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AUTHOR	TABLE OF CONTENTS	PAGE
Marvin L. Cooke	Deindustrialization and the Reorganization of Occupations: The Reorganization of the Labor Market in Oklahoma Between 1970 and 1990	3
Howard F. Stein	The Oppositional Cultures of Rurality and Urbanity in Oklahoma Health Care	13
John Trzcinski	Journey From Dark to Light and Then? The Legacy of Oklahoma's Terry D. Lawsuit	27
Patricia Bell Richard Dodder Jackie Simmons	Deinstitutionalization and the Measurement of Consumer Outcomes: The Oklahoma Experience 1992 -1999	37
Catalina Herrerías Angela Harnden Stephanie Bond	Child Care in Oklahoma: The Reaching for the Stars Program	47
John Duncan	Clandestine Laboratories, Dynamic Systems, and the Deep Social Impact of Methamphetamine Abuse in Oklahoma	65
Donald Yates Ken Amaechi Egbo	Neighborhood Policing in Ponca City, Oklahoma: An Early Exploration of its Value to Positively Impact Low-Income Neighborhood Quality of Life	73
L.M. Hynson, Jr.	Community Work Centers (CWC): Oklahoma's Experiment in Public Works	81
	Current Reviewers	64
	Subscriber and Manuscript Submission Form	91

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DEINDUSTRIALIZATION AND THE REORGANIZATION OF OCCUPATIONS: THE REORGANIZATION OF THE LABOR MARKET IN OKLAHOMA BETWEEN 1970 AND 1990

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Abstract

Studies of deindustrialization generally assume that the decline of craft and laborer occupations is principally associated with a relative loss of manufacturing jobs combined with a gain in service and trade jobs. This study tests this assumption in Oklahoma between 1970 and 1990 using a secondary analysis of U.S. Census data for the state as a whole and for Oklahoma City, Tulsa, Muskogee, Ardmore, and McAlester. Deindustrialization was found principally in Tulsa. Oklahoma City and McAlester lost a significant proportion of employment in the government sector. Tulsa, Oklahoma City, and McAlester each lost significantly more employment in craft and laborer occupations and gained more employment in managerial, professional, and technical occupations than can be accounted for by the change in the industrial distribution of employment alone. In most areas included in the study, employment in administrative support occupations decreased more than expected from changes in the distribution of employment by industry alone while sales occupations increased. This additional change in the occupational distribution was associated with the reorganization of occupations within industries. Finally, a doubling of the rate of part-time workers occurred that cannot be accounted for by the proportional change of employment by industry or by occupation within industries.

INTRODUCTION

Deindustrialization has been a well-studied phenomenon in the United States beginning with the closing of factories in the "rust belt" in the midwest and northeast in the 1970s. Its causes have been linked to the natural maturation of the economy (Levy, 1998; Alderson, 1999), downturns in the business cycle (Rowthorn and Wells, 1987; Levy, 1987, 1998; Alderson, 1999); exporting jobs (Bluestone and Harrison, 1982; Harrison and Bluestone, 1988; Yates, 1994), and importing cheap foreign goods (Wood, 1994; Alderson, 1999). Its effects have been linked to personal and family deterioration (Newman, 1998; Wilkie, 1991; Schor, 1991; Cooke, 1998) and to increasing income inequality (Levy, 1987, 1998; Yates, 1994). Much of the labor movement and many leftists have adopted deindustrialization – defined as a loss of blue-collar jobs in manufacturing — as the principal focus for political action. Globalization – an expanded explanation for exporting jobs – tends to be identified as the driving force behind deindustrialization (Schwartz, 2000a, 2000b; Tabb, 2000).

Though many studies of deindustrialization and the political agenda of much of the labor movement assume that the loss of manufacturing jobs tells the story of the loss of blue-collar employment, other studies link the decline

of blue-collar employment with how occupations and work are organized within firms. For example, Gordon (1996) found that the decline of blue-collar workers was due to simultaneously overstaffing management while cutting blue-collar employment and wages. Another important development in how occupations have been reorganized is the growth of part-time work in various occupations. For example, Edwards (1979) demonstrated how the labor process has segmented employment into full-time employment and "casual" employment in several industrial sectors. While commentators on the labor movement have noted the need for organizing workers to resist such changes, there is still a strong tendency for labor to define its problems in terms of the loss of manufacturing jobs to other countries or in terms of the growth of the service sector (Moberg, 2000). Both definitions focus on changes in industrial sectors rather than changes in the occupational structure within industrial sectors.

The purpose of this study is to explore how much the loss of blue-collar jobs is associated with the proportional loss of employment in manufacturing and how much the loss of blue-collar jobs is associated with the proportional change in occupations within all industries. Additionally, how much of the increase in part-time employment is associated with propor-

tional changes in employment by industrial sector, how much is it associated with proportional reorganization of occupations within industries, and how much is it an independent of the proportional changes? These questions were explored using a secondary analysis of U.S. Census data for the state of Oklahoma for 1970 and 1990. Changes in employment by industry and by occupation were explored and compared for the state as a whole, for the two largest urban areas in the state, Oklahoma City and Tulsa, and for three larger towns in the eastern part of the state: McAlester, Ardmore, and Muskogee.

DEINDUSTRIALIZATION AND THE REORGANIZATION OF OCCUPATIONS AND WORK

Deindustrialization is often defined as a decline in the relative proportion of employment in manufacturing as an industrial category. For example, Alderson (1999, p. 702) defined deindustrialization "as the decline of manufacturing employment relative to employment in other sectors." Since manufacturing as an industrial category has an occupational distribution in which craft and laborer occupations are concentrated, one would expect a decline in the proportion of persons employed in laborer and craft occupations as manufacturing declines as a fraction of total employment. Similarly, one would expect a relative increase in the proportion of those employed in service and sales occupations with an increase in the proportion of those employed in the service and trade industrial sectors. If deindustrialization alone is the cause of the decline of blue-collar jobs, one should be able to predict the changes in the distribution of employment by occupation by changes in the distribution of employment by industrial category alone.

The way in which manufacturing declines could increase the decline in craft and laborer occupations beyond what one would expect from the decline in manufacturing alone. Several mechanisms have been identified that would accelerate the loss of blue-collar jobs beyond what one would expect solely from deindustrialization.

According to the international division of labor model (Cohen, 1981; Reich, 1983), the proportion of the labor force in manufacturing could decline by moving manufacturing plants outside the United States while retain-

ing management, engineering, and sales functions within the United States. Here, employment in manufacturing as an industrial sector would decline, but employment in craft and laborer occupations would decline even more rapidly because of the changing mixture of occupations in manufacturing left in the United States. Maume (1987), Lobao (1990), and Brown and Hirschl (1995) found that such divisions of labor can also occur between urban and rural areas.

Levy (1987, 1998) suggested that the decline of an industrial sector in and of itself could both decrease the relative proportion of employment in that sector and rearrange employment by occupation within it. For example, a large number of blue-collar workers permanently lost their jobs with plant closings in the 1970s. Similarly, many administrative support positions were permanently eliminated with the consolidation of the financial sector in the 1980s.

