blueprint for Advancing and Sustaining CLAS Policy and Practice is a guidance document for the National CLAS Standards that discusses implementation strategies for each standard. Both the National CLAS standards and the blueprint are available at OMH's Think Cultural Health Web site at www.ThinkCulturalHealth.hhs.gov.

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See Also: Cross-Cultural Skills; Cultural Competence, Human Service Providers and; Cultural Competence, Professional Standards of; Multicultural Education.

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Sexual Abuse Survivors

Sexual abuse is a serious social problem affecting approximately one-third of women and more than 10 percent of men in the United States. This entry defines sexual abuse and sexual abuse survivors; reviews potential effects of sexual abuse; and addresses the special needs of sexual abuse survivors, including considerations for assessment, treatment, and recovery. The term sexual abuse refers to unwanted sexual contact that may include touching or penetration or unwanted exposure to sexual material, sexual behavior, or the private body parts of others without consent. Sexual abuse may be forced or coerced by the perpetrator. Most often, the perpetrator is known to the survivor and may be a trusted family member or other trusted adult. The term survivor is used to empower those who have experienced sexual abuse by emphasizing their strength, resiliency, and power to recover.

Sexual abuse survivors have experienced sexual abuse and may be of any age, gender, ethnicity, sexual orientation, or ability level. Sexual abuse occurs across all socioeconomic levels and most cultures. Culture may significantly affect the meaning that a survivor ascribes to having been sexually abused, the ways that family members and significant others respond, and the recovery process. The experience of historical or multigenerational trauma may influence the rate of reporting and help seeking in some cultures such as Native American, people of color, and other marginalized groups.

Effects of Sexual Abuse

Survivors of sexual abuse may experience a range of effects that can occur in the hours or weeks following the abuse and may be long lasting. Some researchers suggest that the negative effects that survivors experience may be exaggerated and minimize the survivors' ability to recover. While survivors experience negative effects to varying degrees, most researchers agree that sexual abuse is harmful.

Trauma effects may include problems regulating emotion and behavior that stem from a heightened state of arousal in response to psychological reminders of the trauma or environmental stressors. Dysregulation of emotion may include increased anxiety, social withdrawal, depressed mood, anger, and shame. Dysregulated behavior may include acting in ways that can cause harm to others, such as aggressive outbursts, or self-harm, such as cutting.

The survivor may develop distorted thoughts such as believing that they caused the sexual abuse or are responsible for consequences that the perpetrator faces. These distortions are often related to messages the perpetrator used to justify his or her sexually abusive behavior or attempt to secure secrecy.

In severe cases, the survivor may experience symptoms of posttraumatic stress. These symptoms interfere with functioning and may include persistent, heightened anxiety, arousal, and reactivity (re-experiencing the abuse by thinking about it when not intending to), having nightmares, or feeling like the abuse is happening when it is not; avoiding reminders of the abuse, such as associated places or objects; having dissociative symptoms (feeling disconnected from one's self or environment); or having changes in thoughts or mood.

Sexual abuse survivors may also develop disruptions in sexual attitudes and development, sometimes reenacting elements of the abuse as a child or engaging in risky sexual behaviors as an adolescent or adult. Additional effects may include somatization that results in various physical symptoms, substance abuse, and poorer health outcomes.

Recent studies have begun to explore the relationship between trauma and changes in brain development affecting the cerebral cortex, hippocampus, and amygdala and neuron activity. Changes to the nervous system have implications for understanding the ways in which sexual abuse survivors are impacted by trauma and the recovery process.

Children and adolescent survivors often experience secondary problems related to the sexual abuse. In situations in which the perpetrator was a parent or a caregiver, the survivor may be removed from the home, enter foster care, lose contact with family members, and have reduced financial stability.

Research suggests that severe forms of sexual abuse that are repetitive and prolonged, abuse characteristics such as having a trusted relationship with the perpetrator, and causal attributions such as self-blame, lead to greater negative effects. Judith Herman and others have described repetitive and chronic sexual abuse and related trauma effects as complex trauma.

Complex trauma may lead to dissociation as a primary coping mechanism, disruptions in the sense of self and personality development, impaired relatedness with others, chronic depressed mood, erratic moods, attachment difficulties, suicidal thoughts or behavior, self-harm behaviors, and being sexually inhibited or engaging in risky or compulsive sexual behavior. The experience of complex trauma often results in a more complicated healing process.

Special Needs of Survivors

In the aftermath of sexual abuse, survivors often participate in forensic evaluations conducted by multidisciplinary teams that include medical and mental health professionals and child welfare specialists to evaluate the extent of abuse and medical treatment needs. While gathering accurate information is necessary, the survivor's emotional well-being and physical safety must be paramount. Training about trauma, trauma effects, and cultural implications for medical and mental health professionals in forensic, health care, and mental health settings is necessary to provide informed and culturally sensitive care.

Given that sexual abuse is interpersonal in nature, healing from sexual abuse best takes place in the context of safe and supportive relationships. For children and adolescents who experience sexual abuse, having at least one caring adult, such as a caregiver, parent, or therapist, who is safe and supportive promotes recovery. Survivors often benefit from individual, family, couples, or group counseling or psychotherapy. Mental health treatment combined with psychopharmacology may be most effective to address symptomatology. A collaborative relationship between the therapist and survivor is fundamental for best outcomes. A thorough assessment of multiple dimensions of the person, environment, and his or her interplay is necessary to determine the unique needs of the survivor. Assessing for safety and establishing safety are particularly important in setting the groundwork for therapeutic work with survivors of sexual abuse.

For children and adolescents, a treatment approach that collaboratively engages, educates, and includes parents or caregivers is most helpful. For adult survivors, including partners in treatment when possible may lead to better outcomes. Cognitive-behavioral treatment approaches that provide psychoeducation, teach skills to regulate emotions and behavior (e.g., relaxation or mindfulness), involve some form of exposure and desensitization, and promote safety have been found to be most effective. Play therapy and sensory-based, trauma-focused treatment approaches are also thought to be beneficial with young children.

Group therapy for sexual abuse survivors also promotes healing and recovery because it connects survivors with other survivors, reducing isolation and stigma, and provides a safe environment for group members to share their experiences. This can be particularly important for male sexual abuse survivors, who may experience greater isolation and stigma.

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See Also: Child Abuse/Neglect, Victims of; Childhood Trauma; Counseling and Psychotherapy Services; Group Therapy; Trauma-Focused Services.

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Sexual Reassignment Surgery

Gender reassignment surgery or sexual reassignment surgery refers to a set of surgical interventions undertaken with the purpose of altering the physiological or anatomical sex of an individual. Both male-to-female (MtF) and female-to-male (FtM) surgeries are available.

While in adults, gender reassignment surgery takes place voluntarily and following a clinical diagnosis, surgical interventions have been used nonconsensually to treat intersex babies and young children. This latter use of medical intervention to treat intersexuality without consent has been condemned by the United Nations Special Rapporteur on Torture (SRT).

Transgenderism and Transsexualism

An individual who self-identifies with a gender that is incongruent with or challenges biological or physiological sex is known as transgender. Included within the umbrella term of transgender are transsexuals: individuals who opt to realign their gender and their sex through medical intervention such as hormone therapy or surgery. The precise number of transgender individuals in the general population is not known. A recent study conducted in the Netherlands suggests that the ratio for males is one in 11,900 and, for females, one in 30,400. The number of surgical procedures carried out is lower than the number of transgender individuals because not all opt for surgery.

Generally, undertaking gender reassignment surgery requires a diagnosis of gender dysphoria. The fifth version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) requires that such a diagnosis in adults requires a strong difference between the experiences and expressed gender of an individual and the gender assigned to that individual by society, and that differences must continue for a minimum of six months. In addition, gender dysphoria is not considered a mental disorder unless it is accompanied by clinical evidence of impairment or distress in occupational, social, or other life domains. The process or the period of time during which gender reassignment occurs is known as transition. Individuals who have undergone surgery, either successfully or unsuccessfully, may continue to be referred to as transgendered or trans.

History of Gender Reassignment Surgery

Although sexual transformation is known to have taken place in early Greece and throughout the Renaissance, the first published account of gender reassignment surgery was not published until 1931. The number of surgeries performed began to grow in the late 1960s and 1970s, with Johns Hopkins University establishing a Gender Identity Clinic in 1965—the first hospital in the United States to formally establish a gender reassignment medical program. By 1979, up to 20 major medical centers in the United States were performing the surgery. Today, MtF surgery is around three times more common than FtM surgery. Possible reasons for the difference are the increased sense of vulnerability felt by boys in developing a gender identity during childhood or the greater ease with which biological women are able to present as male without undergoing surgery. The countries that lead the way in performing gender reassignment surgery are Thailand, Iran, and Serbia.

Diagnosis and Surgical Intervention

The process involved in making a gender transition differs from country to country, but typically it is lengthy and difficult. In the UK and the United States, for example, standards for diagnosis and management of gender dysphoria are established by the World Professional Association for Transgender Health (WPATH), formally known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA).

The so-called Benjamin standards prescribe a three-step approach to gender realignment and require the involvement of a large number of professionals. In the UK, the process is typically begun by the patient's general practitioner (GP) who, upon recognizing the condition, should refer the patient to a specialist gender identity service. Professionals involved in that service include mental health counselors, psychiatrists, psychologists, endocrinologists, speech therapists, and reconstructive surgeons. A psychiatrist will assess the patient, obtaining a full psychiatric history and examining psychosexual development, childhood gender-type behaviors, and any cross-dressing or attempts to conform to cultural gender.

Once a diagnosis of gender dysphoria has been obtained, patients are invited to participate in the real-life experience. This involves the administration of hormones to bring about changes in physical appearance that enable the patient to more closely resemble the opposite sex. The patient is then required to live as the opposite gender for a minimum of 12 months. The purpose of this step is to assess how comfortable the patient feels living and working in society in his or her self-identified gender. Once this trial period is complete, the patient may choose to undergo gender reassignment surgery, but not all patients do so.

During gender reassignment surgery, the physical appearance and functions of the primary sex characteristics, including sexual organs, are surgically altered in order to resemble those of the opposite sex. A number of surgeries are available, depending upon the needs and desires of patient and depending on whether the surgery is MtF or FtM. In MtF gender reassignment surgery, the reshaping of the male genitals into genitals with the form and function of female genitals is known as a vaginoplasty. MtF surgeries may also involve breast augmentation, buttock augmentation, voice feminization surgery, and surgery to reduce the size and appearance of the Adam's apple, known as a tracheal shave. FtM surgeries include a bilateral mastectomy to create a male chest, hysterectomy–ovarectomy, and phalloplasty (creation of a penis).

An individual undergoing gender reassignment surgery may also opt for surgical procedures that alter facial features to provide a more masculine or feminine appearance. Common types of facial feminization surgery, for example, are cheek implantations, scalp advancement, rhinoplasty, and frontal cranioplasty.

Post-Gender Reassignment Surgery

Success rates of gender reassignment surgery vary widely. Many procedures are highly complex, and complications are likely. Generally, however, follow-up research with trans patients suggests that most are pleased with the cosmetic and functional outcomes of the surgery. One comprehensive meta-analysis of follow-up studies with FtM and MtF patients undergoing surgery between 1961 and 1991 found that only around 1 percent of patients felt regret following the surgery. Satisfaction with surgery depends on a number of factors including age (younger patients are typically more satisfied than older patients), family support, and social support.

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See Also: Cisgender; Gender and Clients; Gender Issues and Roles in Developing Countries; Gender Issues and Roles in Non-Western Countries; Transgender Individuals.

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Sikhism

As a growing section of American society, nearly half a million Sikhs currently live in the United States. However, despite being the fifth-largest world religion, Sikhism remains a primarily unheard of and misconceived faith. Gaining cultural sensitivity to Sikhs, though not complicated, is necessary to provide effective and respectful services. Incorporating spirituality, familial decision making, and respecting the articles of the faith are key facets for human service providers to be culturally sensitive toward Sikhs. However, even within a religiously unified group, individual variations in values and beliefs exist, and human services must be tailored to that individual's uniqueness.

Spirituality

A Sikh's faith is intricately woven into numerous aspects of his or her everyday life. From morning routines, including prayers to meal-time limitations eliminating meat, the path Sikhs choose to lead in their daily lives encompasses the guidelines outlined through the Sikh faith. The Guru Granth Sahib is the Sikh holy scripture; a communal interpretation of this scripture led to the writing of the Rehat Meryada by Sikh leaders. The Rehat Meryada provides a detailed description of the parameters within which Sikhs are expected to lead their lives.

Spirituality for Sikhs is achieved through meditation, daily prayers, and singing of hymns from the Guru Granth Sahib. Sikh meditation is performed in various forms. The most common form of meditation is a repetitious chant of a religious word or phrase with the intention of focusing on removal of external stimuli and thought. Meditation allows an individual to spiritually, emotionally, and physically center themselves. A direct benefit is that meditation can often help Sikhs in deciding on treatment options, courses of action, and other involved thought processes by allowing clarity of thought to channel beliefs and values. A human services provider must be aware and sensitive to a Sikh during meditation. By avoiding interruption, facilitating a quiet space, and avoiding external pressures, a human services provider can enhance cultural sensitivity.

Devout, practicing Sikhs pray three times a day. Though prayers are not required to be performed at specific times according to Sikh scriptures, a majority of Sikhs perform their prayers in the early morning after a cleansing bath, in the evening before their meal, and at nighttime before sleeping. However, a number of Sikh prayers can be performed at any point over the course of a day. These prayers are not necessarily part of a Sikh's regular prayer routine as delineated by the Rehat Meryada but are often performed in times of emotional, mental, or physical need such as during a crisis or a hospitalization. Because human services providers often intersect with the lives of individuals during these times of need, allowing Sikhs to pray in a comfortable, safe, and accepting way promotes cultural competency and sensitivity.

Sikh spirituality is also achieved through religious hymns, both listening to and singing hymns. These hymns are direct segments of the Guru Granth Sahib and are thus sung with respect and adoration. Musical instruments often accompany the recitation of hymns but are not required. Human services providers will more commonly come across Sikhs listening to hymns rather than singing hymns, but their purpose remains the same. As these hymns are direct recitations of segments of the Guru Granth Sahib, Sikhs take comfort in the guidance, peace, and support they provide. Similar to a human service provider's role during meditation and Sikh prayer, providing Sikhs with a safe, comfortable, and supportive environment in which they can practice their faith remains the most culturally competent and sensitive approach.

A Sikh candlelight prayer ceremony. Spirituality for Sikhs is achieved through meditation, daily prayers, and singing of hymns from the Guru Granth Sahib. Devout, practicing Sikhs pray three times a day with a majority performing their prayers in the early morning after cleansing baths, in the evening before their meals, and at nighttime before sleeping.

Familial Decision Making

Sikhs are a group of individuals primarily from the northern part of India. Such a uniform location of origin has led to not only religious similarities within Sikhs but also cultural similarities. Though familial decision making is not directly tied to the Sikh faith, as delineated in the Sikh holy scriptures, the cultural uniformity of a majority of Sikhs makes familial involvement not only preferred but at times necessary to decision making in human service situations. The familial decision-making mentality arises from the cohesiveness of a family unit in the culture of majority of Sikhs. Any decision impacting an individual within one of these familial communities is considered to directly affect the remainder of individuals in that community. Culturally, Sikhs often value extended family households with a primary matriarchal or patriarchal figure. Additionally, Sikhs place strong respect and value on the opinions of their elders. Thus, decisions are not made without resorting to the opinions of the elders. However, though respect and value for opinion often lead to more cohesive decisions, Sikhs often place themselves in decision-making situations necessitating familial decision making.

For example, medical decision making often requires familial involvement in the care of elderly Sikh patients. This decision making becomes a required familial effort due to younger generations of Sikhs at times not fully disclosing to an elderly Sikh patient the extent and prognosis of the disease. Though some health care professionals may argue the ethics involved in not fully disclosing health care information to a patient, Sikhs feel the added stress of a negative situation or poor prognosis adds undue stress to that patient, thereby worsening the illness.

Human services providers must respect familial decision making, whether that directly involves the primary individual or not, as this is a belief held firmly by Sikhs. If ethics remains an issue, human services providers should approach organizations that specialize in these situations such as a hospital ethics board or the Sikh American Legal Defense and Education Fund.

Articles of Faith

Sikhs have five major articles of faith. Each article represents a key concept in Sikh belief. The *kara* is a steel bracelet worn by Sikhs to act as a reminder that every action a Sikh takes should be with their faith and God in mind. This reminder should act to prevent Sikhs from performing negative and harmful actions. The *kanga* is a comb that Sikhs wear in their hair at all times to represent a clean mind and body. The *kachera* is long underwear worn to discourage lustful behavior. Human services providers should facilitate Sikhs in wearing the kara, kachera, and kanga and never removing them from a Sikh's body without permission. The *kirpan* is a small sword or dagger that Sikhs keep on their bodies as a symbol that they protect the defenseless.

Respecting that the kirpan will not be used in a malicious manner can be heated and complicated in today's society, but communication with an individual to wear a smaller, harmless version is possible. Finally, *kesh* is uncut hair that symbolizes maintaining the identity of Sikhs as not altering their bodies because Sikhs believe the body is a gift from God. Not removing a single strand of hair from a Sikh's body without permission is a very important lesson for all human services providers, especially health care providers who may feel inclined due to health care practices. Human services providers should be aware and respectful of these articles of faith and understand their symbolism to Sikhs.

Variations in Belief

Despite having a holy scripture delineating the pathway a Sikh should lead, the Sikh holy scripture is often interpreted in various and, at times, conflicting ways. For example, a number of Sikhs eat meat, don't maintain the articles of faith, or cut their hair. These individuals feel the pathway outlined in the Guru Granth Sahib does not require maintaining these aspects of the faith to count themselves as Sikhs. Additionally, individuals may vary by degree of religiosity and thus choose to maintain only those values and beliefs they believe serve them well. It then follows that a human services provider must realize that individuals within the Sikh faith can vary on their personal values and beliefs. Unfortunately, this discrepancy often creates room for confusion and lack of generalizability of understanding. As with providing services to any unique group, the lack of universality of values and beliefs requires human service providers to communicate with the individuals with whom they come in to contact so as to provide the most culturally sensitive services to that particular individual.

Conclusion

Sikhs are a unique and growing religious group in the United States. Human services providers must respect not only a Sikh's incorporation of spirituality, required familial decision making, and articles of faith when interacting with him or her but also understand that, as with any faith, vast variations exist within this group. In order to provide the highest level of cultural competency and sensitivity, human services providers must engage the Sikhs they come into contact with and discuss expectations prior to engaging in the service.

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See Also: Cultural Competence, Human Service Providers and; Cultural Literacy; Diversity and Quality in Health Care.

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Single Parents

Services for single parents constitute a category of child and family services. These services are carried out by public and nongovernmental bodies for people who are single parents by unfortunate events or by their own choice. Individuals come to single parenthood mainly through divorce, separation, birth outside of marriage, child abuse or neglect, death of a partner or widowhood, and adoption. At the end of the 20th century in developed countries, the single-parent family continued to emerge. According to the 2013 World Family Map report, the highest levels of single parenthood are noticed in countries of South America and sub-Saharan Africa (from 16 percent in Bolivia to 43 percent in South Africa). North America, Oceania, and Europe average about one-fifth of children living in single-parent households. The highest levels were noticed in the United States (27 percent), the United Kingdom (24 percent), and New Zealand (24 percent). Lower rates were in Europe (average 15 percent), Asia (9.8 percent), and the Middle East (8.5 percent). Most of single parents are women. Adults in the Americas, Europe, and Oceania lean more toward acceptance of voluntary single motherhood than in other regions. Therefore, these services are often limited as services to pregnant single women who decide to carry the baby to full term and then keep the child.

Reasons of Distinguishing Services for Single Parents

Single parents with children need additional social, professional, educational, and legal support. The single parent is usually also the primary caregiver and breadwinner, meaning the parent with whom the children have residency the majority of the time and parent on whose income the household budget is based. The single parent must play both mother and father roles—not only providing love and nurturance but also interpreting society for the children and being a figure of authority and discipline. This situation creates considerable stress, responsibility, tasks, and emotional overload. Single-parent, mostly mother-only, families have greater likelihood of children living in poverty. Usually post-divorce or separation, a mother's earnings are significantly lower than that of a divorced man. Single parents are likely to have problems associated with combining work with child rearing. Their job mobility, earning power, freedom to work late, and job performance are negatively affected.

Children in a single-parent family might come from abusive or neglectful homes or live in very poor and dangerous communities. Such children also have above-average levels of youth suicide, mental illness, violence, drug abuse, poor school performance, lower levels of education, and higher dropout rates. They are also more likely to have health-related problems as a result of the decline in their living standards, including the lack of health insurance. As children from single-parent families become adults, they are more likely to marry early, have children early, and divorce. Girls from single-parent families are at greater risk of becoming single mothers as a result of nonmarital childbearing or divorce.

General interventions of social policy programs may include child allowances, an education benefit, national health services, access to public housing, promoting family benefits, child care provision, preventing teen pregnancy, increasing access to education, supporting entry into the labor market for low-income women, and identifying mothers early on in the process of marital disruption.

Types of Services for Single Parents

Single-parent families rely on support from immediate family members, which is the most important resiliency factor in helping them to face life challenges. Sometimes, support comes from friends, a style of positively approaching problems, and religious or spiritual support.

Social services of public agencies and nongovernmental organizations depending on the purpose of assistance may be directed to pregnant single women, those who already are single parents, and children from single-parent families.

Services aimed at pregnant single women include the following:

- Alternatives counseling for pregnant single women that aims to help in making decisions about carrying the baby to full term, having an abortion, keeping the child, terminating parental rights, deciding on foster placement, and undergoing adoption counseling.
- Physical and mental childbirth preparation including information about the effects of drug and alcohol abuse on the embryo, information on the effects of venereal diseases, and pre- and postnatal counseling.
- Legal counseling including procedures for termination of parental rights, legitimation and adoption procedures, rights to attend school, and procedures of receiving public assistance.
- Interpersonal relationships counseling focused on the pregnant single women

- and relationships with the alleged father, parents, and other relatives.
- Information and management of alternative living arrangements like a maternity home, home of parents or other relatives, and foster homes.

Services to those who are already single parents include the following:

- Programs for teenage mothers involving them to continue education (e.g., through home study programs) and to instruct them about parenting, sexuality, social services for which they may be eligible, financial and money management, as well as employment opportunities.
- Family planning counseling, including information on birth control and referral to a family planning clinic.
- •Alleged-father counseling, including informing him about his rights and responsibilities, providing birth control counseling and premarital counseling.
- Foster care and adoption—children can live in homes with families other than their birth parents until they are returned to birth parents or adopted. Foster parents should be trained and related to children and their birth parents. Foster care is sometimes used when a single parent relinquishes his or her parental rights or is unsure about whether to give up parental rights. The goal is to protect the children, rehabilitate parents, and return children to their genetic parents as soon as it is feasible.
- Psychotherapeutic interventions including help by community agencies, like guidance centers, including individual or family therapy with a social worker, psychologist, or psychiatrist. Such entities sometimes maintain reference libraries of books and movies on death and divorce for clients.
- Parent-assistance programs aimed at help for the experienced or overburdened parent with dealing with some practical problems of child and home care.
- Family crisis intervention, including services aimed at assisting during intense domestic disputes that require police intervention.
- Support groups and self-help groups like Parents Without Partners, which help individuals realize that they are not the only ones coping with a given problem. They assist members in developing new ways to cope as they learn from each other.
- Child-care programs targeted at working and nonworking parents, families with children who have severe developmental disabilities in which adults care for children during evenings or weekends so parents can have time to themselves. This includes crisis nurseries or shelters, where parents under severe stress or in a serious emergency can leave their children for a limited time.
- Homemaker services to families that are at risk or have neglected or abused their children. Homemakers offer practical suggestions and education about housekeeping, child care, nutrition and cooking, health and safety, shopping, budgeting, and access to community resources. Sometimes, they serve as surrogate parents, developing positive, trusting relationships with family members who have been isolated.
- Volunteer and outreach programs who spend time with families, prevent family disruption, assist in problem solving and gaining access to community resources, or serve as a surrogate parent or friend to parents and family members.
- Child protective services; for example, ensuring that children can be safe in their own homes; arranging for community resources; parent education and support; helping with involvement in a parent support group; and developing a contract with a parent on goals the family must accomplish to be removed from a child's protective services caseload.
- Family preservation services with an emphasis on keeping together families that would have been separated in the past. Services include maintaining and strengthening family bonds, stabilizing a crisis situation that precipitated any need for outside placement, and increasing family's coping

skills, competencies, and use of appropriate and informal helping resources.

Among the services oriented on children in single-parent families are the following;

- School-established support groups for students coping with family problems such as divorce or abuse.
- Peer counseling in the form of rap groups in schools. Groups sponsored by the school or a local counseling agency help children to express feelings about home life and reduce the sense of isolation. Children in group realize that others have similar feelings in similar situations.
- Daytime care programs for young children. The aim is to foster optimal intellectual development and to help overcome some of the emotional effects of early deprivation.
- Big Brothers and Big Sisters programs aiming to fill the gap in a child's life who was left by a departed parent.
- Social and recreational programs for children at different ages offered by community centers.
- Respite care for adolescents who need time away from their parents. Emergency shelter facilities for teens that provide crisis and family counseling to help stabilize the situation so teens can return home.

Services for single parents may be coordinated through resource centers where families can receive thorough assessments, so they can be referred to appropriate agencies and databases that contain information about the services available to single parents run by social groups and networks. Services should be adapted to the cultural diversity of the single-parent family.

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See Also: Adoption Agencies and Services; Divorce; Family Services; Family Structure, Diversity of; Parenting Skills Training; Parenting Styles, Cultural Differences in; Poverty; Pregnancy and Parenting Services; Profile of Parenting Study.

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Size Discrimination

Historically, persons who are different have experienced prejudice and discrimination. Sometimes, generalizations are based on race, religion, gender, socioeconomic status, or a myriad of other characteristics. One characteristic in particular has received much attention from the media and civil rights organizations; this characteristic is size discrimination. Size discrimination is defined as unfair or different treatment based on size and weight. Unfortunately, size discrimination is much more common than one would think, and it has long-reaching consequences. It is much harder to get away with racism (no blacks allowed in this club) as opposed to sizism (no short or fat people allowed in this club). In our culture, we are a very judgmental and superficial group. Until legislation is put in place to prohibit discrimination based on height or weight, size discrimination will continue to occur, both covertly and overtly.

Research on body size has indicated that persons are more likely to get hired, promoted, be well liked, make more money, gain membership into clubs, and get better health insurance when they fit the acceptable weight and height expectations our society holds as normal. Conversely, those who are obese are more likely to be denied medical and life insurance and may pay higher premiums than “average-sized” individuals. They are less likely to be hired for a job in the first place, less likely to be given a raise, and less likely to earn as much as thinner people. Women in particular face social bias and discrimination due to their size. They (larger women) are perceived of as difficult to work with, lazy, hostile, dishonest, unfeminine, and lacking self-discipline. Even with the same qualifications as their thinner counterparts, they will experience discrimination in employment and in daily interpersonal relationships. Overweight men and women suffer socially; they are less likely to marry, have lower self-esteem, and will commonly experience name calling, which leads to poor body image and unhealthy eating habits, perpetuating weight gain.

Employment discrimination of these individuals also leads to lower household income, higher rates of poverty, less-desirable housing, and fewer opportunities overall. Some educational institutions have been known to turn down applicants due to their size. Thus, their level of education is lower on average in comparison to those within the normal weight range. Even when enrolled in school, some research shows that teachers have lower expectations of larger students.

Playing by the Rules

Although employers can require employees to dress and groom appropriately, they cannot exclude persons from employment for social reasons, and any criteria used that might exclude an entire group of people is discriminatory. If a person is physically capable of completing the tasks required for his or her job, it would be unfair to hire (or not hire) that person due to his or her body size. However, if an employee’s size will hinder the ability to perform the tasks that are required for the job, the refusal to hire would be valid. It must be proven that the height and weight requirements for employment are occupational requirements. Where might this situation occur? In policing, if someone does not have the strength to apprehend a suspect, the officer or innocent bystanders could be hurt or killed. In a fire department, if someone cannot carry a hose up a ladder, a house could burn down and people could die. These are examples where size might interfere with the ability to perform necessary tasks.

Interestingly, a recent court case ruled against 22 Borgata Babes (Atlantic City, New Jersey, casino waitresses), who claimed weight discrimination when they were told that they could be fired if they gained 7 percent of their body weight. They lost the lawsuit, as the judges determined that the women were hired with the expectation that they look a certain way and that they were expected to keep up their appearances in order to keep their jobs. Since 2002, Southwest Airlines has instituted regulations requiring larger passengers to buy two seats on their planes. According to the Council on Size and Weight Discrimination, seating on planes is a public accommodation. Yet the airline has been able to cite comfort of passengers as an explanation for its rule.

However, there are situations where size does not really matter. For example, a flight attendant was discriminated against when she was denied employment because she was too short. The 5’2” requirement really was not necessary to perform her duties. Not only is this treatment discriminatory against short women, but it discriminates against entire ethnic and racial groups who might have a tendency to be shorter than other groups.

Specific examples of size discrimination have occurred within many businesses. For example, the chief executive officer of Abercrombie and Fitch stated that their clothing is designed to target the “cool kids,” so they are no bigger than a size 10. Persons have been denied membership to gyms (or refunded their membership fee) because their “large” presence was not good for business. In another case, a nursing student was asked to lose weight or be expelled from her program, and a traveling choir applicant was denied membership because it was assumed her weight would make it difficult to travel. Further, an obese woman was denied a job due to her weight, even though the position was for a receptionist in a car dealership. Finally, a couple was denied the ability to adopt a child due to their size.

Intentional discrimination against a person who might be larger, smaller, taller, or shorter than “average” could be categorized as a violation of the law. The National Association to Advance Fat Acceptance (NAAFA) was established to end size discrimination. It is a nonprofit civil rights organization that was created in 1969. Yet, there is almost no legislation protecting against this type of discrimination. With no federal laws in place to protect individuals from sizism, equitable treatment cannot be guaranteed. In addition to the state of Michigan, Washington, D.C., has incorporated weight and height into their discrimination laws. Some jurisdictions do prohibit discrimination due to physical appearance or physical attractiveness, and there is pending legislation against height discrimination in other states (Massachusetts in particular). However, these definitions are very subjective, and the laws are few and far between. In fact, size discrimination is actually increasing as the percentage of Americans considered fat has increased. Prejudice in hiring and wage discrimination by height has been studied in depth. Not only do these factors affect job performance, but they affect perceived job performance. Some people even believe there is a correlation between height and intelligence as well as between low income and weight (i.e., the lower your income, the higher your weight is likely to be). This "taste-based" discrimination can lead to unfair prejudices that are not true. Thus, a person might not be hired if he or she is short because it is expected that he or she will not think as well as his or her taller counterparts.

An obese person rides a motorized cart through a store. Larger individuals are often denied equal opportunity and discriminated against because their size makes navigating logistically difficult.

Logistics in Regard to Fitting In

Logistically, it is harder for a larger person to access turnstiles, narrow doors, hallways, and small bathrooms. Other areas of concern include seating on buses, trains, at restaurant tables, and in airplanes, which means larger individuals are denied equal opportunity, whether intentional or unintentional. Thus, they are discriminated against due to their size. In addition, their health care is not the same. Medical personnel treat them differently. They are often told to lose weight (regardless of their health), and some facilities and machines simply cannot meet their needs (e.g., magnetic resonance imaging [MRI] machines). In addition, nurses even prefer to not treat overweight patients. Further, those who are too short or too tall might not be able to fit into these machines.

Opportunities and Expectations

Men who are short are judged as less mature, less positive, less masculine, less outgoing, and more passive. Those who are smaller in stature also experience more bullying and harassment. Women who are "too tall" experience negative comments such as being called unfeminine.

Interestingly, shorter men earn less than taller men, and thinner women earn more than obese women. Taller men are seen as natural leaders and assertive. They are more likely to be involved in politics and business and have high-ranking jobs, and are more likely to be hired and make more money than shorter men. In addition, their mating opportunities are better because they appear more attractive to women.

What Does Size Discrimination Stem From?

There are a few theories as to why people are judged based on the size of their bodies. Many people believe that we are obliged to abstain from too much pleasure (gluttony) and that those who are larger are perceived as self-indulgent and unable to control themselves. Others have developed a fear of fatness because our culture is obsessed with thinness. Women in particular struggle with trying to fit the mold of a Barbie doll or a model, which leads to eating disorders and body image issues. Yet women who are "too" thin can also feel the wrath of societal judgment. Why is it acceptable to tell a woman she is too thin, that she should gain some weight, or go eat something? In one instance, models in Madrid were banned from a fashion show for being too thin (based on their body mass index [BMI]).

According to some theories, the focus on normal and acceptable weight began when ready-to-wear clothing was created. Up until the early 1900s, clothing was custom made. Once ready-to-wear clothing was developed, the differences in body sizes became more apparent, and those who were different (i.e., too large, small, short, or tall) were ostracized because they were considered outside the range of normal.

What Can Be Done to Reduce the Incidence of Sizism?

In order to combat discrimination based on size, there are steps that can be taken. For example, sports stadiums and movie theaters have created wider seats to accommodate larger individuals. Airlines could do something similar; by creating a row of seats to meet the special needs of those who are wider or taller than the average individual, they will not be precluded from participating in enjoyable activities. Clothing manufacturers can create more clothing made for plus-sized individuals as well as for those of small stature. Big and tall stores do exist, and those who need to visit these stores should not feel embarrassed to do so. Current television shows can (and some have) depicted larger individuals as the main characters. However, they should not be portrayed as lazy or disgusting.

The media can play a strong role in influencing societal opinions and perceptions of those who are larger or smaller, or shorter or taller, than what is expected. By instilling the notion that one should not be judged for his or her body size, size discrimination can be reduced. Currently, only Michigan prohibits workplace discrimination based on height or weight. Federal legislation against discrimination for age, race, and gender could be extended to encompass body size as well. Unfortunately, there are many disparities in the delivery of services experienced by those who are different. Those who experience size discrimination are no exception. Therefore, it is important to address the social, economic, and legal ramifications of the treatment of those who are too large, small, short, or tall and are judged because they do not meet society's criteria for acceptable size.

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See Also: Americans with Disabilities Act; Bias in Service Delivery; Discrimination and Institutional Racism; Implicit Bias; Overweight and Obese Adults and Children.

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Slavery and Lasting Cultural Effects of Social Biology/Biological Determinism

One of the lasting effects of racialized slavery is a notion of biological determinism, or the belief that basic human abilities and aptitudes are determined by an individual's biology. As documented by A. Desmond and J. Moore, the word *polygenism* itself was coined in the 1850s as part of an effort to justify race-based slavery in the United States. Polygenism—the belief that human races are in fact separate species—was used to explain why certain races could only participate in civilization under the direction of what was believed to be a more advanced species, the whites. The valence of polygenism was that it was a modern, scientific belief in contrast to monogenism, which was linked to Christian theology and therefore was ascribed the status as myth.

An important precursor to the polygenic program was the effort to find quantifiable measures by which to distinguish the supposedly distinct species of humanity. One of the most infamous of these was Samuel George Morton, who attempted to measure the cranial capacity of human skulls. By tallying the skulls according to race, Morton was able to state that those of the European race had larger cranial capacities as compared to the African or (native) American race. Morton's craniometry, which has been analyzed by Stephen Jay Gould, was cited by many authors in the 19th century as evidence of the varying skull sizes, and thus supposedly varying mental capacities, of human races. This finding seemingly disregards the fact that human beings do not have the largest brains among the mammals, and yet they appear to have the most complex cognition. Brain size alone, therefore, does not seem to correlate directly with intelligence.

The notion that human abilities and aptitudes ranged on a continuum of values can be attributed to the Belgian statist Adolphe Quetelet, a pioneer of a sort of social physics in the mid-19th century. Quetelet made use of the error law of astronomy, which transforms the multiplicity of human error found in measurements of astronomical distances into an exact quantity. Measurements of the distance to the same star by different scientists or at different times often differed because of errors in measurement, making a statement of scientific certainty impossible. Assuming that a good-faith effort is made to measure the distance, the error law postulates that all measurements of the same body are more likely to be closer to the actual distance rather than farther away. Expressing the distribution of measurements on a chart exhibits the familiar bell-shaped curve, with the very wrong and least likely measurements on the lower portion (the horns). Progressing from the lower regions along the curve to the highest point, the accuracy of the measurement increases. At the summit, one gets closer and closer to the point of zero error—the actual distance to the star—and even though it is a practical impossibility to take a measurement with zero error, the exact distance can be surmised. The error law uses a statistical principle to make an accurate guess at an unknown, but definite, quantity.

Quetelet used the principle of the error law as a starting point for more broad analyses. In 1844, he started from a simple study of the distribution of height in a population to demonstrate that human characteristics distribute themselves like the errors in measurement of a star's distance—and from there, he took a logical leap to suggest that all human qualities are scientifically demonstrable and arrange themselves around a certain norm. This leap, however, ignores the difference between human characteristics and physical realities. Even in such a simple measurement as height, there are distinct problems. The subject's slouch, impossible to measure, causes a definite variation in height. This objection only becomes more intense when trying to measure subjective qualities of character. Quetelet's work ranged far, from observations on biological variation to analyses of crime and mortality, and it had wide impact on the burgeoning field of social science. Quetelet believed in a magical ability of numbers to conjure an ideal individual. The variation of individuals was seen not as variations on a theme but errors in the execution of a model. Identifying and correcting these biological errors, and finding the basic types around which these traits varied, became a goal of the deterministic racial scientists.

At the end of the 19th century, the idea that the African race had distinctive intellectual and social qualities intertwined with Social Darwinism to create a new justification for racial hierarchy. The neo-Lamarckian Social Darwinists would assert that individuals of a race accumulate biological traits that make them fit for certain kinds of societies. W. J. McGee's 1899 address to the Anthropological Society of Washington, "The Trend of Human Progress," suggested that each society is on its way from savagery to civilization but that there were necessary steps through which each society must pass, including abandoning matriarchal culture and accepting the scientific development of knowledge. Interestingly, McGee suggested that individuals in each society would be like their kin in their ability to form government, respect the rule of law, and contribute innovation in science. Although racial slavery might be over, these authors seem to assert, the former enslaved population has a long period of apprenticeship through which it must develop before it could become full members of society.

This racist notion persisted well into the 20th century. After the success of the modern evolutionary synthesis that brought together endocrinology, paleontology, embryology, population genetics, and other fields in the 1930s and 1940s to support Darwin's notion of natural selection, some sought to unify additional fields of the social sciences with Darwinian thought. The best known of these was E. O. Wilson's 1975 book, *Sociobiology: The New Synthesis*, which suggested that social traits and aptitudes were conditioned through human evolution and, therefore, were engrained within an individual's biology. The differences among members of different sexes and races, the sociobiologists proclaimed, was due to long trends in human evolution. Much like the neo-Lamarckians had at the end of the 19th century, sociobiologists held that there were genetic differences in abilities that would be difficult for an individual to overcome. Richard Lewontin and Stephen Jay Gould, two Harvard scientists with an interest in unraveling the pseudoscience of biological race, became outspoken critics of the movement.

The link between racialized biology and ability did not end with sociobiology. Gould's motivation in writing *The Mismeasure of Man*, he says, was to refute the 1994 book about human intelligence, *The Bell Curve*. This text had a surprisingly large amount of carryover from the craniometric 19th century in its assertions that racial disparities in intelligence and achievement drew from biological causes, extrapolating from the finding that scores on achievement tests fall into a typical bell curve arranged by standard deviation, the kind of argument made by Quetelet.

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See Also: Discrimination and Institutional Racism; Race, Social Definition of; Racial Identity Development, Models of.

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Smoking and Smoking Cessation, Cultural Aspects of

Smoking presents considerable health hazards including risk of heart disease and lung, mouth, and other cancers. In the United States, smoking is the leading cause of preventable death. Around the world, smoking is linked to approximately 5 million deaths annually. Numerous programs have been developed to reduce smoking and its social and economic impact. Smoking cessation aims to help smokers develop skills and strategies and utilize medications to help them quit. Prevention programs aim to deter potential smokers by increasing recognition of the negative consequences of smoking. Smokers and youth at risk for smoking vary in many ways, including their ethnic and cultural backgrounds. Recognizing that ethnic and cultural factors impact smoking and the acceptability of smoking programs, smoking cessation and prevention programs can be tailored to meet the needs of individuals across cultures.

Cultural Variation in Smoking

About 20 percent of the adult U.S. population currently smokes, with rates varying across demographic groups. For example, rates are highest for adults ages 25 to 64, with approximately double the rate for adults 65 and older. Smoking rates are also higher among males than females across most demographic strata. People who are divorced or separated have the highest rates, followed by individuals who are married, widowed, or never married. Geographically, smoking rates are lowest in the west and highest in the Midwest and south. More specifically, smoking rates are highest in West

Virginia, followed by Kentucky, Ohio, Louisiana, Mississippi, Arkansas, and Oklahoma.

Smoking rates vary across racial and ethnic groups and are generally higher among people with a lower socioeconomic status. American Indians have the highest smoking rates, followed by non-Latino whites, African Americans, Latinos, and Asian Americans. Asian American women have a particularly low rate at 4.3 percent in comparison to 36 percent for American Indian women. In terms of socioeconomic status, smoking rates are higher for people with less education and lower incomes. For example, about 45 percent of people with general education diplomas (GEDs) report currently smoking, followed by high school graduates at 24 percent, college graduates at 10 percent, and people with graduate degrees at 6 percent. In summary, poverty, low family income, and low educational attainment are risk factors for smoking.

Smoking Cessation Programs

Efforts to help smokers quit have generally been least effective for culturally diverse groups and people of low socioeconomic status. Smoking cessation interventions include nicotine replacement therapy, self-help programs, and individual, group, and phone counseling. In general, health care providers are less likely to ask patients about smoking, advise quitting, or prescribe a smoking cessation program if patients have a lower socioeconomic status or are African American or Latino. Moreover, smoking cessation programs tend to be less effective for these groups, though estimates of the effectiveness of smoking cessation programs vary widely across studies and smoking cessation programs. Typically, gender differences in effectiveness have not been sizeable, though few studies have examined the interaction between gender and other demographic variables. Relatively few high-quality studies have evaluated smoking cessation in samples of Latino, American Indian, and Asian participants, as well as samples of older adults. More research is needed to determine which types of smoking cessation programs are most effective and for whom.

A number of possibilities exist for adapting existing smoking cessation interventions in order to make them more culturally responsive. In particular, programming should be tailored to the language, clothing, brand names, locations, music, foods, and other characteristics of the targeted population. Moreover, the cultural values of the targeted group should be embedded within the content of the intervention. In order to increase participation in smoking cessation, it may be useful to deliver smoking cessation programs through novel channels such as existing medical programs, prenatal clinics, home-based asthma services, and dental clinics or implemented through nonmedical programs such as churches and salons. Culturally tailored, Web-based interventions and mobile apps also offer opportunities for reaching out to low-income and culturally diverse groups.

Smoking Prevention

Whereas the biomedical model typically focuses on treating diseases after they have occurred, the public health model focuses on disease prevention. Most smoking prevention programs target youth before they begin smoking with media and school-based and online learning programs. Programs, such as the Minnesota Smoking Prevention Program, aim to educate youth on the risks of smoking and provide them with skills to overcome social pressures to smoke. Other prevention efforts include governmental regulations such as taxation of tobacco products, smoke-free establishments, legislation against youth tobacco sales, and enforcement of youth smoking laws—all of which aim to reduce accessibility of tobacco products at the community level.

As with smoking cessation, prevention needs vary by cultural and ethnic groups, and so prevention programs are often culturally tailored. Two aspects of cultural tailoring relevant to prevention are surface and deep structure tailoring. Surface structure tailoring often involves the adaptation of programming to better represent and fit the ethnic and cultural background of target audiences. Programming may incorporate images, language, and arts relevant to the target culture. For instance, smoking prevention videos have included hip-hop music and urban settings to better target African American youth, and the National African American Tobacco Prevention Network provides depictions of African American adults. Deep structure tailoring aims to incorporate cultural values and expectations to enhance the effects of prevention. Deep structure tailoring acknowledges that cultural processes impact how members perceive and conceptualize the causes of smoking and that cultural processes themselves impact smoking. To the extent that some cultures are more familial oriented, programs may emphasize the impact of smoking on the family and also incorporate family in the prevention process. Conversely, peer-oriented cultures may benefit from prevention programs that target the impact of smoking in the context of friend and peer groups. An important caveat is that there are considerable differences among members within the same culture. Efforts that fail to capture the diversity within cultures may backfire to the extent that they stereotype individuals.

In summary, there is substantial sociodemographic variation in smoking rates as well as the factors that cause and maintain smoking. Smoking cessation and prevention interventions should incorporate knowledge of cultural aspects of smoking, which promises to be an important area of future research.

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See Also: Alcohol and Substance Abuse Services; Behavioral Health Disparities for Racial and Ethnic Minority Populations; Community Health, Racial and Ethnic Approaches to; Social Determinants of Health.

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Social and Economic Justice

Human dignity and freedom are achievable when basic human needs are provided such as human services including housing, employment, food, health, education, and water. Social and economic rights of citizens are undeniable rights that are designed to promote equitable distribution of resources without discrimination. Discrimination based on gender, age, religion, background, sex orientation, and so on brings about inequality and injustice and deniable social and economic rights. Inequitable distribution of social and economic rights demands social and economic justice for every citizen. Social and economic rights provisions are the duty of the state or national government based on the Universal Declaration of Human Rights. It is the duty of government to promote the provision of social and economic rights without discrimination even if it is not convenient to do. The present global economic recession has created more poverty, joblessness, homelessness, school dropouts, and other social and economic consequences. It creates constraint for government to meet its obligations to the needy in society. Social and economic justice do not only include human and civil rights but also equal opportunity such as access to education, freedom from poverty, provision of employment, and affordable housing for those with low wages; those who are unemployed, single parents, physically handicapped, or children; and the elderly.

It is very important to identify and know what constitutes social and economic rights before looking at social and economic justice. Rights are freedoms enjoyed by human beings without discrimination. They are naturally given and enshrined in the laws and regulations that govern human behavior. Denial of fundamental human rights leads to injustice. Justice therefore is the ability to provide equity in all aspects of human endeavors. Social and economic rights guarantee that all citizens be afforded conditions under which they are capable of meeting their basic needs. Social and economic rights include the following:

- *The right to education*: This is the guarantee of free, compulsory, and affordable education. The education must be

qualitative and capable of meeting each child's needs and aspirations. The rights to equal access to education must be provided by government.
- *The right to health*: It is the duty of government to provide qualitative and the highest attainable and affordable physical and mental health for its citizens. The provision of standard health includes the right to healthy living conditions.
- *The right to decent work*: Human rights include the rights of citizen to engage in dignified work and work in a dignified environment. The rights at work also involve just and fair conditions of employment, protection against forced or compulsory labor, and freedom to form and be a member of trade unions.
- *The right to housing*: It is the responsibility of government to provide affordable housing for citizens. This also includes access to land, protection from forced eviction, and good living conditions that are well located, habitable, and culturally acceptable.
- *The right to potable water*: This is the provision of a safe water supply and improved sanitation. The water supply should be economically and generally available.
- *The right to food*: Food security is very essential. Food security will ensure freedom from hunger and living a healthy life. Right to food should include food that is adequate, nutritious, and very affordable.
- *Cultural rights*: The rights of minority and indigenous people must be recognized and protected. Cultural relativity, assimilation, diversity, and accommodation must be allowed.

Necessity for Social and Economic Justice

It is very important to understand social and economic rights before discussing social and economic justice. As discussed previously, the absence of social and economic rights, or inequality, brings about a discussion on social and economic justice. Social and economic justice are very necessary because of the inability of many governments in the world to meet their provisions. In many societies today, the neglect of the provision of social economic infrastructures has led to the collapse of social order. As population increases, urbanization creeps in, cities become megalopolises, people are out of jobs, there are cuts in social and welfare support, scholarships are scarce, and food insecurity grows. It is the responsibility of a state to meet the provisions of social and economic rights. Social and economic justice is guaranteed if human services are not discriminatory or are not based on health status, race, ethnicity, age, sex, sexuality, disability, language, religion, national origin, income, or social status.

Guarantee of Social and Economic Justice

The social and economic rights are located in Articles 16 and 22 through 27 of the Universal Declaration of Human Rights. These rights were further articulated in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). In 1948, many nations were signatories to the nonbinding Universal Declaration of Human Rights, but some nations have not ratified the ICESCR.

In keeping with the UDHR and ICESCR, this entry treats social and economic justice as an attempt made by the countries of the world to recognize social and economic rights as inalienable human rights. These articles also put social and economic rights into global perspective and illustrated the interdependence between social and economic rights and social and economic justice.

Social and economic justice ensure that individuals irrespective of differences are able to meet their basic needs. The table shows international agreements that guarantee social and economic justice.

Priority for Social and Economic Justice

The state has to identify and prioritize groups of people that suffer social and economic injustice. State efforts must be geared toward adequately addressing such injustice by promoting social welfare and conditions for the enthronement of social and economic justice. It is the major concern of the state to make provisions for the following vulnerable populations in society: children, women, and family; the elderly and people with disabilities; indigenous people; and refugees and people affected by conflict. It is the responsibility of national governments to shoulder the responsibility for making social and economic justice a reality. Governments must recognize people's rights; they must not violate these rights; they must protect people's social and economic rights.

States hold it as a responsibility to act beyond their borders to respect, protect, and fulfill social and economic justice. These duties extend to the obligations they take by involving other organizations such as religious organizations, community groups, organized private sectors, state and local governments, United Nations bodies such as the World Bank, United Nations Educational, Scientific and Cultural Organization (UNESCO), the International Monetary Fund, and nongovernmental organizations including Oxfam, Rotary, Red Cross, and so on.

Ever since Roosevelt's presidency, the United States has sought to respond to economic and social needs with new policies. These have included health insurance programs, Social Security insurance, unemployment insurance, public works projects, farm support, expanded educational opportunities, and laws supporting worker rights to organize and strike. Other nations, such as Sweden and Denmark, seek to promote both clusters of rights through the establishment of social welfare states along with many of the new nations in Africa and Asia, created since the end of World War II.

However, across the globe, it is evident that we are far from achieving the goals of justice and human dignity for all. There have been social movements toward democratization in many parts of the world, with elected leaders replacing dictators. There have been advances in education, health care, and sanitation. Nevertheless, among the 4.4 billion people who live in developing countries, three-fifths still have no access to basic sanitation, almost one-third are without safe drinking water, one-quarter lack adequate housing, one-fifth live beyond the reach of modern health services, one-fifth of the children do not reach grade five in school, and one-fifth are undernourished.

Achieving Social and Economic Justice

It is most likely for a society to achieve social and economic justice if there is a redistribution of social and economic wealth. It is the constitutional responsibility of a national government to meet the basic needs of its citizens. Most of the conflict around the world today is rooted in the inability of the government to actualize the provision of social and economic needs for the people. Education is social heritage through which a sound mind is developed and a society develops over time. Inequality in education could be redressed by making education compulsory and free at all levels for a period of time until the world economy bounces back. It is also possible to achieve education justice through scholarship and loans for indigent students and women. Food security is a pressing right in the world today. It is essential that a nation's budget includes enough funding to support agriculture and subsidies for food. State programs should include immediate food assistance; many families and children have become victims to rampaging hunger, and it may demoralize them for the rest of their lives. Food insecurity diminishes an individual's ability to lead a dignified life. Social and economic justice in the area of food security are achievable if governments could come up with effective legislation that will ensure that food insecurity does not remain a threat.

Home is very essential to family's security and development. Housing injustice is a basic abuse of human rights. Many families and individuals have become homeless because of the economic downturn. Homelessness has been on the increase over the last two decades, particularly among families with children. Government and nongovernmental organizations must be able to provide alternative shelter for those who have lost their homes because of their inability to pay rent or mortgage. Assistance must be provided to keep some rental units operating, which limits the number of households becoming homeless. Low-income households continue to struggle to secure accommodations for themselves and their families. There must be a sufficient housing stock or housing vouchers. Housing should not be above people's capacity so that thousands will not be living on the streets, bedding with friends and family, or living in their cars. Low-cost (green housing) for those with the least economic power would serve as a means of providing healthy and livable housing and to preserve a healthy ecosystem. To achieve social justice, governments can partner with the National Housing Trust Fund with the support of UNHabitat to provide portable housing for people.

Social economic justice also includes reduction in poverty, income security, and safety. Welfare programs should be initiated to provide security to families through income, support, and refundable tax credits. Other facilities that promote social and economic justice are the provision of Low-Income Home Energy Assistance Program Funds and the Supplementary Nutrition Assistance Program (SNAP).

Also, Medicaid for the most vulnerable, including the elderly and women, must be made available.

Inequality in the distribution of employment could lead to frustration and debasement of human dignity and freedom. Social and economic justice need to be provided to eliminate job creation by proxy and discrimination based on age, sex, family background, gender, disability, and other extraneous factors. Employers of labor must be ready to pay a living wage for all workers. Wages that allow workers to provide for themselves and their families will reduce social economic imbalances. Job creation is another important aspect of social and economic creation.

Social and economic justice through provision of employment should include sick leave, unemployment insurance, and equal pay for women and men. Work sharing could also reduce job inequality. Work sharing enables employers to cut back the hours of employee rather than firing them altogether. Social and economic justice among nations is also important with respect to a nation's sovereignty and equity at the international level. Social and economic justice enthrone fair trade policies among countries. Bilateral and regional agreements form the basis of international trade. Balance of currency exchange is another phenomenon in economic injustice at the international level. Injustice, imbalance, discrimination, inequality, conflict, and economic problems make social and economic justice difficult. Social and economic justice promote progressive human services if they are based on the principle of all-inclusiveness.

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See Also: Equal Opportunity and Civil Rights; Equal Pay Act of 1963; Homelessness; Medicaid.

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Social Capital, Role of

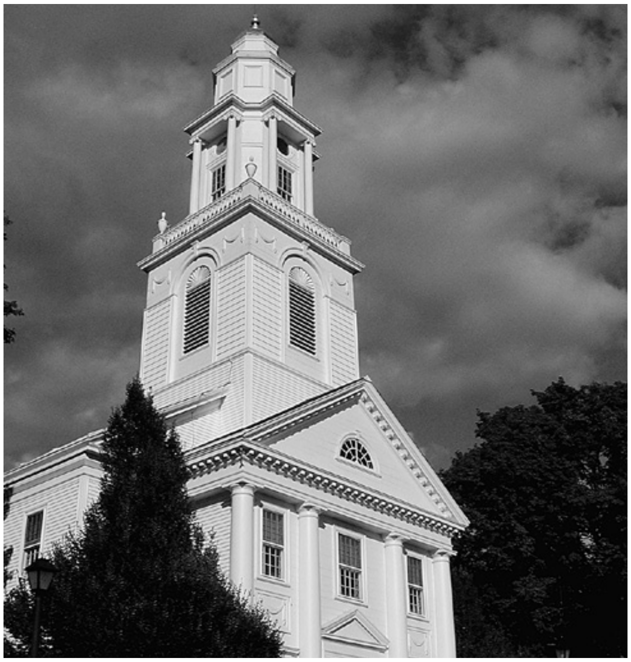
At the core of the concept of social capital is the notion that, like financial capital (e.g., savings and financial investments), physical capital (e.g., real estate and tools), or human capital (e.g., education and training), the exchange of resources between individuals affiliated in social networks (i.e., social capital) holds value.

Social capital facilitates accomplishment of goals. Social workers' pursuit of social and economic justice, community empowerment, and ultimately a state of social welfare make social capital a particularly useful concept. This entry focuses on three main definitions of social capital mapped onto ecological levels of meso, macro, and micro.

Meso-Level Definition

The exploration of the role of social capital really began after J. Coleman popularized the concept among social scientists, celebrating the concept's ability to bridge the level of large social structures and individual decision making, providing a mechanism too frequently missing from analysis that focuses on one or the other level. Social capital is a resource embedded in the relations between members of communities, invisible but valuable for easing pursuits. Coleman's understanding of social capital illuminates the conditions that give rise to these exchanges of resources.

Social networks are created through interactions among individuals, and social networks with closure create social capital. The concept of closure in social networks is best explained with an illustration. If a child has a link of friendship with another child, it is much easier for either of the youths to lie to their parents about engaging in forbidden



A church in Ware, Massachusetts. Institutions such as churches, clubs, and schools are important for the emergence of the types of connections that create social capital.

activity if the respective children's parents are not themselves linked. Yet once communication is established among all the individuals (most importantly between the respective children's parents), the resulting network closure enables parents to verify their children's claims about their activity. In communities where ties among individuals are based on regular meetings in different contexts (e.g., persons are connected through work, leisure, and church), increased surveillance capability and the resulting sanctions and praise for adoption of community norms can be applied to ever-more subtle behaviors. The importance of network closure for the enforcement of social norms is often evident in remote vacation settings.

In communities with social network closure, it becomes more economical for the individual to share resources. With the norm of reciprocity, each favor an actor grants in times of surplus functions as credit toward favors in times of need. Information is the chief resource exchanged as, frequently, it is the easiest to give and otherwise difficult for the recipient to find. Other resources that can be shared include tangible goods and services, even emotional support.

Social capital is understood here as a community resource because it is inherent in the quality of the connections among persons, not owned by any person. When social capital exists, individuals can derive considerable benefit from the exchanges, even if they expended no effort to create these networks per se. For these reasons, institutions (e.g., schools, clubs, or churches) are important for the emergence of such connections. Individuals meeting for a different purpose will typically have conversations that lead to the exchange of resources. For instance, parents chatting while dropping off children in day care could decide to carpool and exchange sleepovers, both of which could free up the parents for other activities. As a communal commodity, social capital is difficult to create but easy to destroy. Because it inheres in social ties, the departure of a particularly active member of a parent–teacher association or the closing of a local bar can dissolve social capital for the members associated with either organization. For any one person to create links among individuals would cost more effort than potential gain from the exchanges.

It is important to note that the concept of social capital as facilitation of activity does not presume that the activities in question necessarily benefit the larger society. For instance, terrorist acts by an individual frequently depend on resources drawn from persons returning favors. It is also possible for the dynamics of social capital to negatively affect individuals. In situations of resource scarcity, community members may benefit from sharing resources to get by. Yet for any member who suddenly gains more resources, the pressure to share with those in need could frustrate attempts to escape poverty. Both examples illustrate negative social capital.

Macro

Nevertheless, the major thrust of social capital research evaluates amelioration of social problems. Perhaps the most famous of these is Robert Putnam's attempt to link social capital to regional or national economic gains. He measures social capital as levels of trust in government and civic participation. Trust in institutions reduces transaction costs; transactions are expensive if trust is not enforceable except through legalistic means. Civic participation is similarly important because participating in local organizations and clubs gives diverse individuals opportunities to interact, in turn leading to exchange of resources and information across social classes. Putnam brought the concept of social capital to popular attention with his book *Bowling Alone*, where he argued that historically low national stocks of social capital foreshadow serious economic problems. Putnam's research was widely cited in international community development.

Micro

Although Coleman popularized the concept of social capital in social science and Putnam to the popular imagination, the term's initial development is credited to P. Bourdieu. He used the concept to explain that resource accrual results in otherwise invisible individual advantage. Bourdieu's micro-level definition of social capital posits social capital as a fungible entity that tends to reproduce itself. This fungibility is evident when parents use money (i.e., financial capital) to purchase their children's education (i.e., human capital) in schools where other parents have access to resources (creating social capital). Elite schools also shape children's tastes and mannerisms (i.e., cultural capital), marking their belonging to a specific class. Consciously or not, gatekeepers to resources (e.g., potential employers) use this information to decide among potential candidates. Indeed, information about a job opening is likely a function of social capital. At that moment, it becomes evident how capital in its many forms tends to reproduce itself and facilitates accumulation of resources for those who already have resources.

Conclusion

The concept of social capital holds particular utility for social workers. For instance, the expense of creating social capital for individuals illuminates the importance of the community organizer's appropriation of existing networks to build a community's political power. The term can be used to explain inequity and to argue for the larger economic benefit of civic participation. Yet the theory is not without criticism. Critics complain its widespread application renders the term confusing and self-contradictory. Coleman's social capital blinds readers to the importance of socially just resource distribution because it insinuates that resources magically materialize. Bourdieu's micro-level use is seen as overly deterministic. Putnam's measures of social capital are seen as better substituted with economic inequality, which could provide a better fit with national economic health. While social workers need to be aware of the concept's limitations, the widespread development of research on the topic makes it necessary for wider dissemination than currently exists.

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See Also: Social and Economic Justice; Social Innovation; Socioeconomic Status.

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Social Darwinism

The term *Social Darwinism* refers to the use of Darwinian evolutionary theory in combination with social and political theory to address human evolution. In other words, a theory that describes how natural selection works to explain how animals adapt to their environments was used to describe how humans adapt to the social environment. The development of Social Darwinism led to the growth of eugenics, where humans were divided into social and ethnic groups and compared for adaptive fit to the social environment. Conversely, Social Darwinism was also used to explain how people could be altruistic and caring of each other, even when that meant there was no benefit (or even harm) to themselves. Thus, Social Darwinism has been a controversial subject over the past century and into the 21st century.

In the mid-19th century, Charles Darwin discussed his theory of evolution by using the principles of natural selection and describing how animals adapt to the environment. In his view, animals would either adapt to the specific conditions of the environment in which they lived and survive long enough to have offspring or fail to adapt and not survive long enough to have progeny. His theory was based on the assumptions that either resources were scarce or that the population was too large for the available resources, creating a struggle to survive.

When there is a struggle to survive, an individual animal that develops a physical trait that is more adaptive to a specific environmental feature might survive longer and thus pass on that trait to a new generation. In time, a species could develop particular traits that are most adaptive to the environment, creating distinct traits or even a new type of animal.

Charles Darwin gave the example of finches that shared the resource of cactus plants by developing different beaks. One set of finches developed long, thin beaks to reach past the thorns to pierce the tough skin of the cactus and obtain pulp. Another set of finches developed shorter, more-robust beaks to eat insects and pulp off of the bottom of the cactus. Considering this example, principles of natural selection and the adaptation of a species depend upon environmental niches that can be exploited by animals living in that environment and are very specific to the needs of the animal and the place within the environment where the animal's needs can be met

The term *survival of the fittest* was coined by Spencer Herbert, an early supporter of the Theory of Evolution, to describe this struggle to adapt to the environment to survive. Charles Darwin later used this term in his own writings. Today, however, the term survival of the fittest is typically taken to mean that only the strongest, swiftest, and most intelligent survive and has been used in human populations with disastrous consequences.

As seen in the previous example, the survival of the fittest actually refers to the ability of an animal to adapt to a specific environmental situation or niche. Therefore, it is conceivable that there are animals that have adapted to survive because they are slower, weaker, or less intelligent. Instead of an active struggle to survive, animals exploit openings in the environment to survive long enough to pass their traits on to the next generation.

In the late 19th century to the mid-20th century, Social Darwinism was used to identify what traits in humans were considered to be more adaptive and desirable. This led to the development of eugenics, as proposed by Francis Galton. Eugenics supported the concept that a racial or ethnic group of people will be more likely to survive if they identify and address those within their group who are not suited for survival. Thus, those with genetic disorders, physical disabilities, or mental disorders would be seen as not suited for, at the very least, procreation and, possibly, survival at all. This led to the sterilization or death of many who were seen as "subhuman" during that time.

Conversely, Social Darwinism has also been used to explain prosocial behaviors in humans. For example, Richard Dawkins proposed that humans would do things that were dangerous to themselves to help others (altruistic behavior) because there was an evolutionary benefit to that behavior. Humans, being of the same species, would want to promote the continued survival of other humans. In a similar vein, an individual would be willing to sacrifice his or her survival for the continued survival of their species. This would explain why some people are willing to rush into a dangerous situation to save others.

In conclusion, Social Darwinism was developed on Charles Darwin's principles of adaptation and natural selection and used to explain how humans have adapted as social and political entities. When based upon a misunderstanding of Darwinian theory, Social Darwinism was used to develop the pseudoscience of eugenics (the concept of survival of the fittest being used inappropriately). However, Social Darwinism has also been used to explain human behaviors that do not seem to be survival oriented, such as altruism.

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See Also: Blue Vein Society/Paper Bag Test; Coca-Colonization; Diversity in the Workplace; Hate Groups; Holocaust Survivors; Intelligence Testing; Racism, Long-Term Effects of.

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Social Determinants of Health

Social determinants of health provide a bridge between social conditions and health disparities. They incorporate societal conditions and psychosocial factors that have proven both a direct and indirect impact on an individual's and community's health outcomes. They can be categorized in a number of different ways; however, they commonly include the following five elements: (1) biological factors, (2) individual behaviors, (3) the social environment, (4) the built environment, and (5) health services. Social determinants of health have become the keys to understanding health disparities and inequities and provided the keys to creating holistic health programs that can effectively create new vectors of health equity. Principles of social justice seek to influence the inequitable distribution of social health determinants in order to address health disparities and poor health outcomes.

Biology—Genetic Health Determinants

Biological factors include gender, race, ethnicity, and genetic predisposition. Biology by itself does not determine health outcomes but does create increased risk factors for many chronic diseases as well as influences behaviors, the social and built environments, and access to health care. There is no denying that genetic predisposition increases risk. However, the risk factors do not guarantee the presence of a disease, but in concert with the other social determinants of health disparities, are clearly identified across many of the biological strata and therefore can be utilized in creating health equity within race, ethnicity, and gender.

Individual Behaviors

A person's or community's health behaviors contribute to overall quality of life and health outcomes. Behaviors can either act as risk or protective factors, and the interplay between behaviors and the other social health determinants contribute to health disparities or health equity. Behaviors such as illicit drug use, sedentary lifestyles, and high-stress lifestyles can increase the chances of chronic disease and poor health outcomes. Conversely, health-promoting behaviors such as maintaining a low-fat diet, attaining education, and utilizing disease prevention measures can decrease the risk of poor health outcomes.

Social Environment

The social environment defines the conditions in which a person is born and lives and impacts the overall quality of life. It includes social norms, socioeconomic status (SES), employment, and exposure to social advantages and or impairments such as economic privilege, racism, sexism, and prejudice. Social and cultural norms shape a person's or community's perceptions, behaviors, and beliefs and therefore can increase or reduce risk of disease and impact health outcomes. Low SES, or poverty, has been established to be a direct correlate to a lower quality of life and poor health outcomes. The social environment impacts the ability to attain education, achieve financial stability, and have access to goods and services, as well as how a person perceives his or her personal abilities, roles within the community, and the treatment he or she receives.

The Built Environment

The built environment encompasses location, type and quality of housing, the presence of crime and violence, as well as the physical quality of the environment. The built environment influences a person's behaviors, quality of life, and level of risk. Where a person can live is often determined by SES; however, the quality and safety of the living environment has a distinct impact on health outcomes. In low-income communities, financial instability, increased exposure to violence, and reduced access to goods and services impact the quality of life and health outcomes. Furthermore, environmental toxins such as air, water, and noise pollution also contribute to the risk of disease, have negative impacts on health outcomes, and contribute to health disparities.

Health Services

Access and quality of health services are critical to achieving and maintaining health. As with all the other social determinants of health, access to good, quality health care is largely dependent of the other determinants of health. This includes cultural competency in health care, the ability to travel to where services are offered, as well as the ability to afford to receive medical treatment and attain prescribed drugs and treatments. Racism, cost, and location all prove to inhibit receiving health care and therefore can contribute to poor health outcomes and health disparities.

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See Also: Health Care, Disparities in; Health Disparities, Role of; Quality of Life, Measurement of; Social and Economic Justice; Socioeconomic Status.

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Social Epidemiology

In 2013, the World Health Organization defined epidemiology as "the study of the distribution and determinants of health-related states or events (including disease) and the application of this study to the control of diseases and other health problems."

Social epidemiology studies the various social, economic, cultural, or political factors that affect both disease and health. Modern social epidemiology goes beyond simply using social factors to understand the spread of disease to suggest that inequities in socioeconomic and political structures can and should be altered to reduce social inequalities in health care. As a professional discipline, it borrows from sociology, psychology, medicine, education, political philosophy, cultural studies, and anthropology. Those who engage in social epidemiology, whether doctors, nurses, sociologists, educators, or other professionals, are influencing policies and programs that provide human services to diverse client populations.

Even when a germ (virus or bacteria) is the principal cause of a disease, social factors may influence exposure to the pathogen, subsequent treatment access, and eventual outcomes. It addition, today we recognize many illnesses such as heart disease, obesity, diabetes, and asthma that are related to heredity, lifestyle, and environment. These exist in the absence of any pathogen, although they may make an individual more susceptible to infectious disease, accelerating disease progress and severity while impeding treatment.

Nancy Krieger suggests all epidemiology is social epidemiology because all human beings exist within a social context, thus affecting the spread, distribution, treatment, and outcomes of all illnesses. Psychosocial epidemiology adds focus to both psychological and social concepts to studying human responses to and patterns of disease. Psychological stress or the lack of psychological coping skills affects the outcomes of disease. Chronic and acute stressors can alter a person's susceptibility to or ability to cope with illness. In addition, certain dysfunctional behaviors such as substance abuse, disordered eating, and risky sexual behaviors are detrimental to health. Social capital, the connectedness of individuals to others within their social network, and the development of psychological coping mechanisms can influence health by affecting norms that support healthy behaviors and improving the social bonds of society to reduce and deal with stressors.

A Brief History

Social scientists have long been interested in the social factors associated with disease and health. Before the discovery of germs, various social and environmental factors were thought to cause disease.

Louis René Villermé (1782–1963), a French physician, used the census data of Paris to demonstrate that mortality rates were higher in poorer neighborhoods. Frederick Engels (1820–95), a German social scientist and political philosopher, in his work *The Condition of the Working-Class in England* (1885), described the effect of industrialization on health and the effects of childhood deprivation on later adult health. He demonstrated that, in large, industrial cities, mortality from small pox, measles, and scarlet fever was higher than in rural communities and that rates rose as communities shifted from agricultural to industrial economies. In his classic work *Suicide* (1897), Émile Durkheim (1858–1917), a French sociologist, studied the effects of social factors such as religion, gender, and nationality on suicide rates.

John Snow (1813–1858), an English physician, is considered one of the founders of modern epidemiology. He traced the spread of cholera in the Soho neighborhood of London in 1954. As modern epidemiologists still do today, he mapped the cases of cholera within the community and determined that the source of the illness was a contaminated water pump. It was after Louis Pasteur (1822–1895), a French chemist and microbiologist, demonstrated that microorganisms caused disease that epidemiologists began to focus on identifying the spread of organisms called germs, the newly understood cause of illnesses.

Diversity and Social Epidemiology

Social epidemiologists focus on diversity within populations and the effects these have on the frequency, progress, and treatment of disease such as socioeconomic disparities, poverty, and deprivation; gender, race, ethnicity, sexuality, and the effects of discrimination; and social justice and human rights issues. Biological expressions of social inequality reflect the effects of the economic and social disparities on peoples' health, access to care, and treatment options and outcomes.

Diversity plays a role in the establishment and maintenance of poverty throughout the world. Poverty can facilitate the progression of disease by exposing people to dangerous living conditions such as contaminated water or poor sanitation, to the pathogens that thrive in these conditions, and to animals that can host them such as rodents, birds, or insects. Once infected, access to and quality of health care are related to socioeconomic factors such as one's ability to pay, access, and discriminatory practices. The ability to pay for care may be tied to one's employment, public welfare status, or age-related entitlements.

The spread of acquired immune deficiency syndrome (AIDS) provides a good example of the intersecting bio-psycho-social factors that facilitate disease progression and impede treatment. While AIDS may have existed in remote areas in Africa during the 1960s and 1970s, it was first identified in the United States among gay men in the early 1980s; soon cases began to show up in intravenous drug users and hemophiliacs who were not gay, heterosexual women, and newborns. The situation worsened in Africa among heterosexual men and women. By 1985, an antibody test was developed to detect the virus and the first anti-human immunodeficiency virus (HIV) drugs, azidothymidine (AZT) or zidovudine, became available in 1987.

Cultural beliefs and social inequality prevented a timely response to the developing epidemic. Stigma and homophobia prevented many men who have sex with men (MSM), not all of whom self-identified as gay, from being tested; they continued to engage in high-risk sexual behaviors. Intravenous drug users (IVDUs), many of whom lived in poverty, continued to share needles and were hard to reach through traditional public health efforts. It was illegal in some municipalities to create needle exchange programs or even to provide information on needle cleaning. IVDUs who were better educated or who had economic resources may not have shared needles. Beliefs that school-age children did not engage in sexual activities prevented the implementation of school-based programs until it became apparent that teenagers were becoming infected. Heterosexual women in patriarchal cultures could not ask their husbands about their extramarital sexual exploits and became infected, as did their children. Language barriers, illiteracy, and social taboos about sex and death prevented many from learning about AIDS. Prostitutes, who are viewed as fallen women, are more at risk of being infected than infecting their customers yet were targeted as vectors, or carriers, of the disease. High-risk immigrant populations, especially those who were undocumented and feared deportation, did not get tested or have access to treatment. Institutional homophobia, sexism, racism, ethnocentrism, and ageism prevented legislation from providing full access to prevention and treatment. The various stigmas and taboos associated with HIV/AIDS impeded an adequate public health response and clearly demonstrated how social disparities facilitated the progression of disease and restricted access to health care.

Human Services and Social Epidemiology

Social epidemiologists are human services professionals working on the macro level to provide the knowledge and data necessary to understand bio-psycho-social factors affecting health and wellness in communities. This work has implications for improving service delivery, designing prevention and outreach efforts, and supporting legislative action. The focus on social disparities supports social justice initiatives to eradicate inequalities in society that affect all people's health and welfare.

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See Also: Behavioral Health Disparities for Racial and Ethnic Minority Populations; Communicable Diseases Common in Developing Countries; Chronic Diseases Common in Developing Countries; Poverty.

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Social Innovation

Social innovations (SI) are emerging in several fields, especially at the intersection of sectors (public, private, and nonprofit) and disciplines. Ideas and resources flow freely between sectors and disciplines to allow SI. SI in human services meet social needs in unprecedented ways, and the reasons for their growth—particularly health care, social services, and education—are varied. Increasing diversity in populations across the globe and complexity of social issues warrant innovative approaches. Practitioners in all fields require skills to think outside the box and creatively address endemic social issues in their communities.

SI focuses on new ideas—products, services, processes, and models—that address or prevent social issues in effective and sustainable ways. They create social impact through social change and add social value to a community. Concepts often associated with SI are social entrepreneurship, social enterprise, and socially minded business. Although social entrepreneurs are individuals or groups of individuals who launch a social innovation using business skills to enable social impact in a financially viable fashion, social enterprise and socially minded businesses may not always implement socially innovative initiatives.

Although the latter organizations have social missions, their mechanisms for implementing the missions may not be innovative in nature. As the topic of SI is fairly new to the field of human services, illustrations of SI, descriptions of reasons for growth in SI, an explanation of processes and skills surrounding SI, and a survey of leading institutions that teach SI can be helpful to human services professionals who are considering professional development opportunities.

Social Innovation Illustrations

Illustrations of SI are evident in education, microfinance, child welfare, and food services. Charter schools, such as the Green Dot management organization of charter schools, are attempting to transform Los Angeles's educational community by employing innovative teaching methods. Similarly, the Teach for America program is attempting to bring highly qualified teachers to inner cities to improve the quality of education. Kiva.org is the world's first person-to-person microlending Web site to connect people online and assist entrepreneurs who live below the poverty line in third world countries to access capital, launch their businesses, and rise out of poverty. Rising Star Outreach, a U.S. nonprofit organization, provides loans to individuals afflicted by leprosy in 46 leprosy colonies in south India to start their own business, and live with dignity instead of panhandling to sustain themselves. Childline is a child rights service in India designed for children living on the streets, child laborers working in the unorganized sector, and sexually abused children. A child in any distress—in a situation with abuse, assault, abandonment, acquired immune deficiency syndrome (AIDS), jaundice, and so on—calls a toll-free number, and he or she is immediately referred to an appropriate organization for long-term care and follow-up. Finally, D.C. Central Kitchen uses food as a tool to strengthen and sustain communities. It provides food preparation training to disenfranchised populations (populations that are homeless) distributes the meals they prepare, and partners with local farmers to access organic produce, all with the goal of effectively addressing poverty, hunger, and homelessness. Several other illustrations exist in economic development, health care delivery, and human rights.

Reasons for Growth of Social Innovation

With increasing devolution of services provided by the federal government, questions about accountability and impact of social and human services, growing diversity of populations served by human services professionals, and growing competition for public and philanthropic funds, practitioners in community-based agencies are being called upon to creatively address endemic issues and create sustainable change in communities. Especially when programs don't eradicate social issues but merely provide so-called band-aids, professionals need to think outside the box to create the desired social impact in communities. Global poverty, climate change, and chronic diseases are complex problems that require interdisciplinary thinking and cross-sector collaborations—which frequently generate SI. Often, perceived failures and desperation for change are engines for innovation, and today, social media has made it easier for like-minded individuals to galvanize their innovations.

Social Innovation Process and Skills

SI is not linear or sequential but iterative and simultaneous. It involves understanding an issue in a fashion such that the root cause of the problem—not the symptoms—are tackled. Social innovators creatively design interventions, drawing insights and experiences from a wide range of sources. These ideas can be tested on an informal basis or more formally through prototypes and pilots. This process of trying the idea, then modifying to make alternations based on results, is iterative. Ensuring financial, environmental, and impact sustainability is the next step in this process. The ultimate goal of SI is system change.

SI does not occur overnight but requires thorough assessment from various angles and perspectives, careful listening, exceptional analytical abilities, frequent reflection, and collaboration. It involves inviting earnest participation of final beneficiaries for generating ideas for SI and thinking differently from the past. Resource development skills are important to tap funds for launching the innovative ideas. Finally, competencies for working across sectors—public, private, and civil—to create systems change are essential.

Educating for Social Innovation

University campuses across the globe are inspiring and training students from all fields to develop solutions to the world's most-pressing social problems. Although most education and training for SI is occurring in business school, several centers, initiatives, master's, minors, and certificate programs exist for this purpose as well. The Dell Social Innovation Challenge at The University of Texas, Center for Social Innovation at Stanford, Impact Entrepreneurs at Portland State University, Ashoka U at Brown University, Skandalaris Center for Entrepreneurial Studies at Washington University in St. Louis, and the Center for the Advancement of Social Entrepreneurs at Duke University are among some of the other institutions known for supporting and nurturing SI spirit among college students.

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See Also: Health Promotion Services; Interprofessional and Interdisciplinary Practice; Rural Communities; War on Poverty Programs.

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Social Security, Services Funded by

Services funded by the Social Security Administration include a variety of means-tested and work-based universal programs and benefits in areas such as retirement, disability and injury, public health, income security, and survivor's insurance. While these services do much to provide income support to millions of Americans, many groups have been systematically excluded from eligibility or access, such as African Americans, gays and lesbians, and people in isolated communities. Additionally, there are dimensions of Social Security that work against female caregivers in favor of a male or occupational model. Over time, amendments and legal decisions have contributed to greater inclusivity.

With a foundation in the Mother's Pensions of the 1910s, Social Security was born during the depths of the Great Depression. At that time, the Committee on Economic Security was tasked with creating a bill to ensure economic security through unemployment and old age supports. Their 1934 report was the foundation of the 1935 Social Security Act, which called for a variety of social insurance, social assistance, and public health and social services programs. In its nascent stage, Social Security was comprised of cash payments to the unemployed and elderly.

Over time, both the scope and range of Social Security grew. In 1939, benefits were extended to wives of retired male workers as well as surviving wives and surviving children of deceased male workers. The mid-1950s saw a rapid expansion of Social Security with the introduction of disability-related insurance for permanently and severely disabled workers between the ages of 50 and 64, known as Supplemental Security Disability Insurance (SSDI). This was later expanded to all disabled workers under the age of 65. Another milestone came in 1972, with the cost-of-living allowance (COLA) and the introduction of Supplemental Security Income (SSI). The 1990s and 2000s saw unsuccessful efforts to privatize Social Security.

A major debate in the history of Social Security is the extent to which African Americans were intentionally and systematically excluded during its early years. The Committee on Economic Security originally recommended a program that would cover nearly all workers, but the Social Security Act was written with an exclusion of agricultural and domestic workers, which de facto left out large numbers of African Americans. At that time, Congress was controlled by white, southern Democrats, and it is argued that President Franklin D. Roosevelt capitulated to their interests. In 1950, coverage was extended to domestic and farmworkers.

The official name of what is commonly known as Social Security is Old-Age, Survivor's, and Disability Insurance (OASDI). OASDI does not include many federal assistance programs such as welfare (Temporary Assistance for Needy Families) or food stamps (Supplemental Nutrition Assistance Program). This large program covers 94 percent of Americans and comprises 37 percent of government expenditure and 7 percent of the U.S. gross domestic product. In 2013, 61.9 million people received benefits.

Unlike social assistance programs, which require a means test and target people with limited income and assets, most Social Security programs are social insurance programs compulsory for the working population. Most workers pay a Federal Insurance Contributions Act (FICA) tax, or income tax, a contribution of 7.65 percent paid by an employee (or 15.3 percent if the person is self-employed) for OASDI and Medicare.

There are five types of benefits offered through OASDI: retirement insurance, disability insurance and assistance, survivor's insurance, worker's compensation, and Medicare. Retirement benefits available through OASDI are based on a formula that considers earnings and amount of time contributing to the fund through workforce participation. Change to the age at which Social Security retirement benefits commence, such as increasing the age of eligibility, may compel people to stay in the workplace longer. Because white-collar workers are more likely to live longer overall and earn higher wages, they can contribute to private retirement programs to supplement Social Security. For African American women age 62 and older, Social Security payments are the leading source of income over assets, earnings, and other retirement programs and represent the biggest factor buffering this group from poverty. Social Security-based retirement equalizes the distribution of income among poor, elderly people on all levels except gender.

The Social Security Administration provides two types of benefits for disabled people. The first is SSDI, which covers workers in the event of a physical or mental disability expected to last at least a year or result in death. The federal government works with state government to establish eligibility and process applications, usually resulting in a waiting period of up to five months. People who receive SSDI are eligible for Medicare benefits. The other form of benefit is SSI, a program consisting of monthly cash payments for low-resourced adults who are disabled, blind, or 65 or older, and disabled or blind children. Unlike SSDI, SSI is a means-tested program for people who lack a significant work history. The two can work in tandem, as SSI supplements SSDI, establishing a greater safety net particularly for poor, elderly people.

Worker's compensation provides health services in the event a person is injured during the course of work. This entitlement is restricted to legal workers, and undocumented laborers and people working in the informal economy, who despite of being at risk for an on-the-job injury, are not legally covered by the program.

Recent technological developments in how Social Security benefits are disbursed have streamlined the process for many but have had unintended consequences. In 2013, the Social Security Administration began to require that monthly checks be automatically deposited into the checking accounts of recipients. Advertised as safe, quick, and convenient, this has created problems for people without bank accounts or without access to banks. It is estimated that 5 percent of the U.S. population is unbanked. For people who are geographically isolated from banks, such as Native Americans living on large, rural reservations, accessing benefits is difficult.

As of 2013, Latinos are the fastest-growing segment of the older adult population in the United States. Social Security is a particularly important source of income for older Latinos because it is their sole or primary sources of income in retirement. Without Social Security, more than half of older Latinos would live in poverty. Older Latinos have distinct demographic and economic characteristics that make their reliance on Social Security critical, such as high marriage rates.

Social Security retirement is designed for a male breadwinner, female, and child dependent family model. Women's employment histories tend to be interrupted by caregiving responsibilities to children, which results in fewer years paying into the Social Security system. Child rearing, as a contribution from the working-age population, is penalized while occupational attainment is rewarded. A solution to this problem would be to give direct benefits to women by supporting the cost of child rearing (family allowance, birth grants, and maternity or paternity leave).

In 2013, the Supreme Court decided that Section 3 of the Defense of Marriage Act (DOMA) was illegal. In response, the Social Security Administration has agreed to process retirement spouse claims for same-sex couples married in a state or tribal nation that accepts legal same-sex marriage.

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See Also: Social Security Administration; War on Poverty Programs; Welfare Reform, Role of.

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Social Security Administration

The Social Security Administration pays out benefits to nearly 60 million Americans. These payouts have been credited with reducing elderly poverty since the late 1930s and early 1940s. However, current Social Security benefits may not be sustainable for much longer. In 20 years, the trust fund will be depleted if projections hold. The Social Security Administration has more than 65,000 employees located in many places: in the Baltimore, Maryland, area, where it is headquartered; throughout the United States, and in American embassies throughout the world. Social Security Administration employees process claims, determine eligibility of benefit applicants, and maintain data on those who pay into the system and those who receive benefits. The forerunner of the Social Security Administration was created during the Great Depression by President Franklin D. Roosevelt. The Social Security Administration's history, which is discussed next, has shaped the organization into what it is today.

History

The Social Security Act of 1935, which President Roosevelt signed into law on August 14, 1935, was the signature legislative achievement of the New Deal. However, the Social Security Administration itself was not established until after World War II, during President Harry S. Truman's first term.

Proposals for government-sponsored social insurance had been circulating among progressive politicians throughout the early decades of the 20th century, and some states enacted such laws. As governor of New York, Roosevelt himself was a proponent of providing income security to mitigate the economic hardships of disability, unemployment, and old age, so it is unsurprising that, very early in his presidency, he set in motion the mechanisms for creating a national social security system and an administrative apparatus to manage it.

In June 1934, Roosevelt created the Committee on Economic Security and charged it with the tasks of sifting proposals and developing a fiscally and politically viable social security plan. He chose Security of Labor Frances Perkins to chair the committee. The Social Security Act of 1935 contained a provision for the immediate establishment of a Social Security Board, a three-member independent agency appointed by the president. In December 1935, the Bureau of Old-Age Benefits was created to administer Title II of the act. In 1937, it was renamed the Bureau of Old-Age Insurance, perhaps reflecting Roosevelt's insistence that the new program was just that—insurance—and not charity or welfare. On July 1, 1939, the Social Security Board lost its independent agency status when it was subsumed by the Federal Security Agency. On July 16, 1946, as part of a broader reorganization of the government, the Social Security Board was renamed the Social Security Administration, and the board's chair, Arthur Altmeyer, became the first Social Security Administration Commissioner. But its status within the Federal Security Agency remained unchanged. On April 11, 1953, President Dwight D. Eisenhower created the Department of Health, Education, and Welfare to replace the Federal Security Agency, and the Social Security Administration was housed within the new entity, where it remained until May 4, 1980, when it became a part of the newly created Department of Health and Human Services, the successor to the Department of Health, Education, and Welfare.

The headquarters of the Social Security Administration near Baltimore, Maryland. The Social Security Administration has more than 65,000 employees in 10 regional offices and nearly 1,400 field offices.

For decades, government officials had advocated for the Social Security Administration to return to the independent agency status it had during its first decade as the Social Security Board. On August 15, 1994, President Bill Clinton signed legislation to this effect, and on March 31, 1995, the Social Security Administration again became an independent agency.

Organization

The Social Security Administration is primarily responsible for dispensing Social Security funds to 57 million American retirees, persons with disabilities, and work survivors and dependents of beneficiaries. Social Security is a pay-as-you-go program, which means that, when workers pay taxes to Social Security, the money is not held in an individual account but rather distributed to present beneficiaries. In other words, today's workers' taxes pay for today's beneficiaries, and today's workers then hope that there will be money to benefit them in the future. Social Security collects money for three general funds: Old-Age, Survivors, and Disability Insurance (OASDI); Supplemental Security Income (SSI); and Medicare. OASDI is a fund for those who have worked and paid into the fund, their survivors, and people who are disabled. SSI is means-tested program for those who need additional money due to their low-level funds, and Medicare is a health insurance program. More than 160 million workers regularly pay into the Social Security fund: 6.2 percent from each worker's paycheck for the Social Security tax plus an equal amount paid by each employee's employer. Employees must also pay a 1.45 percent tax for Medicare, which is also matched by employers. Self-employed workers must pay the entire amount (15.3 percent, which equals 6.2 percent plus 6.2 percent plus 1.45 percent plus 1.45 percent) themselves. The Social Security Administration calculates that the average monthly benefit to retirees should equal about 40 percent of the average American worker's pay. Annual payouts from Social Security exceed $700 billion for retirement and survivors. In addition, the Social Security Administration pays more than $200 billion in disability and supplemental insurance. Currently, the Social Security trust fund has nearly $2.75 trillion. According to the Social Security Board of Trustees, current actuarial projections show the trust fund being depleted by 2033; at that time, tax revenues would only be able to cover three-quarters of the promised payments.

Duties

The Social Security Administration headquarters is located in Baltimore, Maryland. With more than 65,000 employees, the Social Security Administration has 10 regional offices and nearly 1,400 field offices. Carolyn W. Colvin is acting commissioner of the Social Security Administration. The Social Security Administration also has many foreign offices located in U.S. embassies. Wherever their offices, the general duties and services provided are similar:

1. Issuing social security cards—social security cards and the unique number each contains have become a standard forms of personal identification in the United States. Also, Social Security numbers are important for tax reasons; those 2 years old and older listed as a dependent on a tax return must have a Social Security number. By the end of 2014, approximately 16 million requests for new cards and replacement cards are anticipated.
2. Processing approximately 7.5 million claims for Medicare, retirement, SSI, and survivor benefits during fiscal year 2014.
3. Processing 28 million requests to verify new employees in conjunction with Homeland Security regulations.
4. Reconsidering more than three-quarter of a million claims cases.
5. Completing 100 million actions for beneficiaries after they have already started receiving benefits.
6. Posting one-quarter of a billion earnings items to individual records.

The Future of the Social Security Administration

When considering the future of the Social Security Administration, the solvency of the Social Security trust fund is one of the most important issues. Various projections show that revenues and expenditures in the Social Security trust fund will be depleted some time in or near 2033. At that time, there will only be enough revenues from taxes to meet three-quarters of the payment obligations. Although the trust fund currently has $2.75 trillion, this amount will be depleted as payments outstrip revenue from taxes beginning in 2020. Various methods have been proposed to keep solvent the Social Security trust fund.

One of the most simple to understand is the proposal that would simply cut benefits to recipients. This would decrease expenditures and would help bring solvency to the trust fund. Another solution, similar to the first, would be to increase the age at which recipients could start receiving benefits. Under this plan, recipients would still receive the same amount of annual benefits but starting at an older age, such as 67.

The problem with these solutions (decreasing or delaying benefits) is that they would tend to increase the amount of poverty among older Americans. Since the beginning of Social Security, the payments have been given credit for helping to reduce poverty for elderly populations. From the beginning of Social Security payments in the 1940s until recently, the poverty rate in older Americans has been reduced from more than one-third to below one-tenth. Any change in Social Security payouts or increase in the retirement age would certainly be positively correlated with an increase in poverty among the elderly. These costs may be shifted to others such as family members, charities, or even other government-run programs.

Increasing tax revenues could also help to maintain the solvency of the Social Security trust fund. Some proposals recommend an increase of two percentage points for workers' wages in order to increase the total amount of money coming into the fund. While this may seem like a relatively simple solution, it could increase poverty rates among working families and raise childhood poverty rates. Still another solution is to tax more of workers' wages—in other words, place the current tax rate on workers' wages that are currently not being taxed. Currently, wages over $117,000 are not taxed.

In any event, there will either be higher taxes or lower or slower (later) payouts. It is important to remember, however, that this has come about as fewer workers support more and more people who are retired. Some of the other issues around solvency have to do with how soon we should intervene with the current Social Security trust fund tax rate and payment schedule. The Social Security Administration analyzes and reports annually on these issues. The Social Security Administration has analyzed this issue for years, and its projections remain fairly constant putting the insolvency of the trust fund in the early to mid-2030s.