Fundamental changes in how work is organized could also change the distribution of employment by occupation within different industrial sectors and across industrial sectors. Just as the digital revolution automated and deskilled work in manufacturing, Garson (1988) found that the same happened in the office environment. Levy (1998) reported shifts in employment from administrative support to sales occupations as industrial sectors have come under competitive pressure and as administrative support functions have become automated. Office environments are broadly distributed across industrial sectors. Gordon (1996) found that the decline in blue-collar employment and wages was a result of management overstaffing and overpaying itself at the expense of blue-collar employment and wages. Power differences in a hierarchical organization enable managers to exploit workers.

In addition to changing the distribution of occupations within industries, several mechanisms similar to those identified above seem to contribute to an increase in part-time employment. On the demand side of the labor market, Edwards (1979) demonstrated how the labor process has segmented employment into full-time employment and "casual" employment across industrial sectors. Wasmer (1997) found that a slow-down in the growth of labor productivity and higher levels of population

encourage temporary employment. Bluestone and Rose (1998) found that firms have shifted away from dealing with economic growth by hiring more full-time workers as in the 1970s to either employing workers longer hours or employing additional part-time workers in the 1980s and 1990s. On the supply side of the labor market, Yates (1996) found that workers deal with household income maintenance in the face of stagnant wages and a weak labor market by working more part-time jobs

In reviewing these findings, three things stand out. First, these mechanisms are more pervasive than simply those associated with deindustrialization because they affect or potentially affect all industrial sectors rather than simply the manufacturing sector. Second, these mechanisms affect more than traditional blue-collar jobs. For example, employment in administrative support positions was lost while sales positions were added across various industrial sectors. Finally, some of these mechanisms contribute to the growth of part-time employment.

To investigate these trends in Oklahoma, employment in nonagricultural industrial sectors was analyzed to test whether deindustrialization as a proportional loss of manufacturing occurred between 1970 and 1990. Alderson (1999) found that manufacturing composed twenty-five percent of nonagricultural employment in developed nations in 1970 but only twenty percent in 1990. Was the level of manufacturing in Oklahoma in 1970 and 1990 similar to the average developed country? This was explored for Oklahoma City, Tulsa, McAlester, Ardmore, and Muskogee as well as for the state as a whole.

To explore whether changes in employment by occupational category were principally associated with changes in employment by industry or by changes of employment by occupation within industries, three distributions of employment by occupation were generated and compared for each of the areas in the study. First, a percent distribution of employment by occupation was calculated for 1970. Next, a percent distribution of employment by occupation was calculated using the distribution of employment by industry for 1990 and the 1970 occupational distribution of employment for each industry. This provides a picture of the occupational distribution of employment expected in 1990 if changes in the occupational

distribution were due to changes in the industrial distribution alone. Finally, a percent distribution of employment by occupation was calculated for 1990. By comparing the distribution that is expected from changes in the industrial distribution alone with the distribution that actually occurred because of changes in both the industrial distribution and the occupational distribution within each industry, one can estimate the relative importance of deindustrialization compared to the reorganization of occupations within industries on the loss of blue collar and administrative support occupations.

Finally, to explore whether part-time employment has increased by occupation, the percent of employed persons from 16 through 64 years of age that were normally employed less than 35 hours per week in each occupation in 1970 and 1990 for the state as a whole was calculated. The separate effects of changes in the distribution of employment by industry, by occupation within industries, and by the proportion of persons employed less than 35 hours per week in each occupation within each industry on the overall distribution of persons employed less than 35 hours per week by occupation were explored. Because of problems with the comparability of smaller areas between the 1970 and 1990 Public Use Microdata Samples (U.S. Bureau of the Census, 1973c, 1992c) and because of limitations with the 1970 state-wide sample used by this researcher, only a statewide comparison of part-time employment by industry by occupation was made.

METHODS AND DATA

From the technical documentation included in the U. S. Census Public Use Microdata Samples from 1970 and 1990 (U.S. Bureau of the Census, 1973c, 1992c), certain issues of the comparability of data between the 1970 and 1990 U.S. Census for the purpose of this study are apparent. First, the definition of the Oklahoma City and Tulsa Metropolitan Statistical Areas changed between 1970 and 1990. The 1970 definition was used to define Oklahoma City as Oklahoma, Canadian, and Cleveland counties and Tulsa as Tulsa, Osage, and Creek counties. Second, there were some inconsistencies in the definition of occupations in nonagricultural industrial sectors. Some managerial, professional, and technical occu-

pations classified under one of these categories in 1970 were classified in another in 1990. Also, some specific occupations were added. If one aggregates all of the occupations under one general category — managerial, professional, and technical occupations — the comparability between time periods is significantly improved. In 1990, some workers in nonagricultural industrial sectors were classified in agricultural occupations. None were so classified in 1970. The workers so classified in 1990 appear to be principally laborers. One could have classified some of them as craft workers. Since most agricultural occupations in nonagricultural industries seemed to be laborers, they were classified as such. This probably slightly overstates the proportion of workers that are laborers and understates the proportion of workers that are craft workers in 1990.

To test whether a proportional loss of manufacturing occurred between 1970 and 1990, the tables, "Occupation of Employed Persons by Industry Group and Sex: 1970" and "Industry of Employed Persons and Occupation of Experienced Unemployed Persons for Places of 10,000 to 50,000: 1970," from the 1970 U.S. Census (1973a) and the tables, "Industry of Employed Persons: 1990," from the 1990 U.S. Census (1992a) were used to calculate a percent distribution of employed persons 16 years and over by nonagricultural industrial categories for the state as a whole, Oklahoma City, Tulsa, and the towns of McAlester, Ardmore, and Muskogee for 1970 and 1990. These distributions and results are reported in Table 1.

To explore whether changes in employment by occupational categories were principally associated with changes in employment by industry or by changes of employment by occupation within industrial categories, three distributions of employment by occupation were generated and compared for each of the areas in the study. First, a percent distribution of employment by occupation was calculated for 1970 using "Occupation of Employed Persons by Industry Group and Sex: 1970" and "Occupation and Earnings for Places of 10,000 to 50,000: 1970" from the 1970 U.S. Census (1973a) for all of the areas in the study. Using the above data sources, a percent distribution of employment by occupation was calculated using the industrial distribution of em-

ployment for 1990 and the 1970 occupational distribution of employment within each industry for the state as a whole, Oklahoma City, Tulsa, and the part of the state excluding Oklahoma City and Tulsa. Since census data for McAlester, Ardmore, and Muskogee do not include a cross classification of occupation by industry for 1970, the occupation by industry distribution for the part of the state excluding Oklahoma City and Tulsa adjusted by the overall occupational distribution for the three towns in 1970 was used for this procedure for the three towns. This provides a picture of the occupational distribution of employment that one would expect in 1990 if changes in the occupational distribution were due to changes in the industrial distribution alone. Finally, a percent distribution of employment by occupation was calculated for 1990 for all defined areas in the study using the table, "Occupation of Employed Persons: 1990" (1992a). These distributions are reported in Table 2.

To explore the relative contribution of changes in employment by industry, by occupation within industries, and by the use of part-time workers within occupations within industries to changes in part-time employment by occupation across industries, the U. S. Census Public Use Microdata Samples (PUMS) from 1970 (1973b) and 1990 (1992b) were used to estimate the percent of employed persons 16 through 64 years of age that were normally employed less than 35 hours per week in each occupation in 1970 and 1990 for the state as a whole. Following the suggestions in the technical documentation (U.S. Bureau of the Census, 1973c), the 1970 estimate was created by combining the 1/100 sample from the 5% sample and the 1/100 sample from the 15% sample of the PUMS to create a 2% sample. The 1990 estimate was created from the 5% sample PUMS. Because of problems with comparability of smaller areas between the 1970 and 1990 Public Use Microdata Samples, only a statewide comparison of part-time employment by industry by occupation was made. Two additional distributions were created. First, the percent of part-time workers for each occupation that would be expected from the 1990 industrial distribution, the 1970 occupational distribution by industry, and the 1970 distribution of part-time workers in each occupation in each industry was calculated to estimate the effect of the change in the indus-

trial distribution alone on part-time employment. Second, the percent of part-time workers for each occupation that would be expected from the 1990 industrial distribution, the 1990 occupational distribution by industry, and the 1970 distribution of part-time workers in each occupation in each industry was calculated to estimate the effect of the changes in the industrial distribution and in the occupational distribution within each industry on part-time employment. The results are reported in Table 3.

FINDINGS

Statewide employment in manufacturing in Oklahoma hardly meets the standards of a developed nation. Instead of having twenty-five percent of nonagricultural employment in manufacturing as did most developed nations in 1970 (Alderson, 1999), Oklahoma's employment in manufacturing was only seventeen percent. While Alderson (1999) found that employment in manufacturing in developed nations dropped to twenty percent by 1990, Oklahoma's employment in manufacturing dropped only to fifteen percent. While Oklahoma was not as industrialized as the average developed nation in 1970, it also did not experience the level of deindustrialization between 1970 and 1990.

Tulsa most resembled a developed nation with respect to deindustrialization. Nonagricultural employment in manufacturing in Tulsa dropped from twenty-one percent in 1970 to sixteen percent in 1990. As with the state as a whole, Oklahoma City, Ardmore, and McAlester had lower initial levels of employment in manufacturing and small changes in levels between 1970 and 1990. Against the trend of deindustrialization, Muskogee gained employment in manufacturing from sixteen percent in 1970 to eighteen percent in 1990. Employment in manufacturing in Muskogee in 1990 was almost at the level of the average developed nation reported by Alderson (1999).

Some locations had higher proportions of employment in certain industries than average for the state in 1970 and lost significant proportions of employment in those industries between 1970 and 1990. Employment in government in Oklahoma City — the state capitol — dropped from fourteen percent of nonagricultural employment in 1970 to nine percent 1990. In McAlester, employment in government dropped from twenty-four percent to thir-

teen percent between 1970 and 1990. Two towns experienced a greater gain or loss in employment in trade than the state average. Between 1970 and 1990, McAlester gained five percentage points of nonagricultural employment in trade while Muskogee lost four percentage points.

Consistent with the deindustrialization model, employment in the service sector increased between 1970 and 1990 from five to seven percentage points for all areas in the study except Ardmore. No industrial category of nonagricultural employment in Ardmore gained or lost more than two percentage points between 1970 and 1990.

While it is evident from the above examination of Table 1 that changes in nonagricultural employment by industry have occurred, the distributions in Table 2 indicate that these changes have played a minor role in changes in the occupational distribution. If one compares the actual occupational distribution for 1970 with that expected in 1990 based on the occupational distribution by industry in 1970 and the industrial distribution in 1990 and with the actual occupational distribution for 1990, 38 percent of the redistribution of employment by occupation between 1970 and 1990 appears to be attributable to changes in the distribution of employment by industry alone for the state as a whole, 33 percent for Oklahoma City, 23 percent for Tulsa, 29 percent for Muskogee and for Ardmore, and 43 percent for McAlester. Most of the change in the overall distribution of occupations appears to be rooted in changes in how occupations are organized within industries rather than in changes in the distribution of employment by industry alone, i.e., deindustrialization.

An examination of each occupation in Table 2 reveals that more than blue-collar occupations were affected by the reorganization of occupations within industries. Consistent with Levy's (1998) findings, the proportion of those employed in administrative support occupations decreased between 1970 and 1990 more than one would expect from changes in the industrial distribution alone as the proportion of those employed in sales occupations increased more than expected. This was the most uniform change in the distribution of occupations across all towns and cities as well as the state as a whole with the exception of McAlester. In McAlester, the proportion em-

TABLE I
PERCENT DISTRIBUTION OF NONAGRICULTURAL
EMPLOYMENT IN OKLAHOMA BY INDUSTRY

Industry	Statewide		Oklahoma City		Tulsa	
	1970	1990	1970	1990	1970	1990
Mining	4	3	2	2	5	3
Construction	7	6	6	5	6	5
Manufacturing	17	15	14	12	21	16
TCPU *	7	8	7	7	9	10
Trade	23	22	22	23	23	23
FIRE **	5	6	6	7	6	7
Services	29	34	29	35	26	33
Government	8	6	14	9	4	3

Industry	McAlester		Ardmore		Muskogee	
	1970	1990	1970	1990	1970	1990
Mining	1	3	4	4	0	0
Construction	6	4	7	5	7	5
Manufacturing	15	13	14	13	16	18
TCPU *	8	5	6	6	8	6
Trade	15	23	25	26	28	24
FIRE **	3	5	5	7	5	6
Services	28	34	33	35	30	35
Government	24	13	6	4	6	6

* Transportation, Communications, and Public Utilities

** Finance, Insurance, and Real Estate

employed in both sales and administrative support occupations increased more than expected from the change in the distribution of employment by industry alone.

Changes in the organization of occupations within industries decreased the proportion employed in service and craft occupations by 1990 somewhat more than one would expect from changes in the proportion of the workforce employed by industry alone. While one would expect small gains in the proportion of those employed in service occupations because of changes in employment by industry alone, the gains exactly equaled what one would expect for the state as a whole and were slightly less than expected for all of the towns and cities in the study. While one would expect small losses in the proportion of those employed in craft occupations because of changes in employment by industry, the losses

were somewhat larger than expected for the state as a whole as well as for all of the towns and cities in the study.

Changes in the proportion of employment in managerial, professional specialty, and technical occupations and in laborer occupations represent an interesting case. For the state as a whole and for the towns of Muskogee and Ardmore, almost all of the small decline in the proportion of those employed in laborer occupations and small increase in the proportion of those employed in managerial, professional specialty, and technical occupations can be accounted for by changes in the distribution of employment by industry alone. But, for Tulsa, McAlester, and, to a lesser extent, Oklahoma City, employment in managerial, professional specialty, and technical occupations increased and employment in laborer occupations decreased significantly more than ex-

pected because of changes in the industrial distribution alone.