Conclusion

Legislation that led to the creation of the Social Security Administration was signed in 1935. By the late 1940s, the Social Security Administration, the payroll deduction tax, and the trust fund had become an integral part of the social welfare system in America. Although Americans did not think of themselves as socialists, they now had a system in place to provide those in their mid-60s with a monthly income equal to about 40 percent of an average American paycheck. Today, the organization has more than 65,000 employees with its headquarters in Baltimore and 10 regional offices in major cities in the United States.

Nearly 1,400 field offices exist now in the United States and in embassies throughout the world; employees in the field offices help Americans obtain Social Security cards and make claims for benefits. While currently there are a few trillion dollars in funds at the Social Security Administration, those funds will likely be depleted in the next 20 years. Solutions to keep the trust fund solvent involve increasing taxes or decreasing benefits or increasing the age at which benefits are paid out. The various solutions each come with their problems, however. Should we reduce Social Security benefits, delay the age at which they are paid, increase the taxes on workers, or some other more exotic solution?

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See Also: Social Security, Services Funded by; Social Services, Disabled Children and; Welfare Reform, Role of.

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Social Services, Disabled Children and

Social services encompass a multifaceted system that offers programs that provide assistance for families of children with disabilities. From programs that offer resources to enhance the quality of life of individuals with disabilities to agencies that advocate for disability rights, the process of receiving social services can generate a sense of community for families and their children with disabilities. However, the initial step of recognizing the need for social services may be considered as uncustomary practice for families from diverse backgrounds. For example, the act of seeking external assistance may be negatively perceived in a culture that emphasizes a strong tradition of self-reliance. To effectively support families of children with disabilities, practitioners must recognize the cultural differences that could potentially become barriers for families or appreciate the values that are offered through social services.

Person-First Language

Working with families of children with disabilities requires practitioners to view each child and his or her family as an individual entity. Regardless of the disability category, it is imperative for practitioners to avoid profiling a child's needs or abilities based on his or her diagnosis. For example, it is imprudent to make an assumption that an individual diagnosed with an intellectual disability has an identical set of needs or abilities as another individual with the same diagnosis. Therefore, it is best practice to work within the boundaries of a person-centered approach rather than a disability-centered approach.

The discussion of disability can be a sensitive topic for parents or guardians who are in their early stages of understanding their child's diagnosis and may not have fully reached acceptance of their new reality. Due to its delicate nature, it is critical for practitioners to be cognizant with their word choices when referring to the child with a disability. The adoption of person-first language represents a respectable gesture to promote the awareness that a person's disability does not define the individual and such diagnostic labels should not be a representation of his or her identity. Person-first language acknowledges the person prior to his or her disability and allows for a shift of how individuals with disabilities are perceived in the community. For example, instead of referring to a child as an autistic child, person-first language promotes the use of child with autism; instead of he's Downs, person-first language refers to someone as a child who has Down syndrome. The switch in the language structure is a subtle but powerful approach toward the establishment of a trusting and respectable relationship with the family.

Cultural Differences

While it is necessary to acquire a thorough understanding of the characteristics associated with each disability category, the examination of factors that influence a child's everyday life is equally significant to obtain a holistic evaluation of the child and his or her family. Specifically, contributing factors such as family heritage and culture can reveal pertinent information about the family dynamics and their attitudes toward having children with disabilities. For example, a child with a physical disability (e.g., hearing or visual impairment or conditions that impair one's mobility and movement) may be viewed as a symbol of prestige bestowed upon the family's cultural ancestry. Another family's culture may perceive disability as a form of punishment from their ancestors, and a sense of shame or guilt are impressed into the family dynamics.

Furthermore, factors relating to the family's comfort level in seeking external assistance or the awareness of the beneficial implications from social services should also be considered. As mentioned previously, cultural differences can present themselves as barriers for families that may be unaccustomed with the process of requesting social support. Depending on the culture, parents or guardians may be skeptical toward the available services and the authenticity of their offers, while others may be resistant to receiving services from community agencies due to the fear of being culturally stigmatized. Specifically, the acknowledgement that external assistance is warranted may be perceived by a family's culture as a sign of weakness; consequently a sense of fear or hesitation could debilitate their pursuit of such services to avoid further damaging the family's reputation.

Moreover, the dissimilation of information with language translations and disability accommodations relating to social services may be limited among families of diverse backgrounds. Such inconsistent flow of information restricts the accessibilities of services and reinforces the lack of comprehensive understanding of the benefits that social support can provide for the family. While there is an increased effort to develop bilingual informational packets to reach families of linguistically diverse backgrounds, such momentum must be continued to address the unique needs of multilingual families of children with disabilities who may need additional accommodations (e.g., augmentative and alternative communication or Braille) for an accurate translation of resources.

Individual Differences and Collaboration

To cultivate a meaningful and collaborative partnership when working with families of children with disabilities, practitioners must demonstrate culturally responsive practices to effectively support the consumer's needs. If cultural barriers continue to exist, they should not be regarded as restrictions for practitioners from implementing proactive strategies in an effort to bridge the gap between social agencies and families that may not fully comprehend the intricacies of seeking and receiving such support.

One approach toward establishing a respectable partnership with parents or guardians of children with disabilities is to actively identify ways to study the family's culture. Reading about a particular cultural heritage reveals only a single piece of a generally complex dynamic. Qualitative review (e.g., personal interviews) of each member of the family can be useful in gathering information relating to the family's history and interactions with their culture. Notably, interviews should be conducted by a professional (e.g., practitioner or interpreter), who is fluent in the family's native language and in an environment that is convenient for the parents or guardians. Furthermore, depending on the severity of the child's disability, traveling can be cumbersome for families of children with limited mobility. Therefore, it may be a practical option for the practitioners to conduct home visits to help alleviate unnecessary stress on the families.

Another strategy to promote an effective partnership with culturally and linguistically diverse families of children with disabilities is to ensure that it is a reciprocal relationship where their voices are valued. Oftentimes, suggestions relating to their child's disability needs offered by the parents or guardians are quickly dismissed. It is important to be reminded that the parents and guardians can offer invaluable information regarding the lifelong care of their children with disabilities. As with any team effort, it is critical that all members' opinions are equally valued and considered during a decision-making process.

In summary, working with culturally and linguistically diverse families of children with disabilities requires practitioners to distinguish their individual needs in a culturally responsive manner. In addition to understanding the demands of caring for a child with disabilities, it is also crucial to develop a thorough appreciation of any cultural differences in order to meet the needs of the changing demographics in the field. While it is impractical to become an expert in all cultures, being culturally sensitive to the needs of families of children with disabilities is undeniably attainable.

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See Also: Help-Seeking Behavior, Cultural Differences in; Individuals With Disabilities Education Act.

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Social Welfare Policy, Cultural Competence in

Cultural competence has become a salient concept of practice in social work and other human services disciplines. Historically, cultural competence was thought to refer primarily to having knowledge about people of color. It is now recognized that groups and communities in American society are diverse in other ways as well, including ethnicity, religion, language, social class, gender, sexual orientation, age, and ability. These factors are important because they provide the cultural lens through which diverse groups view their lives. In practice with diverse groups, professionals need to be aware of different points of view yet remain committed to values that affirm and respect the dignity of all. Equally important is for professionals to understand and acknowledge how beliefs and attitudes of the dominant society, including their own, have been enculturated into the institution of social welfare.

The institution of social welfare, through its social welfare policies, frames systems of service delivery to diverse groups. Consequently, some policies are delivered in culturally incongruent ways and there may be a need to effect policy or programmatic changes. This entry focuses on the intersection of cultural competence and social welfare policy as it impacts diverse individuals, families, and groups. Human services professionals, through their commitment to social justice, have an ethical responsibility to become involved in this sometimes intricate process of policy change.

The Institution of Social Welfare and Social Welfare Policy

Social welfare is one of the major institutions of a society. It assists members in meeting their basic needs for food, clothing, housing, education, health care, and employment. Such needs are usually met through good jobs in a well-functioning economy. When the economy experiences a downturn, however, resulting in losses of jobs for some individuals and reduction in pay for others, unmet needs emerge and become critical. Social welfare is also needed when individuals face loss of support from other institutions such as the family or religion. In these instances, social welfare policy is there to distribute benefits—goods and services—to individuals and families in need. Social welfare policy is defined broadly as the role of government and its actions and decisions, or not, that have an impact on the welfare of its citizens from taxation, national defense, and energy conservation to health care, housing, and public assistance. This definition is twofold in that it speaks to (1) the actions and decisions of government and (2) the inactions or decisions that government chooses not to take that may have far-reaching effects on its people. For example, in 2005 when Hurricane Katrina hit the Louisiana coast and wreaked havoc on an entire community, the government's inaction as it related to a timely response to the thousands of people who were stranded in their homes and held up in the Louisiana Superdome with no running water or food or other appropriate basic necessities resulted in loss of lives, illness, and major displacement of children and families.

Social welfare policies are administered by voluntary and nonprofit agencies as well as by units of government—federal, state, and local. They may also be formulated by these same levels of government. Policies generally reflect society's dominant values and priorities, which in turn help to frame the design and cultural ethos underpinning service delivery systems. In order to address the social problems and challenges faced by diverse groups in need, it is important that service-providing systems take into account the groups' norms, values, history, and experiences.

What Is Cultural Competence? How Is It Different From Self-Awareness?

Cultural competence refers to the ability to understand, communicate, and interact effectively with individuals and groups who differ on one or more characteristics such as race, ethnicity, language, religion, gender, sexual orientation, social class, age, and ability. An individual who seeks to be culturally competent will (1) study a group's historical as well as current sociocultural and economic experiences; 2) examine his or her own values, beliefs, and attitudes to determine if he or she has the context for assessing the values of others; and (3) become involved in changing unjust policies, programs, and service-providing systems that operate to the detriment of diverse groups.

The literature suggests that self-awareness is the process through which an individual becomes more conscious of his or her personal values, how they were developed, and how they shape the current worldviews about self and others. Self-awareness can be viewed as a first step in the consciousness-raising process that can yield insights into one's assumptions, biases, and stereotypes, and how these impact the helping process. Some writers have voiced concern, however, that self-awareness does not encourage professionals to move beyond the point of self-assessment or to examine the influences of bias on individuals, social welfare policies, or service-delivery systems. As such, human services professionals should focus not only on their own identities and cultures but also on the cultures and identities of others and how these factors impact the policy process.

Significance of Cultural Competence in Social Welfare Policy

Achieving cultural competence is not a static but a dynamic and ongoing process—one that requires the continual acquisition, integration, and sometimes modification of knowledge, especially in encounters with a new, diverse group. In some cases, we may find it necessary to unlearn what was once thought to be valid. Human services professionals who seek to engage in culturally competent practice come to understand the intersection of isms (e.g., between race, gender, and social class) and acknowledge how historical experiences with institutions of society, including social welfare, have influenced the worldviews of diverse groups and communities. Oftentimes, social policy is created in isolation from the population it most likely affects. This caveat makes it important for human services workers to be knowledgeable about the impact social welfare policy has on the delivery of services and the need for advocacy to ensure that the outcome is equitable.

Working With Diverse Groups and Communities in the Policy Process

Human services professionals have a responsibility to work with, and on behalf of, diverse communities to achieve social justice. The quest for justice often involves making needed changes—undoing unjust and culturally insensitive policies and practices and developing new ones. Policy practitioners may undertake many activities in attempting to effect policy changes: (1) the collection and analysis of data that document unmet needs and their impact on the quality of life; (2) understanding how the culture, norms, values, and historical experiences of communities inform the practitioners' conceptual framework for viewing problems or designing policies for intervention; (3) partnering and collaborating with community and agency groups in advocating for change; (4) providing education and support to diverse community groups who are advocating on their own behalves; (5) sponsoring town-hall meetings and community forums; (6) approaching key legislators and briefing them on the policy change proposal; and (7) seeking to testify at legislative committee hearings. Such activities are examples of the roles that human services professionals can attend to when working with diverse groups in formulating, implementing, and evaluating social welfare policies.

Policy implementation involves at least three major phases: (1) the writing of rules and regulations that govern how policy is to be carried out, (2) allocation of funding, and (3) the structuring of service delivery systems within agencies to deliver benefits. As such, rules and regulations provide the specific guidance and clarity needed to carry out the goals of policies. Policies generally require funding. Lack of funding or inadequate funding means that the policy is unlikely to achieve its goals. In designing service-delivery systems, several factors should be taken into account. Among them are: (1) the goodness of fit within the agency for the placement of services, (2) the availability and accessibility of the service-delivery system, (3) educational and cultural qualifications of service providers, and (4) providing information about services to potential beneficiaries.

Activities noted in the policy implementation process may affect the outcomes of policy evaluation. Policy evaluation is intended to indicate whether or not policies have met their stated goals. Therefore, policy implementation and evaluation are closely linked. An example of this point is made by examining the attempt to deliver mental health services to children in the New Orleans area following Hurricane Katrina.

Evaluation reports showed that several barriers prevented children from receiving needed mental health services: (1) lack of providers, (2) transportation, (3) inadequate funding, and (4) stigma associated with receiving mental health services in culturally diverse communities. The involvement of culturally competent human services professionals in policy or program formulation and implementation processes could have made significant differences in both service delivery and evaluation outcomes.

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See Also: Cultural Competence, Human Services Providers and; Diversities.

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Social Welfare Programs, Cultural Competence in

A discussion of social welfare has historically revealed a broad range of descriptions, ideological assumptions about purpose, and political tensions that far exceed a brief, encyclopedic entry. In general and as a social institution, social welfare has functioned as a system of services and programs in industrialized society designed to mitigate or alleviate dependency through the provision of assistance in various forms such as money, goods and services, shelter, food, employment and health, education, and various protections.

Disagreements and debates about the overall purpose of social welfare abound but generally place a large emphasis on, but not exclusive to, the consequences of poverty and social disadvantage. Social welfare services cover a wide range of needs to address transitory, intermittent, and residual or persistent needs. Specific services targeting individual needs typically contribute in ways that are supportive, supplemental, and/or substitutive, depending on abilities and capabilities.

The past few centuries of social welfare challenges have accompanied a range of reforms and shifts in responsibility between local, state, and federal jurisdiction, as well as public and private sector oversight. While social problems emerge concomitant with the changing times, certain consistencies remain relevant to lack of affordable housing, under- and unemployment, aging and associated health care needs, retirement, fixed incomes and the high cost of living, and a wide and complex array of social problems that have serious consequences to overall safety and well-being such as violence (e.g., interpersonal, family, neighborhood, gang, youth, and school), drug and alcohol dependence, and child maltreatment. Important emerging concerns call attention to social welfare needs of our increasingly aging population and the high cost of medical care, including prescriptions; reintegration challenges of returning active duty soldiers; veterans in need of long-term health and mental health services; migrant, immigrant, and refugee services to accommodate the wave of newly arrived populations; and most recently, the increasing number of undocumented and unaccompanied minor children.

Relevance of Cultural Competence in Social Welfare

So how is culture and cultural competence relevant to the discussion of social welfare? It is not uncommon to associate social welfare with the poor, although this is only a subset of the recipients of social welfare services. In 2014, poverty affected nearly 13 percent of the U.S. population (or nearly 37 million people), if one considers the poverty level of U.S. citizens as a pertinent measure of the poor. It is important to note the lack of inclusion of nearly 12 million undocumented individuals residing in the United States, many of whom are educationally disadvantaged, uninsured, living well-below the median household income, and with approximately one-third of undocumented children living in poverty.

The risks and burdens of being poor in the United States falls disproportionately on non-white groups although whites constitute the largest number of poor because they constitue the majority of the U.S. population. The disproportionate number of non-whites has also been reflected in a wide range of social welfare demographic beneficiaries. Cultural explanations for why this is the case tend to locate needs as both individual and cultural, as part of the socialization experience of racial minorities (often used synonymously with cultural minorities). The

An Air Force staff sergeant provides glasses to a Ugandan patient during a 2009 humanitarian relief program that helped 1,300 people from five east African countries. Cultural competence is a process by which people of all backgrounds, cultures, and classes are responded to respectfully and effectively.

culture of poverty, for example, assumes shared values, beliefs, attitudes, and behaviors aligned in ways that maintain the marginalization of individuals within minority groups, within the context of a broad range of institutional barriers and obstacles to social integration. One such value, for example, suggests that there is less incentive for work among the poor.

An alternative perspective, cultural deprivation, suggests that deficiencies in socialization practices do not promote or support larger societal values, beliefs, and opportunities that might otherwise lead to achievement in education and access to other benefits indicative of social integration. For example, in terms of the value of educational achievement, a cultural deprivation perspective might suggest that family socialization and parenting practices did not emphasize the value of education.

Stereotypes and Biases

Critics of these cultural explanations argue that while these “theories” are seemingly rational and convincing, they are fraught with stereotypes, overgeneralizations, and ethnocentric biases. It is as if there is a predetermined set of values, beliefs, and behaviors more likely than others to determine which cultural values are likely to lead to inclusive citizenship, with access to all rights and privileges offered by society.

It also suggests that all persons, regardless of their cultural differences, will achieve access to these rights and privileges fairly and justly. To not achieve these benefits, this consequence has often led to blame being placed on the victim, in which attributions of disadvantage are attributed to culturally different and marginalized individuals themselves. Cultural practices, for example, that align with collective or communal practices are considered inconsistent with values promoting independence, autonomy, and the individual's entrepreneurial spirit.

Cultural value conflicts are present in other areas as well, such as mastery over versus acceptance of one's fate and autonomy, independence versus collectivism and interdependence, and personal versus social responsibility. In attributing values orientations to cultural groups one risks committing the same faux pas suggested earlier—that of cultural overgeneralizing and stereotyping. The point is that dominant values orientations should not (but often do) lend themselves to advantages because they are consistent with larger societal values and beliefs about what leads to integration and success. Conversely, cultural differences should not but may prescribe or proscribe cultural groups to social positions that alienate, marginalize, or otherwise present barriers to social integration within dominant society.

Structural Approach

Not mutually exclusive of cultural explanations, another important contribution to this discussion relates to systemic, structural explanations. From this vantage point, one focuses on institutional processes and structures that not only support or limit access to but also maintain mechanisms that unjustly privilege or disadvantage culturally different individuals or groups.

These mechanisms have been considered to reflect ideological differences that perpetuate social arrangements that privilege or oppress individuals and groups. In this context, social welfare has been suggested to highlight mechanisms of social control that explain a group's social positions. Such mechanisms may impede student performance in school, disproportionately criminalize behaviors (as opposed to accessing treatment interventions and prevention), fail to provide adequate legal representation, sustain lower quality health care, deny essential community-based resources to support integration, fail to invest in or support economic development, and so on.

A structural approach highlights inadequate, insufficient, and otherwise ineffective systemic responses that may present a panacea of caring while at the same time do little to disrupt the social consequences that are often used as institutional justifications of social welfare.

Conclusion

To make sense of social welfare from a cultural perspective, one must accept the cultural diversity of this nation not so much as evidence of how fragmented and complex this society is becoming, but rather as a society rich in its differences and in its capacity to address complex challenges. Cultural differences are important to recognize not so much as threats to democracy but as valued contributions to a diverse society.

Diverse languages, for example, offer opportunities to engage in a global society and should be recognized as assets rather than imposition in educating the masses. It is reasonable to consider the humanitarian goal of social welfare despite the range of causal explanations. The growth of spending in social welfare from $24 billion in the 1950s to an estimated $60 billion in the early 21st century (despite efforts to control government spending) and the upsurge in private and faith-based support suggests the need for greater attention to cultural inclusion. It is a relevant fact that as the population increases, continued alienation, marginalization, and isolation are not likely to address emerging social welfare needs unless greater effort is made toward engagement to the benefit of an overall society's health, well-being, and progress.

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See Also: Adult Education Programs and Services; Adult Literacy Programs; Aid to Families with Dependent Children, Historical Role of; Cultural Capital, Role of; Educational Status and Service Delivery; Environmental Justice; Family Structure, Diversity of; Financial Literacy Programs; Food Desert; Food Insecurity; Health Disparities, Role of; Homelessness; Personal Responsibility and Work Opportunity Reconciliation Act; Single Parents; Social and Economic Justice; Social Capital, Role of; Social Security, Services Funded by; Social Welfare Policy, Cultural Competence in; Socioeconomic Status; Supplemental Security Income, Services Funded by; Temporary Aid to Needy Families; Uninsured Clients; War on Poverty Programs; Welfare Reform, Role of.

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Social Work, Diversity Practice in

Discussing diversity when discussing the field of social work can easily be seen as redundant; social work as a profession is defined through, motivated by, and adherent to practices and policies around diversity, cultural competence, and the intrinsic worth of all human beings. In fact, it is not possible to discuss social work as a profession or social workers as professionals without assuming diversity as part of the context.

The National Association of Social Workers and the Code of Ethics

The National Association of Social Workers (NASW) is the largest professional organization for social workers, with membership exceeding 140,000 people worldwide. Founded in 1955, NASW provides support for the growth of the profession and the professional development of social workers and advocates for social policies. NASW has published a code of ethics that delineates the profession's core values and acts as the guide for social work conduct and standards of care. The foundation of social work is comprised of six core values explained in the code of ethics. These values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence guide micro (practice), mezzo (groups and organizations), and macro (policy) decisions and applications.

While all six of the social work professional values emphasize social work's mission "to enhance human well-being and help meet the basic needs of all people, with particular attention to the needs of those who are vulnerable, oppressed and living in poverty," the particular values of social justice and dignity and worth of the person explicitly discuss the importance of diversity in social work practice. Stressing the need for social workers to understand ethnic and racial issues as they advocate for oppressed populations as well as being respectful of cultural and ethnic differences in working with clients, these values exemplify the fundamental nature of the importance diversity has to the field of social work.

In addition to the code of ethics, NASW has also published standards for cultural competence. Prepared by the NASW National Committee on Racial and Ethnic Diversity and adopted by the NASW Board of Directors in 2001, these standards supplement the values and ethical principles detailed in the code of ethics and provide further direction about the importance of cultural competence in social work practice. The standards for cultural competence indicate that social workers have an ethical responsibility to provide culturally competent services and maintain a culturally competent practice. In this way, cultural competence is necessary for ethical care, not just suggested or advised.

According to the Substance Abuse and Mental Health Services Administration, cultural competence is defined as a set of congruent practice skills, behaviors, attitudes, and policies that come together in a system, agency, or among professionals to work effectively in cross-cultural situations; this enables people to provide mental health treatment within the cultural framework of the consumer and effective services to people of a specific cultural background, including one different from that of the provider.

Diverse Populations and Practice Settings in Social Work

Because of social work's long-standing history of working with oppressed and disenfranchised populations, social workers regularly provide services to culturally, ethnically, and racially diverse populations. In working toward a more just society where everyone has the same fulfillment of basic human rights and the same access to opportunities, it is imperative that social workers come to the aid of populations who are systematically oppressed. Women, people of color, people with physical or mental disabilities, and the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community are populations, among others, with whom social workers provide a variety of psychosocial services and supports. Because the social work profession itself is as diverse as the people it serves, social workers provide services to diverse populations in a great variety of settings.

Social Workers in Schools

Most schools in the United States have interdisciplinary teams of professionals to meet the educational needs of their students. Teachers, teacher's aides, speech pathologists, school psychologists, nurses, educational specialists, and support staff all work as a team to provide an appropriate education to the students in their schools. Often, educational needs are compounded or intertwined with psychosocial issues. These issues are sometimes beyond the scope of other educational professionals and, as such, require the expertise of a social worker to assess and assist. Social workers may assist in testing, complete home visits, participate in child study team meetings, and advocate for children and their families. They may also locate resources for families lacking food, shelter, safety, or other basic human needs; intervene in issues of child abuse or neglect; make referrals for issues such as substance abuse or alcoholism; and provide individual or family counseling.

It is important for school social workers to be cognizant of the issues their students and families face that may be directly correlated with issues of diversity. For example, an immigrant student whose first language is Spanish and whose family speaks only Spanish at home may have social difficulties at school due to language barriers. This can lead to feelings of loneliness and isolation, which would impact the child's self-esteem and interest in school and school-related activities. A school social worker should be aware of the impact of culture and language on this student and communicate that to the rest of the team. Understanding this facet of the child's experience will allow the social worker to provide appropriate treatments and referrals.

Social Workers in Corrections

Of the 1.6 million Americans incarcerated, 65 percent are people of color. This statistic is representative of institutionalized racism, not evidence that people of color just commit more crimes than whites. Because social workers have a commitment to social justice, advocacy, and diversity, they are well suited to provide direct services to people in the correctional system as well as to stand up to issues that affect criminal justice clients such as racial profiling and discrimination. Social workers who provide services to the prison population are called to assist men and women by addressing complex issues including mental illness, substance abuse, family separation, psychological effects of incarceration, and recidivism.

Without social work intervention, many of the issues that precipitated incarceration and are present during incarceration will not be identified or resolved. If a person is arrested for prostitution or drug possession and professionals do not address issues of drug addiction and treatment, poverty, sexual abuse, or trauma history, the client may return to the behaviors that led him or her to incarceration. Advocacy is necessary for this population as well. The laws and law enforcement systems operate with discriminatory and oppressive policies, making people of color greater targets for arrest and imprisonment. Citizens who are in the racial majority may have greater access to means for legal assistance or connections to people in power, causing them to be less likely to face the same consequences of their behavior as people of color.

Social Workers in Health Care

Because social workers working in health care settings provide services to people who are ill, they see a large cross-section of the population. Illness and disease can affect all people, regardless of race, ethnicity, age, sexual orientation, or class. In this way, social workers are challenged with providing culturally competent services to a wide variety of people. Social workers should have a working knowledge and the capacity to accept and understand the full range of diverse clients.

People of all nationalities and backgrounds can come in through the hospital or health clinic's doors. Patients and their family members may not speak English, which can be frustrating for the members of the medical team; social workers can help patients access resources to assist them, including interpreters, language telephone lines, and even health care clinics or offices that offer services geared toward a particular population. Additionally, social workers can advocate for patients and families who may be misunderstood, marginalized, or even discriminated against in the medical setting. Cultural differences are not tolerated appropriately by all staff members at all times; sometimes education and open dialogue are needed to ensure proper treatment of all patients.

Racial issues are also present in health care social work, especially with regard to social justice and access to care. People of color who are often oppressed and discriminated against have barriers to health care that privileged members of society do not, including lack of health insurance or prescription coverage, unsafe living situations, and inability to afford proper nutrition. Conversely, medical staff needs to be cognizant of their own potential for racial prejudice and not assume that a person of color will automatically have these issues. Social workers are involved in creating a safe and tolerant environment and should be vigilant about issues of racism, discrimination, and oppression that occur in medical settings.

Social Workers in Mental Health

Much like the diversity of clients in health care social work, mental health issues can affect anyone, regardless of gender, race, age, or sexual orientation. Unfortunately, many people with mental health issues do not seek help or receive adequate treatment, causing the proportion of consumers of mental health services to not directly correlate with that of the population who actually have mental health diagnoses or would benefit from mental health services. Because of this, mental health diagnoses, including psychosis, schizophrenia, bipolar disorder, depression, and anxiety, are often detected secondarily to another break in psychosocial functioning the client may have. For example, the client with untreated social anxiety may be unable to hold a job, which in turn results in unemployment and issues of poverty and possibly homelessness. This client may then end up seeking mental health treatment after the diagnosis is identified in a public assistance office or a homeless shelter. A person with untreated and undiagnosed mania may seek drugs or alcohol to self-medicate severe mental illness, thus causing arrests or the inability to maintain stable relationships. Not until these issues are assessed by a mental health worker at a prison will the client be able to receive appropriate treatment.

Mental health services are provided in several ways. All mental health services can be delivered on an inpatient or outpatient basis, depending on the severity of the illness and needs of the client. Some mental health clinics offer subsidized services at low or no cost to clients on public assistance or with low income. Other mental health services are provided in the agencies where people are receiving other services, like drug treatment facilities. Many mental health services are provided in private offices, much like doctor's offices, where clients come in on an outpatient basis and receive treatment from a licensed therapist or psychiatrist. This option typically requires insurance coverage (which generally necessitates a copayment) or is a private pay, out-of-pocket expense. A 50-minute hour of therapy can range from $80 to $120 and up depending on location and the qualifications or expertise of the therapist.

Social Workers in Child Protection

Child protection agencies across the country provide services to families and communities in an effort to ensure child safety and protect vulnerable populations. (Protective services are also available for populations besides children, including aging adults and adults with developmental or mental disabilities.) Child protective services involve a variety of services. Initial investigations are provided to investigate allegations of child abuse, neglect, and abandonment. Protective services provide ongoing supervision and case management services to families in which abuse, neglect, or abandonment has been proven. Foster care services arrange and manage care for children who are unsafe in their present family situations and need temporary care until the issues surrounding the abuse or neglect are resolved. Adoption services are provided if it is unsafe for the child to ever return to his or her family, as determined by a court of law or through voluntary surrendering of parental rights.

Social workers in child protection face a very diverse client population. Cultural competence is crucial in working with clients in child protection, especially as cultural norms often dictate discipline practices. While the goal of child protection is to keep children safe from harm, it can also allow for the opportunity for judgment and the imposition of values onto families whose values differ. There are standardized ways that child protective services assess for and determine situations of abuse and neglect in order to minimize subjectivity; however, the social worker still has some power in this process. Only the social worker knows the extent of the condition of the home he or she is investigating that was reported as hazardous. If they verify that the home is, in fact, unfit for the children to remain safe, they have the power to remove the children from the home. The social worker's understanding of the client's cultural differences, socioeconomic situation, and other variables is extremely important in the legitimacy and fairness of this decision.

Social Work in Aging Services (Senior Centers, Long-Term Care Facilities, and Assisted Living Facilities)

Although diversity is often discussed in terms of racial or ethnic differences, there are other differences that can impact a person's well-being. Age is a particularly relevant area of diversity for the United States, considering the population is facing a demographic shift. According to the United States Census Bureau, in 1970, there were 20 million Americans over age 65 and 4 million American over age 85. The projected numbers for the year 2020 increase dramatically to 70 million over the age of 65 and 10 million over the age of 85. With more than 44 million Americans already age 65 and over, aging in America is a significant consideration. Resources of all types (financial, health care, familial, caregiving, and employment) are needed to continue to support the quality of life of an aging population.

The impact of an aging America is significant based on the incidence and prevalence of medical and mental health problems. The majority of Americans over the age of 65 had serious chronic health conditions in 2007 and 2008; 71 percent of men and 57 percent of women had heart disease, cancer, or stroke. In 2006, 10 percent of men and 18 percent of women over age 65 reported depressive symptoms, while 19 percent of Americans over the age of 85 reported signs of clinical depression.

As people age and become less physically and mentally able to meet the standard of productivity and power, they often become marginalized and neglected. A host of practical problems and concrete issues face the older adult population, including substandard housing, income limitations, lack of family support, isolation, and inadequate medical care or health insurance coverage. Social workers who are employed in long-term care facilities, assisted living facilities, or home-based or community senior services face the complex needs of the aging on a regular basis. Social work as a discipline has the skill set and knowledge base to address the concerns of the elderly. This can be done through individual interventions, community-level programs and assistance, or state or federal policy changes or programs.

Promoting and Enhancing Cultural Competence

As previously mentioned, social work as a profession is not only committed to providing services to diverse, oppressed, and minority populations, but it is also committed to ensuring that there are professional standards and methods in place to ensure the highest level of expertise in these areas. The Council on Social Work Education (CSWE), the accrediting body for professional social work programs in higher education in the United States, uses standardized measures when providing accreditation or reaccreditation to schools of social work. The CSWE Education Policy and Accreditation Standards (EPAS) are designed to translate social work values into guidelines for effective and appropriate professional education.

The specific EPAS policy “Educational Policy 2.1.4: Engage Diversity and Difference in Practice” is critical in ensuring that diversity and cultural competence is emphasized in social work education and thus the social work profession. In this policy, it is expected that social workers understand the dimensions of diversity, including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation. It is also expected that social workers will see these aspects of difference as potential sources of oppression, poverty, marginalization, and alienation.

In core social work curriculum, assignments are given that ask students to identify their own race, culture, ethnicity, and values. Having them complete this type of self-assessment and identify these aspects of themselves can help them as they relate and understand clients of different races, cultures, and ethnicities. Self-awareness is crucial in the process of providing culturally competent care.

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See Also: Culturally Diverse Practice, Definitions of; Culturally Diverse Practice, Theories of; Medical Social Workers, Racial and Ethnic Issues for; Values and Ethics, Ethnic Diversity and.

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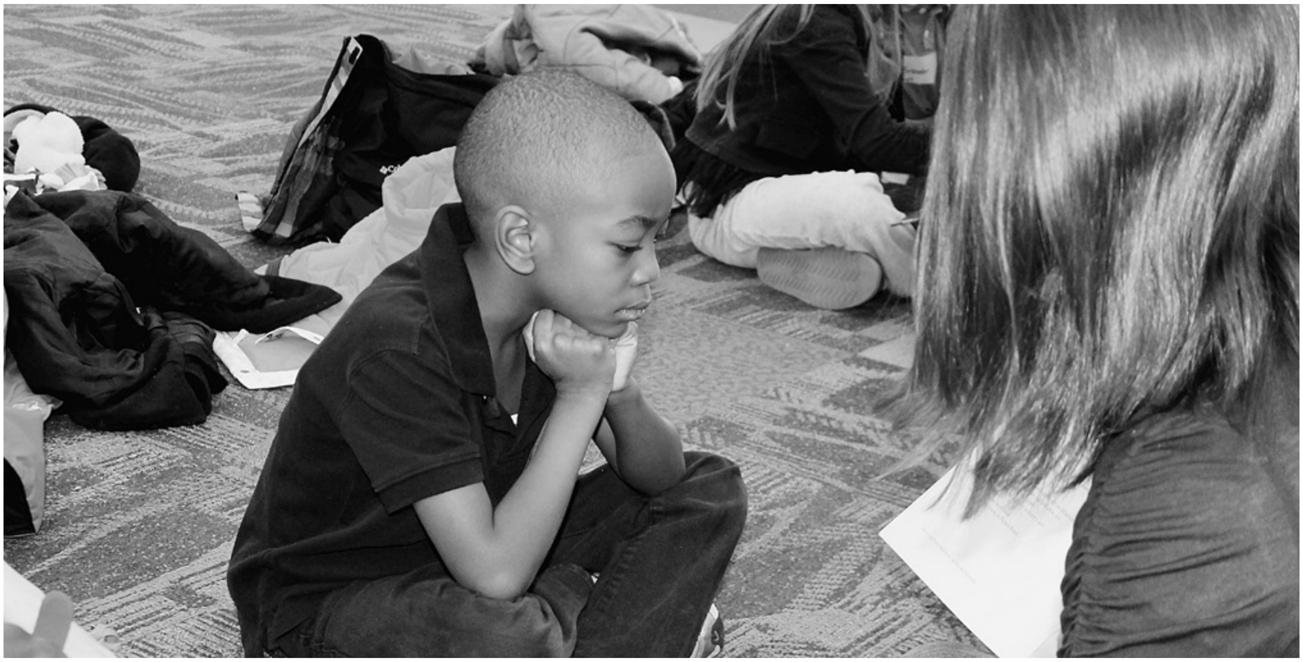
Social Work Practice and People of Color

Modern social work practice takes place in a multicultural and diverse environment, requiring social workers to demonstrate culturally responsive care in working with people of color, defined here as a



A volunteer reads to a child during an African American read-in event. People of color are the fastest-growing segment of the population in North America, presenting tremendous challenges for social work professionals faced with performing the tasks of reflecting a sensitivity to the groups' concerns while helping them meet their sociocultural needs.

heterogeneous group that is not white in race or ethnicity and whose members share a common experience of discrimination based on their non-normative group status. From a North American perspective and excluding aboriginal peoples in Canada, people of African or Caribbean, Asian, Latin, and Native American descent are the groups most commonly associated with this term. Descriptors such as *nonwhite* and *minority* have been used to refer to members of this population, suggesting a lack of consensus on the use of terms.

Debate is ongoing about appropriate terminology. The expression *people of color* seems superior to *nonwhite* or *minority*, given the implication that members of this group are either lacking in whiteness or are perpetually disempowered because of their minority or subordinated status. The term *white* itself eludes description. Importantly, included in the debate is an analysis of racialization, which examines the idea of race as a social construct that has real, material effects for people positioned outside the bounds of whiteness.

The cumulative, disadvantageous effects of whiteness and the continuing legacy of institutional and structural racism that exists in society structure unequal life opportunities for individuals whose identities are differentially marked. Considering the power differentials rooted in racial dynamics is an important factor in working for social justice. Social workers—especially those from the dominant white group—who work with people of color must have a good understanding of the challenges faced by this population. They also need to develop strong skills and particular knowledge regarding how best to tailor services to meet the unique needs of this group.

A Diverse and Growing Segment of the Population

People of color are the fastest-growing segment of the population in North America; immigration acts as an important driver of this growth in some contexts. According to the U.S. Census Bureau, people of color represented 36.2 percent of the American population in 2011. Future population projection estimates that this number will reach 49.9 percent by the year 2050. Of those who completed the most recent national census, 13.1 percent identified as black or African American; 5 percent reported Asian ancestry; 16.7 percent specified a Hispanic or Latino origin; 1.2 percent classified as American

Indian and Alaska Native; and 0.2 percent indicated belonging to a Native Hawai'ian and other Pacific Islander group. The Hispanic or Latino population is the largest non-European racial and ethnic group in the country.

Canada's ethnocultural portrait mirrors that of the United States. In the 2011 voluntary National Household Survey, which replaced the mandatory long-form census, visible minorities (excluding aboriginals) accounted for 19.1 percent of the country's total population—an increase from the 16.2 percent reported in the 2006 census. This number is expected to reach 33 percent by the year 2031. Among the three largest visible minority groups, south Asians made up 25 percent; individuals of Chinese ancestry composed 21.1 percent; and blacks totaled 15.1 percent. Together, these racial and ethnic groups comprised 61.2 percent of the overall visible minority population and represented 5 percent, 4 percent, and 3 percent of the national population, respectively. As was the case five years earlier, south Asia continues to lead as the main source of immigrants to Canada.

The population growth rate of people of color is increasing at a higher rate than that of their white counterparts. This trend is likely to persist into the foreseeable future, with important implications for the delivery of social work and support services. Practitioners' awareness and understanding of appropriate theoretical and practice issues, in working with members of these populations, will help to improve culturally sensitive care and minimize inequities in care–delivery intervention.

Contemporary Issues in Social Work Practice With People of Color

The increasing numbers of people of color in Western democracies present tremendous challenges for social work professionals, who are faced with performing the difficult tasks of reflecting a sensitivity to the groups' concerns while helping them meet their myriad sociocultural needs. However, social workers are uniquely positioned to intervene and help with improving the quality of life and well-being of disenfranchised groups and communities.

Although significant strides have been made toward the inclusion of people of color (both new immigrants and native born) in countries like the United States and Canada, some hardships persist. These include but are not limited to issues of immigration and acculturation; substandard housing and inadequate access to health care; lack of a culturally sensitive educational system; disproportionate minority contact with the criminal justice system; and poverty due to limited access to or exclusion from meaningful employment. For individuals with a nonheterosexual orientation, support is also needed with regard to the complex intersection of multiple social identities of religion or spirituality, ability, race, and gender. Owing to systemic discriminatory experiences such as racism, all of these challenges can be taxing in the absence of culturally competent care and can contribute to physical and mental health difficulties.

Theory-Informed Social Work Practice With People of Color

Social work practitioners are not uniform in their views on the relationship between theory and practice. Some believe that introducing theory into practice can result in the depersonalization of care, particularly in the context of the therapeutic relationship. Others argue, however, that a theory-informed approach to practice has the benefit of ensuring that social work interventions are based on sound evidence. Important as these perspectives are, they present a contradictory and dichotomized representation of social work because they overlook the fact that theory and practice are inextricably linked. Whether a social worker recognizes it or not, the application of theory in response to social issues is ubiquitous in the field.

Awareness about the importance of theory and practice emerges in the context of social work with people of color. Social workers would be limited in their abilities to provide culturally appropriate services to individuals and groups from different racial, ethnic, and cultural backgrounds if they relied solely on practice or professional wisdom. In a white-dominant profession such as social work, discernment about the lived experiences of people who are not white may be affected by the organizational culture and the extent to which practitioners are able to appraise a service user's situation from non-Eurocentric epistemological and ontological vantage points. Incorporating evidence-based theories into social work practice may help to lessen the effect of dominant cultural perspectives and personal biases or values in relation to working with nonwhite, racially and ethnically diverse groups.

Two influential theoretical orientations in social work are systems and psychosocial theories. The former centralizes interactions between individuals and interrelated subsystems, whereas the latter emphasizes a person-in-environment relationship. Rooted in Western, science-based knowledge systems, the applicability of these theories to people of color has been critiqued with regard to their need for uptake of integrated, culturally diverse knowledge. Cultural competence theory, which seeks to promote skills, attitudes, and values conducive to effective multicultural social work practice, emerged as a response to this limitation. An important point in this regard is that becoming culturally competent is a long-term commitment, requiring continuous self- and organizational assessment. Despite cultural competence's favorable properties, debate lingers about whether it qualifies as a theory. Some have also speculated about its potential to sidestep the social realities of racism. However, compared to the two dominant theories used in social work practice, Doman Lum—an expert in culturally competent practice—has pointed out that cultural competence's emphasis on themes such as ethnicity, culture, gender, minority, and social class can help in understanding the multicultural experience of people of color. Such focus might explain the popularity and acceptance of cultural competence in the human services profession, including among social workers who may not all have sufficient understanding regarding implementing and assessing culturally competent practice.

Regardless, support of cultural competency as an institutional imperative has been strengthened since both the National Association of Social Workers and the Canadian Association of Social Workers endorsed a commitment to diversity and understanding of differences between and within cultures in their respective policy statements and codes of ethics. This expression of support reflects the changing social work landscape and the importance of the social dimensions of culture when it comes to empowering groups who, historically, have been and continue to be discriminated against and underserved by the profession.

The Process Stage Approach to Social Work Practice With People of Color

Implicit in a discussion of a process stage approach to generalist social work practice with people of color is the notion of cultural commonality. This idea, not impervious to differences among racial and ethnic groups, stresses the importance of a shared understanding and experience of oppression and the social dynamics of privilege. As well, it emphasizes group over individual functioning, reflecting tendencies and values of people in collectivistic cultures as compared to Western societies' individualistic orientation. Doman Lum's framework for cross-cultural social work acknowledges this differentiation, specifying appropriate helping process stages and culturally relevant practice interventions when working with diverse service users of non-European origin.

For example, in the contact stage, the social worker looks to establish a healthy, nurturing relationship. Among people of color, cynicism may arise from past negative institutional contact and experiences of daily racial microaggressions and discrimination, including disapproving cultural attitudes toward seeking professional help. These situations can hinder the development of a quality, mutually trusting, therapeutic alliance. Therefore, in this stage, effort must be made to assuage any service users' suspicion and mistrust surrounding their receipt of support services. Establishing accessible and integrated systems of care and support that are inclusive of multicultural communities as partners may also help with the relationship building crucial to effective service delivery to individuals.

From the trust and rapport developed, service users can overcome feelings of shame, which may facilitate the identification of problems best addressed by matching problem themes with appropriate problem levels. This approach recognizes that people of color commonly present with multiple problems, owing to the various interlocking matrices of oppression encountered in society.

Likewise, when undertaking assessment with people of color aimed at goal-oriented care planning, social workers should consider individual, cultural, and communal assets and support systems that can be leveraged to resolve problem situations. Reliance on traditional, affective diagnosis may limit identification of culturally responsive intervention strategies. As in the problem-identification stage, intervention levels must be aptly matched with intervention strategies for optimal result. Using task-centered or behaviorally oriented activities can be helpful in this regard.

Finally, akin to social work practice with people in general, termination can occur when the goals and objectives agreed upon by the social worker and service user have been met or resolved. Research suggests that, compared to their white counterparts, people of color are more likely to terminate support prematurely. When possible, these individuals should be supported by identifying alternative helping formats. Clues of when termination might be appropriate include growth of maturity, as reflected by developments achieved from point of contact to termination, followed by the service user's ability to recount affirmatory progress made in the therapeutic process. Periodic telephone follow-up conversation with the service user may help with maintaining therapeutic gains.

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See Also: Cross-Cultural Knowledge; Cultural Competence, Human Service Providers and; Discrimination and Institutional Racism; Immigrant Populations, Human Service Needs of; Power, Race, Ethnicity and; Racial/Ethnic Categories, U.S. Census.

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Social Workers

A social worker is a person who supports people in overcoming their challenges and provides this in a timely and professional manner. The social workers most people have come across are the ones who work within communities (e.g., organizing campaigns, community cleaning, promoting behavior change, etc.) and at institutions such as hospitals, counseling centers, schools, food distribution places, and so on—both during emergencies (or after a disaster) as well as during nonemergency or normal times (e.g., a polio vaccination campaign). The range of social service areas where social workers operate is wide. The skill, training and operational practices for social workers depend on the contextual environment, needs, and the types of support they are providing.

This entry provides an overall description of social workers (mainly those working internationally but also covering those who work in domestic contexts) and the profession of social work, the areas they work in, how they operate, as well as some of the recent discussions and challenges or concerns around social workers and social work and how the profession may change in the future.

The National Association of Social Workers (NASW, http://www.naswdc.org) defines social workers as graduates of schools of social work who use their knowledge and skills to provide social services for clients (who may be individuals, families, groups, communities, organizations, or society in general). Social workers help people increase their capacities for problem solving and coping, and they help them obtain needed resources, facilitate interactions between individuals and between people and their environments, make organizations responsible to people, and influence social policies. Social workers may work directly with clients addressing individual, family, and community issues, or they may work at a systems level on regulations and policy development or as administrators and planners of large social service systems.

Why Does Someone Become a Social Worker, and What Defines the Social Work Sphere?

A deep-seated desire and interest to help others, alleviate their suffering, and make a difference in people's lives by empowering them is what motivates individuals to take on to the profession of social work. Helping others during times of need is a fundamental human nature that can be explained in terms of the value of humanitarianism. Humanitarianism is an ethic of kindness, benevolence, and sympathy extended universally and impartially to all human beings. Humanitarianism has been an evolving concept historically, but universality is a common element in its evolution. No distinction is to be made in the face of suffering or abuse on grounds of gender, sexual orientation, tribe, caste, age, religion, or nationality. Humanitarianism can also be described as the acceptance of every human being for plainly being another human, ignoring and abolishing biased social views, prejudice, and racism in the process if utilized individually as a practiced viewpoint or mind-set. Humanitarianism is a central tenet in the sphere of social work and drives the motivation and value system of social workers.

Some of the fundamental value systems that define the sphere of social work are as follows: supporting the vulnerable and needy in a timely manner and with assistance that they need, ensuring dignity and respect for those who are being helped, providing immediate support yet helping the person become self-reliant, and sympathy and empathy with the cause of social work.

Social work has been emerging as a distinct profession over the last several decades, and there is increasing reliance on social workers by communities and governments to provide support, especially in areas that require soft skills such as building trust and confidence, to be effective. Social workers are also valued for their ability to provide interrupted, long-term, and personalized service to individuals and beneficiary groups. Despite the apparent simplicity with which some perceive social work as a profession and social workers, this is anything but simple and requires a high degree of skills in a multitude of aspects—technical, behavioral, cognitive and perceptiveness, communication, advocacy and lobbying, presentation, forward thinking, personal organization and planning, self-awareness and management, and so on.

John Sudberry, in his paper focused on social work and the need for relationship building, mentions that a core component of social work is the ability to respond to people's emotional needs, to their impulse for emotional development, and to the difficulties they experience in forming or maintaining relationships. Many of the problems have origins in societal dynamics (e.g., of racism, gender inequality, and economics), and social workers have important roles in ensuring material and financial resources. But whatever other dimensions they may have, problems of child abuse, of mental health, of violence in intimate relationships, of bereavement in later life, all involve perturbations in emotions and relationships.

Some of the most desirable skills and behavioral competencies that an effective social worker needs to be effective are as follows. This is not a complete list by all means, and different contexts and needs will require others.

Building a core belief value system, staying true to it, and rethinking it are essential to providing larger purpose to the work that the person does. Building lasting and trusting relationships with others is a crucial necessity to enable the social worker to work effectively with community groups and beneficiaries. Awareness of diversity that exists within the community (e.g., based on gender, age, race, religion, culture, sexual preferences, socioeconomic background, geographic origin—urban or rural, etc.) is an important requirement for a social worker. An ability to interact and work with these diverse populations at ease, overcoming and challenging any stereotypes that may be associated with any group, and not letting one's own personal beliefs and systems interfere are important to ensure the clients effectively participate in the service being provided. Managing expectations between different stakeholders on what is practically feasible in terms of support outcomes is essential.

Emotional intelligence is an important need for a social worker. Emotional intelligence is defined as the capacity of a person to be aware of, control, and express one's emotions and to handle interpersonal relationships judiciously and empathetically. It is not something that can be taught in a training program but what can be acquired over time through experience and empathy toward the beneficiaries. Not being judgmental and biased is an absolute necessity that helps to build trust. Acquiring and developing professional skills necessary on the issue is crucial. There is an increasing need for specific academic courses and certifications to qualify and provide support for social workers. Training and retaining throughout the course of a professional career as a social worker is important to stay abreast of the changing contexts, practices, and professional procedures. Strong skills in communication (verbal and nonverbal) with a diverse group of stakeholders is important, including negotiation skills in order to work with various stakeholders such as beneficiaries and client groups. Skills on diplomacy are equally important. An understanding of the rights that beneficiaries have is an important aspect that social workers have to be aware of. This necessarily means that the beneficiaries have rights to quality and dignified services, and it is the responsibility of the social workers (as well as other stakeholders) to uphold these rights.

Maintaining confidentiality on issues and information related to beneficiaries is important to ensure that trust built over time is maintained. Equality in the social work practice is another important value as well as a practical element that the social worker needs to be aware of. Understanding of equality (or lack thereof) within the society is important for the social worker so that he or she can design interventions for the beneficiary that address these issues in order to be effective.

Self-management is an absolutely important need for a social worker. The social workers experience and come across many accounts of trauma, sad narrations from survivors, and hopelessness, and this can affect them mentally. Staying focused and professional despite this is important, and therefore, social workers are strongly encouraged to seek professional counseling support from time to time to relieve the stress. Cultural understanding regarding the community within which the social worker operates is an important determinant of treatment and support standards. Networking with other social workers, others within the community, and especially a professional body is also important for social workers. The professional networks can help them stay abreast of issues within the sector as well as build a support mechanism. There are several such forums throughout the world. The International Federation of Social Workers (IFSW, http://ifsw.org/what-we-do/), founded in Paris in 1928, is one such body that mentions on its Web site that is has more than 750,000 members worldwide. The Web site also has a plethora of other information and policies related to social work and workers.

Challenges for Social Workers and Social Work

Like any other profession, the arena of social work and social workers also are faced with some of the following criticisms and challenges. Case Study 1 gives a firsthand account of an experience with social work and social workers during a humanitarian crisis.

Professionalism. The performance indicators for social work and social workers remain largely subjective for most of the areas in which they work. The quality of work done is therefore guided by individual skill sets, motivation, training, and experience. While it can be noted that there are guidelines and procedures laid out for a large category of social work types, there are many categories for whom there are no clear and standardized guidelines and therefore clear performance indicators. Owing to this limitation, social workers therefore are sometimes criticized, including negative stereotyping and negative media publicity.

Cost versus benefit. In developing and underdeveloped countries, where resource allocations depend a great deal on tangible outcomes, social workers are seen as an expensive human resource to invest in. Counseling a child with learning difficulties over a long period of time by a social worker is seen as a luxury over, say, building additional classrooms and hiring teachers.

Simplification of approaches. Doubts are often expressed in many situations whether the social workers use an oversimplified approach in dealing with complex issues.

Lack of commonly understood performance benchmarks. Probably one of the most common criticisms of social work and social workers is lack of standardized benchmarks for performance measurement across different sectors and themes.

Accountability. Given the diverse range of areas social workers are involved in and equally diverse practices and standards, lack of accountability is a critical issue that is often cited as a critique of social workers.

Case Study 1

After the 2004 Indian Ocean tsunami, the author saw several examples of social work and social workers that were inappropriate and extremely concerning. Working with a large, international humanitarian organization at that time, the author traveled within days to the worst-hit parts of south India

(Tamil Nadu state, Nagappatinam, Cuddalore, and Kerala state, Kollam district) to assess the damage, plan emergency response, and launch interventions to support the populations hit.

The scale of the disaster was massive, yet the ability of the government and communities to cope with them was equally robust. Even within the early days of the disaster, the government was working with the network of community institutions, and leaders had been able to clean most of the roads and provide drinking water (tankers), temporary shelters, and food to most of the families. Given the enormous scale of the disaster, the damage it had created, and the media attention it created nationally and internationally, a lot of social workers and assistance had arrived in the area. While the author was impressed with the interest and ability of people to help, respected their intentions, and also impressed with the professionalism with which many of the social workers worked, the author also had the worst of experiences. Given below are some examples.

Inappropriate aid. Truckloads of used clothes arrived in the area (including soiled and torn clothes, used undergarments, etc.) that were detested by the local communities. Though the community leaders did not want to hurt the sentiments of the aid givers and did not return them (most of these were piled on street corners for days), they were clearly offended when the trucks kept coming. One community leader told me, "We have lost our families, houses, and livelihoods to the tsunami but not our dignity and self-respect." Many other types of inappropriate materials were brought in, such as cooked food that had become bad during transportation, types of canned meat that the local population did not eat (due to religious reasons), various types of junk food, and so on.

Linking relief support with religious messages. Many so-called social workers were distributing relief assistance along with religious books and messages. Talking to one of them, the author was told, "This is the time when people need religion the most."

Disaster tourism. Hordes of do-gooders had descended into the area with the simple reason to see the impact of the tsunami. While that in itself is not an issue, it was clearly concerning that they did not respect any privacy of the affected people, taking photographs of dead bodies and even by removing the white clothes the bodies were covered in as a mark of respect.

Self-promotion. Private companies, housing societies, social clubs, and so on all had generated funds (and assorted in-kind assistance) for the tsunami-affected population. That was encouraging. What was not so appropriate was when they used it as a photo opportunity to promote the names of their affiliate organizations. In many instances, the author saw long queues of people waiting for relief assistance while first waiting for the speeches and photosessions to end (one such organization realized they had not brought a banner with their name on it and so had to organize one from a nearby village painter, delaying the relief distribution for more than five hours).

Inappropriate Contacts With Vulnerable Groups

Many social workers in these areas claimed they had come in to take care of children in the affected villages and set up tents in open grounds as child care centers. They then encouraged parents to bring in their children to these centers to receive care and support and also to get counseling through play, and so on. The author spent some time at some of these centers observing them (discretely from a distance) and was appalled to see that the social workers clearly were not trained or skilled to handle young children. Several of these centers had both female and male social workers, but many of the male social workers were freely and physically interacting with children (3- to 10-year-olds mainly). In one case, nine days after the disaster, the author saw a social worker discussing with a family the adoption of a 4-year-old boy (his parents had died in the tsunami) and encouraging them to talk to a couple who had come in to adopt a child. This was clearly not the time, nor was the family in a position to make a well-informed decision.

What Does the Future Hold for Social Workers and Social Work?

Given the scope of the social work profession and the range of issues social workers are engaged in, it is difficult to explain how it will change. Given below are some thoughts, especially for social workers in the humanitarian and development (e.g., persons working on issues such as poverty, climate change, gender equality, community empowerment, etc.) work arena. Case Study 2 also gives a sense of some of the experiences of social workers in this realm.

1. Greater and better understanding among the public regarding social work, what it constitutes, and how it is done—there is already a great deal of appreciation for the work that the social workers do, and this can increase if the public understands their work better.
2. There will be greater effort for professionalization of social workers through standardized trainings, certification, and performance review systems.
3. Improvements in working conditions, remuneration, and benefits for social workers are likely to happen with better appreciation of the important roles they play.
4. Better opportunity for governments and nongovernmental or community organizations to coordinate their actions around strengthening the social work sector will likely occur.
5. Continued work on development of standardized protocols and practices that social workers use in supporting their clients will emerge.
6. Increased use of accountability frameworks to guide the social work sphere.
7. Innovations in practices used by social workers will continue to grow, including better documentation and sharing across sectors.
8. There will also be greater emphasis on generation of a clear evidence base around various practices and protocols used by social workers for supporting beneficiaries. This will help strengthen the arguments in favor of increased allocation of resources to the sector as well as other changes within the sector to further improve quality standards.

Case Study 2: What Causes a Person to Become a Humanitarian Worker?

While working in several east African countries and with international nongovernmental and humanitarian or development organizations over the last seven years, the author discussed with several colleagues (both expatriates as well as national staff) the nature of social work and ourselves, the social and humanitarian workers—what is the motivation to do this work in difficult environments, how is it done, and what is being achieved? Problems were discussed as well. It is a very passionate issue for most humanitarian social workers, and everyone has a point of view. Given below are some of the most common observations the author has noted and summarized.

Unequivocally, most colleagues respond that humanitarian workers are needed to help the most vulnerable, and that is why they joined the profession. Many also take pride in the fact that they are professionals with certain skills, and combined with skills of other colleagues, they are able to address the issues that vulnerable people are facing (refugees, internally displaced persons, famine- and drought-affected persons, malnourished children, people living with human immunodeficiency virus [HIV], etc.).

Some of the motivation factors are said to be compassion and sympathy with the suffering, a desire to do something different and meaningful with their lives, and gaining perspectives on real issues on the ground. Given that a large part of international humanitarian work is well organized as a profession, the people who work within this system also receive salaries and other benefits comparable to any other profession, and this is also said to be a motivation. Almost all colleagues the author has met (especially the ones who have worked for three to five years or more) do not consider working in a profession other than social work.

How Are Humanitarian Workers Doing, and What Are They Achieving?

The range of views on this is broad. Many are very sure that what they are doing indeed changes lives, although other do not agree as much and feel that the work that they do provides short-term solutions to deep-rooted and broader issues. Colleagues working with short-term emergency programs tend to find more evidence that their interventions are actually saving lives and helping people get back to normal lives. People working in long-term development issues (e.g., climate change, poverty eradication, behavior change communication, etc.) are a little less sure that the interventions they do are going to have tangible results (or whether they will stay there long enough to see the change). There is a general feeling that the humanitarian work is professionalizing very fast, and the individual as well as organizational performance and accountability measures are becoming more strict (enforced and demanded by organizations, donors, governments, and communities or beneficiaries), and of course, this is welcomed by all.

What Problems Do Humanitarian Workers Have as a Sector?

Many strongly believe that the accountability values within the sector are still lax. Bureaucracy within organizations, needlessly long-drawn analyses of issues (instead of responding sooner), poor coordination, an inability to be dynamic (compared to the corporate sector, which learns and adapts) in line with changing contexts, actions driven by donor funding, and poor leadership within the sector are some of the other often-repeated self-criticisms.

What Changes Will Be Seen in a Decade?

Despite the concerns mentioned, many strongly believe that humanitarians will continue to play a vital role in the years to come. The impacts of climate change and resultant drought and deprivation, long-drawn conflicts in many parts of the world, and increasing trends of natural disasters will continue to impact large populations across the world (especially in the developing and least-developed countries). This demand on humanitarian workers will lead to greater professionalization, accountability, and quality standards, and we should rethink the way we respond to needs. The focus on building resilience in communities will be greater so that they can cope with natural disaster better.

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See Also: Case Management; Case Management Services; Community-Based Services.

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Socioeconomic Status

Socioeconomic status (SES) refers to individuals' socially constructed social class based on their income levels and occupational prestige. Associated are cultural characteristics and norms. Classes range from the affluent of privileged status to those in poverty and of marginalized status. Individuals who experience discrimination based on their socioeconomic status are considered victims of classism. Access to resources is typically correlated with SES. This entry describes the various classes, their characteristics, the consequences of classism, and applicable resources.

Levels of Socioeconomic Status

While much debate exists on the accurate measurement of SES, it is most commonly established based on variables including one's income, assets, education, and social class. Environmental influences, such as natural disasters, government recessions, illnesses, inheritances, and investments, can impact one's social and economic status. Likewise, SES can change from one generation to the next within families. One's socioeconomic status can play a significant role in cognitive and physical development, health and well-being, and overall functioning. SES is commonly broken down into five levels, from poorest to wealthiest: lower class, working class, lower-middle class, upper-middle class, and upper class.

Based on data from the U.S. Census Bureau, in 2012, approximately 15 percent of the American population lived below the poverty line, which was established to be $23,050 per year for a family of four. These individuals are classified as part of the lower or poverty class. Innumerable stressors are associated with this class, including inadequate access to quality health care and education, unsafe living conditions, poor nutrition, and significant discrimination. The majority of individuals living in poverty today are African American female-headed households. An examination of social and institutional variables contributing to the experience of those who identify as part of this class is necessary to adequately address their needs.

Approximately 32 percent of the American population would be considered part of the working class, in which individuals typically have lower levels of education, hold blue-collar jobs, and have less job security. Their average annual income does not typically exceed $30,000. Those of lower-middle class status make up approximately another 32 percent of the population and tend to be college graduates with semiprofessional jobs. Their income tends to average $55,000 annually. The upper-middle class accounts for approximately 15 percent of the population. These individuals commonly hold graduate degrees with professional, white-collar positions. Many make more than $100,000 per year.

Construction workers on a job site. The working class makes up about 32 percent of the American population and includes individuals who hold blue-collar jobs like working construction.

The upper class consists of those who make more than $150,000 per year (about 5 percent) and those who make more than $250,000 per year (1 percent). Individuals in this group tend to be heirs, top executives, and celebrities. They tend to wield the greatest amount of power in decision making for American society. Considering the percentages of the American population that fall into each SES level, it is clear that there is a markedly wide gap in wealth, with its distribution being greatly contained by the uppermost 20 percent of the nation. It is estimated that the top 1 percent of households account for 35 percent of the nation's wealth, while the next 19 percent account for 55 percent. Thus, the remaining 80 percent of individuals living in the United States share the residual 10 percent.

Other socioeconomic classifications include generational poverty, situational poverty, risen-from-poverty middle class, illusory middle class, and the owning rich versus ruling rich. For those experiencing generational poverty, the cycle of poverty is passed through several generations, creating a culture of impoverishment. This cycle tends to be very challenging to break and includes variables that are both individual and systemic.

Individuals of situational poverty have typically either experienced a crisis (divorce) or a major transition (returning to school) that results in temporary income decreases. While experiencing this drop in SES, individuals may struggle to accept the culture of their new status and maintain the beliefs and behaviors of the status from which they dropped. For example, one may be embarrassed to seek assistance from a free county health clinic despite having no insurance. Situational poverty is typically reversible with most returning to their former, higher SES once they have resolved the circumstances resulting in their drop in status.

The risen-from-poverty middle class have obtained resources allowing them the benefits of middle-class financial stability, yet they commonly remain closely tied to the culture of the lower class. These individuals often provide financial support to family and friends of the lower class. They may also continue to engage in many customs associated with the lower class such as shopping at thrift stores for clothing despite having the resources to shop elsewhere.

Individuals of the illusory middle class attempt to represent themselves as financially stable through the ownership of material items and participation in costly activities. Yet these individuals are often heavily burdened with debt. Multiple credit cards are commonly at their maximum. Bills may be shuffled so that the ones that must be paid every month do not go delinquent, while those with fewer consequences for skipping payments are postponed. Much stress can be associated with maintaining the illusion of middle class social status when one's income is, in reality, that of a lower economic status.

The difference between the owning rich and ruling rich is primarily based on power. The owning rich have typically inherited resources that make working unnecessary, while the ruling rich typically hold positions of influence that impact political and social decisions. The owning rich are often referred to as old money. The ruling rich may include those considered community leaders due to owning successful businesses, public servants who have gained respect by constituents through professional and political endeavors, and corporate moguls who impact the American economy through their business endeavors.

It is also important to note that SES may supercede other cultural identities. Those who are similar racially, culturally, and ethnically may hold drastically different SESs that make their experiences dissimilar. For example, an African American adolescent who is impoverished and attending a Title 1 school in an urban environment would likely have very little in common with a wealthy African American adolescent living in a well-to-do suburban neighborhood and attending private school.

Classist Myths and Their Consequences

Attitudes and beliefs about those in other classes, called classism, exist within and between each socioeconomic level. Classism exists as a means for those within a given socioeconomic status to justify their way of being. However, classism often impacts one's self-identity development as well. Four defined levels of classism include downward, upward, lateral, and internalized.

Downward classism occurs when those of a higher SES judge and discriminate against those in lower SES levels. This type of classism is by far the most common and most hurtful. Examples include the belief that the poor are poor by choice due to laziness, lack of effort in school, poor work effort, desire to live off of government subsidies, or stupidity to name a few. As a result, those engaging in downward classism are far less likely to support policies and initiatives to assist those of low SES and to fight against inequities. The consequences of these beliefs can be harmful, resulting in a lack of focus on the systemic and institutional barriers that perpetuate poverty, such as inequitable access to quality education and health care.

Upward classism can also occur. In this case, those of lower SES prejudge and make assumptions about the wealthy. Some of these assumptions may include viewing the wealthy as having easy lives with few troubles or concerns, having rewarding and posh careers, being born with a silver spoon in one's mouth where financial concerns are of no consequence, having the resources to solve all of life's problems, and being snobbish. Often overlooked is the amount of time required to maintain this lifestyle, the psychological and personal sacrifices to uphold this status, the awareness of others questioning one's motives, and the ongoing effort required to maintain this status for multiple generations. As a result, some identifying in this SES engage in efforts to disguise their wealth. They may experience physical health problems as a result of the efforts put into maintaining their wealth. Research also indicates that the wealthy abuse substances at a higher rate than those in lower SES levels. Self-medication appears to be a common coping strategy for those maintaining their wealthy, privileged status.

Lateral classism occurs between those of the same socioeconomic level. It consists of pressure exerted by individuals onto others of the same class to maintain the culture, beliefs, behaviors, and financial status associated with the class. If an individual moves out of a socioeconomic class, either to a lower one or a higher one, he or she is likely to experience a great deal of criticism and judgment from individuals associated with the class that was left. Lateral classism can result in individuals choosing to avoid opportunities that may promote one's status, such as opting not to go to college despite having the grades to get admitted or to take on additional stressors, such as a second or third job, as a means to avoid falling from one's status. The phrase "keeping up with the Joneses" captures the essence of lateral classism.

Those experiencing internalized classism castigate themselves for failing to maintain their socioeconomic culture. This classism is associated with personal feelings of anxiety, depression, anger, frustration, or inadequacy. Internalized classism is not aimed at others but rather is concerned with self-reprimand as a result of experiences with upward, downward, or lateral classism. For example, if an individual is pressured by others in his or her socioeconomic class to purchase the latest commodities owned by his or her peers and then is criticized for not having the means to make those purchases (lateral classism), the individual may experience personal frustration, disappointment, and self-recrimination for failing to conform to the social and financial demands of his or her class (internalized classism).

Human Services Resources

Human services professionals can play a vital role in assisting clients regarding factors related to SES. To be most effective, it is essential for helpers to first challenge personal misperceptions of social class. One must consider classist views inherited from experiences in one's own socioeconomic level and work to develop understanding, empathy, and acceptance of those in other classes. An effective helper will understand that a client of a different SES level may lack trust and require effort to establish rapport and understanding. Through genuine acceptance of those from different social classes, it becomes possible to empower clients to accept themselves and work toward positive growth.

Likewise, helpers must become knowledgeable of the common beliefs, behaviors, and experiences shared by those in each SES level. Helpers must consider the intersecting variables impacting clients' experiences. Challenging personal perspectives and gaining awareness of the cultures of the classes can be accomplished through reading reputable resources on the topic, immersing oneself in the cultures of other classes, consulting with cultural informants from each class, and receiving training specifically related to the topic of SES.

A self-aware and knowledgeable human services professional can be an invaluable resource for clients with concerns related to socioeconomic status and other intersecting sociodemographic factors. For example, awareness that stress can be experienced by individuals at all SES levels can be translated into physical, emotional, and behavioral coping strategies that assist clients in addressing their negative intrapsychic processes as well as their potentially unhealthy and counterproductive practices aimed at maintaining or improving upon one's SES level. Teaching stress management techniques to be implemented by individual clients, engaging in dialogue to challenge internalized classism, and serving as a life coach to assist clients in adjusting their economic practices may all contribute to decreasing SES-related stress.

Teaching information and skills are also essential for work with clients around issues related to SES. Clients can be taught information about the culture of his or her social class and classism, educational resources, healthy living, and available support services. Helpful skills to teach may include job search strategies, interviewing techniques, banking, study skills, and job maintenance practices.

While working with clients of varying SESs, it is also important to refrain from making assumptions about clients with regard to SES. For example, a human services professional would be engaging in downward classism by assuming that all clients wish to pursue a college degree as a means to climb the social ladder. Rather, it is important to assess a client's work goals and encourage that which the client desires, even if the goal is toward a less-prestigious and more blue-collar endeavor. Likewise, a helper could engage in lateral classism by assuming a working-class client is only qualified for blue-collar jobs. Again, it is important for the helper to explore with the client his or her professional goals and assist in removing barriers to accomplishing those goals.

Advocacy is another essential skill for the human services professional that cuts across all levels of SESs. It is most essential to intervene with social systems that create barriers to the marginalized lower or poverty class by promoting the removal of systemic barriers to opportunities, imparting knowledge of the impact of downward and lateral classism, and teaching the marginalized how to become empowered change agents themselves. However, advocacy by human services professionals with regard to refuting classism can occur at any level.

SES is a construct greatly constructed and maintained by the people in a given society. In the United States, the wealth distribution is greatly skewed, with 20 percent of the population holding 90 percent of the nation's wealth and 80 percent of the population holding the remaining 10 percent of wealth. Many differences exist between the various levels of SES. These cultural variations have implications for human services practice. Finally, understanding the impact of classism at each level is essential for addressing issues and concerns accurately.

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See Also: Economic Support and Services; Poverty; Yuppies and Buppies.

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Sociology of Disability

People with disabilities constitute the largest minority group in the United States. As a natural course of the human condition, nearly everyone will be temporarily or permanently impaired at some point in life. The sociology of disability is a focus on the study of disability to illuminate sociological issues (e.g., the role of people with disabilities in society, the relationship between medical and human services providers and those utilizing services, and disabling and enabling frameworks within societal organizations). It is an analysis of disability within the context of its connection to social structures and social interaction.

Historically, sociology has relegated disability to the margins. In recent years, medical sociology or the sociology of health and illness have gained much attention in the discipline. Yet within most standard sociology textbooks, disability has remained relegated to chapters on deviance and limited to Erving Goffman's classic work on spoiled identities; to references of the Americans With Disability Act; or less commonly, to mention of Michel Foucault's work on governing disability. However, a rapidly expanding multidisciplinary arena, disability studies, has served to inform and transform contemporary thinking on disability. As a counterbalance to the medicalization of disability, disability studies reveal the sociopolitical representations of disability, challenging foundational assumptions of normalcy, functionality, attractiveness, wellness, and perfection. Disability studies have been characterized as emerging from the lived experience of persons with disabilities as activists and academics with disabilities have produced much of its body of knowledge.

Citizenship and Ableism

Within the human species, there is a vast diversity of behavior, appearance, functioning, sensory acuity, and cognitive processing. Throughout different eras and locales, societal response to this variation has oscillated between the extermination of those perceived as defective to the provision of paternalistic charity to those viewed as subjects of pity. Eradication attempts have ranged from compulsory sterilization, abortions, and infanticide to eugenics-inspired executions and euthanasia. Segregation attempts include but are not limited to tuberculosis sanitariums, ugly laws and ordinances, the institutionalization movement, nursing homes and group living quarters, sheltered workshops, and "special" education and transit. The pity responses have spurred "affliction"-specific charitable industries, national telethons, research institutes seeking "cures," and a vast network of fragmented, state-sponsored welfare programs. All these responses and some, particularly in recent years, well intentioned have been shaped by ableist influences or the unexamined presumption that impairment or disability is inherently negative.

Ableism is a type of discrimination, like sexism or racism, which results from a fear of, or aversion to, variation in the human body. Fiona Kumari Campbell further clarifies that ableism is beyond a system of oppression where a specific enemy can be identified and extracted. She defines ableism as a network that produces an exclusionary matrix whereby authorities in the governance of disability may change, but other formations such as the use of regimes of law and medicine remain. It is these regimes of laws and policies that effectively build a disabling socially, economically, and physically constructed environment around people with disabilities.

The disability rights movement brought attention to and sought to combat ableist social structures with the demand for the basic rights of all citizens. These demands strove for integration instead of segregation, education and employment opportunities rather than charity, and opportunities for independence rather than dependence. However, the landmark Civil Rights Act of 1964 that afforded civil rights protections to racial and ethnic minorities and women intentionally excluded people with disabilities. Subsequent efforts to gain the inclusion of people with disabilities into the Civil Rights Act were rejected. It was not until nearly a decade later that the disability right movement would begin achieving civil rights at the national level under a series of separate pieces of legislation that culminated in the 1990 American With Disabilities Act.

Disabled Population

Most disabilities are acquired during the human life course and in old age, with a relatively smaller number being present at birth. Advances in modern medicine have increased rather than decreased the number of people with disabilities by extending life expectancies.

There is no single definition of disability. There are innumerable laws, policies, programs, and surveys designed to protect, serve, and count people with disabilities. All of these utilize different, and sometimes multiple, definitions, interpretations, and categorizations to determine disability status. Nevertheless, the U.S. Census estimates the number of people with disabilities to be more than 57 million, or 19 percent of the civilian, noninstitutionalized population. This would increase with the inclusion of people residing in institutional settings such as prisons, nursing homes, and psychiatric institutions. People with disabilities are generally considered the largest minority group in the United States.

The most common cause of disability in the United States is categorized within the physical domains (80.6 percent), which is predominately ambulatory difficulties and is followed by the mental domains (32.6 percent), which includes cognitive and emotional difficulties. The communicative domain constitutes 30.5 percent of all disabilities and includes seeing, hearing, and speech limitations. More than one-third (38.5 percent) of people with disabilities affiliate with more than one domain. According to the Centers for Disease Control, the most common single cause for disability is musculosketal disorders—for example, arthritis and back or spine problems—which are followed by heart disease.

Disability is a primary cause and consequence of income poverty. Working-age people with disabilities have lower levels of education attainment and employment than do people without disabilities. The Center for Economic and Policy Research reports that approximately 50 percent of working-age adults experiencing income poverty have a disability, and two-thirds of those experiencing long-term income poverty report having a disability. Individuals with disabilities represent the largest group of those experiencing income poverty, larger than that of any single minority or ethnic group or all minority ethnic and racial groups in combination.

Conclusion

To be disabled is to have experiences of being excluded and of being confronted on a daily basis by physical, environmental, legal, cultural, and attitudinal barriers that limit opportunities for human experience. Disability status is dependent not only upon the construction of buildings and transit in any given community but also on the standards and methods utilized to assess and (de)value human bodies. In an era of greater acceptance of differences in race, gender ethnicity, and sexual orientation, new reproductive technologies, the human genome project, and selective abortions provide an indication that this tolerance does not extend to disabled bodies.

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See Also: Americans with Disabilities Act; Americans with Disabilities Act of 1990; Convention on the Rights of Persons with Disabilities, United Nations; Disabilities, International Variation in Attitudes Toward; Disability Services; Disability Studies; Disabled Clients.

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South American Immigrants

Hispanics comprise the largest ethnic minority in the United States, with 53 million or 17 percent of the total population according to the 2010 U.S. Census. Projections of the U.S. Census Bureau indicate that, by the year 2060, approximately 128 million Hispanics will reside in the United States and will make up 31 percent of the population. The National Institutes of Health defines Hispanics as individuals from Mexico, Puerto Rico, Cuba, South or Central America, and members of a Spanish culture or origin, regardless of race. Hispanics in the United States, nonetheless, are usually perceived as a monolithic group and considered to have homogenous characteristics. In addition, when speaking of Hispanics in the United States, a great deal of attention is placed mostly on individuals of Puerto Rican, Cuban, or Mexican ancestry. Human services professionals are recognizing that an increasing number of Latin American immigrants are coming from South American countries including Colombia, Peru, and Ecuador. Identifying and understanding the needs of South Americans in the United States may help human services professionals develop policies and offer programs that can meaningfully impact that population.

South America

South America is the world's fourth-largest continent in terms of area and fifth in terms of population, which has been estimated to be in excess of 371 million. It is comprised of 12 independent countries. Of those, nine countries showed increased representation in the United States as reported by the 2010 U.S. Census Bureau: Argentina, Bolivia, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela. The three largest groups of South Americans in the United States include Columbians, with 1,039,923 people living in the United States, followed by Ecuadorians (662,663) and Peruvians (594,418). Although considered a fast-growing group of immigrants, South Americans encompass less than 7 percent of the total immigrant population in the United States.

South Americans come from a multifarious cultural, ethnic, racial, and linguistic background. European colonization and immigration, combined with indigenous people of the continent and the influx of Africans and Asians who immigrated or were brought to South America for economic purposes, contribute to the group's vast racial and ethnic diversity. South Americans who immigrate to the United States can be of African, Chinese, English, German, Italian, Japanese, or Jewish cultural backgrounds to name a few. This blending of cultures in the South American continent has generated a unique ethos that highlights the complexity of its cultural composition. In addition to cultural diversity, South Americans have diverse political ideologies that influence the regions' political and economic programs. South Americans who emigrate from Bolivia, Ecuador, Nicaragua, or Venezuela, countries heavily influenced by socialism, may have different understandings and expectations of governmental and social services agencies.

The literature indicates that, when arriving in the United States, South Americans have a variety of human services needs, especially health coverage, employment and education, transportation, and immigration and legal counsel.

Health Coverage

Many South American immigrants in the United States face challenges related to health care coverage. Although private health insurance coverage has increased significantly in South America—more than half of the population in Uruguay and Colombia and more than 25 percent of the population in Chile and Brazil, for example, are covered through private health insurance—in many of the countries, the public sector still finances health insurance for the poor, elderly, and unemployed. Upon arrival, South American immigrants of low-income backgrounds may lack appropriate health coverage and may find it difficult to navigate the health insurance complexities in the United States. Another concern for this population is absent or insufficient health insurance coverage for their children. In South America, health disparities abound in terms of health coverage for children and adolescents, a trend that may continue as immigrants relocate. This may have implications for public health as children may lack immunizations, may be more prone to contract or carry communicable diseases, and may face more hospitalizations due to poor medical care or disease management.

Employment and Education

Educational level usually determines the types of employment that people seek. In the United States, South American immigrants are found at different levels in the job market. Argentinians and Venezuelans have been identified as having a high percentage of employees in high analytical positions such as those in the science, technology, engineering, and math fields. However, a great number of South American immigrants in the United States are employed in manual labor or routine jobs due to low educational attainment. Employment status influences immigrants' ability to change their economic status in the future. The progression of upward mobility within this group is enhanced through opportunities that increase literacy skills and educational attainment for immigrant workers and their children. Concerted cultivation efforts for the children, as well as an increased number of programs that promote intergenerational mobility, may be necessary to ensure that immigrants have the opportunity to advance from manual or routine jobs to higher-paying positions requiring more complex thinking and decision making.

Transportation

South American immigrants and other ethnic minorities of low economic background heavily depend on public transportation for mobility. In the suburbs and rural areas, where public transportation is lacking due to a greater dependence on automobiles, it is more difficult for immigrants to get around. Low-income South Americans with limited access to transportation services also have limited housing and employment opportunities. In addition, undocumented immigrants are limited by immigration laws that preclude them from obtaining a driver's license. Limited transportation options in many U.S. cities restrict the ability of South American immigrants to find and retain a job, access healthy foods, seek medical care and treatment, or participate in social and community events.

Immigration Services

Improving the economic outlook of their nuclear or extended families continues to be one of the main reasons South Americans immigrate to the United States. Occasionally, political instabilities or wars, as well as drug wars stemming from coca production in Bolivia, Colombia, and Peru, are additional reasons for pursuing immigration. The majority of immigrants from South America arrive in the United States legally holding immigrant visas. However, nonimmigrant visas are also granted to students or travelers planning to return to South America once they have completed their courses or travel. Those with immigrant visas expecting to stay in the United States, however, may require assistance navigating the U.S. immigration and naturalization process. Both legal and unauthorized immigrants may seek advice on how to become temporary legal residents, permanent legal residents, or naturalized citizens. Complex factors, involving family-sponsored and employment-based preferences, as well as the region and country of birth, may influence the outcome.

Legal Counsel

English-language proficiency for South American immigrants varies by country. Although, in general, South Americans in the United States claim good or adequate levels of English-language proficiency, language barriers may be an issue for immigrants arriving from Bolivia, Ecuador, and Paraguay, where the poverty level is high and education level is low. Limited English proficiency becomes an issue for low-income immigrants from South America experiencing discrimination, sexual harassment, or civil rights violations, for example. For these individuals, the need for advocates as well as legal counseling and legal representation is critical.

South Americans represent a small percentage of the total Hispanic immigrant population in the United States; however, the number of immigrants from South America has increased significantly within the past decade. Their varied cultural, ethnic, linguistic, political, and economic backgrounds greatly influence their immigrant experience. When considering their human services needs, South Americans should not be considered as a monolithic group. Instead, careful consideration must be given to the populations' heterogeneity and unique profile.

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See Also: Behavior Support and Management; Caribbean Immigrants; Hispanic Americans; Uninsured Clients; U.S. Immigration and Customs Enforcement.

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Southern Communities and Cultural Competence

What is cultural competence? Being competent regarding culture would seem the natural response. Suffice it to say that there are too few hours in a day for a person to become competent in every culture and every aspect of culture in the United States. Ethnicity is probably what most people think of when they think about culture. Then there is the culture of gender, age, orientation, religion, and so on. There is also the culture of geography. The culture for a white, straight, 30-year-old Methodist female living in Oklahoma (a southern state in the United States) is quite different from a white, straight, 30-year-old Methodist female living in Iran. It is simply the nature of culture and the culture of geography. Humans are puzzles made up uniquely of their cultural puzzle pieces.

The U.S. Census Bureau defines the southern states as Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, North Carolina, South Carolina, Virginia, West Virginia, Tennessee, Kentucky, Maryland, and Delaware. Close to 117 million people live in these states. Five of these states are a part of the original 13 colonies.

Oneself

When speaking of southern cultural competency, professionals must factor in their own cultures, subcultures, frames of reference, and geography. This includes being aware of one's own values, beliefs, and cultural biases. Our human services provider puzzle is made up of the cultural pieces that, if not understood, evaluated, reevaluated, and honed, keep us from providing unbiased, well-informed help.

Demographics

The demographics of the United States are going through a constant transformation. There are more than 1 million people added to the U.S. population every year. This constant change necessitates the understanding of diversity as a fluctuating part of human interaction. Cultural competence is all the more important in the human services industry. It is predicted that, by 2050, one-fourth of the country will be Hispanic and one-tenth Asian. There is no exception for southern communities. Trinity High School in the southern town of Euless, Texas, with a student population of less than 2,500, flies the flags of the 52 nations represented by the student population.

Southern United States culture may be thought of as a place where life happens at a little slower, more-relaxed pace, and loyalty runs deep. Many picture it as the conservative antebellum south full of southern cooking, music, and southern hospitality. Culture competency in the south varies like cultural competency elsewhere in the United States. Just as planet Earth is becoming a global village, so are southern communities.

Divorce rates are somewhat high for the southern states. The national divorce rate is around 9.2 per 1,000 for men and 9.7 per 1,000 for women in the United States, with the south having 10.2 per 1,000 for men and 11.1 per 1,000 for women.

Southern states continue to fall behind in educational advancement as well. Cultural competence is affected by poverty. The southern states have some of the uppermost levels of poverty in the United States. Of the states with the lowest median income, nine out of 10 of them are southern states, with Mississippi having the greatest level of poverty in the United States. With a lack of education and being impoverished generally comes poor health and health care. Accordingly, cases of human immunodeficiency virus (HIV) are higher in the southern United Sates. One-half of newly reported cases of HIV are in the south and nearly half of newly reported acquired immune deficiency syndrome (AIDS) diagnoses are in the southern states. This is surprising because the southern states only make up about 37 percent of the U.S. population.

A woman dressed as a traditional southern belle. A common view of the southern United States is the conservative antebellum south full of southern cooking, music, and hospitality.

Becoming Culturally Sensitive

In order to be culturally sensitive, services need to be attuned and responsive to each person's background and culture. Beyond English and Spanish, the south now includes Farsi, Tongan, Arabic, and so forth. Culture, as with language, comes with many dialects and variations. A person's ethnicity is the part of the iceberg you can see—the minutia that truly makes a person is below the waterline and includes experiences that are unique to him or her, traditions, customs, values, beliefs, and so on. Cultural competence in face-to-face interactions, especially in the human services industries, provides understanding, thereby allowing cultures to meet and work together respectfully while learning and understating their cultural differences and norms. The Internet has extended our boundaries to include every continent being able to communicate instantly with each other. Intercultural communication skills are no longer simply criteria for those doing business in the international market. It is a criterion for life and business in our global community today. We are truly helpers without borders.

Upward and Downward Social and Cultural Comparisons

Within the groups of culture come the subgroups of upward and downward social and cultural comparisons. These are cultures of self-evaluation. Is the south considered a downward social and cultural comparison for those living in the north? Is the south used as a comparison group, so others can feel they are more competent culturally? Cultures have a tendency to do this within themselves. Movie stars compare themselves to television stars, and they feel better about themselves. Television stars compare themselves to theater stars for much the same reason. Social workers, counselors, and psychologists fall into the category as well. Upward social comparison works just the opposite. Television stars, while successful, compare themselves to movie stars and feel worse about their success. Therefore, it appears that some cultural competence falls within the self and one's self-evaluation.

Has Anyone Ever Heard the Term *Northern Cultural Competence*?

To impact a global community and marketplace, it is important to be cross-culturally competent. Knowing the market and the culture of the market is much like knowing the culture of the people being helped by human services. Without a rudimentary understanding of the culture, subculture, and frame of reference of those being helped, the help may not be helpful at all.

Age

Of the 117 million people in the southern states, more than 22 million are age 60 and older. More than 44 percent of these are male, and more than 55 percent are female. There is the culture of age, which is not the most talked about in cultural circles. People are living longer, and the retirement age is increasing. In America, critical events determine what that generation will be called. The older population, those that grew up after World War II and Vietnam, are the baby boomers. The rise of technology brought us Generation X and 9/11 the Millennials. Time defines a person's culture almost as much as any other factor. For some cultures, age is to be revered. For others, there is prejudice against the aging process itself. America is only 237 years old itself.

Ethics

Ethics are rules for governing behavior based on individual ideas about what is morally right and wrong. Ethics and religion play a part in one's ethical culture. Southern states show to be statistically more conservative. The southern states are often referred to as the Bible Belt. Some reports have indicated that even as much as 80 percent of the population of the southern states identify themselves as Christian. As mental health professionals, regardless of affiliation, it is important to seek to embrace cultural diversity and the dynamics of differences.

Understanding that the giving of gifts to those providing services is an act of respect for some cultures but flies in the face of some codes of ethics. Realizing that not accepting the token would be very disrespectful and harmful to the relationship has the helping industry conceding that small concessions can be made. Strict rules of confidentiality for providers are normally individualistic in nature, but understanding collectivistic cultures helps providers realize boundaries are different depending upon the culture.

Technology

Southern providers of human services are now able via technology—FaceTime, live Webinars, video conferencing, and so on—to interact and engage globally in the exchange of knowledge and assistance. Being able to bridge the cultural divide and reach out with expertise and lend a global presence takes the boundaries off of humanitarian work. Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia are all part of the Southern Regional Education Board. Standards for establishing competency in technology have been instituted by all. This includes providing instructors available means to be technologically competent and ensuring that technological progress is made to ensure competency for students. This competency is important for education.

Immersion

As the genre of human services has to reach out to communities of cultural newness, they grow as the immersion becomes a practiced and everyday habit. Immersion is one of the best ways to learn and understand the culture of those being treated or offered services. Taking the time to interact and read culturally diverse literature allows one to absorb and understand the needs and effective interaction necessary to be culturally competent. But nothing quite compares with immersion.

Cultural Competence

Understanding and experiencing different worldviews in the spirit of status equality and cooperation allows growth and understanding for working together and assisting one another. This kind of collaboration allows stereotypes to be dispelled. Each culture has the knowledge of its own needs. By allowing their honest input regarding beliefs, we can gain firsthand knowledge of other cultures beyond what textbooks and research journals can provide. Immigrants who come from war-torn countries bring with them a culture of their own. The culture of being constantly influenced by fighting and death bring with it posttraumatic stress disorder (PTSD) or having lost a healthy sense of fear. Some fear everything, and some fear nothing from having grown accustomed to danger.

We must remember our history, or we are destined to repeat it. However, we do not have to be handcuffed to it. One must bear in mind that, if the discriminated against become the discriminators, no progress is being made—it is just merely a changing of geography.

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See Also: Cultural Competence, Models of; Cross-Cultural Knowledge; Cultural Competence, Human Service Providers and; Cultural Competence, Professional Standards of; Regional Cultural Competence.

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Special Education

Special education is a field within education dedicated to the treatment and educational progress of students with disabilities. Prior to the mid-1970s, there was no federal mandate in the United States that required students with disabilities to attend school or even requiring schools to teach students with disabilities. Children with disabilities did not have the same access to public education as their nonhandicapped peers. Beginning in 1975 with the Education for All Handicapped Children Act (Public Law 94-142), each state within the United States was mandated to provide children with disabilities with a free, appropriate public education beginning at the age of 5. In 1986, this law was amended by Public Law 99-457 and extended the age of children who were eligible for special education services in public education down to 3 years old. Public Law 101-476 amended this law again in 1990 that renamed it as the Individuals with Disabilities Education Act (IDEA). Reauthorization of this act occurred in Congress through Public Law 105-17 in 1997. Finally, the most recent reauthorization of IDEA, now known as the Individuals with Disabilities Education Improvement Act, occurred in 2004, and recent amendments extended the ages of children with disabilities served through public education down to birth. Although the field of special education is guided by specific laws and regulations regarding its implementation, several other federal laws and court cases also guide services provided for students with disabilities. Examples of such laws include the Americans with Disabilities Act (Public Law 101-336) and Section 504 of the Rehabilitation Act of 1973.

Eligibility for Special Education

If a child is too young for school yet demonstrates major delays in attainment of developmental milestones necessary for educational success, the child can undergo an evaluation for special education services before formally entering school. Because early identification and treatment for disabilities can lessen the severity of the disability, IDEA requires that states have specific procedures to locate, evaluate, and identify young children who may be in need of special education services. Typically, the school district in which the child resides must ensure that steps are taken to find and treat these children prior to them entering kindergarten.

Beginning with the reauthorization of IDEA in 1990, and mandated in the current revision, schools are now required to demonstrate that a student is unable to make successful gains in the curriculum with extra interventions in the regular education classroom before referring for a special education evaluation. Typically, the regular education teacher identifies a student who is struggling in the classroom and refers this student to a teacher assistance team. This pre-referral team is made up of other classroom teachers, special education teachers, school counselors, and others who consult with the regular education teacher and parents to provide strategies and interventions to assist the targeted student to improve his or her functioning in the regular classroom. The referring teacher maintains data on the progress of this student for a period of time and returns to the teacher assistance team to determine whether or not a referral for a special education evaluation is necessary.

The question of eligibility for special education services is determined by ascertaining if the student should be diagnosed with a disability and assessing its impact on the educational process in the curriculum. In other words, the student must have a disability that impedes his or her growth in the educational process. If a student does have a disability, but it does not adversely affect the education attainment in the school, then the student does not qualify for special education or any related services. However, this particular student may qualify for other services under Section 504 of the Rehabilitation Act of 1973. Also, a student who does not have a disability but needs special education services does not qualify for special education or related services.