One might be able to argue that Tulsa represents a case consistent with the international division of labor theory of deindustrialization. However, since Tulsa experienced a significant loss in the proportion of those employed in manufacturing while McAlester and Oklahoma City experienced a significant loss of

those employed in government, something other than the mechanisms associated with deindustrialization must affect the reorganization of occupations. The one factor affecting Oklahoma City and McAlester with respect to government and Tulsa with respect to manufacturing was a significant decline in the proportion of those employed in those industrial

TABLE 2
PERCENT DISTRIBUTION OF NONAGRICULTURAL
EMPLOYMENT IN OKLAHOMA BY OCCUPATION

Actual Distribution in 1970

Occupation	Statewide	Oklahoma City	Tulsa	McAlester	Ardmore	Muskogee
Manager et al. *	25	27	26	23	27	25
Sales	7	8	9	7	9	9
Admin. Supp. **	18	21	20	18	16	17
Services	15	13	12	16	18	17
Crafts	15	14	15	16	12	16
Laborers	20	17	18	20	18	19

Expected in 1990 Based on Occupational Distribution by
Industry in 1970 and Industrial Distribution in 1990

Occupation	Statewide	Oklahoma City	Tulsa	McAlester	Ardmore	Muskogee
Manager et al. *	26	28	26	25	28	26
Sales	8	9	9	10	9	9
Admin. Supp. **	18	21	19	16	17	17
Services	16	15	14	17	18	18
Crafts	14	12	13	14	11	12
Laborers	18	15	19	18	17	18

Actual Distribution in 1990

Occupation	Statewide	Oklahoma City	Tulsa	McAlester	Ardmore	Muskogee
Manager et al. *	27	32	32	29	28	26
Sales	12	13	13	11	14	14
Admin. Supp. **	16	18	17	18	15	15
Services	16	14	13	18	16	17
Crafts	12	10	12	12	10	10
Laborers	17	13	13	12	17	18

* Managerial, Professional Specialty, and Technical Occupations

** Administrative Support Occupations

sectors. As Levy (1998) suggested, the downsizing of an industrial sector in and of itself may well affect the loss of laborers in an industry.

From Table 3 it appears that part-time employment for all workers in the state of Oklahoma has more than doubled between 1970 and 1990. Proportionally, craft occupations have been affected least by this trend followed by laborer occupations and managerial, professional specialty, and technical occupations. Sales, services, and administrative support occupations have been affected most by this trend. All occupations seem to have been affected by the introduction of "casual" labor (Edwards, 1979).

If one compares the first and second columns in Table 3, the distributions are the same. Thus, the change in the industrial distribution of employment alone between 1970 and 1990 does not seem to increase part-time employment overall for any occupation. If one compares the first two columns with the third column, the distributions are almost the same. The only difference occurs with a one-percent decrease of part-time workers for service occupations. Thus, the change in the industrial distribution of employment combined with the change in the distribution of occupations within industries between 1970 and 1990 does not seem to increase part-time employment overall for any occupation. The increase in part-time work within each occupation appears to be a third, independent way in which the labor market changed between 1970 and 1990.

CONCLUSION

This study explores to what degree the decline in blue-collar jobs in Oklahoma between 1970 and 1990 was related to deindustrialization and to what degree it was related to the reorganization of occupations. Deindustrialization was found principally in Tulsa. Oklahoma City and McAlester lost a significant proportion of employment in the government sector. Tulsa, Oklahoma City, and McAlester each lost significantly more employment in craft and laborer occupations than can be accounted for by changes in the industrial distribution of employment. The abnormally large loss of employment in craft and laborer occupations and gain of employment in managerial, professional, and technical oc-

cupations was associated with the reorganization of occupations within industries. The most consistent shift in employment from place to place was the shift from employment in administrative service to sales occupations. This change is almost completely attributable to occupational changes within industries.

A doubling of the rate of part-time workers occurred that cannot be accounted for by the proportional change of employment by industry or by occupation within industries. The increase in part-time jobs was least pronounced in craft, laborer, and managerial, professional, and technical occupations and most pronounced in sales, service, and administrative support occupations. On average, the part-time worker in each occupation earned about one-third what the full-time worker earned. This makes the increase in part-time work across occupations the most problematic change in the labor market explored in this study for income inequality.

The use of the decennial census of population and housing does not easily allow one to test the relative contribution of the various factors that have been identified in other studies as contributing to deindustrialization or to the reorganization of occupations within or across industries. But, this study demonstrates that one can use the decennial census of population and housing to assess the relative importance of industry based changes and occupational based changes within industries on the overall distribution of occupations and on part-time employment in a geographical area. The findings of this study suggest that the labor movement should focus more on factors affecting the organization of existing industries. While deindustrialization has contributed to the loss of good paying blue-collar jobs, factors that have been working on the occupational distribution of existing industries seem to contribute as much or more to the loss of those jobs.

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TABLE 3

PERCENT OF EMPLOYEES 16 THROUGH 64 YEARS OF AGE IN OKLAHOMA
TYPICALLY EMPLOYED LESS THAN 35 HOURS PER WEEK IN EACH OCCUPATION

Occupation	1970	Expected from '90 industrial, '70 occupational, '70 part-time	Expected from '90 industrial, '90 occupational, '70 part-time	1990
Manager et al. *	9	9	9	18
Sales	16	16	16	37
Admin. Supp. **	13	13	13	28
Services	20	20	19	48
Crafts	10	10	10	16
Laborers	13	13	13	23
All Employees	13	13	13	27

* Managerial, Professional Specialty, and Technical Occupations

** Administrative Support Occupations

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THE OPPOSITIONAL CULTURES OF RURALITY AND URBANITY IN OKLAHOMA HEALTH CARE

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ABSTRACT

This paper studies rurality and urbanity (in the state of Oklahoma, and elsewhere) as bona fide cultural realities, and explores the consequences of rural/urban cultural differences and conflict for health care in rural settings. The methodology of exploring multiple viewpoints (borrowed from anthropology, as the emic/etic distinction), and the statuses and power associated with these perspectives, is fruitful in elucidating many long-standing issues in rural health care: access, isolation, boundaries, units of measurement, sense of place, stigma, identity, etc. From twenty-three years as a clinically applied psychodynamically-oriented medical anthropologist in rural and urban Oklahoma settings, the author provides numerous vignettes to illustrate the methodological and theoretical points made. The paper concludes that a powerful barrier to improved rural health care is the reciprocal stereotyping between rural and urban cultures, a binary opposition, that prevents accurate assessment of needs and realities.

INTRODUCTION: RURAL MEDICINE AND IDEOLOGIES OF PLACE

This paper inquires into the rural and urban contexts of health care in the state of Oklahoma. It is a study in qualitative anthropology/sociology. It contextualizes recurrent problems in health care delivery within the framework of rural and urban perceptions and relations. A number of vignettes illustrate the often oppositional relationship between these two cultural worlds that are ostensibly situated with "the same" state and national culture. I shall argue that group boundary, culture, identity, and sense of place influence health care decision-making in Oklahoma and elsewhere.