Evaluation and Identification for Special Education

To qualify for special education, a student must have a disability and must have educational needs that cannot be met in the regular education classroom. The types of disabilities identified in IDEA that could qualify a student for special education include developmental delay, autism, intellectual disability (formerly known as mental retardation), specific learning disability, emotional disturbance, traumatic brain injury, speech or language impairment, visual impairment, deafness and hearing impairment, orthopedic impairments, other health impairments, deaf-blindness, and multiple disabilities. To ensure the child is correctly identified for special education, a team of educators and specialists as well as the child's parents or guardians meet to assess the challenges and needs the student has in the school setting. This team is known as the multidisciplinary team. This team determines whether or not the child meets the criteria identified in IDEA as a student with a disability in need of special education. To make such decisions, the team must utilize information from many different assessment procedures including but not limited to functional and developmental evidence; input from the parents or guardians; input from teachers; achievement, intelligence, or personality testing; social and cultural background; adaptive behavior; and visual and hearing conditions. In addition, the team must rule out conditions that may exclude a student from having a disability and needing special education services such as limited exposure to the curriculum, lack of English proficiency, and any other evidence that demonstrates that the child does not meet the disability criteria.

Placement in Special Education

Once students have been determined to have a disability that affects their educational progress in the curriculum, they are placed in special education and are entitled to various procedural safeguards, special services, as well as altered expectations for educational attainment. As part of the identification process, each child with a disability who is identified as needing special education must obtain an individualized education plan (IEP). This plan is developed by the child's parents or guardians and the team of educators and specialists who provide the services necessary for the child's educational success. Each IEP contains goals and objectives specific to the child as well as the programs, services, and interventions required to meet his or her unique educational needs. IDEA also requires that students in special education be educated as much as possible with their nondisabled peers; in other words, the student in special education must be educated in the least-restrictive environment to still maintain progress toward their IEP goals and objectives. Therefore, many students with disabilities and receiving special education must be placed in settings that allow them as much interaction as possible with their nondisabled peers.

Diversity in Special Education

Diversity in education is a subject that has been discussed and researched in great detail. Children from culturally and linguistically diverse backgrounds comprise a large percentage of public school students. Diversity is increasing, and one of the most troublesome issues associated with its growth is the overrepresentation of minority children in special education; that is, more minority children are served in special education than would be expected based on their percentage in the general school population. In the 1960s, during the peak of the civil rights movement, the problem of disproportionality of minority students in special education first received national attention. Since that time, researchers have studied the issue in a way to understand and explain how the processes used to identify, assess, and place students in special education programs may contribute to the overrepresentation of minority students. Researchers continue to look at family involvement in the school and its operation as a major factor in improving student achievement. However, researchers also show that, for successful collaborations to occur, school personnel must respect the cultural background of the families they serve.

Many classrooms across the United States have witnessed an increase in racial, ethnic, and cultural diversity. These classrooms also are receiving increased numbers of children with disabilities or developmental delays. This diversity of children in classrooms provides many challenges as well as many opportunities to educators. With knowledge of effective practices, and with the support of administrators, teachers, families, and local communities, teachers can create classrooms that are adaptable to the diverse needs of all children. Diversity in special education has shown that there is great disparity in the representation of minorities.

Much discrepancy exists concerning the topic of race and ethnicity in special education. Research has shown that more than five times of the Caucasian students receiving special education services have graduated with a high school diploma compared to their African American peers. Studies have shown that African American students are four times more likely than Caucasian students to be in special education. The overrepresentation of African American students has often been explained as a symptom of poverty. Studies have even shown that, among African American and Caucasian students whose parents have a high income and education level, the African American students were more likely to be in special education classes. Studies have found that grossly disproportionate numbers of minority students are identified as eligible for special education services. Moreover, when compared to their white counterparts, African American children were almost three times more likely to be labeled intellectually disabled. The disproportionate number of African Americans in special education derives not only from a problem in special education but a problem with culturally competent educational and evaluation procedures.

The existence of inequality within special education has been widely acknowledged and continues to be an issue in special education. Gender disparity refers to statistical differences in the statuses and opportunities between male and female students in the special education classroom. Research has indicated that a teacher is less likely to refer a female child in need of special education for fear that she will suffer emotionally due to isolation from her peers. As a result, the average ratio of male-to-female students receiving special education services across the United States is two to one.

Human Services in Special Education

A wide variety of services are available to individuals served through the special education process. Depending on the type of disability and the educational needs of the individual, many different specialties may be included in the education of the individual with special education needs.

In addition to teachers with specialties in special education, various professionals also work with these individuals including, but not limited to, physical therapists, occupational therapists, speech and language therapists, and various mental health providers. Physical therapists may be necessary for gross motor needs and evaluation such as walking, sitting, standing, and running. Occupational therapists are necessary for helping the individual with skills associated with daily living and fine motor functioning such as brushing teeth, buttoning a shirt, or handwriting. Speech and language therapists work with students' abilities to articulate their words and understand what is being said to them as well as a wide variety of verbal and written language skills. Mental health providers, such as counselors, social workers, and psychologists, work with individuals in special education concerning social and emotional skills, relationship building, vocational placement, and family functioning. Although all these various therapeutic services are found within the school system, many families and individuals choose to seek out these services in the private sector to augment what is being learned in school. The goal for each of these human service providers is to help the individual with special education needs function as independently as possible and provide support when necessary to help this individual succeed in his or her educational environment.

Summary

The passing of federal laws has necessitated the need for public schools to provide educational services for children with special education needs. These laws have continually been amended and updated to provide for more services for all children served in the United States. Investments in early childhood education in the past years have grown in appreciation of the importance for preparing all children, including those with special education needs, for the school environment.

Young children with developmental delays and other types of disabilities compose a subpopulation for which early interventions are especially important. Although the schools have the primary responsibility for identification, evaluation, and placement in special education programs, other providers in the field of human services are also responsible for helping the individual with special education needs reach his or her fullest potential. As such, all human services providers in all settings must have a broad knowledge of how the variety of diversity, such as age, gender, and socioeconomic status, impacts the outcomes for those individuals with special education needs.

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See Also: ADHD, Services for Individual With; Children With Special Needs; Cultural Competence, Human Service Providers and; Educational Services; Learning Disabilities, Services for Individuals With; Psychiatric/Psychological Assessment; School Psychologists.

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Spirituality/Religion and Diversity

Spirituality is indicated by an expanded sense of self-awareness that emerges through a connection with someone or something that gives life purpose. Some people consider themselves to be more spiritual than religious, while others do not operate from a spiritual worldview. Spiritual competence involves providing human services that are sensitive to a client’s spiritual worldview. Human services workers may also need to work to ensure larger social systems are spiritually supportive of minority group members. Ethical practice sometimes requires a referral to clergy or more-experienced professional.

Defining Spirituality and Religion

Spirituality can be described as the experience of enhanced life meaning, sense of purpose, and transpersonal connection. The experience of spirituality is linked to a heightened awareness of being an essential part of the world. In particular, a transpersonal connection stretches individuals to broaden their understanding of who they are or what they think about one’s place in the world. A transpersonal connection may also enable individuals to have the experience of transcending the self, which can evoke a feeling of being at one with another person or one’s surroundings.

The experience of spirituality has been associated with religion. Religion is defined as being distinct from spirituality in that religion represents a system of beliefs and practices that reflect the worship of a deity (or deities). Religious practices may be individual or communal in nature. Such practices reflect religious adherence and depth of personal religious affiliation that informs life meaning. Likewise, religious practices may provide a vehicle for a deep connection with someone or something outside of oneself, suggesting religious practices can be a vehicle for a spiritual experience. For example, hiking may add value to one's life by enabling that person to feel completely absorbed in the experience of being one with nature. This expanded sense of consciousness or spiritual awareness defines a spiritual experience. There are many other practices, both religious and nonreligious, that can enable a person to have a spiritual experience. It could be that the spiritual practice of meditating at sunrise allows a person to sustain hope in one's ability to cope with loss, while for another, such hope is sustained through the religious practice of attending a church service and praying.

Spiritual and Religious Diversity

People may have different ideas about what leads to and reflects the experience of spirituality. Religion is expected to inform life choices that can help one grow spiritually and lead to joy in an afterlife; however, religion is just one way individuals may use to experience spirituality. Some people may not identify with a religious tradition but feel spiritually connected to someone or something that makes life more meaningful. Spiritual practices may also be considered religious practices, but engagement in these practices does not necessarily mean that person is a member of a particular religious group.

Although there is significant variation, there are also trends in religious affiliation based on race and ethnicity. This can be attributed to sociopolitical influences associated with history of enslavement, migration, and colonization. Women, people with disabilities, and sexual minorities have been at further risk for marginalization in religious institutions. However, for some individuals, religious affiliation has been a significant source of spiritual strength that has enabled personal and community empowerment, and religious affiliation can have significant implications for client identity and experience of spirituality.

Generally speaking, individuals who are not affiliated with a particular religious group, including agnostics and atheists, are considered to be nonreligious. Agnostics believe a god or gods may or may not exist but require scientific proof. Atheists do not believe in the existence of a god or gods. Hence, agnostics and atheists are not likely to identify with having a spiritual worldview. To engage in spiritually sensitive practice, human services professionals must respect client beliefs and experiences of institutionalized religion. This starts with developing spiritual competence.

Spiritual Competence

Spiritual competence is indicated by a provision of human services that are sensitive to a client's spiritual worldview. This requires having a basic understanding of how religion or spirituality influence a client's development and functioning as well as self-awareness and empathy to ensure that services are supportive of what a client believes is essential for the experience of spiritual well-being. For clients who do not operate from a spiritual worldview, it may be more appropriate to address a client's experience of existential meaning that informs biopsychosocial well-being. At a root level, however, human services workers must be able to communicate an appreciation for the innate worth of their clients and help them cultivate what they think makes life meaningful.

Spiritual Needs

Based on a spiritual worldview, individuals have spiritual needs just like biological, psychological, and social needs. There may be overlap in how these needs manifest and how they influence each other. The means of getting spiritual needs met is further relative to individual circumstances and preferences. For example, clients receiving hospice care may have the spiritual need to process thoughts and emotions about pending death. Other examples of spiritual needs include the experience of God's forgiveness, hope in an afterlife, connection with others, and the experience of inner peace.

Unmet spiritual needs can lead to the experience of spiritual pain, also known as spiritual distress, crisis, or emergency. Spiritual pain involves difficulty in processing life experiences in a way that is consistent with the achievement of personal values and goals integral to life satisfaction. Similar to spiritual needs, the experience of spiritual pain can depend on the individual's circumstances and type of spiritual needs that have gone unmet. For example, a physical disability may reduce a person's spiritual need to feel valued as an able-bodied person. This can lead to spiritual pain indicated by feelings of worthlessness.

Spiritual pain may thus manifest through a change in psychosocial functioning. Spiritual pain may include feelings of meaninglessness, anguish, isolation, alienation, and emptiness. People in spiritual pain may detach from others and express confusion or hopelessness. These individuals may ask questions like these: Why is this happening to me? What is the meaning of my life? Do others value me and see me as a person of worth? Those who are religious may believe God abandoned them, begin questioning their religious beliefs, and refuse to engage in religious practices.

Spiritual Well-Being

Spiritual well-being is the product of a relationship with a higher power, deity, or other source that enhances a person's sense of wholeness. Indicators of spiritual well-being are consistent with the fulfillment of a person's spiritual needs. Spiritual well-being may include inner peace and harmony; having hope, goals, and ambitions; social life and place in community retained; feelings of uniqueness, individuality, and dignity; feeling valued; coping with and sharing emotions; ability to communicate with truth and honesty; being able to practice religion; and finding meaning in life.

All human services workers have the capacity to engage in spiritually sensitive care to promote client spiritual well-being. This can be done either directly or indirectly, depending on client needs and worker expertise. Spiritual support may be provided indirectly through the expression of unconditional positive regard, engagement in active listening, and an empathic, compassionate connection with the client. Human service workers with specialized expertise may engage in direct interventions such as spiritual assessment, spiritually oriented psychotherapy, or referral to an appropriate resource for follow-up.

Human services workers also need to be particularly sensitive to the spiritual needs of minority group members given their potential for discrimination that can threaten one's sense of dignity and personal worth. As part of being spiritually competent, human services workers must avoid operating from stereotypes that undermine client spiritual well-being and work to promote a more spiritually sensitive environment. Families, groups, organizations, and communities can all operate in a manner that promotes an individual's experience of spiritual well-being based on cultural norms that affirm mutual respect.

For example, human services workers may need to assist older adults in achieving gerotranscendence. Gerotranscendence enables one to transcend the experience of loss and devaluation in a world that favors youth. This is accomplished by finding new meaning in the process of aging that sustains or enhances one's sense of value. Older adults may transcend the aging process in different ways. One may find new meaning by cultivating deeper emotional contacts with loved ones, discovering new cognitively stimulating pursuits, and gaining self-efficacy by working through perceived limits.

Clients may engage in spiritual or religious practices to promote spiritual well-being. Examples of these practices include visiting with religious clergy, church, or community members; reading inspirational literature; prayer or meditation; listening to music; and participation in worship services or religious sacraments. If a client seeks information about spiritual or religious coping practices, the human service worker must be sensitive to the client's spiritual worldview. The need for this type of assistance, however, would likely involve a referral to clergy or experienced professional.

Ethical Guidelines

In addressing client religion and spirituality, it is important for human services workers to make accommodations to prevent boundary violations and ensure practices respect client rights. Some of these ethical issues involve respect for client confidentiality, informed consent for treatment, conflict of interest, and professional competency. These issues are largely straightforward as they are the custom in working with clients. However, it can be more difficult to identify when there is a conflict of interest relative to spiritual or religious issues. The use of prayer with clients is one such example.

In general, human services workers are not to encourage clients to adopt the human services worker's spiritual or religious beliefs or practices. Clients who solicit human services workers to engage in prayer with them should tell the client in the most respectful way that the human services worker must defer to the client to either lead the prayer or take a moment for the client to engage in a personal silent prayer. Client referral to a professional with appropriate expertise should be considered if client spiritual or religious issues demand further intervention.

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See Also: Fundamentalist Christian Americans; Office for Faith-Based and Neighborhood Partnerships, White House; Religion and Clients.

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State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) was codified as Title XXI of the Social Security Act as part of the Balanced Budget Act of 1997. This program is part of President Bill Clinton's legacy from his terms as president of the United States. SCHIP was designed to provide insurance for children whose parents or caregivers might not be able to afford health care for children in the family. These families were low income, but their income levels were above the range for the children to receive insurance through Medicaid. Consider very hardworking parents whose insurance did not cover prescription costs for children's medications. These parents might have to split a dose of medication, such as penicillin, if their children became ill and were, for example, catching colds that subsequently turned into sinus infections. The inability to afford adequate care was adversely impacting the health of many children residing in low-income families. Thus, SCHIP was designed as a joint insurance program between the federal government and the states, which provided health insurance for low-income children who might not qualify for medical assistance but whose parents might not be able to afford prescription medication or adequate medical care based on their family income level.

In the early stages of SCHIP administration, states wrote plans to enroll children, deliver health services, and provide reimbursement for children's medical care, and these plans were approved by the Health Care Financing Administration. State plans for disbursing SCHIP funding often utilized existing medical assistance funding structures. However, some states developed unique funding structures to disburse SCHIP funding through health care plans or managed care organizations. Initially, SCHIP had the potential to provide services to approximately 30 percent more children in the United States. Although initial operation of the program did not enroll the expected 30 percent, many children benefitted from the plan, which was updated in 2007. SCHIP consequently allowed for expanded medical coverage for the provision of children's health and mental health services as well as dental services and hospital care. There also was a positive impact for children from diverse ethnic groups as more children, often minorities, from low-income families began receiving needed health care.

President George Bush signed a two-year reauthorization bill into law in December 2007 that would extend existing SCHIP services without expansion of the program. Upon election in 2008, President Barack Obama signed the Children's Health Insurance Program Reauthorization Act (CHIRPA) into law through fiscal year 2013.

A pediatrician examines a child's ears. SCHIP was designed to provide insurance for children whose parents or caregivers might not be able to afford health care for children in the family.

CHIRPA reauthorized SCHIP and supplied further funding, and substantially enhanced both Medicaid and SCHIP funding for children's medical services. For example, more funding was dedicated to a national outreach campaign that involved all levels of government and the private sector. Moreover, this national outreach ensured enrollment of eligible children and used technology to simplify enrollment. Funds were available to connect schools to outreach efforts in order to ensure that eligible children were enrolled. In addition, CHIRPA provided new federal funding for outreach to children who were eligible for Medicaid or SCHIP but were not enrolled, which included $100 million in funding.

The Affordable Care Act of 2010 continues the SCHIP eligibility standards through 2019 and provides additional pathways for coverage for millions of uninsured children and their families. Moreover, the Affordable Care Act provides an additional $40 million in federal funding to continue efforts in promoting enrollment and broadening the reach of health care to uninsured children through programs like Medicaid and SCHIP. Evidence gathered on low-income children enrolled in Medicaid and SCHIP suggested that the benefits of these programs include increased access to needed care and insurance coverage to provide health care to children irrespective of family income level. This expanded coverage is related to better health outcomes for children of color and from low-income families. Medicaid and SCHIP offer the possibility to increase the number of children with health insurance and to expand care for millions of low-income children.

SCHIP has had a substantial impact on children's health care coverage. It has elevated policy interest in the effectiveness of coverage for children and the quality of pediatric care and redrawn the political landscape in terms of the government's role in directly subsidizing coverage for children. SCHIP has had a major impact on health coverage due to its ability to identify and enroll children eligible for a state's underlying Medicaid program, reports S. Rosenbaum. SCHIP currently provides health care insurance to approximately 7 million children, enrolled in either a Medicaid expansion or other programs, who otherwise would not receive health care benefits. There are an additional 6 million children who are eligible but not enrolled in either SCHIP or Medicaid. Because SCHIP is not a federally entitled program like Medicaid, families need to enroll in the program to benefit. As more families face job loss and the associated loss of health insurance, SCHIP is even more important for the health and development of infants and children in low-income families, states G. C. McCain.

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See Also: Aid to Families with Dependent Children, Historical Role of; Medicaid; Mental Health Services, Children; State Children's Health Insurance Program.

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Status Offense

Status offenses involve otherwise lawful conduct that is transformed statutorily into a public offense when performed by a minor (*United States v. Ward*, 71 F. 3d 262, 263 [Seventh Circuit 1995]). Typically, states maintain some form of status offense jurisdiction over runaways, truants, curfew violators, underage alcohol consumers, and minors failing to obey a lawful court order. Based on the notion that the state has a legitimate interest in protecting the welfare of children, most states also include broad and generally vague catch-all offenses including unruly behavior, incorrigibility, disobedience, and habitually behaving in manner injurious or dangerous to the health or morals of the minor or others. Public policy, however, is unsettled with regard to juvenile status offenders given the diverse and complex nature of both the risks to the young and the irregular outcomes of current efforts in the areas of human services, treatment, and punishment. These problems are intensified by the diversity of the youths themselves and the desire to provide human services to at-risk youth in the face of public pressure to respond to all forms of youth misbehavior with strong disciplinary sanctions.

Prior to 1899, minors brought before the courts for the commission of a crime were tried as adults. In that year, Illinois established the first independent court system for adjudicating offenses committed by minors, and by the 1940s, all states had followed suit. In the early 1960s, the category of status offender was invented in most states to separate juveniles who had committed crimes (delinquents) from those who had broken rules that constituted offenses only because of their age at the time of the activity. The creation of a special category of offenders discriminated on the basis of age was premised upon a state's interests in protecting the young from harmful behaviors, preventing future criminal behavior, and supporting or substituting for parental authority where it was perceived that a failure to intervene may initiate an escalation of the minor's misbehavior. Toward these ends, status offenders currently receive considerably different treatment than do minors who violate criminal statutes (juvenile delinquents). While delinquents and status offenders alike enjoy procedural due process rights (*In re Gault*, 387 U.S. 1 [1967]), status offenders enjoy more flexible and informal procedures intended to guide and reform. These may include diversion from the court system and deferred adjudication with no formal probationary oversight and no formal ruling that the juvenile committed a status offense as long as he or she does not commit another offense for a specified period of time.

Although all state procedures focus on the needs of the child rather than the behavior triggering court intervention, states handle status offenses quite differently because of disagreement over the proper role of the juvenile courts in these cases. Some are advocates of diverting status offenders into public agencies and private organizations that provide counseling, therapy, and other forms of treatment for personal and family problems. Others, including parents seeking aid in disciplining defiant children, law enforcement officials seeking to detain runaways, and juvenile court judges favoring incarceration as a sanction to enforce court orders, are advocates of criminal justice sanctions, particularly incarceration.

In response to an increasing use of the discretion to incarcerate in the 1970s, Congress enacted the Juvenile Justice and Delinquency Prevention (JJDP) Act, conditioning eligibility for federally funded intervention and prevention programs on a move away from custodial facilities to appropriate community-based alternatives, the insulation of juvenile offenders from adult offenders, and efforts by each state to address the overrepresentation of youth of color in the justice system. In response to objections that the JJDPA limited the court's ability to handle status offenders who did not comply with court-recommended treatments, the JJDPA was amended in 1980 to authorize the secure detention of status offenders who violated a valid court order. Courts employed the amendment to circumvent deinstitutionalization, holding status offenders for longer periods of time than if they had committed a crime and were adjudicated delinquent. This was accomplished, for example, by transforming violations of probation conditions that were merely status offenses into crimes under the court's contempt power and thus converting status offenders into delinquents (bootstrapping). In 2012, the JJDPA was amended again to require that detained juveniles be brought before the court and receive full due process rights. If detained, the juvenile must be separated from juveniles charged or held for acts of delinquency, and the detention must not occur in any facility utilized for the incarceration of adults.

The system as it operates currently is subject to substantial criticism. Many argue that it is a mistake to transform the behaviors characterized as status offenses into public offenses as the process stigmatizes youths for behaviors that are not harmful to others and that are often symptomatic of the minor's environment. The adversarial nature of the court system is thought by some to exacerbate this problem, and many status offenses, such as incorrigibility and running away, place the minor in an adversarial position with the parents as it is they who report the behavior most often. Additionally, there is a conflict inherent between service agencies typically employing therapeutic and voluntary methods and courts often seeking to use their authority to engender quick behavior modifications. Similarly, there is a conflict inherent to state intervention in the family in cases of maltreatment leading to status offenses. Courts are criticized both for overreaching in the family lives and for failure to adequately protect children. There is concern as well over the unbridled discretion of the court, the difficulty of effecting positive changes in the conduct or welfare of minors, the demonstrable fact that time spent in juvenile correctional facilities often worsens prospects for adaptive functioning after release, and the failure of the system to tailor intervention sufficiently to the needs of diverse categories of offenders.

Studies indicate, for example, that there is little practical justification for mandating treatment for detained juvenile offenders who have merely experimented with alcohol but show no indication of a current substance abuse problem. Likewise, the difference between the use and abuse of alcohol by girls and boys indicates the need for discriminating approaches. Girls who use or abuse alcohol are more likely to have considered or attempted suicide, and girls who engage in risky dieting behaviors consume significantly more alcohol than boys and nondieters. Among teens who move frequently from one home or neighborhood to another, girls are at greater risk than boys of drinking, and girls transition from substance use to substance abuse more quickly than do boys. These differences point to the need in juvenile justice systems to tailor rehabilitative approaches to the varied experiences of the youth in their care. While the JJDPA as amended requires the juvenile justice system to plan for gender-specific services, program evaluations find that some gender-specific programs, though increasing self-esteem and educational performance, do not show evidence of reduced recidivism.

Outcomes often vary by race and ethnicity as well as gender, suggesting that interventions honed to the differences among races, ethnicities, sexual orientations, and immigration status are essential for more positive results. Similarly, studies estimate that the prevalence of youth with undiagnosed or unmet special education needs is higher significantly among status offenders than in the general population. The most comprehensive interventions encompass coordinated school, family, and community programs.

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See Also: Adolescent/Youth Services: Overview; Disposition of Juvenile Records; Interstate Compact for Juveniles; Juvenile Delinquents; Juvenile Detention Centers; Juvenile Justice System; Runaway Youth/Human Trafficking; Youth Risk Behavior Surveillance System.

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Stolen Generation

In 2008, the then prime minister of Australia, Kevin Rudd, reflected upon "the mistreatment of those who were Stolen Generations—this blemished chapter in our nation's history." The term *stolen generation* is utilized within Australia to describe those children who were forcibly removed from their families under a policy ostensibly concerned with assimilation. The central tenet of that policy was that, by removing Aboriginal children from their families, the government could sever the children's connections with their families and by extension their culture and traditional land and ultimately lead to them being absorbed into the white community. The Aborigines Welfare Board report for 1921 stated that "the continuation of this policy of dissociating the children from camp life must eventually solve the Aboriginal problem." The "problem," according to P. Read, referred to those Aborigines who could not, or elected not to, live as white people wished them to.

For the governments in Australia (at a time prior to the creation of the current federal or commonwealth government), the key focus was on Aboriginal children of mixed parentage (referred to as half-caste, quadroons, or octoroons, according to the perceived mixture of Aboriginal and European blood, which was crudely determined on the children's complexion), describes K. Healey. Despite the prevalence of the policy in Australia, it was not publicly debated until the issuance of the findings of the Royal Commission into Aboriginal Deaths in Custody in 1989, report P. Nagle and R. Summerrell. The commission noted that, in relation to the 99 deaths investigated, 43 of those who had died had, as children, been separated from their families and, by definition, their communities and culture. The process of forcible removal fully entered the public domain, however, with the publication of the report "Bringing Them Home," commissioned by the Australian Human Rights and Equality Opportunity Commission (HREOC) to study the removal of children in New South Wales between 1883 and 1969. The HREOC noted that, in 1814, the first school for Aboriginal children was created in New South Wales. It was noted by HREOC that the local aboriginal people, the Darug, were aware that the purpose of the school was separation from rather than education of their children and consequently removed them.

In western Australia in 1840, a similar school was opened with the expressed purpose of "Christianizing and civilizing" Aboriginal children. Thereafter, respective state governments created legislation that tacitly authorized the removal of Aboriginal children from their families. Thus, under the Aboriginal Protection Act (1869) in the state of Victoria, the Board for the Protection of Aborigines could authorize removal of children for placement in reformatory or industrial schools if it felt that the children were neglected or unprotected. Under the Aborigines Protection Act (1909), the requirement of neglect continued to be promulgated, with any attempt to remove children without their parents' consent requiring a magistrate to find that the children in question were neglected.

However, there were occasions where the magistrate, having found them to be well fed and well dressed, released them. The Aborigines Protection Board became discontented at what it regarded as an undermining of its powers under the act as a result of the magistrate's actions. The act was subsequently amended in 1915 such that any Aboriginal child could be removed without parental consent if the board considered that it was in the interests of the child's moral or physical welfare to do so. The parents were required to demonstrate that the child had a right to remain with them. Read notes that, on the part of the relevant document sanctioning the removal, the reasons for the board taking control of the child would invariably be simply that the child was Aboriginal. In 1911, the federal parliament introduced the Aboriginals Ordinance (1911) under which the ironically named chief protector could remove any "Aboriginal or half-caste child" if deemed to be in the best interests of that child. In 1939, the Child Welfare Act brought Aboriginal children under the auspices of generic child welfare provisions. However, a new category within the act of an "uncontrollable" child brought a number of Aboriginal children within its ambit with those children who refused to attend school; for example, being deemed uncontrollable and therefore able to be removed from their families.

During the 1950s and 1960s, state legislation was enacted that removed the specific power to remove Aboriginal children, relying instead upon such children being covered by generic child welfare legislation. This did not, however, prevent removal of Aboriginal children from their homes albeit under the premise that such removal was for reasons of welfare rather than a continued attempt at assimilation. The HREOC report concluded that between one in three and one in 10 Aboriginal children were forcibly removed from their families between 1910 and 1970. Healey has further argued that, during the 1900s, some 40,000 Aboriginal children were removed, but there are inadequate historical records to more accurately reflect the number removed. Conditions in the missions and institutions in which the children were placed were said to be poor with insufficient resources in place to effectively house, feed, and clothe the children. The level of education offered was thought to be extremely basic, with the key driver of that education seemingly being to facilitate the children working as menial laborers.

There were allegations of severe physical punishment being meted out to the children and in many cases sexual abuse. Children were forbidden from speaking in their Aboriginal languages and were punished if they elected to do so. Read recounts a private letter sent to the manager of Kinchela Boys' Home in 1935 in which he was warned not to be drunk on duty, to no longer horsewhip the boys in his charge, to not use dietary punishments, and to refrain from sending the boys out as labor on local farms. Since the prime minister's apology in 2008, the Australian government has created its Stolen Generations Working Partnership through which it hopes to engage with stolen generations in order to address their immediate and practical needs. A number of key priorities have been recognized and funding provided. Such priorities include access to services, healing (e.g., through the recording of oral histories), the justice system (e.g., in terms of providing support for those in prison both pre-and post-release), and education (in terms of ensuring that the lives of the stolen generations are captured in delivery).

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See Also: Child Labor, International Variations in Attitudes Toward; Indian Boarding Schools; Tribal Social Services; United Nations Convention on the Rights of Child.

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Student Visas

The United Sates Immigration and Naturalization Service (INS) identifies a visa as a document that allows a foreign citizen to enter a port of entry into the United States. Ports of entry include airports, harbors, and border crossings. Approximately 4 percent of foreigners entering the United States each year travel on student visas.

Before coming to the United States to engage in vocational, undergraduate, or graduate studies at American colleges and universities, all citizens of foreign countries must first obtain student visas. Those visas allow them and their spouses and children to remain in the United States for a specified time. Students below the university level do not usually need student visas if they have been allowed in the United States on their parents' visas. Administering agencies for student visas are the Student and Exchange Visa Program (SEVP) and Immigration and Customs Enforcement (ICE), both of which are housed within the Department of Homeland Security. Any student who fails to attend classes for more than five months may be required to apply for a new visa.

The student visa program has been threatened by outside influences that include 9/11, the Boston Marathon bombing, and scandals involving unscrupulous school officials. Because foreign students who come to the United States have already been admitted to a specific college or university, any need for financial, social, and psychological assistance is generally met by school programs already in place at the school he or she is attending. In addition to international student programs designed to help foreign students adjust to life in the United States, individual schools also help students to find jobs when necessary, and they offer access to physical health care and mental health counseling.

Student visas are available in three categories: J-1 qualifies the foreign student to participate in a cultural exchange program; M-1 means that the student is pursuing vocational studies; and F-1 is the category assigned to all students engaged in academic studies. There are also subcategories within each category. F-2 signifies a spouse or child of a student with an F-1 visa. F-3 is assigned to students from Canada and Mexico who commute to the United States for academic study. M-2 identifies the spouse or child of students with M-1 visas, and M-3 categorizes Canadian and Mexican students commuting to the United States for vocational studies. J-2 is the classification given to spouses and children of J-1 students. All minor children who enter the United States on a parent's student visa are eligible to receive a free public education. In 2013, for the first time in history, same-sex spouses were considered in the same way as opposite-sex spouses when obtaining student visas.

Background

Students who entered the United States to pursue higher education were classified as immigrants until 1921. Like other immigrants, they were subject to being detained for questioning on Ellis Island upon entry into the United States. The number of students was limited by immigration quotas imposed on particular regions. The motivating force behind opening the doors of educational opportunity was the Institute for International Education, which devised an application and a process that became standard for obtaining student visas. In 1946, the Fulbright Scholarship program was launched, providing a means of sending the brightest American students to other countries and promoting the benefits of international education. Two years later, the United States Advisory Commission on Public Diplomacy became involved in the promotion of international and cultural studies. In 1961, Congress passed the Mutual Educational and Cultural Exchange Act, which provided continued federal funding for the Fulbright Scholarship. Bowing to pressure from President Lyndon Johnson in 1966, Congress passed the International Education Act and increased the scope of programs for international students. The atmosphere had changed by 1969, and funding was abolished. It was not until the 1990s when the issue of international education returned to the national consciousness after Senators David Boren (D–OK) and Claiborne Pell (D–RI) introduced the Education Enhancement Act of 1990 as a means of fostering student exchange programs.

Throughout modern history, foreign students have been interested in pursuing educational opportunities in the United States because of the high quality of institutions of higher learning, the variety of choices in considering programs of study, and the prestige that an American degree carries in many other countries. In 2012, 42 percent of international students were pursuing science, technology, engineering, and math (STEM) studies, with 19 percent in engineering, 10 percent in math and computer science, 8 percent in the physical and life sciences, 4 percent in the health professions, and 1 percent in agriculture. Other fields of study included business and management (22 percent), social sciences (9 percent), and fine and applied arts (6 percent).

In 2009, there were 671,000 students in the United States on student visas. Together, those students spent $15 billion each year. During the 2012 to 2013 academic year, the number of students grew to 819,644, with most coming from China (29 percent), India (12 percent), and South Korea (9 percent). Those students swelled the American economy by $21.7 billion in 2012. Most international students contribute to local economies by paying out-of-state tuition that may be up to three times that paid by in-state students. They also spend large amounts on groceries, clothing, housing, transportation, and entertainment.

The Visa Process

For most individuals, the process of obtaining an American visa begins in their own countries. Many would-be students visit the Web sites of the State Department or United States Citizenship and Immigration Services (USCIS) to discover how to apply for a student visa. Form DS-160 (nonimmigrant visa application) can now be filed online, the required photo can be uploaded, and the fee can be paid electronically. Interviews are still required for all individuals between the ages of 14 and 79, and digital fingerprints may be taken at that time. Traditionally, the first step in obtaining a student visa has been to be accepted at the college or university at which a student intends to study. School officials are generally familiar with the process by which visas are obtained, and many offer assistance in completing the process. Additionally, school Web sites are valuable sources for information.

In order to obtain a student visa, all individuals must be able to prove that there is no reason for them to be denied legal entry. The next step is to obtain the necessary paperwork from a USCIS facility. All applicants are required to pay a fee at this time. Documentation that accompanies the application includes acceptance letters from colleges or universities and proof that the student will be able to support him- or herself while in the United States.

Once the visa is obtained, 90 percent of all individuals seeking admission to the United States on student visas visit a designated port of entry and request a I-94 form, which details the stipulations of the student's stay in America. Any student who fails to adhere to those stipulations may be considered out of status and ineligible for benefits available to legal immigrants. Initially, individuals with valid student visas may enter the United States up to 30 days before the designated study period begins. No such restrictions apply to students returning to the United States after visits abroad. Upon entry, those carrying student visas are required to present valid passports, Form DS-160, a receipt for the required payment, a photo, and either a Certificate of Eligibility for Nonimmigrant Student Status for Academic and Language Students (FORM 120 A-B) or a Certificate of Eligibility for Nonimmigrant Student Status for Vocational Studies (Form 120 M-N). Students may also be asked for proof of their academic preparation, a statement outlining their intent to leave the United States at the end of the study period, and proof of being able to support themselves while studying in the United States.

Outside Impacts on Student Visas

On September 11, 2011, al Qaeda terrorists hijacked four jetliners. Two planes launched attacks on the World Trade Center in New York City, and a third rammed the Pentagon in Washington, D.C. A fourth plane was forced to the ground in Shanksville, Pennsylvania, by its passengers before it could launch an additional attack. The sense of vulnerability of Americans experienced by those attacks led to a major change in the ways that foreign citizens are allowed into the United States, including those who travel on student visas. Rumors suggested that several of the terrorists were in the United States on student visas, but the rumors were proved false.

The major changes that affected international students were changes in procedures, the implementation of the National Security Entry–Exit Registration System (NSEERS), and the launching of the Student and Exchange Visitor Information System (SEVIS). In 1996, the Illegal Immigration Reform and Immigrant Responsibility Act had stipulated that a computerized system of monitoring international students be instituted; however, it was not generally considered a high priority. After 9/11, the war on terrorism set the stage for students from countries such as Afghanistan, Egypt, Iran, Iraq, Lebanon, Libya, and Syria, which have been associated with terrorism, to be assumed to have links to terrorists, placing them under suspicion. SEVIS is specifically designed to keep up with international students living in the United States. Data that is available to all schools via the Internet include home addresses, educational backgrounds, fingerprints, and the designated dates of entry and exit. Schools are required to update the information regularly and report students who fail to remain in good standing.

In the aftermath of 9/11, the number of applications for student visas declined but increased steadily after 2005. The distrust of foreigners associated with 9/11 also began to decline, but on April 15, 2013, two brothers, Dzhokhar and Tamerlan Tsarnaev, set off bombs at the Boston Marathon, killing three and injuring 264, many of them seriously. The fact that Azamat Tazhayakov, who had obtained a student visa to study at the University of Massachusetts–Dartmouth, was linked to one of the perpetrators led to renewed cries for greater vigilance when admitting foreign students to the United States. The situation was made worse by the fact that Tazhayakov's visa had been revoked because he was no longer enrolled in school, but border agents at the airport had no access to that information and allowed him back into the United States. Tighter restrictions enacted after the bombing included banning students from regular academic study who have not already achieved proficiency in the English language and requiring them to enroll in language study instead.

The move toward digitalizing student visa information that followed these crises has resulted in student visas no longer being stamped by customs officials. Without physical proof of legal entry, some students have been unable to obtain driver's licenses, Social Security cards, and state identification cards. Without a Social Security card, graduate students who have teaching and research assistantships cannot get paid.

Both the student visa program and international students were damaged by revelations in 2011 that some colleges were exploiting the system. Suspicion was aroused when California's Tri-Valley University gave the address of the same two-bedroom apartment for 553 students. After a lengthy investigation, federal agents raided the school and shut it down. The investigation had revealed that, rather than attending classes on campus, students enrolled at the university and then spread out over the country, taking low-end jobs for minimum pay. Similar situations were discovered at a number of unaccredited schools, mostly in California and Virginia, where students were paying schools more than $3,000 a term to live and work in the United States.

Many international students choose to remain in the United States after graduation by becoming either citizens or permanent residents. Such actions are encouraged by most Americans who recognize the contribution of immigrants to American society. In 2011, Partnership for a New America reported that 40 percent of Fortune 500 companies had been established by immigrants and their children. In 2011, three-fourths of all patents filed by the top 10 schools in the United States had at least one foreign-born contributor. In addition to expanding diversity and improving the quality of life in a variety of fields, those companies generated a total of $4.2 trillion in 2011.

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See Also: Immigration Law, History of U.S.: Immigrant Populations, Human Service Needs of; U.S. Immigration and Customs Enforcement.

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Subcultures

Subculture, or coculture, refers to the undercurrent in a culture and stands as a commonly used term in sociology, anthropology, and cultural studies. David

Riesman used the term *subculture* for the first time in 1950 to distinguish the ways and manners of the majority group and the minority group in any culture. He finds that the majority passively accepts commercially provided styles and meanings, and the subculture always tends actively toward seeking a minority style. He finds the subculture's orientation toward a new set of values. So, subculture may be taken as a group of people inside the rim of a culture. There can be any number of subcultures plying at global or regional level.

Drug subculture, sexual subculture, music subculture, the beat generation, body building, bohemianism, casuals, cybergoth, demoscene, emo, fandom, fetish, freak scene, glam rock, gopnik, goth, hip-hop, B-boy, graffiti, junglist, LGBTQ (lesbian, gay, bisexual, transgender, and queer), bears, new romanticism, nudism, naturism, vampire lifestyle, punk rocker, role-playing gamers, and so on are the major subcultures across the globe. The practitioners of the subculture differentiate themselves from the larger culture to which they belong and in which they operate. Some practitioners of subculture lock their horns with the use of the term *subculture*, finding the association of inferiority with the prefix sub. They find the use of coculture as the more authentic term. *The Oxford English Dictionary* defines the term *subculture* as "a cultural group within a larger culture, often having beliefs or interests at variance with those of the larger culture."

Dick Hebdige finds subculture is a subversion to normalcy and has argued for taking it as a negative paradigm because of its being critical to the dominant societal standard. On the connotations of subculture, M. P. Orbe has a point when he says, "Whereas some define subculture as meaning 'a part of the whole,' in the same sense that a subdivision is part of—but no less important than—the whole-city, other scholars reject the use of the prefix sub as applied to the term culture because it seems to imply being under or beneath and being inferior of secondary. As an alternative, the word coculture is suggested to convey the idea that no one culture is inherently superior to other existing cultures." Subcultures, therefore, exist under the wider umbrella of an elite or national culture, which is marked by certain specific indicators and icons. We can find the markers of subculture as the opposition of mass against the elite culture, the ideological opposition of ideological and moral colonization, postcolonial reply to the oppressing life style, free mode lifestyle among youths, generation gap and its manifestation, differences among the elite and intellectual culture, and finding a new way different from the boring set of societal norms.

In the present-day world when our conventions are propelled by the markers and traces of technology, we find orientations toward many subcultures every day. Even contemporary fantasy is expelled by technology. The future remains influenced under the charm of technology, and our psyche cannot travel too far to relax, as in previous times, and to let emotions swell. Here, the by-routes emerge as the last resort. Contemporary fantasy finds its way to a unique pedestal, which leads us to the postmodern mirage, where there is the end of all great traditions, there is a free and frank discussion of sex, personal always becomes political, and local histories rattle with the national and civilizational histories for securing prime places for themselves. It also scales many a common paradigm between two divergent cultural canvases.

Media play a big role in airing subcultures, which has emerged today with the cohesion of classic with the base context of the other. Here, metadiscourses are recognized and make subculture. Subcultures of drugs, sex, and music subculture are well supported by the media. These subcultures are antielitist and born out of mini-narratives. In itself, it becomes so strong that the preexisting meta-discourse no longer keep themselves capable to digest them, and they emerge as crystals, which later make diamonds out of themselves and overshine as grand narratives. If we look at the different manifestations of these subcultures—be it cinema, music, institutions, workplaces, or anything else, the subcultures have stood shoulder to shoulder with tradition. The subcultural periphery is swallowing the center. There is a visible desire among the subcultures of drugs, sex, and music to politicize the conventional establishment. The trend may be cited as something detoxifying the forces of elitist cultures.

As far as the inclination toward drugs and sex in the popular paradigm of human life is concerned, the subcultures no longer find these as negative things in the present time, but these emerge as the vehicle of modernity. The spectacle of modern life makes the metamorphoses of stock identities all across the globe. The subculture of music too has stamped a universal symphony, drifting far away from the barriers of cultural and regional identities. Subculture is giving such a big stroke to the mainstream culture that, in the postmodernist milieu, there is no longer much difference in the perception of these two on the issues of music and sex. A craving for new hegemony puts a question mark after all the discussions, ideologies, and desires that have ruled over the criteria of entertainment and success in the academic discourses of culture. As far as the subcultures of drugs, sex, and music are concerned, these touch upon the youth at large, and they in all respects search for entertainment alone. Globalization and liberalization are equally motivating catalysts for promoting the mighty youth subculture, whose emotions demand an encyclopedic range of amusement. The social media, cyberculture, and free markets have brought divergent things together in a salad bowl.

Subculture happens to be very fascinating and charming, which attracts the like-minded individuals who are deprived of the realization of their aspirations under the mainstream culture and remain neglected. It allows them to make their own norms and rules and subsequently allows them to develop a sense of identity.

The practitioners of subculture differentiate them from the main culture through a number of ways and by the level of immersion in society. Ken Gelder has found six indicators for identifying subcultures. They can be identified by "often negative relations to work (as idle, parasitic, at play or at leisure, etc.); negative or ambivalent relation to class (since subcultures are not class-conscious and don't conform to traditional class definitions); association with territory (the street, the hood, the club, etc.) rather than property; movement out of the home and into nondomestic forms of belonging (i.e., social groups other than the family);

An electronic dance music (EDM) concert, part of the rave subculture. Others subcultures include drug subculture, sexual subculture, music subculture, the beat generation, body building, bohemianism, casuals, cybergoth, demoscene, emo, fandom, fetish, freak scene, glam rock, gopnik, hip-hop, B-boy, graffiti, junglist, LGBT (lesbian, gay, bisexual and transgender), bears, new romanticism, nudism, naturism, vampire lifestyle, punk rocker, and role-playing gamers.

stylistic ties to excess and exaggeration (with some exceptions); and refusal of the banalities of ordinary life and massification."

Drug Subculture

Drug subculture is a negative subculture that starts in pleasure and ends up in pain. It is destructive and antisocial and works as a sweet poison to its members. Drug subcultures are the groups of people, especially the young, who come together with a common habit of taking drugs. They work as friends and operate at different levels—those taking drugs together, those managing the drugs illegally, drug traders, and those helping the group to thwart antidrug laws and avoid arrest.

The use of drug also becomes seminal in other subcultures, like reggae and hip-hop music, Rastafarianism, hippie movements, rave subculture (club scene), hipster subculture, rock subculture, and to some extent heavy metal subculture and stoner metal subculture. The drug subculture is often seen so deeply engrossed in their practice that all other chores of daily life look simply farce to them, and they make their own world. Sometimes, they start believing that the only way to get what they want is through their typical behavior, which sometimes proves dangerous to the common society.

The most common understanding in drug subculture is seen in their deliberations on how to obtain drugs, how to obtain money to buy drugs, how to avoid arrest, and how to avoid potential health risks. The subculture, most of the time, joins together to solve the common problems they encounter. Once caught in the labyrinth of drug subculture, it becomes very difficult for a person to come out. Procuring the drugs, maintaining their security, and evading the laws is how those in the drug subculture spend most of their time. The most disastrous effect of the drug subculture is seen on the teenagers who, once entering this, find no way other than involving themselves in many antisocial practices like theft, robbery, fraud, and so on until they become incapable both physically and mentally under the effects of the drugs.

Sexual Subculture

The sexual subculture is a group of people who believe in rejecting the established patterns of sexual norms and making and adopting their own. The postmodernist phase has ratified many sexual practices that used to be suppressed from time immemorial as taboos. The 1960s sexual revolution aired the countercultural rejection of the traditional sexual norms and gender constructs, starting especially from the urban life and entering to rural society as well in Europe, America, Australia, some parts of Asia, and in South Africa. LGBTQ groups have been formed, and sexual subculture has shown strong solidarity among followers and supporters.

The sexual subculture many times adopts their own codes, vocabulary, behaviors, and social etiquettes, which become visible in dressing patterns as well. In the sexual subculture itself, there are many subcultures—like those of gays, lesbians, transvestites, nonmonogamys, eunuchs, bisexuals, girlfag, guydyke, cisgender, faghag, cross-dressing, and so on, and they too are sub-branched. For example, the gay subculture has many subgroups like leathermen, bears, feeders, and the bareback, and the lesbians have butch and femme in the same pattern. Gay homosexuals have emerged as the largest sexual subculture in contemporary times. The sexual subculture asserts them through typical behavior as expressed in speaking, actions, clothing, and beliefs. Goth sexual subcultures, women's bathhouse subculture, hook-up subcultures, sexual citizenship, polymory, followers of vogueing, the Daughters of Bilitis, and so on, also lodge their significant presence in sexual subcultures. With the popularity of social networking sites, the sexual subculture is widely spreading across the globe.

Music Subculture

Music subculture is a positive subculture that starts in innovation and travels into finding new ways of entertainment. The music subculture mostly finds young members of society who have a flair for change. Here, we find many online music-sharing communities and bands. They believe in fusion and collage rather than the pure base. Revival of popular and folk music is a visible trait in music subculture. The music subculture strives to create a youth lore by adapting old music into the new patterns through the use of technology and reveals the trend of cyber-ethnography. The examples of music subculture are mainly mods, rockers, punks, hippies, hip-hop, urban, rappers, emo, indie, hardcore, glam rockers, and goths. They differentiate themselves from others with their musical tastes and prefer dressing to affiliate themselves with similar members. The Internet has helped the music subculture to organize online, allowing the members to exchange their ideas, views, and works freely. The 10 main musical subcultures, in chronological order, are flappers, original hipsters, deadheads, B-boys, Goths, gangstas, straight edge, emo kids, juggalos, and derivative hipsters.

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See Also: Drug and Alcohol Screening; Racial Identity Development, Models of; Same-Sex Couples/Marriage.

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Substance Abuse and Mental Health Services Association

Crime, homelessness, and medical problems associated with substance abuse and mental illness place substantial social and financial burdens on most communities. Despite their high consumption of community resources, approximately 20 million substance abusers and 10 million people with mental illness go without treatment annually. In 1992, United States Department of Health and Human Services (DHHS) established the Substance Abuse and Mental Health Services Administration (SAMHSA) to reduce the impact of substance abuse and mental illness. SAMHSA identified strategic initiatives to help people with mental and substance use disorders, support the families of people with mental and substance use disorders, build strong and supportive communities, prevent costly behavioral health problems, and promote better health for all Americans.

SAMHSA operates under the premises that prevention works, treatment is effective, and people do recover from mental illness and substance abuse. SAMHSA invests in prevention, treatment, and recovery by making information, funding, and research more available.

Prevention

Each year, based on assessed needs, SAMHSA mobilizes individuals, families, schools, faith-based organizations, and workplaces to assist in efforts to help populations at-risk for substance abuse, mental illness, and suicide. Youth, Native Americans, and persons in the military are some of the target groups for prevention services. National Prevention Week raises public awareness of substance abuse and mental illness through health fairs, town meetings, and other local events. SAMHSA also retains a searchable database of interventions that promote mental health and substance abuse prevention.

Substance abuse prevention efforts extend to schools, workplaces, and health care providers. Grants provide resources for schools to conduct programs for the prevention of substance abuse and violence. Employers receive assistance in the development of drug-free workplace programs. Personnel in primary care facilities, trauma centers, and hospital emergency rooms are often the first point of contact for at-risk for substance abuse. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) program informs health care providers about the best methods of intervention. The Center for Substance Abuse Prevention aids in the development of prevention policies that fortify the efforts of workplaces, schools, and communities and promotes drug-free neighborhoods. October is the National Substance Abuse Prevention Month, during which SAMHSA distributes materials to individuals and prevention professionals.

Efforts to promote mental health include programs that disseminate accurate information about mental illness. What a Difference a Friend Makes is a program that teaches people between the ages of 18 and 25 how to support peers who are experiencing mental and emotional problems. Because psychosocial stressors often trigger mental illness, SAMHSA also provides information on coping with traumatic events and financial difficulties. SAMHSA's suicide prevention programs include a hotline that is available to take crisis calls around the clock every day of the year. A suicide prevention tool kit is available for senior living communities, where substance abuse and suicide rates are increasing as the population ages.

Treatment

To improve access to mental health services, SAMHSA provides the 24/7 Treatment Referral Line. A Mental Health Services Locator and the Substance Abuse Treatment Facility Locator are among SAMHSA's efforts to assist substance abusers and mentally ill persons to find appropriate treatment. SAMHSA maintains a significant store of publications and materials about prevention and treatment. The Center for Substance Abuse Treatment (CSAT) integrates research results with clinical and administrative expertise to create treatment improvement protocols (TIPs). More than 50 TIPs booklets provide best practice guidelines to substance abuse treatment providers.

SAMHSA's Center for Mental Health Services helps states improve their mental health care systems by promoting evidence-based practices, supporting outreach and case management programs for the homeless, and improving access to mental health services. SAMHSA makes information about treatment programs available to the public and provides a treatment facility locator on its Web site in addition to a treatment referral hotline. The Center for Substance Abuse Treatment promotes evidence-based practices and supports community-based treatment efforts. Office of Behavioral Health Equity (OBHE) addresses disparities in resources for underserved groups that include racial populations, ethnic populations, and lesbian, gay, bisexual, and transgender (LGBT) populations.

Recovery

SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. To sustain positive recovery outcomes, SAMHSA promotes health and resilience by addressing issues of housing, employment, education, and social exclusion. The homeless and persons with co-occurring substance abuse and mental illness are vulnerable to relapse. SAMHSA provides resources to guide individuals, professionals, and communities in supporting vulnerable populations and assisting in their receipt of any Social Security Disability Insurance or Supplemental Security Income to which they are entitled.

Research

SAMHSA's Office of Policy, Planning, and Innovation (OPPI) maintains a presence in health research and collaborates with the National Institutes of Health (NIH) and the Centers for Disease Control (CDC). The Center for Behavioral Health Statistics is the government's lead agency in behavioral health statistics and epidemiology. The SAMHSA Web site provides a constantly updated compilation of research results on the data, outcomes, and quality (DOQ) page. DOQ addresses SAMHSA's strategic initiative to provide data that informs policy, measures program impact, and leads to improved quality of services and outcomes for individuals, families, and communities. Research results are available on a searchable database on the SAMHSA Web site. Results of research that describe trends in substance abuse and mental illness inform prevention programs. Research on treatment outcomes help to provide a basis for evidence-based practice.

SAMHSA awards millions of dollars in grants each year. Grants for substance abuse provide for things such as prevention programs, human immunodeficiency virus (HIV) screening programs, and drug-free community programs. Grants for mental health provide for the types of programs that support education, law enforcement, and families. SAMHSA's grants for substance abuse treatment expand existing programs and target at-risk populations. Grant-funded programs that demonstrate effectiveness may apply for renewal. The management of funding is transparent in that SAMHSA reports its funding distributions by state and program.

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See Also: Substance Abuse Treatment for Children and Adolescents; Suicide Prevention Services; Twelve-Step Programs.

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Substance Abuse Treatment for Children and Adolescents

Adolescent substance use is a widespread public health problem that impacts the health, safety, and future success of youth. Substance use disorders refer to problems resulting from use of a substance (e.g., alcohol, marijuana, or cocaine), which the individual continues to take despite experiencing problems as a result. Several treatment approaches have been developed to treat children and youth for problems related to substance use. Regardless of the specific focus or treatment strategies that are used to address substance-use problems, it is essential that treatment considers the youths' unique needs based on age and developmental status, motivation for treatment, as well as other cultural and demographic characteristics. These factors can have a substantial influence on the outcomes of treatment.

Substance use disorders are viewed on a continuum from mild to severe and are defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as having experienced two or more problems arising from substance use in the past year. These problems include not accomplishing what one should at home or school because of substance use, taking the substance in larger amounts or for longer than one meant to, and wanting to cut down or stop using the substance but unable to do so. Substance use disorders are often first diagnosed in adolescence. Substance use disorders in childhood and adolescence have been associated with several serious psychosocial problems. These problems include behavioral problems, neurological problems, skills deficits, academic difficulties, and family problems. Youth dependent on drugs or alcohol also report increased rates of co-occurring mental health disorders (e.g., conduct, mood, and anxiety disorders).

According to estimates from the National Survey on Drug Use and Health, each year 1.7 million youth between the ages of 12 and 17 need treatment for illicit drug or alcohol use problems. However, only approximately 10 percent of these youth exhibiting severe drug or alcohol problems receive treatment. The discrepancy between adolescents who enter treatment and those who do not is a profound gap in services, leaving a significant number of youths still vulnerable to problems in young adulthood. Moreover, the potential positive impact of empirically supported substance abuse treatments is severely diminished. In reaction to these serious consequences that are associated with adolescent substance use, several treatments have been developed to reduce youths' drug and alcohol use and related behavioral problems. Most American youth who are treated, in either a publicly or privately funded facility, are receiving outpatient services, with only an even smaller minority treated in inpatient hospital or residential settings. The complexity of the problems young people typically bring to drug abuse treatment underscores their need for multimodal approaches that address a broad range of mental health and psychosocial problems in addition to substance use. Interventions to address drug and alcohol problems among youth use two primary approaches: directly treating the adolescent or focusing on the adolescent in the context of the family.

Individual treatments that focus on the adolescent commonly use behavioral interventions to identify internal and external stimuli that trigger substance use. These treatments then train youth on refusal skills, emotional regulation, and behavioral management techniques. Often, cognitively oriented therapies will also focus on distorted thoughts and maladaptive perceptions that lead to substance use and other problematic behaviors. Motivational interviewing is another individual treatment approach that is often used with this population. This treatment is designed to help clients recognize their substance use as a problem and build internal motivation toward changing their substance use behaviors. Some researchers conclude that motivational interviewing may be especially effective for adolescents because they are often coerced into treatment and, consequently, often do not view their behaviors as problematic.

Although some family members may deny the existence of problems or provide negative role models (e.g., parents use drugs), support from immediate and extended family members can be a key resource for young people in drug and alcohol treatment. Family dynamics are an integral component in the lives of children and adolescents. For clients who are under age 18 and not legally mandated to attend treatment, parents or guardians must agree that treatment is required and provide consent before any services can begin. Involving families has been identified as key for achieving positive treatment outcomes among those whose ethnic and cultural backgrounds place a high value on the family. Among Asian American adolescents, for example, weak family ties have been shown to be a risk factor associated with higher levels of substance use. Similar results have been seen in studies focusing on Latino youth. Ambivalent family attitudes toward treatment may also contribute to a reluctance to support ongoing monitoring of behaviors. The most common family-based treatment programs are multisystemic therapy, integrated family and cognitive behavioral therapy, multidimensional family therapy, and brief, strategic family therapy. Each of these treatments approaches focuses not only on changing a youth's behavior but also on reducing risk factors for substance use present in the youth's family or other social environments (e.g., school, peers, or community).

Regardless of the specific treatment model that is used in treating young people, there are several important considerations for those who treat children and adolescents. Professionals should take into account the different developmental needs, depending on the age of the child or adolescent. Younger children have different needs than older adolescents, who may be dealing with issues such as developing autonomy and resisting or reacting to authority. Although the DSM-5 does not have developmentally specific criteria for identifying substance use disorders among youth, it is important to recognize that symptoms of substance use disorders may present differently in youth compared to adults. Most adolescents, for example, have shorter histories of alcohol use than adults and do not typically show withdrawal symptoms for alcohol. Truancy is one of the most frequently occurring signs of substance use problems among adolescents, and it is not included in the current diagnostic criteria.

Similarly, children and adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and unique environmental considerations. Peer influences are particularly salient during adolescence and can have a strong impact on adolescents' decisions to use drugs or alcohol. It is also important to recognize that many adolescents have been coerced explicitly or implicitly into attending treatment. The majority of youth receiving treatment in publicly funded facilities are referred by the criminal justice system. Studies have suggested that African American youth are even more likely than other youth to be referred to treatment this way. Treatment providers must be sensitive to the potential for motivational barriers to change, particularly at the onset of treatment.

In addition to age and treatment referral source, substance abuse treatment for children and adolescents must also take into account the ethnicity and cultural background of youth. Survey research has documented heterogeneity in the prevalence rates and patterns of substance use among adolescents among different racial and ethnic groups including Hispanics or Latinos, African Americans, Asian Americans, Native Americans, and whites. There is continued concern about whether or not interventions are equally effective for individuals from various racial or ethnic backgrounds. African American youth, for example, generally have lower rates of substance use than do Caucasian and Hispanic or Latino youth. Despite their lower rates of substance use, African American youth experience greater social, economic, and health consequences and have higher rates of attrition in substance use treatment. In order to ensure that youth from different ethnic groups respond to interventions, it is important to understand and address the cultural needs of these youth.

Similarly, it is important to recognize how gender and sexuality can impact the treatment needs of this population. Rates of substance use and disorders among female adolescents have increased dramatically in recent decades, and there are now fewer differences between males and females. Despite the similar rates of substance use, adolescent females typically present a distinctive clinical portrait compared to their male counterparts. Adolescent females more frequently present with depression and difficulties attributed to family problems in addition to the externalizing symptoms also found among males. Studies have consistently shown that lesbian, gay, and bisexual (LGB) youth report significantly higher rates of substance use and disorder compared with heterosexual youth. Even higher rates have been found among some subpopulations of LGB youth, such as bisexual youth and females. Although few interventions have been tailored to specifically address the needs of LGB youth, efforts are increasing to better understand the unique factors associated with substance use disorders among LGB youth to better tailor interventions to their needs.

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See Also: Adolescent/Youth Services: Overview; At-Risk Youth Services; Child and Adolescent Needs and Strengths; Monitoring the Future; Youth Risk Behavior Surveillance System.

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Suicide, Cultural Aspects of

Suicide is a type of intentional self-destructive behavior generally resulting with the loss of life. Émile Durkheim defines suicide as the death of an individual as a consequence of direct or indirect and positive or negative acts of him- or herself. Being a worldwide social problem, suicide is accepted as one of the most important causes of death. Sociological and psychological standpoints offer different explanations on the causes of suicide. The first approach highly focuses on the impact of social structure, demographics, and culture, while the latter relates suicide to the mental state of the individuals.

Suicide is a continuum involving three significant steps: ideation, attempt, and completion. However, many studies point out that suicidal ideation is more common than attempt and completion of suicide. Individuals may only have suicidal ideation but not a tendency for suicidal attempt. Completion of a suicide case is totally related to how lethal the method used is. The patterns of suicide also vary among age and gender groups and different geographical locations in the world. Current studies show that males are more likely to complete suicide than females, while women are more prone to suicidal attempt. In that, males use more lethal methods for committing suicide, and women adopt less-violent acts to take their lives. Yet suicide rates for females may also be higher in different cultural settings.

The scientific community agrees that suicide is a result of a combination of a number of psychological, social, economic, and cultural factors. Among all other factors explaining suicide, culture has become a strong determinant of suicidal behavior. Culture involves social norms and rules shared by the individuals in a society. Behavioral patterns are also influenced by these cultural traits of a society. Cultural codes in a society are strong determinants of human behaviors and cultural influence and, therefore, cannot be undermined in the understanding of suicide in one cultural setting. Cultural factors either precipitate or initiate the processes leading to suicidality. In many cases, culture has a certain effect on individual choices in crisis situations such as failure in life.

Studies explaining the causal relationship between suicide and culture date back to Durkheim. Durkheim categorizes four types of suicide: egoistic, anomic, altruistic, fatalistic. Egoistic suicide is a result of too little social integration. Individuals who are not sufficiently bound to social groups lack social support and guidance of the community and, as a result, are more likely to commit suicide. Altruistic suicide is a result of too much integration. As altruistic people are more integrated into social groups, their individuality lost its importance in their minds, and they are willing to sacrifice themselves to the benefit of a group. In this case, suicide gains a form of self-sacrifice. On the other hand, disengagement of individuals from social ties is the main factor leading to anomic suicide. Durkheim indicates that societal changes break social ties between the individuals and the society. Lack of social ties, the idea of belongingness, and loss of societal influence on individuals contribute to the occurrence of anomic suicide. Fatalistic suicide is a rarely observed type in the real world (e.g., suicide among slaves).

All types of suicide in Durkheim's categorization are related to the instability of cultural dynamics such as social integration and regulation. The level of social integration and moral regulation in a community is a concomitant factor leading to suicidal behaviors. Similarly, in heterogeneous societies, clash of cultural values may create a sense of cultural shock and adaptation problems. In return, acculturation may create a social anomie, which may lead to increases in suicide rates.

Meaning of Suicide in Culture

Cultural approach and social perception of suicide are also influential in understanding the action. Suicide has various meanings for both the one committing suicide and the society. In developed countries, mainstream culture decriminalizes the action, while in more traditional societies, suicide is unacceptable yet instrumental in meeting cultural expectations. However, the act of killing oneself is not perceived positively in cultures intertwined with religious values. Hence, it would be quite difficult to explain suicide with only one universal definition.

In general, suicide is perceived as a way of escaping from negative stimuli in one's life as well as a response to the social environment. In developed countries where economic prosperity is the main determinant of cultural codes, loss of wealth or increasing debts may lead individuals to commit suicide as they have difficulties adopting new conditions. In Scandinavian countries, especially in Denmark, domestic anomy is a root cause of suicide. Loss of spouse or divorce increases the likelihood of dependency of elderly parents on their children, and suicidal ideation accompanying reunion thoughts with the beloved one results in suicide. Similar suicidal motives are seen among women as a ritual of grief for husbands in India and Japan. On the other hand, in countries where divorce is culturally prohibited, wives are prone to commit suicide. Suicide for loss of honor and failure in daily life is also reported in many traditional (China and Japan) and developed (Sweden) countries. In Chinese culture, suicide is stigmatized and seen as a shameful act, which collapses esteem of the family. In Japan, in many cases, suicide is a way of restoration or preservation of the honor of the self and the family honor. Japanese women's suicide (*Jigai*) had also become a form of culturally imposed ritual up to the 19th century.

Methods of Suicide and Culture

Previous studies lay out that various methods were chosen for suicide in different cultural settings. Jumping from a high place, drowning, strangulation, stabbing, self-poisoning, suffocation, hanging, and firearm use are the most common methods adopted for suicidal actions, while burning oneself and use of domestic gas are observed in some specific locations as way of taking one's life. These methods are observed in both developing or underdeveloped countries. Use of domestic gas has been reported as a popular method of suicide for a long time in the United Kingdom. In Trinidad and Tobago, use of an agricultural poison is quite common among the farmers in rural areas. This pattern of suicide is observed in most cases in rural areas of the United States. Burning of a wife on a husband's funeral pyre is a common pattern of suicide in India, which may not be deemed as a suicide in other cultures.

Considering Cultural Differences in Suicide Prevention

Understanding cultural aspects of suicidal behavior is also of importance in suicide prevention in different cultures. Suicide theories and definitions are not that comprehensive to explain all suicidal behaviors around the world. By the same token, strategies aimed at intervening with the risk groups in one society may be adapted to the other one, taking into account the culture-specific issues. Extant research shows that there is a large spectrum of suicidal patterns among racial and ethnic groups in countries such as the United States, India, and China. Therefore, cultural and even subcultural characteristics need to be understood well.

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See Also: Self-Harm, Cultural Aspects of; Suicide Prevention Services.

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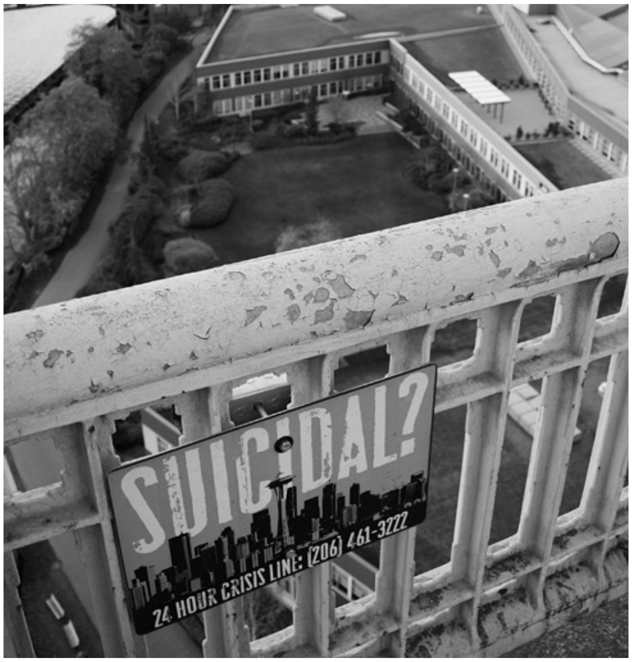
Suicide Prevention Services

Suicide is the 11th-leading cause of death in the United States, and international rates of suicide vary widely from country to country. Rates of death by suicide also vary greatly depending upon individual characteristics. Suicide rates and an individual's age, sex, religion, race, and ethnicity have been widely studied, while there is less evidence linking sexual orientation, gender identity, employment status, occupation, and social status to suicide. In 2010 (the most recent rates available), adults 45 to 64 years old and 85 years and older had the highest rates of suicide. Males died by suicide at a rate that was four times higher than that of females, while females attempted suicide three times more frequently than males.

In the United States, the highest rate of suicide was found among those living in the western states with the south, midwest, and the northeast following. In 2010, Caucasian and American Indian or Alaskaß Native people had the highest rates of suicide in the United States, while African American, Hispanic (with the exception of Hispanic adolescent females), and Asian or Pacific Islanders had substantially lower rates. Most experts in suicide believe that suicide rates are lower in communities where cultural or religious prohibitions against suicide are strong, social supports are plentiful, and the use of alcohol and other drugs to cope is less prevalent.



A sign for suicide prevention services on the George Washington Memorial Bridge in Freemont, Washington. Jumping from a high place is one of the most common methods of suicide.

Attention to suicide and efforts to decrease its incidence have expanded in recent years. There are two main approaches to suicide prevention: community- and individual-based services. Community-based approaches use a variety of strategies to attempt to lower the suicide rate within communities as a whole. Individual approaches seek to identify and treat individuals at risk for suicide. This entry reviews the most prevalent community- and individual-based approaches.

Suicide Prevention Initiatives and Programs

Community-based approaches seek to reduce the incidence of suicide by enhancing connectedness, increasing peoples' knowledge of suicide statistics, risk factors, protective factors, warning signs, and resources. Community-based approaches also focus on increasing community members' responsiveness to persons who are at risk for suicide and reducing social stigma associated with seeking help for mental health concerns.

The National Strategy for Suicide Prevention serves as a guide for effective suicide prevention services utilizing a public health approach to collect information, plan programs, and evaluate their effectiveness. Suicide prevention in local communities, such as cities, schools, universities, and Native American tribes should take into account the unique vulnerability of members in terms of ethnicity, sexual orientation, age, and other characteristics. As a part of the public health approach, educating people about suicide is an important service as misinformation about suicide stands in the way of people providing and accessing needed help. Educational efforts include informing people about suicide risk factors and warning signs, dispelling myths about suicide, and providing people with information about helpful services.

Social norms marketing strategies are similar to advertising campaigns and seek to change socially held beliefs about suicide, mental health problems, and receiving treatment. Social stigma (social discomfort or disapproval) about having mental health problems is thought to block people from getting and providing social support and seeking treatment. Social messages that let people know that it is not crazy, weak, or uncommon to have mental health struggles may help change the social climate and allow people to get needed assistance.

Many communities use gatekeeper trainings to teach basic suicide prevention and intervention skills to those in positions to intervene with someone who is suicidal. Some trainings are intended for everyone in a community, while others are meant for people in certain roles such as teachers or peer counselors. Trainings most often include facts about suicide, warning signs, and direct instruction and practice in intervening with people at risk. Research on gatekeeper trainings indicates that the trainings are often effective in educating people about suicide and increasing their skill and the likelihood of approaching and assisting someone at risk.

Survivor Support

People who loved someone who died by suicide are known as suicide survivors. Because suicide carries such social stigma, suicide survivors often benefit from specialized support services. Individual counseling, support groups, and participation in online forums are some of the main ways survivors find support. Common issues survivors confront are a lack of understanding of their experience and feelings of guilt, blame, anger, bewilderment, and shame. Postvention services are sometimes offered to groups of people who have lost someone to suicide. These most often include a single group meeting led by a mental health professional and aimed at helping participants process and begin to deal with the death. Survivor support services are especially important because some survivors think about suicide themselves as they experience the extreme pain of their loss.

Hotlines

One important service for people at risk for suicide is telephone support and referral services, also known as hotlines. Nationwide, toll-free hotlines can be reached by anyone with telephone access. Hotlines are staffed mostly by highly trained volunteers who try to evaluate what may be most helpful. When a caller is considering suicide, the staffer provides support and can encourage the caller to access mental health services. If the caller seems intent on making a suicide attempt, hotline staffers may contact law enforcement. Research has shown that hotlines are helpful in reducing suicidal thoughts during the telephone conversation, and callers continue to experience a decrease in distress and hopelessness in the weeks after the call. Some hotlines follow up on calls to provide support and encourage the caller to access recommended services.

Medical and Mental Health Evaluation and Treatment

Studies have shown that many Caucasian suicidal people seek out medical care in the months before they end their lives; many do not let their care provider know they are suicidal. Those coming from minority or underrepresented groups are thought to access family and community supports more often and do not tend to access medical services. Primary care medical professionals provide suicide prevention services if they routinely ask about suicidal thoughts, screen and treat co-occurring mental health conditions, and refer for mental health treatment. Emergency medical personnel encounter people who have threatened suicide or made suicide attempts. Careful evaluation is necessary to determine their level of risk and appropriate interventions. Inpatient medical care may be warranted to protect patients from making a suicide attempt and to initiate medication or counseling.

Psychiatrists often evaluate and treat people at risk for suicide with medications in inpatient and outpatient settings. Mental health evaluations are also conducted by other mental health professionals (psychologists, social workers, counselors, or psychiatric nurses) when there are concerns related to a client's or patient's thoughts, behaviors, or emotions. During evaluation, a mental health professional most often talks with the person directly to understand his or her problems and assess his or her functioning, thoughts about suicide, and level of risk.

In addition, the mental health professional may talk with significant others, such as partners or family members; administer screening measures to assess symptoms such as anxiety, depression, and suicidal thoughts or behaviors; and explore suicide history, planning, intent, and access to available means to complete suicide such as pills or firearms.

After evaluation, most individuals are referred to mental health counseling or psychotherapy. The goal of treatment is to improve a person's mental health and overall functioning, thereby reducing the pull of suicide as an option. When working with a suicidal client, a mental health professional must address both the suicidal behavior and underlying concerns or psychiatric conditions (e.g., depression, substance use, or recent losses) that have contributed to his or her pain and desire to die. During the course of treatment, many individuals benefit from medication to alleviate symptoms. If a person appears to be at immediate risk for suicide, inpatient hospitalization may be warranted. Research has led to the identification of a number of evidenced-based prevention programs and practices. For many people at risk for suicide, effective mental health services are lifesaving.

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See Also: Mental Health Services, Adult; Mental Health Services, Child; Psychiatric/Psychological Assessment; Substance Abuse and Mental Health Services Administration; Suicide, Cultural Aspects of.

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Supplemental Security Income, Services Funded by

Supplemental Security Income (SSI) consists of monthly cash payments for low-resourced adults who are disabled, blind, 65 or older and disabled, or blind children. Unlike other Social Security insurance and retirement programs that are based on contributions, SSI is a means-tested program for people who lack a significant work history. SSI is of unique concern to the diverse field of human services because it serves as a safety net for the most economically vulnerable people in the United States.

SSI was established in 1974 by the Nixon administration to restructure federally funded but state-run disability assistance programs for the purpose of ensuring standardized eligibility and other program components. Financed through U.S. Treasury general funds, SSI is run by the Social Security Administration. It provides monthly cash benefits to low-income elders as well as adults and children who are both poor and severely disabled or blind. A medical verification of the disability is required, and the disability must severely limit functioning. In situations where the person is disabled to the extent to which he or she cannot manage his or her money, a representative payee, such as a relative, friend, or case manager, is assigned.

As of 2013, the maximum payment for a single person is $710 per month and $1,066 for a couple. This benefit increases annually based on the consumer price index. Most states supplement SSI payments except for Arizona, North Dakota, Mississippi, and West Virginia. SSI recipients are automatically enrolled in Medicaid in most states and qualify for food assistance in all states except California. Additionally, recipients are eligible for Section 8 housing assistance vouchers, and all Social Security offices offer work incentives and other employment supports. SSI considerably adds to income security of the elderly poor, and true to its name, supplements often-meager Social Security retirement benefits.

Because the program is targeted at the most economically disadvantaged people, there is an asset and savings ceiling of $2,000 for a single person and $3,000 for a married couple. In other words, to qualify for SSI, there must be income and asset scarcity. This poses problems for anyone who has assets in excess of the cap but who nonetheless are impoverished. Consider the elders who are on fixed incomes through modest Social Security retirement payment, and own their own small home, despite having an income that may hover around the poverty line, they would not qualify for SSI. Policy analysts point to the relaxation of asset caps to enable more elderly income poor (especially women) to avoid severe poverty. People with disabilities who seek work experience another consequence of the resource cap. The program does not count the first $65 earned, but after that, benefits are reduced $1 for every $2 earned. SSI's restrictions on earnings hamper people from seeking gainful employment. This is pronounced among people who would benefit greatly from working and does not contribute to meaningful engagement.

The passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted eligibility for low-income immigrants and low-income substance abusers. Only legally recognized immigrants can now qualify for benefits. PRWORA eliminated drug addiction and alcoholism from the list of qualifying disabilities. The law loosened eligibility requirements among children, however, most notably with the addition of Attention Deficit Hyperactivity Disorder (ADHD).

With the 2013 repeal of the Defense of Marriage Act (DOMA), the Social Security Administration accepts SSI applications from same-sex couples whose marriages are legally recognized in their home states.

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See Also: Elder Care/Geriatric Services; Social Security, Services Funded by; Social Security Administration.

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Supported Housing

Supported housing is a model that merges both housing and services to sustain such housing. While this model can be used for a variety of circumstances, this entry will focus on supported housing for those with mental illness, developmental and intellectual disabilities, and addictions, and as a solution aiding those who were formerly homeless.

Supported Housing for Those With Mental Illness

Supported housing for those with serious mental illness generally consists of an independent apartment structure that is considered to be a permanent home. This differs from supportive housing, which may include group homes or clustered apartments, and custodial housing, which may include foster families or another caregiving model. Typically, the consumer is looked upon as a tenant and the staff act as facilitators, allowing the consumer to maintain the locus of control. Interventions are individuals. This approach is commonly known as the Housing First approach, which was first introduced in 1995. Rental supplements, often known as Section 8, distributed by the U.S. Department of Housing and Urban Development, provide financial assistance in many cases. Housing is offered first, and other mental health services may follow. This reflects the idea that housing is a basic human right and an essential need. Choice and control are emphasized in this model so that the consumer is able to choose where, and with whom, he or she would like to live. Once housing has been secured, ancillary services are then offered based upon individual need. These services may include individual, family, or group counseling for mental health issues with a goal of increasing housing stability and minimizing hospitalizations. Services may also include community activities, part-time or full-time employment and vocational supports, and other efforts to promote community integration.

Supported Housing for Those With Developmental and Intellectual Disabilities

Many supported housing programs for those with developmental and intellectual disabilities were born out of parents for their children to live in the community and not in an institution. Their ideals coincided with the deinstitutionalization movement of the 1960s and 1970s, which sought to close large institutions, thought to be at the least ineffective, and at worst inhumane, and move those residents to small, community-based homes, with an increase in individual involvement in decision making and the development of innovative agencies to provide such services. The initial move, in most jurisdictions, was to group homes, and this continues in many areas to this day. The move to group homes certainly improved quality of life as well as community presence, given their scattered presence within towns and cities.

At the same time, the group home was still thought to signal a difference, and staffing relationships were often temporary and shift based. Community participation was within a group of other people with disabilities and on a schedule, as opposed to when one naturally might want to go out. In the early 1990s, some agencies running group homes began shifting to a shared living model. Shared living is when a relative, nonrelative family, or roommate may share his or her home or the home of the person served. These programs are funded through state agencies such as the Department of Developmental Services or state and federal Medicaid programs. The ultimate goal is a concept called life-sharing based on the ideals of the L'Arche communities, in which case the relationship is nonpaid. The provider in shared living does receive a stipend, but the relationship is based on the values of mutuality, love, and unconditional respect. In addition to the companionship derived from living with a roommate or family, caregivers provide support or hands-on care for those adult daily living skills that the person served requires. This may include bathing, toileting, dressing, as well as travel and accompaniment to appointments and community activities. Both having a voice and choice in day-to-day life and living arrangements has resulted in adaptive, behavioral, and community membership gains. Numerous studies have shown that moving from segregated settings to homes of their own choosing results in an increase in community membership and inclusion.

Supported Housing in Substance Abuse Recovery

There are a variety of supported residential options available to people in regard to treatment and recovery from substance abuse. In the typical model, a series of step-down approaches are made available. The majority of these models follows a prescribed treatment approach and also links the recovering substance abuser to community support options.

A first step for substance abusers of alcohol or opiate addiction is often detoxification. Most treatment facilities require that an individual be substance free prior to enrollment. It is not necessary to enroll in a program from a detoxification center, though that method is desired so as not to expose the substance abuser to opportunities to reuse. A first residential option and step down from a detoxification center is a post-detox stabilization program. These programs usually last up to 30 days. A primary focus is to provide health monitoring, biopsychological assessment, individual and group counseling, individual treatment planning, aftercare planning, as well as referral and follow-up. The successful candidate may move directly to a structured recovery home, frequently referred to as a halfway house or step-down to a transitional support program. Frequently, the individual does not have visitation with his or her family or only limited and controlled visitation.

Transitional support services are designed to provide a secure environment to assist the individual in maintaining sobriety and learning skills to sustain recovery. Typically, these centers provide highly structured schedules. Treatment services include providing self-help groups, psychoeducational groups, and counseling. An emphasis is placed on allowing the individual to understand and learn techniques to deal with his or her illness. Usually, these programs provide case management services. This service includes creating an individual treatment protocol and assisting the individual to transition to the next step in treatment. A typical length of stay in this type of programming is up to 30 days.

Another option is a structured recovery home (or halfway house). These stays last from six months to a year. The emphasis is transitioning the individual back to the community. These services provide 24-hour residential services including counseling and case management. Ongoing treatment in the form of group counseling and educational services is emphasized in addition to learning independent living skills, vocational or employment supports, returning to community medical and mental health services, and assisting in family reunification. Planning for aftercare is stressed.

A final option is often referred to as a sober home or a three-quarter house, which tends to be less regimented but requires proof of sobriety. This is an option for individuals who do not feel ready to return to their home communities. There is some structure through house meetings and group counseling. Individuals are usually required to work and pay for their room and board. An individual may be required to be employed at the time or shortly after his or her enrollment. These services provide the recovering individual with treatment protocols, skills training, and a support network to return to in the community. A comprehensive treatment plan lasts from six months to more than a year and follows a step-down model from detoxification and individual and group training to skill development, employment emphasis, and family and community reunification.

Supported Housing for the Homeless

Often, the connection between homelessness and supported housing begins with an effort to reach out for help. Given that communities design their own services, the quality and quantity of options vary. One option may be a shelter. Most communities and many not-for-profit or religious organizations provide shelters. Shelters are space limited and usually are made available on a first-come basis. Shelter access also depends on the nature of the condition and the agencies assisting in finding shelter. In ideal circumstances, a shelter, or short-term stabilization, is accompanied by case management services that facilitate more-stable housing options. One such option is transitional housing.

Transitional housing is usually temporary but in some cases can last up to two years while a family or individual is stabilized. Housing supports are accompanied by skill training, ongoing case management (resource and referral service), and creation of a plan to move into permanent housing, which may include continued subsidized low-income housing for the qualified individual or may entail a more typical residential experience.

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See Also: Alcohol and Substance Abuse Services; Deinstitutionalization; Group Homes for Adults; Long-Term Residential Care; Mental Health Services, Adult.

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Sweatshop Laborers

Labor trafficking is a form of modern-day slavery that affects millions of people including sweatshop laborers. Sweatshops are shops or factories that violate labor laws by disobeying the minimum labor standards while undermining minimum living standards. Most sweatshop workers are girls and women. These individuals endure extremely harsh working and living conditions as they labor in garment sweatshops and other factories that produce a wide range of goods. Some of the major products produced and processed in sweatshops and factories include clothing, shoes, rugs, coffee, flowers, vegetables, and fruit. Sweatshop conditions are deplorable and gross violations of human rights. Sweatshop perpetrators pay workers little to no wages; ignore minimum wage requirements; require and demand excessive overtime with little or no overtime pay (e.g., 10- to 16-hour days six to seven days a week); deny meal breaks; impose high fees for frivolous infractions; wrongfully fire workers who refuse or complain about work requirements and conditions; hire child laborers; prohibit unions development among workers; or operate under unsafe, unsanitary, and crowded work conditions.

Given the diversity of trafficking experiences of women, men, and children in the sweatshop industry, human services providers must innovatively seek to address the plethora of challenges facing these individuals. Identified problem areas include advocacy and case management services related to: safe housing, accessing health care, income to cover basic necessities, legal representation (oftentimes), job training or skill development, education, and adjustment of status, for some, along with a host of other pressing needs. Federal legislation in the United States is attempting to address these issues on a larger scale by first identifying what labor trafficking is.

Labor trafficking was first recognized and adopted as a federal crime in the United States with the enactment of the Trafficking Victims Protection Act (TVPA) of 2000, which has since been reauthorized four times (i.e., 2003, 2005, 2008, and 2013). This legislation, arguably the most influential of its kind in the world, in its original scope asserted that severe human trafficking involved sex and labor trafficking. Both forms of trafficking involve recruiting, harboring, transporting, providing a person to someone else for a specific purpose, and obtaining a person for a specific purpose. In the case of labor trafficking, the purpose relates to involuntary servitude, peonage, debt bondage, or slavery. Involuntary servitude involves a person coercively laboring against his or her free will to the benefit of others. Peonage involves holding a person (and possibly his or her family members) against his or her will in lieu of a debt or a penal sentence. Debt bondage involves a person's pledge of his or her labor or services as repayment for a loan or other debt only to be held in a situation whereby the debt never liquidates despite the work performed. Slavery, which can include elements of all the previously mentioned forms of labor trafficking, offers no provisions of human rights to its victims.

The Act Versus the Means and Labor Trafficking

Severe human trafficking legally takes place through five recognized acts and three recognized means according to the TVPA. The acts include recruiting, harboring, transporting, providing the person for labor or service-related purposes, and obtaining a person for labor or service-related purposes. The means involve force, fraud, and coercion. Specific to sweatshop laborers, force involves making someone participate in forced labor situations through acts of aggression, violent beatings, confinement, deprivation of food, confiscation of legal or travel documents, or other extreme means of submission.

Fraud involves deceiving, luring, or tricking a victim into work situations. It may manifest itself in the form of false advertisements of good-paying jobs or a specific type of work that would afford the individual enough income to care for oneself and his or her family members. Instead, once employed, the individual is subjected to sweatshop conditions and little to no pay. Coercion involves intimidation, threats, or perceptions of real danger related to acts of violence toward the victim or his or her loved ones. Depending on the victim, threats may also include informing law enforcement or immigration of that person's undocumented or expired legal status, for example. Combined, acts and means work in tandem to both entrap and enslave victims in sweatshops.

Sweatshops and Companies

Sweatshops are known for employing children and women to produce their products despite the horrific abuses (verbal, physical, and sexual), morbidity, and mortality associated with such practices. It is estimated that more than 250 million children work in sweatshops abroad. Children ranging in age from as young as 5 to 14 are commonly subjected to sweatshop work in many developing countries. It is reported, however, that 85 percent of sweatshop workers are young women between the ages of 15 and 25. As is the case abroad, most sweatshop workers in the United States are young women as well. In 2011, however, more than $2 million were assessed for civil money penalties due to U.S. companies' Fair Labor Standards Act child labor violations. In 2012, the Department of Labor reported that 134 products made in 74 countries were produced by child labor or forced labor persons.

A wide range of companies in the United States are guilty of involvement with sweatshop entities. Many are able to plead innocent, nonetheless, amid (1) persistent allegations of abuse and unethical practices among its contracted manufacturers, (2) millions paid in fines, and (3) gross violations of labor standards. Weak internal monitoring systems are often blamed for the offenses versus admission of direct participation and knowledge of such practices by the parent retailer.

The TVPA forbids contracting with organizations abroad that engage in labor trafficking activities. As a loophole to such requirements, however, many companies allow for internal monitoring systems abroad to operate as the conscience of those companies' operations. This includes allowing for the prevalence of inspectors who are bribed to fail to properly review documents, inspect sites, and interview managers, supervisors, and workers during their required and unannounced visits. Retailers, buyers (stores and brands that lure the consumer in), and unethical contracted manufacturers (the producers of goods) lure in unsuspecting and vulnerable contractors (sweatshop workers) who are then subjected to violent and aggressive overseers. As a result of this infrastructure, this inherently oppressive system lends itself to sweatshop practices. Sweatshop abuses involving American companies have been reported in a number of countries including India, China, Pakistan, Bangladesh, Mexico, Ecuador, Columbia, Brazil, and Indonesia, to name just a few. In the United States, sweatshops are also well documented in California and New York.

Sweatshops are a widespread problem in many parts of world, including the United States. The United States has identified sweatshops as a major social ill both domestically as well as abroad. With goods being imported into the United States from more than 100 countries across the world, sweatshop victims continue to grow in number. These victims include persons subjected to sweatshop work in the United States. Comprehensive measures that include worldwide cooperation in the manufacturing of consumer goods, close monitoring of contracted manufacturers abroad and domestically, conscientious and responsible business practices, and an acknowledgment of the severity of the matter have marked the beginning of an extensive fight to end sweatshops worldwide.

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See Also: Child Labor, International Variations in Attitudes Toward; Children, Youth, and Human Trafficking; Fair Labor Standards Act; Human Trafficking.

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Targeted Case Management

Provision of effective human services are often compromised owing to a standardized, cookie-cutter approach to service delivery. While services that target general populations need to be standardized in order to maintain quality, consistency, and cost-effectiveness, it is important that specific individuals or population groups (owing to the uniqueness of their situations) are provided with focused services that meet their needs. Examples of such groups include people with disabilities, people living with human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), children with learning difficulties, and so on. Though all of them require human empathy and support as does anyone else, the specificities of their conditions require a different (and sometimes more intensive) service approach to be effective.

Targeted case management (TCM) is an approach and support system that ensures that an integrated range of support and service coupled with social support systems are available to the beneficiary or group. The integrated and comprehensive nature of the TCM is well defined by the case management work group set up by the commissioner of the Department of Behavioral Health and Development Services (DBHDS), Virginia, United States. According to the work group, "Targeted case management, as it has developed and is provided in the public behavioral health and developmental services system, includes the elements of basic case management and a full range of care and support that individuals with more severe disabilities require in order to live successfully in the community. These services include but are not limited to: supportive counseling; crisis intervention; direct assistance with limited activities of daily living; coaching; intake and discharge planning; relationship building; teaching decision making; self-advocacy and wellness planning; education regarding the need for medications, primary care, and therapy; promoting continuity of care among various health systems and providers; providing family education and support; and generally overcoming barriers for accessing appropriate care."

The entry provides an overview of the various support services used in TCM. The entry also covers the duties and responsibilities of the persons providing TCM (case workers and case managers). An effective TCM will include the following approaches.

Outcome Oriented

This is making sure the various service providers involved, the family, and other social networks all work toward a common goal for the client and his or her family. Outcome orientation also means the milestones toward the common goal are clearly identified, and should any deviation take place (such as when the desired progress is not achieved), the treatment or support plan is reviewed, and a new set of targets or goals are set.

TCM also focusses on the final outcome of positive change for the beneficiary, ensuring that there is improvement manifested through, for example, quality of life, medical condition, physical and mental ability, social acceptance, and so on.

In a TCM approach, continuity of care will make sure the client receives uninterrupted services and that support and suitable social, financial, medical, and any other needs are continuously available.

Coordinated support will include networking with a wide range of support providers such as hospitals, family members, counselors, insurance providers, state institutions including legal assistance (if necessary), and case workers to make sure the beneficiary receives assistance from all relevant stakeholders.

Treatment and Support Plan Based on Strengths and Opportunities

This is a fundamental cornerstone for a quality TCM approach. This makes sure that all service providers and family members involved in the process build on something positive and work toward an incremental improvement in the client's condition. Professional counselors commonly use this approach through positive reinforcement, creating a sense of optimism for individuals.

Provision of Intensive Support

This is one of the key necessities for persons requiring TCM, and the institution or case manager focusing on this approach needs to have the means and systems in order to ensure it. The value base and humane principles in TCM are critical to bringing about successful outcomes for the clients. The Johnson country TCM policies and procedures manual outline their operating principles and value statements for TCM as follows:

1. The TCM process focuses on the individual using the service's strengths, interests, abilities, and competencies.
2. The TCM process takes place in the community. The client is viewed as the director of the TCM process.
3. The relationship between the client and case manager is primary and essential.
4. TCM is based upon effective communication in providing information to the individual, his or her family, and those providing services.
5. TCM provides for the individual's maximum participation in the decision-making process.
6. TCM involves the individual, families, guardians, and other professionals or agencies in identifying, developing, implementing, and monitoring comprehensive plans.
7. The community is viewed as a resource, not as an obstacle.
8. TCM facilitates access to available public and private resources.
9. TCM advocates for resources to meet the current and future needs of individuals.
10. TCM strives to attain a greater level of integration of the individual into the community.
11. TCM is confidential and professional.

On a practical level, the following factors are linked to the achievement of successful outcomes as outlined by Shilpa Ross and colleagues.