Ultimately, this viewpoint leads to a re-definition of place, and specifically of rurality. I shall argue that not only, culturally speaking, are things not what they seem, but they are not even entirely where we usually think they are. I shall explore the health care implications of the fact that these two ostensibly distinct cultural domains are deeply entwined with one another.

The material in this paper derives from my role since 1978 as a clinically applied medical anthropologist in the Department of Family and Preventive Medicine at the University of Oklahoma Health Sciences Center. I have spent most Fridays as be-

havioral science director/coordinator of the family medicine residency training program located in the Enid Family Medicine Clinic, in Enid, Oklahoma, a rural primary care training site in north-west Oklahoma. From 1979-1985, I worked in a similar capacity at the Shawnee Family Medicine Clinic, also an affiliate of the Department of Family Medicine at the University of Oklahoma Health Sciences Center, Oklahoma City.

RURAL HEALTH CARE AND ITS CONTEXTS

It is widely assumed that, when the term "culture" is used, it denotes certain *kind* of groups or units: e.g., ethnic, nationality, religious, and racial (that is, an American sociological category that is held to be biological). Thus, when a topic such as cultural aspects of rural health, or of rural medicine, in Oklahoma is brought up, we are accustomed to think, for instance, about Blacks *in* Oklahoma, Hispanics or Latinos *in* Oklahoma, Native Americans (or tribal groupings such as Choctaw and Cheyenne-Arapaho) *in* Oklahoma, Southern Baptists *in* Oklahoma, Vietnamese *in* Oklahoma, Mennonites *in* Oklahoma, Jews *in* Oklahoma, Germans *in* Oklahoma, and so on. The tendency is to view the culture as residing in the ethnic, nationality, or religious group, and for Oklahoma to be largely, or merely, a geo-

political entity in which the culture is geographically located.

Put differently, we tend to assume that, say, ethnicity is a matter of personal identity, while Oklahoma (or another state, or city, or region) is merely a matter of place. The same holds for other states and regions in the U.S. Yet, at its broadest, culture is a matter of boundaries, and with them, the sense of identity that distinguishes between “we” or “us” and “they” or “them” (Barth 1998; Stein and Hill 1977). The sense of group is primary; the label for the kind of group (ethnic, national, religious, occupational, professional, gender, racial, state-province-canton, etc.) is secondary (Stein 1992). The making of a distinction between groups – that “We are ABC” and “You are XYZ” – is itself a cultural claim. In a number of works I have argued that “Oklahomaness” (that is, the sense of being “Oklahoman,” whatever other identity[-ies] one claims or with which one is identified by others; see Stein 1987a,c) is itself a distinctive cultural system (Hill and Stein 1988; Stein and Hill 1989; Stein and Hill 1993; Stein and Thompson 1991). In this paper, I develop this perspective of cultural localism further, to explore “rural” and “urban” as distinctive cultural systems that, among other things, have an effect upon health care.

It will be my argument that the cultural duality of “rural”/“urban” itself governs much health-related perception and behavior among practitioners, patients, and communities alike. Further, these two additional cultural categories crosscut conventional ethnic, national, racial, religious, and state understandings. In this paper, then, I shall devote attention to rurality, and urban-ness as themselves cultural ways of organizing life, and to their influence upon rural medicine in Oklahoma.

Stated colloquially, rural-ness, and urban-ness (in Oklahoma and elsewhere), are matters of who one is, not only a matter of where one is located. “Where-ness” becomes a defining part of “who-ness.” Place becomes incorporated into the sense of place. This sense of place may, or may not, be articulated in language. It may be asserted (“emic”, e.g., Oklahomans’ and

Texans’ emphasis on their differences from each other) or inferred from behavior (“etic”, e.g., cultural continuities throughout the Great Plains). This paper has implications for the broader culture areas (Kroeber 1951; Devereux 1969) that intersect within the state: viz. “Little Dixie [The Old South],” the North American Great Plains or the Midwest, and the Southwest.

Before proceeding, I wish to attempt to systematize a number of terms I have thus far introduced. Such concepts as group, culture, identity, place, and sense of place all constitute facets or aspects of a unitary, ongoing, dynamic social process, one that occurs simultaneously at conscious and unconscious levels, and one that is undergoing constant “construction” and reworking. Recent critiques of the notion of a unified, consistent “self” (Schweder 1991) and of fixed ethnic or other social characteristics and units (Kondo 1990; Lamphere 1987) emphasize the processual nature of all social structures. I use these concepts more evocatively and descriptively than definitively. They all express the linkage of “I” and “me” (singular, individual), with “we” and “us” (plural, group) with boundary formation and border regulation, and with the often binary opposition between “us” and “them” (Volkan 1988).

Put formulistically: “group” may be seen as the social, intersubjective process of boundary creation and maintenance; “culture” may be seen as the specific content of the group process, and hence of the boundary (the notion of “a” culture fuses form and substance); “identity” may be seen as the conscious and unconscious sense of belongingness and continuity with the group; and “sense of place” may be seen as an extension or projection of “whoness” or “whatness” into “whereness.” This approach draws heavily from the pioneering work of Erikson (1968) on identity, and Barth (1998/1969) on social boundaries. Its relevance to the study of health care in rural and urban settings will be shown to lie in the fact that (1) “urban” and “rural” are in fact facets of one another, even when those links are con-

sciously disavowed; and therefore (2) "urban" and "rural" are inseparable, even when they are ideologically split into two distinct geographic realms.

METHODOLOGY AND THEORY: OVERVIEW

My methodology is that of an applied anthropologist whose data derive from long-term fieldwork in urban and rural Oklahoma health care settings (Stein 1999b). I "collect" what I know from day-to-day activity as clinical teacher, supervisor, group facilitator, faculty member, listener and observer, and participant/presenter at national Family Medicine conferences. In this paper, my two roles are those of (1) observer, participant observer, and cultural interpreter, and, occasionally (2) key informant (one who aspires to be self-observant). My data here consist largely of vignettes -- stories -- which can be read as cultural exemplars (Nuckolls 1997) that is, as instances of widespread, recurrent, patterns. Most of the data I "collect" -- indeed, most of what I have learned about rural and urban medicine -- comes less from questions I ask as from being present at "moments" when I discover that these cultural distinctions are precisely the point (often implicit) being made.

For instance, a frequent, rebuke-filled, comment made often at lectures on rural health care that I present to medical students and resident physicians in urban medical training centers, is: "If these people want to have good health care, why do they insist on living out in the country? It's their own fault if they can't get state-of-the-art medicine when they choose to live where it isn't accessible."

I shall argue that, in addition to their scientific, biological dimension, rural and urban medicines are also a species of cultural medicine or ethnomedicine (see Gaines 1992; Purtilo and Sorrell 1986; Snider and Stein 1987; Stein 1987b,d; 1990a; 1991, 1992, 1995b, 1996; Stein and Pontious 1985). Situated within American and Oklahoman culture, rural and urban medicine are rife with stereotyping, "ethno"centrism, and bigotry toward one another (Miller 1979; Stein 1990b). The universal tribal claim that "Our way is the only right way, the human

way, and the way they do things is crazy if not evil" governs these professional cultures as much as it does ethnic ones.

One of the most fruitful contributions of anthropology to social research has been the distinction, originally borrowed from linguistics, between "emic" and "etic" perspectives or viewpoints (see Agar 1996; Sanjek 1990; Spradley and McCurdy 1988). Initially, "emic" referred to the "native" or "insider" point of view, while "etic" referred to the "observer" or "outsider" (even "universal" or "scientific") perspective. The distinction between viewpoints has been fruitful in conflict-identification and in problem-solving. As intra-group diversity and conflict came to be recognized, the distinction has come to be used to understand cognition, meaning, feeling, and power *within* groups as much as between them. Often, "etic" comes to represent official viewpoints, while "emic" comes to represent unofficial ones.

For instance, official compilation of healthcare data in and about Oklahoma often is based on the county as a fundamental unit, the hospital and its service or "catchment" area, and United States Census categories such as the Standard Metropolitan Statistical Area (SMSA). Actual patterns of access and utilization often differ widely from the official model (cf. Bachrach 1983). I shall return frequently to this distinction between cultural viewpoints, to the role of power in constructing and enforcing the distinction, and to their consequences for rural medicine.

One may also learn about Oklahoma rurality by proceeding in the "opposite" or reverse direction: that is, outward, to more encompassing systems that link the grain- and cattle-farming ethos of Oklahoma to Great Plains patterns that transcend state boundaries. These systems are characterized by such prominent structural features as "crossroads" towns and the *Einzelhofssiedlung* ("open country neighborhood") that originated in England, Ireland, and much of western Europe (Arensberg 1955: 1153-1156). The spatial patterning of settlement and cultivation is that of individual, dispersed farms.

The geographic expanse of Euro-American rural culture is attested to by the virtual identity between the findings of Long and Weinert (1987) for ranchers, wheat farmers, and loggers in Montana, and my own findings (Stein 1982, 1987c, 1995b, 1999a) among wheat farming and cattle raising families in central and northwest Oklahoma. Dominant or core values – all of which affect health care attitudes, timing, and “compliance” with medical authority – include: independence (personal, family), self-reliance, the desire to do for oneself (to “take care of our own”), the distinction between old timer and newcomer or outsider (status measured by length of residence and family links, rather than the medical school of one’s training), isolation and distance (willingness to drive large distances, but infrequently, thereby making “routine” medical follow-up difficult), health defined as the ability to work and perform social role(s) rather than by the absence of symptoms, resistance to control by outsiders, closeness to and sense of control by nature and God, lack of personal anonymity, role generalism, and stigma toward mental health conditions and practitioners.

This identity of values and worldview – despite other large cultural and political differences -- commends a model advanced by Kroeber (1951) and Devereux (1951/1969) wherein individual tribal and ethnic boundaries become subsumed within a larger “culture area” possessing a distinctive “culture areal ethos.” I have argued similarly (Stein 1978) for Slavic eastern, central, southern, and western Europe. The scope of North American Euro-American rural family culture stretches from north Texas to the Dakotas and Montana, and eastward on the central plains through Iowa.

What, then, is rural? It is foremost a word to which are attributed many, often conflicting, meanings (Bachrach 1983; Stein 1987a, b). People create and are entrapped in these emotion-laden meanings. Rural and rurality are often used as residual demographic categories, denoting those living outside Standard Metropolitan Statistical Areas (Bachrach 1983).

These same terms are also often used to denote agricultural, in contrast with industrial or high technology, ways of life and economic base. They are further used to refer to sparsely populated areas remote from densely settled urban centers. They are also associated with a worldview of close personal ties, of often-overlapping social roles. When they are not associated with a place distant (by some measure) from the city, they are associated with worldviews and values of groups of recent immigrants from foreign lands, “urban villagers” (Gans 1962) of one type or another, clustered geographically or in closely articulated social networks within cities. Within this diversity of meanings, a common thread is (1) a dichotomy that radically distinguishes between some “us” and some “them,” and which in turn (2) neglects crucial lived social reality in both.

To summarize, then: I shall denote rurality to be less specifically a place as it is a sense of place and a way of thinking about a relationship between an “us” and a “them” (self and other). People who live far from “the city” might be considered living “in the boonies,” while non-university physicians who practice within the urban community might also be regarded by their urban-academic counterparts as “boonie doctors.” This paper will examine the nature of this polar state of mind and its consequences for health care in rural Oklahoma and beyond.

CENTER AND HINTERLAND AS CULTURAL DICHOTOMY

Within rural medicine, and between rural and urban medicines (in Oklahoma, on the Great Plains, and throughout the United States), there has long been conflict between the view that (1) rural medicine is real, genuine, biomedicine, one contextually tailored to the context of patients and doctors’ lives, one that is simply different from that practiced in cities by virtue of geographic remoteness and factors intrinsic to rural life; and the view that (2) rural medicine is deficit medicine, sub-standard, medical practice. Urban physicians often label their rural counterparts as “LMD’s,” “Local Medical Doctors,” “Boonie Doctors” (physicians who

elect to practice hinterland medicine and who lack much scientific knowledge and advancement), who practice far from the city because "they couldn't make it here in the city."

In Oklahoma as elsewhere in the U.S., rural and urban physicians often reciprocally stereotype one other: e.g., "The Center" and "The Mecca" versus "The Boonies" and "The Sticks." A common joke is that "It isn't the end of the world, but you can see it from here/there (name of town)." It should be noted that one member of the ideological pair does not exist apart from the pair itself; each requires the other for self-definition. In both cases, projection is part of the regulation of perception and knowledge of the other: put colloquially, what you see is where you look from, and what you project onto your counterpart or adversary.

In many respects, the relationship between rural and urban medicine recapitulates the broader sociological distinction between urban center and rural hinterland, the city as the source of control and the countryside as the source of resources (Kraenzel 1966; Miller 1979), the city as exploiter and the country as exploited. While "center" and "hinterland" are emotionally-charged cognitive distinctions between "here" and "there," they are often further governed by power relations of subordination and the struggle against subordination. Often, in health-related decision-making, urban, academic center-based views "count" and govern, while rural, community-based views tend to be discounted.

In a study of the psychology of place, Fullilove (1996) considers the rural adaptation to urban stigma, to the

...feeling that one's place is viewed with disdain by others. Julia Eilenberg, a psychiatrist working in a rural area of New York State, has studied the ways in which degradation of one's place is an alienating experience (1995). She has observed that rural America, no longer the center of national life, has settled into a state of invisibility that is lifted only by tragedy or disaster. A big tornado, for ex-

ample, suddenly brings the camera to the threatened town or county, only to have it leave again when the storm is over. Because people identify with the localities in which they live, the loss of visibility has led to a profound collapse of self-pride. The psyche is injured, she postulates, as a result of the involution of one's place.