1. Assigned accountability of an individual or team to the patients being case-managed
2. Clarity about the role of the case managers and support to ensure they have the right clinical and managerial competencies
3. Accurate case finding to ensure interventions target patients with defined care needs
4. Appropriate caseloads to ensure that patients are receiving optimum care
5. A single point of access for assessment and a joint care plan
6. Continuity of care to reduce the risk of an unplanned admission to hospital
7. Self-care to empower patients to manage their own conditions
8. Joined-up health and social care services with professionals working to aligned financial incentives and in multidisciplinary teams
9. Information systems that support communication and data that is used proactively to drive quality improvements.

Research and practitioner's literature on TCM provides a wide variety of approaches and phases to set up a TCM system for an individual. The most commonly used process involve the following steps.

Identification of Clients

Two approaches could be used in TCM—first in which the caregivers or institutions respond to someone (or family or social system such as a school) who reports to them and seeks assistance specifically. The second approach could be when the institution proactively engages with community (through social workers) and institutions (hospitals or schools) to identify individuals who already need specialized care or who are in high risk or susceptible to such conditions and brings them in the fold of TCM (with consent of the family or individual). The second approach is particularly useful when the condition could be associated with certain stigma leading to nonreporting voluntarily.

Review and Assessment

The first and most important aspect in a TCM process is the need for a comprehensive assessment of the client, which will determine the information base for various providers and decide the treatment course necessary. This stage includes looking at both the immediate symptoms and concerns that are visibly manifested in the person, while the review is being done. Careful assessment needs to be done to separate these symptoms into clinical, social, cognitive, behavioral, and other categories. Going beyond the immediate, there is also a vital need for looking beyond into a range of other issues. These could include, for example, the person's social background, social network and support system, occupation and any risks therein, skills and training, financial status, disease history including diagnosis and treatment, behavior, cognitive skills and habits, and so on. In line with the approaches mentioned (focus on strength), there is also a need for identifying any positive strengths, which can serve as a foundation on which the treatment system can build on.

Depending on the individual, and the severity of symptoms and the nature of the treatment necessary, the assessment process if necessary can be phased over a period of time as well as involving multiple actors or specialists to generate a well-informed case history. Assessment, if interrupted for a long period for some reason, needs to be initiated once again. Given the detailed, in some instances intrusive, and subjective nature of the factors that need to be assessed, it is vitally important that the case worker and the client have a level of trust that can generate quality discussions and observations. Skills of the social worker to elicit information as well as to analyze it (including linking to get a wider picture) are also key. Having a dedicated case manager who deals with a particular case file is critically important to enable him or her to know of the client's history as well as establish a level of trust.

Individualized Support Plan Development

The assessment information will become the basis for generating a case file as well as development of a comprehensive support and treatment plan for the client. Development of the plan must involve the client and his or her family as much as possible as well as various other stakeholders. This will ensure collective ownership of the plan and avoid any confusion at a later stage. Participation of the client and his or her family also ensures individual accountability and need for discipline. The element of self-care within the treatment plan is important as the client (and his or her family) is foremost responsible for his or her own conditions and plays a crucial role in achieving the desired outcome.

The plan will outline the outcome, periodic milestones in achievement of the outcomes, and specific treatment plans and support needs. All these need to be outlined in clear terms and in a standardized model. In other words, the plan must answer the five Ws: what will be done (specific action necessary to support the client and in the areas of clinical, institutional, and social aspects); who will do it (responsibilities of different actors); when it will be done (time frame and at which stage); where it will be done (physical location, home, clinic, or elsewhere); and how it will be done (specifics of the treatment protocol as well as any financial aspects).

Changes to the plan could be affected during the course of treatment and include similar inclusive processes wherein all the stakeholders join together.

Referral, Networking, and Coordination

Coordinated action between the various service providers is necessary to ensure concerted action in addressing the multiple support needs the client may have. Some of the activities include setting up joint review meetings between providers to agree on a common plan of action, scheduling treatment and meetings with the client, sharing relevant progress information with each other, adding or taking away other specialized providers during the treatment process if necessary, and so on. This is vital to making sure that the services are continued uninterrupted as planned and that any deviations are noted and acted up on or corrective action is taken.

Monitoring and Review

Monitoring is an ongoing process throughout the treatment pathway and provides critical information to all concerned on the progress (or lack thereof, triggering alternates). This requires close interaction between the case manager and the client and a strong element of trust and, therefore, is absolutely vital between the two to enable this. Intensive engagement also means that the case worker can only handle a few cases at a time to do a quality job. The progress and monitoring report needs to provide standardized information in line with the original support plan and progress toward the final outcome.

Ending the TCM for the Client

M. Roland has outlined four different situations where a TCM program could be terminated for the client. They are: the death of the client, self-discharge, decision by the case manager or the multidisciplinary team that care has been optimized (i.e., that the person is well enough to live independently or that he or she requires more or less intensive and ongoing support, such as a nursing home, or specialist care, such as end-of-life care), or the patient's risk of hospital admission, identified by a risk prediction tool, falls below a certain level as determined by the case management program.

As mentioned, success of an effective TCM system depends on the quality of the case management, and case managers play a pivotal role in this. Some of the key roles of the case managers are as follows: coordination between different stakeholders and the client, managing the referral system among providers, information gathering and sharing, decision making based on information and advice from the service providers, identifying support needs and ensuring these are available, and advocating for the quality support needed with the providers and government institutions.

In order to perform these roles efficiently, the case managers need to have specialized competencies and skills. The following section outlines some of these while recognizing the fact that individual client needs may require other specialized skills.

Personality, Behavior, and Attitude-Related Competencies

- Empathy with the client and the condition she or he is suffering from as well as willingness to engage with the case and advocating for quality care and support for the person
- Patience to deal with individual's needs and demands as well that of the service providers
- Organization skills and self-discipline
- Analysis and observation skills
- Sensitivity to the individual's cultural, social, and religious affiliations and the ability to avoid being biased or judgmental
- Language skills
- Ability to maintain confidentiality with information
- Objectivity and not allowing personal relations to cloud observations

Specific Technical Skills Regarding the Case

- Understanding of the condition of the client, including social, medical, behavioral, and other aspects—this will help the person understand the symptoms and conditions well
- Awareness regarding personal and the client's safety and security needs
- Technical understanding regarding the TCM approaches and models, various good practices in addition to relevant educational and experiential knowledge as well as professional certification
- Awareness regarding the service providers, their ways of working, and technical and procedural aspects of their work
- Coordination skills with a wide range of stakeholders and interpersonal skills
- Conflict management skills
- Organizational skills—the ability to independently manage an often large caseload

and prioritize both direct service and accountability for recipient records and other related tasks and activities.
- Knowledge and awareness on use of various standards and technologies including case record documentation and management
- Research and analysis skills to stay relevant on the issues

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See Also: Case Management; Case Management Services.

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Telecommunications Devices for the Deaf

Telecommunication services are vital for functioning in the modern world, a truth which has been recognized since the middle of the 20th century, when the Rural Electrification Agency in the Department of Agriculture began providing loans and resources to ensure the installation of telephone lines throughout the country. Over the course of the 20th century, the telephone evolved from a luxury to a necessity, with many of everyday life's challenges becoming difficult to address without such access. For deaf people and the hard of hearing, ensuring these services was a more complicated matter, especially in the decades before the Internet.

A telecommunication device for the deaf (TDD) is a type of teletypewriter (TTY) that has become the standard generic term because such devices are not exclusively used by the deaf community. The basic form of the TTY is a printer and typewriter that transmits text over telephone lines. Modern TTYs usually have both a screen and a printer; older models had only the printer as an output device. While the basic function of a TTY is to transmit text back and forth to another TTY, additional services are sometimes available, such as relaying the text to a relay operator: a hearing person who acts as the intermediary between a TTY user and a hearing voice phone user, reading the TTY's output aloud to the hearing user, and typing the hearing user's responses to the TTY. Similarly, hearing carryover and voice carryover services assist users who can hear but not speak or can speak but not hear.

Abuse of Telecommunication Services

Today, telecommunication relay services have considerably expanded and do not always require the use of a TTY but accept input from computers over the Internet, cell phones, tablets, and other devices. In the United States, such services are provided by phone companies and subsidized by the federal government, which reimburses phone companies for certain expenses incurred by operating relay services. In 2012, the federal government sued AT&T for not properly making sure that users of the system were located in the United States, thus receiving reimbursement for calls that the government did not owe payment for. The original national telecommunications relay service is available by dialing 711 on any phone in the United States.

There are numerous variations of such services, all of which involve providing an intermediary who can make a voice call on behalf of the deaf or speech- or hearing-impaired user. Some stories in the news, notably an NBC news story in 2006, have claimed that these services are widely abused for the placement of prank calls because relay operators are required to relay the communications that they handle without question. While pranks—and more dangerously, fraudulent scams—are a serious problem in the industry, it is not clear how common they are relative to the volume of legitimate

A Miniprint 425 tellecommunication device for the deaf. The acoustic coupler on the top is for use with telephone handsets, and a printer records the conversation. The specific GA and SK keys allow for speedier use of common abbreviations. It has become a wideheld belief that access for the deaf to telecommunications and information is as vital as any other civil right.

calls. There are also cases in which such services are used for legitimate purposes by those who have no hearing or speech disability, but who have some other motivation for wanting to use an intermediary or avoiding speech communication, such as an anxiety disorder.

History of Teletypewriters

Teletypewriters or teleprinters were not originally designed for use by the deaf but were rather an augmentation of 19th-century telegraph technology. Only when telephony became common did TTY devices become mainly associated with the deaf and hearing-impaired community. Rather than use devoted lines as telegraphs had done, TTY devices for the deaf used modems to transmit their data over normal phone lines. Many of the first modern TTY devices were distributed to the St. Louis deaf community in the 1960s by deaf engineer Paul Taylor. Taylor's device repurposed teletypewriters from Western Union, and he soon instituted the first telephone relay system for the deaf, followed by statewide relay services in New York, a project that was funded by the telephone service providers. After the Americans with Disabilities Act of 1990 required statewide telephone relay systems throughout the country, Taylor assisted with writing the FCC's regulations for them.

More TTY devices followed after Taylor's innovation, notably deaf news anchor Kit Patrick Corson's Manual Communications Module (1973), the first battery-powered TTY, which simplified installation and allowed the device to be brought on the road by deaf travelers. The MCM was marketed by Pac Bell, which coined the term Telecommunications Device for the Deaf (TDD), and rented the device to subscribers for $30 a month (versus its $600 retail cost). Today, the TDD term is primarily used outside the deaf community.

TTY devices present a form of communication similar to early Internet chat programs like TALK. For instance, because traditional TTY devices do not have separate output displays (whether printer or monitor) for Party 1 and Party 2, if both parties type at the same time, the result will be garbled—much as happens when two speaking people talk over each other, but it is confusing for people who expect the interface to work like a 21st-century Internet chat program with dedicated output display zones that permit synchronous input from both parties. This presents a problem similar to that encountered in using walkie-talkies or CB radios, in which each party must alternate between speaking and listening modes, and so a similar convention has arisen: North American TTY users commonly use “GA,” meaning “go ahead,” to indicate that they have finished typing and the other person may respond, while “SK,” or “stop keying,” means that the party has nothing more to say and is only awaiting a goodbye.

Modern Devices

Modern TTY devices use a number of different protocols for transmitting data over phone lines, the oldest of which is the Baudot code, an old character set predating ASCII and inherited from the repurposed teletypewriter technology. The best-known child protocol based on Baudot is Turbo Code, a proprietary implementation of Baudot used and licensed by the UltraTec company. Baudot remains standard in the United States, but other protocols have been implemented in Europe, where the history of telephony took different turns.

Today, traditional TTYs are an increasingly antiquated technology as Internet-based communication, whether through standard Internet technologies like email and instant messaging, or Internet-enabled gateways for text-over-IP, become the preferred mode. However, even in the 21st century, analog phone line access is more widespread than IP connections and is cheaper in most cases. Modern TTYs can often be used over modems, while Internet-based services in most cases facilitate communication only with other Internet users. The rise of mobile cell phones and smart phones, and the growing interest of charitable organizations in providing such phones to people in need, may prove to change this, as Internet access becomes decoupled from computer ownership and Internet service accounts.

A newer variation on the TTY is the captioned telephone or captioned relay, which displays captions of spoken conversation on a screen in the base of a telephone attached to a ground line, or on a computer using the WebCapTel service launched in 2008. Because captioned telephone service is not mandated by the FCC’s Americans With Disabilities Act regulations, it is not universally available in the United States, though coverage is wide.

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See Also: Americans with Disabilities Act of 1990; Deaf/Hard of Hearing; Disability Services; Disability Studies; Disabled Clients.

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Temporary Assistance to Needy Families

Temporary Assistance to Needy Families (TANF) was created with passage of the Personal Responsibility and Work Opportunity Reconciliation Act of

1996 (PRWORA, P.L. 104-193). TANF replaced the Aid to Families with Dependent Children (AFDC) program, an original component of the Social Security Act of 1935, which had made available federal cash assistance to low-income mothers and their dependent children based on state-determined eligibility of financial need independent of their attachment to the labor force.

Unlike AFDC or Title I, TANF provisions in PRWORA capped federal welfare spending to the states, limited federal cash assistance for welfare recipients to five years maximum while permitting states to end it sooner (which 17 did), set labor force participation targets for recipients of cash and other public benefits, such as vouchers for food, and restricted welfare and other public benefits for illegal immigrants. Scheduled for reauthorization in 2010, Congress has since extended TANF several times, most recently through the end of September 2013.

A Texas family applies for assistance after a fire destroyed their apartment. Temporary Assistance to Needy Families (TANF) replaced the Aid to Families with Dependent Children (AFDC) program, which was part of the Social Security Act of 1935.

TANF Provisions in PRWORA

Under Title I of PRWORA, AFDC, Emergency Assistance (EA), and Job Opportunities and Basic Skills (JOBS) were combined into a single, capped entitlement to states. The total cash assistance block grant was estimated at $16.4 billion for each year from fiscal year (FY) 1996 to FY 2003, with states receiving a fixed amount based on a formula that took into account prior AFDC, EA, and JOBS expenditures. States were permitted to carry over unused grant funds to subsequent fiscal years, and they were mandated to maintain 80 percent of FY 1994 state funding on AFDC and related programs. This maintenance of effort (MOE) spending requirement replaced the state match that AFDC had required. TANF programs had to be operational by July 1, 1996. PRWORA deemed ineligible for federally funded cash assistance families who had received such assistance for 5 cumulative years or less at state option.

States had to demonstrate that they would require families to work after two years on assistance and set work participation rates for single-parent families at 25 percent in FY 1997, increasing to 50 percent by FY 2000 and for two-parent families from 75 percent to 90 percent by FY 1999. Work hours were also specified for single-parent and two-parent families, 20 and 35 hours per week respectively, with some exemptions for single parents with children under 6 years old who could not find child care. Work activities included unsubsidized or subsidized employment, on-the-job training (OJT), work experience, community service, up to 12 months of vocational training, or providing child care services to individuals who were participating in community service.

Up to six weeks of job search were also permitted, although states with unemployment rates 50 percent above the national average could count up to 12 weeks. No more than 20 percent of the caseload was permitted to count vocational training toward meeting the work requirement. Those convicted of drug-related crimes after the date of enactment were prohibited for life from receiving benefits under the TANF and food stamp programs. States were penalized with a percentage reduction of their block grants for, among other things, failure to meet work participation rates. Unmarried minor parents were required to live with an adult or in an adult-supervised setting and participate in educational and training activities. Based on total TANF and MOE funds totaling $33.3 billion in 2011, approximately 29 percent of expenditures go to cash assistance, 38 percent to other services, 17 percent to child care, 9 percent to other work support and employment programs, and the remainder to administration.

The Impact of TANF on Welfare Caseloads

Reductions in welfare caseloads were immediate and steep. At the end of FY 2001, the average monthly number of TANF recipients was 5.5 million, or 56 percent lower than the AFDC caseload in 1996. By 2006, the average monthly number of TANF recipients had dropped to 4.2 million. From its peak of 14.4 million in March 1994, the number dropped by 63.2 percent to 5.3 million in September 2001. As a percentage of the U.S. population, the caseload had reached its lowest point, about 2 percent, since the 1960s. Caseloads dropped by more than 70 percent between FY 1996 and FY 2001 in eight states (Colorado, Florida, Idaho, Illinois, Louisiana, Mississippi, Wisconsin, and Wyoming) and between 40 and 70 percent in 35 states. A robust economy with relatively low unemployment rates, ranging from 5.6 percent in 1996 to 4.0 percent in 2000 before increasing to 4.7 percent in 2001, and expansion of the Earned Income Tax Credit (EITC) program contributed to the decline in TANF caseloads, with 7.2 million persons having left the welfare rolls between FY 1996 and FY 2001.

Caseload reduction was initially accompanied by a decline in child poverty and an increase in single-mother employment. The child poverty rate dropped from 22.2 percent in 1995 to 15.6 percent in 2000, with the related number of children decreasing from 14 million to 11 million, respectively. The percentage of single-mother employment increased from 64.0 percent in 1995 to 75.5 percent in 2000. Caseloads continued to decline until reported notable increases in 2008, with unemployment rates ranging from a low of 4.6 percent in 2006 and 2007 to highs of 6.0 percent in 2003 and 5.8 percent in 2003 and 2008.

Early gains, however, masked the decline in the number of families receiving AFDC/TANF benefits for every 100 families with children in poverty from 68 in 1996 to 27 in 2011. Further, the role of TANF in providing income support to poor families declined dramatically during the Great Recession of 2008 and 2009 through 2011 as the uptick in caseloads from about 1.8 million to 2 million was less than increases in families with children in poverty, which jumped from about 6 million to 7 million, and in families with children in deep poverty (income below half the poverty line), from about 2.8 million to 3.2 million. Finally, the value of TANF benefits has declined in most states since 1996: Benefits did not keep pace with inflation, such that in 2011, they were below the poverty line in half the states; in addition, seven states had value declines of 10 to 20 percent, 28 states of 20 to 30 percent, and six states above 30 percent.

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See Also: Aid to Families with Dependent Children, Historical Role of; Child Support Agencies and Services; Food Support; Medicaid; Poverty; Social and Economic Justice; War on Poverty Programs; Welfare Reform, Role of.

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Tobacco Use, International Variations in Attitudes Toward

Smoking kills—this is a fact. But, even if people know about that, there are variations in international attitudes toward tobacco use, which are a consequence of human diversity and the several differences of societies around the globe. There are nearly 1 billion males and 250 million females who smoke daily. Almost every day, more than 80,000 people begin to use tobacco, and many of them are children who, if they become addicted, will be in need of a special human service. The diversities of the attitudes toward smoking are mainly influenced by the situations of the people in each country. There are countries—mainly industrialized nations in North America and Europe—where smoking is seen as an evil, but there are also mainly poor countries, where people do smoke a lot because the health threat of tobacco use is not seen as a high priority.

Decision for Tobacco Use

In general, the tobacco industry aims to market their products to children, replacing the customers, who are dying day by day. For this, cool packages that symbolize a modern and nonconformist living style are used to attract the buyers of the next generation. Because of this strategy, many young boys and girls start smoking between the ages of 11 and 14. In many European countries, like Sweden, many children smoke cigarettes regularly. Despite the national background, there are factors that are responsible for the decision to smoke. Factors relating to one's social environment include the attitudes of family members or friends. When parents or friends are active smokers, there is a high chance that the children will start smoking as well because children adopt habits that they see every day at home. There are other reasons as well. Rebelliousness, the testing of a risk, or the lack of self-esteem could be responsible for the first cigarette of a young smoker trying to be seen as cool or strong by their peers.

International Attitudes

There might be similar reasons for young smokers around the globe to start smoking, but one decisive factor is the country where the person is living. Whereas it is forbidden in many Western countries to sell tobacco to young persons, there are countries where any laws against the smoking habits of children are not enforced. Especially in poor countries, youth are less protected by law. Even if there were restrictions in the usage of tobacco in poorer countries, the police would not be interested in enforcing tobacco restrictions while dealing with high crime rates. The higher the level of safety in a society, the greater the need for medical care and preventive measures to protect the masses from bad health.

The so-called sin taxes are one possible measure against the smoking habits of U.S. smokers, forcing smokers to pay higher fees for their health insurance. This is a consequence of the fact that these patients would possibly need special treatment for their smoking-related illnesses. In many countries in western Europe, smoking has been banned from public life step by step. While smoking was an elemental part of daily life during the postwar period from the late 1940s onward, it was gradually restricted to protect the health of the whole society, especially as it became known that tobacco use is damaging to passive smokers as well.

The European Union is actually planning to ban special products that are particularly harmful, including menthol cigarettes, while many countries have already started campaigns that show the consequences of heavy smoking by depicting the diseases on the boxes. In the future, and as an addition to the ban of tobacco commercials from the public media, there are few smoking scenes in modern movies, which is a visible contrast to classic movies, where stars like Humphrey Bogart smoked cigarettes on-screen. Smoking should not be individualized, giving all brands the same box design to make neuro-marketing ineffective.

In contrast to this, poorer countries do not possess the financial abilities to provide a broader education on health issues. As smoking is one of the few pleasures available after onerous work in inhuman conditions, people are not willing or are unable to quit tobacco use. That's why, in Africa especially, the number of people who smoke is increasing.

Ratio Between Wealth and Health

It could be concluded that there is a traceable ratio between the wealth and the health of a nation. This ratio signifies how a rich nation is more willing and able to protect its people from health-destroying habits. To achieve this aim, there could be pressure on the tobacco lobby and on smokers in every single case. The industrialized nations of Europe and North America are trying to ban smoking in society by introducing education about the consequences of this harmful habit. In contrast, the number of young smokers is increasing in poorer countries, where smoking is not the most imperiling factor in daily life and a very important part of the national tax income. Just an improvement of the general situation in these countries would make discussion about the attitude toward tobacco use possible. A stronger economy could provide the basis for a checkup of the tobacco lobby in poorer countries, where smoking cigarettes remains the last affordable pleasure and a prevalent part of society.

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See Also: Health Care, Disparities in; Health Care Delivery, Models of; Health Insurance; Health Promotion Services; Medical Necessity; Youth Risk Behavior Surveillance System.

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Torture, Survivors of

Despite international recognition of torture as a human rights violation, torture remains a widespread blight with horrendous consequences for individuals, families, and communities. This entry will define torture, identify methods of torture, describe its physical and psychological effects, describe the network of service providers for survivors, provide a brief overview for identifying and working with survivors, and address the importance of self-care for clients and workers.

For the purposes of this entry, torture is defined as government-instigated or government-sanctioned infliction of severe physical or mental pain or suffering for the purpose of obtaining information, punishment, or intimidation or for any reason based on discrimination. Physical forms of torture include beatings, food and sleep deprivation, simulated drowning, sexual assault, burning, suspension by the arms or legs, electrical shock, forced ingestion of psychoactive drugs, and exposure to extreme heat or cold. Mental forms of torture include threats to the victim or his or her family or associates, forced witnessing of the physical torture or killing of others, mock executions, exposure to vicious animals, isolation, and humiliation. The specific form of torture is probably less important than its effects.

Effects of Torture

Victims of physical torture may suffer temporary or permanent physical disabilities. Regardless of whether the torture was physical or mental, victims are almost certain to suffer symptoms of psychological trauma. These psychological effects may last for decades. Symptoms of trauma include nightmares, recurrent and obtrusive memories of the torture, hypervigilance, an exaggerated startle response, a low tolerance for stress, and a general mistrust of people and institutions. These symptoms in turn may lead to secondary psychosocial difficulties such as depression, substance abuse, agoraphobia, family conflict, employment difficulties, and so on.

Services for Torture Survivors

Unless the governmental regime of a country that practices torture changes, victims will not be able to get help in that country. Thus, most services to survivors of torture are provided in other countries that have granted the victims political asylum, that is, refugee status. It is estimated that 5 to 35 percent of refugees in the United States are torture survivors. Survivors are served by a network of more than 200 centers and programs around the world, including more than 30 in the United States, that provide intensive support to torture victims through comprehensive medical, psychological, psychiatric, legal, and social services.

Identifying Torture Survivors

Most human service providers do not work in centers for torture survivors, but they may well encounter survivors in diverse practice settings. Thus, practitioners should be prepared to recognize torture survivors so that they may refer them to appropriate services. Most survivors of torture will not readily self-identify as such. Typically, survivors are reluctant to discuss their painful memories. Thus, human service providers must be alert to the symptoms of trauma already described. Once service providers have established a relationship with a client (which may take some time), providers can gently ask questions about the client's past in his or her country of origin, such as whether he or she experienced persecution, detention, arrest, violence, threats, and so on, and whether such experiences were perpetrated by government officials such as police or military. It would be wise for providers to first find background information on the political situation in a client's country of origin in order to approach the client in an informed manner. A good way to open up such discussion is by stating, "I read that in your country . . . Did something like that ever happen to you?"

Working With Torture Survivors

The critical foundation for services to torture survivors is case management that is comprehensive, coordinated, compassionate, and culturally competent. Survivors are dealing not only with the trauma of the torture experience but also the loss of their homeland and adjustment to life in a foreign culture. Thus, most need services in multiple arenas, including health, legal status, education, employment, life skills training, cultural orientation, language training, housing, mental health, and spirituality. The case manager must be skilled in developing and nurturing an interagency network to serve these multiple needs in order to help the client navigate that network and to advocate for the client and help the client learn to advocate for him- or herself.

Trust is central to any helping relationship. Human service providers working with torture survivors must recognize that building trust is likely to be a slow process. Workers must exhibit patience, transparency, reliability, and judicious self-disclosure. They must also be familiar with and respect the client's cultural norms (as long as those norms are not harmful to anyone). Workers must also identify a client's strengths, help the client recognize them, and thus foster the client's empowerment. Finally, workers must use evidence-based practices. For example, decades of research with persons with posttraumatic stress disorder due to war and torture experiences have yielded effective treatment approaches, most of which involve some form of imagined exposure.

Torture survivors should be taught skills to soothe themselves, including health behaviors such as nutrition and exercise, relaxation behaviors such as meditation and deep breathing, and engagement in social and community activities. For many survivors, the idea of self-care will be a foreign concept as, by definition, these are individuals who have essentially sacrificed themselves for a cause. Thus, workers would do well to model these behaviors. Finally, workers need to engage in the same behaviors for their own sake because those working with torture survivors are vulnerable to vicarious traumatization.

Conclusion

Work with torture survivors exposes us to the worst aspects of humanity, yet it can be highly rewarding in helping survivors build and thrive in their new lives.

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See Also: Cultural Competence, Human Service Providers and; Office of Refugee Resettlement; Refugee Assistance; Trauma-Focused Services; War and Terrorism, Survivors of.

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Traditional Medicine

Traditional medicine is a term generally used interchangeably with indigenous or folk medicine. It is commonly thought of as health practices that were developed and have been passed on by generations prior to the modern medicine era. Examples of such practices include ayurveda, traditional Indian Medicine, acupuncture, traditional Chinese medicine, traditional African medicine, traditional medicines developed by Incas and Mayas of Central America, and U.S. Native American traditional medicine, and so on.

The World Health Organization (WHO) characterizes traditional medicine as the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illness. Global health and wellness is greatly facilitated by traditional healing. According to WHO, more than 80 percent of the world's population relies on traditional healing for primary health care, and greater than 25 percent of modern medical drugs stem from traditional healing knowledge.

Though traditional medicine is the main recourse for the majority of the population in developing countries, surveys show that more and more people in developed nations, such as the United States, are leaning toward traditional medicine. The main belief in traditional medicine centers on self-healing: restoring the harmonious workings of the body, mind, sprit, and the environment.

History of Traditional Medicine

The earliest known records of the medicinal use of herbs date back to approximately 5000 B.C.E. in the Sumerian society. Many different cultures have reported the medicinal use of herbs in the 1st millennium B.C.E. For example, traditional Chinese and Indian medicines date back to this time frame. The first known physicians were also noted about 5000 years ago in Egyptian society. Further records also indicate designated physicians in ancient Babylonian, Greek, Roman, Indian, and Chinese cultures.

Traditionally, indigenous medicine has been orally passed on. In many cultures, this knowledge may culminate in a figure designated as a healer. These healers, in many situations, are revered and respected as spiritual leaders, such as priests, shamans, or medicine men. This reflects the fact that much of traditional medicine is intertwined within culture, representing a way of life. The practices may be based on the philosophy of cultural traditions, such as the central principle of balance in many practices, which includes Chinese and ayurvedic medicine.

Hippocrates is considered the father of modern Western medicine. He is renowned as the founder of the Hippocratic School of Medicine, which revolutionized medicine in ancient Greece and laid the foundation for modern medicine. *Tradition in Medicine* is a treatise in the *Hippocratic Corpus*, a collection of ancient Greek medical texts attributed to Hippocrates and written around late 5th century B.C.E. It established medicine as a distinct branch of science and as a profession. The Hippocratic Oath, still taken by most medical students upon graduation today, signifies ethical practices by physicians.

Evidence of ancient civilization and its views on the nature of health and wellness is prevalent in contemporary society. Unlike modern medical intervention, traditional approaches to healing do not involve long-term side effects and incorporate elements of nature as well. Indigenous people around the world believe that plants, insects, birds, animals, and human beings possess an innate ability to heal themselves without external stimuli. Unfortunately in modern society, there is an ever-growing disconnection from the natural world.

Since time immemorial, people have enhanced their own health by immersing themselves in nature, engaging in physical and mental exercise and by eating well. Traditional healers of the world have, for millennia, sensitized millions to humankind's inevitable connection to nature and to nature's timeless nurturance of humankind. This form of thinking has been in place over the course of history as a solid foundation for the interaction between humans and nature. Respecting the environment was one way ancient civilizations thrived while maintaining good health.

History of Medication

Most early medications were initially based on naturally occurring substances. For example, penicillin, aspirin, morphine, digitalis, and quinine were all derived from natural sources. Many medications used today are still based on naturally occurring compounds. It has been suggested that approximately 50 percent of new chemical entities launched onto the market may be based on naturally occurring compounds.

In addition to standard medical therapy, about 38 percent of people use some form of complementary and alternative medicine regularly. In some Asian and African countries, 80 percent of the population depends on traditional medicine as a primary source of health care. Herbal treatments are the most popular form of traditional medicine.

Traditional Medicine

Traditional medicine helps facilitate patients during the critical phase of their struggles within the process of self-realization. Traditional systems of medicine were developed in different ancient civilizations and cultures. It seems the science of life has always been in existence, and there have always been people who understand it in their own way. Some of the traditional systems are based on rational and sound fundamental principles, while others are only empirically based. Some of these traditional systems did not survive and have become subjects of history of medicine. Some others, such as traditional systems of medicine of India and China, are not only surviving but also steadily progressing.

Several types of folk medicine are prevalent in different tribal areas of the world. They have a rich tradition in the use of plants, minerals, and nature.

In modern medicine, more attention is paid to correct the afflicted part of the body. But in traditional medicine, while treating a particular disease, the individual is taken into consideration as a whole. This includes taking into consideration the condition of his or her mind and environment, in addition to the physical self, while treating the patient. Along with traditional medicine, certain diets and regimens are often prescribed to the patient in line with the local customs of the people. The essence of food intake is central to many cultures. All religions enjoin fasting as a duty. The desire for food and timely hunger are related to lifestyles habits, while some tribes only eat one meal per day.

One of many types of the traditional medicine is naturopathy. This can be considered as a type of lifestyle, and within it, the patient lives in harmony with nature. Water, clay, sunlight, fruits, and raw vegetables are the ingredients to tackle ailments.

Healing Practices and Beliefs Across Cultures

Healing traditions are as age-old and diverse as humanity itself. Learning from long-standing cultures is significant to many areas in our lives. The diversity of these healing traditions is in part attributable to compartmentalized and largely isolated cultural evolutionary processes in the context of a need for health and wellness. In spite of this relative isolation, however, there is a remarkable degree of similarity in healing practices, beliefs, and founding principles when comparing rich and varied cultures throughout the global community.

The Maya communities of Central America lead a traditional lifestyle in the rainforest, and they maintain intact traditional medical systems as part of their culture today. The Mayan culture has successfully used nature to treat primary and complex ailments for more than 4,000 years. Within the past decade, Todd Pasek has been leading a group of scientists in working with gatherings of traditional Maya healers in Belize and Guatemala, who are working together to employ their traditional healing knowledge toward the conservation of their healing heritage and rainforest surroundings.

Other examples of populations living close to the land and struggling to protect the natural environment can be found among the people living along the Appalachian mountain chain in the United States, an area extending from western New York to northeastern Mississippi. The Appalachian people have resided in this region for hundreds of years, but Native Americans had inhabited parts of the region for centuries before European settlers arrived. Appalachian people hold firm beliefs about their ability to maintain their health and prevent or cure illness. They tend to take a holistic approach to health care, using combinations of traditional healing approaches to health and wellness as derived from their Native American cohabitants generations ago. They are inclined to use mainstream medical care only when necessitated by acute symptom management.

In ancient times, people always learned from and worshipped nature: our Earth and the cosmos. Spirituality and healing have always been a combined tradition. Even today in Hindu and Indic lifestyles, Buddhist and other Eastern philosophies, Native American and Appalachian cultures, and traditionally living indigenous peoples the world over, nature worship is uniformly present. Oral traditions of healing oftentimes have thousands of years of history and, over the years, have brought to the forefront some of the prominent healing techniques of today. These belief systems and practices are passed on from one generation to another. It is unfortunate in Western society that many in the scientific community discount the oral traditions and ask for proof. Only very recently, in the United States, writings of Deepak Chopra and Dali Lama brought to the attention of the mass media the importance of ancient healing traditions.

Across the world, traditional healing is still prevalent in India. Thousands of years ago, Indian scholars identified the art of healing. In many of their ancient writings, auyervedic (or traditional Indian) healers communicated thousands of ways for healing a person's body, mind, and spirit. For example, the Charaka Samhita is believed to have arisen around 400 to 200 B.C.E. It is thought to be one of the oldest and most important ancient authoritative writings on ayurveda (a healing practice that reveres nature in healing, originated thousands of years ago, and is concerned with the integrated healing of mind, body, and spirit). Unlike modern medicine, elements in nature are integrally incorporated into their approaches.

The Indian healing practices of ayurveda and astrological methods date back more than 10,000 years. The ayurvedic form of healing enriches the quality of life of a person through the different sensations of intuitive feeling, sound, touch, vision, taste, and smell. Much like the Appalachian mountain people, Native Americans, Mayans, and others who embrace stewardship worldviews, elements of nature are very much incorporated into the healing practices of the people of India.

Cross-culturally, there are several themes that are consistent within traditional healing systems. For example, we all possess innate healing capacities in which healing occurs from within in the context of healthy lifestyles and ecosystems. We can learn from nature by careful observation of (i.e., listening to) the plants themselves (e.g., morphologic and physical features, energetics, and habitat associations).

Cultures around the world have practiced the holistic form of health and wellness. There are so many strengths in the understanding of healing harmony with nature. Natural and herbal practices have been developed through careful observations and consistently refined with trial and error. These practices have been used successfully as evidenced by cultural vibrancy and stories of health and wellness passed down from one generation to another.

A group of yoga practitioners stretching. Traditional medicine uses nature as an example; for example, felines instinctively stretch in different poses as part of their daily routine.

For decades, modern medicine has been not only skeptical about but often closed off to hearing the stories of individuals who proclaim the healing powers of various forms of alternative medicine, such as shamanism and prayer, acupuncture, ayurveda, healing with whole foods, and herbalism. A range of health traditions from the natives of North America, the rainforests of Central America and South America, the Appalachian Mountains, the Far East, and other locations around the world continue to be used by those who embrace their preventive and curative benefits.

Spirituality of Nature

Through mindful study, nature also teaches us how to keep fit. For example, from housecats to lions on the Serengeti, felines always stretch in different poses as part of their daily routine. We now know that, by doing so, our mobility and flexibility can be improved—something essential to us all.

In ancient times, people always learned from and worshipped nature, our Earth: the sunlight, the water, the fire, and the wind. Spirituality and healing have always been a combined tradition. Even today in Hindu, Native American, and Appalachian cultures, nature worship is uniformly present. Oral traditions of healing oftentimes have thousands of years of history and, over time, have brought to the forefront some of the prominent healing techniques of today. Some Far Eastern traditions can appreciate noble lineages in different forms of healing reaching as far back as more than 10,000 years. While learned medical systems are generally practiced in towns and cities, oral traditions are still quite common in villages. These belief systems and practices are passed on from one generation to another.

Conclusion

Cultures around the world have practiced the healing arts for thousands of years, and they still practice these holistic forms of health and wellness. There are so many strengths in the understanding of healing approaches across cultures as well as lessons for how we as a society can survive in harmony with nature. Natural and herbal health practices have been used successfully as evidenced by cross-cultural congruency, with stories of health and wellness passed down from one generation to another. Younger generations must be encouraged to take a vested interest in learning the healing traditions and practices of those aging family members still alive and be able to share their wisdom. This intergenerational interaction can further inspire many younger and middle-aged individuals today who, in ever-increasing numbers, believe in the extensive benefits of complementary and alternative medicine.

The authors propose a holistic collaboration in developing mutually beneficial, cross-cultural educational opportunities, combining modern medical knowledge and practice with the methods and wisdom of traditional healers around the world. This will ensure economic viability of their ideals and propagation of traditional healing knowledge to both younger generations and an interested global audience, while it promotes cultural relativity and develops fresh revenue for the preservation of our world's natural places and the deep cultural traditions therein.

By developing the knowledge of traditional healers in a mutually beneficial exchange of wisdom and practice, all global communities can reap rewards through not only the development of holistic collaboration and innovation in healing but also the generation of economically viable outlets for cultural self-empowerment and ecological integrity.

This approach to global health and wellness will provide not only ways of healing ourselves as nature had intended but also a reawakening to the benefits and health-giving resources of nature's bounty. Along with this newfound awareness will emerge an inevitable respect for maintaining the environment that nurtures the world—people, animals, and plants. The growing realization of the intricate connections among mind, body, and spirit in the context of our natural world is long overdue within modern society. Our understanding of healing across cultures sets us on a path that can lead only to a better sense of self within the context of the universe—a more appropriate idea as we increasingly discover ourselves as a global community.

We can learn from the traditions and folk healing practices and apply them to modern-day methods for health and wellness, inclusive of modalities for sustainability and harmonious coexistence with our natural world. Through their wisdom, we could potentiate the growing global consciousness necessary for our existence in a sustainable and healthful fashion into the next millennium.

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See Also: Alternative Medical Systems; Medical Social Workers, Racial and Ethnic Issues for; Meditation/Yoga.

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Transgender Individuals

Transgendered individuals identify with the gender roles of the opposite sex. The transgender spectrum includes individuals diagnosed with gender dysphoria, cross-dressers, and transsexuals. Throughout their growth and development, transgendered individuals struggle to feel comfortable in their own bodies and in their social contexts. Ultimately, some transgender individuals defer to societal gender roles, withholding expression of their preferred gender. Some marry and have children. Those who choose to commit fully to the gender with which they identify seek sexual reassignment.

Gender Dysphoria

Gender dysphoria, discontent with one's biological sex, often emerges long before adolescence. A child may feel uncomfortable in play activities with children of the same sex. Some desire to wear only clothing worn by the opposite sex. Gender dysphoria is often accompanied by anxiety and depression, the treatment of which may lead to the initial diagnosis of gender dysphoria. Most cases of childhood gender dysphoria subside, but for the remaining transgender individuals, family education and family therapy can be useful in assisting the child and his or her family with feelings of denial, anger, and fear.

In adolescence, transgender students present challenges to high schools that have no policies and procedures to govern accommodation of transgendered students. The high rate of suicide among transgendered youth indicates that access to the appropriate services for transgender adolescents is critical. Parents, teachers, and administrators face difficult decisions about which restrooms the student will to use, how the student will dress, and which activities and sports are right for the student. School guidance counseling for the transgender student may be so involved with gender issues that important education and career issues are not adequately addressed.

Gender dysphoria in young adults interferes with the normal transition to partnership. Determining a life path is particularly difficult for someone who has not yet determined his or her identity. An essential part of providing services to young transgender individuals is facilitating their involvement in peer services. Online resources include information, support, blogs, social networking, and advocacy Web sites. Many communities have lesbian, gay, bisexual, transgender, and queer (LGBTQ) support groups as well as support groups for families and friends.

Adult males who have lived in traditional gender roles often decide to transition after they have been married for many years and have had children. Because transitioning produces visible changes, social and work relationships also change. The parents, spouses, and children of those who transition later in life have a significant adjustment to make. Spouses go through a significant grieving process, having lost the partner they married. Some couples remain married. Some become friends and may provide support through sexual reassignment therapy. The children of a transgendered individual may experience confusion about their relationship with their parent. Group, family, and individual therapy, as well as attendance at a support group, can aid the patient and family in making the transition and managing the associated stress.

Care and Services for Transgendered Individuals

Effective services for transgendered individuals are comprehensive and include mental health services, medical services, social services, and social advocacy. Since 1979, the World Professional Association for Transgender Health (WPATH) has published standards of care for working with transgendered individuals. Fenway Health maintains an informational Web site that links to materials for training clinicians in all disciplines.

Mental health professionals serving transgender individuals should have adequate knowledge in growth and development and sexual issues and should be certified by the American Association of Sexuality Educators, Counselors, and Therapists (AASECT). Individuals seeking sexual reassignment are required to provide referrals from qualified mental health professionals documenting the patient's emotional preparedness to undergo medical procedures. Providers should be familiar with resources for education, medical intervention, family therapy, career services, and gender reassignment, so they can make timely and appropriate referrals. Sound collegial relationships with all types of providers promote an effective, community-based, interdisciplinary approach.

Sexual Reassignment Services

Transgender individuals who seek sexual reassignment also require a spectrum of ancillary services. Testosterone therapy for masculinization redistributes fat and muscle, deepens the voice, increases libido, stimulates hair growth on the face and body, and promotes clitoral enlargement and vaginal atrophy. Estrogen therapy for feminization initiates breast development, redistribution of fat and muscle, and decreases growth of facial hair. Estrogen therapy continues through life, which increases the risk of strokes, heart attacks, and cancer. Sexual reassignment surgery reconstructs the genitals. Male-to-female transsexuals may also have breast augmentation, facial surgery, and reduction of the Adam's apple.

Voice therapy assists people in transition with achieving an appropriate tone. Communication therapy addresses both verbal and nonverbal behaviors, including walking and gesturing. Body shaping may include breast binding, genital tucking, or hip padding. Changing from male to female also entails hair removal. Legal documents must be changed to reflect the new gender, and many transgender adults legally change their names. Education, support, and couples or family therapy assist significant others in making the transition to having a loved one whose gender has changed.

Social Advocacy

Transgendered individuals have a higher rate of job loss and a lower rate of health insurance than the general population. Some health coverage excludes transgender-specific health services, and transgender individuals can enlist the help of peer advocates to accompany them to medical appointments and assure that practices are nondiscriminatory. Research that informs evidence-based practice is scarce. Research that provides a basis for funding programs to meet the medical and social needs of transgender individuals is also lacking. It is incumbent upon human service providers to promote social advocacy by educating the public, training professionals, and collaborating with colleagues.

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See Also: LGBT Clients; Social Welfare Policy, Cultural Competence in.

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Transportation Services

In much of the United States, personal automobiles are the most common means of transportation for individuals and families, particularly when the distance to be traveled is too great for walking to be a feasible alternative. However, relying exclusively on automobiles has many disadvantages, including harm to the environment, time expended in lengthy commutes and in congested traffic, and discrimination against individuals who do not own a car or cannot drive for a multitude of reason including age (both those too young to hold a driver's license, and those too elderly to drive safely), disability, and poverty. A variety of transportation services are available in many areas that provide an alternative to automobile travel and improve the quality of life in a region while also enabling each resident to fully participate in life.

Transportation services are particularly critical in areas of poverty, high concentrations of minority populations, and for the elderly and disabled. For instance, in the United States, members of minority groups are less likely than white Americans to own automobiles, women are less likely than men to have a car registered in their name, and members of poor households generally pay a higher percentage of their income on transportation than do middle-class households.

In the United States, Title VI of the Civil Rights Act of 1964 forbids discrimination in public accommodations, including public transportation, and this has been interpreted broadly by the courts to include the adequate provision of services and consideration of the needs of all residents. Following this interpretation, when service changes or fare increases are scheduled, they must be examined to see that minority or disadvantaged residents are being treated fairly; particularly in large cities, public hearings are often scheduled to allow residents to provide input into proposed changes.

Because of the key role that adequate transportation can play in an individual's daily life, some organizations, such as the Leadership Conference on Civil Rights and Human Rights, believe that adequate transportation should be considered a civil right. They define transportation equity as a key value in local and regional planning because affordable, reliable transportation provides individuals and families with access to social benefits such as health care, education, and employment. However, in the United States, transportation services often fall short of this goal, and sometimes, transportation services are arranged to favor the needs of the more-prosperous residents of a region, while those in greatest need may receive fewer services, although their need is greater.

Even the basic design of transportation services in a region may favor some individuals over others. For instance, city transit systems laid out on a rectangular grid system are often the most useful for individuals who do not own an automobile because no point in a region is too far from a transit line, and making connections between different lines in a rectangular grid system is generally relatively intuitive and quick. In addition, grid systems do not need to favor one part of a city over another and provide relatively equitable coverage to all areas of the grid. In contrast, a radial grid system designates one area as central, with transit lines radiating out from this area.

This type of design is often used when the focus of the transit system is bringing suburban residents into a central city during the workday and taking them home again in the evening. Such a system may operate only during limited hours, and the transit lines may become widely separated, without connecting services, as they become more distant from the central area. While a radial grid can provide regional benefits in terms of reducing traffic congestion and air pollution, it favors suburban commuters, who tend to be more prosperous and probably own automobiles to use for their personal transportation in the evenings and for trips where the transit lines do not reach over urban residents who may have lower incomes and lower rates of car ownership and hence depend on the transit system for most or all of their transportation.

Although transportation services are often associated with urban areas, they play a vital role in rural areas as well. Rural residents have the same need to access education, health care, employment, and other services as well as the ability to travel longer distance (e.g., between cities), and it cannot be assumed that all individuals in rural areas have access to automobile transportation. In addition, rural residents need to access long-distance transportation services such as bus, rail, and air travel.

In the United States, according to the Bureau of Transportation Services, intercity rural transportation services have declined in recent years. As of September 2010, 11 percent of rural residents had access to intercity transportation (by air, bus, ferry, or rail transportation), although 3.5 million rural residents lost access to intercity transportation between 2005 and 2010. The primary decline was in bus transportation, followed by rail transportation, and access was lowest among residents of North Dakota, where fewer than 60 percent of rural residents had access to intercity transportation.

Transportation for elderly and disabled residents who require special services is typically organized at the local level. Many handicapped and elderly residents can be accommodated on regularly scheduled services—for instance, through buses with accommodations for wheelchairs and that have kneeling entry platforms that can be lowered to street level and then raised to the level of the bus aisle. Often, handicapped and elderly residents are eligible for free or reduced-price transportation on regularly scheduled transit service. In addition, special on-call transportation services are provided in many areas for rural and handicapped residents by specially equipped vans that can accommodate riders with special needs and provide point-to-point transportation similar to a taxicab service but at a much-reduced fare.

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See Also: Age and Clients; Medical Transportation; Poverty; Rural Communities; Urban Communities and Human Services.

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Trauma-Focused Services

Trauma refers to the negative physical and/or emotional results of a distressing event, situation, or condition that exceeds an individual's ability to cope. Those who experience trauma are often referred to as "victims." The impact of trauma can be short- or long-term and includes unintended and often unhealthy physical, psychological, and behavioral conditions. Physical repercussions of trauma may include hormonal damage as well as impairments in neurological structure. Specifically, stress resulting from trauma increases the release of "fight or flight" hormones, including cortisol and norepinephrine. Long-term activation of these stress systems may harm one's sympathetic nervous system and hypothalamic-pituitary-adrenal pathways by impairing the body's ability to deactivate its stress response when appropriate. These stress hormones, although useful in true moments of endangerment, are toxic in excess and may result in long-term structural and developmental damage.

Three areas of the brain are particularly affected by stress and trauma: the amygdala (associated with emotional regulation), the hippocampus (associated with memory), and the prefrontal cortex (associated with behavioral control). Psychological and behavioral repercussions of trauma may include some or all symptoms associated with PTSD as defined by the American Psychiatric Association, including re-experiencing of the traumatic event, avoidance of triggering stimuli or thoughts, negative mood and/or impaired memory surrounding the traumatic event, and arousal or hypervigilance.

Primary Trauma, Secondary Traumatic Stress, and Vicarious Trauma

Trauma occurs as a result of adverse experiences that compromise an individual's physical or emotional safety. The severity of a traumatic experience depends on the degree to which the triggering episode exceeds one's capacity to face its associated stress. Trauma can be classified as primary, secondary, or vicarious, depending upon its source. Primary trauma results from an individual's unique experience of powerlessness in the face of a distressing or threatening event. Primary trauma can occur at any age and is a consequence of personal victimization (e.g., emotional or physical abuse/neglect, or sexual assault). Primary trauma can also result from exposure to community environments that challenge one's feelings of safety (e.g., neighborhoods with markedly high levels of crime and violence), institutional and systemic injustice (e.g., institutional abuse and institutionalized discrimination), or victimization associated with an unanticipated natural or manmade disaster.

Secondary traumatic stress, also known as "compassion fatigue," refers to the stress that emerges in those providing assistance or support to direct victims. Resulting from repeated exposure to another's traumatic experiences and stories, secondary trauma is common in many professions specializing in victim support (e.g., psychotherapists, social workers, medical personnel, public safety officers, and law enforcement) as well as among members of the victim's personal support system (e.g., family members and friends). Symptoms of secondary trauma often resemble the same physical, psychological, and behavioral outcomes expressed by direct victims including chronic fatigue, detachment, avoidance, and absenteeism. Recently, secondary trauma has become associated with the high burnout rate of helping professionals.

Vicarious trauma, similar to secondary trauma, results from long-term exposure to others' traumatic narratives or experiences. In contrast to secondary trauma, however, vicarious trauma refers to overarching cognitive shifts that may occur as a result of another's traumatic experience. Specifically, vicarious trauma disrupts the belief systems and cognitive schemas of a second party, leading to long-term shifts in identity and engagement. Trauma services include interventions with the goal to address the unique effects of trauma. Trauma services can be categorized three ways: long-term versus short-term, intensive versus nonintensive, and medical versus mental, behavioral health/addictions.

Long- and Short-Term Trauma-Focused Services

Trauma-focused services may be provided long- or short-term. Short-term services seek to stabilize the physical and mental/behavioral health of the patient or client through immediate action. Short-term interventions promoting physical health and safety may include emergency medicine, such as care provided in an emergency department, intensive care unit, or via outpatient, ambulatory services. Short-term interventions promoting mental or behavioral health include crisis services such as crisis counseling, lethality and safety assessment, and protective services.

Long-term services seek to reduce the impact of the initial trauma on long-term medical or mental health and to support the prevention of reinjury or retraumatization. Long-term interventions promoting physical health and safety may include extended follow-up medical care for any physical injuries or resulting conditions related to the initial trauma, as well as potential relocation or physical protection services. Long-term interventions promoting mental or behavioral health include extended mental health counseling and support services (in particular, mental health treatment for acute stress and PTSDs), as well as integrated behavioral health care.

Intensive and Nonintensive Trauma-Focused Services

Depending on the acuity and duration of a patient's trauma-related symptoms, health and mental health professionals are charged with determining whether a patient is in need of intensive or nonintensive care. For patients deemed to need intensive care, the goal of practitioners is to deescalate the severity of physiological and emotional stress symptoms, to address the immediate safety needs of the patient, and to support the patient's return to homeostasis.

Intensive trauma-focused services are often provided within the context of emergency medical or mental health facilities, including emergency departments, intensive care units, mental health respite centers, or within a patient's home. For patients deemed in need of nonintensive care, the goal of trauma-focused services is to promote ongoing, enhanced, functionality through activities and interventions that increase the patient's resiliency and access to resources. Nonintensive services tend to be provided for shorter durations of time than for intensive services and often include referrals to community resources.

Medical Versus Mental/Behavioral Health Interventions

Medical trauma-focused services may serve three primary purposes: to sustain life, reduce long-term damage associated with a traumatic event or injury, and/or to obtain evidence for potential legal action. Life-sustaining trauma-focused services are typically delivered in hospital emergency departments, intensive care units, or via outpatient ambulatory services. In addition to emergency medicine, medical trauma-focused services can include interventions such as physical therapy, rehabilitation, and occupational therapy, which aim to improve a patient's medical condition post-injury and to reduce the potential for long-term physical damage.

Mental/behavioral health trauma-focused services may include either crisis response or ongoing mental health treatment. Mental health crisis response interventions aim first to assess and reduce potential for physical or psychological harm to oneself or others. Ongoing mental health trauma-focused treatments seek to protect patients from the residual effects of trauma, including PTSD and acute stress disorder. Common mental health interventions for trauma include cognitive behavioral therapy, motivational interviewing, eye movement desensitization and reprocessing (EMDR), and the prescription of antidepressant medications.

Services for Secondary and Vicarious Trauma

Prevention and treatment of secondary and vicarious trauma entails intervention at the individual, supervisory/peer and organizational levels. At the individual level, it is often recommended that those at high risk for secondary and vicarious trauma diligently engage in self-care practices. One common self-care practice in trauma-care fields is safety planning. Having a safety plan in place assists individuals in coping with vicarious and secondary trauma by identifying emotional or environmental triggers of distress, emotional or physical cues of stress, potential behaviors or techniques for de-escalation, and people who may be capable of providing external support.

At the supervisory/peer level, it is often recommended that supervisors openly discuss the high incidence of secondary and vicarious trauma within the helping fields, and work with their subordinates/peers to identify external cues of vicarious/secondary trauma, as well as preferred interventions or forms of support. It is recommended that that this information be shared among helping team members and recorded for occasional review.

At the organizational level, vicarious and secondary trauma can be minimized through the adoption of trauma-informed policies and employee wellness programs. For example, policies that reduce exposure to trauma (e.g., share graphic or traumatizing case information on a "need to know" basis) and that enforce self-care practices (e.g., mandatory self-care, training, and time off) can help to reduce burnout and staff traumatization. In addition, employee assistance programs that provide free or reduced-cost mental health care, fitness, or other wellness programs may also serve as a protective factor for secondary and vicarious trauma among helping professionals.

Diversity Considerations for Trauma-Focused Services

As is true of interventions in other areas of health and human services, effective trauma-focused services will apply cultural competence, both for the patient and for his or her support system (e.g., family, friends, and caretakers). When delivering services to a traumatized patient or collaborating with a patient's support system, providers must be sensitive to the unique contributions of multiculturalism (which per the American Psychological Association "recognizes the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions") and its implications for a chosen intervention, as well as to any barriers to receiving effective care, including limited literacy, access to transportation, medical vocabulary, previous experience with discrimination or institutional discrimination, cultural values surrounding trauma or mental health, and barriers to informed consent. Guidelines on multicultural practice are provided by numerous health and mental health governing bodies, including the National Committee for Quality Assurance and the American Psychological Association.

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See Also: Childhood Trauma; Counseling and Psychotherapy Services; Emergency Medical Care; Victim Services.

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Tribal Social Services

In the 1800s, health services for Indians were provided by the Department of War and focused mostly on containment of contagious disease. These services were probably aimed more at protecting U.S. soldiers than benefitting the native peoples. Control of services by the military ended in 1849, when they transferred to the Department of the Interior.

In 1955, Indian Health Services (IHS) was established as responsible agent within the Department of Health and Human Services (HHS) for Tribal Health Services. Today, IHS provides both medical and mental health care to tribal groups in 35 states. Services are provided directly by the IHS through tribal-operated health programs and privately purchased services. IHS service delivery is available to approximately 2.1 million of the nation’s estimated 3.4 million American Indians and Alaska Natives. IHS employs 2640 nurses, 820 physicians, 670 pharmacists, 640 engineers and sanitarians, 340 physician assistants and nurse practitioners, and 310 dentists as well as nutritionists, health administrators, and medical records administrators. American Indians and Alaska Natives, as U.S. citizens, are also eligible to participate in all public, private, and state health programs available to the general population.

In addition to sites established through the IHS, self-governing reservation tribes, as authorized by the Indian Self-Determination and Education Assistance Act of 1975, run 16 hospitals, 235 health centers, 75 health stations, and 164 Alaska village clinics through self-determination contracts. Any progress in the quality and availability of services in Native American Indian communities is largely due to the tribes’ taking charge through this act.

Successes

Substantial health improvements can be observed in recent decades among tribal people. Life expectancy has increased by about 10 years since 1973, and mortality rates have decreased for maternal deaths, tuberculosis, gastrointestinal disease, infant deaths, unintentional injuries and accidents, pneumonia and influenza, homicide, alcoholism, and suicide.

The Indian Health Services recognizes self-governance as a successful initiative, indicated by the increasing number of tribes participating. The program constitutes almost 35 percent of the IHS budget. Other benefits of self-governance include increased communication among tribal programs, partnerships with state and local governments, innovative health programs, and increased technical assistance to tribes through the Office of Tribal Self-Governance Advisory Committee, a federal liaison.

Challenges: Recruiting Staff

Though steadily improving, recruiting qualified health and social service professionals has been a challenge. Barriers to enlisting physicians and mental health care providers to work in tribal health establishments include low pay, remote locations, and few resources. A strong emphasis on employing Native American Indian professionals from the local community and an increasing number of Native Americans obtaining professional training bring IHS and tribal governments closer to meeting their goal.

Intertribal Relations

In the midst of an external sociopolitical victory for federal recognition of rights, internal discord and discrimination have occurred. The Nooksack Tribe in northwest Washington state has elevated disparity issues by disenrolling 15 percent of tribal members. This is the largest such cultural–political crisis within a tribe and has had a serious impact on individual rights to legal, medical, and other human services.

A crucial landmark in the long fight for tribal sovereignty places any effort toward recourse under tribal courts as opposed to federal courts. Consequently, it is imperative for self-directed groups, based on various forms of self- and group-identified diversity, to assure attunement to the most basic of nondiscrimination beliefs and behaviors within themselves.

Barriers to access may be heightened as a result of intergroup dynamics. While there is a strong history of intertribal marriage and support for those not living on the reservations, the risk of jeopardizing tribal membership and losing access to services must be considered. Moreover, for those who were historically accepted as "two-spirited" in regard to gender, modern fears and religious beliefs have created exclusion issues. Elders were once revered, but today elder abuse rates are rising to an alarming degree. The issue is not whether humans will continue to fight for their personal preferences but whether the provision of overall human rights and human services will meet their basic needs.

Funding

The Snyder Act of 1921 authorized federal funds to reduce distress, conserve health, and employ staff for the health benefit of Indian tribes throughout the United States. Funds for the IHS have increased over the past few decades, reaching 4.1 billion for 2013, but are still insufficient for the needs of the population. Funds allocated by Congress covered an estimated 60 percent of health care needs of American Indian and Alaska Native people eligible for services in 2013. Due to limited resources, services that IHS is unable to provide at its own facilities, and therefore contracts to other providers, are limited. For these cases, life-threatening illnesses or injuries are given highest priority.

Cultural Competence

While Native American Indians are eligible for state and local programs, many do not use them because of cultural insensitivity in the staff. In the Native American Indians for Community Action Family Health Center in northern Arizona, for example, only 48 percent of Native American Indian clients found the mental health services useful. Of Native American Indians who stopped using the services, 16 percent did so because they felt judged by the mental health professionals. Barriers to utilization of mental health services cited throughout the past 40 years include mistrust of services, beliefs that the services are unresponsive to their needs, and differing cultural views, particularly of the healing process.

Health Disparities

Despite recent successes, American Indians and Alaska Natives still have a life expectancy 5.2 years less than the general U.S. population. Rates of mental and physical health disablement, mortality, substance abuse, and other health indicators, though slowly improving, are higher within the tribal nations than among white Americans, but tribal groups also fall far behind in access to care due to causes such as the remote location of services or lack of funds.

Future Directions

The first White House Tribal Nations Conference was held in 2009; leaders from 300 tribes were invited for personal discussions with government officials, including President Barack Obama. Breakout sessions included Strengthening Tribal Communities: Economic Development, Housing, Energy and Infrastructure; Protecting Our Communities: Law Enforcement and Disaster Relief; Securing Our Future: Cultural Protection, Natural Resources and Environmental Protection; and Strengthening and Advancing the Government-to-Government Relationship.

Minority and protected classes traditionally have moved from dialogue to legal remedy and have enjoyed parallel sociocultural awareness and inclusion. The tribal nations are taking steps to overcome a painful past with the government and integrate changing social and cultural mores while maintaining tradition and heritage, both within their own affiliations and on an intertribal basis.

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See Also: Indian Civil Rights Act of 1968; Indian Health Service; Tribal Sovereignty; Two-Spirits.

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Tribal Sovereignty

Starting in 1778, the United States has been negotiating treaties, ruling on court cases, establishing laws, and issuing presidential resolutions to create, change, and alter Native American tribal sovereignty. After years of negotiations, Native American tribes are a quasiautonomous nation within a nation and governed by the U.S. government. Presently, the tribal sovereignty rests upon three principles, which are local sovereignty; Congressional authority over (e.g., Plenary Power Doctrine) Native American tribes; and the U.S. government being obligated to protect Native American rights, lands, resources, and survival.

Many Native American tribes are recognized as tribal nations within the United States. Today, there are approximately 550 federally recognized tribal nations in the contiguous 48 states. Under the U.S. Constitution and subsequent federal laws, tribes are dependent nations that have been granted local sovereignty. Local sovereignty allows tribes to determine membership in the nation, form their own tribal governments, create and enforce criminal and civil laws, as well as manage, regulate, and govern tribal property and commerce. A designation of a dependent nation results in the U.S. government having authority over the tribes in regard to the laws they are governed under and the tribal government's role and relationship to the federal and state governments and determines the self-governing abilities of the tribes.

Prior to the formation of the United States as a country, tribes were sovereign nations with significant self-government powers. Under Article I (Section 8) of the U.S. Constitution, Congress has the authority to regulate commerce between foreign nations and Native American tribes. Additional court cases that have heard congressional authority issues include: *Ex parte Joins* (191 U.S. 93) of 1903; *Antoine v. Washington* (420 U.S. 194) of 1975; *United States v. Sioux Nation of Indians* (448 U.S. 371) of 1980; and *United States v. Lara* (541 U.S. 193) of 2004. In 1789, Congress created the Department of War, among whose assigned duties was negotiating treaties with various tribes. In 1790, Congress enacted the Nonintercourse Act, which explicitly forbids individuals and states from negotiating with tribes or purchasing tribal lands.

Treaties (1778–1871)

The first treaty between the United States and a tribe was the treaty with the Delaware in 1778. From 1778 to 1871, there were almost 400 treaties that were voluntarily or forcibly negotiated among individual tribes, tribal groups, and the U.S. government. These treaties were negotiated as two sovereign nations, with the executive branch representing the United States and the tribal leadership representing the tribes. The negotiated treaties were ratified by the U.S. Senate. The volume of negotiated treaties indicates the increased importance the U.S. government placed on maintaining relations with the tribes. Although the details of the treaties varied, many were based on tribes' relinquishing rights to hunting and traditional lands in exchange for trade goods and monetary compensation. In many of these treaties, tribes agreed to place themselves under U.S. protection and live on reservations in order to maintain limited self-governance. A number of these early treaties are still binding today.

Marshall Trilogy

In the early 1800s, there were three U.S. Supreme Court decisions that affirmed the legal status of tribes and defined the limits of tribal sovereignty. These are called the Marshall Trilogy (1823–32) and were named after Chief Justice John Marshall (1755–1835). The first case was the *Cherokee Nation v. Georgia* (30 U.S. [5 Pet.] 1) of 1831. In this case, the Cherokee Nation wanted the Supreme Court to force an injunction on the state of Georgia from establishing certain laws on the Cherokee reservation. The Court refused to grant the injunction because the Cherokee

Nation was viewed as neither a foreign nation nor a state and was a domestic dependent nation under the U.S. government. The domestic dependent nation status meant tribes were only allowed to make agreements with the U.S. government, and Congress had the authority to manage and regulate the tribe's transactions with nonnatives.

The next case of the Marshall Trilogy was *Johnson v. M'Intosh* (21 U.S [8 Wheat] 543) of 1832. This case was over a disputed land title. In 1773 and 1775, Thomas Johnson purchased land from the Piankashaw tribe. These properties were willed to his descendants (plaintiffs), who were lease holders. William M'Intosh (defendant) was given an exclusive land grant to allegedly the same land from the U.S. government. Justice Marshall ruled that the Piankashaw tribe had only occupancy rights to the land, not title to it, and thus the land sold to Johnson was invalid. This ruling restricted the tribal sovereign powers and clarified that tribes were only provided with the right to occupy and use their designated lands. Further, the U.S. government was the only entity to purchase tribal lands under the doctrine of discovery.

Another case of the Marshall Trilogy was *Worcester v. Georgia* (31 U.S. 515, 8 L.Ed. 483) of 1832. Missionary Samuel Worcester refused to follow the state of Georgia's law that required white people living on the reservation to obtain a residency permit. The law was enacted to hinder Worcester and other missionaries who were working with the Cherokee liberation movement. Worcester and others refused to comply with the new law and were brought up on criminal charges. The Supreme Court struck down the state of Georgia's law, noting that the state had no criminal jurisdiction on Native American land. Worcester and others charges were dismissed.

From Sovereign Nations to Congressional Wards

In 1851, the Indian Appropriations Act made funds available to place western tribes onto reservations in order to "protect" them from the mostly European migrants. A rider on the Indian Appropriations Act of 1871 forbade the recognition of additional tribes and prohibited new treaties because the tribes were no longer recognized as an independent nation. The passage of this act made Native Americans wards of the nation. After 1871, the relationship between tribes and the U.S. government was conducted by acts of Congress, executive orders, and amendments.

Congressional authority over tribes, tribal law, and decision-making abilities date back to 1883 in the court case *Ex parte Crow Dog* (109 US 556). Crow Dog was alleged to have killed Spotted Tail, a government-installed Lakota chief, and was tried in tribal court. He was found guilty and under traditional Sioux tribal punishment was required to pay restitution. The U.S. government, however, tried Crow Dog for murder, found him guilty, and sentenced him to death by hanging. Crow Dog appealed his case to the Supreme Court, which held that, unless authorized by Congress, the U.S. government had no jurisdiction in the case. Following this, in 1885, Congress passed the Major Crimes Act, 18 U.S.C. § 1153, which mandated that seven major crimes (e.g., murder, manslaughter, rape, assault with intent to committee murder, arson, burglary, and larceny) committed in Indian country be adjudicated in the federal judicial system. This act placed the responsibility for investigating and prosecuting major crimes under the domain of the federal government and deterred tribes from prosecuting and punishing tribal members for major crimes. The 1885 act was affirmed in 1886 in *United States v. Kagama* (118 U.S. 375) by the Supreme Court. This court case limited tribal sovereignty by establishing Congress's plenary authority over Native American tribes.

Land Owning, Assimilation, and Jurisdiction

In the 1800s, Native Americans were not considered U.S. citizens. They were tribal members with few exceptions. One exception was serving in World War I, and another was becoming a farmer under the General Allotment Act of 1887 (called the Dawes Act). The Dawes Act sought to eliminate reservations. The act allotted a number of acres, ranging from 160 to 40 acres, to Native Americans based on household size. The Native Americans who accepted the allotment could become American citizens. Few tribal members benefited from the Dawes Act. Ultimately, 90 million acres or two-thirds of the reservation land was taken from tribes and given to white settlers. Citizenship was made available when Congress passed the Indian Citizenship Act of 1924 (also called the Snyder Act), which allowed Native Americans to become U.S. citizens while retaining their tribal affiliation.

The Dawes Act's native lands privatization was ended with the passage of the Indian Reorganization Act (IRA) of 1934. This act allowed for tribes to rebuild their governments by creating constitutions and economies and renewing local tribal sovereignty. However, tribal actions were still under U.S. governmental authority, and all tribal actions could be reviewed by the Bureau of Indian Affairs (BIA). Thus, the IRA provided a space for tribal self-governance but limited tribes to operating under Western governmental models, which were not always compatible with tribal culture, values, and ways of life.

During the 1940s and 1950s, the United States enacted laws that would "assimilate" tribal members into mainstream American society because it was seen as being in the best interest of the Native American groups. The Native American tribes were under bureaucratic management that was notorious for being rigid and mismanaged. This policy was called Indian termination, where the U.S. government no longer recognized tribal sovereignty, ended tribes' exclusion from state laws, and turned Native Americans from reservation trustees to U.S. citizens who were subject to state and federal laws and taxes. Examples of these policies include the Klamath Termination Act of 1954 (Public Law 587); the Western Oregon Indian Termination Act of 1954 (Public Law 588); and the California Rancheria Termination Act of 1958 (Public Law 85-671 [72 Stat. 619]).

In 1953, Congress enacted Public Law 83-280. This law transferred jurisdiction from the federal to state governments (e.g., California, Minnesota, Nebraska, Oregon, Wisconsin, and Alaska) in Indian country. Congress allowed all states to assume jurisdictional control over Native American lands with the passage of either a statute or a state constitutional amendment. This act, in essence, overturned *Worcester v. Georgia* (1832). The states listed in the act were mandatory, and the Native American nations had limited recourse for gaining control over creating their own judicial systems. There were several exceptions when the nations successfully demonstrated that they already had reasonable law enforcement capabilities. Public Law 83-280 was an unfunded mandate.

Another jurisdictional barrier was handed down by the Supreme Court in 1978, with the *Oliphant v. Suquamish Indian Tribe* (435 U.S. 191, 98 S. Ct. 1011, 55 L.Ed.2d 209) case. Mark Oliphant, a nonnative who was living on the Port Madison Indian Reservation of the Suquamish Tribe, was arrested for allegedly assaulting a tribal officer and resisting arrest. Mark's lawyers claimed he was not under tribal jurisdiction because he was not Native American. In a 6–2 decision, the Supreme Court ruled in his favor, and this court case limited tribal jurisdiction to only native members who have allegedly committed a crime on a reservation. Even though the court decision resulted in tribes having no jurisdiction over nonnatives, it did affirm local sovereignty over tribal members. A later case confirmed local sovereignty over activities on tribal land. The Supreme Court case was *Montana v. United States* (450 U.S. 544) in 1981. In this case, the Crow Nation claimed it could regulate nontribal members' hunting and fishing activities on the Crow Indian Reservation based on treaty rights and sovereign governing authority. The Supreme Court ruling resulted in tribes having the ability to regulate significant nonnative American operations that were on tribal lands, providing there is a consensual agreement with the tribe. This ruling gave tribes the capacity to regulate any activity that was related to tribal security or safety interests over state authority.

ICRA and ISDEAA

In 1968, the Indian Civil Rights Act (ICRA, 25 U.S.C.§§ 1301-1304) was passed. The goal of this legislation was to have the Bill of Rights integrated into tribal governments. Congress passed the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA, Public Law 93-638) and authorized the U.S. government to contract with and provide grants to tribal governments. The tribes were authorized to administer the funds as well as operate their own schools. The ISDEAA marked a change from the Indian termination policies of the 1940s and 1950s. This act authorized tribes to operate their own schools. The ICRA and ISDEAA were the product of Native American activism.

After years of negotiations, Native American tribes are a self-autonomous nation within a nation and governed by the U.S. government. Through various negotiated treaties, court rulings, establishment of laws, and presidential resolutions, Native American tribal sovereignty has changed over time. The current trajectory indicates a loosening of U.S. governmental control over tribes to one of increased tribal sovereignty and self-government powers. The issue of tribal sovereignty is important because it is a subtext that human service providers and agencies need to be aware of when operating in Native American areas, especially Native American reservations. Many people and agencies have come to tribal areas with the best of intentions, only to make programs and policies that exacerbate negative situations and frequently make situations significantly worse. It is important that human service providers and agencies partner with tribes in order to address the social structural issues and problems affecting tribal areas.

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See Also: American Indian Movement; Indian Civil Rights Act of 1968; National Congress of American Indians.

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TRIO Programs

The federal TRIO programs are outreach and student services designed to provide services for individuals from disadvantaged backgrounds. TRIO includes seven student-centered programs to help low-income individuals, first-generation college students, and individuals with disabilities to progress academically from middle school to postbaccalaureate programs. These seven programs include (1) Educational Opportunity Centers (EOC), (2) Talent Search (TS), (3) Upward Bound (UB), (4) Upward Bound Math/Science, (5) Veterans Upward Bound (VUB), (6) Student Support Services (SSS), and (7) Ronald E. McNair Post-Baccalaureate Achievement. Aside from these student programs, TRIO also offers staff training program designed to help personnel improve the operation and success of TRIO projects. TRIO is not an acronym; rather, it was given its name because it started as a group of only three programs. In fiscal year 2012, TRIO programs allocated a total of $838,629,436 to fund 2,815 projects serving 789,676 participants. Federal TRIO program legislative requirements can be found in the Higher Education Act of 1965, Title IV, Part A, Subpart 2.

TRIO has a progressive history. Over the years, TRIO programs have been expanded and improved to provide a wider range of services to reach more students in need. TRIO started with the UB program, which emerged out of the Economic Opportunity Act of 1964 in response to the administration's war on poverty. UB provides college entrance preparation support to high school students from either low-income families or families in which neither parent holds a bachelor's degree. All UB projects must provide instruction in math, laboratory science, composition, literature, and foreign language. UB seeks to increase rates of secondary education completion, postsecondary education enrollment, and postsecondary graduation.

In 1965 the second TRIO outreach program, TS, was created as part of the Higher Education Act. TS identifies and assists individuals from disadvantaged backgrounds who have the potential to succeed in higher education. It provides academic, career, and financial counseling and encourages participants to graduate from high school and continue with postsecondary education. TS publicizes the availability of financial aid and helps individuals with the postsecondary application process. TS also encourages persons who have not completed secondary or postsecondary education programs to enter (or reenter) and complete postsecondary education. TS seeks to increase the number of youth from disadvantaged backgrounds who complete high school and enroll in and complete postsecondary education.

In 1968, SSS, which was originally known as Special Services for Disadvantaged Students, was authorized by the Higher Education Amendments and became the third in a series of educational opportunity programs. By the late 1960s, the term *TRIO* was coined to describe this group of federal programs. Through a competitive grant process, SSS funds are awarded to institutions of higher education to provide opportunities for academic development, assist students with basic college requirements, and motivate students to complete postsecondary education. The Omnibus Consolidated Appropriations Act of 2001 amended the SSS program to permit the use of program funds for grant aid to current SSS participants who are receiving federal Pell Grants. SSS seeks to increase college retention and graduation rates. Requirements for SSS grant aid can be found in Public Law 106-554.

The Higher Education Amendments of 1972 added the fourth TRIO program by authorizing the EOC to provide college admissions counseling and information to qualified adults who want to enter or continue postsecondary education. EOC also provides financial and economic literacy services. An important objective of the program is to counsel participants on financial aid options and to assist in the application process. EOC seeks to increase the number of adults who enroll in postsecondary education.

The 1976 Education Amendments authorized the Training Program for Federal TRIO Programs, initially known as the Training Program for Special Programs Staff and Leadership Personnel. These programs are designed to help personnel improve the operation and success of TRIO projects. Training priorities are legislated by Congress and determined by the Department of Education to be the most appropriate in meeting TRIO personnel needs.

Amendments in 1986 added the sixth program, the Ronald E. McNair Postbaccalaureate Achievement Program. McNair funds are awarded to institutions of higher education through a competitive grant process to prepare individuals from disadvantaged backgrounds for doctoral studies involving research and other scholarly activities. Institutions work closely with participants throughout their undergraduate studies, and they encourage participants to enroll in graduate programs. The McNair program seeks to increase the attainment of Ph.D. degrees by students from underrepresented segments of society.

In 1990, the department created the Upward Bound Math/Science program to address math and science instructional needs. The program seeks to help students recognize and develop math and science skills, and it encourages participants to pursue postsecondary math and science degrees.

The VUB began in 1972 during the Vietnam War to provide educational and support services enabling veterans to transition to postsecondary education. It is designed to motivate and assist veterans in the development of academic and other requisite skills necessary to succeed in a postsecondary education program. VUB provides assessment and enhancement of basic skills through counseling, mentoring, tutoring, and academic instruction. VUB projects must provide instruction in mathematics through precalculus, laboratory science, foreign language, composition, and literature. VUB projects are also expected to help veterans secure local support services. VUB seeks to increase veteran postsecondary education enrollment and completion rates.

Depending on the specific program, TRIO grant recipients are typically institutions of higher education, secondary schools, public and private agencies, and community-based organizations with experience in serving disadvantaged youth. Collaborative applications from multiple institutions, agencies, or organizations are also accepted so long as they plan, develop, and carry out the proposed student services.

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See Also: Adult Education Programs and Services; Adult Literacy Programs; Department of Education, U.S.; Education Support Services; Educational Services.

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Truancy

Truancy is generally defined as unexcused absence from school. As such, it is a violation of school rules and of state law. Students who have excessive absences, as defined by a statute in a specific jurisdiction, are subject to sanctions by the state through the juvenile court. Usually, however, the front line of dealing with this is through the affected school or school district. In addition, parents who are ineffectual, uncooperative, or hostile to the school's or court's efforts may be held criminally liable for their child's truancy and subject to fines, or rarely, incarceration.

In the past playing hooky, or being truant, was seen as a minor transgression—even a springtime rite of passage when boys would head to the old fishing hole rather than spend a stultifying day in the prototypical one-room schoolhouse pondering Latin grammar or solving mathematical problems. But, modern social science and criminological research paints a much grimmer reality for truancy and dropping out. One critical issue is that children who are out of school miss out on learning and fall behind, sometimes far behind, their cohorts. They then become discouraged and are much more likely to drop out than those who are not habitually truant. As such, they are more likely to become delinquent, make less money throughout their lives, have a series of dead-end jobs, and are unlikely to advance in economic terms. They are more likely to become delinquent simply because they are outside of adult supervision while truant, are in the company of other similarly antisocial young people at that juncture, and are additionally socializing with underemployed and unemployed young adults who have discretionary money, freedom, and time. This increases their discontent with the structure of their status as minors and with school and leads them into situations where precocious sex and experimentation with alcohol and illicit drugs is likely. With parents working or absent truants are prone to use the family home as a locale for deviant and delinquent activity. It is no accident that most unintentional teenage pregnancies are conceived in that very context.

National statistics on truancy are notably lacking. Informed sources estimate that truancy varies from 10 to 30 percent. Some schools, generally in the urban districts, have truancy rates as high as 40 percent. Such high rates negatively impact school funding as state support is based on school attendance. However, some have suggested that some school administrators, realizing that truants are not the best students, do not actively discourage truants or dropouts in order to achieve higher scores on standardized tests. These students, many of whom will drop out eventually, are called push outs. Additionally, administrators and teachers see many truants as potential troublemakers and are not unhappy to see them no longer in attendance. Also, some educators and sociologists in the past opined that truant dropouts would be happier and productive once free of the oppressive environs of school. While that may have been true when factory jobs and manual labor occupations were plentiful, that belief no longer holds sway in academe or in educational circles. The notion that truants are bright diamonds in the rough who are simply turned off by the routine of modern educational methods and institutions is not borne out by research. It is clear that no one benefits from truancy or dropping out, most especially the truants themselves.

Reasons and Background for Truancy

Children with learning disabilities or who are the victims of bullying frequently are truants. They simply want to avoid a traumatic or dangerous situation. Children whose parents are drug dependent or mentally ill frequently are called upon to be a family hero and take care of younger siblings, pets, or the parents themselves and thus miss school. Sometimes, children are forced to work in family businesses rather than go to school. It is clear that some parents, usually operating from a subcultural context, simply don't see school as particularly useful. That notwithstanding, many times, truants report that school itself is impersonal or uninspiring or that individual teachers are hostile. It is worth noting that truancy is especially high at large, impersonal urban schools.

Another school-related factor that discourages below-average (and average) students is that, in such large schools, inordinate amounts of scarce resources are poured into athletics and to reward a few exceptional students, leaving almost nothing in the way of activities or positive reinforcement for those who are marginal and disaffected. Moreover, truants are likely to come from a disadvantaged minority background and have unemployed or criminal parents and delinquent siblings. Their parents are likely divorced or have serious marital conflict. Parents may be recent immigrants who do not understand the law or speak English and are somewhat at the mercy of the child to be their translator and intermediary with the larger American national culture. The children of lower-class rural whites and poor urban African Americans are more likely to be truant than upper-middle class or upper-class people of the same respective races. Rural, white disadvantaged parents sometimes hold children back, saying, "Don't get above your raisin," meaning, "Don't transcend and rise above the circumstances of your culture and your parents." Another way of looking at this is "Don't get too big for your britches." This is a particularly defeatist and challenging lower-class cultural norm with which young people may have to deal. It reflects a lack of support children of this background can expect from their parents and extended family. Hispanic youth are also at risk and often get ambiguous and nonsupportive message from poorly assimilated elders. Social service personnel have their work cut out for them dealing with such negative overt messages and cultural subtexts.

Children of divorce are also at risk for truancy and dropping out. Girls, even those who do not have to drop out after becoming pregnant, will sometimes fall by the wayside due to expectations that girls need to start childbearing early. Being truant is an ideal setting for promiscuous and precocious sexual activity and for becoming pregnant. For whatever reason, the truant is often under-supervised at home and in many cases basically outside of parental control. In juvenile court terms, they are technically ungovernable. This is because the parents themselves are not really in control of their own lives and may be consumed by fiscal trauma and excessive personal drama. Court sanctions on such parents are usually ineffective and amount to adding financial deprivation and legal harassment to already chaotic lives. In such settings, a motivated school social worker, guidance counselor, juvenile officer, or sympathetic teacher will struggle mightily to make a difference.

Dealing With Truancy

Today, parents may be informed of a truancy event by means of an automated phone message. Understandably, truant children, if so empowered and available, try to delete such messages from voice mail and answering machines. It sometimes happens that children may accumulate many days' worth of unexcused absences without the parents being any the wiser. When notified in writing, or by a summons, the parent may be called upon to visit the school, the school board office, or even appear in juvenile court or in a specialized truancy court. A truant officer may be assigned to the case to follow up and insure that the juvenile subsequently attends school. If the child or parents resist or ignore the school's action or court's ruling, they may be assigned to a therapeutic context where counseling, mentoring, and testing might occur—a truancy resource center. At that point, it may be helpful to have the child removed from the problematic school situation and be reassigned to an alternative school. In some cases, students have been allowed to take courses online in order to avoid repeated interactions with a teacher with whom they have an unfortunate history of conflict. A sympathetic and resourceful school social worker or juvenile officer, given enough imagination and funding, can often find a way to get a resistant young person back into school and motivate him or her to graduate. But, failing that significant presence, the outlook is not positive. Children who continue to be truant despite the efforts of social agencies will find themselves referred to juvenile court as children in need of supervision (CHINS). They may be removed from parental custody and placed in foster care, in the care of relatives, or in a few severe cases, in group homes or juvenile custodial institutions.

There is no question that, while parental fecklessness or active neglect is usually involved in truancy, our schools definitely promote truancy and dropping out in a number of ways. In general, they are too big and impersonal to attend to the needs of those on the margins of school attendance, participation, and student culture. It is a major task to simply monitor attendance and inform parents. Guidance counselors and teachers are overloaded with large classes and caseloads and performing non-education related tasks (such as monitoring lunchrooms and school bus loading) to focus on problematic individuals. Activities that might engage all students, such as intramural athletics, art, drama, and literary efforts, are not adequately funded or encouraged by administrators. All school activities become subordinate to having students perform well on tests. Such an atmosphere is dispiriting to all students and only encourages marginal students to be truant and to drop out entirely.

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See Also: Adolescent/Youth Services: Overview; At-Risk Youth Services; Youth Risk Behavior Surveillance System.

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TuDiabetes

Diabetes mellitus is a chronic disease that affects 347 million people worldwide. The World Health Organization estimates that diabetes will be the world's seventh-leading cause of death by 2030. In addition, the Centers for Disease Control and Prevention estimate that nearly 26 million people in the United States, or 8.3 percent of the population, have diabetes.

Diabetes threatens the quality of life of millions of individuals in the United States, especially ethnic minorities who are at a higher risk of developing the disease. TuDiabetes.org is a social support Web site dedicated to increasing public awareness of diabetes prevention, diagnosis, and treatment. Because TuDiabetes is committed to improving the quality of life of individuals of diverse ethnic and socioeconomic backgrounds, the site is of interest to human services professionals in the United States and abroad.

Diabetes

Diabetes is characterized by high levels of glucose in the blood as a consequence of poor insulin production, an inappropriate response of the body's cells to insulin, or both. Diabetes is grouped into three main types: type 1, type 2, and gestational diabetes. Type 1 diabetes is often diagnosed in young children, adolescents, and young adults. Type 2 diabetes occurs over time and mostly affects people over 40. Gestational diabetes develops during pregnancy in women not previously diagnosed with the disease. If not managed properly, diabetes can cause serious complications, including heart disease and stroke, blindness, gangrene, and kidney failure.

Diabetes disproportionately affects ethnic minorities in the United States. African Americans, Native Americans, and Hispanics are almost twice as likely to develop the disease as non-Hispanic whites, which places diabetes among the top health disparities in the nation. Type 1 diabetes is not preventable; however, type 2 diabetes can be avoided through lifestyle changes, such as dieting and exercising. Research suggests that social support is crucial for individuals who are trying to make and maintain these lifestyle changes and manage their illness.

TuDiabetes Inception

TuDiabetes is an online community and social support network serving people with diabetes, their families, and friends. The Web site is part of the Diabetes Hands Foundation, a nonprofit organization dedicated to developing awareness for diabetes-related causes. The nonprofit was founded in 2007 by Manny Hernandez, a Venezuelan-born electrical engineer and social media author, and his wife, Andreina Dávila, an architect and designer also from Venezuela. Hernandez, who graduated with a master's degree from Cornell University, was diagnosed with latent autoimmune diabetes in adults (LADA).

As described by the National Institutes of Diabetes and Digestive and Kidney Diseases, LADA is characterized by signs of both diabetes type 1 and diabetes type 2 and is generally diagnosed after age 30. LADA is not officially recognized as a type of diabetes, but it is considered a subset of type 1 diabetes. Following his LADA diagnosis, Hernandez became aware of the importance of having a strong support network for diabetes management and control. He and Dávila created TuDiabetes in particular for individuals who lack that support.

TuDiabetes.org

TuDiabetes claims more than 31,000 members. In addition, it reaches an excess of 24,000 members via EsTuDiabetes, the Spanish-language version of the site. Both versions of the Web site share the same platform, which includes 11 tabs and five main page sections. The tabs include home, my page, members, forum, blogs, groups, events, media, other programs, donate, and chat. The my page section allows members to create a personalized space where they can maintain a blog, initiate discussions, post milestones and photos, create groups, and answer questions about their particular situation. The members section highlights participants from all ages and nationalities who are selected by the organization for their high level of activity in offering helpful and friendly advice to other members on the Web site. Approximately 13 members are featured on any given day. Participants can engage in conversations with other members through the forum section. Forums are divided by themes that might appeal to the different interests of participants. Some topics or themes include type 1 and type 2 diabetes, new to diabetes, diabetes treatment, diabetes sports and fitness, and continuous glucose monitoring.

In addition to forums, participants express their opinions and concerns through blogs. More than 13,500 blog posts have been featured on the site. Members can search the Web site for blogs in several main categories, including featured, latest, and most popular. The blogs center on a variety of topics tagged under descriptors such as type, insulin, pump, blood, and diabetes. Blog posts are archived by month from 2007. Besides forums and blogs, TuDiabetes members are active in more than 400 group discussions. The group setting allows members to connect with other individuals who share their concerns, interests, or geographical region. The United Kingdom Diabetics group, for example, has 367 members. Other groups include the Diabetics in Southeast Asia and India, Dexcom Users, Diabetic Food and Cooking, and even Inked Diabetics, a group for diabetics with tattoos.

Events, Programs, and Advocacy

Whereas forums, blogs, and groups provide members with venues to express their ideas, opinions, and thoughts, the events tool offers outside community experts the opportunity to advise members on a wide range of diabetes-related subjects. Online talks featuring diabetes educators, ophthalmologists, nutritionists, and other experts specializing in diabetes care are conducted live, recorded, and posted under the events tab. Members can join and remotely participate in the online events as they are taking place, or they can view the recordings later at their convenience.

Diabetes programs and advocacy efforts that go beyond the membership community are also incorporated into the Web site. Diabetes Advocates is a program of the Diabetes Hands Foundation prominently featured on TuDiabetes.org. The program aims to educate the public and the media about all matters related to diabetes. The advocates' main objective consists of disseminating information about the proper reporting of diabetes-related information and to emphasize that diabetes is a conglomerate of metabolic diseases, all with different characteristics that the media should not lump into one single category.

The Big Blue Test is another of the organization's central programs. It strives to demonstrate that exercise decreases blood glucose levels by as much as 20 percent. The program encourages members with or without diabetes to record their blood glucose, get active for 14 to 20 minutes, test their glucose again, and share the results online. For every entry that is logged, the Diabetes Hand Foundation, with help from corporate donors, makes a donation to nonprofit organizations serving people with diabetes around the world. Fund-raising results are revealed every year on November 14 during World Diabetes Day. In 2013, Big Blue Test beneficiaries included projects in Haiti and the Dominican Republic. Selecting nonprofits in the Caribbean as beneficiaries of the Diabetes Hands Foundation's grants contributes to diabetes awareness efforts in that region and promotes the efforts of EsTuDiabetes.org.

EsTuDiabetes

Although EsTudiabetes.org follows an identical design and navigation as TuDiabetes.org, EsTuDiabetes is entirely Spanish-language based, and it tailors its forums, blogs, and groups to its

Spanish-speaking members. This is most apparent in the events section, where diabetes-related events taking place in Spanish-speaking countries are highlighted, including *La Marea Azul se Mueve* in Spain, the *Desafío Urbano en Tiempo Real* in Argentina, and the *2do Encuentro Multidisciplinario en el Día Mundial de la Diabetes* in Mexico. EsTuDiabetes features more than 2,600 blogs, almost 150 groups, and more than 6,047 forum discussions. Video chats featuring experts on diabetes issues are also available on the events tab. Unlike TuDiabetes, the live interviews and informative segments are not as prominent. EsTudiabetes also lacks the advocacy tab featured in TuDiabetes.

Diabetes has been labeled a global epidemic. The Web sites TuDiabetes and EsTuDiabetes have developed a diverse network for diabetes patients and their families, and are inclusive of individuals from various ages, nationalities, and diabetes types. Through these Web sites, the Diabetes Hands Foundation is developing awareness about the disease and providing emotional support to a diversity of people in the United States and around the world.

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See Also: Caribbean Immigrants; Hispanic Health and Nutrition Examination Survey; Hispanics Immigrants; National Alliance for Hispanic Health; Native Americans; Pregnancy and Parenting Services.

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Twelve-Step Programs

Since 1935, 12-step recovery programs have been a staple in the treatment of alcoholism. Bill Wilson and Dr. Robert Smith founded Alcoholics Anonymous (AA), resting on the belief that people who shared the same problem could assist each other in overcoming that problem. In 1948, Al-Anon was established to support the spouses of alcoholics. In 1953, Narcotics Anonymous (NA) was founded upon the AA principles. Subsequently, Cocaine Anonymous, Pills Anonymous, and Marijuana Anonymous have emerged. The 12-step program model has been adopted by compulsive gamblers, overeaters, sex and love addicts, debtors, and codependents. Twelve-step groups maintain the AA format with minimal adaptations to address their specific issues. Overeaters, for instance, abstain from specific foods.

The original tenets of AA remain in practice as the 12 traditions. These traditions address how all 12-step programs operate.

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose, there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.

5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. AA should remain forever nonprofessional, but our service centers may employ special workers.
9. AA, as such, ought never be organized, but we may create service boards or committees directly responsible to those they serve.
10. AA has no opinion on outside issues; hence, the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

Resources

Twelve-step programs provide written materials for their membership free of charge. The *Big Book*, written by the founders, includes general information about alcoholism and includes chapters written to wives and to employers. Stories of recovery are the core of the *Big Book*. Indexed topics covered in the personal stories include spirituality, anger, jealousy, and guilt. The fourth edition of the *Big Book* is available on the Internet in an interactive format.