The disparagement is as subtle as it is pervasive. It is revealed by off-hand comments such as "We in Oklahoma City and Tulsa have *stress*; you in rural Oklahoma don't," or, "*You out there* don't understand; in the city, *here*, we have these problems...." Implicit urban idealization and romanticization of rural life, together with rural peoples' reluctance to complain to outsiders, fuels the stereotyped distinction between anxiety-ridden city and idyllic country (Stein 1987b; De Vos 1974). The moral universe is split along the lines of "good" and "evil," a fairly stable historical distinction. For example, rural violence (Stein 1994, 1995a) has, until the recent interest in "militant" and "survivalist" groups, passed mostly unnoticed in urban-based studies, because its presence conflicts with romanticization of the quality of rural life.

The emotional valency or affective "charge," however, can quickly switch. Sometimes, the idealized "country" is contrasted with the problem-ridden city, such that chronic problems in the country are both not seen and well hidden. Other times, the technology-wealthy city is set as polar opposite to the technology-deficient countryside. Rural peoples' expectations and values of local control, self-reliance, and autonomy occur alongside, and in the face of, increased outside control (ranging from international markets, to government regulations, to banking chains, finally to the weather, nature, and God).

METHODOLOGY AND MEASUREMENT: WHAT YOU SEE IS WHERE YOU ARE LOOK- ING FROM: A VIGNETTE (#1)

Like all scientific methodologies, social science methodologies can simultaneously help us to "see" (to use the visual sense

and metaphor) and prevent us from seeing (Devereux 1967). A method presupposes the kind of data that we will find. In and of itself, this is not bad, but becomes limiting when we fail to recognize that every method presupposes a vantage point. That is, what you see is where you are looking from. To be aware of this as one is seeing permits us to see from other viewpoints. To be unaware of this – at worst, to be vested in a single viewpoint as reality itself – is to be self-blinded to other ways of seeing, and to be unable to discern data sets from those other perspectives.

For example, standard and standardized ways of gathering health-related statistics consist, among others, of US Census, CDC (Centers for Disease Control), SMSA, and the seventy-seven counties in Oklahoma. Issues of health care access and facility utilization are studied in terms of various official units. Within Oklahoma, such an approach can conceal as well as reveal. If one thinks demographically in county units exclusively, one will miss crucial cultural patterns that fall outside these ways of seeing. Rural Oklahomans often drive across the county line to towns in adjacent, or more remote, counties, for their health care. Those who live in counties near state borders might, in fact, cross state lines for their health care.

I know of several instances where, after physicians who have practiced for many years in one Oklahoma community move one or two hundred miles away to a new practice, many of their patients will “follow them” and drive the distance so that they can keep the same physician. Further, because of the stigma associated with “mental” illness, family members may travel several counties away from their home county for psychiatric, psychological, or family therapy. The official (“etic”) measures are not wrong as much as they are limited in what they are able to conclude about lived patterns of health care access and utilization (“emic”).

A vignette will make this point even more concretely. It illustrates how an unconsciously urban viewpoint can consciously distort rural lived reality by se-

lecting certain data and overlooking crucial other data. In the middle 1990’s, an eminent medical epidemiological researcher took me aside and offered me some advice on my work. He was familiar with my studies of Oklahoma culture, rural and urban facets of Oklahoma culture, from the early 1980’s through the present. My notes here are approximate, but capture the spirit of his admonition.

Your research and publications about rural farming and its relation to health care may have been true for when you first came to Oklahoma (1978), but they just don’t apply now. There’s practically nothing left of rural culture in Oklahoma. It’s a myth that we’re a rural state [I have always tried to stay out of the ideological, either/or, argument, as to whether Oklahoma is rural or urban. HFS] You know full well that there’s been migration to the cities, and rural depopulation, for a half-century. If you look at the 1990 US Census, even in the region of Enid [a city in northwest Oklahoma] that you talk about so much, practically no households earn a primary income from farming. Look at the data. Most people have urban jobs. I don’t see how you can keep talking and teaching about rural Oklahoma and health care. It’s become so minimal quantitatively.

My colleague was, I believe, speaking from an “etic” viewpoint, that is, from the (or at least a) official scientific standard of population trends, the US Census. I do not quarrel with his account of historical patterns. I question his conclusions based on his (and many others’) limited data. Put colloquially, what one “counts” (enumerates) depends on the kind of data that “count” (that matter, that one takes into account, data that one notices and includes). Status becomes a part of science. Neither my colleague nor the US Census were close enough to the lived lives of many Oklahomans -- and, beyond that, many inhabitants of the North American Great Plains – to be able to conclude that there is a vital difference between “farm-

ing to live" (income) and "living to farm" (value).

Many individuals, and married couples, I know throughout Oklahoma earn wage-incomes in manufacturing, government, health care, banking, insurance, and other jobs in order to earn a livelihood and in turn in order to keep the farm in operation. Thus, the farm does not sustain them economically; they sustain the farm in order to "farm" (verb). Further, as grain and cattle farming have become increasingly technologized, industry has been located throughout ostensibly rural areas as well as concentrated in urban ones. My colleague is thus technically, statistically, correct, but his conclusions are misplaced. An "emic," or internal, viewpoint would be essential to notice the very kinds of data I have described – and then to "collect" it. I emphasize that I have not set out to prove that Oklahoma is "rural." Rather, I have discovered that much rurality flourishes and languishes, and that a part of the latter is because we fail (are motivated to fail) to look, to ask, and to listen. Our methodological assumptions and categories interfere with the very data we need to make rurality less "hidden" a variable.

CULTURE AND TECHNOLOGY TRANSFER: A VIGNETTE (#2) ON FIBEROPTIC TELECOMMUNICATION AND RURAL MEDICINE

Since the early 1990's the collaboration between urban academic health sciences centers and telecommunications companies has promised to bridge the chasm between rural and urban access to medical care. What could be viewed as errors in cross-cultural communication complicated and compromised the very media and technology that were designed to bridge cultural regions and hence to improve communication. In Oklahoma and elsewhere in the United States, fiberoptic telecommunication networks were depicted from the urban centers and government as the solution to the problem of high cost, high technology, concentration in cities. Distributive clinical justice would be achieved by statewide outreach from the city (-ies). Small, rural hospitals would now become -- almost magically -- equipped to perform tests and procedures, and have their inter-

pretations, diagnoses, and clinical recommendations made as if much of the urban subspecialists and high technology were located in rural areas. Technology would conquer geography. Rural isolation would be a thing of the past.

The problem is that this "promise" is in fact a viewpoint ("etic") rather than the whole of social reality. It is a viewpoint from and with power, so that its adherents can attempt to impose point-of-view as if it were the only legitimate view. The neglect of these disturbing "facts" has led to unexpected, and costly, results. Greater initial attention to rural/urban factors in perception, power, and communication would have prevented at least some of the consequences.

Biomedical colleagues in rural Oklahoma, and in rural hospitals elsewhere, have repeatedly told me that millions of dollars of high technology lies idle in little hospitals. Why? They explain that when their urban counterparts installed it, they failed to ask the people who would be using it what they needed and wanted, that is, how *they*, the rural practitioners, would be using it. Health sciences centers and urban hospitals made assumptions about what rural clinicians should have and should want. By contrast, rural Oklahomans value doing things personally, one-to-one, to meet people face to face, then conduct business (cf. Hall 1959). Urban health and telecommunications planners just wanted to "get down to business."