The book titled *One Day at a Time* has a thought for each day of the year, written to be read each day and used as a basis for prayer and meditation. Some 12-step programs have their own guides. Codependents Anonymous, for instance, has a big book titled *Codependency* and a book of daily meditations titled *The Language of Letting Go*.

The serenity prayer is a staple of recovery, recited at the end of each meeting and displayed in the homes, vehicles, and workspaces of recovering and nonrecovering people. It simply asks, "God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference." The sentiment of the serenity prayer is congruent with the 12-step philosophy, and the first line of its next verse, "Living life one day at a time," is a mantra in the recovering community.

Recovery

The original philosophy of AA asserted that alcoholism is a chronic condition from which one can never fully recover. In a struggle with alcohol, drinking will always prevail. The road to recovery begins when one ceases the futile struggle and admits that he or she is powerless over alcohol. Alcoholics maintain abstinence one day at a time but will refer to themselves as recovering, not recovered, no matter how long they are abstinent. Programs for other addictions retain the philosophy that people are powerless over their respective addictions and that one must practice the principles of the program in every area of his or her life to remain in recovery. Twelve-step programs have a jargon, hereafter shown in quotations, that asserts the philosophy in a down-to-earth, often metaphoric, manner.

The Twelve Steps

Each of the 12 steps asserts a principle of recovery. The newly recovering member is assisted by others in "working the steps" in order. The first three steps address powerlessness. The first step is "We admitted we were powerless over alcohol—that our lives had become unmanageable." The first step is acceptance of "hitting a bottom" due to addiction and generally entails loss of a relationship, loss of a job, or legal problems. The second step is "Came to believe that a power greater than ourselves could restore us to sanity." After many solitary attempts to overcome addiction, the addict hereby admits that he or she needs help to achieve recovery. The third step is "Made a decision to turn our will and our lives over to the care of God as we understood Him." The third step introduces spirituality. Those who do not believe in a supreme being are often encouraged to consider God as an acronym for good orderly direction. In the third step of Gamblers Anonymous, "a power of our understanding" is substituted for the word *God*. Adolescents in recovery often find the 12 steps difficult to comprehend. An adaptation of the beginning steps for adolescence is "Step 1: I have a problem. Step 2: Someone can help. Step 3: Let them."

The next four steps define the process for personal healing. The fourth step requires that the recovering person has "made a searching and fearless moral inventory." The fourth step is often guided by worksheets that define character flaws such as selfishness and resentment and ask the addict to give an example of a time he or she demonstrated this flaw. The fifth step, "admitted to God, to ourselves, and to another human being the exact nature of our wrongs," requires the addict to disclose the findings from the fourth step aloud to another person. The fourth step is generally spoken to another member of the program, but it is acceptable to seek a member of the clergy outside of the program for this confession. The sixth step, "were entirely ready to have God remove all these defects of character" more directly requires belief in God as a higher power. The seventh step, "humbly asked Him to remove our shortcomings," is one of prayer.

Reparation of damaged relationships and self-forgiveness are addressed in the eighth step, "made a list of all persons we had harmed and became willing to make amends to them all." The addict begins the process of making amends in the ninth step: "Made direct amends to such people wherever possible, except when to do so would injure them or others." Some addicts, at this point, must accept that some relationships are forever lost. To maintain this level of moral clarity, the 10th step is "continued to take personal inventory, and when we were wrong, promptly admitted it."

The last two steps address giving back to the program that has restored them. The 11th step is "sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out." Throughout the program, members are often encouraged to "let go and let God." The 12th step is "having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs." Twelfth-step work often entails taking new people to meetings and supporting them in their recovery.

Twelve-Step Meetings

AA is the largest 12-step program, reporting more than 2 million members and 100,000 meetings worldwide. Most newspapers publish the times and locations of local 12-step meetings. Attendance at all 12-step meetings is anonymous; therefore, only first names are used, and members do not disclose each other's identities outside of the meetings. Twelve-step programs have no affiliations and no leaders. Members pay rent wherever they hold their weekly meetings, and the role of chairperson rotates among the membership. Meetings usually start and end with a prayer. It is customary for all in attendance to introduce themselves and identify their addiction if they have one. The chairperson then awards a coin to those celebrating milestones in abstinence. Coins are given for the first months in recovery and for each year of recovery.

Meetings can be open or closed. An open meeting permits people who are not seeking recovery to attend. A friend or family member can attend as a support to someone in early recovery. Counselors in training can observe an open meeting. Most open meetings are lead meetings in which a member takes the podium to tell his or her story of addiction and recovery. Questions and comments are entertained after the lead has told his or her story. Closed meetings are usually discussion groups. Discussion meetings often address a specific topic, such as resentment, forgiveness, or relationships. Some discussion meetings forbid cross talk, which means each member in the discussion takes a turn in reading or making a statement about the topic without receiving feedback from other members. If a member does not wish to make a comment on the given topic, it is acceptable to withhold from making a statement by saying, "Pass."

Some meetings are for the discussion of a specific step. For example, an 11th-step meeting may meet every Sunday morning for discussion of spiritual matters. Women; atheists; nurses; lesbian, gay, bisexual, transsexual, and queer (LGBTQ); the hearing impaired; and addicts with co-occurring mental and emotional disorders are among groups that hold exclusive meetings. Most recovering people establish a home group in which they are most comfortable. Even though members can and do attend other meetings, they generally celebrate their milestones and receive coins at their home group. At their home group, members may enlist the help of a sponsor. A newly recovering addict can call upon a sponsor for support through cravings, information about working the steps, and guidance through social or emotional issues associated with recovery.

Listening to the stories of others who have had similar experiences helps to lift the shame of addiction. Confrontation by peers helps to break through denial. Meetings provide fellowship, nurturance, guidance, and opportunities for mastery.

Criticisms

Twelve-step recovery programs have been effective for people from all walks of life, but white, middle-aged males have dominated the programs since their inception. Women's meetings have emerged to address the special needs of women who have social phobias and who have been victimized by men. Hispanics generally do not attend 12-step recovery meetings owing to cultural constraints. Blacks sometimes have difficulties related to cultural trauma, and literature to assist them in assimilating to the program is available at many meetings.

Critics of 12-step recovery programs object to the suggestion of a Christian dogma, but 12-step supporters hold that the serenity prayer is applicable to any religion and that the term *God* refers only to a power greater than the individual. Responsible-use messages are not permitted by agencies licensing substance abuse treatment providers, but the goal of total abstinence has been challenged as an all-or-nothing approach that prevents some addicts from seeking treatment.

Anonymity and fluid membership make research of 12-step programs difficult, but recently, research has been conducted, and the results suggest that cost-free 12-step programs are as effective as cognitive behavioral and motivational approaches.

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See Also: Alcohol and Substance Abuse Services; Substance Abuse and Mental Health Services Administration; Substance Abuse Treatment for Children and Adolescents.

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Two-Spirits

"Two-spirit" is a term that Native Americans use to self-identify as gay or lesbian, transgender, or as an alternate to binary gender roles (male and female). It is a contemporary term but has roots in Native American precolonial history. Identity development is suggested to evolve over a relatively linear cycle of stages; however, some argue for an indigenous way of understanding identity that does not conform to the linear and standardized approaches to knowledge that are embraced by the dominant Western culture in the Americas. Human service workers should be aware of the many health disparities faced by this population and should approach working with these individuals in a culturally competent manner.

Definition, Background, and History

Two-spirit is a term that Native Americans coined in 1990 during a Native American and First Nations gay and lesbian conference in Winnipeg, Canada. The meaning depends on what identity the Native American person associates it with, thus it is relative and not easily defined. It often carries components of gender, sexuality, and spirituality. Prior to the colonization of the Americas, native tribes embraced an alternative gender and sexuality outside of the binary male-and-female and heterosexual European norm. The term varied among tribal languages, with as many variations as there were tribal languages. The meaning associated with the term would vary widely among tribes; some anthropologists speculate that it referred to a person who had a special spirit or held a valued position within the tribe because of his or her ability to serve roles for both genders, while others say that they were androgynous. Most anthropologists agree that two-spirit ultimately represented the fluid understanding that Native American people had of sexuality and gender, and when Native Americans were colonialized, they lost this sense of fluidity due to the influential European norm of only two genders (male and female) and only one sexuality (heterosexual). A common term used by European colonizers to identify Native American people who did not comply with gender and sexual norms was *berdache*, a word derived from the Arabic word *bardaj*, meaning a boy slave kept for sexual purposes.

In contemporary times, two-spirit Native Americans sometimes identify within the lesbian, gay, and bisexual (LGB) community. However, many two-spirit people refute that association and insist that being two-spirit is not an issue of sexual orientation. Modern critique of the term comes from indigenous and queer scholars who take issue with the way that Native Americans are understood through a Western or Eurocentric lens. They argue instead for an indigenous way of knowing, which begins with indigenous-identified people and is applied back to them without outsider interference. In this indigenous knowledge, gender and sexuality are not separate identities, and a binary understanding of male and female or heterosexual and homosexual is rejected. In this view, the outsider should step back from his or her preconceived understanding of indigenous people and start from the beginning at the individual's indigenous knowledge instead. Those in the human services field may find this difficult because it is not a prescribed way of approaching serving an individual and does not align with Western ways of delivering human services. However, an acceptable way of going about the understanding of two-spirit people involves first acknowledging outsider status and giving respect to the indigenous culture that the client holds.

Identity Development

Because the two-spirit identity is sometimes associated with a lesbian, gay, bisexual, or transgender (LGBT) identity, it can develop over time in a similar fashion to sexual orientation or gender identity. In 1979, Vivienne Cass created and validated a theoretical model of homosexual identity development that explains how such an identity would develop. It involves a series of six steps in which a person comes to understand and accept his or her homosexual identity: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. For some two-spirit people, Cass's model fits quite well because of the struggle that they faced while coming to terms with a nonnormative identity. Other two-spirit people do not fit the model at all because there was never a struggle to accept their two-spirit identity; they were always embraced for who their spirit was no matter how it was expressed, and their community encouraged the development of their two-spirit identity.

Homophobia and Racism

Some tribes openly accept and teach their children about two-spirit people and about fluid concepts of gender and sexuality. Some embrace it as part of their religious and spiritual heritage, and it is integrated with their identity as Native American. Other tribes do not accept nonbinary genders or nonheterosexual identities, thus creating an environment of homophobia and heterosexism. Homophobia is the fear of homosexuals or of being associated with them. Heterosexism is the assumption, whether overt or covert, that heterosexuality is the only normal and acceptable sexual identity. Heterosexism is expressed both psychologically and culturally. This environment usually becomes hostile to the two-spirited person, who often leaves his or her tribal community either by force or by choice, thus leaving him or her without an important source of support. There is not a set of knowledge as to which tribes take which approach to sexuality and gender, thus the human services worker should assess this with each individual client. Some two-spirit individuals attempt to socialize and gain support within the LGBT community but face racism that exists in that community. Therefore, they can be ostracized from both their tribal community and their LGBT community, leaving them with even fewer sources of support.

Health Disparities

Native Americans have documented health risks that exceed those that nonindigenous people face, such as the highest teen suicide rate among Americans; higher incidence of alcohol and drug abuse and dependency problems; the highest rates of chronic diseases such as diabetes, tuberculosis, liver disease, and pneumonia; and an average 10-year shorter life span than nonindigenous people. Two-spirit people add the additional risk factors associated with that of nonheterosexual or nongender-conforming people, such as increased risk of mental health issues, substance abuse problems, and human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS). These disparities are believed to be a result of cultural and psychological oppression faced by nonwhite, nonheterosexual persons encapsulated in what is commonly known as racism and heterosexism.

Historical Trauma

Historical trauma is a concept that applies to all Native American people but has special meaning for two-spirit people. It refers to the culmination

A contingent of Native American Two Spirits representing the Bay Area in the San Francisco Pride parade in 2013. In many Native American cultures, a Two Spirit is a person who has both masculine and feminine qualities and is often considered to have extraordinary powers and abilities. The Two Spirits are often mentioned as part of the narrative of the American transgender experience as a whole.

of the negative impacts of the systematic genocide and whitewashing of Native American people during and beyond the European colonization of the Americas. After the colonization of the Americas, indigenous people were forced to relinquish their native religions, thus giving up the berdache identity. Many who still held such an identity at that time were intimidated, harassed, and sometimes incarcerated for upholding their native religious beliefs toward a two-spirit identity. Therefore, the history that many two-spirit people hold is that they were abandoned by their own people. That history is pertinent because of how Native Americans view their past, present, and future to be spiritually interconnected. Thus, the context of historical trauma is important to consider when working with a two-spirit individual.

Culturally Competent Practice

Culturally competent practice with two-spirit people requires a human service worker to have competency in the areas of attitudes, knowledge, and skill. The area of attitude involves self-reflection and awareness of the biases and beliefs that one holds. When practicing with two-spirit people, this involves attitudes about both Native American people and LGBT people. The area of knowledge involves education about cultures and values of various groups. Practice with two-spirit people requires the human services worker to respect the spiritual values and tribal beliefs held by each individual encountered in practice as they will differ across tribes and communities. The area of skill involves the ability to recognize and use Native American-specific treatment strategies that sometimes involve indigenous knowledge for healing practices.

Finally, culturally competent practice with two-spirit people requires respect for and attention to the indigenous ways of knowing that are important to the individual. Such practice embraces multiple ways of knowing (relativism), values historical and spiritual perspectives, and is person centered—that is, centered on the person's self-defined goals and outcomes in care.

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See Also: Cultural Competence, Model of; Heterosexual Privilege; Isolated Communities and Cultural Competence; LGBTQ Clients; Native Americans.

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Undocumented Immigrants

Undocumented immigrants, in accordance with the definition of the International Organization for Migration, are described as persons who enter or stay in a country without necessary documents. This includes the ones who have no legitimate documents to enter a country but manage to enter illegally, who enter using counterfeit documents, and who, after entering using appropriate documents, have overstayed or violated the conditions of entry and remain without authorization. In current literature, they are also named as clandestine, illegal, or irregular immigrants.

Undocumented Immigrants: Threat or Not?

Migration-related issues have been progressively reconceptualized since the early 1990s as posing a security threat to immigrant-receiving countries, being linked to organized crime, terrorism, or extremism. Some scholars, including Ayse Ceyhan, Ankica Kosic, Karen Phalet, and Jef Huysmans, argue that undocumented immigrants are being perceived as a potential threat against national identity and security.

Therefore, undocumented immigrants tend to be projected in terms of either a security-based or rights-based approach. The security-based approach concentrates on the need to control illegal immigration in view of its perceived potential threat to internal or external stability and welfare of a country. However, the rights-based approach, which constitutes the basis of human needs of undocumented immigrants, concentrates on human rights obligations (Geneva Convention and European Convention on Human Rights) and the presence of civil society organization as well as adheres to basic principles, such as accountability, transparency, and ethical values, while performing duties regarding undocumented immigrants.

There is an emerging concern that these legal measures and institutional actions regarding undocumented immigrants do not consider human service needs and rights of undocumented immigrants. Thus, human service needs are based on key principles, such as ensuring the voluntary return of undocumented immigrants as well as adhering to accountability, transparency, and democratic principles, which are illustrated next.

Human Service Needs of Undocumented Immigrants

Readmission agreements, which specify the conditions of readmitting citizens of third countries who have passed through their territory, are considered to be one of the effective measures in dealing with undocumented immigrants because they urge immigrant-sending countries to take serious actions against those involved in illegal immigration. Furthermore, ensuring the voluntary return of the undocumented immigrants is crucial in terms of efficiently managing migration and considering human service needs of undocumented immigrants. Thus, the 2003 Thessaloniki European Council emphasizes the importance of the voluntary return of undocumented immigrants and cooperation with third countries.

Legitimacy of Duties Regarding Undocumented Immigrants

Many legal issues are contested among countries being exposed to undocumented immigrants, especially when it comes to migration control. Accordingly, there may be some serious concerns about the breach of international human rights law, specifically the nonrefoulement principle, which is guaranteed by 1951 Geneva Convention on the Status of Refugees. For example, if a vessel of a state intercepts persons in the territorial waters of a third state and returns them to the shore of this state without providing the possibility to ask for asylum, the state would violate international agreements on protecting refugees. Another shortcoming is the lack of access of civil society organizations to the actions of law enforcement agencies engaging with undocumented immigrants. In this sense, governmental authorities should create an environment for the access of civil society organizations and democratic oversight of duties regarding undocumented immigrants.

Moreover, the emergence of data gathering systems with regard to undocumented immigrants may raise crucial issues in terms of individual rights, particularly in the field of data control. For example, there are lots of data systems in the European Union, such as SIS-I, SIS-II, VIS, and Eurodac, where the data of undocumented immigrants are processed. Therefore, efficient protective measures should be ensured for undocumented immigrants, whose data should be protected against any human rights violations or violations of the right to privacy.

Ensuring Accountability and Transparency

By definition, accountability is the ability to call public officials, requiring that they be answerable for their policies, actions, and use of funds. Transparency can be described as the opening of public institutions to other institutions and organizations, where they are required to reveal the costs and the state of services. Henceforth, contemporary security measures regarding undocumented immigrants should prioritize retaining proficiency and being loyal to civilian principles such as transparency and accountability.

However, there is some concern that law enforcement agencies may continue the culture of secrecy, thus lacking transparency regarding border security practices toward undocumented immigrants. In this respect, the promotion of professional structures relies on being transparent to citizens and accountable to authorities as well as being loyal to ethical values. Human dignity is also important when performing duties related to undocumented immigrants.

The increasing number of undocumented immigrants, overstay visa holders, refugees, and unchecked population growth indicate that human service needs of undocumented immigrants are of utmost importance and necessitate further measures. Therefore, defining human service needs of undocumented immigrants is of the highest importance in dealing with undocumented immigrants.

In this respect, practitioners should consider ensuring the voluntary return of undocumented immigrants and prioritizing their human service needs by being loyal to ethical values as well as employing transparency and accountability. Thus, a better and efficient policy approach toward undocumented immigrants depends on ensuring the balance between security and freedoms and defining human service needs. In metaphorical terms, apart from the sword function (security), the shield function (freedoms or human service needs) should also be highlighted while performing duties regarding undocumented immigrants.

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See Also: Refugee Assistance; United Nations High Commissioner for Refugees; U.S. Immigration and Customs Enforcement.

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Uninsured Clients

The term *uninsured* can be defined as not having the financial resources to cover expenses in the event of medical emergencies, illnesses, death expenses, and damaged motor vehicles and property. Hence, the uninsured are unable to meet the demands of life, including preventative care. The phenomenon of the uninsured can affect undocumented clients, immigrants, uninsured drivers, victims of uninsured drivers, temporary workers, low-income earners from different ethnic groups or cultures, and others. Over the last decade, there has been a steady increase in the number of the uninsured population. In 2005, approximately 45 million Americans did not have health insurance. Six years later, the number has increased to more than 48 million. This steady increase of the uninsured population can ultimately impact the society negatively, particularly the health care system. Consequently, the individuals at the micro and macro system level or both can experience these negative outcomes. At the micro level, individuals can experience social impacts such as severe stress, poor health, and shorter life spans. Thus, these incidences over time influence the macro systems. For example, health care providers and government services will have an increase in financial burdens that require immediate action. Current literature demonstrates that uninsured clients can be extremely costly to hospitals and other health care facilities. The average uninsured patient cost is approximately $10,000 per day depending on the type of care. Stakeholders at the governmental level intervene by setting policies to ensure services are delivered for free or at a low rate.

Causes of the Uninsured Population

Several factors have contributed to the growth of the uninsured population. These determinants include poverty, loss of employment, high insurance premiums, divorce, chronic illness, or death within the family structure. Undoubtedly, poverty is the common denominator among the list. It is defined as the lack of resources such as health care, assets, and the ability to direct or manage one's own future. Among the U.S. population today, more than 16 percent of individuals are living below the standard poverty line. These include children, adults, and the elderly. Loss of employment is correlated with high insurance premiums. Individuals with full insurance benefits are more likely to work a full-time job. Another factor impeding access to insurance is sudden family crisis (divorce, death, or chronic illness). If a family has five children with one working parent who encounters any of the issues listed previously, then one of the outcomes could be lack of insurance.

The New Shift Toward the Uninsured

Traditionally, the uninsured population receives less preventive and primary care treatment. For example, an uninsured woman may be less likely to receive annual breast examinations than the insured woman. The uninsured child may be provided with less opportunity to receive care for sore throats and ear infections than a child who has health insurance. Over the years, numerous efforts have been made to improve the quality of life of the uninsured population. Some designated health care providers receive federal support to care for the uninsured. More programs have been opened in underserved communities, and awareness campaigns have resulted in more individuals being willing to access the services available. Recently, the Affordable Care Act was passed to assist the uninsured population with health care services. This act has the potential to increase coverage to the uninsured across America and to help people maintain coverage and access affordable insurance.

Services Delivered to the Uninsured

There are many services available to the uninsured population. The federal government established various services with eligibility criteria for the uninsured. Also, the government implemented policies that protect the uninsured population, such as prohibiting the health care service providers from denying services. The majority of the uninsured population receives services from local, federal or state agencies. Some agencies specialize in services for different age groups.

For example, WIC provides nutrition services for children below the age of 5 years old as well as pregnant and breast-feeding mothers. On the other hand, community health centers, neighborhood centers, churches, and schools provide preventative health care services such as dental and vision care. Sometimes, these services are available free or at a reduced price. In addition, prescription assistance programs are available at some of these facilities. Generic drugs are available to the uninsured at a reduced cost or free. Today, these services can be found in all geographical areas of the United States. Studies show that residents referred daily to community emergency health care are admitted for sudden injury or illness, such as sprains, mild asthma attacks, minor infections, small cuts, sore throats, rashes, urinary tract infections, respiratory infections, and family planning services.

Barriers Among the Uninsured

Despite the various services available to the uninsured, they are faced with challenges daily. Some of these barriers include lack of knowledge and awareness about the services available to them. On the other hand, those who are aware of the services may feel embarrassed to access service. Also, hopelessness may impact the unemployed due to not having enough money to cover living expenses and medical bills. In certain geographical areas, some service facilities are available for a limited amount of time during the month or day. For example, a rural underserved community may have only one health center that opens three times per month for four hours. In these circumstances, specialty health care services, such as mammograms and Pap smear testing for the uninsured, may be delayed. Another challenge facing the uninsured is availability of physicians, nurses, and other health care providers. For example, these providers may only visit the health center once per month due to obligations at other facilities. These barriers may affect the uninsured population and sometimes place a serious constraint on the economic and the health care system.

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See Also: Educational Status and Service Delivery; Employment/Career Assistance Services; Medical Necessity; Migrant Workers; National Assessment Governing Board; Primacy of Place.

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United Farm Workers of America

During the violent 1930s strikes in California's Central Valley, migrant workers were herded like cattle at gunpoint, and farmers dehumanized workers for fear that labor organizing would raise production costs. Mexican and African American farmworkers were segregated from white farmworkers and more likely to live in polluted areas. In the absence of any formal assistance from federal or state agencies, the United Farm Workers of America (UFWA) was established during the

1960s as a workers' rights organization with the merging of the Agricultural Workers Organizing Committee (AWOC) and the National Farm Workers Association (NFWA). The UFWA recruited members one at a time with grassroots organizing, often providing basic needs or strategically connecting needy migrant workers with federal and state agencies. The rise of the UFWA coincided with the civil rights movement in America. The UFWA built itself in the fields and used boycotts to pressure agribusinesses to create awareness using the media. The civil rights movement brought attention to racism for migrant workers related to housing, employment, education, and voting. The issues were basic: a living wage, decent housing, an end to spraying pesticides while workers were in the fields, and collective bargaining.

The struggle for migrant farmworkers dates to the early 20th century. California agribusinesses began to import Filipino farmworkers during the 1920s. The National Labor Relations Act of 1936 provided most American workers with the right to collective bargaining but did not extend it to agricultural workers because many were African American. The U.S. government and the Mexican government enacted the Bracero Program (Public Law 78) between 1941 and 1964 so that Mexican workers could come as guest workers to temporarily replace domestic workers during crop harvests to alleviate labor shortages during World War II. American growers quickly undercut the competition by utilizing braceros because they were not required to pay foreign workers domestic wages.

Braceros had restricted rights and were often sent back to Mexico if they challenged employers. Distress in the bracero camps grew when managers ignored complaints: Letters to consuls, work stoppages, and attempts to get local governments to listen to their needs went unheeded. Basic safety standards such as portable toilets in the fields were neglected. Migrant families eked out livings following the harvesting of produce in the United States, and families exploited the labor of their own children to subsist. In the equivalent to company towns, braceros rented substandard housing with no indoor plumbing or heating in employer-owned labor camps and purchased food from farmer-owned stores in company towns. Farmworkers were vulnerable to preventable fatal accidents, and their life expectancy was about 49 years.

Grassroots Organizing

Community organizer Fred Ross worked as a social worker during the Great Depression, established the Community Service Organization (CSO) in 1948, and increased voter registration in segregated areas. Ross created a dynamic organization with grassroots organizing by mentoring Cesar Chavez and Dolores Huerta, who became the cofounders of United Farm Workers. Chavez brought a charismatic, nonviolent sensibility to organizing. Huerta earned a provisional teaching credential in elementary education from the University of the Pacific and later witnessed the plight of migrant families when she taught children who regularly attended school hungry and without basic necessities like shoes. Working with the CSO, Ross led the effort to get Mexican Americans to register to vote, while Huerta built coalitions and lobbied the state legislature to address issues of social justice and equity for migrant workers.

Chavez employed specific strategies in building the UFWA. He made a point to create case files on farmworkers. In Ventura County, where a Farm Placement Service (FPS) issued referral cards needed to get the best jobs to braceros and worked in collusion with growers to eliminate the local workers who had protections and expected better pay as U.S. citizens, Chavez filed complaints against the FPS for job preference violations. He then used the paperwork to collect data on the filers' experience and capabilities along with their worker ID numbers and referral card numbers. This informal registration of farmworkers eventually created a demographic portrait of poverty, family struggles, and systematic discrimination that Chavez used to pit different agencies against each other. Chavez would first put pressure on the Welfare Department to provided groceries, and then California state agencies acted so that farmworkers could get grocery orders.

Huerta cofounded the Stockton chapter of the CSO in 1955 to address segregation, police brutality, and voter registration. McCarthy-era politics in the United States meant the term *un-American* was used to challenge prounion, antisegregation individuals and those who encouraged minority groups to vote by making them targets for harassment if they protested the status quo. Huerta cofounded the Agricultural Workers Association (AWA) in 1960. She successfully lobbied for initiating Spanish-language election ballots and California Department of Motor Vehicle exams; the end of California's prerequisite of citizenship to access public assistance, pension programs, and disability insurance; and the repeal of the Bracero Program in California in 1962, which authorized deportation of undocumented immigrants.

Huerta and Chavez established the NFWA in 1962. Despite challenging personality conflicts, Huerta and Chavez lobbied the legislature to extend Aid to Families With Dependent Children to California farmworkers in 1963. They led the UFW boycott of San Joaquin grape growers in 1965 that included sit-ins, blocking Schenley Industries trucks, and picketers on the Schenley ranch getting sprayed with insecticides; Huerta subsequently negotiated a contract between UFW organizing committee and Schenley.

Filipino farmworkers affiliated with the AWOC, holding charters with the American Federation of Labor and Congress of Industrial Organizations, initiated the Delano grape strike in 1965, when children were used as strikebreakers. Chavez motivated Mexican and Chicano workers to join the strike. Chavez understood the power of the media and used newspapers, radio, and television to get the message out. Luis Valdez (1940–) established *Theatro Campesino* (the *Farmworkers Theater*) in Delano to energize the strikers.

Boycotts as Nonviolent Pressure for Change

The First Amendment guarantees the freedom to boycott, so the UFW launched the most ambitious boycott in American history in July 1966. The FBI started extensive files on Chavez during the boycott of table grapes grown in the Delano fields that culminated with the creation of the UFWA. At the time, few labor laws existed to protect migrant farmworkers, and no agencies addressed this. The UFWA's strategies exposed unconstitutional injunctions by violating them in order to bring awareness. With the UFWA, Huerta lobbied for passage of the California Labor Relations Act (1975) and created awareness of the effects of toxic pesticides on farmworkers. The work of the UFWA continues as the U.S. Congress introduces more variations of bracero programs.

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See Also: Child Labor, International Variations in Attitudes Toward; Grassroots Leadership; Immigration: Human Services Issues; Mexican Americans.

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United Nations Convention on the Prevention and Punishment of the Crime of Genocide

There has always been a controversy in global politics with respect to the contextualization of the crime of genocide over the course of the last century. In his book *Axis Rule in Occupied Europe*, published in late 1944, Raphael Lemkin was the first who used the term *genocide*. The roots of the word *genocide* come from the word *geno*, used to describe race or tribe in Greek, and the word *cide*, used for *killing* in Latin. In his book, he attempted to bring an explanation to Nazi policies that resulted in the systematic killings of European Jews.

While keeping in mind that the accusation of genocide has always been controversial in terms of world politics, the United Nations (UN) Convention on the Prevention and Punishment of the Crime of Genocide has been the primary document that provides to the states a context to reach consensus with regard to the definition of genocide; hence, it is the foremost formal consensus that designates

Grave markers at the Srebrenica Genocide Memorial, where the victims were mostly male Bosnian Muslims and Croats. The convention defines genocide as acts that are implemented against a national, ethnical, racial, or religious group and committed with the purpose of destroying all or part of the group members.

genocide in legal terms in international law. More to the point, the convention is substantial in global politics in terms of emphasizing the protection of human rights and the right to life of communities and human beings. In this context, preventing the crime of genocide in a community is an essential responsibility of a state to protect human rights and right to life of individuals.

Background

Although the UN General Assembly accepted the convention on December 9, 1948, it was not put into force until after the ratifications of 20 member states in the UN on January 12, 1951. As of November 2013, not only has the international community adopted the principles of the convention more than ever before but also three-quarters of all countries (143) have ratified the convention. The adoption of the convention gives the responsibility to the states to prevent and punish the crime of genocide in times of peace and war. The convention has become one of the milestones in international affairs history, emerging as a result of agreement of the states to condemn the crime of genocide and, by doing so, to protect human lives and rights.

Framework of Genocide in the Convention

The convention defines genocide as acts that are implemented against a national, ethnical, racial, or religious group and committed with the purpose of destroying all or part of the group members. In essence, those acts against the groups that are under threat include killing, causing serious bodily or mental damage, destroying the life conditions with the intent of deliberate extermination, enforcing precautions to prevent childbirth, and compulsorily moving children of the group to another group.

The convention stipulates the penalization of individuals, including rulers, public officials, and private citizens, who commit genocide crimes or any other act that leads to the crime. The convention requires the contracting states to put into force necessary regulations and rules complying with their respective constitutions in order to punish those persons who commit the crimes designated by the convention.

Implementation of the Convention in Global Politics

There are two tenets in the structure of the convention that the international community endorses to implement against the crime of genocide. Those tenets are to prevent the crime and to punish the crime. In terms of punishment, the responsibility of jurisdiction is given to state tribunals or to the international courts that are recognized by the contracting parties of the convention. Pursuant to this, the international criminal court (ICC), which is not under the UN system, is the primary responsible international court in judging those who commit the crime of genocide. However, only in 1998, by the Rome Statute, which allowed establishment of a stable international court, could it be possible to judge those kinds of international crimes. This decision came as a result of the experiences of international community in the conflicts of Bosnia and Rwanda.

On the other hand, in terms of prevention, the convention works to establish an international cooperation to protect humanity against the crime of genocide or acts that might lead to such a crime. Therefore, any contracting parties, or the states, may ask the UN to take necessary steps against the crime of genocide or acts that could possibly lead to the crime. By doing so, the convention recognizes an international organization, the UN, as the primary responsible entity in protecting individuals under the threat of genocide or those whose were exposed to it. The competent organs of the UN focus on the crime of genocide or crimes against human rights and lives through their offices located throughout the world.

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See Also: Colonialism, Lingering Effects of; Conflict Resolution and Diversity; Discrimination and Institutional Racism; Holocaust Survivors; Power, Race, Ethnicity and; Universal Declaration of Human Rights; Values and Ethics, Ethnic Diversity and.

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United Nations Convention on the Rights of the Child

The United Nations (UN) Convention on the Rights of the Child (CRC) is an internationally recognized agreement between nations that outlines entitlements and freedoms that children everywhere should hold and that all governments should respect. It is the highest authority in international law on children. Unanimously adopted by the UN General Assembly in 1989, the CRC is the most widely ratified human rights treaty in history, with 193 countries party to it. The United States stands with only two other nations (Somalia and South Sudan) in not yet ratifying the CRC. Articulating the entitlements and freedoms of children in universal terms has roots in the UN’s Universal Declaration of Human Rights (1948), adopted in the wake of World War II. Conceptions of children’s rights are linked to universal human rights, though they differ from ideas of adult rights in important ways. The UN’s Declaration of the Rights of the Child (1959) preceded the CRC of 1989. While the earlier documents emphasized children’s needs for protection, the CRC strives to balance standards outlining the needs of children that governments and parents are obliged to meet with those describing children’s rights to specific freedoms, such as the rights of participation and self-expression, offered in accordance with age and maturity.

The CRC has 54 articles and two optional Protocols. The first two articles define a child as every human being under the age 18 and prohibit discrimination of any sort against any child. Articles 3, 4 and 5 assert the standard of the best interests of the child in all actions concerning children, assign primary responsibility to families or legal guardians, and outline the roles of the states. Articles 4 through 41 describe the economic, social, political, cultural, and civil rights assigned to children. These articles include entitlements (to survival and development, name and nationality, health care, education, an adequate standard of living, parental care, rehabilitative care, and juvenile justice, among others); protections (from abuse, trafficking, sexual exploitation, economic exploitation, drug use, torture, capital punishment, and participation in armed conflict, among others); and freedoms (to express opinions, to acquire information, of association, of privacy, of conscience and religion, to play, and to participate in cultural life, among others). Specific articles address the rights of minority children, refugee children, adopted children, and children without families. Articles 42 through 54 address how the CRC is to be administered. These articles assign responsibility for carrying out the treaty to the states party to it. State parties report to the Committee on the Rights of the Child regarding their plans and progress toward full implementation. These articles also outline the ways that states can ratify with reservations, understandings, and declarations (RUD) that modify the agreement.

Though many of the provisions of the CRC are implemented in the law and practice of the United States, ratification of the CRC remains controversial in the United States. Under the administrations of Ronald Reagan and George H. W. Bush, representatives of the United States played an active role in drafting the CRC. In 1995, the U.S. delegate to the UN signed the CRC on behalf of President Clinton and the United States, indicating the nation's intent to ratify. However, the convention has not been forwarded to the Senate for consideration due to a variety of political and procedural obstacles. Organizations including the Christian Coalition, the Family Research Council, the John Birch Society, and the Eagle Forum have led the opposition to ratification. In general, objections are based on beliefs that the CRC undermines the authority of parents in raising their children and concerns that ratifying the treaty will undermine U.S. sovereignty. In addition, the CRC defines positive economic rights for children, which many conservatives oppose.

On the other hand, a large number of human service organizations have united in support of the campaign for U.S. ratification of the CRC. Leaders of the National Association of Social Workers, the Child Welfare League of America, the Children's Defense Fund, the Council on Social Work Education, the American Red Cross, the National Education Association, and other nonprofits have urged that the CRC be placed before the U.S. Senate for ratification. Supporters argue that the United States should ratify the CRC in order to provide a national framework of goals and standards in relationship to the care of children; to draw attention to the persistence of poverty and hunger among young people; and to enhance U.S. standing as a global leader in human rights. Supporters also note that the United States has regarded treaties such as the CRC to be non-self-executing, meaning that these treaties are only executed through the legislative process. Therefore, supporters argue, the CRC does not represent a threat to national sovereignty.

Even without ratification, the CRC has impacted U.S. law and policy. In 2005, the Supreme Court abolished capital punishment for juveniles, influenced in part by a desire to end the nation's international isolation on the issue. (The CRC expressly prohibits capital punishment and life imprisonment without possibility of release for offences committed by persons below age 18.) In 2002, the United States ratified two optional protocols—on the sale of children, on child pornography and child prostitution, and on the involvement of children in armed conflict.

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See Also: Convention on the Rights of Persons With Disabilities; International Adoptions and Families; International Federation of Social Workers; Universal Declaration of Human Rights.

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United Nations Declaration on the Rights of Indigenous Peoples

The declaration on the rights of indigenous people refers to a nonbinding declaration that was adopted on September 13, 2007, in the United Nations (UN) Grand Assembly after 20 years of negotiation with indigenous peoples and national governments from all around the world. The UN declaration, which was adopted by a vote of 144 in favor, four votes against (Australia, Canada, New Zealand, and the United States, in which indigenous people intensively inhabited), and 11 abstentions, mainly recognizes the distinct cultural rights of indigenous peoples. The specific purpose of the declaration was to strength the international collaboration on the remedy of problems that indigenous people were exposed to in the areas of human rights: education; health; housing; environment; law; territorial issues; economic, social, cultural, and religious rights; political rights; and self-determination.

Therefore, it can be argued that the declaration is the first UN treaty that has been negotiated with indigenous people whose human rights have been exploited for years as well as with nation-states, thus bringing the rights of indigenous people onto the agenda of the international community. During the last century, the rights of indigenous people have been disregarded. It is believed that the declaration is of importance for the benefit of more than 300 million indigenous people from 70 countries throughout the world.

The Historical Development of the Declaration

Until the 1970s, there was no specific attribution to international law regarding indigenous peoples' rights other than the International Labor Organization Convention. In order to ensure the coherence of international law about indigenous peoples' rights, some important matters, such as land rights, self-determination, and collective right, needed to be handled with a particular view. Thus, the emergence of the universal declaration could be seen as an important attempt to address the concerns of indigenous people. In this context, in 1971, a special reporter, Jose Martinez Cobo from Ecuador, was appointed by the UN Economic and Social Council to search patterns of discrimination against indigenous people around the globe.

Having considered Cobo's report containing issues related to human rights, the UN Subcommission on Prevention of Discrimination and Protection of Minorities created a Working Group on Indigenous Population (WGIP) in 1982, which can be considered as the first human rights mechanism focusing on indigenous people and a supplementary organ of the subcommission with dual responsibilities: (1) to review developments pertaining to the promotion and protection of human rights and fundamental freedoms of indigenous peoples and (2) to give special attention to the evolution of international standards concerning the rights of indigenous populations.

In 1985, with the leadership of Chairperson Erica Irene A. Daes, the working group started to develop a draft, taking into consideration the comments and suggestions of representatives of indigenous peoples and governments. The draft declaration, consisting of 19 preamble paragraphs and 45 articles, was extensive and overelaborate in comparison to ordinary international human rights documents. Each article in the draft declaration reflected historical and cultural demands of indigenous peoples, thereby pleasing them.

In 1993, the final text of the draft declaration was produced by the working group at its 11th session and sent to the subcommission. Then, the subcommission adopted the text in 1994 and submitted it to the commission on human rights for consideration. In order to examine and review the text, and provide a consensus on the draft declaration, the commission established an open-ended and intersessional working group, the Working Group on the Draft Declaration (WGDD). Even though government participation predominated in this new working group, special arrangements were made in order to ensure broader indigenous participation as observers. Over the years, the WGDD arranged several formal and informal meetings aiming to call for the adoption of the draft declaration. It was initially supposed that the draft declaration would be adopted by the UN General Assembly in the first period of 1994 to 2004. However, participants of the WGDD could not reconcile on several articles of the draft text. Though 12 years passed from its adoption by the subcommission, the working group agreed on only two out of 45 articles of the draft text. It was a clear signal that the text was still far from being ready to be fully adopted. One of the main reasons was that indigenous observers adopted a no-change strategy on the draft text until 2005 that slowed the progress of the WGDD. Because notable progress could not be made on the text, they eventually abandoned the no-change position. Thus, the negotiating process started to gain impetus.

After several changes by participants of the WGDD on the draft declaration during the period between 2004 and 2007, the final version of the declaration was eventually adopted on September 13, 2007, in the General Assembly. As mentioned, unlike four countries—the United States, Canada, Australia, and New Zealand—who voted against it, 144 states in the General Assembly voted in favor, and 11—Azerbaijan, Bangladesh, Bhutan, Burundi, Colombia, Georgia, Kenya, Nigeria, Russia, Samoa, and Ukraine—were absent when it was on the agenda of the assembly.

During the negotiation process on the UN declaration recognizing the rights of indigenous peoples, there were three controversial issues—self-determination, collective rights, and territories and resources—that caused the suspension of this process in several ways.

The Right to Self-Determination

One of the most difficult issues concerning the development of the rights of indigenous peoples within the framework of international law has been related to the right to self-determination. During the negotiations, several states made objections and held serious reservations regarding the recognition of indigenous peoples' right to self-determination owing to the fact that indigenous participants stated that the right of self-determination was the heart and soul of the declaration. Finally, after a long-lasting debate, the Human Rights Council adopted Article 3 of the declaration and recognized that indigenous peoples should have the right to self-determination, which is also a recognized right for other peoples. Article 3 also recognizes and determines a political status for indigenous people and highlights economic, social, and cultural development of indigenous peoples. From the point of the declaration, self-determination means that indigenous peoples have the right to determine their relationship with the state and to be involved in setting up state structure and governance. In addition to that, indigenous people are entitled to maintain their own institutions, such as political, legal, economic, social, and cultural aspects. The UN declaration also addresses the right of remedy for indigenous peoples when they face violations of the right to self-determination.

Collective Rights

Another most contentious area during the negotiations of the declaration was restricted to collective rights. The collective rights of indigenous peoples are recognized in the UN declaration, which caused tension between the individual nature of Western human rights discourse and the rights of indigenous peoples. When relations between individual and collective rights were compared, collective rights, for some states, were evaluated as a part of the domestic legal system. The UN Human Right Council recognized the right of indigenous peoples to self-determination as collective rights. Indigenous populations supporting the idea that collective rights were already accepted in international law have referred to a number of international instruments. During discussions in the WGDD, the use of the term *peoples* has caused a lot of debate in negotiations. Finally, the secretariat solved the problem in the UN report by claiming that terms should be used tentatively in order to prevent misunderstandings.

Territories and Resources

The right to ownership of lands, territories, and resources has been a controversial issue during negotiations concerning Articles 25 through 30. The declaration emphasizes the importance of land, resources, and environment that have traditionally have owned by indigenous people. The land and resources in the declaration are related to the militarization of the lands; free, prior, and informed consent; and the principles of preservation of territories, protection, and restoration of the environment. The most controversial article in the WGDD related to Article 28, which recognizes the restitution right of the territories and resources that indigenous people have traditionally owned or occupied or used and that have been confiscated, taken, occupied, used, or damaged without free and fair compensation or prior and informed consent.

Within the framework of these articles, states, with the cooperation of the indigenous peoples affected, are obligated to establish a system that seeks legal recognition and protection of indigenous populations' right to own their land, territories, and resources, where the environment should be protected and hazardous materials should not be stored. In addition, Article 30 foresees an obligation of the states that military activities should not take place on indigenous peoples' lands or territories unless they freely agree.

To conclude, having considered the aforementioned discussions, it can be argued that some states expressed their concerns about the most controversial articles, and the WGDD finally compromised on these issues after long-lasting discussions and negotiations. However, it is important to identify whether these efforts were beneficial, after more than 20 years of negotiations, for a nonbinding instrument. As discussed in this entry, the declaration is worthy because it provides indigenous people with considerable status within the international human rights framework and international law and draws the attention of the international community to indigenous peoples' rights. The declaration is also noteworthy for its potential to stimulate the development of future instruments concerning the rights of indigenous peoples. In addition, one can argue that the declaration is the principal formal universal document regarding indigenous peoples' rights within international law. Finally, the UN declaration also demonstrates the need to establish more dialogue highlighting partnerships and mutual respect between the international community and indigenous peoples.

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See Also: American Indian Movement; Indian Civil Rights Act of 1968; Rural Communities.

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United Nations High Commissioner for Refugees

The United Nations High Commissioner for Refugees (UNHCR), which was established in 1950, initially emerged as a response to the needs of displaced Europeans who suffered from the devastating effects of World War II. The scope of duties of the UNHCR and its competency have extended over the course of time with the emergence of the Hungarian Revolution in 1956, the decolonization of Africa in 1960, and intrastate conflicts in some African countries in subsequent years. The agency, being engaged with 33.9 million people, is currently active in 126 countries in 135 main locations, such as regional and branch offices as well as with 279 suboffices and field offices. The budget of the agency has increased from $300,000 in its first year to more than $3.59 billion in 2012.

Having considered the extensive responsibilities concentrating on diverse and fragile groups all around the world, the UN High Commissioner for Refugees is the main global organization that aims to meet human service needs of disadvantaged and vulnerable groups such as internally displaced people, refugees, returnees, stateless people, and asylum seekers whose rights are safeguarded by means of returning home voluntarily, integrating locally, or resettling in a safe third country.

As emphasized by the 1994 UN Human Development Report, human security should be prioritized, and it is a vital human need for all individuals. Freedom from want, freedom from fear, and rule of law principles have all contributed to the creation of a human security paradigm. According to this paradigm, no one is secure as long as someone is insecure anywhere. The interests of humanity have become the focus, and human security becomes a comprehensive condition in which individual citizens live in freedom, peace, and safety.

There are currently 60 fragile countries (failed states) where the number of refugees, economic structure, and demographic and public service conditions are below standard. For example, at the time of the conflict in 1994, 50,000 people fled from Rwanda into eastern Zaire. Bangladesh and Cameron saw also some of the biggest relative downturns because of the need to import high-priced food and other commodities. Countries suffering from a rapid rate of population growth coupled with a lack of developmental opportunities as well as adverse conditions pose a threat, thus forcing the movement of refugees, asylum seekers, and economic migrants to the countries where life standards are at higher levels.

Global Refugee Flows and Limitations of Nation-States

The political instability and economic deficiencies of nation-states lead to the emergence of refugee crises and influxes of asylum seekers. For example, there are more refugees from fragile countries than stable states due to poor political and economic environments. The reason lies in the fact that people from fragile countries migrate to anywhere in order to gain refugee status to survive. In this sense, it can be argued that refugees or asylum seekers are considered as a forced migration, and there are more refugees from failed states than stable states. According to UN figures of 2008, there are currently 15.2 million refugees worldwide. Of all the states, Afghanistan, Somalia, and Iraq are the main countries of origin of refugees, while the United States, France, and Canada are hosting most refugees in the world.

One of the distinguishing features of refugee problems is that they do not respect national boundaries. Therefore, they cannot be solved by individual efforts of nation-states, thereby necessitating international solutions. The states are no longer the only actors that deal with asylum, there are also several international institutions acting on the problems of refugees and asylum seekers.

Good governance of refugee flows lies in understanding the root causes of immigration. Therefore, nation-states, while dealing with refugee crises, should cooperate with international institutions on issues related to managing and controlling forced migrations.

Global refugee crises have gone through a very rapid process where states, governmental, and nongovernmental organizations, as well as international organizations, have engaged in greater interactions with each other. Not only states and civic advocacy groups but also intergovernmental organizations like the UN are trying to shape the system to manage global human movements and global refugee crises.

The UN's Role on the Development of Global Asylum Policy

International institutions are considered to be major actors that play important roles in the creation, development, and operation of international regimes. They act not only in the global arena but also regionally. The main purpose of this type of institution is to address problems of policy areas such as immigration, asylum, rapid population growth, and global warming and climate change and to find solutions to these problems all around the world.

The UN and its family organizations, the UNHCR, High-Level Dialogue for Migration, Global Commission on Migration, International Labor Organization, and International Organization for Migration, are among the international institutions acting on issues related to asylum and migration. Nation-states must inevitably get used to global governance and its requirements if they seek to manage refugee flows efficiently.

As one of the prominent global governance institutions, the emergence of the UNHCR will contribute to bringing asylum issues to international policy agendas. The UNHCR is virtually the sole authority capable of carrying out and managing asylum procedures, acting on the 1951 Convention Relating to the Status of Refugees and its supplementary protocol dated 1967.

International asylum regime cannot be implemented on a global scale solely by efforts of nation-states. This makes the UNHCR still important due to its endeavors in setting rules and standards with regard to the status of refugees. There is no other international organization that could replace the UNHCR and take on its vital role. Despite all criticism regarding the UNHCR and its role in global asylum policy, there is no alternative to deal with these issues on a global scale.

Conclusion

In order to develop a global approach toward refugees and asylum seekers, the UN established a specific dedicated unit, the UNHCR, focusing on problems of refugees and asylum seekers. The UNCHR's efforts in order to form an international regime regarding refugees and asylum seekers have produced concrete results. If the UNHCR wants to stop the influx of refugees, there is a need to develop measures to maintain sustainability in the countries (failed states) that produce refugees. In this respect, the sustainable development of those countries dealing with refugee crises will also establish basic standards for them, such as gross domestic product (GDP) and literacy and health standards, which contribute to the emergence of Human Development Index (HDI) rates. In order to meet the basic human needs of asylum seekers and refugees, the main focus of the UNHCR should concentrate on increasing the HDI and GDP rates in those countries suffering from unstable political and economic environments and infrastructures. The global community needs to work together to find solutions with regard to the human service needs of refugees and asylum seekers. In this respect, existing global structures like the UNHCR should be efficient and effective to set the international asylum agenda in accordance with global requirements and international norms, highlighting the importance of meeting human service needs of refugees and asylum seekers.

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See Also: Office of Refugee Resettlement; Refugee Assistance; United Nations Declaration on the Rights of Indigenous Peoples.

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United States, Demographics of

Demographics refers to a set of statistical data that describes the population of any country. In particular, the United States Census Bureau, since its creation in 1790 until 2010, has registered its population every 10 years. The bureau surveys changes and trends of that population based on age, race, gender, ethnicity, disability status, employment, educational level, and other demographic categories or identifiers. It is critical to note that the United States' population has increased dramatically over the past two centuries and continues to grow. According to the 2010 U.S. Census, the total population of the United States is 308.7 million. They live, by and large, in urban areas, but, in smaller numbers, others reside in rural areas as well. The national population also has been studied systematically by diverse scholars such as demographers, political scientists, sociologists, and educators, among others. The makeup of the United States population is diverse, encompassing various ethnicities, racial groups, cultures, and linguistic groups.

Population Change and Growth

The first census was conducted in 1790. In that year, the total population of the United States was 3,929,625. In the early years of the republic, the population growth rates were higher, as noted from 1790 to 1810, a period during which the population increased by more than 3 percent per annum. The same phenomenon was also documented between the 1840s and 1850s. That rapid population growth, from 1840 to 1850, was a result of the influx of immigrants, primarily from western Europe. Among them were Germans, Irish, and other ethnicities who sought opportunities then available in North America. For them, the Western Hemisphere offered opportunities in business, access to cheap land, farming, and better employment. Additionally, others came to this country to escape religious prejudice and intolerance in Europe. They sought the religious freedom available in America. Still others, the Irish in particular, fled their homeland to avoid the great potato famine and the political upheaval caused by the conflicts between Ireland's Protestants and Catholics.

It is important to understand other factors contributing to this surge in migration after 1840. For example, in 1850, the population increase in the United States was documented to have resulted from an expanded number of foreign born by nearly 10 percent (of which more than 90 percent were from Europe). This knowledge emerged from the census of 1850, which for the first time, asked all persons about their respective places of birth. Between 1890 and 1910, during an immigration boom, the population increased again with up to 15 percent of men, women, and children residing in the United States foreign-born. The share of the white population in these numbers increased steadily between 1790 and 1930 (from 80.7 percent to 89.8 percent) largely as a result of the substantial net immigration of white Europeans through 1920.

After World War I, and because of the restrictions placed on immigration (e.g., quotas on national origin and other excluding selection criteria), there was a severe reduction in immigration. Furthermore, the Great Depression of the 1930s and related economic challenges in the United States contributed significantly to the further decline in migration from abroad and to the nation's overall fertility rate. However, the situation changed in the aftermath of the World War II. A rising rate in population growth and new immigrants were seen particularly in the 1940s and 1950s. Later, due to changes in immigration policies, regulations, and laws, there was a surge in net immigration, with 37 to 47 percent population growth by the 1970s on through the 1990s.

Immigrants from Latin America, Asia, the Caribbean, and Africa to America contributed again to the rise of foreign-born Americans by more than 10 percent in 2000 census. Until the 1970s, the foreign-born population declined and was only 4.7 percent of the nation's total population. Profoundly dramatic, however, was the rising share of other ethnic groups in the population in the late 20th century. Specifically, from less than 1 percent of the population in 1960, this share rose to 12.6 percent in the 2000 census. This increase had its origins mostly in the heavy immigration of east and south Asians as well as expanding American Indian populations.

The 2010 census revealed compelling evidence that deals with dramatic changes both racially and ethnically in the United States from 2000 to 2010. During that 10 years, the Asian American population expanded by more than 43 percent, African Americans grew by more than 12 percent, and like Asian Americans, Hispanics expanded by 43 percent. Hispanics alone provided more than half of the country's growth during those 10 years. The white, non-Hispanic population in the United States, as a majority, grew by less than 2 percent, indicating that this white population is in decline. On the other hand, the composition of multiethnic groups throughout society is not only expanding but is also undergoing profound social, cultural, economic, and political changes.

It is likely that, based on demographic projections in the years to come, by 2050, according to the Pew Research Center, there will be even greater demographic change in the United States. Based on projections and demographic trends, non-Hispanic whites will cease to be the majority of this nation's population, thereby confirming the transformation of the United States into a demographically pluralistic nation with a new majority.

The Black Population of the United States

When the first census was conducted in 1790, more than 90 percent of all blacks lived in the South, with only 40 percent of whites residing there. It is critical to note that slavery's end did not immediately end racial and other divisions. In addition, at the beginning of the republic, about four-fifths of the population was white and one-fifth was black. People of African descent, usually identified as blacks, were enslaved and lived in the south. In the 1820 census, the first to distinguish slaves from free blacks, the free black population was 13 percent of the total black population. Later, due to social movements, political developments, and other factors, blacks moved to states across the United States, thus there were no longer any black majority states as compared to 1900s America. In the aftermath of the World War II, particularly in the 1960s, blacks returned to the south from the north and west.

In 2010, the U.S. Census offered the option for respondents to answer the question of race based on self-identification. They also had the opportunity to self-identify with one, or more than one, race. This means they could describe as black alone or in combination with another race. The 2010 census provided a portrait of the black population in the United States that advanced our understanding of the nation's transforming and expanding ethnic and racial diversity. It is known that both the black-alone population and the black-alone or in combination population grew from 12 percent in 2000 to 15 percent in 2010, and the black-in-combination population experienced growth by 17 percent, the highest.

The 2010 U.S. Census showed the geographic distribution of the black population across the United States. Here, the black population is mainly concentrated in the south, and the number has increased from 2000 to 2010. The data suggest that the black population that resided in the north and west tended to be more concentrated in metro areas. Based on the data, blacks are more likely to live in a larger city in contrast to the non-Hispanic and white populations.

Hispanic Population of the United States

According to the 2010 U.S. Census, the total population of Hispanics, Latinos and Latinas is 50.5 million, which accounts for 16 percent of the total 308.7 million people residing in the United States. It is important to understand that those who are identified as Hispanic, Latino, or Latina refers to a person of South and Central American, Mexican, Puerto Rican, Cuban, and Spanish origin or culture regardless of race. Indeed, they are placed in the ethnicity category, not race, on the U.S. census. Based on 2010 U.S. Census data, people of Mexican origin are the largest group, comprising 63 percent of the total Hispanic population in the United States. This is an increase from the 2000 census, up to 58 percent. The second-largest group, Puerto Ricans, declined from 10 percent in 2000 to 9 percent in the 2010 census. The Cuban population was approximately 4 percent in both the 2000 and 2010 census.

A sign in Miami welcomes visitors to Little Havana. Hispanics, Latinos, and Latinas make up 16 percent of the U.S. population, most live in California, Texas, and Florida.

The states with the most Hispanics are California, Texas, and Florida; they account for more than half of the total population of the nation's Hispanics. For instance, 28 percent (14.0 million) reside in California and 19 percent (9.5 million) reside in Texas. In addition, more than three-quarters of the Cuban population (77 percent) reside in the South, mainly in Florida. Based on the 2010 census, 41 percent of Hispanics live in the west and 36 percent live in the south. The northeast and Midwest accounted for 14 percent and 9 percent, respectively, of the Hispanic population. The Hispanic population grew in every region between 2000 and 2010, and most significantly in the south and Midwest.

Demographics and Education, Communities, Organizations, and Government

The census in the United States is taken every 10 years as mandated by the U.S. Constitution. The collected data is critical for policy makers, educators, and state and federal officials to address educational challenges regarding the student academic achievement gap and other success measures. Because the national statistics on proficiency levels in various subjects became available by race and age, it became clear that there were differences in children's academic achievement by ethnicity and race. These differences exist across all age groups. In order to create educational opportunities for all students and improve their academic success, various initiatives and programs have been implemented at federal and state level. Yet, school reform, the academic achievement gap, and other academic performance issues remain a challenge for educators, policy makers, and federal officials alike.

Demographics are also critical for communities and organizations. Both public and private organization use various demographic identifiers to find areas where groups may need special services and to plan and implement education, housing, health, and other programs that address these needs. For example, a school system might use this information to design cultural activities that reflect the diversity in their community. In addition, census information helps identify areas where residents might need services of particular importance to certain racial groups, such as screening for hypertension or diabetes, and other community medical and business needs.

Finally, U.S. data are usually used to determine the congressional seats for each state. They are essential in allocating electoral votes and redistricting and have proven to be valuable for other legislative and judicial purposes. In addition, different federal and state programs, initiatives that are aimed at helping particular segments of population, use U.S. Census data.

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See Also: Immigrant Populations, Human Service Needs of; Naturalized Citizens; Racial and Ethnic Categories, U.S. Census; U.S. Citizenship and Immigration Services; U.S. Immigration and Customs Enforcement.

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Universal Access/ Universal Design

Universal access or universal design (UD) is a process for creating products and environments so that people with widely varying abilities can use them. Formerly known as Design for All or Accessible Design, UD recognizes that all people have changing abilities throughout their lives. For example, people might injure themselves or lose mental or physical function through disease or aging. When designing buildings, products, and software, for instance, UD guides the designer to create accessibility for as many people of as many abilities as possible. UD principles also are used for the design and delivery of programs and services.

Origins of Universal Design

The concept of UD developed in part because of a growing population of senior citizens and the mainstreaming of people with disabilities. As a result of the civil rights movement, legislation like the Architectural Barriers Act of 1968 mandated that builders had to remove barriers in order to allow all people access to public buildings. During the 1970s, as architects started building ramps and installing other accessible features (e.g., lever handle doorknobs, wider doors and hallways, and larger bathroom stalls), they realized that these modifications helped people with and without disabilities and that, economically, it was more beneficial to include them in new designs rather than add them later.

Ron Mace at North Carolina State University coined the term *universal design*. At age 9, Mace contracted polio and used a wheelchair. After getting a degree in architecture, Mace decided to focus on building homes that everyone could get into, regardless of their ability. Eventually, others adopted Mace's view, and architects, engineers, product designers, and various other researchers developed a set of principles in order to ensure buildings and products were made in such a way to ensure a wide variety of people could use them.

Seven Principles of Universal Design

Equitable use. The design must be able to be used by a diverse population. For example, automatic doors allow people who use wheelchairs easy access to buildings and rooms, but they are also helpful to parents pushing strollers, people with their hands full and anyone else who goes through them.

Flexibility in use. The design accommodates varying abilities and preferences. Many elevator buttons are low so people in wheelchairs can use them, and they are marked with Braille, so people with visual impairments can read the labels next to the buttons. Some elevators announce the floors when the doors open. These options allow people with a range of abilities to ride on elevators.

Simple and intuitive use. The product or design must be easy to understand, regardless of the user's language level or ability to concentrate, and it should be intuitive to use. A Web site designed with clear text headings or universally recognized symbols, the ability to change text size, and content written on a lower reading level are good examples. Adjustable text size allows people with low vision to read more easily and people with fine motor impairments to click on links more easily.

Perceptible information. Information is conveyed so that users of all abilities can access and understand it. For instance, cardiopulmonary resuscitation (CPR) directions in public settings are written in language that is easy to understand and have clear pictures to enhance understanding. Trains and buses announce stops audibly as well as visually.

Tolerance for error. The design must minimize the chance for a hazard to occur. Computer software is a good example. Most programs have an undo option to correct mistakes, and many have autocorrect built in for commonly misspelled words and formatting options. Others have an auto-save function, so users don't lose their work if the program closes unexpectedly.

Low physical effort. It must be easy to use without much physical effort in any position (e.g., standing or sitting) and should not require repetitive actions. Lever doorknobs and faucets fit this principal, as do moving walkways and escalators.

Size and space for approach and use. The design must accommodate differing body size, posture, and mobility. It must provide sufficient space for users with adaptive equipment or a personal assistant, display instructions that are visible to people sitting and standing, and be easy to approach. A front-loading washing machine and wide entrance gates in sports arenas are good examples.

UD practices have been adopted for a wide variety of design purposes, including smart homes, workplace efficiency, training practices and materials, monetary currency, and communication systems

Universal Design in Homes

By law, most buildings in the public and private sector need to be accessible, but this is not true of private residences. Developed by Eleanor Smith, visitability is a collaborative effort by the Center for Inclusive Design and Environmental Access and Concrete Change, which uses UD to make all new homes they build accessible. The philosophy of visitability is that people of all abilities should be able to get in and out of every home and have access to everything in the home. To accomplish this goal, houses are visitable if they have three qualities: at least one accessible entrance, doors that are 32 inches wide, and a wheelchair-accessible bathroom on the main floor. Visitability perceives that aesthetics are as important as accessibility, so houses are appealing as well as accessible, making them more marketable.

Universal Design in Education

Although UD is applied to the design of products and places, it also is applicable to the design and delivery of programs and services. As a means to differentiate curriculum in better serving children with disabilities, the Center for Applied Special Technology created Universal Design for Learning (UDL) in 1984. UDL recognizes that all children learn in different ways and learn better if lessons are designed to suite their learning strengths.

The old paradigm of learning stated that each student learned the same way using the same materials. If students were unable to learn the same way as their peers, they were considered less capable or intelligent or labeled as having a disability. Research has shown that all individuals have learning differences, strengths, and weaknesses. With UDL, lessons are adapted to the student rather than students having to adapt to a single form of instruction to become unsuccessful. There are three principles of UDL: representation, actions and expression, and engagement.

Representation

Representation is about what and how students are presented with information. Students come from different backgrounds. Some students may have disabilities, while others have cultural differences, and still others may be learning the language while learning the subject matter. Educators need to take these and other differences into account and plan lessons that use multiple forms of representation, such as written words, images and symbols, and audio presentations. For example, a teacher doing an addition lesson might use colored sticks as well as symbols to represent adding.

Action and Expression

The second principle is aimed at helping students express themselves. Educators often expect students to effectively express themselves or demonstrate skill competence through writing or speech. These may not be the most successful ways, for instance, for students with learning disabilities or language barriers. Rather, a student with a disability may more effectively demonstrate understanding or achievement through art, music, videos, PowerPoint, or Web 2.0 applications. Educators should provide options for physical action, expression and communication, and executive functions to account for the different ways students express themselves. Providing an adapted keyboard to a student with a physical disability or giving more instruction on goal setting to a student with an executive function disorder are two examples.

Engagement

Engagement refers to why and how students learn. Cultural background, personal preference, content, and many other factors affect how students learn and what sparks their interest. Some like to work with peers, while others prefer to work alone. A structured classroom with strict rules may help one student flourish, whereas another student may need an extremely flexible atmosphere for success. In order to cultivate this principle, educators must provide options to attract student interest, sustain effort and persistence, and learn self-regulation. Engaging practices may include giving students choices, providing a safe learning environment, and using socially or culturally relevant information and sources.

Conclusion

UD is used to make products, environments, programs, and services accessible for people of widely varying abilities, especially people with disabilities. UDL is gaining acceptance as a tool for educators to prepare and present lessons, and UD is being used by the Global Universal Design Commission to develop voluntary commercial building design standards.

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See Also: Accommodation; Americans With Disabilities Act; Educational Services.

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Universal Declaration of Human Rights

The Universal Declaration of Human Rights (1948) is one of the milestones in history of humankind endeavoring to protect the rights of the individual throughout the globe. Although human rights are violated in many parts of the world, the declaration stands apart from any other similar documents pertaining to human rights issues. Of course, the declaration was not the first effort toward protecting human rights. In earlier times, there was the Hammurabi Code and Justinian Codes. England promulgated human liberties in Magna Carta (1215), habeas corpus (1674) and the Bill of Rights (1689). The Bill of Rights of the U.S. Constitution (1776) heavily influenced the declaration. Likewise, the Rights of Man and of the Citizen (1789) during the French Revolution inspired the declaration. The Napoleonic Code (1804) had enshrined unalienable rights of humankind.

The codification of human rights became an important issue after the Holocaust and devastation during the World War II. The American President Franklin D. Roosevelt's four freedoms, freedom of speech and belief, as well as freedom from fear and want, also became guiding principles behind the declaration. The Charter of the United Nations, signed on June 26, 1945, put the promotion of human rights as one of the purposes of the international body. It asked the member states to respect human rights and fundamental freedom for all. Article 68 of the charter mentioned the Commission on Human Rights by name to be set up by the Economic and Social Council.

The chairperson of the interim nine-member commission (April 1946) was Franklin D. Roosevelt. Rene Cassin of France and K. C. Neyogi from India were vice chairperson and rapporteur, respectively. Afterward, a new 18-member Commission of Human Rights was established. The three influential members were P. C. Chang (China), Rene Cassin (France, and who won the Nobel Peace Prize in 1968), and Charles H. Malik of Lebanon. The latter, who became the president of the Economic and Social Council (1948), played a major role in deliberations. The eight-member drafting committee prepared a draft International Declaration of Human Rights by June 1948.There was much debate over various issues in the climate of the Cold War.

The Soviet Union, along with Belorussia, Ukraine, and Yugoslavia, emphasized the duty of the individual to the state and the priority of economic as well as social rights over individual rights. In spite of ideological differences, the General Assembly of the United Nations meeting at Palais de Chaillot in Paris adopted the Universal Declaration of Human Rights on December 10, 1948, proclaiming it as "a common standard of achievements for all peoples of all nations." Some 48 countries supported it, and eight countries (Saudi Arabia, South Africa and the Soviet bloc) were absent from the voting. There was not a single dissenting vote. During preliminary voting of each article by the General Assembly, 23 out of 30 articles witnessed no abstentions. Encompassing a broad spectrum of political, economic, social, and cultural rights, the declaration consisted of a preamble and 30 articles. The document was translated into 407 languages and proclaimed that all human beings were born with "equal and inalienable rights and fundamental freedoms."

The eight-paragraph preamble mentioned that the foundation of freedom, justice, and peace in the whole world was to be equal rights of all members belonging to what it called the human family. The highest aspiration of common people was to enjoy liberty of speech and belief along with freedom from fear as well as want. The preamble also proclaimed development of friendly relations among the countries. The member states were asked to keep the rights and freedoms of the declaration secure. Article 1 proclaimed the noble thought that all humans were born free and equal in dignity and rights. The next article stated that every individual is entitled to the rights and freedoms expressed in the declaration without any discrimination on the grounds of race, color, sex, language, religion, or nationality. Article 3, one of the core articles of the declaration, affirmed rights to life, liberty, and security of person. Slavery and the slave trade were banned by Article 4. The following article prohibits inhuman treatment and punishment. Articles 6 through 12 set forth basic legal rights of human beings such as equality before the law, no arbitrary arrests, the right to be presumed innocent until proved guilty, the right to noninterference with privacy, including correspondence and family. The right to freedom of movement, residence inside the boundaries of a state, and asylum in another country from persecution were provisions of Articles 13 to 15. The declarations embodied the importance of family in society and the right to marriage in Article 16. Rights to property, freedom of thought, peaceful assembly, and equal opportunity in public services were mentioned in Articles 16 to 21.

The next five articles embodied various social and economic rights such as the right to social security, employment, equal pay for equal work, an adequate standard of living, education, and special care for mothers as well as children. Article 28 recognized the need for social and international order so that rights mentioned in the declaration were achieved. The next describes the duties of everyone to community. The last article restricts a person or state for acting in a way to destroy the rights and freedoms enshrined in the declaration.

Although the declaration was not legally binding on the member states, its moral implication was noteworthy. It aimed to protect human dignity and touched many spheres of an individual's life. There were expressions of human rights much earlier, but they were restricted to particular countries, be it Magna Carta or Bill of Rights in the U.S. Constitution. For the first time in human history, a universal declaration came into being. It was to the credit of declaration that the moral character of the declaration was buttressed by series of international human rights laws passed by many states. One could argue that the declaration had been invoked by countries till today, and this made it somewhat binding. A normative foundation of world politics was laid down with details of various human rights. The declaration became a frame of reference for subsequent human rights covenants, treaties, various nongovernmental organizations, human rights activists, and even countries with axes to grind with other nations on the pretext of violating human rights. Whether it was the demise of Soviet satellite states in the 1990s, racial discrimination, persecution by a dictatorial regime, or violence against ethnic minorities, the universal declaration was referred into. The declaration was followed by legally binding International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural Rights, which came into force in January 1976. It codified the ideas expressed in the declaration. It, along with the two covenants, was referred to as the International Bill of Rights. One of the criticisms leveled against the declaration was that it was based on the values of the West, and its ideas were derived from documents of Western governments.

However, the members of the human rights commission were not only from the Western world. In the deliberations, Chang from China and Malik had played important roles. A number of third-world countries criticized the emphasis on political and civil rights. The Soviet delegate said that it was a conspiracy against communism. Although Pakistan, a Muslim majority state, signed the declaration, Saudi Arabia abstained, mentioning that it was against Islamic laws. For uplifting the ideals of the declaration, the member states as well as peoples from all over the world have to take strong measures against human rights abuses. Only then will the purpose of the declaration be realized.

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See Also: Equal Opportunity and Civil Rights; Office for Civil Rights; Social and Economic Justice.

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Urban Communities and Human Services

Governments and organizations delivering human services in urban areas face many challenges. This entry proposes that human service organizations serve their urban constituents better when they understand that each individual community has its own particular mix of social, economic, and cultural attributes that define its problems and their potential solutions, and paramount among these attributes are types and degrees of leadership, social cohesion, and most importantly, strategic partnerships. Consequently, interventions must take community differences into account and provide specific rather than generic solutions.

This entry suggests important relationships among community types and intervention strategies in order to suggest partnerships for success. For successful implementation of human services in urban areas, only partnerships can achieve a high level of synergy and participant ownership. Human services providers in urban areas have increasingly engaged stakeholders in partnerships. Consequently, the urban community has become more invested in solutions and motivated to achieve together tangible and intangible, sustainable solutions that are in the best interests of the urban communities. A multifaceted, integrated approach to building relationships among urban communities and human services providers in all phases of human services will result in more effective, sustainable interventions.

Disparity in income and opportunity among Americans is increasing. Many urban American neighborhoods are commonly referred to as communities at risk because this is where disparity manifests itself in a multitude of social issues that include illegal drug distribution and use, violence and crime, inadequate education, and social dislocation. Earlier, government tackled such challenges generically, imposing one-size-fits-all solutions: policies and programs. However, failure to recognize the unique character of a community may result in a mismatch between the human services provided and the needs of the at-risk population, and generic policies cannot be modified to fit local human service situations. Moreover, inadequate communication often has exacerbated relations between local political leaders and urban communities at risk.

Understanding Urban Communities

A community is any group of individuals sharing common values or interests and may inhabit a common area. Community describes social units with continuous communication and interaction as well as similar needs and obligations: A community is composed of neighbors. Urban communities are a cluster of social units or groups of individuals who reside in an area of high population and a high level of residential to commercial or industrial ratio.

An urban area contains multicultural communities, high population density, and a high ratio of residential to commercial or industrial areas. Urban implies cities. Urban communities present a paradox. They are motors of growth in an increasingly global economy, concentrating wealth, knowledge, and technical capacity, and at the same time, many of the worst problems facing society today are concentrated in urban areas, including congestion, crime, intolerance and racism, economic and social exclusion, degradation of the natural and built environment, and the loss of local identity. Consequently, they also must provide public services such as education, health care, communication, and transportation as discussed in the U.S. Department of Health and Human Services Administration for Children and Families; Administration on Children, Youth, and Families; Children's Bureau; and Office on Child Abuse and Neglect combined report.

Human services are community-wide actions planned to support or assist humans, usually in the confines of a system directly responsible for such assistance. According to Dr. Alan Tomkins, these actions and systems can be governmental or nongovernmental institutions, public as well as private. The field of human services maintains a commitment to improving the overall quality of life of the populations to be served; it is broad and includes interdisciplinary knowledge, a focus on prevention, as well as remediation of problems. As such, human services promote improved service delivery systems by addressing the quality of direct services and by seeking to improve accessibility, accountability, and coordination among professionals and agencies in service delivery through partnerships. The provision of human services is an investment in the current and future health of urban communities.

Approaches for Understanding Urban Communities and Human Services

The interweaving of the urban community with human services, and the many paths and connections among its people and institutions, creates a unique, complex social fabric that is an urban community. Three theoretical approaches contribute to the understanding of urban communities: (1) sustainable development, (2) civil society and social capital, and (3) organizational development and management theory. Each theoretical approach is supported by research and a body of literature that highlights different aspects of the relationships among communities and human services.

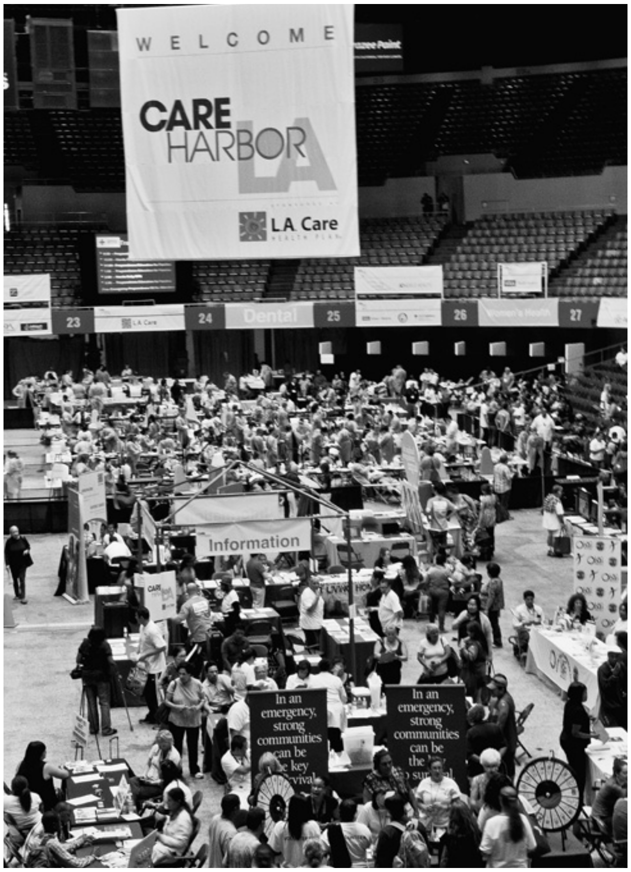
Sustainable development theory (research and literature) illustrates the inherent tensions and trade-offs that are associated with investment versus consumption of physical and human resources. Civil society and social capital theory provides insights into the dynamics of building trust among individuals and institutions leading to citizen action and emphasizes the relational aspects of urban community life. These theories hold that participation in formal and informal partnerships builds trust in individuals and institutions and forms habits of interaction. Organizational development and management theory address the internal versus external pressures and trade-offs that are frequently encountered in designing and implementing a capacity-building strategy. The nexus of these three intersecting theories (research and literature) provides an important approach for capacity building community and human services and, at the same time, frames important accumulations of human experience and knowledge; this is an example of social capital according to Roz Lasker and Elisa Weiss.

Promoting Community Participation in Human Services

Increasingly, public- and private-sector organizations involved in human services have been creating partnerships with community stakeholders. The rationale for this interest in community partnerships is compelling. Janet V. Denhardt and Kelly B. Campbell report that, from a philosophical perspective, people living in democratic societies have a right to a direct and meaningful voice about issues and services that affect them. At a practical level, many local problems have not responded to top-down, single-solution programs, while a growing number of people are involved in improving community health and the delivery of human services that go beyond the capability, resources, and authority of any single organization or sector, reports Michael Homan.

The role of community stakeholders may limit or enhance the effectiveness and sustainability of partnerships. A growing body of literature on partnerships has emphasized the importance of involving people who understand the needs, assets, priorities, and dynamics of the urban community, according to Michael Homan. Yet, little research has focused on the process of partnership building and what is needed in order to sustain community involvement and partnerships.

An understanding of the synergy of partnerships can help leaders and managers of partnerships appreciate and optimize the roles of community stakeholders. Synergy is the breakthroughs in thinking and action that are produced when a collaborative process successfully combines the complementary knowledge, skills, and resources of a group of participants. Synergy is the advantage that partnerships gain by involving diverse people and organizations in the community. Of most importance, synergy is the mechanism that explains how broad community participation strengthens the ability of partnerships to identify, understand, and solve complex problems, according to Lasker and Allegrante.



Doctors, volunteers and uninsured citizens in the dental care and information section of a free clinic provided by Care Harbor LA. Urban communities must provide public services such as education, health care, communication, and transportation.

Community Participation

Synergy is a key indicator of a successful partnership process because it reflects the extent to which a partnership can accomplish more than any of its individual participants and become a whole that is greater than the sum of its parts. When a partnership achieves a high level of synergy, the group as a whole has an advantage over its individual participants in solving complex problems, is able to think in new and better ways about the problems it is trying to address, takes more comprehensive actions to address those problems, and develops stronger and more supportive relationships with the greater community. The potential of partnerships to create synergy explains their unique value in addressing complex problems such as those related to urban community health. Problems like inadequate access to care, substance abuse, obesity, environmental hazards, and poverty go beyond the capacity of any single person, organization, or sector to solve. These problems are influenced by a variety of social, economic, environmental, and biological determinants, many of which are interrelated, affect diverse populations, and occur in many different kinds of local contexts. Only by combining the knowledge, skills, and resources of a broad array of people and organizations can communities understand the underlying nature of such problems or develop effective and locally feasible solutions to address them, reports Lisa O'Donnell.

Although partnerships must create synergy in order to realize their full potential in solving complex problems, most partnerships are far from realizing this potential. At a practical level, the capacity of partnerships to create synergy appears to be related to three factors: (1) who is involved in the partnership, (2) how they are involved, and (3) how well the leadership and management of the partnership support the interaction of the partners. A partnership that promotes ongoing discourse among people who have different kinds of knowledge is one that, as a whole, may overcome individual limitations.

Who Is Involved in the Partnership

The people and organizations involved in a partnership are the building blocks of synergy. They bring different kinds of knowledge, skills, and resources to a partnership, and partnerships with a broad and diverse array of participants have increased and more varied knowledge, skills, and resources with which to create synergy. It is not surprising that the community stakeholders involved in synergistic partnerships often go beyond the usual suspects, including service providers and also people who use the services; youth and low-income residents who are directly affected by problems; formal and informal community leaders; academics in different disciplines; government, private, and not-for-profit agencies; and schools, businesses, and faith-based organizations.

When a partnership brings together community stakeholders with many kinds of knowledge, it greatly enhances its ability to understand the problems it is trying to address and to plan an effective and realistic course of action, according to Lasker and Weiss. Together, a broad array of participants can do the following:

1. Obtain more accurate information (e.g., about the concerns and priorities of people in the community).
2. See the big picture (e.g., appreciate how different services, programs, and policies in the community relate to each other and to the problems the partnership is trying to address).
3. Break new ground (e.g., combine statistical and qualitative information to get a better understanding of the root causes of problems and discover innovative approaches to solving them).
4. Understand the local context (e.g., appreciate the values, politics, assets, and history of the local environment, and use this information to identify strategies that are most likely to work in that environment). For example, by combining the complementary skills, services, and resources of its diverse participants, a partnership is able to carry out interventions that build on community assets; are tailored to local conditions; connect multiple services, programs, policies, and sectors; and attack a problem from multiple vantage points simultaneously.

How Partners Are Involved

The range of urban community stakeholders plays a key role in determining the amount of synergy that a partnership can create. But, if these participants are not involved in a way that makes it possible for them to contribute their knowledge, resources, and skills, even a diverse partnership cannot create such synergy. The importance of focusing on how community stakeholders are involved can be illustrated by comparing two types of successful partnerships: the lead agency model and the community engagement model, which vary considerably in their ability to create synergy, reports Pennie Foster-Fishman.

The lead agency model refers to partnerships that are established to help a public- or private-sector organization carry out a predetermined program. These kinds of partnerships are quite common in the human services areas but, unfortunately, have a very limited capacity to create synergy regardless of how diverse the participants are. The reason these partnerships cannot create much synergy is that most of the thinking and planning is done by the lead human service agency, which is usually a hospital, health department, social service agency, or academic center. Generally, the lead agency diagnoses the problem in the community and develops the intervention to address the problem. While community residents and other stakeholders may provide the lead agency with some feedback and input about its plans (e.g., advice about how to tailor a program to a particular neighborhood or group), their primary role is to help the lead agency obtain community buy-in and provide the additional skills and resources needed to carry out the program. So, for example, they are often engaged to provide the lead agency with access to a target audience it currently does not reach, greater credibility for its message and program, or co-sponsorship of programs and events, according to Marsha Zibalese-Crawford and Lucius Botes.

In the community engagement model, a broad array of community stakeholders work together in all phases of the partnership's work—understanding the problem, developing plans, taking collective action, and refining the partnership's actions over time. The community engagement model has a much greater potential to create synergy than the lead agency model because diverse participants have an opportunity to influence the thinking and plans of the partnership as well as its actions. As a result, a cross-section of community stakeholders can create new ideas and strategies together, and the way the group ultimately understands issues and the actions it takes to address issues are usually very different from the way any single participant in the partnership started out, according to Zibalese-Crawford.

Synergistic partnerships often involve a number of people in the provision of leadership in both formal and informal capacities. Consistent with other work on collaborative leadership, the people who seem to be the most successful in these roles are not traditional leaders who tend to have a narrow range of expertise, speak in a language that can be understood only by their peers, are used to being in control, and relate to people as subordinates rather than partners. Instead, synergistic partnerships benefit from having boundary-spanning leaders who have backgrounds and experience in multiple fields, understand and appreciate different perspectives, can bridge diverse cultures, and are comfortable sharing ideas, resources, and power, propose Lasker and Zibalese-Crawford.

The management of partnerships is the glue that makes it possible for a broad array of community stakeholders to combine their knowledge, skills, and resources, so they can understand complex problems and develop and carry out innovative and comprehensive interventions to address these problems. Consequently, to be effective, partnerships need to find approaches to management that can support a synergistic group process as well as oversee the implementation of the projects and programs that come out of that process, according to Zibalese-Crawford and Stephen Shortell. The set of management capacities that these authors find important for inclusion are the ability to orient new partners as they join the partnership; to minimize barriers that can prevent some community stakeholders from participating in meetings and activities (e.g., by providing transportation, child care, and translation services and by holding meetings at convenient places and times); to make good use of participants' financial and in-kind resources and time; to facilitate timely communication (not only among a broad array of participants but also with community stakeholders outside the partnership); to coordinate meetings, projects, and other activities; and to provide the partnership with analytic support (e.g., by preparing documents that inform participants and help them make timely decisions and by evaluating the progress and impact of the partnership.

Implications

Understanding the relationship of community participation is important for urban communities and human services because the major impact is on who is involved in community partnerships, how community stakeholders are involved, and how different kinds of participants interact in the partnership. Increasing the role of urban community stakeholders in partnerships encourages community empowerment and community capacity building, which have been the focus of increasing attention in recent years. Community partnerships are unlimited in their capacity to create synergy and to achieve the breakthroughs in thinking and action that are needed to understand complex human services problems and develop, carry out, and sustain the kinds of interventions that can effectively address such problems. By involving a cross-section of urban community stakeholders in all phases of partnership work and by providing the kind of leadership and management that make it possible for diverse participants to combine their resources and create something new and valuable together, partnerships can create synergy and substantially increase their own capacity and sustainability as well as that of the urban community.

Although community partnerships are proliferating at a rapid pace, partnering is not a magic bullet, and partnerships are not the best way to develop or carry out all actions to improve community or the delivery of human services. Nonetheless, synergistic community engagement partnerships are becoming an increasingly important strategy human service administrators in urban communities because many of the problems they face—and are being held accountable for—are very complex. To make services more responsive to community residents and address the environmental and socioeconomic factors that ultimately determine the need for human services, administrators need to combine their knowledge and resources with those of many other people and organizations in the community.

For the successful implementation of human services in urban communities, the emphasis must be on working with the community versus taking care of the community. There is a need for many professionals to appreciate the limitations of their own expertise as well as to value combining that expertise with the knowledge and skills of other people in the community. Another challenge that many professionals face relates to their own role in partnerships. It may not always be optimal or appropriate for health and human services administrators to play leadership or management roles in partnerships; some community partnerships can create more synergy when these professionals function as participants.

Although many administrators are not used to participation in partnerships without being in a position of control, there are good reasons for them to consider doing so. It is not possible to assure that community stakeholders have real influence in the collaborative process if the partnership is—or is perceived to be—dominated by the agenda of a powerful agency. In addition, we propose it is not possible to achieve the significant breakthroughs that are needed to address complex and interrelated problems or if a partnership's thinking is constrained by any particular professional paradigm or if its actions are limited to the services or programs that only one organization or sector provides.

Conclusion

Governments and organizations delivering human services in urban areas face many challenges. These may be addressed successfully only when each community is considered unique and, hence, in need of unique, evidence-based solutions that include the support and active involvement of members of the community being served. A multifaceted, integrated approach to building relationships among urban communities and human services providers in all phases of human services will result in more effective, sustainable interventions. For successful implementation of human services in urban areas, only partnerships can achieve a high level of synergy and participant ownership. Human services providers in urban areas have increasingly engaged stakeholders in partnerships. Consequently, the urban community has become more invested in solutions and motivated to achieve together tangible and intangible, sustainable solutions that are in the best interests of the urban communities.

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See Also: Adolescent/Youth Services: Overview; Adoption and Foster Care Analysis and Reporting System; Alcohol and Substance Abuse Services; At-Risk Youth Services, Behavioral Health Disparities for Racial and Ethnic Minority Populations; Child Welfare Services; Community Development Block Grants; Community Development Corporations; Community-Based Services; Crisis Services; Cross-Cultural Service Models; Cultural Services; Disability Services; Domestic Violence; Economic Support and Services; Educational Services; Employment/Career Assistance Services; Family Services; Housing Services; Neighborhood Reinvestment Corporation, Substance Abuse and Mental Health Services Administration; Workplace Health Services; Youth Risk Behavior Surveillance System.

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U.S. Citizenship and Immigration Services

Since 1965, immigration to the United States has increased substantially, and the majority of new immigrants have hailed from developing countries, especially Asia and Latin America. Partly as a result of post-1965 immigration, America has become increasingly multiracial and multiethnic. Immigration is also an integral part of globalization that has increasingly characterized the world in the last about four decades. U.S. Citizenship and Immigration Services (USCIS) plays a crucial role in serving the very diverse populations from around the world in the age of globalization. What kind of organization is USCIS? How have the services of immigration and naturalization provided by the U.S. government evolved organizationally over time? Currently what types of services are provided by USCIS? This brief entry provides answers to these questions.

What Is USCIS?

USCIS is a U.S. government agency within the Department of Homeland Security (DHS) that provides services in the areas of immigration to the United States and U.S. citizenship. Its mission, as it appears on the USCIS official Web site, states that "USCIS will secure America's promise as a nation of immigrants by providing accurate and useful information to our customers, granting immigration and citizenship benefits, promoting an awareness and understanding of citizenship, and ensuring the integrity of our immigration system."

USCIS has 250 offices around the world and employs 18,000 employees and contractors. Various USCIS offices handle different types of jobs. For example, field offices within the United States conduct scheduled interviews on nonasylum related applications. They also provide limited information and customer services that supplement those provided through the USCIS Web site and by phone. International offices provide services to U.S. citizens, permanent residents of the United States, and some other persons who are visiting or residing outside the United States and need assistance in immigration affairs. Application support centers provide fingerprinting and related services. Asylum offices handle scheduled interviews for asylum-related issues only. The National Records Center receives and processes Freedom of Information and Privacy Act requests. Service centers and the National Benefit Center receive and process a large variety of applications and petitions.

Brief History of USCIS and Its Predecessors

USCIS, with a formal name of the Bureau of Citizenship and Immigration Services, was created in 2003 by the Homeland Security Act of 2002 (Pub. L. No. 107–296, 116 Stat. 2135) in response to the September 11, 2001, terrorist attacks. Before then, services of immigration and naturalization offered by the U.S. government were carried out by different agencies under various departments. From the founding of the United States in 1776 until the late 1800s, there was no need for a government agency for immigration because the borders were open to everyone. Immigration became a federal issue starting in 1875. In 1891, the first federal immigration agency called the Office of Superintendent of Immigration (OSI) was established under the jurisdiction of the Treasury Department. OSI was upgraded to the Bureau of Immigration in 1895, and the superintendent of Immigration became commissioner-general of immigration. In 1903, the Bureau of Immigration was moved to the newly created Department of Commerce and Labor. In 1906, Naturalization Service was established after Congress enacted the Naturalization Act of 1906, and the Bureau of Immigration became the Bureau of Immigration and Naturalization. In 1913, the Bureau of Immigration and Naturalization was split into two separate agencies: the Bureau of Immigration and the Bureau of Naturalization, both of which were within the new Department of Labor. In 1924, as a result of the National Origins Act of 1924, a new agency, the U.S. Border Patrol, was formed within the Bureau of Immigration. In 1933, the Bureau of Immigration and the Bureau of Naturalization were merged into a single agency named Immigration and Naturalization Service (INS). In 1940, The INS was transferred from the Department of Labor to the Department of Justice.

The INS had been in existence for seven decades until 2003. The Homeland Security Act of 2002 dismantled the former INS into three components within the DHS. Immigration and Customs Enforcement runs immigration enforcement. Customs and Border Protection takes charge of border security functions. USCIS handles the administration of services related to immigration and naturalization.

Services Provided by USCIS

USCIS provides services in the following areas:

1. *Immigration services*: These include the processing of applications for permanent resident status (popularly known as green card), granting of permanent resident status, and renewal of green cards.
   Green cards can be obtained under the categories of family-sponsored immigrants, employment-based preferences, and diversity immigrants also known as lottery immigrants.

2. *Naturalization or citizenship services*: These comprise the processing and approval of petitions for naturalization. During the application process, USCIS will conduct an interview, including an English and civics test. Once the petition is granted, USCIS will send out a notice to take the oath of allegiance and hold a naturalization ceremony for new citizens to take the oath of allegiance.
3. *Asylum and refugee application and approval*. Refugees are people outside of their country of nationality who are unable or unwilling to return home because of prosecution or well-founded fear of prosecution. Asylum seekers or asylees are people living in the United States or at a port of entry who are unable or unwilling to return to their country of nationality or who seek the protection of the United States because of persecution or well-found fear of persecution. This is considered a humanitarian service.
4. *International adoption*. USCIS processes the immigration and U.S. citizenship of adopted children from abroad. The type of immigration visa issued to adopted children determines when and how they can acquire U.S. citizenship.
5. *Issuance of nonimmigrant visas*. USCIS processes and adjudicates petitions for nonimmigrant visas such as temporary visitors, temporary workers, exchanged scholars, and students. Some of the well-known nonimmigrant visas include B-1 and B-2 for temporary visitors and their dependents; F-1 and F-2 for international students and their dependents; J-1 and J-2 for exchange scholars and their dependents; H-1B for workers in a specialty occupation; H-1C for registered nurses working in a health professional shortage area as determined by the U.S. Department of Labor; H-2A for temporary or seasonal agricultural workers; H-2B for temporary nonagricultural workers; Q-1 for persons with extraordinary ability in sciences, arts, education, business, or athletics and motion picture or TV production; P-1A for internationally recognized athletes; R-1 for religious workers; and TN for North American Free Trade Agreement (NAFTA) temporary professionals from Mexico and Canada.

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See Also: Immigration Law, History of U.S.; Naturalized Citizens; U.S. Immigration and Customs Enforcement; .

Further Readings

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U.S. Cultural Regions

Regions are physical geographies bounded or connected by similar spatial features. Cultural regions are physical geographies of states that are connected by factors such as history, economy, or topography. In the United States, cultural regions have been nuanced by the intersection of historical, political, and human connections that collude to formulate regional identities that may or may not be imagined geographies. The borders of the regions and the confinement of individuals within a specific set of boundaries produce a cultural identity and narrative that operates to limit the agency of a particular place and people. The power relations that are in concert with regional formation have to be recognized as the agents of knowledge formation. The intervention of gender into geographical analyses and into the creation of place allows for more intersectional approaches to be utilized and more nuances of race, class, gender, and sexuality to become central to an understanding of geographic locale.

How Regions Become

It is important to understand how regions become understood in particular ways because the understanding allows for an interrogation into specificities of place and therefore understanding of service applications. In these examinations, considerations of how the people of a place are shaped by their location, both the natural and the built environments are brought into the consciousness of the discursiveness of place. The borders of a region are often contested. In many cases, regions are delineated by a subjective boundary, while in other cases, the demarcations are considered objective, formulated by quantitative measures. For example, the agencies of the federal government of the United States are not completely synchronized in their official definitions of region. Across the board, however, cultural regions have not actually been defined organically but rather manifest as remnants of sociohistorical processes and human–environment interactions. This type of definitiveness is problematic because it insinuates dichotomous categorizations that that do not acknowledge the opportunities, or realities, for more nuanced contexts, realities, and experiences of region that can be differentiated from one area to its neighboring space or placated in a comparative across distances, such as that of the west to the northeast.

Conceptualizing Regional Borders

Approaches to regional formation are traditionally problematic for their one-dimensional approach to conceptualization. As such, it is important to theorize the socio-spatial relationships that move beyond historical dimensions of regional circumstances. Rather, regional descriptions should be augmented to include the way regions characteristically shift over time, intertwined with multiple dimensions of space in the present in which regions are becoming. As a foundation to describing cultural regions, the location of regions must be identified. Regional identity is often a subjective process, often delineated by power relationships to policy, nature, or economy. For example, the U.S. Department of Health and Human Services divides the nation into 10 distinct regions, which are centered on the nation's urban core—Seattle, San Francisco, Denver, Kansas City, Dallas, Chicago, Atlanta, Philadelphia, New York, and Boston. Alternatively, the U.S. Census Bureau has long categorized the country into four distinct regions: northeast, Midwest, south, and West. This entry utilizes these divisions for the sake of discussing cultural complexities of use to human services as they align most closely with typical cultural connotations of U.S. regions. On a regional scale, cultural differences can account for variations in life that are of concern to human services professionals—such as parenting and child rearing and expectations in the labor sector.

United States Regional Delineations: Northeast

The northeast region is delineated by the following states: Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, and Pennsylvania. The states included in the northeast are subdivided into New England and midatlantic. New York, New Jersey, and Pennsylvania make up the midatlantic subregion, while the remaining six states compose the New England subregion. The region has historically been referred to as the rustic northeast. This nickname highlights the landscapes of the northeast, which are characterized by the natural beauty of the land (with the exceptions being the major metropolitan areas of New York City, Boston, and Philadelphia). Much effort has been made to preserve the rural idyll of the rustic northeast, which is important for sustaining the local economy. The region is heavily reliant on tourism, shipping, timber, and fisheries.

As of the 2010 U.S. Census, the northeast's total population was 55,378,402. Of this population, 43,364,085, or 78.3 percent, identified as white. In the New England states, self-identified whites account for 82 percent of the population (in Connecticut) up to 95.4 percent (in Vermont). The largest racial or ethnic minority group in the northeast region identified as Hispanic or Latino on the 2010 census. Approximately 51 percent of northeast people were women. The northeast is one of the most economically stable areas of the nation. Approximately 6,540,379, or 11.8 percent, of people were living at or below the poverty level. From a cultural standpoint, these numbers are significant because the data quantitatively support the diverse needs of human services in the region.

The Midwest Region

The Midwest region is defined by the U.S. Census Bureau as the following states: Ohio, Indiana, Michigan, Illinois, Wisconsin, Iowa, Minnesota, North Dakota, South Dakota, Nebraska, Missouri, and Kansas. The regions are divided into two subregions: west north central and east north central. West north central includes North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, and Minnesota. The remaining five states—Ohio, Indiana, Michigan, Wisconsin, and Illinois—make up the east north central subregion. Midwest culture is characterized by its industrial relationships to the land, as evidenced by its nickname Prairie Grain Belt. In particular, industries such as agriculture and manufacturing have historically sustained the region's economy. A broad-scale issue facing the Midwest, as with other areas around the nation, has been the impacts of globalization. As a result, much of the labor force has shifted from manufacturing jobs to work in various management and service-sector positions.

As of the 2010 U.S. Census, the midwest's total population was 66,648,663. Of this population, 56,059,052, or 84.1 percent, identified as white. The largest racial or ethnic minority group in the midwest region varied based on a state level, with larger proportions of self-identified blacks in Ohio, Michigan, Indiana, Wisconsin, Minnesota, and Missouri. Self-identified Hispanics and Latinos constituted the largest minority proportion in the remaining six midwest states. Women made up slightly more than 50 percent of the population. Approximately 8,946,831, or 13.4 percent, of people were living at or below the poverty level.

The Southern Region

According to the U.S. Census Bureau, the south is comprised of the following states: North Carolina, South Carolina, Georgia, Florida, Mississippi, Alabama, Virginia, Tennessee, Arkansas, Texas, Oklahoma, Kentucky, Maryland, Delaware, Louisiana, and West Virginia as well as the District of Columbia. The south is divided into three subregions: south atlantic, east south central, and west south central. The South Atlantic subregion includes: Delaware, Maryland, the District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida. The east south central subregion includes: Kentucky, Tennessee, Alabama, and Mississippi. The west south central subregion includes: Oklahoma, Arkansas, Louisiana, and Texas. Perhaps more so than any other region in the United States, the south continuously battles with its historical legacies. The mention of the south as a location conjures varied images usually stemming from ideas about the country south or old south of the Civil War years. These notions of the south as a region are often impositions from socially constructed ideas based on presumed knowledge of cultural history. This idea creates a monolithic worldview that projects the south as incapable of possessing multiple lifestyles and thought processes.

As of the 2010 U.S. Census, the south's total population was 114,555,744. Of this population, 84,198,474, or 73.5 percent, identified as white. The largest racial or ethnic minority group in the south identified as black or African American on the 2010 census. Approximately 51 percent of southerners were women. Approximately 16,326,628, or 14.3 percent, of people were living at or below the poverty level.

West

The West region of the United States, as named by the U.S. Census Bureau, includes the following states: Wyoming, Idaho, Montana, Colorado, New Mexico, Arizona, Nevada, Washington, California, Oregon, Alaska, Hawaii, and Utah. The west is divided into two subregions: Mountain and Pacific. The Mountain subregion includes: Wyoming, Idaho, Montana, Colorado, Utah, New Mexico, Arizona, and Nevada. The Pacific subregion includes: Washington, Alaska, Oregon, California, and Hawaii. The west region is not typified by the same unifying characteristics of the other three regions described earlier in this entry. However, the west offers an interesting complexity due to its large indigenous or first nations presence (and reverence) as well as the influence of Asian ethnic and national cultures due to its geographically close position of the western United States to the continent of Asia. Moreover, the west has often been broadly construed and connected to visions of the Old West, which holds a particular position in American sociomythology. Relics of the Old West can be readily found in states such as Nevada, Arizona, and Colorado.

As of the 2010 U.S. Census, the west's total population was 71,945,553. Of this population, 28,778,221, or 40 percent, identified as white. The largest racial or ethnic minority group in the west region identified as Hispanic or Latino on the 2010 census. Roughly 51 percent of west people are women. Approximately 9,824,029, or 13.7 percent, of people are living at or below the poverty level.

Other U.S. Cultural Regions

Because regions often overlap—based on topography or sociocultural characteristics—the territories of multiple regions can cocreate other regional borders. With this consideration, two particular types of cultural regions in the United States are important to mention.

Appalachia is an imagined geographic region and a culture of people whose boundaries correspond with the Appalachian mountain range of the Eastern United States. The Appalachian mountain range runs through 13 states. The areas included in the region called Appalachia are determined through the research by the Appalachian Regional Commission (ARC). Appalachia as a region is not significantly different from other populated areas of the United States. The distribution of wealth varies. Social status in community is contingent on affiliation with certain networks, where a higher social status is indicated by a strong set of power relations. Negotiations of difference—religion, race, ethnicity, gender, sexuality, and class—are as present in Appalachia as they are in the most cosmopolitan of U.S. sites and regions. The romanticism of the Appalachian region has contributed to an othering of place, one in which the dominant, middle-class hegemony has set as the opposition to the standardized sense of time and place. Scholars argue that this leads to the idea of Appalachia versus an actual, tangible connection to a geographical and cultural locale.

Border regions categorize overlapping geographies of existing regions. Most often, a border region is used to describe the contact zone of two or more international borders. In the United States, the northern fringe of the country intersects with Canadian influences. To the south, the United States connects to Mexico. As such, both of these distinct areas are geopolitically and socially relative to their border spaces. The U.S.–Mexican border has gained significant attention over the past several years as the national, state, and local authorities in the United States contend with the influx of immigrants from Mexico and other Latin American countries. The geopolitical impacts of the mobility of people in the region carries significant implications for the ways that services have to be approached.

Issues Impacting Regions

In understanding United States cultural regions, attention must be given to national-scale political, economic, and social issues that have local implications.

Rural and Urban Divide

Regional culture provides an important perspective from which to understand place. However, the widely noted descriptions of region often create urbanized exceptions, creating a divide between the urban and the rural. The needs of city dweller can be differentiated from that of a rural resident, particularly based on perspectives such as access to resources, housing arrangements, and kinship networks. From a cultural standpoint, the borders of regions seem to be mediated by specific recognitions of aesthetic markers, marked by denotations of particular body performances and delineated by invocations of certain states of being. Exact codification of a region invoked as an idea of a place in discourse is grounded in the knowledge that it is specific to a particular location and context, which can be so identified by the recognition of the variance of terms that are seemingly synonymous—rurality, the country, farmland or agrarian, open space, and countryside, among many others.

Furthermore, the dichotomy of urban and rural is exacerbated in the popular imagination that understands rurality at any point on a continuum that operates both on a material and a discursive scale. The continuum encompasses anything from a romanticized idyll to an oppressive, backward existence for humans. The material status of the rural is recognized as a potential place to live and work, to vacation, and to experience forms of nature, perhaps in conjunction with or as opposed to the built environment. With this variance of rural subjectivities, the imagined and discursive significance of the rural space are undoubtedly important conceptualizations with which to grapple, if for nothing more than to be made relevant and securely defined.

Certain changes in the concepts of cultural necessities have been indoctrinated into the contemporary mainstream. The Internet and the mediums of film, television, and periodicals all play a role in rural identity formation. These social forces likewise contribute to how the location of the rural and rurality are portrayed, often as spaces that are out of place and abnormal, which affect how people negotiate their identities. People are more likely to know about rurality and the rural through television and media rather than through personal

A view of the Lehigh Valley from the Appalachian Trail. Appalachia is an imagined geographic region and a culture of people whose boundaries correspond with the Appalachian mountain range of the eastern United States.

experience. As such, the cosmopolitan experience is privileged as normal and the standard for human experience.

Demographic Shift

The demographic profile of the United States is changing rapidly. It is estimated that, by 2050, the face of America will comprise more than 50 percent minority racial and ethnic groups. In the wake of this reality, it is important to understand the ways the shift in demography impacts spatial issues. Cultural regions have already begun and will continue to be influenced by the change in residents. One major change involves the phenomenon of reverse migration—where descendants of the Great Migration (blacks leaving the south for the northeast and midwest) are returning to their southern roots. The outmigration of African Americans from the northern United States impacts the cultural exchange and sociopolitical visibility of blacks in those regions. Another change involves the current influx of Latinos and Latinas to the United States. The migrant population, largely from Mexico, has instigated the transformation of goods and services provided in the region. For example, many public health clinics and retailers now have signage and instructions in Spanish as well as English, whereas that was not the case a decade ago. Moreover, the issues around immigration law and deportation are important to conceptualize contemporary cultural regions, particularly as they impact service needs.

U.S. Social Movements

Contemporarily, social movements have entered the national conversation in an effort to invoke societal changes. These issues have direct impact on the ways regions are considered and the ways that services can be provided. Same-sex equality movements have become influential in changing attitudes toward and legislation in favor of marriage equality. With the dismantling of DOMA and with several individual states continuously providing access to the institution of marriage for all couples, the conversations can impact the way providers view the issue with respect to a cultural region's history and broadly cast political stance. Gender and sexual minorities are often stigmatized in their lives for living in opposition to heteronormativity.

Heteronormativity is defined as the normative behaviors privileging opposite-gender attraction and intimacy. Regions such as the south and the Midwest have been slower to grant privileges of same-sex marriage than others. However, service providers should be wary of stereotyping or pathologizing individuals from a specific cultural region because of these broader knowledge productions. Likewise, women's reproductive rights have been at the core of national conversations. Stereotypes of cultural regions limit the ways one might perceive the acceptance (or lack thereof) of women's right to choose. It cannot be assumed that, because of the historically liberal leanings of the northeast, all individuals from that region would identify with a prochoice stance.

United States cultural regions can provide a useful framework for encapsulating the social, historical, economic, and political climate of a region. This framework, however, must be expanded in order to understand how regional culture is enacted on a local level. Additionally, the expansion must include the impacts of systemic cultural divisions—race, class, gender, an sexuality—as well as social structures such as religion in order to fully incorporate a human services model that is sensitive to and supports diversity.

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See Also: Appalachia and Human Services; Diversities; Ethnicity and Clients; Heterosexual Privilege; Intangible Cultural Heritage; LGBTQ Clients; Monoculturalism; Policing and Safety; Power, Race/Ethnicity and; Race and Clients; Regional Cultural Competence; Rural Communities; Same-Sex Marriage/Couples; Southern Communities and Cultural Competence; Spirituality/Religion and Diversity; Undocumented Immigrants; United States, Demographics of; Western Communities and Cultural Competence; White Privilege.

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U.S. Immigration and Customs Enforcement

Special police forces emerged as a pattern in the federal government by the middle of the 20th century. Often, these organizations are created as a perceived need in society that traditional police forces are unable to address. By the mid-20th century, the United States had 80 such agencies, including the Immigration and Naturalization Service (INS), housed in the Department of Justice and tasked with the investigation and suppression of alien smuggling. Special police forces are then created by legislation to perform a particular function that might otherwise remain unaccomplished. The Immigration and Customs Enforcement (ICE) represents a 21st-century version of the process.

The U.S. Customs Service was created in 1789 and tasked with the collection of import duties. The agency was housed under the Department of the Treasury and served not only as a revenue collection agency at the nation's ports but also the supervisor of lighthouse builders and law enforcers. In the 19th century, U.S. Customs became the enforcer of the 1882 Chinese Exclusion Act, and special immigration personnel were assigned to stop the flow of undocumented migrants through the nation's ports and along the northern and southern borders. Although the Bureau of Immigration was established in 1864, it was primarily a keeper of statistics, and immigration enforcement was carried out by the U.S. Customs Service until the early 20th century. The U.S. Customs Service ended its role as enforcer in 1910. However, the U.S. Customs Service has played a major role as a social enforcer during Prohibition and the current war on drugs and works closely with immigration officials in the Department of Homeland Security (DHS).

In 1882, the federal government began an oversight of immigration policy and assumed complete control over immigration policy in 1891. The Immigration Act of 1882 assigned the responsibility of examining new immigrants to the secretary of the

Treasury. This was followed by the Immigration Act of 1891, which ended all state involvement in immigration issues and created the Bureau of Immigration within the Treasury Department. However, the Bureau of Immigration was moved in 1903 to the Department of Commerce and Labor. The role of immigration enforcement was assumed with the 1904 creation of a set of inspectors to patrol the Mexican border to stop illegal immigration. The Bureau of Immigration became the Bureau of Immigration and Naturalization and in1913 and was assigned to the Department of Labor.

In an effort to understand immigration impact, the 1907 United States Immigration Commission was created and became known as the Dillingham Commission. A series of immigration acts followed the submission of the report, which represented efforts to control immigration through screening, numerical quotas, and banning of selected categories. The restrictions and quotas created by the Immigration Acts of 1917, 1921, and 1924 remained in effect until 1965. The goal of the Immigration Act of 1965 was not to increase the number immigrants but to reunite families and follow the example of a 1952 program designed to attract workers whose skills were needed. Inadvertently, the act set off a fourth wave of immigration that currently continues and is currently framed in the aftermath of September 11, 2001.

The aftermath of September 11, 2001 (commonly referred to as 9/11), resulted in the passage of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act (the U.S.A. Patriot Act) and the creation of the DHS. The INS was moved to the DHS, and in 2007, the Bureau of Immigration was renamed ICE, while the closely connected Bureau of Customs and Border Protection was renamed the U.S. Customs and Border Protection (CBP). ICE has grown to the principle and largest criminal investigation agency within the DHS and the second-largest criminal investigation agency in the federal government. ICE is primarily tasked with the investigation and enforcement of immigration policy within the interior of the United States but also engages in border security and transnational enforcement focusing on transnational crime.

Immigration policy post-9/11 focused on four objectives: (1) enhanced border security, (2) restrictions on immigration, (3) increased surveillance of immigrant populations, and (4) an active effort to enforce immigration policy. The focus of ICE lies in surveillance and enforcement, thus framing immigration as a matter of national security or homeland security. The results of this reframing were a criminalization of immigration law and a dejurisdiction of immigration enforcement. In 2003, ICE formed the first national program dedicated to the enforcement of nonimmigrant visa violations. The Compliance Enforcement Unit (CEU) focused on visa overstays and status violations.

CEU responsibilities were expanded in 2010 with the Counter Terrorism and Criminal Exploitation Unit (CTCEU) that was designed to prevent exploitation of the immigration system by known terrorists and criminals. Its focus also centered on violations of the student and exchange visitor program. Detention and deportation of immigrants became easier with expedited removal and in a reversal of tradition policy, local, nonfederal law enforcement became involved in detention and deportation. ICE agents and local agencies created task forces for antigang programs, workplace raids, fugitive apprehension, and drug enforcement. A section of the Immigration and Nationality, known as 287g, was used to create a local community program for specially trained officers to investigate immigration status. ICE negotiated with local authorities for the use one of two models offered. The jail enforcement model allows local authorities to establish immigration status during regular booking procedures for those arrested. The task force model gives local authorities much broader discretion and does not require a criminal arrest, and local officials may hold an individual for as long as it takes to establish immigration status. ICE bureaucracy and responsibilities continue to expand into involvement with border control, interior enforcement, and transnational criminal investigation.

ICE's Homeland Security Investigation (HSI) reported significant increases in criminal arrests by 2012. Goals included border security, new approaches to interior enforcement, and the dismantling and disruption of transnational criminal organizations (TCOs). Transnational criminal investigative units (TCIUs) work in other countries to stop illegal activities and immigration of known criminals. ICE had employees in 48 countries as of 2012 focusing on human trafficking and the connections to drug traffic. Domestic responsibilities focus on border and interior enforcement.

ICE's enforcement and removal operations (ERO) concentrate on enforcing U.S. immigration policy. In 2012, ERO managed six processing centers, seven contract detention centers, and 1.71 million immigrants in the removal process. ERO also cooperates with the Criminal Alien Program (CAP) by supplying officers from the Office of Detention and Removal Operations (DRO). The purpose of this effort is to identify, process, and remove immigrant criminals that are incarcerated in federal, state, and local prisons and jails in the United States. Once again, local law enforcement may share in these activities. ICE also teams with local law enforcement to secure borders from criminal activity. The Border Enforcement Security Task Force (BEST) represents one ICE's border programs.

The scope of responsibilities and size of the bureaucracy have expanded greatly since ICE's inception. While framed on the "immigration problem," ICE has become both a global and local immigration policy enforcer. ICE investigates everything from workplace violations to the protection of intellectual property, from the smuggling of counterfeit goods to smuggling of humans, and from undocumented migrants to students and visitors overstaying their visas. DHS and ICE have also become powerful voices in the immigration reform debate.

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See Also: Colonialism, Lingering Effects of; Displaced Persons; Family Reunification; Global South/Global North; Immigrant Populations, Human Service Needs of.

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V

Values and Ethics, Ethnic Diversity and

Values held by human service workers play an instrumental role in how services are delivered to persons of diverse backgrounds. In human services, how one responds to ethnic diversity is central in service provision. Understanding how one's values impact the development and delivery of services is a vital training component for human service workers. The type of services, the manner in which they are provided, and to whom services are delivered hinge on the values, beliefs, and perceptions of service providers at the micro, mezzo, and macro levels. The ideological foundation for the appreciation of ethnic diversity supports the idea that disparities should not exist in human service and that human service workers have an obligation to be familiar with and knowledgeable of diverse populations.

Values develop as a result of environmental, familial, cultural, and socioeconomic influences. Values are promoted through the belief systems of individuals, groups, communities, and societies. They help to shape how one views themselves, others, and the world. Values are what is held to be truth and are based on individual, group, community, and society experiences. Truth, or what is believed to be fact, for how the world functions or should function influences interactions and communications within and among these entities. Values impact judgment and help to shape the rules or ethics that human service workers are expected to abide by when providing services.

Morality and moral judgment are concepts that play a major role in the development of values. Morals cannot be seen or touched. They are merely one's inner feelings about right or wrong. A person often lives by a set of moral values and uses it as a yardstick by which to measure acceptable behavior. How one sees oneself in the world is oftentimes how he or she sees others. Conflict arises when moral values are so stringent that any behavior seen outside of one's own set of values is deemed as negative, adverse, or undesirable. This is moral judgment and should be avoided by human service workers. Human service workers may have their own set of values, but at no time should their values be pushed off on their clients. Standards, guidelines, and principles for human service workers on how they might avoid such situations are obvious in the human services field code of ethics.

Ethics are the procedures for professional conduct in human services. These ethics are mostly derived from values and can be seen in a number of human service disciplines. Many of the human service disciplines, including but not limited to, social work, psychology, nursing, education, and health care are governed by specific principles, guidelines, and standards for how one should react to ethical dilemmas within their field. Ethical dilemmas are situations that present to human service workers as matters that may cause one to question appropriate procedure when addressing ethically conflicting issues.

For example, a human service worker providing mental health services may face an ethical dilemma and have questions on how to proceed if asked to counsel a family member. Although the worker may have the expertise to provide counseling services, there may be a chance of conflicts of interest in provision of service because of a familial connection that may compromise impartial judgment and professional discretion. The principles, guidelines, and standards that address ethical dilemmas are referred to as codes of ethics and give the worker a point of reference or framework by which to measure his or her own practice behaviors. To address ethnic diversity issues related to the development and implementation of programs, policies, and services, a common thread highlighting requirements for addressing ethnic diversity in human services can be seen throughout discipline specific codes of ethics. Although these codes of ethics outline principles, standards, and guidelines for addressing ethically challenging issues, they are not prescriptive. It is expected that the human services worker has been educated and trained in the area in which he or she works and is competent in the field.

Ethnic diversity has been historically referred to the differences among people as it relates to ethnic origin. However, over time, the meaning of the term *ethnic diversity* has been expanded and is often talked about as multiculturalism. Today, the terms ethnic diversity and multiculturalism or multicultural diversity are interchangeably used and refer to the recognition, acceptance, and appreciation of people's unique characteristics while acknowledging the worth of distinctive qualities of varying cultures in creating and supporting a world of tolerance. Tolerance here refers to being open-minded to the fact that no one culture is superior to another culture and that the greatest benefit to society is the collective contributions of all cultures in creating a better world for all.

Human beings are diverse in a number of ways. Differences among people separate us by race, ethnicity, language, culture, national origin, gender, gender identity or expression, socioeconomic class, age, sexual orientation, color, marital status, political belief, religion, immigration status, ability, educational level, geographic origin, and values, among others. Familiarity and knowledge of diverse populations are believed to enhance service provision by assisting human service workers in assessing presenting issues and problems and developing and implementing culturally sensitive interventions.

As human service agencies, organizations, and workers strive to assist changing client populations in acquiring necessary supports services and successfully navigating negative circumstances, a one-size-fits-all approach in dealing with issues and problems presented by diverse clientele is detrimental to the human services field. Individuals do not respond the same to varying interventions and approaches. This difference in response can be attributed to several factors. One factor that may impact the differences in response to varying interventions and approaches may be diversity. It is imperative that agencies, organizations, agencies, and workers are aware of issues related to diversity when formulating, developing, and implementing policies and practices that may be offensive, inappropriate, or inadequate for use with diverse populations.

Education and Training on Diversity in Human Services

Educational requirements in consideration for employment in the human service field vary across disciplines. Although most employers prefer a bachelor's degree in sociology, psychology, or human services, a high school diploma is acceptable for entry-level positions. Professional degrees or master's or doctoral degrees in social work and psychology are preferred and, in some states, are required because each of these disciplines require licensing and are categorized as clinical positions. Beyond the hiring requirements for working in human services, workers must stay abreast of current knowledge and emerging developments related to practice and ethics by continuing their education through coursework, conferences, and workshops.

In human services, understanding the relationship among values, ethics, and ethnic diversity and how individual values and ethics impact service provision are at the core of preparation for working in the human service field. In order to provide appropriate direct services to individuals, families, groups, and communities, it is important that human service workers are educated and trained on ethnic diversity. Under the Equal Protection Clause of the Fourteenth

Amendment (1868) of the U.S. Constitution, states are required to provide equal protection of individuals and reject discrimination based on ethnic diversity. The law attempted to dispel the myth that ethnic diversity has little to do with hiring practices, service provision, and racial segregation.

However, it was the Civil Rights Act of 1964 that made it a criminal offense for institutions serving the general public to discriminate against persons because of race or ethnicity. Following the ending of separate-but-equal laws and policies in the 1960s, military and police departments were the first to put in place formal education and trainings on ethnic diversity. Institutions of higher learning soon followed. Today, most human service agencies have some form of required comprehensive diversity training for its employees. Mandatory comprehensive trainings on ethnic diversity are required for most human service personnel adhering to the International Human and Civil Rights Code of Ethics. These trainings have assisted in institutionalizing multiculturalism in human service agencies with policies and programs that promote ethnic diversity.

The trainings, mostly known as diversity, cultural diversity, or multiculturalism trainings, focus on understanding people's differences and learning to appreciate differences among varying groups. The trainings, most times, include a self-assessment of individual values, morality, presentations of ethical dilemmas, and best practices for handling issues related to diversity. The end result should be improved worker competency in the areas of diversity.

While mandatory comprehensive education and training on ethnic diversity in human services is the norm rather than the exception for human service workers, it is a controversial topic. Opponents argue that mandatory diversity education trainings have no real merit. They believe that social integration cannot truly be achieved and refer to this as the diversity illusion. They reason that the educational trainings are merely an exercise that organizations and agencies participate in to seem morally just and to comply with requirements of funding sources. Educational diversity trainings are seen to have little value in preparing workers to work with diverse populations. In the same vein, opponents of multiculturalism argue that multiculturalism is detrimental to the values of the country and can lead to social conflict. They maintain that persons of different cultures should assimilate into the existing dominate culture to avoid division among social groups.

Proponents of mandatory education and training argue that mandatory education and training are necessary and appropriate for anyone in the human services field. They purport that knowledge about and familiarity with characteristics and cultural history and background of the persons they are serving assist human services workers in developing and providing adequate interventions. They claim that understanding diversity helps workers to effectively communicate and interact with the persons to which they are providing services. It is believed that effective communication and interaction between the worker and client is the foundation for positive outcomes. They also believe that acceptance, appreciation, and respect of diversity are inevitable as the world becomes more diverse.

Human Service Settings and Ethnic Diversity

Human services professionals work in a variety of settings. They can be found in social service agencies, correctional facilities, youth service agencies, residential facilities, educational institutions, health-related institutions, mental health centers, and elsewhere. The settings are usually very busy and sometimes seem chaotic. The demographics of the persons whom these agencies and institutions serve include persons of diverse populations. Human service agencies address client issues and problems by accessing available benefits, providing counseling, educating, developing and implementing programs, and so on.

Human service workers find success in their work from helping other human beings in difficult situations. The work is hard, thankless, and usually low paying. Much of the work that human service workers engage in is referred to as case management. Heavy caseloads have been cited as a major cause of high turnover rates. The job requires gathering sensitive data on clients. Human services workers are privy to a host of personal identifying information about clients. Privacy and confidentiality of the data gathered are vital. In most human service agencies, workers are required to sign privacy and confidentiality statements that ask the worker to protect client information by not sharing it without getting informed consent.

Human service work can also be difficult and may require long hours. Because of the complexity of the job, workers must work efficiently. Being able to establish a rapport with the client assists in attaining efficiency. The worker must make the client feel that he or she is important, respected, and heard. This is often referred to as respecting the dignity and worth of individuals. For clients of diverse backgrounds, it is critical that the worker exhibit some knowledge of who the client is in order to establish a rapport with the client. Establishing this rapport leads to positive interactions and communications that help the worker to provide effective and efficient interventions for the client.

The Economy, Human Services, and Ethnic Diversity

The global economic decline began in 2007 and resulted in an economic crisis in 2008. The loss of jobs, closing of businesses, home foreclosures, and a bottoming out of the banking industry left many people in need of human services. The economic recovery, although steady, has been slow. Historically, when society experiences an economic crisis, funding to social services are decreased. Human service agencies have been impacted by the economy with cuts in federal and state funding, decreases in private donations, and few opportunities for additional funding above and beyond federal and state funding appropriations. This creates a very contingent situation.

As human service organizations and agencies continue to struggle to provide services to increasing client numbers with evolving needs, funding to support services to those requiring assistance has decreased. The evolving needs of increasing client populations, while contextually connected to the economic crisis, are partly due to the diversity of the clients served. While providing services to those in need and multiculturalism are seen as societal values, the decreases in funding to provide these services presents an ethical dilemma for human services organizations, agencies, and workers. They are left with the task of determining who receives limited available services. This determination often has no room for consideration of ethnic diversity, lending itself more toward the provision of services for those suffering the most devastation. It can be argued that those mostly impacted by economic crises would be those with more diverse backgrounds as greater numbers of minorities would suffer the greatest impact of an economic crisis. One of the goals of the institutionalization of ethnic diversity or multiculturalism in human service agencies is to provide culturally specific assessments and interventions. However, with swelling numbers of persons needing services and limited resources, the focus on multiculturalism and ethnic diversity may not be possible.

For example, one of society's most basic needs is for people to be able to eat. During economic crises, the number of persons needing assistance to provide food for themselves or their families increases. In September 2013, the U.S. government cut $4 billion from the budget of the Supplemental Nutrition Assistance Program (SNAP), commonly referred to as food stamps. The cuts limited who was eligible to receive food stamps and the dollar amount recipients received and and increased the number of ineligible applicants by implementing stricter guidelines for those applying for SNAP. In this case, human services workers assisting individuals and families in obtaining food through federally funded SNAP would have little time to consider ethnic diversity or multiculturalism. The immediate need would be to help applicants to obtain food assistance. This situation is a practical one that questions the applicability of ethnic diversity education and training in human service agencies impacted by economic crises.

Ethnic Diversity, Multiculturalism, and Multicultural Diversity

As mentioned, ethnic diversity is more commonly known today as multiculturalism or multicultural diversity. In past years, the protection of cultural identity has been the focus of ethnic diversity discussions. However, in recent years, diversity has been acknowledged as a construct that goes far beyond cultural differences. This paradigm shift has led to the acknowledgment that differences among people exist at many different levels and should be respected and valued. For example, while physical differences of race, gender, age, or color may be apparent, more subjective characteristics of immigration status and gender identity or expression may not be so readily identifiable.

The term *multiculturalism* or *multicultural diversity* usually describes a place and the demographics of individuals or populations at the group, community, organizational, and institutional levels. In human service agencies, demographics plays a vital role in determining the types of services provided and the manner in which they are provided. For example, in the Hispanic culture, there is a greater sense of value for elders. If an agency outside of a particular Hispanic community wants to implement a new program and partner with an agency within such a community, it would be difficult to gain buy-in and participation from the residents of that community without the approval of the elders, whether that approval is verbal or nonverbal. It is important that human service organizations understand the community for which they are providing services in order that cultural idiosyncrasies are respected.

Since the 1980s, there has been an increase in the international population movement. While globalization and multiculturalism are welcome tenets for the world at large, the extent of the increase in the international population movement to different countries around the world was not anticipated. Adequate preparation to receive persons of differing backgrounds was not universally apparent. Hence, the need for education, training, and policies that assist in preparation to receive these diverse populations was brought to the forefront. Both national and international policy exist to address this issue.

Multiculturalism or multicultural diversity refers to theoretical frameworks within agencies and organizations that support the ideological constructs of diversity. This framework is determined by the specific policy and program initiatives developed and implemented within human service agencies to manage and respond to ethnic diversity. The constructs of diversity include the knowledge, awareness, and skills to work with diverse populations. The importance of culturally and ethically sensitive acknowledgement and recognition of differences when working with diverse populations are also emphasized. Multiculturalism or multicultural diversity also attempts to ensure access to resources for ethnic and cultural minority groups.

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See Also: *Code of Ethics* of the National Association of Social Workers; Cultural Competence, Human Service Providers and; Cultural Competence, Training in; Ethnic Diversity and Values; Multiculturalism.

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Veterans Services

While the United States military strives for unity and cohesion, each member is inherently unique. In providing services to veterans, it is imperative to keep in focus the various areas of diversity. Specifically, generational differentiation is significant as are combat and noncombat experiences. Veteran service delivery is often complex when symptoms of post-traumatic stress disorder (PTSD), military sexual trauma (MST), and other mental health and medical complications such as traumatic brain injury (TBI) are involved. The Department of Veterans Affairs (VA) and non-VA veteran service organizations (VSOs) are often available to help veterans with many aspects of their post-military needs. The most salient are financial support (e.g., compensation and pensions for service connected disabilities), educational and vocational services (e.g., the G.I. Bill), health care, and burial and memorial services.

Military and Veteran Culture

The military has a distinctive culture of unity and cohesion. Within the military, though, lies significant diversity. In addition to differences in ethnicity, class, and gender, members of the military also differ in their reasons for being a part of the armed forces and in their professional and life experiences. Some who face discrimination in the general society may seek relief in the military. Due to its mission, the military strives to be fundamentally nondiscriminatory in its organizational behavior. For example, Native Americans who served during World War II were well integrated in military units but were discriminated against in general society.

Generational differences are also significant. Veterans of World War II and the Korean War, today's oldest veterans' groups, established a reputation as being heroes. In contrast, the Vietnam era veterans, due to societal changes, gained a reputation as being antiheroes. As time passed, and more was learned about the challenges of military service, veterans have attained a more positive status in society, and various organizational alliances have been reaching out to support them.

It is relatively easy to understand how and why military culture has its own distinction, origin, and purpose. It is much more difficult to understand what happens when members come back from combat and leave the military. There is no organized basic training to deconstruct military culture and prepare a person for reentry to civilian life. Veterans often come home dealing with reintegration issues, isolation, physical or emotional wounds from war, family alienation, and ambivalence about getting help.

One veteran's experience of the military will differ from another's. In addition, military experience during times of peace and times of war are often markedly different. In most cases, veterans are eligible to receive many services that enable them to reintegrate back into society, including access to health care. However, many veterans do not understand their benefits, so connecting them with services remains an ongoing challenge.

Workforce Services

All federal services for veterans are designed to be sensitive to issues of diversity and seek to work with the military in assisting veterans in transitioning to civilian life. This includes vocational rehabilitation and workforce development programs. The Office of Diversity and Inclusion (ODI) in the VA aims to foster a diverse workforce and an inclusive work environment that ensures equal opportunity through national policy development, workforce analysis, outreach, retention, and education to best serve veterans. One important role of the ODI is to measure how all groups protected by law are represented in the diverse workforce of federal offices. The government is also designating new funds for research on the integration of women and sexual minorities in the military.

To recognize the role of veterans in public service, and in appreciation of their thorough training, there is a requirement that veterans have priority in hiring for positions in federal agencies. However, the preferential hiring of veterans means that the number of employees from protected groups will not mirror their respective percentages in general society; this is especially true of women and naturalized citizens who haven't been well represented in the military. This effect is even stronger for groups not protected by law but only by recent presidential executive order, such as lesbians, gays, and bisexuals (LGBs). The Don't Ask Don't Tell (DADT) policy significantly affected the participation of LGBs in the military. Consequently, there was no official recruitment of these individuals to the military. The repeal of DADT and the Supreme Court ruling that the Defense of Marriage Act (DOMA) is unconstitutional insure that many current military members and subsequent veterans will be less affected by adverse discrimination.

Recent changes in the access to the military of women and some sexual minorities will increase overall diversity in the military and consequently in federal offices. The next steps will be changes to address persistent gender gap problems, transgender, and immigration policies.

Health Care

The VA provides health care for about 6 million recipients. Although largely male represented, by 2021, the number of women veterans enrolled in the VA's health care system is expected to increase by 45 percent. The VA is the single largest provider of health care services for several conditions, for example, hepatitis C and Agent Orange registry disorders. The need for mental health services has grown to be larger than for physical health services. One of the most recognized mental health problems related to military service, especially among veterans who were in combat, is PTSD. Many with PTSD also have symptoms related to TBI.

Often, the symptoms of PTSD and TBI coincide, and it is difficult to evaluate and choose the best treatment plan. Among women, PTSD is often related to MST, a significant problem in a quickly changing military culture. Other common mental health conditions for which veterans seek professional help are depression, anxiety, and substance abuse. Difficulties with sleep and digestive problems are also common. Because of readjustment difficulties, many veterans suffer legal consequences. The VA and local justice systems have recently teamed up to provide reduced sentencing in exchange for comprehensive rehabilitative care to these veterans.

In recent years, the VA has made battling the high occurrence of homelessness and suicide attempts or thoughts among veterans a top priority. To meet the increased need for mental health, family, and homeless services, the VA has begun to create new, integrative programs in cooperation with community providers. Telehealth initiatives and evidence-based therapies (EBTs) are on the front lines with devoted staffing hours and 24-hour hotlines available to ensure maximum service delivery. The implementation of Patient Aligned Care Teams (PACT) within the VA health care should help improve access to services due to direct, hands-on coordination among primary health care providers and several other clinical and nonclinical staff.

Community and Veteran Service Organizations

Veterans often turn to non-VA-sponsored avenues for services. VSOs are grassroots, nonprofit organizations often run by veterans themselves in support of other veterans. Services generally include working alongside veterans in advocacy for empowerment and rights in accessing health care and other benefits. According to the *Directory of Veterans Service Organizations,* there are more than 140 national non-VA VSOs. Examples of these organizations include the African American Post Traumatic Stress Disorder Association, Disabled American Veterans, Paralyzed Veterans of America, Women Marines Association, and the Wounded Warrior Project. There are also state and local government-based VSOs that connect veterans with benefits and services and provide outreach to veterans in rural areas.

A good example of cooperation between different government organizations and community agencies are recent grants for community providers to help homeless veterans. Funds from a joint effort of U.S. Departments of Housing and Urban Development (HUD) and VA Supportive Housing (VASH) helped to develop evidence-based housing programs for homeless veterans. Additionally, the government has funded a program known as Supportive Services for Veteran Families (SSVF), run by community providers, to help veterans receive or maintain stable independent housing. Many universities and colleges have special programs for veterans assisting them with education, training, and employment and meeting life's challenges.

With cumulative years of wars, and several members enduring multiple deployments, there is an increased need for veteran services. It appears that, more than ever in American history, society recognizes the sacrifice and service of veterans by widely extending the support and diversity of the services they need.

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See Also: Homelessness; Immigration: Human Service Issues; Military Personnel; Military Veterans; Same-Sex Marriage/Couples; Suicide Prevention Services; Transgender Individuals.

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Victim Services

Survivors of crime may experience depression, anxiety, sleep and eating disorders, substance abuse, suicidal ideation, self-blame and posttraumatic stress disorder. To address their needs, crime victims assistance programs, rape crisis centers, and battered women's shelters have been in existence since the 1970s. Victim service organizations may be community based (independent of the criminal justice system) or system based (housed within and affiliated with police agencies). Services provided by community-based organizations include individual, collateral, and group counseling services; legal support; accompaniment to medical and police appointments; assistance in accessing federal compensation; information and referrals; updates on the status of legal cases; and preventive education.

While victim service agencies can assist with any crime, most focus is on domestic violence, sexual assault, stalking, and rape—crimes most frequently reported (both officially and unofficially) by girls and women. It is important for service providers to be aware of these services because any client can become a victim of crime, although not all workers know how to address the complex needs of survivors. Victim service workers, who often participate in interdisciplinary teams, may be a useful resource for other human service workers. Despite the valuable services victim advocates can provide, they are currently underutilized by victims and professionals.

Work With Secondary Survivors

Victim service organizations work to prevent and minimize, as well as intervene with, victimization. To accomplish this goal, victim advocates may assist co-victims of crime (also known as secondary survivors), who include family members, spouses, lovers, friends, and children of survivors. Co-victim responses are crucial in that social support is a key element in a survivor's recovery from trauma. As a result of their own feelings, co-victims may engage in behaviors that threaten a survivor's recovery. These may include overidentification, blaming, doubt, overprotection, silencing, embarrassment, avoidance, or pressure for resumed normalcy. Adolescents, the most frequent victims of rape, are especially prone to encounter these reactions. Among spouses and romantic partners, tensions may lead to the dissolution of relationships. Professionals such as police officers, nurses, and therapists may also exhibit these negative reactions. Counseling of co-victims can alleviate the stress they feel as a result of the crime and help them respond more helpfully to survivors.

Prevention Education

Victim service organizations have been instrumental in providing free community education (primarily in elementary, middle, and high school classrooms) on the subjects of rape prevention, bullying, and dating violence. Presentations are geared to specific age groups and may be vetted by teachers and parents. These programs have at times been viewed as controversial because they are associated with sexuality (rape and dating) and may result in disclosures of abuse to teachers unprepared to handle them. As a result, parents were permitted to have their children opt out of these programs. However, it is in keeping with the philosophy and mission of victim services organizations to engage in prevention of, as well as assistance after, criminal victimization.

History and Values

Before the 1970s, victims of crime sought help from traditional institutions such as police departments, hospitals, and counseling centers. However, studies showed that women were not receiving the information and support they needed following rape and domestic violence. This made recovery from crime-related trauma and accessing redress through the criminal justice system difficult. Thus, as part of the women's movement, victim service agencies were established by volunteers through grassroots activism. They were independent of other institutions, which they sought to reform. Today, victim advocacy organizations have become professionalized, leading to tension between the early goals of independence from mainstream institutions and the contemporary impetus to collaborate with systems of power.

The philosophy behind victim services agencies is that of empowerment, freedom from judgment, confidentiality, and choice. In many states, a victim advocate's case notes cannot be subpoenaed; in other states, advocates take minimal notes to protect their clients from confidentiality violations. Services are expected to be delivered in an egalitarian, respectful manner, free of charge. Community-based organizations do not require victims to lodge a police report or undergo a forensic exam in order to receive services; rather, they help the survivor explore options

Senator Barbara Boxer, the junior U.S. senator from California, speaks at a women's rights event. Boxer was a sponsor of the original Violence Against Women Act in 1994.

and come to his or her own conclusions. In addition, through a beeper service, agencies characteristically offer 24-hour availability.

A main activity of crime victim advocates is to inform survivors of their rights. Although state laws vary, there is a Federal Crime Victims Bill of Rights that asserts victims' needs for respect, access to information about their cases, compensation, opportunity to make statements before the court, and others. However, these rights are interpreted differently by states and jurisdictions. The right to have a victim advocate present during police interviews is currently discretionary in many states, despite the difficulty of undergoing this process.

The federal government provides most of the funds for sustaining victim service agencies, most notably through the Violence Against Women Act of 1994, which is renewed periodically. However, funding has been reduced in recent years, which has limited the preventive and collaborative activities of victim advocacy organizations. In addition, the 2013 reauthorization of the act was delayed by lawmakers who objected to its provisions for Native American and immigrant victims.

While victim advocates are not lawyers, they are familiar with aspects of legal policy and procedure that may impact survivors. In addition, they are familiar with local judges, prosecutors, and police officers. As a result, they are valuable resources for clients contemplating criminal justice involvement.

Effectiveness

In a groundbreaking study, Rebecca Campbell demonstrated that rape victims were treated more professionally by police and medical staff when a victim advocate was present. It is not known whether the same result would occur if survivors were accompanied by friends. Qualitative studies indicate that survivors of rape and domestic violence feel better about themselves when involved with victim advocates. That said, studies to measure the effectiveness of victim advocates are sparse. However, there is evidence that police officers who work collaboratively with victim advocates are better rape victim interviewers.

Other Victim Service Programs

Another kind of victim-specific program is domestic violence shelters, organizations within each community that provide refuge for women fleeing abusive partners. They are staffed by paraprofessionals who provide concrete services, counseling, and referrals. As a result of meager funding, they characteristically have more applicants than available beds; however, shelters are well utilized by clients. Some issues remaining to be addressed are where to house male adolescent children of survivors, accommodation of gay survivors, and provision of aide services to women with disabilities dependent on physical assistance.

Another important service for survivors is Sexual Assault Nurse Examiner (SANE) units in hospitals. These are composed of one or more nurses, available 24 hours a day, to provide specialized emergency rape exams for victimized women. Forensic evidence needed for prosecution can thereby be collected in the most effective and compassionate way possible—minimizing survivor trauma. Pregnancy and venereal disease testing are provided at no cost to survivors. SANE nurses are cognizant of legal requirements and are often members of multidisciplinary teams to assist survivors. They were developed as an alternative to long hospital waits, disgruntled physicians uncomfortable performing forensic exams, and lack of physical privacy.

Diverse Populations and Use of Victim Services

Crime victim agencies may be underutilized by vulnerable populations who need their services. Cultural groups vary in terms of attitudes and approaches to crime; some cultures believe the public disclosure of victimization exposes a survivor's family to dishonor and shame. Lack of trust is another issue. Marginalized populations, such as Native Americans, may not expect help from official (county, state, or federal) agencies. Survivors in military environments may doubt the ability of civilian victim assistance organizations to protect them. Fears of deportation may limit the willingness of immigrants to seek help. Persons with disabilities may fear that disclosure will result in lost privileges or placement in restrictive environments. Men may feel that programs will be unresponsive to their needs, and gay victims may not be able to access accommodations within shelters. Thus, there are many holes in the service delivery system despite the value of these organizations to clients.

Interdisciplinary Collaboration and Challenges

Victim advocates experience satisfaction in their work but are also at risk for stress and burnout. This may be due to the nature of the work they do, their exposure to secondary trauma (as a result of hearing so many stories of victimization), their lack of adequate monetary compensation, and the lower status they hold in the perception of criminal justice authorities. They may head up teams of community professionals (nurses, police administrators, advocates, mental health counselors, shelter workers, case managers, disability professionals, school principals, and others) where their values about confidentiality and client empowerment may be challenged. Psychologists may feel that clients need formal psychotherapy rather than the informal counseling (devoid of diagnoses, fees, and session notes) provided by victim advocates. As with all multidisciplinary collaborations, there are perceptual, linguistic, ideological, and cultural barriers to be addressed—although the usual outcome is improved services to survivors.

Victim advocacy organizations vary in their relationship to a feminist ideology, with some adhering closely to the feminist ideals with which they were founded and others espousing a more conciliatory viewpoint. This has resulted in competing opinions about the role of victim service organizations in serving men or transgendered women. It has also resulted in conflict among those who propose compromise and interdisciplinary collaboration and others who resist perceived co-opting by other disciplines. The recent creation of in-house victim advocacy organizations by police departments has sparked a controversy based on these competing principles. These special victims units are located at police stations and usually staffed by female officers; they may also comprises human service workers whose goal is to ensure cooperation with police. From one perspective, this situation undermines the victim services goals of client empowerment, confidentiality, and freedom of choice; from another perspective, the collaboration among advocates, survivors, and police officers can happen easily and with a minimum of conflict.

Future Goals

A recent interest of governmental authorities is trafficking in persons; task forces across the United States are currently being developed, with victim advocates playing key roles that utilize their skills in survivor engagement, networking, advocacy, and community education. In addition, legal, housing, and medical professionals are developing victim assistance protocols for the unique needs of this population.

In the present legal environment, when a survivor's case is tried, he or she is viewed only as a witness, not a complainant, in the proceedings. This means that his or her interests and those of the prosecutor may not be in alignment; instead, he or she becomes a tool in the state's action. However, the notion of a victim's attorney, whose interest is solely to protect the survivor in legal proceedings, is being developed. If this were institutionalized, at a criminal trial, there would be the state's attorney (prosecutor), the accused party's lawyer (defense), and a third lawyer for the victim. This would increase the likelihood of victims' coming forward and would create another collaborative opportunity (with survivors' legal aid societies) for victim advocates.

Another goal for legal professionals is to strengthen federal and state Victims Bills of Rights. This would elevate the status of victim advocates, some of whose authority rests on the existence of this law. The right to have a victim advocate present during police interviews could be made enforceable.

Strengthening and elaborating existing policies may go a long way toward improving institutional responses to survivors of these crimes.

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See Also: Child Abuse/Neglect, Victims of; Institutional Oppression.

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Vietnamese Americans

The Vietnamese population of the United States is the fifth-largest immigrant population. The rapid growth of this group began after the end of the Vietnam War in the mid-1970s. While the inflow of immigrants has slowed, the needs of this large group are significant to the human services community. While the total Vietnamese population in the U.S. is approximately 1.6 million, at the last census, just over 1 million in this community are immigrants. California has the most Vietnamese Americans. Los Angeles and several other nearby cities makes up the metropolitan area with the most Vietnamese. Other cities in California with large populations include San Jose, Sunnyvale, and Santa Clara. The Houston, Dallas, and Washington, D.C. metro areas also host large numbers. The U.S. Census Bureau estimates the age distribution of Vietnamese Americans as follows: under 5 about 8 percent, 5 to 17 about 19 percent, 18 to 64 about 65 percent, and over 65 about 8 percent. While Vietnamese immigrants have adapted better than many immigrants to the economy of the United States, there is a continuing need in this population for human services. Cultural issues are crucial in this community. If those seeking to help this immigrant population are to be effective, there must be an understanding of the Vietnamese culture. One of the major factors in the culture of those in this population is the importance of family. It is only in the context of family that the most effective help can be offered.

The length of time that Vietnamese immigrants have been in the country impacts the level of human service needs evidenced in a particular population. Certainly those who came in first were primarily refugees fleeing from the communist takeover of South Vietnam. Most refugees came with no material possessions. They needed everything. They first had to be provided with a place to live. Some lived first in temporary housing, many on army bases in the U.S. Gradually, through help provided by the U.S. government, churches, and other organizations, more permanent housing was provided. These new residents were given financial help and help in finding work. Language learning opportunities were provided. Family reunification services were very important to new Vietnamese arrivals in the U.S. Because the family is so important in Vietnamese culture the effort to reunite families was valued very highly. The trauma that many refugees faced in their efforts to come to the United States made necessary the provision of counseling services for many of the new arrivals. Some spent months, or years, in refugee camps in some very difficult places. Some left Vietnam in crowded and dangerous boats. Many lost family members and friends in the difficult journey away from Vietnam. Often they were troubled by family members left behind in Vietnam.

Due to a very strong work ethic and strong family support many Vietnamese adapted quickly and very effectively to the American environment in which they found themselves. As the years passed immigrants adjusted to their new home. At the same time, new immigrants continued to come in from Vietnam and from other countries where they had resided since initially leaving Vietnam. Language acquisition continued to be a real need for many. Many older immigrants, having been in the United States for decades, still have not learned to speak

English. While normally more aged immigrants might have a higher level of needs for human services delivery, among some in the Vietnamese population this might not be the case given the special status older individuals have and also because of the importance of family. Older family members would be given extraordinary care by their family members. However, in many families, leaving Vietnam has led to a loss of many of their cultural values. Senior adults would not have the place of honor and respect that traditional Vietnamese families would give to them. This would leave elders in these families facing undue hardships and feeling lost in a world they were not familiar with.

Most competent human service providers are able to provide somewhat effective service to Vietnamese clients, but language and cultural differences prevent the level of service from being what many Vietnamese desire. This has led to the formation of Vietnamese social and other service organizations. These organizations, staffed mostly by people of Vietnamese background, are able to deal with the language and cultural mazes that those not very familiar with special issues Vietnamese face are not able to navigate. These entities are usually found near high concentrations of people of Vietnamese descent. One example of an organization that has specialized in providing services to this community is Vietnamese Social Services of Minnesota. This is a nonprofit organization providing basic social services for the Vietnamese community. Education, health, work with elders and youth, and language work are among the services provided. In recent years this organization has broadened its scope of services to provided help to those from other backgrounds like Karen and Somali refugees.

Another example of a service provider reaching out to Vietnamese Americans in special circumstances is the Mary Queen of Vietnam Community Development Corporation (MQVCDC). This organization was formed as an extension of the Mary Queen of Vietnam Catholic Church in New Orleans. This is a large, primarily Vietnamese, church planted in the heart of an immigrant Vietnamese Community. MQVCDC was created in 2005 to help those in the Vietnamese community rebuild their lives after the devastation of Hurricane Katrina. This organization provided case management to residents seeking to rebuild their homes, lives, and businesses after the flood. MQVCDC was also very influential in getting a post-Katrina landfill very near the Vietnamese neighborhood closed. The Vietnamese community in New Orleans was among the first communities to start rebuilding and was restored almost before any other neighborhood. The Vietnamese emphasis on family helped get this community restored much more quickly. There was no shortage of neighbors and family members to help rebuild. In the years after Katrina, MQVCDC continued to provide much-needed services for the mostly immigrant community and to promote economic development. MQVCDC even helped get a new charter school in the neighborhood. The school was multicultural and taught the Vietnamese language to the students.

In 2011 the massive BP oil spill in the Gulf of Mexico, just off the Louisiana coast, had a dramatic impact on many Vietnamese residents. One of the reasons that so many Vietnamese immigrated to Louisiana after the end of the Vietnam War was that Louisiana offered a climate much like that of Vietnam and also had rich fishing and shrimping waters. A large percentage of Vietnamese earned their living from the fishing industry. The oil spill virtually shut down fishing in the Gulf of Mexico, especially near New Orleans. MQVCDC mobilized to provide a place where those negatively impacted by the oil spill could come for help. Case managers once again reached out and provided guidance and resource referral. Claims were filed for reimbursement on behalf of Vietnamese and others who had lost jobs and income. MQVCDC also helped residents develop urban farms and aquaponic endeavors so that fish could be raised in tanks on land. MQVCDC has become a needed fixture in the Vietnamese community of New Orleans.

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See Also: Acculturation; Asian Americans; Asian Immigrants; Family Reunification; Immigrant Populations, Human Service Needs of; Immigration, Human Service Issues; Legal Services; Office of Refugee Resettlement; U.S. Citizenship and Immigration Services.

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Volunteer Services

Volunteer services are programs or activities provided to benefit the public without the expectation of receiving payment in exchange for services. Volunteer services preceded almost every field of practice in human services. Historically, during the 18th and 19th centuries, volunteer services were responsible for improving transportation, sanitation, fire prevention, public safety, and education. Volunteer services helped bring about fair labor practices, better medical practices, and the humane treatment of the mentally ill, and brought attention to the debilitating effects of alcohol. Volunteer services founded relief societies, children's homes, day care programs, recreation services, and family and child welfare associations. Currently, volunteer services remain crucial to the quality of life of individuals and communities. Individuals benefit from receiving services. They also benefit from helping others and participating in civic matters. Volunteer services benefit communities by helping citizens gain a sense of responsibility to the greater welfare of the public. Communities also benefit from the assistance provided to individuals by volunteer services. In some instances, volunteer services are the only option for people in communities with certain needs. In other instances, communities form partnerships between volunteer services and other community agencies to expand access and improve the effectiveness of human services.

Volunteer Services and Individuals

Giving and receiving support from volunteer services contribute positively to the well-being of all people. In fact, volunteer service opportunities are one of the few activities that bring people together from diverse backgrounds to support one another. People of different races, genders, ethnicities, and religious backgrounds often interact when participating in volunteer services. The services received can benefit people regardless of their age, marital status, occupation, or socioeconomic level. In the same way, individuals from diverse backgrounds experience similar benefits when they invest time and energy volunteering to help others. For instance, one reason people volunteer is to express altruistic and humanitarian values that are important to them. Volunteering gives individuals the opportunity to act on their concern for other people. Another benefit involves providing people new learning experiences. Volunteer services give individuals a chance to acquire and use new knowledge, skills, and abilities that they might otherwise go undeveloped. Increasing and reinforcing social networks is another benefit of volunteer services. When people volunteer, they often meet new people, develop new relationships, strengthen acquaintances, and gain a sense of enhanced social status by engaging in volunteer activities that are often viewed favorably by others. For some people, volunteering can have career-related benefits. Volunteer services give individuals the chance to explore a new career or progress in their current field by gaining new skills in a short amount of time.

Human service professionals should recognize and appreciate the treatment potential of incorporating volunteer services when working with individual clients. Volunteering can be a healthy way for individuals to cope with stress, loss, or even trauma. When individuals volunteer, they usually interact with people experiencing difficult circumstances. Working with people in need helps individuals gain insight and perspective, allowing them to reduce feelings of guilt and begin feeling different about their own circumstances. Likewise, volunteering, for some people, can be a way of coping with feelings of isolation, uselessness, and hopelessness. Instead of feeling trapped by such negative feelings, individuals who volunteer can increase their self-confidence and sense of self-worth. Overall, volunteer services offer individuals the unique opportunity to build upon their strengths and capacities while simultaneously addressing social problems.

Volunteer Services and Communities

The positive influence of volunteer services on communities is multilayered and multifaceted. Consider, for instance, the effect of volunteer services on communities from an abstract, theoretical perspective. Providing opportunities for people to serve and volunteer promotes a community ethos or culture where people believe it is important to care for the needs of others. In essence, volunteer services in the community help to create an expectation that citizens participate in giving and receiving support for each other. Moreover, volunteer services help cultivate a sense of commitment for the welfare of the community beyond self-interest. As people volunteer, they take on a vested interest in what is best for everyone in a community.

Another powerful benefit for the community is the ability to bring a diverse group of people together for common purposes. Volunteer services is one of the few ways that communities can promote interaction of people from different ages, genders, income levels, or even religious beliefs. The interaction among such diverse people makes it possible for volunteer services to effectively address social problems. Stated differently, when a need or issue arises that affects enough individuals, they will collaborate with each other to address the problem. For example, if a community is dealing with an increase in vandalism, bringing a diverse group of volunteers together to clean up will help personalize the issue with a cadre of concerned citizens. Beyond cleaning up, the concerned citizens are then in a position to mobilize their efforts to minimize or eliminate vandalism in the community more so than if they simply learn about the issue from watching the news on television or reading about it in the local newspaper.

Volunteer services are usually provided at minimal or no financial cost to communities. Perhaps the best way to appreciate the financial impact on communities is to consider the replacement value of volunteer services. Replacement value represents the cost it would take to replace the services and assistance provided by volunteer services. Assessing the value of volunteer services to be approximately $18 per hour and estimating that volunteers give, on average, 4 hours per month, the overall economic contribution generated by volunteers in the United States, for example, is $239 billion each year. In some instances, the help provided by volunteer services is the only method of support available for people in a community. In such cases, the impact is even more valuable, making it difficult to assess a replacement value. For example, volunteer emergency services are usually the only avenue of support for people in crisis. If individuals in a community are without food, are about to lose their place of residence, need help paying a utility bill, or need clothing or other basic necessities for survival, volunteer services are usually the only means of getting help as quickly as needed. Even when people seek help from public agencies, when they need immediate support or relief, human service professionals at public agencies will often refer them to volunteer services for short-term assistance.

The Future of Volunteer Services

Volunteer services will continue to be important to the welfare of communities in the future. Historically, at first, volunteer services were primarily responsible for providing social welfare services. The role of public community services was minimal. Next, in the process of providing services and addressing social problems, volunteers advocated that government participation was necessary. As public community services expanded, however, a major pendulum shift occurred where government and professional human services became primarily responsible for social welfare, while volunteer services took on a supplemental role. Currently, there is a need for an optimal balance of shared responsibility between government and professional human services and volunteer services determined by the unique contexts of different communities. In some instances, government and professional human services will continue to play a leading role in addressing the well-being of people in communities. In other instances, volunteer services will play a larger role. In either case, volunteer services will continue to expand and play a crucial role in the overall quality of life for individuals and communities.

Volunteer Services and Human Service Professionals

It will be important for human service professionals to appreciate the important role of the volunteer sector in the future. As part of the knowledge and skills necessary for competent social work and other human service practice, professionals will need to know how to access volunteer services. They will also need to know how to initiate and maintain strategic partnerships with volunteer service providers as public funding for services will likely decline, and the need for services will continue to increase.

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See Also: Aftercare Services for Children Aging Out of Foster Care; After-School Services; Aging and Adult Services; Changing the Client Versus Changing the Environment; Community Action Agencies; Community-Based Services; Economic Support and Services.

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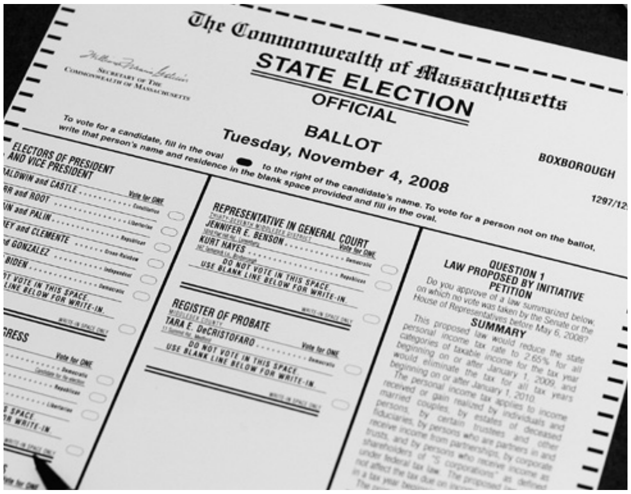
Voting Rights Act of 1965

The Voting Rights Act of 1965 (VRA) is widely considered to be landmark civil rights legislation that enforces the 15th Amendment to the U.S. Constitution. This act, signed into law by President Lyndon B. Johnson on August 6, 1965, authorized the federal government to oversee voter registration and elections in counties that had employed voter suppression tactics or where registration or turnout had been less than 50 percent in the November 1964 election. It also banned discriminatory literacy tests and expanded voting rights for non-English-speaking Americans.

Background

After the Civil War, several amendments to the U.S. constitution were ratified, including the 13th Amendment, which prohibited slavery, the 14th Amendment, which granted citizenship to all people born or naturalized in the United States, and the 15th Amendment, in which citizens were guaranteed the right to vote. The 15th Amendment gave Congress the authority to regulate voting.

After Reconstruction (1865–77), other means of voter suppression like violence, intimidation, and Jim Crow laws were aimed at minority voters. Initially, the Supreme Court upheld some voting provisions (*United States v. Cruikshank*), but by the early 20th century, the Supreme Court began to find these provisions unconstitutional. However, through the early 1960s, southern states effectively disenfranchised most black voters. Following the 1964 presidential election, a variety of civil rights organizations joined forces to demand federal intervention to prevent voter discrimination. Following the March 1965 protests in Selma, Alabama, known as Bloody Sunday, which included TV coverage of Alabama police officers beating nonviolent protesters, President Johnson addressed a joint session of Congress and called for them to pass a strong



A paper ballot from a 2008 Massachusetts state election. The Voting Rights Act of 1965 ensured that citizens could participate in the political process and vote for candidates of their choice.

voting rights bill. Johnson's administration drafted a bill that passed the Senate in May 1965 and the House in July 1965. President Johnson signed the VRA into law on August 6, 1965, with civil rights leaders, including Martin Luther King, Jr., and Rosa Parks, in attendance.

Provisions

The Voting Rights Act prohibits poll taxes (Section 10), the refusal of a qualified voter to vote or the use of voter intimidation (Section 11), and literacy tests (Section 201), among other acts of voter suppression. Section 203 allows for language assistance for minority populations. Section 2 is a general prohibition on voting discrimination, allowing for federal enforcement. Congress amended this section in 1982, prohibiting any voting practice that has a discriminatory result. This section is permanent and does not require renewal. Section 3 provides for federal election examiners, suspension of any voting eligibility testing, and the requirement of preclearance for certain states and counties before changing voting practices. Section 5 states that any covered jurisdiction may not make voting changes without federal preclearance. Initially, the coverage formula of the VRA (in section 4[b]) to determine preclearance was if, as of November 1964, the jurisdiction used some form of test to restrict voter registration or if less than half of eligible voters were registered or voted in November 1964. In June 2013, the preclearance formula in section 4(b) was found to be unconstitutional in the Supreme Court case *Shelby County v. Holder*. Section 5 of the VRA is still enforceable, but Congress needs to readdress the preclearance formula.

States and Counties Covered by Preclearance

Many, but not all, of the preclearance states and counties were in the South, highlighting voter suppression across the United States. Before the June 2013 decision that struck down the preclearance formula, the following jurisdictions were covered by Section 5 of the VRA:

- *States*: Alabama (except Pinion), Alaska, Georgia (except Sandy Springs), Louisiana, Mississippi, South Carolina, most of Texas (except for two districts), and most of Virginia (except for 24 counties).
- *Counties*: California (King, Monterey, and Yuba), Florida (Collier, Hardee, Hendry, Hillsborough, and Monroe), New York (Bronx, Kings [Brooklyn], New York [Manhattan]), North Carolina (40 out of its 100 counties, and South Dakota (Shannon and Todd).
- *Municipalities*: Michigan, including Clyde Township and Buena Vista Township.

Bail In and Bail Out

Bail out is a process by which covered jurisdictions can seek exemption from Section 4(b) preclearance. Eighteen Virginia jurisdictions; Kings Mountain, North Carolina; Sandy Springs, Georgia; and New Hampshire have all successfully bailed out. Section 3(c) provides a process for jurisdictions outside of those covered by Section 4(b) to become subject to preclearance, or bail in. While the 2013 Supreme Court ruling held section 4(b) unconstitutional, it did not affect Section 3(c), thus those jurisdictions remain subject to preclearance.

- *States*: Arkansas and New Mexico (has since been terminated).
- *Counties*: California (Los Angeles), Florida (Escambia), Nebraska (Thurston), New Mexico (Bernalillo), and South Dakota (Buffalo and Charles Mix).
- *Municipalities*: Tennessee (Chattanooga)

Enforcement

Section 3 provides for federal election examiners, suspensions of voter eligibility testing, and the requirement of federal preclearance to change voting practices. With the 2013 suspension of Section 4(b) preclearance formula, states, including Mississippi and Texas, immediately put into action changes to their voting laws. Section 12 of the VRA provides for civil fines and the possibility of imprisonment for anyone violating the VRA. Section 14 of the VRA describes how to bring enforcement proceedings.

Voting Rights Act Renewal

The VRA became law in 1965, and temporary provisions of the VRA were renewed in 1970, 1975, 1982, and 2006. In 2006, a group of legislators signed a letter by Steve King (R–Iowa) that objected to part of the VRA requiring language provisions for U.S. citizens who do not speak English, and a group headed by Lynn Westmoreland (R–Georgia) claimed it was unfair to continue targeting their states with preclearance; however, the VRA was renewed for another 25 years and signed by President George W. Bush in July 2006. The June 2013 ruling by the Supreme Court found Section 4(b) unconstitutional by a 5–4 margin, but the preclearance rule in Section 5 was not invalidated by this ruling. The majority opinion noted Congress cannot subject a state to preclearance based on a history of discrimination. The dissenting opinion held that Congress should have sufficient evidence to determine the coverage formula. Further, the decrease in voter discrimination is attributed much to the VRA itself, noting that "[t]hrowing out preclearance when it has worked . . . is like throwing away your umbrella in a rainstorm because you are not getting wet."

Implications for Human Services and Diversity

Voting is a way for citizens to be ensured the opportunity to participate in the political process and be represented by candidates of their choice. The VRA worked to broaden franchise to include more voters rather than discourage voting, particularly by minority populations. While the opportunity to vote is integral to democratic rule in the United States, not all populations have had that right. Building upon the 15th and 19th Amendments, the VRA of 1965 implicitly included African American, Asian American, and Alaska Native citizens and allowed for equal opportunity to vote in elections free from bias and intimidation. The VRA, however, did not just cover federal elections; it allowed for increased voting in presidential elections all the way to local school board elections.

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See Also: African Americans; Border Communities; Colonialism, Lingering Effects of; Critical Race Theory; Cultural Literacy; Cultural Paradigms; Equal Opportunity and Civil Rights; Ethnic Diversity and Values; Ethnocentrism and Ethnorelativism; Global South/Global North; Hate Group; Implicit Bias; Indian Civil Rights Act of 1968; Institutional Oppression; Intelligence Testing; Literacy Testing; Model Minority Stereotype; Naturalized Citizens; Office for Civil Rights; Power, Race, Ethnicity and; Prejudice, Theories of; Race, Social Definition of; Race and Clients; Racism, Long-Term Effects of; White Privilege.

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War and Terrorism, Survivors of

Given the abundance of political violence and conflict in the 20th and 21st centuries, the ability to observe and make sense of how survivors of war and terrorism have fared in their communities has been widespread and, in many cases, thorough. Genocide, torture, ethnic cleansing, terrorism, civil war, and forced migration are all part of the complex puzzle that informs how researchers' understand various survivors. In the United States and other industrialized nations around the globe, more information about survivors is known and accessible. The fields of psychology, social work, sociology, health communication, and medicine, among others, provide many of the richest understandings of the various outcomes associated with survivors of war and terrorism. To distill and begin to understand the vast database of information on this topic, it may be simplest to proceed by considering the following four broad categories: health and emotional outcomes, domestic survivors of war and terrorism, international survivors of war and terrorism, and community engagement and interventions.

Health and Emotional Outcomes

Major disasters, specifically war and terrorism, are frequently associated with increased rates of psychological distress and morbidity among survivors. Posttraumatic stress disorder (PTSD) and crisis intervention have been two of the foundational routes to examining survivor populations and although it varies by population and how the study is conducted, it has been found that, in the year following terrorist incidents, the prevalence of PTSD in directly affected populations varies between 12 and 16 percent.

More recently, a plethora of theory and data has focused on the systemic relationships between political violence and individual and collective trauma, individual and collective healing, and individual and community resilience. The individual and the collective may experience trauma, healing, and resilience differently, though they are usually interrelated experiences. Across several fields of inquiry, it is widely accepted that the disparate health and emotional needs and outcomes of survivors of war and terrorism need to be addressed in culturally diverse and context specific ways. Similarly, it is often found that traumas such as war or terrorism spur new or preexisting tensions related to race, discrimination, and social and economic inequalities, making health care and community intervention all the more necessary. Because of the intensity of the feelings of loss or displacement often associated with surviving war or terrorism, coping skills become essential. Relational communication has also been considered integral given the high levels of anxiety, depression, and loneliness found among survivors, with many reporting reduced social involvement, feelings of social detachment, a sense of alienation, and diminished interest in life.

Domestic (United States) Survivors of War and Terrorism

Given the nation's relative involvement in political violence in the past 100 years, the United States has a comparatively large population of survivors of war and terrorism. One group that has been effectively tracked, specifically by the Department of Veteran Affairs (VA), in terms of overall well-being are veterans. According to the 2010 census, there are 21.8 million veterans (20.1 million male and 1.6 million female) in the United States, represented mainly by the veterans from World War II, the Korean War, the Vietnam era, and both Gulf War eras. Among these veterans, 17.5 million are Caucasian, 2.4 million are black, 1.4 million are Latino or Hispanic, 265,000 are Asian, 157,000 are American Indian or Alaska Native, and 28,000 are Native Hawaiian or Pacific Islander (note: the figures represent only those reporting a single race). Among these veterans, there are several notable distinctions.

First, on average, veterans make $10,000 more per year than nonveterans and own 9 percent of all businesses in the United States. Still, roughly 8,000 veterans commit suicide each year, often as a result of an untreated mental health issue such as PTSD or other adjustment reactions. Close combat during war has been one of the major predictors of mental health complications among veterans. In addition, experiences of war and terrorism by civilians have been examined.

Most notably, the 9/11 attacks and the Oklahoma City bombing had enormous effects on survivors. A more recent American Medical Association study found that 11 percent of all New Yorkers showed symptoms of PTSD 2 months after the 9/11 attacks, which is almost three times the national average. Not surprisingly, this was found to be heavily correlated with the amount of media coverage consumed. Also, the emotion found to be more common than anger among survivors is a pervasive fear of everything that begins to loom in the survivors' consciousness, beginning with their first awareness of their loved one's death and persisting for several years or more.

International Survivors of War and Terrorism

International political conflict is quite prevalent, with several wars occurring in various locations around the globe at any given time. Cultural, social, economic, and political factors all impact survivors of these conflicts in a myriad of ways. For example, in an individualistic culture like the United States, in terms of health care and adjustment support, more attention may be paid to the individual who survived, while in a collectivistic culture like Japan, the recovery focus will likely be on the larger group. The culture in which survivors are living may greatly impact the experience of recovery.

The era in which the violence occurred may play a large role. Rwanda's genocide occurred in 1994, and in the aftermath of the enormous national trauma, a progressive form of transitional justice was used: the Gacaca Courts. The Gacaca Courts system was a process of justice rooted in the notion of reconciliation and unity for all Rwandans. Similarly, independent nongovernmental organizations (NGOs), nonprofit organizations (NPOs), national governments, and internationally recognized entities such as the United Nations (UN) have examined survivors of the Holocaust, the Khmer Rouge, and Sudan's Civil War, among others, revealing widespread and prolific experiences of suffering, migration, displacement, and grief following these major traumas.

Community Engagement and Intervention

The role of the community in recovering from war or terrorism plays a crucial role in survivors' lives. There are several engagement and intervention models that have been used in various communities, yet many overlap with some basic ideas related to developing multilayered approaches, considering social ecology, increasing community competence, fostering a sense of safety and calm, and valuing connectedness. Nearly all models argue for several phases of recovery. More specifically, the project on trauma, peace building, and development initiated by the International Conflict Research Institute (INCORE) generated several recommendations for psychosocial support and transformation including, but not limited to, creating historical and intergenerational awareness, supporting livelihoods and economic initiatives, taking into account the valuable role of dialogue, the interconnection between psychosocial support and peace-building efforts, and avoiding the narrow focus of the individual trauma and instead focusing the collective strengths. Needless to say, communities and thoughtful interventions play a crucial role in helping survivors reacclimatize in society.

Unfortunately, survivors of war and terrorism are not uncommon, with local and global political violence impacting millions of individuals domestically and internationally every year. Some estimates suggest that terrorism is likely on the rise, yet it is hard to predict the future in this realm. Still, the experience of war or terrorism is harsh for many survivors, and individual and community intervention is almost always necessary to provide the needed support required by these vulnerable populations.

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See Also: Children and War; Department of Health and Human Services, U.S.; Displaced Persons; Holocaust Survivors; Military Veterans; National Institute of Mental Health; Office of Refugee Resettlement; Rape as an Instrument of War; Torture, Survivors of; Veterans Services.

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War on Poverty Programs

The war on poverty began in the 1960s, and as legislation was implemented, programs developed, and staffing needs were met by skilled human service workers. Diverse populations and relevant social issues were addressed creating a range of solutions and service providers.

In 1963, President John F. Kennedy asked his advisors to prepare a legislative agenda to address poverty. During his 1964 State of the Union address, President Lyndon B. Johnson declared: “Unfortunately, many Americans live on the outskirts of hope—some because of their poverty, and some because of their color, and all too many because of both. Our task is to help replace their despair with opportunity. This administration today, here and now, declares unconditional war on poverty in America. I urge this Congress and all Americans to join with me in that effort.”

The call to action suggested that society should not just deal with the symptoms but rather attack poverty at its roots through improved educational opportunities, health care, and job creation. President Johnson set in motion the largest package of legislation to deal with poverty and unemployment since Franklin D. Roosevelt’s (FDR) New Deal legislation to counter the effects of the Great Depression. The war on poverty legislation and the Civil Rights Act of 1965 formed the basis of the Great Society domestic programs of the 1960s.

Legislation and Programs

Four pieces of legislation are identified with the war on poverty: the Economic Opportunity Act of 1964, the Social Security Act of 1965, the Food Stamp Act of 1965, and the Elementary and Secondary Education Act of 1965.

The first piece of legislation was the Economic Opportunity Act of 1964, which created the Office of Economic Opportunity (OEO). The OEO provided state grants to establish antipoverty projects, which resulted in numerous education and work training programs, many of which continue to today. Job Corps provided work, basic education, and training for young men and women, while Neighborhood Youth Corps provided work and training for those from impoverished families and neighborhoods. Work Study funded grants to colleges and universities for part-time employment of students from low-income families to help them finance their educations.

Urban and Rural Community Action provided financial and technical assistance to local projects for community-based activities that included the participation of poor individuals. Adult Basic Education programs focused on teaching reading and writing in English to improve job opportunities. Investment incentives provided small business loans. Funding was provided for demonstration projects to provide training and work opportunities to individuals who were poor or receiving public assistance. Volunteers in Service to America (VISTA), envisioned as the domestic Peace Corps, trained volunteers for public agencies or private nonprofit organizations. Young people were given the opportunity to see and combat poverty at the community level. In the summer of 1965, Project Head Start began as an 8-week OEO program designed to help break the cycle of poverty by providing preschool children of low-income families with educational enhancement to reduce the achievement gap between poor and middle-class students.

The original Social Security Act of 1935 was part of FDR's New Deal legislation to eradicate poverty among retired workers. The Social Security Act of 1965 created Medicare and Medicaid, the first federal programs to provide health care to the elderly and the poor. Both were seen as alternatives to universal health insurance for all Americans. Health care options for the elderly had been debated and various options proposed since the original 1935 legislation. Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid does not provide benefits for all poor individuals but only for those who fall into federally defined needy groups. States have the option of offering Medicaid assistance to additional individuals.

In 1961 President Kennedy signed an executive order to expand food distribution to the poor, and in 1965, President Johnston signed the Food Stamp Act to make these food projects permanent. Administered by the U.S. Department of Agriculture, its goals were to strengthen the agricultural economy and provide improved levels of nutrition for low-income households. The income levels established for eligibility for this program were set higher than other welfare programs and allowed many low-income and working-poor families to subsidize their food budgets when they did not qualify for other welfare programs.

The Elementary and Secondary Education Act of 1965 promoted equal access to education and established high standards and accountability. Title I provided funding to schools and school districts, with a high percentage of students from low-income families, to develop programs to improve academic performance. This legislation was revised by the Education Amendments of 1972, which instituted Title IX, prohibiting discrimination on the basis of sex in educational institutions receiving federal aid. In 2002, it was reauthorized by Congress as the No Child Left Behind Act (NCLB).

Diversity and the War on Poverty

President Johnson also signed the Civil Rights Act of 1964 to eradicate racial discrimination, which allowed many African Americans to take advantage of federal and state programs. According to Joseph A. Califano, Jr., a former U.S. Secretary of Health, Education and Welfare, Johnson's Great Society legislation has been credited with reducing the national poverty rate from 22 percent in 1963 to approximately 13 percent by 1970.

At the time of the war on poverty, the poverty rate for African and Latino Americans was higher than for non-Latino whites and Asian Americans. The legislative programs that composed the war on poverty were very effective in reducing the rate of poverty for African and non-Latino white Americans. The percentage of non-Latino white Americans living at or below the poverty rate dropped from 18.1 percent in 1959 to 9.1 percent in 1969; similarly, the rate dropped from 55.1 percent to 32.2 percent among African Americans, according to the U.S. Census Bureau. Unfortunately, data was not collected on poverty rates for Latino or Asian Americans until later. By 1972, the poverty rate among Latino Americans was 22.8 percent, and the earliest data on Asian Americans, in 1987, was 16.1 percent. Poverty continues to reflect racial disparities in the United States.

The war on poverty, coupled with the Civil Rights Act, allowed many African Americans to have access to public welfare, education, and job training programs. Barriers were removed that had historically prevented many from participating in federally funded programs, and many settings became racially integrated.

The new and expanded programs required staffing by human services workers holding vocational training certifications, high school diplomas, and associate's or bachelor's degrees. Participants in many job training and educational programs were able to get off of welfare and continue their educations, eventually entering the human services fields as paraprofessional or community workers. Because many of the participants in the war on poverty programs were members of minority groups, this brought staffing diversity to agencies and programs.

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See Also: Education for Diversity in Human Services; Equal Opportunity and Civil Rights; Head Start and Prekindergarten Programs; Poverty.

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Welfare Reform, Role of

The Great Depression was the most traumatic phenomenon that America experienced during the 19th century. During the Great Depression, our traditional faith in ourselves was badly shaken. We came to the realization that government intervention was needed to effectively counter life's blows. The 1920s decade was largely a time of prosperity in the United States. Then in October 1929, the New York Stock Exchange crashed. Many investors lost their businesses, homes, and life savings. The number of people who were unemployed rose from 3 million in the spring of 1929 to 15 million in January 1933. Many banks closed as farmers and business owners went bankrupt. In some states, relief efforts were launched to provide assistance for the millions of people who were poverty stricken as a result of the depressed economy. However, only 40 percent of the population received some type of aid.

In 1932, Franklin Delano Roosevelt was elected president of the United States. Roosevelt instituted emergency legislation that provided assistance for the jobless and poor. He also admonished the legislature to review the constitution and remember its responsibility to provide for the welfare of each American. The states were the conduits through which federal dollars would flow to provide for those affected by the economy's depressed state. Programs such as the Works Progress Administration, a workforce program in which Americans obtained employment through state, local, and the federal government were established. Low-interest loans were given to farmers and to small business operators to regain entrepreneur status, and it also gave them an opportunity to hire those who did not have federal jobs. Programs were also designed for youth that provided resources for college and employment training.

Today, fewer people are staying on welfare, and fewer are applying for benefits. Several state evaluations of the welfare reform program indicate that many welfare recipients have foregone cash payments for paychecks. Of course, there is ample room for debate over what constitutes a decent job and self-sustaining wage. Further, initial studies show that, while most people who left the welfare rolls found jobs, about one-third of the recipients could not obtain employment. Research intimated that the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which replaced Aid to Families of Dependent Children (AFDC) with the Temporary Assistance for Needy Families (TANF) program, made the massive contemporary experiment possible in accessing the role of welfare reform in society. TANF strictly limits the number of months a family can receive cash aid. Welfare under TANF became a block grant to the states instead of an entitlement, allowing states to set work requirements and to sanction citizens who were not willing to meet them. Simply put, welfare reform was designed to move people from dependence to self-sufficiency. The welfare reform law allows former welfare recipients to retain some of their cash assistance as well as noncash benefits such as health insurance and child-care services while making the transition into the workplace. The welfare program underwent many changes when TANF replaced AFDC. Under AFDC, women and children received cash and in-kind benefits, which provided their sustenance on a monthly basis. For more than 60 years, the federal government in cooperation with state governments provided cash and in-kind benefits to families who met certain eligibility requirements.

In order to obtain the cash and in-kind benefits from AFDC, however, a family had to qualify for this assistance by meeting certain rigid eligibility requirements. For a family to meet these requirements, applicants should demonstrate that they were the custodial parents; that they were unemployed; and that their children were under the age of 18. Families had to be literally penniless to qualify for assistance. Families were cleared for assistance only after they were cleared by a state welfare worker. It is interesting to note that, after qualifying for the resources, the recipient was then restricted from working to earn any additional income. This self-defeating regulation virtually guaranteed that a family would stay on welfare and would remain poor.

Under the new law, TANF limited the number of months a family would receive welfare assistance. Another major change was that recipients were now required to work in order to receive cash and in-kind benefits. Also, in an effort to gain cooperation from state governments, the federal government gave the power to the states for the management and operations of the new reform programs. Under the reform rules, each state would now be responsible for developing workforce programs that would equip their constituents with employment skills and provide jobs when these skills were actualized.

In the state of Georgia, Governor Zell Miller began to look at the bulging welfare rolls. In 1995, there were 150,000 active cases in the state. Initial steps were taken to connect welfare benefits to personal responsibilities and work. Legislation was submitted by Governor Miller and was passed by the Georgia general assembly, which established a family cap on the number of months a parent could receive benefits. An employment requirement was instituted that sanctioned able-bodied recipients, with no children under the age of 4, who quit or refused to take a full-time job. Eligible teenage mothers were forced to live with their parent or guardian before they were eligible to receive services. Georgia was one of the nation's first states to target TANF recipients who reached the end of their assistance through its Good Works Program. In 1997, the number of adults on assistance dropped from 84,801 to 57,236. This was a reduction of about 33 percent. However, celebration of the success of this decrement was short-lived when the financial solvency of the U.S. economy took a nosedive. Corporate moguls over the years concocted elaborate fiscal schemes through stocks, bonds, and subprime loans. These actions precipitated a domino effect that caused the collapse of the economy. Highly skilled individuals who lost their jobs in corporate America and local midlevel positions moved to service areas. This action closed opportunities for TANF recipients as employers opted for hiring highly skilled employees for lesser pay.

The implementation of a workforce development program was put forward as a way to help these new welfare reform workers adjust to the new requirements of the new law. Workforce development was designed as a multifaceted approach, which addressed the range of factors impacting the ability of individuals of various classes, specifically former welfare recipients, and their ability to function on a job. The Workforce Development Program instituted a systems perspective. Unlike more traditional approaches, it was broad and comprehensive rather than just addressing education and the training of individual frontline workers. The primary aim of the Workforce Development Program was to facilitate change and to help sustain a welfare-to-work, or TANF, workforce. Methods utilized were formal education, training, workplace training, mentoring, supervision, on-the-job training, online training, and best practice guidelines.

Collaboration between welfare and workforce development agencies has increased since the implementation of welfare reform, the Welfare to Work Grant program, and the Workforce Investment Act. The welfare and workforce development system has proven to be an effective system of employment and training services for welfare recipients. Different patterns of coordination and integration have emerged on the state and local levels in response to the flexibility afforded by the TANF program. The Personal Responsibility and Work Opportunity Reconciliation Act, the Workforce Investment Act and legislation authorizing the Welfare to Work Grant program created new opportunities and incentives for collaboration. However, in 2007, America faced a general slowdown in economic activity, a downturn in the business cycle, and a reduction in the amount of goods and services produced and sold. Furthermore, in 2011, states implemented some of the harshest cuts in recent history for many of the nation's most vulnerable families with children who were receiving assistance through the federal TANF block grant. The cuts affected 700,000 low-income families that included 1.3 million children; these families represented more than one-third of all low-income families receiving TANF nationwide.

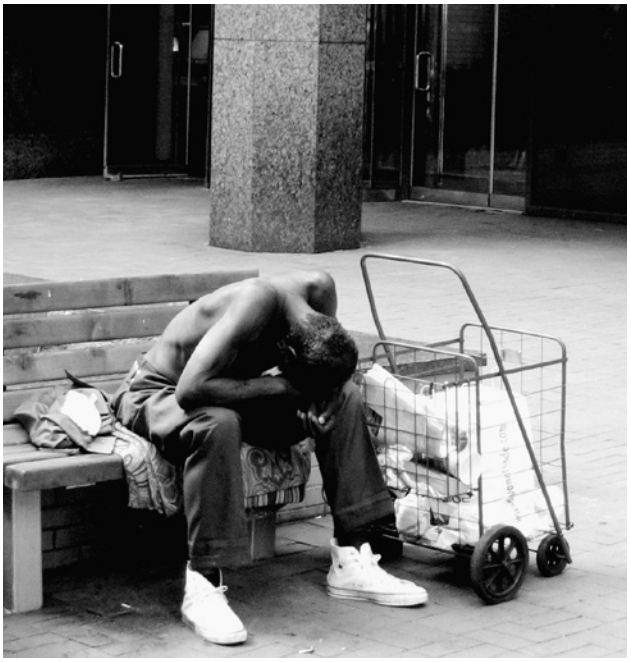
Finding jobs for welfare recipients presented another problem. Communities discovered that this was not an easy task because most of the welfare recipients had virtually no job skills and required extensive training. As a result, most of the recipients were placed in low-paying service jobs that had little to no opportunity for promotions and very little chance for a successful work experience. Also, communities discovered that many welfare recipients were not suited for any type of job because of their low educational attainment. Because of their lack of education, even jobs available to former welfare recipients were dead-end, low-paying positions that offered little chance for a satisfactory job experience.

Welfare recipients represent a large segment of the nation's population and a large portion of the nation's budget. Single adults, mostly mothers, are the head of about 70 percent of all the households who were receiving assistance from TANF. The rest of the families, or about 30 percent, are composed of two-parent families or children living with an adult caretaker not included in the welfare grant. The average monthly TANF payment amount per family in 1997 was about $362, which was about one-third of the amount of the federal poverty line for a family of three. Welfare recipients often face personal or family challenges that make it difficult for them to switch from welfare to work. One survey indicated that 44 percent of parents on welfare experienced significant obstacles to work. These obstacles included but were not limited to remedial levels of education, lack of work experience, caring for young or disabled children, lack of day-care services when employment was obtained, and very poor mental or physical health. An even greater problem was that many of the TANF recipients were unhappy with the jobs they had acquired from their state social service agencies under the new welfare reform programs.

Additionally, a number of states have cut cash assistance deeply for families that already live far below the poverty line, ended it entirely for many other families with physical or mental health issues or other challenges, or cut child care or other work-related assistance that make it harder for many poor parents fortunate enough to have jobs to keep them. At least five states—California, Washington, South Carolina, Wisconsin, and New Mexico—and the District of Columbia have cut monthly cash assistance benefits for TANF families, reducing already very low benefits. These cuts are pushing hundreds of thousands of families and children below, or further below, half of the poverty line. Many of the cuts run counter to states' longstanding approaches to welfare reform. For example, some states that had provided support to poor parents working in low-wage jobs have abandoned those policies. Similarly, states have shortened their time limits, eliminated some bases for extensions or exemptions, and applied these changes retroactively. As a result, states have terminated or reduced benefits for some of the most vulnerable families.

The initial premise of welfare reform was to break the cycle of poverty and end generational welfare dependency in America as outlined under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. It was largely dependent upon former welfare recipients successfully finding and keeping permanent jobs. The evaluation of the welfare reform program has focused on how well business employers are able to relate to and accommodate former welfare recipients as new employees in the workforce and decrease the number of individuals who have been recipients of these benefits throughout their family life cycle. However, because of the recent cuts in the federal budget and the ever-increasing unemployment rate, analysts have found that many of the strides made in removing welfare recipients from the federal and state apportionments have flip-flopped the economy into a menagerie of sorts because now there are now more people in poverty due to the loss of their income as a result of the recession. Those who are not eligible for the monthly benefits provided by the social welfare system are now applying for food stamps and general assistance (GA) after passing through an eligibility or means test.

Studies concerning welfare reform are limited to analyzing the need for welfare for those individuals who are considered poverty stricken. The decision by the government to place the responsibility of the care of its constituents on the states is a major departure from contemporary welfare and appears to be returning its attention back to rugged individualism. Also, the changes caused by welfare reform have shifted the way research is conducted. In analyzing the role of welfare reform, it is important to note that society has shifted from an environmental reform approach to more technological reform. Life is interpreted through images and sound bites. In answering this question it is important to keep in mind the following: (1) Research is encouraged in order to develop baseline data on the former welfare recipients who were participants in workforce development and other programs. (2) Policy makers encourage the use of research of the workforce development programs to find out what part of the program was successful and how could they improve on meeting the needs of the indigent and those who are displaced in the job market. (3) Programs should be developed to deal specifically with research findings related to welfare reform and workforce development. (4) Human services professionals can become advocates for this population group to insure that they receive adequate training in addition to job referrals and placements.



A homeless man on a New York City street. While the initial premise of welfare reform was to break the cycle of poverty, it was largely dependent on recipients finding jobs.

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See Also: Aid to Families with Dependent Children, Historical Role of; Personal Responsibility and Work Opportunity Reconciliation Act; Temporary Aid to Needy Families.

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Western Communities and Cultural Competence

Western communities include, broadly, those of Europe (especially western Europe and in some contexts, the differences with eastern Europe are relevant) and the countries formed in large part by European immigration and colonization, such as those of the Americas, Australia, New Zealand, and South Africa. Though much of Africa is as far west as much of Europe, Africa is usually not considered part of either the West or the East (which generally refers to Asia). Western communities share a cultural heritage in which Christianity and Judaism, the philosophers and political traditions of the ancient Mediterranean world (especially Greece and Rome), and the arts, sciences, philosophy, and political thought of the Renaissance and Enlightenment have all played formative roles, as have the Scientific Revolution, the Industrial Revolution, the Catholic Church, and the early Protestant denominations in shaping European history, and the economic, political, and cultural effects of the age of discovery and colonization.

Though there are clearly many differences within Western culture, and within any given Western culture there are great differences of opinion and of values, when we speak of Western culture, we speak of the cluster of facts, events, associations, works of art and writing, scientific and political traditions, and other cultural elements that provide a common frame of reference. This frame of reference includes a tradition upholding the values of rational thought (and the scientific method), human rights, equality and equal justice, democracy, fairness, free thought, the separation of church and state, and a respect for the variety of cultures and faiths in the world. It also includes a history of racism, sexism, cultural imperialism, and economic exploitation, and many important modern features of Western culture developed in response to these ills.

Culture is a messy concept. Any individual is a member of multiple cultures. In addition to being an American and a resident of South Carolina, she may be a Red Sox fan, a Wellesley alumna, a progressive Democrat, a Daughter of the American Revolution, a debutante, a Methodist, a feminist, a graduate of the Iowa Writers Workshop, a poet, a blogger, a hipster, a mother—all descriptors that refer (or can refer) to membership in some larger group with its own traditions and values, its own sense of itself, and what is or is not a part of itself. Some of these cultures loom larger than others: Being a Red Sox fan may not make her any less able to relate to other Americans, but attending two prestigious college programs and having time to spend on low-paying work like blogging and poetry despite having at least one child to raise may make it difficult for her to relate to migrant workers with poor English fluency who send most of their income home to a family they only see for a few months a year.

Cultural competence is the ability to interact with members of other cultures in a way that is respectful, effective, and meaningful without adopting stances like culture blindness, which claims to ignore differences and deal only with the individual without acknowledging that culture impacts not only what sort of individual we are but also how we conduct ourselves, how we communicate, and how we expect to be communicated with. (Just as color blindness with respect to race often means treating others as though they were white, so does culture blindness often mean treating others as though they share one culture, which is not as productive as the "culture blind" may believe.) Cultural competence is important for everyone, particularly as the United States becomes less predominantly white and globalization and the Internet increase contact and communication among people in far-flung corners of the world. But, it is critical for people working in human services because that increasingly diverse world means that it is more and more likely that, in any worker–client combination, there will be some cultural difference. The nature of human services work is such that failing to negotiate with this difference, failing to effectively engage and communicate with the client, is a serious problem and may be serious enough to prevent any work from being done.

Working with a victim of domestic abuse, for instance, requires understanding the norms of the victim's culture (and of the perpetrator's culture) in order to know which questions to ask, which signs to look for, and which responses to expect. Cultural norms have successfully been used as a defense in domestic violence cases by Asian immigrant defendants; for instance, the court upheld the idea that, if physical discipline of a wife was the norm back home, it did not become abuse when transpiring in the United States. This is not to say such a view is acceptable—no matter the court decision—only to underscore the cultural differences that arise when dealing with issues like gender and violence. An abused wife may not identify with the idea of being the victim of abuse if she has been raised to expect it, which does not excuse it, but means that the abuse is likely to continue or go unpunished if the human services worker is not competent enough to bridge the cultural gap in order to meaningfully work with the victim,perhaps the abuser, and their family and community. At the same time, cultural competence means avoiding false positives in detecting such problems: The red marks on a minor patient's skin may look like physical abuse but be the result of a coin harmlessly rubbed on the skin, a cultural practice for treating fever. Other symptoms may be the result of side effects of home remedies that should be discontinued but do not constitute abuse.

Cultural competence should not be confused with linguistic competence, and it is not a service that can be provided by an interpreter; often competence means knowing when one's own fluency in a second language is insufficient and a more fluent interpreter should be called upon, but simply interpreting dialogue is not sufficient to confer cultural competence.

Textbook examples of cultural competence in a service context frequently refer to health care examples because health care is the field that has pioneered implementing cultural competence in workers. Community health centers first developed culturally competent care programs in the 1960s. Urgent care facilities in New York City, for instance, have a long history of serving a population with incredible cultural, religious, ethnic, and linguistic diversity. The Ryan-NENA Community Health Center in New York's Lower East Side has developed a cultural competence program that has in turn been used as a model for a proposed cultural competence program for Denmark's universal health care system. Staff at Ryan-NENA are almost all bilingual, and community needs assessments are performed on a regular basis.

But, cultural competence is not limited to health care either. The American Library Association lists 11 standards in its guide to cultural competence: cultural awareness of self and others; cross-cultural knowledge and skills; organizational and professional values; development of collections, programs, and services; service delivery; language diversity; workforce diversity; organizational dynamics; cross-cultural leadership; professional education and continuous learning; and research.

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See Also: Acculturation; African Americans; Alaskan Natives; Arab Americans; Asian Americans; Assimilation; Biculturalism; Cuban Americans; Cultural Competence, Human Service Providers and; Cultural Competence, Training in; Cultural Literacy; Culturally Specific Services; Dominican Americans; Ethnicity and Clients; Ethnocentrism; European Americans; Haitian Americans; Hawai'ian Native Americans; Hispanic Americans; Mormons; Muslim Americans; Pacific Islanders.

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White Privilege

White privilege describes unearned advantages afforded to people who are assumed, based largely on complexion and specific physical features, to be of European, especially western European, ancestry. The concept of white privilege emerged from within critical race theory (CRT), a branch of jurisprudence that argues race-based (and other) preferences are embedded in societal laws and policies rather than merely a function of discrepant interpretation and enforcement of these directives. CRT scholars assert that justice (meted out via societal rules) has never been blind, neutral, or objective, but because it is touted to be all of these things, it favors people who are, or are presumed to be, white by enabling political and economic systems and corresponding power structures to grant only these people unmerited and simultaneously unacknowledged advantages. At the same time, these systems and structures disadvantage people who cannot pass as white while simultaneously denying that such institutional disadvantage is occurring and asserting that challenges these people experience are a function of their individual or group (often characterized as cultural) deficiencies.

In the 1990s, CRT began to be formally extended from law to other fields of study, including human services. As a result, the manners in which white privilege operate in society have been further explicated. From a human services work perspective, white privilege can be understood as the standard against which so-called normal human functioning is measured. Inherent, but often undeclared, in this work is the focus on the individual rather than on groups or communities in the context of a competitive rather than cooperative or collaborative social order. Because white privilege erroneously promotes the ideal that white people function independently (as individuals), at the same time that it affords only white people various forms of assistance (based on group membership), people of color are more likely to be judged as functioning abnormally because they are both visibly identifiable as nonwhites (a group) and also often consciously identify themselves as members of various other groups and because they often prioritize alliance-oriented approaches in pursuing the activities of daily living (ADLs) at the focus of human services interventions.

Illness in Man or Society

In the 1960s, progressive social scientists began asking whether madness originated in humans or society. Was mental illness a function of human biological predisposition or social maladaptation, or was society itself sick, thus were people deemed unwell actually expressing what could be understood as normal (adaptive) responses to a dysfunctional system? If the latter, then people deemed well had to be undertood as, in fact, mentally ill in that they failed to express recognition of societal malady.

This line of inquiry led to the development of racial identity development models, which examined the manners in which the self-concepts of white and black peoples, born into institutionally racist societies, are systematically differentially impacted. Inherent in these models (and others that have been developed since) is the argument that racism (among other forms of discrimination) is a sickness that infects both agents and targets of it. However, when racism is codified in a society (as opposed to simply being expressed between peoples engaged with one another on more or less equitable footing), the sickness of the dominant group is, through white privilege, rendered invisible, and that of the nondominant group is amplified.

Medical scientists have consistently maintained that mental and physical illnesses are the function of physiological imbalances in human biology that can be corrected with medication or behavioral modification. While these scientists use the phrase *allostatic load* to describe the wear and tear on the body produced by chronic exposure to stress, they pay only limited attention to the idea of institutional racism as a chronic stressor that disproportionately impacts racial minorities.

Multicultural Transformation of Human Services Practice

While individual human service workers cannot change larger societal biases that more negatively affect some of their clients than others, they can alter the perspectives from which they engage their work and, in so doing, enable their clients to secure more durable solutions to life challenges. Toward this end, beginning in the 1970s, a degree of multicultural consciousness has emerged in the literature and practice deriving therefrom in various human services-related fields. Largely well-meaning, this work has been framed in terms of working with the culturally different, or the diverse client, or multicultural populations.

While these orientations are a step in a positive direction, they continue to center whiteness as the point of reference from which most of the work is being done. That is, the white client and her or his culture are still, at least implicitly, the covert norms against which so-called cultural difference is being recognized. Further, white clients are not typically included in the pool of clients named diverse or multicultural. As a result, there is an implicit bias, still eminanting from white privilege, that continues to regulate the work. According to this bias, white clients are just clients, and thus, the nature of human services work with them is just work. In contrast, racial minority clients are, on the one hand, made unique, often even to the point of being seen as exotic and, on the other hand, reduced to a monolithic, often still deficit other.

While the manners in which people of color are being engaged as clients in human services work are beginning to trend toward a more sociopolitically located or socially just frame of reference, there is work still to be done to more effectively extricate this work from its historical tethering to institutional racism and white privilege. Foundational to this effort are the needs to: (1) better prepare human service workers to understand how power relations function in the work for individuals, groups, and society at large; and (2) proactively recruit and retain people of color as researchers and practitioners in human service fields. It is imperative that white people and culture, and related mental and physical health needs, can be examined in human services work as pathological and deficit at the same time that people and cultures of color, and corresponding comprehensive health care requirements, are considered through myriad human service work lenses that uphold them as models of health and well-being, thus models to which white society should aspire.

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See Also: Bias in Service Delivery; Changing the Client Versus Changing the Environment; Critical Race Theory; Cultural Determinism; Discrimination and Institutional Racism; Ethnocentrism; Institutional Oppression; Melting Pot Theory; Monoculturalism; Race, Social Definition of; Race and Clients; Racial Identity Development, Models of; Reverse Discrimination; Social Darwinism.

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Women, Battered

A battered woman is a woman who experiences physical and psychological abuse within a romantic relationship. Interpersonal violence is observed worldwide; however, it occurs more frequently in some cultures than in others. In these cultures, violence and the violent treatment of women may be socially condoned either directly or indirectly. Interpersonal violence also occurs across socioeconomic groups, with more reported violence occurring within lower income groups. Most of the interpersonal violence studied occurs in heterosexual relationships; however, some lesbian and transgender people also batter their female partners.

Battering Relationships

Battering relationships can be distinguished from nonbattering (but also violent relationships) by several characteristics. In battering relationships, the violence is conceived as the means a batterer uses to exert power and control over his partner. In the United States, many women describe the early development of the battering relationship in similar terms. Often, the relationship with the batterer develops quickly, and the batterer develops a rapid and intense affection for the female partner. Over time, the relationship changes, and the batterer may become jealous, controlling, or volatile. The batterer may or may not express remorse for early episodes of physical or emotional abuse, but most often, the violence is minimized and excused. Over time, the violence or psychological abuse used against the partner tends to become more frequent and severe. The term *cycle of abuse* is used to describe abusive relationships that are characterized by periods of relative calm, increasing tension, and an eventual violent episode, sometimes followed by a honeymoon period, where the batterer expresses remorse. Not all battering relationships fit this pattern, and patterns can change over time.

Across the globe, battering most often consists of a combination of physical violence, maltreatment, and psychological abuse inflicted upon a partner. Physical abuse ranges from behaviors unlikely to cause lasting harm, for example, pushing, shoving, or restraining, to violence causing a need for emergency medical treatment. Violence causing severe damage, disability, or death is possible. Many abusers engage in sexual abuse, including harm to breasts and genitals, vaginal or anal rape, and genital mutilation. Maltreatment and psychological abuse may consist of the battering partner's engaging in behavior designed to create humiliation, shame, intimidation, or fear in the victim and often involves threats of violence or the implication of threats of violence to the partner or others (children, pets, or other loved ones). The batterer may try to isolate his partner from any and all sources of support and independence and monitor and control avenues of communication, transportation, finances, and connection with others. Batterers may stalk their partners to observe their behavior using a variety of means. Batterers may also engage in inconsistent behaviors, sometimes behaving in loving and supportive ways, at other times, withdrawn, rejecting, demanding, or inconsolable and dejected. A common thread is often the implication or direct message that the battered partner is the cause of the distress.

Some controversy exists in the study of interpersonal violence as to whether heterosexual women are more often battered by their male partners, engage in mutual violence, or initiate violence. In the United States, some research has found that female heterosexuals engage in individual acts of violence at rates higher than or equal to their male partners. International research examining rates of female-initiated violence indicate a small percentage of women initiating violence. Most experts in the field of domestic violence agree that women are less likely to engage in battering behavior. Some point out that women generally cause less injury when they are violent and are harmed more frequently by violence because of their generally smaller size and reduced muscle strength as compared to males.

Effects of Being a Victim of Battering

Battered women may experience many consequences as a result of the abuse they endure. Women in ongoing violent relationships may experience physical harm from injuries, disease, and malnutrition. They are also likely to experience mental health difficulties, including traumatic stress-related disorders, alcohol and other substance use disorders, anxiety disorders, depression, suicidal thoughts and behaviors, and an overall poor quality of life. Women who are currently in, or have recently left, an abusive relationship report more mental health difficulties as compared to nonvictimized women. Research indicates that women with a past history of a single abusive partner do not seem to differ from women who have not experienced an abusive relationship and will likely recover well psychologically. Research has also found an association between the number and severity of symptoms experienced by the survivors and the duration and severity of abuse suffered. Most negative mental health outcomes have been found for those who were abused by multiple partners or suffered severe abuse and experienced childhood trauma in some form.

Understanding Battered Women

Many factors contribute to the continuation of the relationship between a batterer and the battered woman. Early in the relationship, a woman may experience intense feelings of love and attraction for her partner; the batterer may appear contrite following violent episodes, blame the woman for relationship problems, and beg for love and assistance. The violence, which typically does not begin at frequent and extreme levels, may be perceived as unusual.

As the relationship progresses, the attachment between the batterer and the battered woman may grow, and the partners' social lives, finances, families, and domiciles become common. They may share children and have legal status as married partners. The more intertwined the partners' lives become, the more difficult it is to contemplate ending the relationship. In some cultures, divorce is very uncommon or comes with significant social and financial consequences. The battered woman may accept some degree of responsibility for the violence, rationalize and minimize its effects, and perhaps perceive it as a normal occurrence. Battering may be perceived as beyond the batterer's control and the batterer perceived as a "good" person who does not mean to do harm. In some battering relationships, the battering partner's abusive behavior occurs primarily under the influence of alcohol or other drugs, and the battered women may perceive that she has no control over her partner's behavior.

The coping strategies battered women use to endure the abusive relationship may paradoxically contribute to increased difficulties in leaving the relationship. Abused women often focus upon fulfilling the wishes or demands of the abusive partner in an effort to maintain calm and good relations. Concentrating upon trying to keep the abuser happy or calm may become the dominant goal of a woman's life. Women who use alcohol and other drugs or exhibit excessive work, food, or other behaviors usually intensify these behaviors in an effort to cope with the stress of the abusive relationship. These behaviors may serve to numb, distract, or calm the abused partner and may also make it more difficult for her to realistically appraise her situation. Women who have experienced extreme abuse interspersed with periods of good treatment may develop a traumatic attachment to their partner. Other women may believe that they can never leave the abuser or find someone better and have a profound resignation and helplessness. Leonore Walker used the term *Battered Woman Syndrome* to describe women who developed posttraumatic stress disorder (PTSD), and she described a pattern of physical and psychological symptoms in response to exposure to relationship violence.

Those who are poor, live in rural areas, are immigrant, lesbian or transgender, elderly, very young, mentally or physically disabled, or women of color often face additional obstacles in coping with and trying to leave an abusive partner. These obstacles include but are not limited to financial dependence upon the abusive partner, dependence upon the partner for care, fear of deportation, fear of racist or sexist treatment, fear of judgment for sexual orientation or transgender status, fear that abuse will be discounted or minimized, fear that the abuser will suffer harsh treatment, lack of knowledge of and ability to access services, or the absence of any support services.

When an Abused Woman Leaves Her Abuser

Battered women attempting to leave an abusive relationship may face enormous obstacles, including lack of social support, lack of money, and condemnation from friends, family, and religious authorities. Additionally, abusers often become increasingly violent and controlling when their partner attempts to leave them. Some will attempt to thwart or sabotage any attempt at independence. Threats to injure or kill the battered woman, her family, pets, or their children are common. The batterer may threaten or attempt suicide or stalk, harass, or try to woo their partner to return. Despite this, women can and do leave abusive relationships. Several factors are considered facilitators for this process. Many formerly abused women describe their concern for their children's welfare as a primary stimulus to leaving an abuser. Some women leave when there is an increase in the level of violence in the relationship, they have better financial resources, they give up on the relationship, or the battering becomes public in some way.

In the United States, many battered women eventually leave their abusive partners, although some may leave and return to the battering partner several times. Many communities have shelters, counseling, legal aid, and other services to aid in their departure and recovery. Internationally, many countries do not have specialized programs and services for battered women, and some may turn to their families or religious leaders for assistance. Unfortunately, in many countries where battering occurs in a marriage, battered women may find little support or be blamed for the violence.

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See Also: Domestic Violence; Domestic Violence, Victims of; Family Violence Prevention and Services; Interpersonal Violence.

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Women Minorities

Women of color is a broad category of women that includes nonwhite women and multiple racial and ethnic groups in the United States, according to L. Cornelius and colleagues. The category includes but is not limited to African Americans, Asians or Pacific Islanders, American Indians, and Latino women. Women of color experience a lower quality of life, shorter life expectancy, and higher rates of a many chronic disease states, including cardiovascular disease (CVD), diabetes, and reproductive health. Women of color not only experience these diseases disproportionately but also experience reduced access to screening, linguistic, and culturally appropriate education and materials; lower quality of care; and higher mortality and morbidity rates, reports L. Mullings. Women of color represent more than half of all women in the United States, and therefore, the disparities experienced by this large group require that all health and social science research continue to explore how and why the health disparities are so great as well as what needs to be done to reduce if not eliminate the multiple health disparities. Social determinants of health, such as poverty, racism, and limited access to care, contribute to health outcomes, quality of life, and overall life expectancy of this group and serve as mediating and moderating factors that contribute to the disparities.

Cardiovascular Disease Among Women of Color

CVD is a collection of conditions that result in the abnormal functioning of the heart or blood vessels. It includes coronary heart disease, hypertension, congestive heart failure, congenital cardiovascular defects, and atherosclerosis, describes the Office of Research on Women's Health. The greatest risk factors for CVD are genetic predisposition, having diabetes, physical inactivity, obesity, smoking, and increased age. Genetics contribute to the risk of CVD; however, social determinants of health such as socioeconomic status (education, income, and wealth), health behaviors, and access to health care are the greatest predictors for CVD among women of color. Almost half of all women of color at or below the poverty line have little or no access to health care and underestimate their risk of CVD. Additionally, women of color experience higher levels of stress related to social bias, racism, and sexism that ultimately result in disproportionate mortality rates from CVD in comparison to their Caucasian counterparts, report V. Earnshaw and colleagues. Health and social science research focusing on identifying the unique signs and symptoms of CVD, how the social determinants of health contribute to the risk of CVD, and establishing best practices of prevention, treatment, and monitoring need to be further identified for women of color collectively and within each subcategory.

Diabetes

Diabetes is a disease identified by the presence of high levels of glucose in the bloodstream resulting from an insulin deficiency (type 1) or a rejection or insufficient production of insulin (type 2). Type 1 diabetes is an autoimmune disease where the insulin-producing cells of the pancreas are destroyed and insulin is no longer produced to properly metabolize sugar. Less than 10 percent of those diagnosed with diabetes have type 1, states the Office of Research on Women's Health. Therefore, 90 percent or more of all diabetes cases are type 2; the risk factors for type 2 diabetes are CVD, genetic predisposition, obesity, physical inactivity, and a history of gestational diabetes. Women of color are almost twice as likely to experience diabetes as Caucasian women; additionally, women of color have poorer outcomes and have a higher mortality rate from diabetes than Caucasian women.

The health disparity is glaring, and the social determinants of health prove to contribute a great deal to the risk, treatment, and outcome of diabetes among women of color. Social stress deriving from racism, sexism, and social bias, access to health care, and socioeconomic status predict a women's ability to manage diabetes as a chronic illness as well as her quality of life and health outcomes. As more and more people are diagnosed at younger ages with diabetes, the clinical treatment of the disease has improved; however, prevention and effectively managing the disease for better health outcomes remain a challenge among women of color. There is a need for more research in order to identify better prevention, education, and management of diabetes among women of color.

Reproductive Health

Reproductive health encompasses conditions and diseases that affect a women's ability to reproduce. The category includes breast and cervical cancer, low birth weight and infant mortality, sexually transmitted infections (STI), and human immunodeficiency virus (HIV), describes R. Webb. The challenge among women of color is access to reproductive health care, including annual gynecological exams, prenatal care, disease screening, and access to medically appropriate birth control. The greatest barrier to reproductive health among women of color is access to regular gynecological care. Early detection and treatment is also key to establishing positive health outcomes for the treatment of breast and cervical cancer, STI, and HIV. The diagnosis of reproductive disorders and diseases among women of color occur in later stages, resulting in more complications and higher mortality rates.

Women of color experience many diseases disproportionately, and also experience reduced access to screening, linguistic, and culturally appropriate education and materials; lower quality of care; and higher mortality and morbidity rates

Women of color are diagnosed with breast cancer less often than their Caucasian counterparts but have greater mortality. The prevention or early identification of STI can eliminate cervical cancer and reduce high-risk pregnancies and the occurrence of preterm labor and infant mortality. The barriers to reproductive health among women of color are multifaceted but include the social determinants of health, cultural and linguistic barriers, failure or delay to follow up on results, and lack of culturally and linguistically appropriate information and education. Reproductive health is culturally sensitive with a large social component; women of color report having negative experiences within the health care setting that result in delayed or lack of annual exams and follow-up report V. Earnshaw and colleagues.

Social and cultural paradigms hinder understanding, identification, and action. Although women of color may underestimate their risk of disease, there have also been systemic policies that, in the past, did not support women's health and contributed to poor reproductive health outcomes. Continued research and new educational platforms need to be established so women of color fully understand their risks and options for prevention and treatment in order to achieve and maintain reproductive health across the life span.

Conclusion

Women of color live with a menagerie of social challenges, stressors, and lack of understanding of health risks. The outcome has been health disparities, poor health outcomes, and reduced quality of life across the life span. Legislation, research, and cultural shifts are required to reverse the incidence of disease and early death among women of color. Education; access to prevention, including screening and timely, culturally, and linguistically appropriate care; and information and treatment are needed to reduce health disparities and improve the quality and span of life for women of color.

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See Also: Cultural Paradigms; Health Disparities, Role of; Social Determinants of Health; Social Work Practice and People of Color.

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Workplace Health Services

A company's human workforce is its most valuable asset. Even highly technical industries that rely on computerized equipment during production require a solid foundation of human capital to be successful. The provision of workplace health services by an organization helps to demonstrate a commitment to the wellbeing of its employees, thereby transforming the "most valuable asset" sentiment from rhetoric into practice.

There is neither a standard definition of what constitutes workplace health services nor a requirement in most jurisdictions for a company to provide services outside of its legally mandated health and safety obligations. However, many companies provide forms of workplace wellness programs, medical services, executive health services, and disability management to its workers as a total compensation benefit. Workplace health services is a term that captures a broader range or composition of benefits, whereas occupational health services is much narrower in focus.

At its fundamental level, a company's workplace health service will consist of an occupational health and safety department that provides emergency and standard medical care for occupational and nonoccupational injuries or illnesses. Typically provided by a registered nurse, services may include workplace hazard screening, ergonomic assessments, health education, stress management, blood pressure monitoring, allergy injections, and immunizations. In industrial settings, occupational health services may also offer proactive services such as respiratory fit testing, hearing protection, and air and water quality monitoring. These departments may also serve as a liaison with a company physician, the human resources department for injury and return to-work issues, and the risk management department when hazards are identified.

In many occupations, such as that of commercial pilot or oil field worker, a worker's participation in and satisfactory completion of regulated medical exams is required as a condition of employment. Companies in these industries will provide expanded workplace health services to ensure that these nonnegotiable testing requirements are met and that overall risk is mitigated. Additionally, many services are offered with the hope of preventing the development of chronic illnesses later in a person's career. These expanded health services will include mandatory physical, psychological, and drug and alcohol assessments but will also screen for cardiovascular risk factors, diabetes, concerns related to diet and exercise, and personal challenges that interfere with the quality of both work and home life.

Building on these services, many companies will offer senior executives an expanded health program as both an employment benefit and way of mitigating turnover, preventable death, and disability risks. However, these services are extremely comprehensive and offer testing that is extraneous to that offered by the government and most private insurance plans. As a result, from a business perspective, they are not cost effective and thus are reserved only for the most senior executives in large firms. Executive health services typically include diabetes, cancer, and cardiovascular screening; heart and lung function testing; nutritional assessments; bone density, vision, and hearing tests; complete blood and urinalysis; mole mapping; and, gait analysis. Outside of a clinic setting, health club memberships and a personal health coach may be provided free of charge. Health benchmark reports and accessible, online health records may be offered to the employee, along with an individual health and wellness plan. These services are more proactive than reactive, which is ideal in the long-term prevention of illness and disability. Unfortunately, they remain cost-prohibitive in a primarily reactive medical care industry, where only medically necessary treatment, not prevention, is compensable.

Finally, disability management services may be subsumed under workplace health, although they may be the responsibility of a company's human resources department rather than its occupational health department. Disability management services address absences from work that are the result of illness, injury, or disability, and strive to prevent recurrences that can negatively impact engagement and productivity. Access to an employee and family assistance program (EFAP) may be offered to help the employee adjust to the illness or disability and associated stressors. However, most employers now offer this service to all employees, regardless of classification, in recognition of the effects that personal and occupational stress can have on the person and the broader workplace. Disability management services often resemble case management in that an individual plan for accommodation is developed, which includes duty or scheduling modifications and a return to work timeline. The employer will also facilitate disability benefits and workers' compensation if the injury is work related.

Emerging models of workplace health and wellness are more holistic than those congruent with the traditional medical model of disability. Newer conceptualizations recognize the interactive impact that factors such as working relationships, the physical environment, the work–home life interface, and control and decision-making practices can exert on the workforce. They attempt to move away from individual pathology in favor of contextual approaches. They emphasize not only physical risks but also the psychological, social, spiritual, intellectual, and cultural components that promote a well workplace. Many are premised on principles of participatory democracy, encouraging shared leadership and decision making at all levels of an organization. Regardless of the industry, workplace health services recognize that workforce issues are as important as profit and productivity. The challenge now is to maintain the momentum toward holistic and preventive approaches to illness and disability that address environmental and individual concerns in tandem.

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See Also: Accommodation; Employee Assistance Programs; Reasonable Accommodations.

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Wraparound Services/Systems of Care

Wraparound services are a comprehensive plan of care integrating several services for an individual developed by an interdisciplinary team. Team members include the patient, caregivers, an advocate, a case manager, and service providers (e.g., educators and health professionals). The plan is tailored to an individual's need for care rather than being based on any type of standard care or theoretical model. Services are patient centered and designed to ensure that the patient's quality of life improves in one of several domains, including education, health, safety, social relationships, and so on. Two standards, with several core principles, are central tenets of the wraparound philosophy. The first standard defines the practice model, which focuses on engaging team members, preparing the care plan, implementing the plan, and developing a transition process to maintain care and service delivery when the wraparound process concludes. The second standard determines core principles guiding care, which include maintaining a team-driven process, ensuring that service provision meets individual needs, implementing flexible care plans based on the individual's strengths, utilizing natural and community supports for implementing culturally appropriate care, and evaluating the effectiveness of service provision. In communities where patients who have complex needs may not have access to diverse services, such as those residing in rural areas, wraparound plans can be an ideal. However, this approach can be time-consuming and expensive.

The wraparound approach has been at the forefront of mental health service delivery in the United States for children and youth with serious emotional and behavioral disturbances since the mid-1980s. The effectiveness of wraparound services for children with serious emotional and behavioral issues is mixed. In some studies, these services were more successful than comparison treatment programs, while in other studies, alternative treatments, such as those including family therapy, were more successful. Researchers have concluded that the effectiveness of wraparound services may vary based on the population served and the setting and conditions where these services are implemented. Key examples of successful wraparound services include the Kaleidoscope project in Chicago, Alaska's Youth Initiative, and Wraparound Milwaukie.

The system of care philosophy upholds the notion of developing a broad array of all services needed for individuals with special health and mental health care needs. A system of care ensures that a system exists, such that all individuals receive the most appropriate services to meet their special needs in the least-restrictive environment. The system of care philosophy could be interpreted as enlarging the wraparound concept on a large-scale level for populations with special healthcare needs. A system of care rests on several tenets, including interagency collaboration, knowledge and application of innovative methods of service delivery, patient- and family-centered care, patient and family involvement in care plans, culturally competent care and respect for diversity, and outcomes-based research to ensure that the service delivery system is functioning well and delivering cost-effective, high-quality services. Cultural competence and respect for diversity are defined at a broad level, incorporating responsiveness to ethnic, racial, and cultural differences of the population receiving services. Other key principles of systems of care are having screening mechanisms in place for early identification of individuals who might need services, providing case management to integrate the diverse array of services and individual needs, and advocating for community-based services and transitional services that will advance the individual to less restrictive care as functioning improves. In a system of care, the individual and family are at the hub of all activities. Often, a case manager may be needed to coordinate the broad array of services. Services that can be included to improve functioning vary based on individual needs but are grouped in many of the following areas: social services, mental health treatment, recreational planning, health and substance abuse services, and educational and vocational planning. The notion of social services comprises a vast array of services including, but not limited to, financial assistance, protective services and respite care, self-help and support groups, transportation, and legal services, states B. A. Stroul.

The federal government's Child and Adolescent Service System Program (CASSP) standards, which promote tailored programs to meet the clinical and systemic needs of the child and family through collaboration, coordination, and integration of services, has promoted key concepts synonymous with both wraparound services and the system of care philosophy. The objective of CASSP was to improve systems of care for children and families in their communities and in the least-restrictive environment. Systems of care can be successful for other high-need populations. For example, providing care plans for individuals experiencing mental health or substance use problems has been another area where the concepts of having a system of care with wraparound services is a mechanism for providing a broad array of integrated services. Systems of care also can be crucial to providing services for homeless and runaway youth or children who have experienced trauma and are in foster care.

Here is a basic example of a case in which several types of services can be provided to a young child and his family. Kwan is a 7-year-old boy with attention deficit hyperactivity disorder (ADHD) and significant delays in reading comprehension. He attends a low-income school in an urban area, where the school psychologist is present only one day per week. He often attends school hungry and appears very tired. An additional step might be to refer Kwan to receive an evaluation of his academic skills. Then, wraparound services could be developed to support his learning by addressing problems with attention and activity level related to ADHD and additional supports, perhaps with weekly visits to the school reading specialist, to support improvement in reading skills. Moreover, Kwan might benefit from having his school-based counselor become involved to interview his parents and ensure that he has enough food to eat at home and is getting appropriate rest.

His parents might benefit from attending a support group for parents to learn ways to work with a child with ADHD to help him complete homework and follow instructions at home. Determining services needed to support Kwan and his family in achieving better lives is a hallmark feature of wrapping services around a child to fit the needs of the child within his or her immediate contexts, such as the family and school. As services are provided and wrapped around the child to improve functioning, it will be important to ensure that providers are sensitive to broader contextual issues, including cultural and religious needs and background as well as the financial situation for the family.

Challenges to implementation of systems of care include coordinating services, and addressing financial concerns. Whether such large systems can function optimally in managed care and privatized environments must also be addressed. Furthermore, ensuring that service providers have the necessary training in service integration and cultural competence in the care provided are other key facets that promote the positive functioning of a system of care. Finally, integration of the system of care, within existing service structures and with other governmental and system reforms to health care, can be challenging. However, these systems can be instrumental in a patient- and family-centered approach that wraps care around individuals based on his or her needs. Consequently, systems of care can be the hub for full-service care to improve the voice and choice of individuals and their families.

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See Also: Continuum of Care; Culturally Specific Services; Home and Community Services; Mental Health Services, Children; Rural Communities.

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Y

Yale Center for Dyslexia and Creativity

The Yale Center for Dyslexia and Creativity (YCDC), a part of the Yale University School of Medicine, is a nonprofit center founded in 2007 to conduct and communicate the latest research and treatments for dyslexia as well as to advocate for individuals with dyslexia. Under the codirection of Drs. Sally E. and Bennett A. Shaywitz, the YCDC advocated in Washington, D.C., for recognition of individuals with dyslexia under the Americans with Disabilities Amendments Act (ADA). The YCDC also started the Multicultural Dyslexia Awareness Initiative (MDAI) a two-day symposium at Yale University in 2013, where leaders in education, legislation, and public policy can share and gain insight into dyslexia. YCDC research has been published in *Psychological Science*, *School Psychology Quarterly*, and *Development and Psychopathology*. The YCDC is conducting clinical research studies of children and adolescents with dyslexia ages 10 to 16 to test whether the prescription drug Strattera improves reading outcomes.

Sally Shaywitz (BA, CUNY; MD, Yeshiva University) is the Audrey G. Ratner Professor in Learning Development at the Yale University School of Medicine, while Bennett Shaywitz (BA and MD, Washington University) is the Charles and Helen Schwab Professor in Dyslexia and Learning Development and Chief of Pediatric Neurology; together they are the inaugural codirectors of the YCDC. Shaywitz's research provides conceptual models and epidemiology for studying dyslexia. Shaywitz's research explores the neurobiological basis of reading and dyslexia via functional magnetic resonance imaging (fMRI) to develop better treatments for dyslexia. Together, the doctors developed the sea of strengths model of dyslexia that argues that individuals with dyslexia have a sea of strengths that include capacities for higher critical thinking and creativity. Both codirectors are nationally recognized doctors and researchers, having between them authored more than 500 scientific articles, chapters, and books and holding several editorial and advisory board and committee positions in addition to their positions at YCDC.

YCDC uses scientific research to advocate for the right of individuals with dyslexia, through lobbying in politicians in Washington, D.C., to recognize dyslexia in an amendment to the ADA. The ADA was written and first introduced in the U.S. Senate by Tom Harkin (D–IA) in 1989 to honor his brother Frank, who was deaf, and signed into law in 1990 by then President George H.W. Bush. The YCDC argued that, since its enactment, the ADA was being interpreted as only protecting the rights of individuals with visible disabilities that could not be remedied by a medical or other intervention.

The YCDC supported an amendment to the ADA because the Supreme Court rulings of *Sutton v. United Airlines, Inc., Murphy v. United Parcel Service, Inc.* and *Albertsons, Inc. v. Kirkingburg* in 1999 seemingly excluded individuals, like those with dyslexia, from ADA protection if they could outwardly adapt (e.g., with a prosthetic, medicine, or a coping strategy) and could function like the average person. The YCDC used fMRI scans of dyslexic and nondyslexic brains to provide visible evidence of the need for the ADA to protect individuals with dyslexia.

YCDC representatives met with the U.S. government's disability coalition and with business leaders and shared with them the current dyslexia research. The YCDC communicated with Representatives George Miller (D–CA), Rob Andrews (D–NJ), and Joe Courtney (D–CT), and Senator Chris Dodd (D–CT).

In passing the ADA, Representatives Stark, Miller, and Courtney spoke on the congressional record about the intent of ADA to cover conditions like dyslexia. This is significant because the Supreme Court refers to the congressional record when deciding how to interpret the ADA that went into effect in January 2009. Since the passage of the ADA, YCDC awarded Representatives Bill Cassidy (R–Louisiana) and Pete Stark (D–California) with Champion for Dyslexia Awards for forming the bipartisan Congressional Dyslexia Congress in 2012.

Since the passage of the ADA, the YCDC still continues to advocate for social changes that allow individuals with dyslexia to reach their full potential. The YCDC argues that persons with dyslexia who excel academically are denied accommodations for extra time for reading-based tasks, even though reading can be an extremely slow process for them, because their grades are so high. One such case is when Dr. Fred Romberg sought the help of the YCDC when the National Board of Medical Examiners (NBME), which administers the exam for doctors to be licensed to practice medicine in the United States, initially turned down his request for extra time to take the exam. The NBME cited Romberg's prior exemplary academic and work record when initially turning down the request. Romberg contacted YCDC and codirector Sally Shaywitz, and as a result, he filed a complaint with the U.S. Justice Department, which then opened its own investigation. The NBME reconsidered its position and eventually doubled the allotted time for Romberg to take the exam, though it denied in any way violating the ADA.

In 2013, YCDC launched the MDAI, a 2-day symposium at Yale University in 2013 for leaders in education, legislation, and public policy. The symposium was designed to bring awareness to dyslexia in the African American and Hispanic American communities, where the YCDC argues, dyslexia more often goes undiagnosed and thus untreated. The YCDC argues that dyslexia affects one in every five people regardless of race. The keynote for the event was celebrity and activist Harry Belafonte, and the event drew accomplished dyslexics such as Pulitzer Prize nominee Victor Villasenor. The MDAI was funded via the YCDC and the Seedling Foundation.

Also in 2013, the YCDC has undertaken two clinical studies on children ages 10 to 16 to test whether the prescription medication Strattera (drug name atomoxetine) could improve their reading ability. Strattera is currently approved to treat attention-deficit hyperactivity disorder in children and adults and has been studied as a treatment for depression, binge eating, and bedwetting. Children and adolescents in the study are assigned to medication and placebo groups to test the effectiveness of the drug. Children and adolescents with good reading skills are recruited for the study as a group for interpreting the results in the children with dyslexia.

The YCDC Advisory Council is chaired by Kurt C. Mobley and includes celebrities such as actress Kate Capshaw and director Steven Spielberg, educators such as Sarah Gund and Kyle Redford, and political figures including Sam Gejdenson and Reed Hundt. The YCDC and its codirectors, the Shaywitzes, work primarily to discover and share the latest research on and most effective treatments for dyslexia in order to advocate for people with dyslexia so that they might reach their full potential. In so doing, the Shaywitzes and YCDC have challenged laws on disability (e.g., working to amend the ADA) and questioned the efficacy of current treatments for dyslexia (e.g., response-to-intervention models).

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See Also: Americans with Disabilities Act; Individuals With Disabilities Education Act; Learning Disabilities, Services for Individuals With.

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Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance System (YRBSS) was established in 1991 by the Centers for Disease Control and Prevention (CDC) to understand the major risks to the long-term health of young people in the United States. The data system was designed to enable public health professionals, educators, policy makers, and researchers to describe the prevalence of health-risk behaviors among youths, assess trends in health-risk behaviors over time, and evaluate and improve health-related policies and programs. YRBSS data are obtained from multiple sources, including a national school-based survey conducted by CDC as well as school-based state, territorial, tribal, and large urban school district surveys conducted by education and health agencies. The national surveys include representative samples of students in Grades 9 through 12. The oversampling of black and Hispanic youth makes the YRBSS particularly useful in examining these racial and ethnic subgroups.

The YRBSS monitors six categories of health-risk behaviors that have been identified as priority areas. The CDC identified these categories of interrelated and preventable behaviors as the leading causes of morbidity (illness) and mortality (death) among youths and adults. The majority of all deaths among young people (72 percent) result from car accidents, accidental injuries, homicides, and suicides, reports N. D. Brener and colleagues. The major causes of deaths among adults are cardiovascular disease and cancer, which can be linked to unhealthy behaviors around inactivity, diet, and tobacco, drug, and alcohol use, all of which often begin in youth. The goal of the YRBSS is to improve understanding of young people's health behaviors around these issues in order to better help young people improve their health in both the short and long terms. The YRBSS's six priority areas include (1) unintentional injuries (e.g., car accidents) and violence; (2) tobacco use (e.g., cigarettes and smokeless tobacco); (3) alcohol and other drug use; (4) sexual behaviors that can lead to sexually transmitted infections and to unintended pregnancy; (5) unhealthy eating; and (6) physical inactivity. Behaviors in these areas often are established during childhood and adolescence and set the groundwork for adulthood. In addition to the six priority areas, the YRBSS monitors asthma and obesity among youth.

As part of the YRBSS, the CDC has administered the national Youth Risk Behavior Survey (YRBS) every two years since 1991. It is a nationally representative school-based survey, and its results describe the population of students in the United States. It is administered to students in all four years of high school, so it provides data about students at different ages. This survey can be used to separately examine patterns of risk in different subgroups based on age, race or ethnicity, and gender. The YRBS does not include demographic questions on socioeconomic status, family patterns, immigration status, or sexual orientation. Therefore, it cannot be used to study how these factors influence health behaviors. There are also limits in using the data from the survey to describe state- or local-level populations, but the most recent YRBS (in 2011) has extensive state-level data for 43 states, and some data is available for four additional states as well as six nonstate territories (including Puerto Rico) and two tribal governments.

In addition to the national YRBS, which is administered to high school students, many states and local school districts also use the middle school YRBS. The middle school questionnaire does not include all of the questions on the high school version, but it does track students' alcohol, tobacco, drug, and sexual practices, as well as car and bike safety. Although the survey does show that middle school students engage in risky behavior, it is difficult to make statements about the national population of middle school students as a whole based on this data. However, it can be used by individual school districts and states to understand health behaviors among students before high school.

Since its inception in 1991, the YRBSS has conducted ongoing revision of the questionnaire, added new populations, and adopted innovative methods for data collection (e.g., web-based surveys).The YRBSS has been used by many different stakeholders concerned about young peoples' health and well-being. School districts and local health agencies have used the information from the YRBSS to educate students, to identify unhealthy behaviors that are a particular problem in their state or school, to seek funding for programs to improve student health and health behaviors, and to influence health program design at the local and state level.

Access to the YRBSS data is readily available through the CDC. They have compiled a variety of reports on the results of the surveys and health-risk behavior trends over time. Most users will best be able to access the data through Youth Online, a web-based portal that allows the user to select responses for any individual question on the YRBSS. There is also functionality to examine subpopulations based on sex, race or ethnicity, or grade. Users can also use Youth Online to create customized tables and graphs and perform basic statistical analysis. Youth Online includes national, state, and local data from both middle school and high school students. For those who want to conduct more-detailed statistical analysis, the national-level data can be directly downloaded from the CDC in a number of formats. State, district, and other data can be accessed by contacting the CDC.

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See Also: Adolescent/Youth Services: Overview; At-Risk Youth Services; Child and Adolescent Needs and Strengths; Monitoring the Future; Substance Abuse Treatment for Children and Adolescents.

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Yuppies and Buppies

Social acronyms and semantic neologisms, words created from the initials of other words to communicate new meanings, often sound silly. However, one characteristic of this specialized form of language is that it often reflects new social, economic, and political trends. Although the history of socioeconomic or sociopolitical acronyms has never been systematically explored, new words have been introduced to describe new social trends throughout the 20th century in the United States. For example, flappers (1920s), swingers (1930s and 1940s), rockers (1950s and1960s), and hippies (1970s) are commonly recognized words. Yuppies appeared in the 1980s, a term derived from young, urban professional, which describes the defining characteristics of the yuppie demographic.

"Buppies" and "guppies" followed the term *yuppies* in the late 1980s and 1990s as a way to refer to well-educated, young, black or gay upwardly mobile achievers, respectively. This phenomenon is by no means restricted to the United States. For example, the term *WASP* (white Anglo-Saxon Protestant) is used in Australia and Canada to refer to a high-status group of people, or families, with disproportionate social and financial power. Now, there are OINKs (one income, no kids) and DINKs (dual income, no kids), DIMPS (dual income, money problems), and NIKS (no income, kids to support). It appears that this creative process of socially constructing acronyms could work with anyone or anything.

Several linguists suggest that the innovation of new words reflects innovation and change in society. The evolution of language and the role of discourse in establishing and making distinctions among people ensure a recognition of differences and diversity across groups that has a place within human services professions. Effectiveness in the human service sector requires consideration of individual differences, of course. Some key individual differences include, but are not limited to, age, ethnicity, gender, geographic origin, and race. Human service professionals also consider the broader distinctions within communities and society that influence individual differences in ability and disability, educational level, religion, and sexual orientation. As the social acronyms presented earlier suggest, there are obvious distinctions across socioeconomic class and values. As such, human service personnel do their jobs with an increased awareness and focus on inclusion among an increasingly diverse service population.

Yuppies

Yuppies are associated with social and economic class movement from middle class to the upper-middle or upper class. The term is most often used to refer to individuals who have acquired their increased wealth on their own and not to individuals who have had or come from wealth. Besides being typically young, usually between the ages of the mid-20s and 30s, yuppies are also generally affluent and working in well-paid professional positions that may come with benefits. It is common for yuppies to partner with other yuppies, thereby significantly increasing their purchasing power. Many yuppies work hard to play hard, putting in long hours at work so that they can pursue expensive hobbies and extracurricular activities. Yuppies are also characterized as politically conservative and upwardly mobile, working hard to achieve the goal of rising within the social and economic class system.

Yuppies are often found living in up-and-coming neighborhoods, which sometimes causes community tensions. This urban gentrification typically displaces people in the lower classes and minorities. Some people also resent the yuppie subversion of their culture and traditions, arguing that an arrival, or invasion as the case may be, of wealthy people into a neighborhood can change the character of a community markedly. Opponents of urban gentrification suggest that it promotes homogeneity over individuality, eradicating the very unique characteristics that might have made a neighborhood appealing in the first place.

Buppies, Guppies, and So On

The term *buppies* (black urban professionals) seems to have originated in South Africa with the disillusion of apartheid and the rise a black middle class. Buppies are also associated with social mobility and the acquisition of material wealth, like yuppies. Buppies are also sometimes seen as being overly interested in materialist status symbols. However, it is a movement from the lower class to the middle or upper-middle class. The emergence of the buppies, with their increased economic and therefore political clout, has altered the political and financial landscape in South Africa and the West. Unlike yuppies, buppies are more economically liberal and more socially conservative.

Like yuppies, the term *guppies* (gay urban professional) has its origins in the 1980s United States. Specifically it is a term used to refer to homosexual individuals who have embraced a middle-class lifestyle. This includes, like the yuppies, a focus on career and the accumulation of wealth. Also, like the yuppies, guppies are seen as being overly interested in materialistic status symbols. Guppies are also associated with mobility to the upper class. Like yuppies, they are associated with fiscal conservatism and social liberalism. However, for this group, there is a particular emphasis on the advancement of gay and lesbian rights, in particular the advancement of the institution of marriage to include homosexual populations.

Guppies also challenge the status quo implicitly. Gay men and women who are out in society often face economic and political hardship as a result of bigotry and oppression. Being out could accompany a huge loss in social status for an individual, making it difficult to get employment, receive basic protections from the state, or in some cases, have any connection to one's own family. Guppies are sometimes viewed as abandoning or attempting to abandon their lower status social group by embracing the higher status, middle-class, heterosexual lifestyle.

Social Acronyms, Class, and Class Distinctions in Human Services and Diversity

All of the groups discussed represent challenges to the economic and political status quo. This challenge can be implicit, as in the case of the yuppies. Yuppies are seen for the most part in popular culture as a group that is in a socially advantageous position as white, middle-class, and educated. However, they are distinguished as yuppies by their social mobility from the middle class to the upper-middle or even upper class, hence, the accusations of being superficial, and nouveau riche, a common accusation levied against the upwardly mobile.

Also, all three of these groups represent people who have moved up in social class, making their social positions more precarious than someone born middle class, upper-middle class, or upper class. Perhaps more notable, however, is the social process involved in identifying, distinguishing, differentiating, and naming these groups with unique names and specialized meanings. The creation and use of these social acronyms and semantic neologisms may also reflect an increase in economic and political power for groups that may not have originally had any.

In a world where the field of global economic competition is leveling, there are also individual mountains and valleys. People born into fortunate conditions and circumstances have the opportunities to attend schools that will educate them and connect them to others who will stimulate them and help them flourish. Others may live in an industrialized or otherwise wealthy country but reside in communities where the schools are poor, the education is substandard, and where, most unfortunately, a pool of bright and creative children are not pushed or motivated to be the best that they can be. They may fall through the cracks of a social or economic system in which a life with encouragement and enthusiasm is unavailable. Therefore, human service professionals need a breadth of tools to employ in working with these diverse populations.

Many educational and vocational disciplines have a rich history of addressing social problems (e.g., social work, public health, public administration, community and social psychology, anthropology, sociology, education, and law). As such, these diverse disciplines have informed the development of public policies and human service programs concentrating on the most disenfranchised. Combining the unique assets of different professional disciplines has the potential to minimize the redundancy of services and better serve client populations.

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See Also: Bias in Service Delivery; Blue Collar/Pink Collar/White Collar; Cultural Determinism; Social Capital, Role of; Social Welfare Policy, Cultural Competence in; White Privilege.

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Z

Zero Tolerance Approach in Schools

"Zero tolerance" is a term used to describe an all-or-nothing, prescriptive approach employed by school programs or districts to managing student behavior. In other words, a predetermined punishment, usually suspension or expulsion, is applied consistently and without regard for age, intent, severity, or any other factors. There is no middle ground and no room for compromise. Zero tolerance policies can be traced back to the passage of federal legislation in the United States that made possession of a weapon on school grounds a criminal offense. The Gun Free Schools Act of 1994 introduced a national policy for zero tolerance of weapons. The act then required states to enact statutes that included mandatory one-year expulsions from school for students in possession of weapons.

Since that time, zero tolerance approaches have gradually expanded in many states to encompass a variety of other, mostly severe, infractions, such as violent behavior, drug use, and sexual harassment. While there is no single definition of zero tolerance, there is a set of associated characteristics. Zero tolerance policies are applied uniformly without consideration of circumstance. Consequences for infractions are predetermined and are usually severe and punitive in nature—usually mandatory expulsion or suspension.

Rationale for Zero Tolerance Policies

Concerns about school violence are linked to overwhelming popular support of the media and of local communities for zero tolerance policies. Supporters believe that uncompromising approaches to serious infractions will make school environments safer. Removal of disruptive students diminishes the risk of violent behavior and allows others to focus their attention on their studies in a secure and safe environment. Additionally, the presence of harsh penalties for infractions is presumed to act as a deterrent for the general populace of students. Despite the widespread adoption of zero tolerance approaches in schools across the United States and Canada, there is growing opposition to their utilization.

The Impact of Zero Tolerance Policies

Questions remain over whether zero tolerance policies have achieved their intended objective of making schools safe. Many indicators seem to suggest that they are not making a difference. There is no causal evidence, for example, that the employment of zero tolerance policies results in reduced instances of violence. In fact, instances of school violence have continued to trend upward. On an individual student level, zero tolerance policies are not associated with changes in student behavior. Mandatory expulsion and suspension can lead students on a path toward juvenile delinquency and may affect academic achievement and lead to dropping out of school.

Students return from suspensions displaying the same problematic behaviors or worse. There is also evidence to suggest that zero tolerance policies, on a broad scale, do more harm than good. Schools with greater levels of mandatory expulsions, even when demographics and other variables are controlled for, tend to have lower levels of overall academic achievement.

Controversies and Potential for Harm

As the number of school expulsions and suspensions increase in response to zero tolerance policies, so too do the criticisms associated with this approach. The inflexible nature of zero tolerance policies eliminates discretion and prevents the consideration of any exceptional circumstances. As a result, zero tolerance policies sometimes lead to the inequitable and nonsensical treatment of students. For example, zero tolerance policies provide no consideration for students with special needs. Zero tolerance policies also make no allowances for mistakes and errors of judgment that are known features of child development. Age-appropriate responses, in contrast, would include a range of more supportive and instructional consequences for problematic behavior.

Zero tolerance policies have the potential to harm children because they do away with the principle of innocent until proven guilty. In response, students' attitudes toward justice and fairness may be damaged, as may their ability to develop trusting relationships with adults. These policies also have long-range consequences for students, with reduced opportunities for social mobility and decreased earnings a potential result. Zero tolerance policies in schools also stand in opposition to the educational mission of schools and are incongruent with the roles educators play in helping students learn from their mistakes and develop good judgment.

Zero Tolerance Policies and Disproportionality

While the original intent of zero tolerance policies was not to discriminate, discrimination on the basis of race, gender, and socioeconomic status has been the result. Male students, minority students, and students from lower socioeconomic backgrounds are disproportionately impacted by zero tolerance approaches. These are groups that are generally overrepresented in cases of school expulsion and suspension.

Alternatives to Zero Tolerance Policy

There are many alternatives to zero tolerance policies. These alternative solutions focus on building supportive school environments and developing preventive instructional strategies. Prevention programs may target a variety of concerns, such as bullying and harassment, conflict resolution, gang prevention, or drug and alcohol abuse programs to name a few. Some programs are aimed at helping students with emotional and behavioral disorders. Stop and Think and Positive Behavioral Interventions and Supports (PBIS) are two such programs. Preventive instructional strategies that include better quality training for school staff in classroom behavior management are other alternatives. Addressing academic deficits that put students at risk for school failure and chronic behavior problems can also be put in place. Involvement of school mental health experts is important, as is the involvement of families, and communities represent another significant measure.

Alternative consequences for disruptive behavior are available. These consequences are generally less severe and more supportive of students than are those imposed by zero tolerance policies. These include peer mediation, teen courts, restitution, and anger management training, among others. Early intervention programs may also prevent inappropriate behavior from escalating into violence, and programs such as these can significantly reduce the need for harsh consequences later. Programs such as First Step to Success (Kindergarten) and Positive Adolescent Choices Training (developed for African American youth) are examples of these.

Zero Tolerance Policies and Common Sense

Critics of zero tolerance policies point to numerous examples of their use that seem to defy common sense. For example, an instance of a kindergartener being expelled for bringing a toy gun to school or of a child being suspended for making gun sounds while waving a pencil—zero tolerance punishments for these types of behaviors are an indication for some that an all-or-nothing approach to school discipline may be going a bit too far.

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See Also: Gangs in Schools; Office of Safe and Drug-Free Schools; School Mental Health Project.

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Glossary and Acronyms

ABA: Applied behavior analysis, a behavior modification technique derived from the work of B. F. Skinner that uses rewards and punishments to shape behavior. ABA is most commonly applied in teaching children with autism, although it may be applied in other areas as well.

Accommodation in education: The act of making adjustments or modifications to allow a student with a disability to take part in academic programs and activities and removing barriers to their participation.

Acculturation: The process of becoming comfortable in a culture different from one's culture of origin; originally conceptualized as a movement away from the culture of origin and toward the new culture, acculturation today is conceptualized as more of a process in which values from the old culture are retained while aspects of the new are assimilated.

ACT: Action for Children's Television, a national organization organized in 1968 to address issues with television advertising aimed at children and to militate for the production of higher quality children's programming.

Adult Basic Education (ABE): Educational services for adults with less than a high school education, who are not currently enrolled in school and are over the age of 16.

Affinity group: A group of individuals sharing common interests and who work together to support each other through means such as sharing knowledge, networking, and problem solving.

African American English (AAE): Also known as African American Vernacular English, a dialect of English spoken by many African Americans in the United States.

Agency-based research: Research carried out within a social service agency, by that agency's staff, as opposed to research carried out under university auspices.

American Homecoming Act: A 1987 federal law simplifying the process for Vietnamese American children, many of whom had fathers who served in the military during the Vietnam War, to immigrate to the United States; close relatives of eligible children are also allowed to immigrate. By 2009, about 25,000 Vietnamese American children and 60,000 of their relatives were admitted to the United States under this law.

American Public Human Services Association (APHSA): A nonprofit membership organization, founded in 1930, to improve public health and human services; APHSA members are the top-level leaders of their organizations.

Americanization movement: A movement between approximately 1880 and 1920 focused on teaching new immigrants to assimilate to American culture, including learning English and adopting American cultural and political norms.

Antioppressive education: A term coined by Kevin Kumashiro in 2002 referring to efforts teachers could use to challenge what they saw as the oppressive functions in schools.

APS: Adult Protective Services, public agencies allowed to investigate and to intervene in cases of adult self-neglect, neglect, and abuse.

ASPIRA: An organization founded in New York City by Antonia Pantoja in 1961 to support educational achievement among Latin American young people; the core of ASPIRA is school-based clubs that offer leadership training, community projects, and cultural enrichment.

Bicultural education: Education in which two cultures are valued equally and during which aspects such as the language and images of both cultures are incorporated simultaneously.

Big Book, The: *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered From Alcoholism*, first published in 1939 by Bill Wilson and Robert Smith; it is a founding text of Alcoholics Anonymous and includes a description of the 12-step program that has since been adopted by many other self-help groups.

Bilingual education: An approach to education in which students are taught for part of the day in one language and part of the day in another; for instance, schoolchildren whose home language is not English might have some of their classes in their home language and some in English.

Brown Berets: A Mexican American organization founded in Los Angeles in 1967, aimed at ending discrimination, improving schools, and supporting Mexican Americans in exercising their civil rights.

CAPTA: The Child Abuse Prevention and Treatment Act, passed in 1974, the first U.S. federal law to create and enforce national standards for the prevention of child abuse throughout the nation.

Carl D. Perkins Vocational Education Act: A federal law, first passed in 1984 and reauthorized in 1990 and 1998, providing federal funds to develop high-quality vocational and technical education programs for young people and adults.

Case management services: Services that coordinate the care or other services (e.g., medical care, social services, counseling) received by an individual for the purpose of meeting his or her needs in a cost-effective manner.

CBPR: Community-based participatory research, a method of research in which community members, researchers, and representatives of organizations work as partners to conduct research that responds to the needs and experiences of the community members.

CCBA: The Chinese Consolidated Benevolent Association, also known as the Chinese Six Companies, an organization founded in the 1850s to serve the needs of the Chinese American community.

CCC: The Civilian Conservation Corps, an organization created in 1933 as part of the New Deal, to employ young men, provide academic and vocational training, and perform work in the nation's parks and forests.

CDF: Children's Defense Fund, a private organization founded in 1973 to advocate for the rights of children.

CETA: The Comprehensive Employment and Training Act, a 1973 federal law providing funding for job training and job creation.

Chautauqua Movement: An adult education movement in the late 19th and early 20th centuries that included correspondence courses, reading circles, and traveling exhibitions and lectures.

Citizen Schools: A nonprofit organization founded in 1995 to provide quality after-school programs to middle-school students, including academic support and apprenticeship programs; the organization was founded in Boston, but now exists in several other cities, including New York and Houston.

Client-centered therapy: A type of therapy developed by Carl Rogers that focuses on providing an accepting environment, so that patients are able to see their situations more clearly, and eventually arrive at solutions to their problems.

College Settlement Association: An organization founded in the United States in 1890 to address the role of women in the settlement house movement. Although the first settlement house was populated by men, by 1910, over 75 percent of U.S. settlement houses had been founded by women.

Congregate meal programs: Programs that provide meals to adults in a social setting, such as a senior center or church, usually five or more days per week.

Contracting out: The governmental purchase of social services from a nongovernmental provider, such as a nonprofit or for-profit organization; the practice dates back at least to the English Poor Law of 1732 and was in widespread use in the United States by the 18th century.

COS: Charity Organization Society, a type of charitable organization first founded in London in 1869, with the first American COS established in Buffalo, New York, in 1877. The COS movement emphasized requiring the poor to help themselves, rather than simply distributing money or other assistance to them.

Council on Social Work Education: A nonprofit association founded in 1952 that is the accrediting agency for social work education in the United States

Country Life Commission: A commission created in 1907 by President Theodore Roosevelt; among the commission's recommendations were ways to strengthen rural schools and to assist farmers in becoming more efficient.

Creole language: A language that began as pidgin, that is, as a simplified version of another language, but is then adopted as a first language by a group of people.

CRT: Critical race theory, an approach to legal analysis that evolved in the 1970s and was later applied in other fields; CRT focuses on analyzing how dominant groups (e.g., white Americans) exert institutionalized authority over other groups.

CSWE: The Council on Social Work Education, an organization that sets standards for academic social work programs; the CSWE was created in 1952 by the merger of the American Association of Schools of Social Work (AASSW) and the National Association of Schools of Social Administration (NASSA).

Cultural relativism: A doctrine, first developed in anthropology by Franz Boas, arguing that the institutions and practices of culture should be understood in context and not judged by the standards of another culture.

Culture-bound syndrome: Physical or mental illnesses and symptoms, such as amok or ghost sickness, which occur only within a particular cultural group.

***Delgado v. Bastrop Independent School District*:** A 1948 decision by the U.S. District Court of the Western District of Texas ruling that public schools could not segregate Mexican American students into separate schools, although they could provide separate classes for students needing language enrichment.

Demand-responsive transportation services: Transportation that allows people to schedule door-to-door rides to medical appointments and many other places; demand-responsive transportation services are most often provided to the elderly and to handicapped individuals who are unable to provide their own transportation or use conventional, route-based public transportation.

Dialogical education: A method of education developed by Paulo Freire in which students and teachers engage in discussion and learn from each other.

Diaspora: A population living outside the geographic area of its origin, for instance, the Caribbean community in the United States.

Ethnic Dilemma in Social Services, The**:** A 1981 book by Shirley Jenkins, based on the study of 54 agencies in six states serving Asian Americans, African Americans, Puerto Ricans, Chicanos, and Cherokees.

Ethnic group: A group of people who are linked by biology and culture, sharing characteristics such as a kinship system, a belief system, a common biological heritage, and/or a common place of origin.

Ethnic minority agency: A service agency providing services to members of an ethnic minority group, which is staffed by members of the same ethnic minority group, thus reducing cross-group tension.

Everson v. Board of Education, Irving Township**:** A 1947 U.S. Supreme Court ruling that it was not a violation of the First Amendment for public funds to be used to bus children to schools run by religious organizations.

Fair Housing Act: A 1968 federal law prohibiting discrimination in the sale or rental of housing on the basis of race, religion, gender, ethnicity, national origin, family status, or handicapped status.

Family foster care: The most common type of out-of-home care provided for children, family foster care is offered to children in the home of a family not related to them.

Farrington v. Tokushige**:** A 1927 U.S. Supreme Court decision that establishes the right of parents to send their children to Japanese-language schools.

Freedom Summer: In summer 1964, many civil rights movement volunteers traveled to Mississippi to assist in voter registration efforts and establish Freedom Schools; these actions met with reprisals, including the murder of some of the volunteers.

Friendly visiting: A practice championed by the Charity Organization Societies, in which individuals, often volunteers and generally members of the middle and upper classes, would visit poor families and serve as an example, while also counseling members of the family about ways to escape poverty. The practice was widespread in the late 19th century; for instance, in 1892, Boston had 683 friendly visitors, and Brooklyn, New York, had 532.

Fukuin Ka: The first Japanese American organization in the United States, founded in 1877; the Fukuin Ka ran a boarding house, offered English lessons, and provided meeting rooms.

Gender variant: Sometimes called gender nonconforming, children whose interests, behaviors, and gender expressions are outside the norm for their biological sex; for example, a girl who prefers boys' sports or a boy who prefers to play with dolls. A gender-variant child will not necessarily grow up to be transgender.

Gender-neutral language: Language that does not favor or omit mention of one gender over the other; also known as nonsexist language.

General Education Board (GEB): A philanthropic organization created by John D. Rockefeller in 1902, and chartered by Congress in 1903, to improve education in the southern United States, without regard to the race, religion, or gender of students.

GLSEN: The Gay, Lesbian and Straight Education Network, an organization founded in 1990 by Kevin Jennings to advocate for the rights of people of all gender identities and sexual orientations to feel safe and respected in primary and secondary schools.

Gong Lum v. Rice**:** A 1927 U.S. Supreme Court decision that denied the right of a Chinese man in

Mississippi to send his daughter to a white public school and ruled that it was not discriminatory to require her to attend the local black school instead.

***Griffin v. School Board of Prince Edward County*:** A 1964 U.S. Supreme Court decision ordering the Board of Supervisors of Prince Edward County, Virginia, to reopen their public schools, which had been closed in 1959 in order to avoid integrating them.

HBCU: Historically black colleges and universities, institutions of higher education founded before 1954 with the primary mission of educating African Americans; as of 1996, there were 103 HBCUs in the United States, educating about 16 percent of African American college and university students.

Head Start: A program authorized in 1964 by the federal Economic Opportunity Act to provide enriched, educational summer programs for children from poor families, with the goal of improving long-term outcomes for these children.

Hidden curriculum: "Lessons" learned by children in school, even if they are not explicitly taught; for instance, if teachers expend more attention on the education of male or white students, the lesson learned by female and nonwhite students is that they, and their education, are not a priority.

Holt International Children's Services: An adoption agency found in the 1950s by Harry and Bertha Holt, an American couple who adopted eight children from Korea.

Home health care: Medically oriented services provided in the home to someone recently discharged from a hospital, including nursing service and social work; home health care services are typically provided for a limited time, often only for two to three months.

Home-delivered meal programs: Programs that provide cooked meals to homebound adults in their homes, usually one or two meals per day, five days per week.

Homemaker and personal care services: Home-based services to support an individual's personal care (e.g., bathing, ambulation) and instrumental activities of daily living (e.g., housekeeping, meal preparation) that may be provided on a long-term basis.

***Hopwood v. State of Texas*:** A 1996 decision by the U.S. Court of Appeals for the Fifth Circuit, ruling that colleges and universities may not use race or national origin as a factor in admissions decisions; the plaintiff was a white applicant to the University of Texas Law School who claimed she was discriminated against because of her race.

Hospice care: Services provided, either in the home or in a facility, to offer holistic and palliative care for individuals with terminal illnesses; hospices generally do not provide treatment to either forestall or hasten death, but concentrate on making individuals comfortable and helping them prepare for the end of their lives.

ICWA: The Indian Child Welfare Act, a 1978 federal law creating conditions that must be met before Indian children can be taken from their families, and favoring placements within homes reflecting Indian culture when children must be placed out of their own homes.

IDEA (1975): The Individuals with Disabilities Education Act, a 1975 federal law, originally called the Education for All Handicapped Children Act; IDEA provides federal grants to states to improve education for individuals with disabilities and specifies procedures for individuals to appeal for services specified in the act.

IDEA (1990): The Individuals with Disabilities Education Act, a 1990 federal law requiring that children with mental, emotional, and physical disabilities be provided with a free and appropriate public education, and providing money to the states to improve their educational offerings for these children.

IEP: Individualized education program, a legally binding document that specifies an instructional plan for a school-age or preschool child with a disability, developed jointly by the child's parents and a team of professionals, and possibly the child as well.

IES: The Institution of Education Sciences, a federal organization within the U.S. Department of Education, created by the Education Sciences Reform Act of 2002.

Indian Self-Determination and Education Assistance Act: A 1975 federal law providing funds to construct schools on Native American reservations, giving Native Americans more control over the education of their children, and allowing preferences toward Native Americans in the granting of subcontracts.

Institutionalized racism: Racism that occurs through the usual practices and policies of an institution, possibly without a deliberate attempt to discriminate; for instance, if jobs are discussed and advertised only on occasions when, and in locations where, African Americans are unlikely to see or hear about them, that could be considered institutionalized racism.

Involuntary client: A client who is pressured or forced into taking part in social work services by those who have power over them, as opposed to a voluntary client, who freely chooses to participate.

***Keyes v. School District No. 1*:** A U.S. Supreme Court decision regarding public schools in Denver, Colorado, which rules that Latinos are a minority group that must be considered in desegregation plans, and that segregation due to gerrymandered school districts is illegal.

Kinship foster care: Foster care provided to children by someone who is related to them, often grandparents.

LEP: Limited English Proficiency, a designation for individuals (often students in elementary and secondary school) who are not fluent in spoken and written English.

Life-span development: A theory of development, put forth in 1987 by P. B. Baltes, arguing that development does not end in adolescence but continues over the life span, is a multidimensional and multicausal process, is modifiable, and includes both gains and losses with increasing age.

LULAC: The League of United Latin American Citizens, an organization founded in 1929 in Corpus Christi, Texas, with the goal of using constitutional means to enhance the well-being, civil rights, education, and economic conditions of Latinos.

MALDEF: The Mexican American Legal Defense and Educational Fund, founded in 1968 in El Paso, Texas, to protect the civil rights of Latinos; some initial funding was provided by a grant from the Ford Foundation.

***McCollum v. Board of Education*:** A 1948 decision of the U.S. Supreme Court ruling that holding religion classes in a public school in Champaign, Illinois, during the school day is a violation of the First Amendment.

Melting pot: A model of integration in which immigrants from diverse countries, races, and backgrounds give up some of their unique identities to create a new type of person, the American.

***Mendez et al. v. Westminster School District of Orange County*:** A 1946 decision of the U.S. Court of Appeals for the Ninth Circuit that ruled that requiring Mexican American children to attend different schools from white students is a violation of their rights.

Mexican repatriation: A response to the Great Depression in which people from Mexico, including U.S. citizens, who applied for social services were encouraged to return to Mexico; an estimated 400,000 people left the United States, not all of them voluntarily, between 1929 and 1934.

***Meyer v. Nebraska*:** A 1923 decision of the U.S. Supreme Court overturning a Nebraska state law banning foreign language instruction in schools before the eighth grade.

Model minority: A description of an ethnic group believed to be particularly successful or to otherwise have admirable traits, such as strong family values or high per capita income; Asian groups are sometimes stereotyped as model minorities.

NASW: The National Association of Social Workers, the largest membership organization of social workers in the world; the NASW was created in 1955 through the merger of the American Association of Social Workers, the American Association of Psychiatric Social Workers, the American Association of Group Workers, the Association for the Study of Community Organization, the American Association of Medical Social Workers, the National Association of School Social Workers, and the Social Work Research Group.

National Association of Black Social Workers: An organization founded in 1966 by African American social workers upset with the lack of interest in the National Association of Social Workers (NASW) in addressing social issues; it split from the NASW in 1969.

National Human Services Assembly: An organization founded in 1923 as the National Social Work Council to help existing agencies work more effectively by exchanging information with each other.

Naturalization Act of 1790: The first U.S. law to address the process of becoming a naturalized citizen, it offered naturalization to white persons of good moral character who had resided for at least two years in the United States.

NCANDS: The National Child Abuse and Neglect Data System, a federal program that collects child abuse data from the states.

Neighborhood Guild: The first settlement house in the United States, established in New York City in 1886, and later renamed the University Settlement.

OAA: The Older Americans Act, a 1965 federal law that created the Administration on Aging and provided funds to states to create services for older adults, including senior and adult day care centers, employment support, protective services, and home delivery of cooked meals.

Pensionado Act of 1903: A federal program to provide scholarships for Filipino students to study in the United States which aimed to foster the Philippines independence movement and create goodwill between the two countries.

Pidgin language: A simplified language that is not native to any community but is used for communication among people who do not share a common language.

***Plessy v. Ferguson*:** An 1896 U.S. Supreme Court decision upholding the constitutionality of state laws requiring segregation in public facilities; the original lawsuit was brought by Homer Plessy, a man of mixed race who was arrested after he refused to leave a train coach reserved for white passengers.

***Plyler v. Doe*:** A 1982 U.S. Supreme Court decision overturning a Texas law that denied public education to undocumented immigrant children; among other things, the court's decision bars schools from refusing to admit undocumented children, treating them differently from other students, and investigating and disclosing their immigration status.

Progressive Era: A period in late-19th- and early-20th-century American history, often described as beginning in 1890 or 1895 and ending in 1914 or 1917, during which many charitable organizations, societies, settlement houses, and other organizations serving the poor were founded and expanded.

Proxemics: The study of personal and social norms and how they affect interactions with others; for instance, the expected physical distance between two speakers differs among cultures.

Pygmalion effect: Also known as the self-fulfilling prophecy, the concept that expectations can exert a strong influence; for example, children whose teacher expects them to do well will learn more than the same children taught by a teacher who expects little of them.

Respite services: Services provided to allow caregivers, often relatives, to take a break from their duties of providing care; most respite services are provided in the home and for a few hours at a time, but some programs also offer overnight respite services.

***Roberto Alvarez v. the Lemon Grove School*:** A successful 1931 challenge to the segregation of Latino students in San Diego, California, resulting in Latino children being allowed to attend the Lemon Grove School with white children rather than being required to attend a separate and unequal facility for Latino students.

***Roberts v. City of Boston*:** An 1849 decision by the Massachusetts Supreme Judicial Court, upholding the city's right to force an African American child to attend a black-only school, although several white-only schools were located nearer her home.

Rosenwald Fund: A philanthropic fund established in 1917 by Julius Rosenwald that played a key role in financing programs to improve the health and welfare of African Americans in the southern United States and also provided partial funding for the construction of almost 5,000 schools in that region.

SAMHSA: The Substance Abuse and Mental Health Services Administration, an agency within the U.S. Department of Health and Human Services, whose goal is to reduce the impact of mental illness and substance abuse in the United States.

Settlement house: A residence for university graduates in city slums, where they could offer education and services to help residents escape poverty and address other social problems. In 1897, there were 74 settlement houses in the United States, and 413 by 1909.

Social context: As described by D. Lum in 2003, elements of the environment that play a crucial role in shaping an individual.

Social control: Methods to directly or indirectly encourage or force people to conform to values and behaviors approved in a society, with social control often exerted by dominant groups such as members of the society's political or economic elite.

"Standards for Cultural Competence in Social Work Practice": A 2006 document issued by the National Association of Social Workers (NASW) and covering areas such as language diversity, cross-cultural leadership, service delivery, empowerment and advocacy, self-awareness, and ethics and values.

Stereotype threat: The fear harbored by a member of a minority or nondominant group that he or she will be treated or judged in terms of a prevailing, distorted view of his or her group.

Supportive housing: Noninstitutional housing that provides residents, such as elderly adults, with more assistance and oversight than is typical in private housing.

***Swann v. Charlotte-Mecklenburg Board of Education*:** A 1971 U.S. Supreme Court decision establishing that the responsibility for creating desegregation plans lies with school authorities.

***Tarasoff v. the Regents of the University of California*:** A 1976 California Supreme Court decision ruling that the responsibility to prevent harm to a third party could take precedent over the usual presumption of the confidentiality of patient records if a psychotherapist has knowledge suggesting that his or her patient may cause harm to someone.

Theory of general systems: A theory created by the Austrian American biologist Karl Ludwig von Bertalanffy, which has been used to describe the way groups of human beings function, including families, professions, and communities. According to Bertalanffy, at its most basic level, a system is a complex of components that interact with each other.

Trabajadores de la Raza: A national social work organization founded in 1969 by Mexican Americans who believed the National

Organization of Social Workers (NASW) was not responsive to the needs of their communities.

Twelve steps: A set of 12 behavioral steps fundamental to Alcoholics Anonymous but also used in other self-help programs; the steps begin with the need for the addict to admit that they cannot control their addiction and end with helping others who also suffer from addition.

War on Poverty: A political movement in the 1960s, led by presidents John F. Kennedy and Lyndon Johnson, to create a more equal U.S. society through means such as improved education and job training programs.

White Rose Mission: The second settlement house in New York City to serve the needs of the African American community, the White Rose Mission was founded in 1898 by Victoria Earle Matthews and operated until the 1960s.

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Resource Guide

Books

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American Journal of Drug and Alcohol Abuse
American Journal of Family Therapy
Anthropology & Medicine
Archives of Women's Mental Health
Asia Pacific Journal of Social Work
Asian American Journal of Psychology
BMC Women's Health
British Journal of Social Work
Community Mental Health Journal
Couple and Family Psychology: Research and Practice
Cultural Diversity and Ethnic Minority Psychology
Culture, Medicine, and Psychiatry
Diversity in Health and Social Care Drug and Alcohol Dependence
Drug and Alcohol Review
Ethnicity & Disease
Family Journal
Family Violence Prevention and Health Practice
Gender Issues
Gender Medicine Georgetown Journal of Gender and the Law
Harm Reduction Journal
International Journal of Family Therapy
International Journal of Mental Health
International Journal of Mental Health and Addictions
International Journal of Social Welfare
International Perspectives on Sexual and Reproductive Health
Issues in Social Work Education
Journal of Addictions and Offender Counseling
Journal of Addictive Diseases
Journal of Comparative Social Welfare
Journal of Cultural Diversity: An Interdisciplinary Journal
Journal of Diversity in Higher Education
Journal of Ethics in Mental Health
Journal of Ethnic and Cultural Diversity in Social Work
Journal of Ethnobiology and Ethnomedicine
Journal of Feminist Family Therapy
Journal of Global Social Work Practice
Journal of Health and Social Behavior
Journal of Human Behavior in the Social Environment
Journal of Indigenous Voices in Social Work
Journal of Latina/o Psychology
Journal of Muslim Mental Health Journal of Rural Mental Health
Journal of Social Work
Journal of Women's Health
Medical Anthropology
Medical Anthropology Quarterly
Mental Health, Religion & Culture
Minority Nurse
New England Journal of Human Services
Perspectives on Sexual and Reproductive Health
Psychology of Men & Masculinity
Psychology of Sexual Orientation and Gender Diversity
Psychology of Violence
Rehabilitation Counseling Bulletin
Social Psychology Quarterly
Social Science & Medicine
Social Service Review
Social Work Abstracts
Social Work Forum
Society and Mental Health
Spirituality in Clinical Practice
Studies in Family Planning
Widener Journal of Law, Economics, & Race
Women & Health
Women & Therapy
Women's Health & Urban Life
Women's Health Issues

Web Sites

American Psychological Association: Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. http://www.apa.org/pi/oema/resources/policy/provider-guidelines.aspx
Association for Lesbian, Gay, Bisexual & Transgender Issues in Counseling. http://www.algbtic.org/resources/lgbtq-references-and-resources
Association for Multicultural Counseling and Development. http://www.multiculturalcounseling.org

Centers for Disease Control and Prevention. Immigrant and Refugee Health.
http://www.cdc.gov/immigrantrefugeehealth

Centers for Disease Control and Prevention. Minority Health.
http://www.cdc.gov/minorityhealth

Centers for Medicare & Medicaid: Medicaid.
http://www.medicaid.gov

Children's Defense Fund.
http://www.childrensdefense.org

National Association of School Psychologists: Resource Library.
http://www.nasponline.org/resources/index.aspx

National Association of Social Workers: Social Work Month 2012 Toolkit Topics.
http://www.socialworkers.org/pressroom/swMonth/2012/default.asp

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http://www.ruralhealthweb.org/go

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http://www2.ed.gov/about/offices/list/ovae/pi/AdultEd/index.html

U.S. Department of Health and Human Services, Administration for Children & Families, Adoption.
https://www.childwelfare.gov/adoption

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http://www.ada.gov

World Health Organization: Social Determinants of Health.
http://www.who.int/social_determinants/en

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Appendix

Centers for Disease Control and Prevention
Health Disparities and Inequalities Report — United States, 2013

Selected Reports

Social Determinants of Health

Health Outcomes: Morbidity

Health Outcomes: Mortality

Education and Income — United States, 2009 and 2011

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Introduction

The factors that influence the socioeconomic position of individuals and groups within industrial societies also influence their health (*1*,*2*). Socioeconomic position has continuous and graded effects on health that are cumulative over a lifetime. The socioeconomic conditions of the places where persons live and work have an even more substantial influence on health than personal socioeconomic position (*3*,*4*). In the United States, educational attainment and income are the indicators that are most commonly used to measure the effect of socioeconomic position on health. Research indicates that substantial educational and income disparities exist across many measures of health (*1*,*5*–*8*). A previous report described the magnitude and patterns of absolute and relative measures of disparity in noncompletion of high school and poverty in 2005 and 2009 (*9*). Notable disparities defined by race/ethnicity, socioeconomic factors, disability status, and geographic location were identified for 2005 and 2009, with no evidence of a temporal decrease in racial/ethnic disparities, whereas socioeconomic and disability disparities increased from 2005 to 2009.

The analysis and discussion of educational attainment and income that follow are part of the second CDC Health Disparities and Inequalities Report (CHDIR) and update information on disparities in the prevalence of noncompletion of high school and poverty presented in the first CHDIR (*8*). The 2011 CHDIR (*9*) was the first CDC report to describe disparities across a wide range of diseases, behavioral risk factors, environmental exposures, social determinants, and health-care access. The topic presented in this report is based on criteria that are described in the 2013 CHDIR Introduction (*10*). The purposes of this analysis are to discuss and raise awareness about group differences in levels of noncompletion of high school and poverty and to motivate actions to reduce these disparities.

Methods

To monitor progress toward eliminating health disparities in the prevalence of noncompletion of high school and poverty, CDC analyzed 2009 and 2011 data from the Current Population Survey (CPS), using methods described previously (*8*). The CPS is a cross-sectional monthly household survey of a representative sample of the civilian, noninstitutionalized U.S. household population that is conducted jointly by the U.S. Census Bureau and the Bureau of Labor Statistics (*11*). Data on the continuous income-to-poverty ratio (IPR) in the 2009 and 2011 National Bureau of Economic Research (NBER) data sets based on the March CPS were merged with the March supplement files from the 2009 and 2011 Integrated Public Use Microdata Series — Current Population Surveys (IPUMS-CPS) (*12*,*13*).

Self-reported data were collected on various characteristics, including demographic, socioeconomic, and geographic characteristics and place of birth. Group disparities in age-standardized prevalence of noncompletion of high school and poverty were assessed according to sex, race/ethnicity, age, educational attainment, poverty status, disability status, place of birth, world region (country) of birth, U.S. census region of residence, and metropolitan area of residence.

Race/ethnicity categories included non-Hispanic white, non-Hispanic black, American Indian/ Alaska Native, Asian/Pacific Islander, Hispanic, and multiple races. Age groups included 25–44, 45–64, 65–79, and ≥80 years. Educational attainment categories included less than high school, high school graduate or equivalent, some college, and college graduate. Poverty status was derived from the IPR, which is based on family income relative to federally established poverty thresholds that are revised annually to reflect changes in the cost of living as measured by the Consumer Price Index (*14*).

Disability status was defined by the national data collection standards released by the U.S. Department of Health and Human Services (HHS) in 2011 (*15).* World region of birth was aggregated to approximate the regions of the world from which the foreign born now originate (*16*). Absolute and relative disparities in noncompletion of high school were assessed separately for adults aged ≥25 years and 18–24 years; for poverty, disparities were assessed for the total population aged ≥18 years.

Disparities between groups were measured as deviations from a referent category rate. Referent categories were usually those that had the most favorable group estimates for most variables; for racial/ethnic comparisons, white males and females were selected because they were the largest group (*17,18*). Absolute difference was measured as the simple difference between a group estimate and the estimate for its respective reference category, or referent group. Relative difference, a percentage, was obtained by dividing the absolute difference by the value in the referent category and multiplying by 100. To evaluate changes in disparity over time, relative differences for the groups in 2009 were subtracted from relative differences in 2011 (*17,18*). The z statistic and a two-tailed test at $p<0.05$ with Bonferroni correction for multiple comparisons were used to test for the statistical significance of the observed absolute and relative differences and for changes over time. To calculate the standard errors for testing the change over time, a previously described method was used (*19*), modified to account for the parameter being compared (i.e., relative difference). Statistically significant increases and decreases in relative differences from 2009 to 2011 were interpreted as increases and decreases in disparity, respectively. CDC used statistical software to account for the complex sample design of the CPS and to produce point estimates, standard errors, and 95% confidence intervals. Estimates were age standardized by the direct method to the year 2000 age distribution of the U.S. population (*20*). Estimates with relative standard error ≥30% were not reported.

Results

In the 2011 population aged ≥25 years, statistically significant absolute disparities in noncompletion of high school were identified for all the characteristics studied (Table 1). Noncompletion of high school increased with age; the absolute differences between the age-specific percentages in the referent group (45–64 years) and the age groups 65–79 years and ≥80 years were 6.6 and 14.8 percentage points, respectively. The absolute racial/ethnic difference between non-Hispanic whites and each of the other racial ethnic groups was highest for Hispanics (30.4 percentage points), lowest for the multiple races group (4.0 percentage points), and intermediate for non-Hispanic American Indian/Alaska Natives (11.6 percentage points), and non-Hispanic blacks (8.8 percentage points). This pattern was similar in both sexes, except that among women, the absolute difference for the multiple races group (3.1 percentage points) was not statistically significant. Absolute differences between the age-standardized percentages of adults who had not completed high school in each poverty status group and the referent group (high income, IPR ≥4) were statistically significant overall and in both men and women. Noncompletion of high school increased with increasing poverty; the absolute difference for the poorest group was approximately three times the absolute difference for the middle-income group (6.4 versus 1.7 percentage points). Significant absolute differences between adults with and without a disability in noncompletion of high school also were found (total: 9.8 percentage points; men: 9.5 percentage points; women: 10.1 percentage points).

Among adults aged ≥25 years in 2011, noncompletion of high school was generally more common among foreign-born than U.S.-born adults (Table 1). Significant absolute differences from the U.S. born were observed in the total population (24.9 percentage points), among non-Hispanic whites (3.1 percentage points), A/PIs (9.0 percentage points), and Hispanics (27.7 percentage points). Disparities in noncompletion of high school also were found according to world region (countries) of birth. In 2011, significant absolute differences were found between persons born in the United States (referent group) and those born in Latin American and Caribbean countries (46.1 percentage points) or in countries in Asia and the Pacific (6.1 percentage points). In 2011, significant absolute differences were also found between residents of the U.S. census regions of the Midwest, South, or West and the referent group (the Northeast). The absolute difference in age-standardized noncompletion of high school between residents who lived inside metropolitan areas and those who lived outside metropolitan areas (referent group) also was significant. In 2009 and 2011, the magnitude and pattern of age, poverty status, and disability differences were similar in men and women. No significant differences were identified in the relative differences of any these characteristics from 2009 to 2011.

Among younger adults aged 18–24 years in 2011, significant disparities in place of birth and in demographic, socioeconomic, disability, and geographic characteristics were found in the age-standardized percentages of adults who did not complete high school (Table 2). Unlike adults aged ≥25 years, the absolute difference between the percentages of young adults who did not complete high school in the younger age group (18–19 years) and older referent group (20–24 years) was significant (33.1 percentage points). The relative difference between persons aged 18–19 years and the referent group increased significantly by 61.6 percentage points from 2009 to 2011, whereas no change occurred from 2009 to 2011 in age-specific disparities in the older population (≥25 years) (Table 1). Among racial/ethnic groups, absolute differences from non-Hispanic whites were only significant among non-Hispanic blacks (7.2 percentage points) and Hispanics (12.4 percentage points), with the magnitude and pattern

TABLE 1. Age-standardized[*] percentage of adults aged ≥25 years who did not complete high school, by selected characteristics — Integrated Public Use Microdata Series, Current Population Survey, United States, 2009 and 2011

	2009				2011				Change in relative difference from 2009 to 2011 (percentage points)
Characteristic	% who did not complete high school	(SE)	Absolute difference (percentage points)	Relative difference (%)	% who did not complete high school	(SE)	Absolute difference (percentage points)	Relative difference (%)	
Sex									
Male	14.1	(0.2)	1.4[†]	11.0	13.2	(0.2)	1.4[†]	11.9	0.9
Female	12.7	(0.2)	Ref.	Ref.	11.8	(0.2)	Ref.	Ref.	Ref.
Age group (yrs)[§]									
Both sexes									
25–44	11.7	(0.2)	0.7	6.2	11.0	(0.2)	0.4	4.1	-2.1
45–64	11.0	(0.2)	Ref.	Ref.	10.5	(0.2)	Ref.	Ref.	Ref.
65–79	19.5	(0.4)	8.5[†]	77.3	17.2	(0.4)	6.6[†]	63.1	-14.2
≥80	27.6	(0.8)	16.6[†]	150.7	25.3	(0.7)	14.8[†]	140.6	-10.0
Male									
25–44	13.0	(0.3)	1.3[†]	11.5	12.1	(0.2)	1.0[†]	9.0	-2.5
45–64	11.7	(0.3)	Ref.	Ref.	11.1	(0.3)	Ref.	Ref.	Ref.
65–79	18.5	(0.6)	6.8[†]	58.0	16.6	(0.5)	5.4[†]	48.7	-9.4
≥80	27.2	(1.1)	15.5[†]	132.1	26.0	(1.1)	14.9[†]	133.5	1.4
Female									
25–44	10.3	(0.2)	0	-0.3	9.8	(0.2)	-0.2	-1.7	-1.4
45–64	10.4	(0.2)	Ref.	Ref.	9.9	(0.2)	Ref.	Ref.	Ref.
65–79	20.4	(0.5)	10.0[†]	96.7	17.7	(0.5)	7.7[†]	77.8	19.0
≥80	27.9	(0.9)	17.5[†]	169.0	24.9	(0.8)	15.0[†]	150.6	-18.4
Race/Ethnicity									
Both sexes									
White, non-Hispanic	8.0	(0.1)	Ref.	Ref.	7.3	(0.1)	Ref.	Ref.	Ref.
Black, non-Hispanic	17.0	(0.4)	9.0[†]	112.6	16.1	(0.4)	8.8[†]	121.2	8.9
Asian/Pacific Islander	12.7	(0.7)	4.7[†]	59.1	12.1	(0.6)	4.9[†]	66.8	7.7
American Indian/Alaska Native	20.0	(1.8)	12.0[†]	149.8	18.8	(1.9)	11.5[†]	158.5	8.8
Multiple races	13.4	(1.0)	5.4[†]	67.8	11.3	(1.0)	4.0[†]	55.4	-12.4
Hispanic[¶]	40.1	(0.6)	32.1[†]	400.8	37.7	(0.5)	30.4[†]	419.3	18.5
Male									
White, non-Hispanic	8.6	(0.2)	Ref.	Ref.	7.9	(0.2)	Ref.	Ref.	Ref.
Black, non-Hispanic	17.6	(0.6)	9.1[†]	106.0	17.3	(0.6)	9.4[†]	120.1	14.1
Asian/Pacific Islander	10.3	(0.8)	1.8	20.9	10.2	(0.7)	2.3[†]	29.5	8.6
American Indian/Alaska Native	21.0	(2.2)	12.4[†]	145.0	20.8	(2.4)	13.0[†]	165.1	20.1
Multiple races	13.3	(1.4)	4.7[†]	55.1	12.7	(1.5)	4.8[†]	61.6	6.5
Hispanic	41.1	(0.7)	32.5[†]	380.4	38.4	(0.7)	30.5[†]	388.2	7.8
Female									
White, non-Hispanic	7.4	(0.2)	Ref.	Ref.	6.7	(0.2)	Ref.	Ref.	Ref.
Black, non-Hispanic	16.6	(0.5)	9.2[†]	123.3	15.2	(0.5)	8.5[†]	127.1	3.8
Asian/Pacific Islander	14.6	(0.8)	7.2[†]	96.1	13.6	(0.7)	7.0[†]	104.2	8.1
American Indian/Alaska Native	19.6	(2.1)	12.2[†]	163.8	16.9	(2.1)	10.2[†]	152.8	-11.0
Multiple races	13.1	(1.2)	5.7[†]	76.3	9.8	(1.2)	3.1	46.3	-30.1
Hispanic	38.7	(0.6)	31.3[†]	420.0	36.8	(0.6)	30.1[†]	450.9	30.9
Income-to-poverty ratio[**]									
Both sexes									
Poor, <1.00	18.4	(0.5)	7.4[†]	66.6	16.6	(0.4)	6.4[†]	61.9	-4.7
Near poor, 1.00–1.9	15.6	(0.3)	4.6[†]	41.7	14.7	(0.3)	4.4[†]	42.9	1.2
Middle income, 2.00–3.9	13.2	(0.2)	2.1[†]	19.4	12.0	(0.2)	1.7[†]	16.9	-2.5
High income, ≥4.0	11.0	(0.2)	Ref.	Ref.	10.3	(0.2)	Ref.	Ref.	Ref.
Male									
Poor, <1.00	18.9	(0.6)	7.5[†]	66.5	17.3	(0.6)	6.5[†]	60.1	-6.4
Near poor, 1.00–1.9	17.0	(0.5)	5.7[†]	50.2	16.0	(0.5)	5.2[†]	48.1	-2.1
Middle income, 2.00–3.9	14.1	(0.3)	2.8[†]	24.3	12.7	(0.3)	1.9[†]	17.6	-6.7
High income, ≥4.0	11.3	(0.3)	Ref.	Ref.	10.8	(0.3)	Ref.	Ref.	Ref.
Female									
Poor, <1.00	17.9	(0.5)	7.2[†]	67.1	15.9	(0.5)	6.2[†]	63.0	-4.1
Near poor, 1.00–1.9	14.3	(0.3)	3.6[†]	34.1	13.5	(0.4)	3.7[†]	37.9	3.8
Middle income, 2.00–3.9	12.3	(0.3)	1.6[†]	14.9	11.3	(0.3)	1.5[†]	15.8	0.9
High income, ≥4.0	10.7	(0.2)	Ref.	Ref.	9.8	(0.2)	Ref.	Ref.	Ref.

See table footnotes on the next page.

TABLE 1. (*Continued*) Age-standardized[*] percentage of adults aged ≥25 years who did not complete high school, by selected characteristics — Integrated Public Use Microdata Series, Current Population Survey, United States, 2009 and 2011

	2009				2011				
Characteristic	% who did not complete high school	(SE)	Absolute difference (percentage points)	Relative difference (%)	% who did not complete high school	(SE)	Absolute difference (percentage points)	Relative difference (%)	Change in relative difference from 2009 to 2011 (percentage points)
Disability status									
Both sexes									
Disability	23.3	(0.5)	11.4[†]	95.5	21.1	(0.5)	9.8[†]	87.3	-8.3
No disability	11.9	(0.2)	Ref.	Ref.	11.2	(0.1)	Ref.	Ref.	Ref.
Male									
Disability	23.3	(0.8)	10.4[†]	80.8	21.5	(0.7)	9.5[†]	78.9	-1.9
No disability	12.9	(0.2)	Ref.	Ref.	12.0	(0.2)	Ref.	Ref.	Ref.
Female									
Disability	23.2	(0.6)	12.2[†]	111.2	20.6	(0.7)	10.1[†]	96.3	-14.9
No disability	11.0	(0.2)	Ref.	Ref.	10.5	(0.2)	Ref.	Ref.	Ref.
Place of birth									
All racial/ethnic groups									
United States or U.S. territory	9.6	(0.2)	Ref.	Ref.	8.7	(0.1)	Ref.	Ref.	Ref.
Foreign country	35.6	(0.6)	26.0[†]	270.0	33.7	(0.6)	24.9[†]	286.0	16.0
White, non-Hispanic									
United States or U.S. territory	8.0	(0.2)	Ref.	Ref.	7.2	(0.1)	Ref.	Ref.	Ref.
Foreign country	10.6	(0.7)	2.6[†]	33.1	10.3	(0.7)	3.1[†]	43.3	10.3
Black, non-Hispanic									
United States or U.S. territory	17.3	(0.5)	Ref.	Ref.	16.1	(0.4)	Ref.	Ref.	Ref.
Foreign country	15.7	(1.3)	-1.6	-9.2	16.3	(1.4)	0.2	1.1	10.3
Asian/Pacific Islander									
United States or U.S. territory	4.7	(1.1)	Ref.	Ref.	4.7	(1.0)	Ref.	Ref.	Ref.
Foreign country	14.2	(0.8)	9.5[†]	199.8	13.7	(0.7)	9.0[†]	191.3	-8.5
American Indian/Alaska Native									
United States or U.S. territory	20.1	(1.8)	Ref.	Ref.	19.0	(2.0)	Ref.	Ref.	Ref.
Foreign country	—[††]	—	NA	NA	20.0	(5.7)	1.0	5.2	NA
Multiple races									
United States or U.S. territory	14.4	(1.2)	Ref.	Ref.	12.3	(1.2)	Ref.	Ref.	Ref.
Foreign country	—	—	NA	NA	—	—	NA	NA	NA
Hispanic									
United States or U.S. territory	22.3	(1.0)	Ref.	Ref.	20.5	(0.9)	Ref.	Ref.	Ref.
Foreign country	50.5	(0.7)	28.1[†]	125.9	48.2	(0.7)	27.7[†]	135.3	9.3
World region (country) of birth									
United States	9.8	(0.2)	Ref.	Ref.	8.8	(0.1)	Ref.	Ref.	Ref.
Canada, Europe, Australia, or New Zealand	5.3	(1.0)	-4.5[†]	-45.9	6.0	(1.3)	-2.8	-32.2	13.7
Mexico, South America, Central America, or Caribbean	57.2	(0.9)	47.4[†]	485.8	54.9	(0.9)	46.1[†]	522.9	37.1
Africa or the Middle East	11.6	(2.3)	1.8	18.5	9.1	(2.3)	0.3	2.9	-15.6
Asia or the Pacific Islands	17.3	(1.7)	7.5[†]	77.3	14.9	(1.6)	6.1[†]	69.3	-8.0
U.S. census region[§§]									
Northeast	9.4	(0.4)	Ref.	Ref.	8.7	(0.4)	Ref.	Ref.	Ref.
Midwest	10.7	(0.4)	1.3	13.9	10.2	(0.4)	1.5[†]	17.4	3.5
South	12.2	(0.4)	2.8[†]	30.4	11.3	(0.3)	2.6[†]	29.5	-0.8
West	12.6	(0.6)	3.3[†]	34.8	11.0	(0.5)	2.3[†]	26.8	-8.0
Area of residence									
Inside metropolitan area	16.4	(0.4)	1.4[†]	9.1	15.7	(0.4)	1.4[†]	9.5	0.4
Outside metropolitan area	15.0	(0.5)	Ref.	Ref.	14.3	(0.5)	Ref.	Ref.	Ref.

Abbreviations: FPL = federal poverty level; NA = not applicable; Ref. = referent; SE = standard error.

[*] Age standardized to the 2000 U.S. standard population.

[†] Difference between a group estimate and the estimate for its respective referent group is significant ($p<0.05$, two-tailed z test with Bonferroni correction for multiple comparisons).

[§] Age-specific estimates are not age standardized.

[¶] Persons of Hispanic ethnicity might be of any race or combination of races.

[**] On the basis of the U.S. FPL. FPL was based on U.S. Census Bureau poverty thresholds (available at http://www.census.gov/hhes/www/poverty.html).

[††] Estimate is statistically unreliable because relative SE ≥30%.

[§§] *Northeast:* Connecticut, Maine, Massachusetts, New Jersey, New Hampshire, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest:* Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South:* Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West:* Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

TABLE 2. Age-standardized* percentage of adults aged 18–24 years who did not complete high school, by selected characteristics — Integrated Public Use Microdata Series, Current Population Survey, United States, 2009 and 2011

	2009				2011				
Characteristic	% who did not complete high school	(SE)	Absolute difference (percentage points)	Relative difference (%)	% who did not complete high school	(SE)	Absolute difference (percentage points)	Relative difference (%)	Change in relative difference from 2009 to 2011 (percentage points)
Sex									
Male	22.4	(0.5)	4.6[†]	25.8	22.4	(0.5)	3.6[†]	18.9	-6.9
Female	17.8	(0.4)	Ref.	Ref.	18.8	(0.5)	Ref.	Ref.	Ref.
Age group (yrs)[§]									
Both sexes									
18–19	40.1	(0.7)	28.7[†]	252.8	43.6	(0.8)	33.1[†]	314.4	61.6[§§]
20–24	11.4	(0.4)	Ref.	Ref.	10.5	(0.4)	Ref.	Ref.	Ref.
Male									
18–19	43.9	(1.0)	30.9[†]	238.9	47.0	(1.1)	35.4[†]	305.2	66.3
20–24	13.0	(0.5)	Ref.	Ref.	11.6	(0.5)	Ref.	Ref.	Ref.
Female									
18–19	36.2	(1.0)	26.4[†]	271.3	40.2	(1.1)	30.8[†]	327.1	55.8
20–24	9.7	(0.4)	Ref.	Ref.	9.4	(0.4)	Ref.	Ref.	Ref.
Race/Ethnicity									
Both sexes									
White, non-Hispanic	16.3	(0.4)	Ref.	Ref.	17.2	(0.5)	Ref.	Ref.	Ref.
Black, non-Hispanic	24.4	(1.1)	8.2[†]	50.2	24.3	(1.0)	7.2[†]	41.7	-8.5
Asian/Pacific Islander	13.8	(1.3)	-2.5	-15.3	16.2	(2.0)	-1.0	-5.9	9.4
American Indian/Alaska Native	25.1	(3.2)	8.9	54.4	26.0	(3.7)	8.9	51.7	-2.7
Multiple races	19.9	(2.2)	3.6	22.2	18.8	(2.2)	1.6	9.4	-12.8
Hispanic[¶]	31.5	(1.0)	15.2[†]	93.7	29.5	(0.9)	12.4[†]	72.0	-21.7
Male									
White, non-Hispanic	18.2	(0.6)	Ref.	Ref.	18.4	(0.6)	Ref.	Ref.	Ref.
Black, non-Hispanic	26.7	(1.8)	8.6[†]	47.2	26.7	(1.5)	8.3[†]	45.0	-2.2
Asian/Pacific Islander	14.6	(1.8)	-3.6	-19.7	17.1	(2.5)	-1.3	-7.2	12.5
American Indian/Alaska Native	28.6	(4.7)	10.4	57.4	31.0	(5.9)	12.6	68.4	11.0
Multiple races	22.5	(3.1)	4.3	23.6	16.0	(2.5)	-2.4	-13.0	-36.6
Hispanic	35.1	(1.4)	17.0[†]	93.3	32.0	(1.2)	13.6[†]	73.8	-19.5
Female									
White, non-Hispanic	14.3	(0.5)	Ref.	Ref.	15.9	(0.6)	Ref.	Ref.	Ref.
Black, non-Hispanic	22.2	(1.3)	7.9[†]	55.4	22.0	(1.5)	6.1	38.5	-16.9
Asian/Pacific Islander	12.7	(1.6)	-1.6	-11.3	15.2	(2.3)	-0.7	-4.5	6.9
American Indian/Alaska Native	21.9	(4.1)	7.6	53.4	23.2	(5.0)	7.4	46.3	-7.0
Multiple races	17.0	(2.8)	2.7	18.9	21.3	(3.4)	5.4	34.1	15.2
Hispanic	27.6	(1.2)	13.3[†]	92.8	26.6	(1.1	10.7[†]	67.4	-25.4
Income-to-poverty ratio**									
Both sexes									
Poor, <1.00	23.7	(1.1)	5.9[†]	32.9	23.5	(0.9)	4.7[†]	25.1	-7.8
Near poor, 1.00–1.9	22.8	(0.8)	5.0[†]	27.8	22.3	(0.9)	3.6[†]	19.0	-8.7
Middle income, 2.00–3.9	19.8	(0.6)	1.9	10.8	20.4	(0.6)	1.6	8.5	-2.3
High income, ≥4.0	17.9	(0.5)	Ref.	Ref.	18.8	(0.5)	Ref.	Ref.	Ref.
Male									
Poor, <1.00	25.0	(1.4)	5.4[†]	27.4	24.9	(1.3)	4.4	21.3	-6.1
Near poor, 1.00–1.9	26.0	(1.2)	6.3[†]	32.0	24.6	(1.3)	4.1[†]	19.9	-12.1
Middle income, 2.00–3.9	22.5	(0.9)	2.9	14.6	22.0	(0.9)	1.5	7.2	-7.4
High income, ≥4.0	19.7	(0.8)	Ref.	Ref.	20.5	(0.7)	Ref.	Ref.	Ref.
Female									
Poor, <1.00	22.5	(1.4)	6.5[†]	40.6	22.0	(1.1)	5.0[†]	29.6	-11.0
Near poor, 1.00–1.9	19.5	(1.0)	3.5[†]	21.6	20.0	(1.1)	3.0	17.9	-3.7
Middle income, 2.00–3.9	17.0	(0.7)	1.0	6.3	18.6	(0.8)	1.6	9.2	3.0
High income, ≥4.0	16.0	(0.7)	Ref.	Ref.	17.0	(0.7)	Ref.	Ref.	Ref.
Disability status									
Both sexes									
Disability	32.4	(2.0)	12.7[†]	64.5	35.5	(2.3)	15.4[†]	76.3	11.8
No disability	19.7	(0.4)	Ref.	Ref.	20.1	(0.4)	Ref.	Ref.	Ref.

See table footnotes on the next page.

TABLE 2. (*Continued*) Age-standardized* percentage of adults aged 18–24 years who did not complete high school, by selected characteristics — Integrated Public Use Microdata Series — Current Population Survey, United States, 2009 and 2011

	2009				2011				Change in relative difference from 2009 to 2011 (percentage points)
Characteristic	% who did not complete high school	(SE)	Absolute difference (percentage points)	Relative difference (%)	% who did not complete high school	(SE)	Absolute difference (percentage points)	Relative difference (%)	
Male									
Disability	29.5	(2.4)	7.3†	32.7	38.0	(2.8)	16.1†	73.8	41.1§§
No disability	22.2	(0.5)	Ref.	Ref.	21.8	(0.5)	Ref.	Ref.	Ref.
Female									
Disability	36.0	(3.4)	18.8†	109.4	32.0	(3.3)	13.6†	73.7	-35.7
No disability	17.2	(0.4)	Ref.	Ref.	18.4	(0.5)	Ref.	Ref.	Ref.
Place of birth									
All racial/ethnic groups									
United States or U.S. territory	18.5	(0.4)	Ref.	Ref.	19.1	(0.4)	Ref.	Ref.	Ref.
Foreign country	32.7	(1.4)	14.2†	77.1	31.4	(1.4)	12.0†	63.0	-14.1
White, non-Hispanic									
United States or U.S. territory	16.5	(0.4)	Ref.	Ref.	17.3	(0.5)	Ref.	Ref.	Ref.
Foreign country	13.2	(2.3)	-3.4	-20.3	16.6	(3.2)	-0.7	-4.1	16.2
Black, non-Hispanic									
United States or U.S. territory	24.9	(1.2)	Ref.	Ref.	24.7	(1.1)	Ref.	Ref.	Ref.
Foreign country	22.1	(4.1)	-2.8	-11.4	23.3	(4.4)	-1.4	-5.6	5.7
Asian/Pacific Islander									
United States or U.S. territory	—††	—	Ref.	Ref.	—	—	Ref.	Ref.	Ref.
Foreign country	18.1	(2.3)	NA	NA	22.1	(3.6)	NA	NA	NA
American Indian/Alaska Native									
United States or U.S. territory	24.7	(3.2)	Ref.	Ref.	26.8	(3.9)	Ref.	Ref.	Ref.
Foreign country	0	(0)	-24.7	-100.0	—	—	NA	NA	NA
Multiple races									
United States or U.S. territory	21.1	(2.7)	Ref.	Ref.	20.4	(2.6)	Ref.	Ref.	Ref.
Foreign country	—	—	NA	NA	—	—	NA	NA	NA
Hispanic									
United States or U.S. territory	24.6	(1.5)	Ref.	Ref.	24.5	(1.4)	Ref.	Ref.	Ref.
Foreign country	44.9	(1.9)	20.4†	82.9	40.6	(1.8)	16.0†	65.4	-17.4
World region (country) of birth									
United States	18.4	(0.3)	Ref.	Ref.	19.2	(0.4)	Ref.	Ref.	Ref.
Canada, Europe, Australia, or New Zealand	—	—	NA	NA	—	—	NA	NA	NA
Mexico, South America, Central America, or the Caribbean	46.5	(2.1)	28.1†	153.1	42.5	(2.1)	23.4†	121.9	-31.3
Africa or the Middle East	—	—	NA	NA	30.5	(0)	11.3	58.9	NA
Asia or the Pacific Islands	20.1	(4.0)	1.7	9.3	24.8	(3.8)	5.6	29.2	19.9
U.S. census region¶¶									
Northeast	15.5	(1.1)	Ref.	Ref.	18.0	(1.2)	Ref.	Ref.	Ref.
Midwest	18.6	(0.9)	3.1	20.0	19.2	(0.8)	1.2	6.8	-13.2
South	20.8	(0.9)	5.3†	34.1	21.1	(0.9)	3.1	17.3	-16.8
West	22.6	(1.2)	7.1†	46.0	20.4	(1.0)	2.4	13.4	-32.6
Residence in metropolitan area									
Inside metropolitan area	21.3	(0.8)	0.1	0.3	22.1	(0.7)	-1.3	-5.3	-5.6
Outside metropolitan area	21.3	(1.0)	Ref.	Ref.	23.4	(1.0)	Ref.	Ref.	Ref.

Abbreviations: FPL = federal poverty level; NA = not applicable; Ref. = referent; SE = standard error.

* Age standardized to the 2000 U.S. standard population.

† Difference between a group estimate and the estimate for its respective referent group is significant (p<0.05, two-tailed z test with Bonferroni correction for multiple comparisons).

§ Age-specific estimates are not age standardized.

¶ Persons of Hispanic ethnicity might be of any race or combination of races.

** On the basis of the U.S. FPL. FPL was based on U.S. Census Bureau poverty thresholds (available at http://www.census.gov/hhes/www/poverty.html).

†† Estimate is statistically unreliable because relative SE ≥30%.

§§ Difference between the relative differences in 2011 and 2009 is significant (p<0.05, two-tailed z test with Bonferroni correction for multiple comparisons).

¶¶ *Northeast:* Connecticut, Maine, Massachusetts, New Jersey, New Hampshire, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest:* Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South:* Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West:* Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

similar in men and women. Overall, absolute differences in noncompletion of high school between the referent group (high income) and those who lived in poor (4.7 percentage points) or near-poor families (3.6 percentage points) were significant; however, absolute differences were only significant for men in middle-income families and women in poor families. Significant absolute differences in noncompletion of high school also were found among young adults with a disability (15.4 percentage points); however, unlike men aged ≥25 years, the disparity among younger adult men worsened from 2009 to 2011 by 41.1 percentage points. No temporal change in disability disparity was observed among young adult females (Table 2). In 2011, absolute differences in the age-standardized percentage of persons who did not complete high school among those who were foreign born and U.S. born (referent group) were significant in the total population (12.0 percentage points) and among Hispanics (16.0 percentage points). In addition, absolute differences were only significant between U.S.-born young adults and young adults born in Latin American and Caribbean countries (23.4 percentage points). No significant differences were found by U.S. census region or metropolitan area. No significant changes in the U.S. census region disparities occurred from 2009 to 2011.

In 2011, overall and for men and women, significant absolute differences in the age-standardized percentages of adults in poor families (IPR <1.00) were found among the youngest adults, non-Hispanic blacks, and Hispanics; all groups that had not completed college; and adults with disabilities (Table 3). In 2009 and 2011, disparities in poverty increased with decreasing level of educational attainment, with the greatest disparity experienced by the group with the lowest level of educational attainment. Significant absolute differences in the age-standardized percentages in poor families were found between persons of either sex with a disability and those with no disability (referent group) (men: 3.2 percentage points; women 3.5 percentage points). In 2009 and 2011, the absolute differences between persons who were foreign born and U.S. born (referent group) in age-standardized percentages of adults in poor families were significant in the total population (1.7 and 1.6 percentage points, respectively) but not by race/ethnicity. In addition, significant absolute differences also were found between adults born in Latin American and Caribbean countries and those born in the United States. In 2009 and 2011, significant absolute differences in the percentages of adults who lived in poverty were found between residents of the U.S. census regions of the West, South, or Midwest and the referent group (Northeast region) but not between residents who lived inside compared with outside metropolitan areas. From 2009 to 2011, no statistically significant changes in the relative differences in poverty by any characteristic were found (Table 3).

Discussion

The findings in this report indicate that racial/ethnic, socioeconomic, and geographic disparities in noncompletion of high school and poverty persist in the U.S. adult population; little evidence of improvement from 2009 to 2011 was identified. Within each year studied to date, significant absolute and relative differences were found; however, between years, these differences were not statistically different. The pattern of disparities is consistent with sociodemographic and geographic differences reported by several national surveys (*6–8*,*16*,*21–25*). The findings also reveal that young racial/ethnic, foreign-born, and poor adults might be especially vulnerable to early onset and progression of poor health as evidenced by marked disparities in noncompletion of high school among these subgroups.

Educational attainment and income provide psychosocial and material resources that protect against exposure to health risks in early and adult life (*1–3*). Persons with low levels of education and income generally experience increased rates of mortality, morbidity, and risk-taking behaviors and decreased access to and quality of health care (*1*,*6–8*). This report confirms that the lowest levels of education and income are most common and persistent among subgroups that systematically exhibit the poorest health. For example, two out of five Hispanics and nearly one out of five non-Hispanic blacks or American Indian/Alaska Natives had not completed high school, and at least one out of 10 of these racial/ethnic groups had incomes less than the official poverty threshold. However, substantial empirical evidence from the United States and elsewhere consistently shows no thresholds in the relationships between education or income and health. Among children and adults in the overall population and within racial/ethnic groups, rates of mortality, morbidity, and poor health behaviors decrease in a continuous and graded manner with increasing levels of education and income (*6*,*7*,*23–25*).

Health-promotion efforts have emphasized racial/ethnic disparities in health as part of an approach to risk reduction that focuses on groups at high risk, with little or no improvement in disparities (*24,26*). The patterns described in this report suggest that interventions and policies that are also designed to take account of the influence of educational attainment, family income, and other socioeconomic conditions on health risks in the entire population might prove to be more effective in reducing health disparities (*27,28*).

TABLE 3. Age-standardized* percentage of adults aged ≥18 years with incomes less than the federal poverty level, by selected characteristics — Integrated Public Use Microdata Series — Current Population Survey, United States, 2009 and 2011

	2009				2011				
Characteristic	% with IPR <1.00	(SE)	Absolute difference (percentage points)	Relative difference (%)	Percentage with IPR <1.00	(SE)	Absolute difference (percentage points)	Relative difference (%)	Change in relative difference from 2009 to 2011 (percentage points)
Sex									
Male	11.4	(0.2)	Ref.	Ref.	13.2	(0.2)	Ref.	Ref.	Ref.
Female	11.9	(0.1)	0.5[†]	4.0	13.5	(0.2)	0.4	2.9	-1.1
Age group (yrs)[§]									
Both sexes									
18–24	12.8	(0.3)	1.9[†]	17.1	15.1	(0.4)	2.4[†]	18.6	1.5
25–44	11.9	(0.2)	0.9	8.5	13.5	(0.2)	0.8	6.2	-2.3
45–64	11.0	(0.2)	Ref.	Ref.	12.8	(0.2)	Ref.	Ref.	—
65–79	11.1	(0.3)	0.1	1.1	12.5	(0.3)	-0.2	-1.6	-2.7
≥80	12.1	(0.6)	1.1	10.0	12.8	(0.5)	0	0	-10
Male									
18–24	12.3	(0.4)	1.7[†]	15.8	14.8	(0.5)	2.1[†]	16.2	0.4
25–44	11.7	(0.2)	1.1[†]	10.2	13.5	(0.3)	0.8	6.1	-4.1
45–64	10.6	(0.3)	Ref.	Ref.	12.7	(0.3)	Ref.	Ref.	Ref.
65–79	11.1	(0.5)	0.4	4.2	11.6	(0.4)	-1.1	-8.7	-12.9
≥80	11.4	(0.9)	0.8	7.5	13.0	(0.9)	0.3	2.1	-5.4
Female									
18–24	13.3	(0.4)	2.1[†]	18.6	15.5	(0.5)	2.7[†]	21	2.4
25–44	12.0	(0.2)	0.8	6.9	13.6	(0.2)	0.8	6.3	-0.6
45–64	11.2	(0.2)	Ref.	Ref.	12.8	(0.3)	Ref.	Ref.	Ref.
65–79	11.1	(0.4)	-0.2	-1.7	13.3	(0.4)	0.5	4.0	5.7
≥80	12.4	(0.6)	1.2	10.4	12.6	(0.7)	-0.2	-1.5	-11.9
Race/Ethnicity									
Both sexes									
White, non-Hispanic	10.7	(0.2)	Ref.	Ref.	12.4	(0.2)	Ref.	Ref.	Ref.
Black, non-Hispanic	14.4	(0.4)	3.7[†]	34.8	16.4	(0.4)	4.1[†]	32.8	-2.0
Asian/Pacific Islander	10.7	(0.5)	0	0.1	11.5	(0.5)	-0.8	-6.8	-6.9
American Indian/Alaska Native	15.3	(1.9)	4.7	43.6	18.9	(3.5)	6.6	53.4	9.7
Multiple races	11.2	(0.9)	0.5	4.6	12.4	(1.0)	0	0.2	-4.4
Hispanic[¶]	14.5	(0.4)	3.9[†]	36.3	16.0	(0.4)	3.7[†]	29.7	-6.6
Male									
White, non-Hispanic	10.5	(0.2)	Ref.	Ref.	12.2	(0.2)	Ref.	Ref.	Ref.
Black, non-Hispanic	14.0	(0.5)	3.5[†]	33.4	15.6	(0.5)	3.4[†]	28.1	-5.3
Asian/Pacific Islander	10.8	(0.6)	0.3	3.0	12.0	(0.7)	-0.2	-1.6	-4.6
American Indian/Alaska Native	12.9	(1.9)	2.4	22.5	18.6	(3.1)	6.4	52.1	29.6
Multiple races	9.4	(1.2)	-1.1	-10.3	12.6	(1.4)	0.4	3.3	13.6
Hispanic	14.3	(0.5)	3.8[†]	36.2	15.8	(0.5)	3.5[†]	29.0	-7.2
Female									
White, non-Hispanic	10.8	(0.2)	Ref.	Ref.	12.5	(0.2)	Ref.	Ref.	Ref.
Black, non-Hispanic	14.7	(0.5)	3.9[†]	35.6	17.0	(0.6)	4.5[†]	36.1	0.5
Asian/Pacific Islander	10.5	(0.6)	-0.3	-3.0	11.1	(0.5)	-1.4	-11.1	-8.1
American Indian/Alaska Native	17.7	(2.4)	6.9	63.8	19.3	(4.3)	6.8	54.2	-9.5
Multiple races	12.6	(1.2)	1.8	16.9	12.1	(1.2)	-0.4	-3.4	-20.4
Hispanic	14.9	(0.4)	4.1[†]	37.6	16.2	(0.4)	3.8[†]	30.1	-7.5
Educational attainment									
Both sexes									
Less than high school	15.8	(0.4)	5.6[†]	55.0	17.6	(0.4)	6.1[†]	53.1	-1.8
High school graduate or equivalent	11.8	(0.2)	1.7[†]	16.2	13.8	(0.3)	2.3[†]	20.3	4.2
Some college	10.9	(0.2)	0.7	6.8	12.9	(0.3)	1.4[†]	12.5	5.8
College graduate	10.2	(0.2)	Ref.	Ref.	11.5	(0.3)	Ref.	Ref.	Ref.
Male									
Less than high school	15.1	(0.5)	4.6[†]	43.5	17.1	(0.5)	5.6[†]	48.4	4.9
High school graduate or equivalent	11.2	(0.3)	0.7	7.1	13.2	(0.3)	1.6[†]	14.1	7.1
Some college	10.8	(0.3)	0.3	2.5	12.8	(0.3)	1.3[†]	11.5	9.0
College graduate	10.5	(0.3)	Ref.	Ref.	11.5	(0.4)	Ref.	Ref.	Ref.
Female									
Less than high school	16.6	(0.5)	6.7[†]	66.9	18.0	(0.5)	6.7[†]	58.4	-8.5
High school graduate or equivalent	12.5	(0.3)	2.6[†]	26.0	14.6	(0.3)	3.2[†]	27.6	1.6
Some college	11	(0.2)	1.0[†]	10.5	13.0	(0.3)	1.6[†]	13.7	3.3
College graduate	10	(0.3)	Ref.	Ref.	11.5	(0.3)	Ref.	Ref.	Ref.

See table footnotes on the next page.

TABLE 3. (*Continued*) **Age-standardized* percentage of adults aged ≥18 years with incomes less than the federal poverty level, by selected characteristics — Integrated Public Use Microdata Series — Current Population Survey, United States, 2009 and 2011**

	2009				2011				
Characteristic	**% with IPR <1.00**	**(SE)**	**Absolute difference (percentage points)**	**Relative difference (%)**	**Percentage with IPR <1.00**	**(SE)**	**Absolute difference (percentage points)**	**Relative difference (%)**	**Change in relative difference from 2009 to 2011 (percentage points)**
Disability status									
Both sexes									
Disability	14.7	(0.5)	3.4[†]	29.8	16.4	(0.6)	3.4[†]	25.8	-4.0
No disability	11.4	(0.1)	Ref.	Ref.	13.0	(0.2)	Ref.	Ref.	Ref.
Male									
Disability	14.1	(0.7)	2.9[†]	26.0	16.1	(0.7)	3.2[†]	24.9	-1.1
No disability	11.2	(0.2)	Ref.	Ref.	12.9	(0.2)	Ref.	Ref.	Ref.
Female									
Disability	15.4	(0.7)	3.8[†]	33.2	16.7	(0.8)	3.5[†]	26.8	-6.4
No disability	11.5	(0.2)	Ref.	Ref.	13.2	(0.2)	Ref.	Ref.	Ref.
Place of birth									
All racial/ethnic groups									
United States or U.S. territory	11.4	(0.2)	Ref.	Ref.	13.1	(0.2)	Ref.	Ref.	Ref.
Foreign country	13	(0.3)	1.7[†]	15.1	14.6	(0.3)	1.6[†]	12.4	-2.7
White, non-Hispanic									
United States or U.S. territory	10.6	(0.2)	Ref.	Ref.	12.3	(0.2)	Ref.	Ref.	Ref.
Foreign country	11.1	(0.6)	0.5	4.7	13.4	(0.7)	1.1	8.7	3.8
Black, non-Hispanic									
United States or U.S. territory	14.4	(0.4)	Ref.	Ref.	16.5	(0.5)	Ref.	Ref.	Ref.
Foreign country	13.3	(1.0)	-1.1	-7.8	16.8	(1.3)	0.3	1.5	9.3
Asian/Pacific Islander									
United States or U.S. territory	10.2	(1.4)	Ref.	Ref.	12.6	(1.8)	Ref.	Ref.	Ref.
Foreign country	10.8	(0.6)	0.7	6.7	12.0	(0.6)	-0.6	-4.8	-11.5
American Indian/Alaska Native									
United States or U.S. territory	15.4	(1.9)	Ref.	Ref.	19.7	(3.7)	Ref.	Ref.	Ref.
Foreign country	—**	—	NA	NA	—	—	NA	NA	NA
Multiple races									
United States or U.S. territory	11.8	(1.0)	Ref.	Ref.	12.9	(1.1)	Ref.	Ref.	Ref.
Foreign country	—	—	NA	NA	—	—	NA	NA	NA
Hispanic									
United States or U.S. territory	13.7	(0.7)	Ref.	Ref.	16.0	(0.8)	Ref.	Ref.	Ref.
Foreign country	14.8	(0.5)	1.1	7.8	16.3	(0.5)	0.2	1.5	-6.3
World region (country) of birth									
United States	11.4	(0.1)	Ref.	Ref.	13.1	(0.2)	Ref.	Ref.	Ref.
Canada, Europe, Australia, or New Zealand	12.2	(1.8)	0.8	7.0	11.7	(1.7)	-1.4	-10.6	-17.6
Mexico, South America, Central America, or the Caribbean	15.6	(0.6)	4.2[†]	37.0	16.5	(0.6)	3.4[†]	26.0	-11.0
Africa or the Middle East	7.1	(1.2)	-4.3	-37.5	14.0	(3.1)	0.9	6.6	44.1
Asia or the Pacific Islands	8.9	(1.1)	-2.4	-21.4	12.6	(1.3)	-0.5	-4.1	17.3
U.S. census region[††]									
Northeast	9.4	(0.5)	Ref.	Ref.	9.8	(0.5)	Ref.	Ref.	Ref.
Midwest	11.1	(0.4)	1.7[†]	18.2	12.7	(0.4)	2.9[†]	29.1	10.9
South	11.3	(0.3)	1.9[†]	20.3	13.8	(0.4)	4.0[†]	40.8	20.5
West	11.7	(0.5)	2.3[†]	24.5	12.9	(0.6)	3.1[†]	31.6	7.1
Residence in metropolitan area									
Inside metropolitan area	12.7	(0.3)	0.2	1.2	14.4	(0.3)	0.4	2.5	1.3
Outside metropolitan area	12.6	(0.4)	Ref.	Ref.	14.1	(0.4)	Ref.	Ref.	Ref.

Abbreviations: IPR = income-to-poverty ratio; NA = not applicable; Ref. = referent; SE = standard error.

* Age standardized to the 2000 U.S. standard population.

[†] Difference between a group estimate and the estimate for its respective referent group is significant.

[§] Age-specific estimates are not age standardized.

[¶] Persons of Hispanic ethnicity might be of any race or combination of races.

** Estimate is statistically unreliable because relative SE ≥30%.

[††] *Northeast:* Connecticut, Maine, Massachusetts, New Jersey, New Hampshire, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest:* Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South:* Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West:* Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Limitations

The findings in this report are subject to at least two limitations. First, all data were self-reported and therefore are subject to recall and social desirability bias. Second, CDC used cross-sectional data for the analyses; therefore, no causal inferences can be drawn from the findings. The limited findings for disparities in place of birth among racial/ethnic groups might reflect small sample sizes in single years of data, as suggested by unstable estimates in the foreign-born strata of several racial/ethnic groups.

Conclusion

The U.S. Department of Education's Institute of Education Sciences recommends effective evidence-based interventions to prevent or reduce the dropout rates among middle school and high school students (*29*). The U.S. Task Force on Community Preventive Services recommends interventions that promote healthy social environments for low-income children and families and to reduce risk-taking behaviors among adolescents (*30)*. Since 2011, HHS has released several complementary initiatives to eliminate health disparities (*26*,*31*). The 2011 HHS action plan focuses specifically on reduction of racial/ethnic disparities but includes education and social and economic conditions among its major strategic areas (*26*). The 2012 National Prevention Council action plan will implement strategies of the National Prevention Strategy by targeting communities at greatest risk for health disparities, disparities in access to care, and the capacity of the prevention workforce; research to identify effective strategies; and standardization and collection of data to better identify and address disparities. CDC proposes increasing its efforts to eliminate health disparities by focusing on surveillance, analysis, and reporting of disparities and identifying and applying evidence-based strategies to achieve health equity (*31)*. Integration of these efforts across federal departments; among federal, state, and local levels of government; and with nongovernment organizations could increase understanding of how socioeconomic disparities in health arise and persist and provide information on how best to design effective interventions for populationwide and targeted approaches.

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Health-Related Quality of Life — United States, 2006 and 2010

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Introduction

Health-related quality of life is physical and mental health, as perceived by a person or group of people, during a period of time (*1*,*2*). This measure complements traditional public health measures of mortality and morbidity. Fair or poor self-rated health, physically unhealthy days, and mentally unhealthy days are reported by higher percentages of women, older persons, minority racial/ethnic groups (except Asian/Pacific Islanders), and persons with less education, with lower annual household incomes, who are unemployed, with a disability or a chronic disease, and who are widowed, separated, or divorced than, respectively, men, younger persons, and non-Hispanic whites, and those with more education, with higher annual household incomes, who are employed by others or self-employed, without a disability or a chronic disease, and who are married (*1*).

This report is part of the second CDC Health Disparities and Inequalities Report (CHDIR). The 2011 CHDIR (*3*) was the first CDC report to assess disparities across a wide range of diseases, behavioral risk factors, environmental exposures, social determinants, and health-care access. The topic presented in this report is based on criteria that are described in the 2013 CHDIR Introduction (*4*). This report provides information concerning disparities in health-related quality of life, a topic that was not discussed in the 2011 CHDIR. The purposes of this health-related quality of life report are to describe and raise awareness of how different kinds of disparities affect health-related quality of life among adults in the United States, whether and how these effects changed from 2006 to 2010 and to prompt actions to reduce disparities.

Methods

To examine health-related quality of life disparities by selected characteristics among adults (aged ≥18 years) in the United States, CDC analyzed 2006 and 2010 data from the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is a continuous, random-digit–dialed telephone survey of noninstitutionalized adults aged ≥18 years in the 50 states, the District of Columbia (DC), Puerto Rico, the U.S. Virgin Islands, Guam (*5*,*6*) (available at http://www.cdc.gov/brfss/index.htm). This analysis compares health-related quality of life measures stratified by specific characteristics in respondents from the 50 states and DC in 2006 (N = 347,790) and 2010 (N = 444,927).

Two indicators of BRFSS survey quality are its cooperation rate and its overall response rate (*7*,*8*). The cooperation rate is the proportion of all respondents interviewed of all eligible units in which a respondent was selected and actually contacted. In 2006, the cooperation rate ranged from 56.9% in California to 83.5% in Minnesota; in 2010, the cooperation rate ranged from 56.8% in California to 86.1% in Minnesota. The overall response rate is an outcome rate with the number of complete and partial interviews in the numerator and an estimate of the number of eligible units in the sample in the denominator that assumes that more unknown records are eligible, specifically, that all likely households are households and that 98% of known or probable households contain an adult who uses the telephone number. In 2006, the overall response rate ranged from 20.5% in Georgia to 58.4% in Utah, and in 2010, from 19.2% in Oregon to 57.4% in Utah.

The three health-related quality of life measures represented in BRFSS are 1) self-rated health status, 2) number of physically unhealthy days, and 3) number of mentally unhealthy days. The related BRFSS questions were as follows: 1) "Would you say that in general your health is excellent, very good, good, fair, or poor?" 2) "Now thinking about your physical health, which includes physical illness and injury, for about how many days during the past 30 days was your physical health not good?" and 3) "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for about how many days during the past 30 days was your mental health not good?" CDC calculated the percentage reporting fair or poor self-rated health, mean number of physically unhealthy days, and mean number mentally unhealthy days as the primary health-related quality of life outcome measures. Respondents with the responses "do not know/not sure" or "refused to respond" were excluded from the analysis on a question-by-question basis.

Health-related quality of life disparities were assessed by stratifying results by sex, age group (18–24, 25–34, 35–44, 45–64, 65–79, and ≥80 years), race/ethnicity (non-Hispanic white, non-Hispanic black, Hispanic [might be of any race or any combination of races], non-Hispanic Asian/Pacific Islander [A/PI], non-Hispanic American Indian/Alaska Native [AI/AN], and other), educational attainment at the time of the survey (less than high school, high school graduate or equivalent, some college, and college graduate), the primary language spoken at home (English, Spanish, or other), and disability status, which was defined as an affirmative answer to either or both of the following questions (*9*): "Are you limited in any way in any activities because of physical, mental, or emotional problems?" and "Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?") Each outcome measure was analyzed separately. Household income was not examined because educational attainment was considered a sufficient indicator of socioeconomic status for examination of disparities and because approximately 14% of BRFSS respondents did not know or refused to report household income, but <2% did not know or refused to report their educational attainment.

CDC used statistical software for the analyses to account for the stratified, complex sampling design of BRFSS (*10*). Data were weighted using the respondents' sampling weights based on the population of noninstitutionalized adults aged ≥18 years in their states of residence and aggregated across the 50 states and DC. Because age is associated with the health-related quality of life measures and because the age composition differs among the various categories analyzed, CDC adjusted the health-related quality of life measures by using age group categories in the specific survey year as covariates in logistic regression (for fair or poor self-rated health) and linear regression (for number of physically and mentally unhealthy days). No formal statistical testing was conducted for this analysis. Differences were assessed by calculating and comparing the 95% confidence intervals (CIs) around the age-adjusted percentages and means. In this approach, CIs were used as measure of variability, and nonoverlapping CIs were considered statistically different. Using CIs in this way is a conservative evaluation of significance differences; this might lead to a conclusion that estimates are similar when the point estimates differ at a significance level of 0.05. CIs were assessed before rounding for the tables.

Disparities were measured as the deviations from a referent group, which was the group that had the most favorable estimate for the variables used to assess disparities during the time reported. Absolute difference was measured as the simple difference between a population subgroup estimate and the estimate for its respective reference group. The relative difference, a percentage, was calculated by dividing the difference by the value in the referent category and multiplying by 100. Change in percentage and mean from 2006 to 2010 was calculated by subtracting the estimate for 2010 from the estimate for 2006. The significance of changes over time was assessed by comparing CIs as described in this section.

Results

Overall, the age-adjusted percentage of respondents rating their health as fair or poor did not change significantly from 2006 (16.3%) to 2010 (16.1%) (Table 1). A higher percentage of women than men reported fair or poor health in both years. However, neither of the groups experienced a significant change from 2006 to 2010. A higher percentage of persons in older age groups than younger groups rated their health as fair or poor in both years. The percentage of persons aged ≥65 years reporting fair or poor health significantly decreased approximately 2 percentage points from 2006 to 2010. Both in 2006 and 2010, a significantly lower percentage of non-Hispanic whites rated their health as fair or poor than all other racial/ethnic groups except A/PIs. However, only two of these racial/ethnic groups experienced a significant change in self-rated health from 2006 to 2010: the percentage of non-Hispanic blacks reporting fair or poor health increased by 2 percentage points, and that of Hispanics decreased approximately 3 percentage points. In both 2006 and 2010, a higher percentage of those who had not graduated from high school reported fair or poor health than did high school graduates, and a lower percentage of college graduates reported fair or poor health than did high school graduates. From 2006 to 2010, the percentage of high school graduates who reported fair or poor self-rated health increased by 1.2 percentage points, and the percentage of persons with some college education who reported fair or poor self-rated health decreased by 1.6 percentage points. A higher percentage of persons who spoke a language other than English at home reported fair or poor health than those who spoke English at home. However, the percentage of those who spoke Spanish at home and reported fair or poor health decreased by 7 percentage points from 2006 to 2010. A higher percentage of persons with a disability rated their health as fair or poor than did those without a disability both in 2006 and 2010. Nonetheless, the percentage of persons without a disability who rated their health as fair or poor decreased by 0.8 percentage points from 2006 to 2010.

From 2006 to 2010, the overall age-adjusted mean number of physically unhealthy days in the last 30 days increased by approximately 0.1 days (2006: 3.6 days; 2010: 3.7 days (Table 2). A higher mean number of physically unhealthy days were reported by women than men in 2006 and 2010. However, only men experienced a statistically significant increase in mean number of days (0.2 days) over time. A higher mean number of physically unhealthy days was reported by older respondents than younger respondents. From 2006 to 2010, only persons aged 25–34 years reported a statistically significant increase in mean number of physically unhealthy days (0.3 days). In both 2006 and 2010, the fewest physically

TABLE 1. Estimated percentage of adults aged ≥18 years who rated their health as fair or poor, by selected characteristics — Behavioral Risk Factor Surveillance System, United States, 2006 and 2010

	2006				2010				
Characteristic	Age-adjusted percentage	(95% CI)	Absolute difference (percentage points)	Relative difference (%)	Age-adjusted percentage	(95% CI)	Absolute difference (percentage points)	Relative difference (%)	Change from 2006 to 2010 (percentage points)
Total	**16.3**	**(15.9–16.6)**	**—**	**—**	**16.1**	**(15.9–16.4)**	**—**	**—**	**-0.2**
Sex									
Male	15.8	(15.3–16.3)	-0.8*	-5.3*	15.4	(15.0–15.8)	-1.4*	-8*	-0.4
Female	16.7	(16.3–17.0)	Ref.	Ref.	16.8	(16.5–17.1)	Ref.	Ref.	0.1
Age group (yrs)									
18–24	9.3	(8.3–10.2)	-2.4*	-21*	7.6	(6.8–8.4)	-4.0*	-34*	-1.7
25–34	9.9	(9.2–10.7)	-1.7*	-15*	9.9	(9.3–10.5)	-1.6*	-14*	0.0
35–44	11.7	(11.0–12.3)	Ref.	Ref.	11.5	(11.0–12.1)	Ref.	Ref.	-0.2
45–64	18.8	(18.3–19.3)	7.2*.	61*	19.0	(18.6–19.4)	7.5*	65*	0.2
65–79	27.4	(26.6–28.2)	15.8*	135*	25.1	(24.6–25.6)	13.6*	118*	-2.3*
≥80	33.2	(31.9–34.5)	21.6*	185*	31.1	(30.3–31.9)	19.6*	170*	-2.1*
Race/Ethnicity									
White, non-Hispanic	13.1	(12.8–13.4)	Ref.	Ref.	13.3	(13.0–13.5)	Ref.	Ref.	0.1
Black, non-Hispanic	21.3	(20.3–22.2)	8.1*	62*	23.3	(22.5–24.1)	10.0*	76*	2.0*
Hispanic[†]	31.0	(29.5–32.5)	17.9*	137*	28.1	(27.1–29.1)	14.8*	112*	-2.9*
Asian/Pacific Islander	11.8	(9.8–13.7)	-1.3	-10	11.9	(10.7–13.1)	-1.4	-10	0.1
American Indian/ Alaska Native	26.7	(23.9–29.6)	13.6*	104*	30.8	(28.0–33.6)	17.6*	133*	4.1
Other	22.0	(18.5–25.5)	8.9*	68*	18.6	(15.9–21.3)	5.3*	40*	-3.4
Educational attainment									
Less than high school	39.1	(37.8–40.5)	20.0*	104*	38.4	(37.4–39.5)	18.1*	89*	-0.7
High school graduate or equivalent	19.2	(18.6–19.7)	Ref.	Ref.	20.3	(19.8–20.8)	Ref.	Ref.	1.2*
Some college	13.8	(13.3–14.3)	-5.3*	-28*	15.5	(15.0–15.9)	-4.9*	-24*	1.6*
College graduate	7.1	(6.8–7.4)	-12.0*	-63*	7.3	(7.0–7.6)	-13.0*	-64*	0.2
Language spoken at home									
English	14.8	(14.5–15.1)	Ref.	Ref.	15.0	(14.8–15.3)	Ref.	Ref.	0.2
Spanish	44.8	(42.3–47.3)	30.0*	203*	37.6	(35.9–39.3)	22.6*	151*	-7.2*
Other language	41.9	(18.2–65.6)	27.1*	183*	40.7	(31.3–50.1)	25.7*	171*	-1.2
Disability status									
With disability	38.7	(37.9–39.6)	29.3*	312*	39.4	(38.7–40.0)	30.7*	356*	0.6
Without disability	9.4	(9.1–9.7)	Ref.	Ref.	8.6	(8.4–8.9)	Ref.	Ref.	-0.8*

Abbreviations: 95% CI = 95% confidence interval; Ref. = referent.

* Difference considered statistically significantly different by comparison of nonoverlapping 95% CIs. Unrounded CIs do not overlap.

[†] Persons of Hispanic ethnicity might be of any race or combination of races.

unhealthy days were reported by A/PIs (2006: 2.4 days; 2010: 2.5 days) and the most were reported by AI/ANs, (2006: 6.2 days; 2010: 6.3 days). Hispanics showed an increase in mean number of physically unhealthy days from 2006 to 2010 (0.6 days). Compared with high school graduates, more physically unhealthy days were reported by those who had not graduated from high school than by those with at least some college. However, all but college graduates experienced an increase in physically unhealthy days from 2006 to 2010, with the least educated showing the largest increase (0.8 days). More physically unhealthy days were reported by those who spoke a language other than English at home than by those who spoke English at home. From 2006 to 2010, those who spoke Spanish at home had an 0.8-day increase in physically unhealthy days, compared with an almost 10-day decrease among those who spoke languages other than English and Spanish. Approximately 8 more physically unhealthy days were reported by persons with a disability (10 days) than by those without a disability (1.8 days). Neither group had a significant change in number of days from 2006 to 2010.

From 2006 to 2010, the overall age-adjusted mean number of mentally unhealthy days in the last 30 days increased by approximately 0.1 days (2006: 3.4 days; 2010: 3.5 days) (Table 3). The mean number of mentally unhealthy days for women exceeded those for men by approximately 1 day in both years. However, only men showed a significant increase from 2006 to 2010 (by 0.2 days). A higher percentage of younger respondents reported a mean number of mentally unhealthy days than older respondents. Only those aged 35–79 years experienced an increase in mean number of days from 2006

TABLE 2. Mean number of physically unhealthy days in the past 30 days among adults aged ≥18 years, by selected characteristics — Behavioral Risk Factor Surveillance System, United States, 2006 and 2010

	2006				2010				
Characteristic	**Age-adjusted mean no. of days**	**(95% CI)**	**Absolute difference (percentage points)**	**Relative difference (%)**	**Age-adjusted mean no. of days**	**(95% CI)**	**Absolute difference (percentage points)**	**Relative difference (%)**	**Change from 2006 to 2010 (percentage points)**
Total	**3.6**	**(3.5–3.6)**	**—**	**—**	**3.7**	**(3.6–3.7)**	**—**	**—**	**0.1***
Sex									
Male	3.2	(3.1–3.3)	-0.7*	-19*	3.4	(3.3–3.5)	-0.6*	-14*	0.2*
Female	3.9	(3.8–4.0)	Ref.	Ref.	4.0	(3.9–4.0)	Ref.	Ref.	0.1
Age group (yrs)									
18–24	2.1	(1.9–2.3)	-0.7*	-24*	2.0	(1.9–2.2)	-0.8*	-29*	-0.1
25–34	2.2	(2.1–2.3)	-0.6*	-20*	2.5	(2.4–2.6)	-0.4*	-13*	0.3*
35–44	2.8	(2.7–2.9)	Ref.	Ref.	2.9	(2.8–3.0)	Ref.	Ref.	0.1
45–64	4.3	(4.2–4.4)	1.6*	55*	4.3	(4.3–4.4)	1.5*	51*	0.1
65–79	5.3	(5.2–5.5)	2.6*	92*	5.1	(5.0–5.2)	2.3*	79*	-0.2
≥80	6.6	(6.3–6.9)	3.8*	127*	6.2	(6.0–6.4)	3.3*	116*	-0.4
Race/Ethnicity									
White, non-Hispanic	3.4	(3.4–3.5)	Ref.	Ref.	3.5	(3.4–3.6)	Ref.	Ref.	0.1
Black, non-Hispanic	4.0	(3.9–4.2)	0.6*	18*	4.3	(4.1–4.4)	0.8*	22*	0.2
Hispanic†	3.8	(3.6–4.0)	0.4*	10*	4.4	(4.2–4.5)	0.9*	25*	0.6*
Asian/Pacific Islander	2.4	(2.2–2.7)	-1.0*	-30*	2.5	(2.3–2.7)	-1.0*	-29*	0.1
American Indian/ Alaska Native	6.2	(5.5–6.9)	2.8*	82*	6.3	(5.7–6.9)	2.8*	79*	0.0
Other	5.2	(4.3–6.1)	1.8*	52*	4.3	(3.9–4.8)	0.9*	24*	-0.9
Educational attainment									
Less than high school	5.7	(5.4–5.9)	1.6*	40*	6.5	(6.3–6.7)	2.2*	51*	0.8*
High school graduate or equivalent	4.0	(3.9–4.2)	Ref.	Ref.	4.3	(4.2–4.4)	Ref.	Ref.	0.3*
Some college	3.7	(3.6–3.8)	-0.4*	-9*	3.9	(3.8–4.0)	-0.4*	-9*	0.2*
College graduate	2.2	(2.2–2.3)	-1.8*	-44*	2.3	(2.2–2.3)	-2.1*	-48*	0.0
Language spoken at home									
English	3.5	(3.5–3.6)	Ref.	Ref.	3.6	(3.6–3.7)	Ref.	Ref.	0.1
Spanish	4.0	(3.6–4.4)	0.5*	13*	4.8	(4.5–5.1)	1.2*	33*	0.8*
Other language	12.7	(4.4–21.0)	9.2*	260*	2.9	(1.8–4.0)	-0.7	20	-9.8*
Disability status									
With disability	10.0	(9.8–10.2)	8.3*	464*	10.2	(10.0–10.3)	8.4*	471*	0.1
Without disability	1.8	(1.7–1.8)	Ref.	Ref.	1.8	(1.7–1.8)	Ref.	Ref.	0.0

Abbreviations: 95% CI = 95% confidence interval; Ref. = referent.

* Difference considered statistically significantly different by comparison of nonoverlapping 95% CIs. Unrounded CIs do not overlap.

† Persons of Hispanic ethnicity might be of any race or combination of races.

to 2010 (0.2–0.3 days). A/PIs reported the fewest mentally unhealthy days, and AI/ANs reported the most. However, from 2006 to 2010, only Hispanics showed a significant increase (0.6 days). The number of mentally unhealthy days in 2006 and 2010 was higher for persons with less education than for those with more education. However, all groups without a college degree experienced a significant increase in the number of days from 2006 to 2010. Similar to the change among Hispanic respondents, who experienced an increase of 0.6 mentally unhealthy days from 2006 to 2010, the mean number of mentally unhealthy days increased among those who spoke Spanish at home by 0.9 days. The mean number of mentally unhealthy days among persons with a disability (7 days) was approximately five more than among persons without a disability (2 days). Nonetheless, only persons with a disability showed a statistically significant increase from 2006 to 2010 (0.3 days).

Discussion

The patterns of the health-related quality of life measures among the various groups in this report are similar to previous findings (*1*,*11*). Groups with higher percentages of fair or poor health and who report more physically unhealthy days and more mentally unhealthy days are usually women, older persons (with respect to physical health), younger persons (with respect to mental health), minority racial/ethnic groups (except for A/PIs), those with less education, those who speak another language besides English at home, and those with a disability.

Groups that had statistically significant changes in health-related quality of life from 2006 to 2010 differ from groups with statistically significant differences from the reference groups during the individual years. Although minimal change occurred overall, statistically significant changes occurred in

TABLE 3. Mean number of mentally unhealthy days in the past 30 days among adults aged ≥18 years, by selected characteristics — Behavioral Risk Factor Surveillance System, United States, 2006 and 2010

	2006				2010				
Characteristic	Age-adjusted mean no. of days	(95% CI)	Absolute difference (percentage points)	Relative difference (%)	Age-adjusted mean no. of days	(95% CI)	Absolute difference (percentage points)	Relative difference (%)	Change from 2006 to 2010 (percentage points)
Total	**3.4**	**(3.3–3.5)**	—	—	**3.5**	**(3.5–3.6)**	—	—	**0.1***
Sex									
Male	2.7	(2.7–2.8)	-1.3*	-32	3.0	(2.9–3.0)	-1.2*	-28*	0.2*
Female	4.0	(4.0–4.1)	Ref.	Ref.	4.1	(4.0–4.2)	Ref.	Ref.	0.1
Age group (yrs)									
18–24	4.3	(4.0–4.5)	0.9*	26*	4.0	(3.8–4.2)	0.4*	10*	-0.3
25–34	3.7	(3.5–3.8)	0.3*	9*	3.8	(3.7–4.0)	0.2	6	0.2
35–44	3.4	(3.3–3.5)	Ref.	Ref.	3.6	(3.5–3.8)	Ref.	Ref.	0.3*
45–64	3.6	(3.5–3.7)	0.2	6	3.8	(3.8–3.9)	0.2*	6*	0.3*
65–79	2.1	(2.0–2.3)	-1.2*	-37*	2.3	(2.3–2.4)	-1.3*	-36*	0.2*
≥80	2.0	(1.9–2.2)	-1.3*	-40*	2.0	(1.9–2.1)	-1.7*	-46*	-0.1
Race/Ethnicity									
White, non-Hispanic	3.4	(3.3–3.4)	Ref.	Ref.	3.5	(3.4–3.5)	Ref.	Ref.	0.1
Black, non-Hispanic	3.8	(3.6–4.0)	0.5*	13*	4.0	(3.8–4.2)	0.5*	15*	0.2
Hispanic†	3.2	(3.0–3.5)	-0.1	4	3.8	(3.6–4.0)	0.3*	10*	0.6*
Asian/Pacific Islander	2.1	(1.9–2.4)	-1.2*	-37*	2.0	(1.7–2.3)	-1.5*	-42*	-0.1
American Indian/ Alaska Native	5.7	(5.0–6.3)	2.3*	68*	5.7	(5.1–6.4)	2.3*	65*	0.1
Other	5.1	(4.3–6.0)	1.7*	52*	3.9	(3.4–4.5)	0.5	14	-1.2
Educational attainment									
Less than high school	4.9	(4.6–5.1)	1.1*	28*	5.6	(5.4–5.8)	1.6*	40*	0.7*
High school graduate or equivalent	3.8	(3.7–3.9)	Ref.	Ref.	4.0	(3.9–4.1)	Ref.	Ref.	0.2*
Some college	3.6	(3.5–3.8)	-0.2	-5	3.9	(3.8–4.0)	-0.1	-3	0.3*
College graduate	2.3	(2.2–2.4)	-1.5*	-39*	2.3	(2.3–2.4)	-1.7*	-42*	0.0
Language spoken at home									
English	3.5	(3.4–3.5)	Ref.	Ref.	3.5	(3.5–3.6)	Ref.	Ref.	0.1
Spanish	2.9	(2.6–3.3)	-0.5*	-15*	3.8	(3.6–4.1)	0.3	9	0.9*
Other language	8.9	(0.0–17.9)	5.5	159	3.9	(2.3–5.5)	0.4	11	-5.0
Disability status									
With disability	7.2	(7.1–7.4)	4.9*	207*	7.5	(7.4–7.7)	5.2*	220*	0.3*
Without disability	2.4	(2.3–2.4)	Ref.	Ref.	2.4	(2.3–2.4)	Ref.	Ref.	0.0

Abbreviations: 95% CI = 95% confidence interval; Ref. = referent.

* Difference considered statistically significantly different by comparison of nonoverlapping 95% CIs. Unrounded CIs do not overlap.

† Persons of Hispanic ethnicity might be of any race or combination of races.

specific groups. Men (but not women) reported an increase in the number of physically and mentally unhealthy days over time. Persons aged ≥65 years rated their overall health better in 2010 than in 2006. Hispanics and those who spoke Spanish at home also rated their overall health better in 2010 than in 2006, despite reporting increases in numbers both of physically and mentally unhealthy days. Numbers of physically and mentally unhealthy days increased from 2006 to 2010 among persons without a college degree. The number of mentally unhealthy days but not of physically unhealthy days increased among persons with a disability, although persons without a disability rated their overall health better.

Reasons for particular changes in health-related quality are unclear. Differences in risky and protective health behaviors, in socioeconomic circumstances such as employment status and household income, and in disease status have been associated with differences in the measures used in this analysis to assess health-related quality of life (*1,11*). Hispanics and those without a college degree reported more physically and mentally unhealthy days in 2010 than in 2006; however, others in similar socioeconomic circumstances (e.g., non-Hispanic blacks and AI/ANs) did not. What accounted for these differences is unclear. Additional analyses that adjust for changes in employment status, the effects of housing loss, and the recent increase in enforcement against illegal immigrants might clarify these differences.

Limitations

The findings in this report are subject to at least four limitations. First, although the BRFSS health-related quality of life questions have been shown to be reliable in predicting 30-day and 1-year hospitalization and mortality (*12*,*13*), because the health-related quality of life data are self-reported, they might be misclassified because they are not objectively verifiable and are subject to recall bias and measurement error. Second, although BRFSS uses poststratification to adjust respondent sampling weights for non-response (*7*,*8*), this adjustment assumes that nonrespondents would have answered in similar ways to respondents with similar demographic characteristics; such poststratification might not have fully adjusted for differences between nonrespondents and respondents, given the low, state-specific overall response rates. Third, BRFSS data are cross-sectional; therefore, changes in the composition of the BRFSS sample from 2006 to 2010 that affect responses to the health-related quality of life questions might affect measured differences from 2006 to 2010. Finally, the results were adjusted for age only; therefore, other confounding variables also might have affected measured differences from 2006 to 2010.

Conclusion

Although direct interventions to improve health-related quality of life are not possible, indirect interventions to change characteristics associated with health-related quality of life might result in improvements. For example, risky health behaviors can decrease health-related quality of life. Persons who smoke cigarettes have worse health-related quality of life than former smokers or never smokers (*14*), and smoking is more prevalent among those with certain health conditions such as epilepsy (*15*).

Cigarette smoking is a well-known cause of multiple types of cancer (*16*). Persons with epilepsy (*17*) and cancer (*18*) have worse health-related quality of life than those without these conditions. Moreover, protective health behaviors can increase health-related quality of life. For example, persons who engage in physical activity have better health-related quality of life than those who are sedentary (*19*). Physical activity also reduces obesity (*20*) and its complications and has been associated both with reduced colon cancer rates (*20*) and reduced complications from different kinds of arthritis (*21*). Persons who are obese (*22*), have cancer (*18*), or have arthritis (*23*) have worse health-related quality of life than those without these conditions. Therefore, interventions to eliminate risky behaviors, promote protective behaviors, and delay or prevent complications from diseases and other conditions would probably improve health-related quality of life.

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Suicides — United States, 2005–2009

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Introduction

Injury from self-directed violence, which includes suicidal behavior and its consequences, is a leading cause of death and disability. In 2009, suicide was the 10th-leading cause of death in the United States and the cause of 36,909 deaths (*1*). In 2005, the estimated cost of self-directed violence (fatal and nonfatal treated) was $41.2 billion (including $38.9 billion in productivity losses and $2.2 billion in medical costs) (*2*). Suicide is a complex human behavior that results from an interaction of multiple biological, psychological, social, political, and economic factors (*3*). Although self-directed violence affects members of all racial/ethnic groups in the United States, it often is misperceived to be a problem affecting primarily non-Hispanic white males (*4*).

This report is part of the second CDC Health Disparities and Inequalities Report (CHDIR). The 2011 CHDIR (*5*) was the first CDC report to assess disparities across a wide range of diseases, behavior risk factors, environmental exposures, social determinants, and health-care access. The topic presented in this report is based on criteria that are described in the 2013 CHDIR Introduction (*6*). This report updates information that was presented in the 2011 CHDIR (*7*) by providing more current data on suicide in the United States. The purposes of this report are to discuss and raise awareness of differences in the characteristics of suicide decedents and to prompt actions to reduce these disparities.

Methods

To determine differences in the prevalence of suicide by sex, race/ethnicity, age, and educational attainment in the United States, CDC analyzed 2005–2009 data from the Web-based Injury Statistics Query and Reporting System — Fatal (WISQARS Fatal) (*8*) and the National Vital Statistics System (NVSS). In this report, NVSS data provided as of February 2012 were used. The 2009 data were used to describe the overall patterns in suicides. The aggregate 2005–2009 reporting period was used to describe patterns for the combined age group and race/ethnicity because sample sizes for any single year were limited. Mortality data were drawn from CDC's National Vital Statistics System (NVSS), which collects death certificate data filed in the 50 states and the District of Columbia (*1*). Data in this report include suicides from any cause during 2005–2009. The WISQARS database contains mortality data based on NVSS and population counts for all U.S. counties based on U.S. Census data. Counts and rates of death can be obtained by underlying cause of death, mechanism of injury, state, county, age, race, sex, year, injury cause of death (e.g., firearm, poisoning, or suffocation) and by manner of death (e.g., suicide, homicide, or unintentional injury) (*8*).

NVSS codes racial categories as non-Hispanic white, non-Hispanic black, American Indian/Alaska Native (AI/AN), and Asian/Pacific Islander (A/PI); ethnicity is coded separately as Hispanic or non-Hispanic (*1*). Persons of Hispanic ethnicity might be of any race or combination of races. Absolute differences in rates between two populations were compared using a test statistic, z, based on a normal approximation at a critical value of $\alpha = 0.05$ (*9*).

Educational attainment is recorded by two methods on death certificates. In 28 states* and the District of Columbia (DC), the 2003 version of the standard certificate of death is used (which collects the highest degree completed), whereas 20 states† use the 1989 version of the certificate (which collects the number of years of education completed). For this reason, these two groups of states were analyzed separately. Death rates by educational attainment were based on population estimates from the U.S. Census Bureau's 2009 American Community Survey (ACS) (*10*). Data for Georgia and Rhode Island were excluded because educational attainment was not recorded on their death certificates. Rates are presented only for persons aged ≥25 years because persons aged <25 years might not have completed their formal education (*9*).

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* Arkansas, California, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Kansas, Michigan, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, and Wyoming.

† Alabama, Alaska, Arizona, Colorado, Hawaii, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, North Carolina, Pennsylvania, Tennessee, Virginia, Wisconsin, and West Virginia.

Unadjusted (crude) suicide rates were based on resident population data from the U.S. Census Bureau (*10*). Rates based on <20 deaths were considered unreliable and not included in the analysis. Confidence intervals were calculated in two ways: 1) groupings of <100 deaths were calculated by using the gamma method (*9*), and 2) groupings of ≥100 deaths were calculated by using a normal approximation (*9*).

Results

In 2009, a total of 36,909 suicides occurred in the United States, 83.5% of which were among non-Hispanic whites, 7.0% among Hispanics, 5.5% among non-Hispanic blacks, 2.5% among A/PIs, and 1.1% among AI/ANs (Table). Although AI/ANs represented the smallest proportion of suicides of all racial/ethnic groups, they shared the highest rates with whites. Overall, the crude suicide rate for males (19.2 per 100,000 population) was approximately four times higher than the rate for females (5.0 per 100,000 population). In each of the racial/ethnic groups, suicide rates were higher for males than for females, but the male-female ratio for suicide differs among these groups. Among non-Hispanic whites, the male-female ratio was 3.8:1; among Hispanics it was 4.5:1; among non-Hispanic blacks it was 4.7:1; among A/PIs it was 2.3:1; and among AI/ANs it was 2.8:1. These male-female ratios did not change significantly from those reported previously (*7*).

Overall, suicide rates varied by the level of educational attainment. Persons with the highest educational attainment had the lowest rates, those with the lowest educational attainment had intermediate rates, and those who had completed only the equivalent of high school (or 12 years of education) had the highest rates. This pattern was consistent for males, but the pattern of educational inequalities was different among females. Females with a lower educational level had the lowest suicide rates followed by those with the highest educational level, while those females with a high school education (12 years of education) had the highest suicide rates. For each version of the death certificate, whether overall or by sex, suicide rates differed significantly between levels of educational attainment, except that rates for females did not differ significantly between the lowest and highest educational attainment levels in the states on the basis of data from the 1989 death certificate version.

Suicide rates by race/ethnicity and age group demonstrated different patterns by racial/ethnic group, with the highest rates occurring among AI/AN adolescents and young adults aged 15–34 years (Figure). Rates among AI/ANs and non-Hispanic blacks were highest among adolescents and young adults, then declined or leveled off with increasing age, respectively. Among A/PIs and Hispanics, rates were highest among young adults in their early 20s, then leveled off among other adults but increased for those aged ≥65 years. In contrast, rates among non-Hispanic whites were highest among those aged 40–54 years. Although the 2009 overall rates for AI/ANs are similar to those of non-Hispanic whites, the 2005–2009 rates among adolescent and young adult AI/ANs aged 15–29 years were substantially higher.

Discussion

The burden of suicide among AI/AN youths is considerably higher than that among other racial/ethnic groups. In 2009, suicide ranked as the fourth leading cause of years of potential life lost (YPLL) for AI/ANs aged <75 years, accounting for 6.8% of all YPLL among AI/ANs (*8*). Studies examining the historical and cultural context of suicide among AI/AN populations have identified multiple contributors to the high rates such as individual-level factors (e.g., alcohol and substance misuse and mental illness), family- or peer-level factors (e.g., family disruption or suicidal behavior of others), and societal-level factors (e.g., poverty, unemployment, discrimination, and historic trauma [i.e., cumulative emotional and psychological wounding across generations]) (*11*). Although certain protective factors exist within AI/AN communities, including spirituality and cultural continuity, these factors often are overwhelmed by the magnitude of the risk factors (*11*). If the overall suicide rate among the AI/AN population (highest rate) could be decreased to that of non-Hispanic blacks (lowest rate), 271 (66.6%) of the total 407 AI/AN deaths during 2009 might have been prevented. This idea of achieving rates of the lowest group is similar to that proposed in the *Healthy People 2010* objectives (*12*).

Prevention efforts and resources also should be directed toward adults aged 40–54 years because this age group has the highest (and increasing) suicide rate, but this age group often is overlooked as a group at which prevention efforts should focus (*13*). The National Strategy for Suicide Prevention has identified males in this age group as one of the populations at increased risk for suicide for whom additional surveillance, research, and prevention programs need to be focused (*14*).

The findings regarding the association of suicide rates and educational attainment are mixed in this study and in others. Certain studies (*15*) have found an inverse relationship between educational status and suicide among males (i.e., suicide rates decrease as educational attainment increases), whereas other studies (*16*) have not found this pattern. Patterns among females identified in other studies seem more consistent (i.e., the lowest rates occur among those with the lowest educational attainment) or find no association, but the

TABLE. Number and rate[*] of suicides, by selected characteristics — National Vital Statistics System, United States, 2009

Characteristic	Male			Female			Total			
	No. of deaths	Rate	(95% CI)[†]	No. of deaths	Rate	(95% CI)	No. of deaths	Rate	(95% CI)	% of total
Age group (yrs)										
0–4	0	—[§]	—	0	—	—	**0**	—	—	—
5–9	4	—	—	2	—	—	**6**	—	—	—
10–14	171	1.7	(1.4–1.9)	88	0.9	(0.7–1.1)	**259**	**1.30**	**(1.1–1.5)**	**0.7**
15–19	1,325	12.0	(11.3–12.6)	344	3.3	(2.9–3.6)	**1,669**	**7.75**	**(7.4–8.1)**	**4.5**
20–24	2,270	20.5	(19.6–21.3)	432	4.1	(3.8–4.5)	**2,702**	**12.5**	**(12.1–13.0)**	**7.3**
25–29	2,184	19.7	(18.8–20.5)	515	4.9	(4.5–5.3)	**2,699**	**12.5**	**(12.0–12.9)**	**7.3**
30–34	2,109	20.9	(20.0–21.8)	512	5.2	(4.8–5.7)	**2,621**	**13.2**	**(12.7–13.7)**	**7.1**
35–39	2,414	23.3	(22.4–24.3)	681	6.7	(6.2–7.2)	**3,095**	**15.1**	**(14.5–15.6)**	**8.4**
40–44	2,728	26.0	(25.0–27.0)	854	8.1	(7.6–8.7)	**3,582**	**17.1**	**(16.5–17.6)**	**9.7**
45–49	3,176	28.1	(27.1–29.1)	1,036	9.0	(8.4–9.5)	**4,212**	**18.5**	**(17.9–19.0)**	**11.4**
50–54	3,293	30.8	(29.8–31.9)	1,093	9.9	(9.3–10.5)	**4,386**	**20.2**	**(19.6–20.8)**	**11.9**
55–59	2,661	28.9	(27.8–30.0)	830	8.5	(7.9–9.1)	**3,491**	**18.4**	**(17.8–19.0)**	**9.5**
60–64	1,796	23.7	(22.6–24.8)	521	6.3	(5.8–6.9)	**2,317**	**14.7**	**(14.1–15.3)**	**6.3**
65–69	1,357	24.6	(23.3–25.9)	312	5.0	(4.4–5.5)	**1,669**	**14.2**	**(13.5–14.8)**	**4.5**
70–74	1,037	25.4	(23.9–27.0)	211	4.3	(3.7–4.9)	**1,248**	**13.9**	**(13.1–14.6)**	**3.4**
75–79	945	30.0	(28.1–31.9)	157	3.8	(3.2–4.4)	**1,102**	**15.0**	**(14.2–15.9)**	**3.0**
80–84	844	36.7	(34.3–39.2)	117	3.3	(2.7–3.9)	**961**	**16.5**	**(15.5–17.6)**	**2.6**
≥85	763	42.8	(39.8–45.8)	115	3.0	(2.4–3.5)	**878**	**15.6**	**(14.6–16.6)**	**2.4**
Unknown	12	—	—	0	—	—	**12**	—	—	—
Race/Ethnicity										
White, non-Hispanic	24,248	24.4	(24.1–24.7)	6565	6.4	(6.2–6.5)	**30,813**	**15.2**	**(15.1–15.4)**	**83.5**
Black, non-Hispanic	1,649	8.9	(8.5–9.3)	385	1.9	(1.7–2.1)	**2,034**	**5.2**	**(5.0–5.5)**	**5.5**
American Indian/Alaska Native	298	23.2	(20.6–25.8)	109	8.2	(6.7–9.8)	**407**	**15.6**	**(14.1–17.1)**	**1.1**
Asian/Pacific Islander	639	8.8	(8.1–9.5)	295	3.8	(3.4–4.3)	**934**	**6.2**	**(5.8–6.6)**	**2.5**
Hispanic[¶]	2,135	8.5	(8.2–8.9)	438	1.9	(1.7–2.1)	**2,573**	**5.3**	**(5.1–5.5)**	**7.0**
Unknown	120	—	—	28	—	—	**148**	—	—	**0.4**
Educational attainment (28 states[**] and DC)										
Less than high school graduate or equivalent	2,211	22.4	(21.5–23.4)	431	4.5	(4.0–4.9)	**2,642**	**13.6**	**(13.0–14.1)**	**14.0[††]**
High school graduate or equivalent	6,283	37.1	(36.2–38.0)	1,436	7.9	(7.5–8.4)	**7,719**	**22.0**	**(21.6–22.5)**	**40.8[††]**
Some college/college graduate	6,336	18.1	(17.7–18.6)	2,242	5.9	(5.7–6.1)	**8,578**	**11.8**	**(11.5–12.0)**	**45.3[††]**
Educational attainment (20 states[§§])										
<12 yrs	1,548	33.3	(31.7–35.0)	244	5.4	(4.7–6.1)	**1,792**	**19.5**	**(18.6–20.5)**	**16.0[††]**
12 yrs	3,963	39.7	(38.4–40.9)	948	9.0	(8.4–9.6)	**4,911**	**23.9**	**(23.3–24.6)**	**43.9[††]**
≥13 yrs	3,273	18.5	(17.8–19.1)	1,203	6.0	(5.7–6.3)	**4,476**	**11.9**	**(11.5–12.2)**	**40.0[††]**
Total	**29,089**	**19.2**	**(19.0–19.4)**	**7,820**	**5.0**	**(4.9–5.1)**	**36,909**	**12.0**	**(11.9–12.1)**	**100.0**

Abbreviations: 95% CI = 95% confidence interval; DC = District of Columbia; GED =general equivalency diploma.

[*] Unadjusted (crude) suicide rates per 100,000 population.

[†] CIs based on <100 deaths were calculated by using a gamma method; CIs based on ≥100 deaths were calculated by using a normal approximation. Additional information available from Xu J, Kochanek KD, Murphy SL, Tejada-Vera B. Deaths: final data for 2007. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2010. National Vital Statistics Reports Vol. 58, No. 19. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf.

[§] Rates based on <20 deaths were considered unreliable and not included in the analysis.

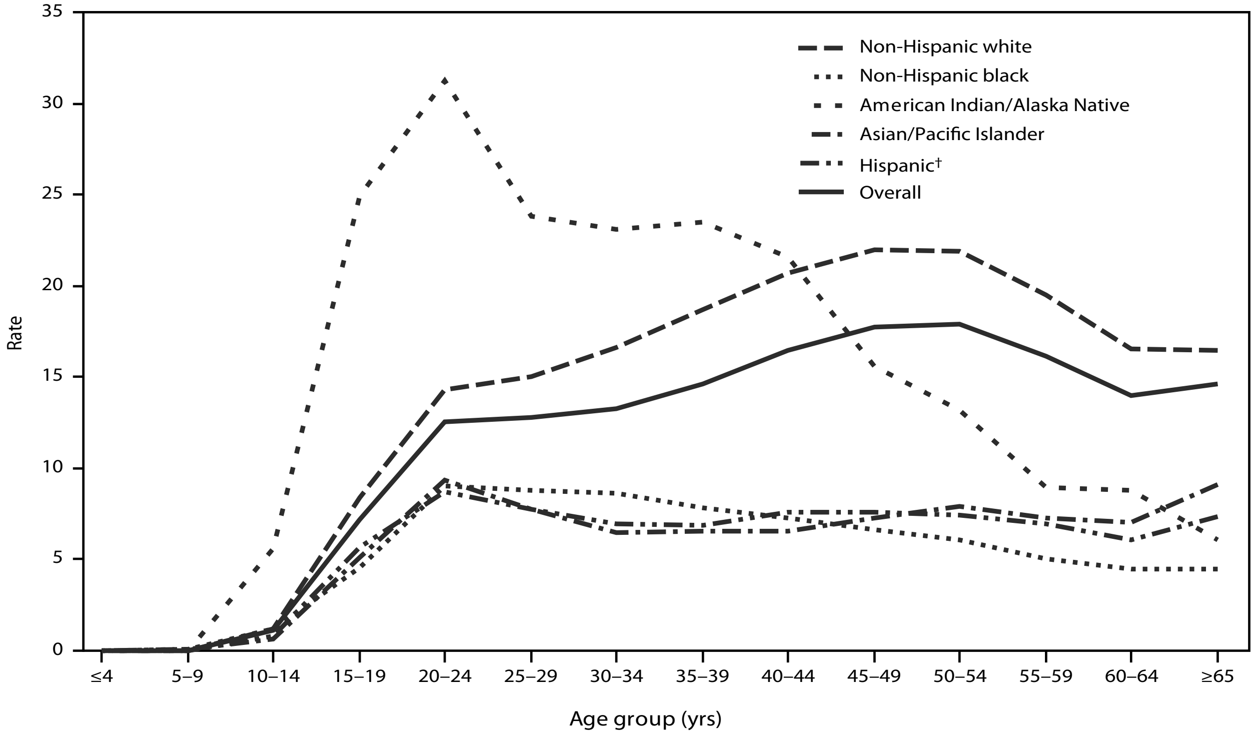
[¶] Persons of Hispanic ethnicity might be of any race or combination of races.

[**] Arkansas, California, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Kansas, Michigan, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, and Wyoming used the 2003 version of the Standard Certificate of Death for persons aged ≥25 years.

[††] Percentages reflect a percentage of the three levels of educational attainment shown for each set of states with their respective versions of the Standard Certificate of Death, not a percentage of the total count of suicides. Suicide counts shown do not include 1) 4,648 suicides for persons aged 0–24 years or whose age was unknown; 2) 1,104 suicides from Georgia and Rhode Island, which do not collect data on educational attainment; and 3) 1,039 suicides for whom the state in which the suicide occurred records educational attainment in a different version than that used by the deceased's state of residence.

[§§] Alabama, Alaska, Arizona, Colorado, Hawaii, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, North Carolina, Pennsylvania, Tennessee, Virginia, Wisconsin, and West Virginia used the 1989 version of the Standard Certificate of Death for persons aged ≥25 years. For rates, the definition of educational attainment differs for the numerator and the denominator. Additional information available from Xu J, Kochanek KD, Murphy SL, Tejada-Vera B. Deaths: final data for 2007. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2010. National Vital Statistics Reports Vol. 58, No. 19. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf.

FIGURE. Suicide rates,* by race/ethnicity and age group — National Vital Statistics System, United States, 2005–2009



* Unadjusted (crude) suicide rates per 100,000 population.
† Persons of Hispanic ethnicity might be of any race or combination of races.

underlying explanation is unclear (*17,18*). It has been suggested that studies on the association between education and suicide should perform more specific analysis (e.g., by examining combinations of age, ethnicity, culture, and sex variables to assess the true association) (*19*).

As a result of multiple challenges (e.g., narrow theoretical focus, lack of longitudinal studies to provide a range of modifiable risk and protective factors, and insufficient study designs), the evidence for the proven effectiveness of suicide prevention programs is sparse (*20*). Suicide prevention efforts often focus on counseling, education, and clinical intervention strategies for persons at high risk for suicide, neglecting a broader population-based approach (*20*). Although these efforts might assist those persons at the highest risk for adverse outcomes, they also require high levels of effort and commitment and might have a limited population-level impact, a critical goal of public health (*21*). In contrast, strategies that seek to address societal-level factors demonstrated to be associated with suicide (e.g., economic strain, poverty, and misuse of alcohol and other psychoactive substances) and improving the health-care system infrastructure in impoverished and underserved communities to address this problem might have a greater population impact but need additional development and testing (*22*).

Limitations

The findings presented in this report are subject to at least four limitations. First, suicides often are undercounted on death certificates, and studies have indicated that they are differentially undercounted for females and racial/ethnic minorities (*23*); therefore, the suicide rates in this analysis are likely to be underestimated. Second, injury mortality data likely underestimate by 25%–35% the actual numbers of deaths for AI/ANs and certain other racial/ethnic populations (e.g., Hispanics) because of the misclassification of race/ethnicity of decedents on death certificates (*24*). Third, data on educational attainment must be interpreted with caution because of misclassification of the decedent's years of education, which has been shown with comparisons between educational attainment as recorded on the death certificate versus that in census surveys (*9*). Finally, certain variables that have been associated with suicidal behavior (e.g., psychiatric illness, sexual orientation, and social isolation) are not collected in U.S. mortality data, and therefore patterns of suicide based on these factors cannot be described. Other data sources (e.g., the National Violent Death Reporting System) that collect a broader array of information about the circumstances surrounding suicides and other violent deaths can provide additional insight (*25*).

Conclusion

Comprehensive suicide prevention programs focus on risk and protective factors, including coping skills, access to mental health treatment, substance misuse, and social support. However, only a limited number of programs have been developed specifically for higher risk or racial/ethnic minority populations (*3*). An example of a comprehensive prevention program that has been reported to reduce suicidal behavior within an AI/AN community is the Natural Helpers Program (*26*). This program includes health education and outreach activities to the community and at-risk persons, training for community members in identification of at-risk persons, and support for local behavioral health efforts like alcohol and substance abuse programs.

Strategies that address the health and well-being of persons at risk and that support the widespread implementation of culturally relevant and effective programs are needed to reduce the rates of suicide among groups that are disproportionately affected. To address some of these issues, CDC has focused on studying and promoting individual and organizational connectedness as a way to prevent suicide (*27*).

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Conclusion and Future Directions: CDC Health Disparities and Inequalities Report — United States, 2013

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The reports in this supplement document persistent disparities between some population groups in health outcomes, access to health care, adoption of health promoting behaviors, and exposure to health-promoting environments. Some improvements in overall rates and even reductions in some health disparities are noted; however, many gaps persist. These finding highlight the importance of monitoring health status, outcomes, behaviors, and exposures by population groups to assess trends and target interventions. In this report, disparities were found between race and ethnic groups across all of the health topics examined. Differences also were observed by other population characteristics. For example, persons with low socioeconomic status were more likely to be affected by diabetes, hypertension, and human immunodeficiency virus (HIV) infection and were less likely to be screened for colorectal cancer and vaccinated against influenza.

CDC plays a key role in addressing disparities by collecting and analyzing data and identifying, monitoring, and reporting differences and trends. CDC's national survey data and some state level data are used by the *Healthy People* initiative to monitor trends in health outcomes and determinants. The *Healthy People* initiative provides goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts to improve the health of all persons in the United States. It is grounded in the principle that setting national objectives and monitoring progress can prompt action and improve health. The *Healthy People 2000* initiative had goals to reduce health disparities among persons in the United States. *Healthy People 2010* added elimination, not just reduction, of health disparities, and *Healthy People 2020* goes even further to achieve health equity, eliminate disparities, and improve the health of all population groups (*1*). State and local health departments use the *Healthy People* program as a way to track the effectiveness of local health initiatives.

This supplement provides decision makers with information that they can use to select interventions for certain populations to reduce health disparities. There is a growing awareness that limited health-care coverage and lack of access are only part of the reason why health disparities exist. Many of the strongest predictors of health are social, economic, and environmental factors. Reducing disparities requires national leadership to engage a diverse array of stakeholders; facilitate coordination and alignment among federal departments, agencies, offices, and nonfederal partners; champion the implementation of effective policies and programs; and ensure accountability (*2*). In addition, a complementary national strategy is required that focuses on a comprehensive, community-driven approach to reduce health disparities in the United States and achieve health equity through collaboration and synergy (*3*).

Data to Identify Health Disparities

A persistent barrier to documenting health disparities is the lack of data on certain population characteristics. All of the reports in this supplement (n=29) examined differences by race/ethnicity. The next most frequent population characteristics that were examined were age (n=24), sex (n=24), education (n=17), poverty (n=14), place of birth (n=11), and disability (n=nine). The least frequently reported characteristics were the language spoken at home (n=four) and sexual orientation (n=one). Only the paper on HIV infection reported rates by sexual orientation. Some data sources used in this report have very limited information on social and demographic characteristics. For example, death certificates do not have information on sexual orientation, poverty level, or disability (*4*). Some national health surveys have begun to collect data on sexual orientation, but there are issues that affect the usability of this data. In many instances, the sample sizes are too small to provide meaningful estimates for categories other than heterosexual, and the response rate to the questions on sexual identity is often low. In addition, lack of familiarity with terminology used to describe sexual orientation might have resulted in some misclassification (*5*).

To promote uniform collection of data on sex, race, ethnicity, primary language, and disability status, in October 2011, the U.S. Department of Health and Human Services (HHS) promulgated standards pursuant to Sec. 4302 of the Patient Protection and Affordable Care Act (ACA) (*6*). The standards were developed by the Section 4302 Workgroup organized by the HHS Data Council in collaboration with the Office of Management and Budget (OMB) and the U.S. Census Bureau. These data standards apply to all population health surveys conducted or supported by the federal government that use self- or proxy-reported data "to the extent practicable." The recommended data standards require that questions be tested and demonstrate adequate performance in national surveys and comply with any existing mandates by OMB (*7*). The recommended questions are considered to be a minimum set, and additional questions can be asked in surveys "provided that the additional detail could be aggregated back to the minimum standard and the sample design and sample size support estimates at that level of granularity" (*7*). The purpose of this provision of ACA is to provide standard approaches for collecting, analyzing, and reporting on health disparities that might exist between various demographic segments of the U.S. population. A standard set of questions to be asked in all national population surveys will improve understanding of the role of certain conditions as a risk factor for preventable poor health. CDC is evaluating the feasibility of incorporating the new data standards into many of its surveys and public health surveillance systems. Some modes of questionnaire administration might not readily support elements of the data standards because of the length of time needed to collect the data. For example, the 2011 data standard for classifying race establishes 14 categories that can be collapsed into the five categories established in 1997 by OMB. The 14 categories are preferred when sample sizes can support the increased detail. More than one race can be specified but there is no "multiracial" category.

Although a mandatory minimum set of six questions was established for determining disability status, no provision exists for modifying data collection modes to accommodate the new questions. One of the questions is, "Are you deaf or do you have serious difficulty hearing?" Notably, persons with serious hearing difficulties might not be able to participate in telephone surveys without the assistance of a Telecommunications Relay Service or other adaptive telephone equipment or services, making it problematic to collect reliable information on the prevalence of this disability and health outcomes for which they might be at risk. Another option for gathering data on persons with serious hearing difficulty is internet panel surveys.

CDC Initiatives to Reduce and Prevent Health Disparities

CDC is conducting many activities that support reducing health disparities and promoting health equity. For example, CDC provides technical support to the independent Community Preventive Services Task Force (Task Force). The Task Force makes recommendations based on systematic reviews of published studies on many important public health topics (*8*). These recommendations identify programs, services, and policies proven effective in a variety of real-world settings (e.g., communities, worksites, schools, and health plans). One topic the Task Force considered was effectiveness of interventions to improve colorectal, breast, and cervical cancer screening. After reviewing the evidence, the Task Force recommended nine strategies for helping bring those who are eligible for colorectal, breast, and cervical cancer screening to the point of care, including such services and programs as client reminders, one-on-one education, reducing structural barriers (e.g., providing scheduling assistance and transportation and offering extended hours), and provider reminders to screen patients. Many of these services have been effective for underserved populations and communities that are at greatest risks for cancer (*9*).

CDC's Office of Minority Health and Health Equity (OMHHE) advances policy, scientific, and programmatic efforts to eliminate health disparities affecting populations at social, economic, or environmental disadvantage and achieve health equity in the U.S. population. For example, OMHHE provides leadership in the development and promotion of *Healthy People 2020* Social Determinants of Health objectives and is leading an effort to compile promising practices and strategies used by CDC-funded programs to address health disparities. Through all of its activities, OMHHE focuses attention on efforts to achieve health equity, facilitating implementation of relevant policies, furthering the science of health equity and its application, and building and strengthening national and global partnerships for health equity.

CDC provides scientific and technical support to the National Prevention Council. Created by ACA, the National Prevention Council developed the National Prevention Strategy (NPS) to realize the benefits of prevention for all persons in the United States. Eliminating health disparities is one of four strategic directions identified in NPS (*2*). NPS recommends five approaches to reducing disparities: 1) focus on communities at greatest risk, 2) increase access to quality health care, 3) increase workforce capacity to address disparities, 4) support research to identify effective strategies to eliminate disparities, and 5) standardize and collect data to better identify and address disparities. Recognizing that disparities are closely linked with social, economic, and environmental disadvantage (e.g., lack of access to quality affordable health care, healthy food, safe opportunities for physical activity, and educational and employment opportunities), the National Prevention Council has representation from 20 federal departments including Agriculture, Housing and Urban Development, Defense, Education and Transportation, and is chaired by the Surgeon General.

CDC supports the implementation of the National Prevention Council Action Plan (*10*). The plan outlines the Federal commitment to implementing the vision, goal, and recommendations of NPS. CDC is working with the U.S. Department of Housing and Urban Development and the Environmental Protection Agency on Health Impact Assessments (HIAs). HIAs examine ways to create healthy communities, provide health protection, and promote health.

CDC also works to reinforce cross-sector collaborations that can advance CDC programs, priorities, and initiatives. CDC's Community Transformation Grant (CTG) program seeks to improve health and wellness by implementing strategies included in NPS. CTG communities are engaging partners from multiple sectors, such as education, transportation, housing, and business, to create healthier communities where persons work, live, learn, and play. CDC's grant programs strive to achieve the greatest possible health impact and eliminate health disparities. Since October 1, 2012, all CDC domestic nonresearch funding opportunity announcements require that grantees describe how health disparities will be addressed, where relevant. When addressing health disparities, CDC programs might require grantees to identify existing health disparities in their communities and develop or implement evidence-based strategies to address those disparities.

Future Directions

Despite persistent racial, ethnic, and socioeconomic gaps in health care and health status, awareness of such disparities remains low among the general public (*11*). Much can be accomplished within the health and public health arena; however, the multiple and complex web of causes of health disparities can be fully addressed only with the involvement of many partners in fields that influence health such as housing, transportation, education and business. Identifying disparities and monitoring them over time is a necessary first step toward the development and evaluation of evidence-based interventions that can reduce disparities. CDC will continue to document health disparities and promote awareness of disparities as part of its contribution to the national goal to eliminate health disparities for vulnerable populations as defined by race/ethnicity, socioeconomic status, geography, sex, age, disability status, sexual orientation, and primary language, and among other populations identified to be at-risk for health disparities.

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