There was a poor fit in communication style from the outset. One rural physician said to me, "Rural doctors have not been invited to design how the telemedicine equipment would be used. It's as if all the expertise and intelligence is in the city. It's a one-way street. And the money flows one way." In a paper on "U.S. Health Care Reform: Origins, Development, and Impact," medical anthropologist Carole E. Hill (1994) argued similarly with respect to health care policy-making. Health policy planners tended to view rural areas as extensions of urban areas. Health care solutions were designed in an urban-to-rural direction, centralizing services, and offering health care as a commodity rather

than as part of a relationship. Worldwide, not only nationally, telemedicine demonstration projects were being offered as a large part of the solution to "access to care." Yet that access was a highly controlled access (politically, economically, social status), one that maximized urban viewpoints and largely ignored rural ones.

Hill described one study, from Buckingham County, Virginia. A new, modern multi-specialty clinic had been built, yet it was poorly utilized. Middle class and aspiring middle class patients refused to travel to what they perceived as the "welfare" clinic. Perception of space, or cultural geography, and not distance alone, is an important, often neglected consideration in planning the location of new medical facilities. Rural peoples throughout the American (United States) South, Midwest, and West often travel large distances (say, 100-150 miles) for family visiting, shopping, and the like. The question of "Where?" is inseparable from the question of "How far?"

In summary, many rural clinicians' objection is not to telecommunication networks per se, but to the sense of disrespect, of discounting, that is imbedded in the planning and implementation of the projects. Rural Oklahomans often remind me that they are hardly the backward, simple, country folk they are often portrayed to be. Grain and cattle farming require much high technological and scientific skill. And no sooner do the farm implement companies develop tractors, balers, and combines that are safer than farmers figure out how to take them apart and "jerry rig" them themselves! Rural physicians and their colleagues have increasingly linked themselves to computer networks of national medical databases and personal networks. Such linkage helps to reduce the sense of isolation and to help rural practitioners keep up with current medical advances. What they reject is the image of medical technology as self-standing, an independent variable, when it also symbolizes rural-urban relationships. "Technology transfer," they remind me, is never merely about technology, but about networks of relationships,

meanings, and power – topics which often may not be discussed at the conference table.

RURAL AND URBAN, BACKWARDNESS AND CUTTING EDGE: A VIGNETTE (#3)

Just as the internalization of (projected) stigma can be devastating in inter-ethnic and inter-religious relations, it can be equally destructive in one's estimation of self-worth – and, by extension, the worth of place – in urban-rural relations. Around 1985, L. W. Patzkowsky, M.D., the medical director of the Enid Family Medicine Clinic, a rural Family Medicine residency training site, called me aside to visit. He was also my supervisor at this work-site. He said, with urgency and embarrassment:

Howard, I'm just an old country doctor. I knew families because I practiced in the small town of Kiowa, Kansas, for 25 years, and I got to know them the old fashioned way. One a time. I got to know their stories. But with Bill Doherty and Mac Baird now in the Department, I feel way behind. (William Doherty, Ph.D., and Macaran Baird, M.D., had recently published [1983] *Family Therapy and Family Medicine: The Primary Care of Families*, a work that, even when in manuscript form, had been touted by the chair and others as *The Book*, "The Bible," a sacred text, one required by everyone in the department, and one that would "put the department on the map" and help give Family Medicine stature in medicine.) Would you set me down one of these days and teach me about 'family systems'? It's a whole new world, and I guess I don't know about families as I should. I don't know their language. All I know is that I got to know my patients by taking care of them for many years, by listening to them. I guess I just missed a lot....

As he spoke, my eyes began to water. I was shaking my head from side to side, incredulous at what I was hearing. I felt humiliation in his behalf. Here was a man whose medical chart notes on the personal and family history of clinic patients were

like little paragraphs out of a novel or short story. The people and their lives as well as their ailments leapt off the page. Once, I had begun long-term counseling of a patient of his based exclusively on a reading of her chart — he was too occupied at the moment to sit down and visit with me about her. I said to him that, certainly I would tell him the principles and language of family systems medicine that I knew, but that I couldn't accept a world that had made HIM of all people feel inferior and backwards, when in fact HE had so much to teach us, the younger and ostensibly more rigorously scientific of the generations.

What kind of disrespectful world of clinical education are we creating, I wondered, where many of those who had so much to offer were intimidated into feeling they had nothing to teach but, instead, had to learn all over again? Certainly I could acquaint him with family systems theories and clinical models, but in the very least, did the new and the old, the big city and the small town, both have not to learn from one another? Other, non-clinical, issues seemed to be at stake and to permeate the ostensibly linguistic and methodological differences: social status, narcissism, power, to name but three. Among the processes at work was, I believe, what Freud termed the "narcissism of minor differences" (1930), a narcissism that induces one group to believe that it "knows," that it possesses truth, and that another group knows little or nothing of merit, and that induces self-doubt and shame (and often compensatory pride) in the devalued group.

STATUS AND RURAL MEDICINE: VIGNETTE (#4)

A chronic conflict in cultural identity within the discipline Family Medicine over its thirty-year history has been between those who advocate "rural," and those who advocate "urban" medicine. Although I have long striven to bridge and integrate contexts, I have come to be seen by many Family Medicine academic colleagues as strictly a ruralist rather than as a contextualist — since one is culturally permitted to be in only one camp, not both.

A linguistic cognate of the rural/urban conflict is that between two domains: (1) community-based medical training and practice sites (whether those sites are geographically remote or located within the city), and (2) urban, academic, health sciences health sciences center-based medical training and practice sites.

The following personal example illustrates the role of us/them, inside/outside, urban/rural, health sciences center/community, distinctions in identity negotiation.

In 1992, I received the Donald J. Blair Friend of Medicine Award from the Oklahoma State Medical Association. It is an annual award bestowed to a lay person (non-physician) who is seen as having contributed much to the health of the state of Oklahoma. I learned more than I bargained for about cultural identity, and its statuses, when my immediate academic supervisor in Oklahoma City, himself an eminent family physician teacher and researcher, tried to explain to me why there was virtually no mention of the award in my "home" department: "You just don't understand, Howard. You got a 'boonie award' from 'boonie doctors.' The award you received doesn't count at the health sciences center. If you were to receive an award that counted, it would have to be bestowed by the health sciences center."

On this occasion, as on others, he admonished me: "You keep asking for respect. Don't you understand, you don't deserve respect? Your work is marginal to the discipline and to the university."

In his lecture to me, he assimilated rural physicians into the stigmatized category of supposedly backward, uneducated, uncultured, hinterland people, folks of the "boondocks." He blurred "community" physicians — even practitioners in the cities — with "rural" physicians, saying essentially that even urban-based physicians who are not in the academy are just as second class as physicians who practice in the remote "boondocks." "Boonie" and "boondocks" is more a place in the mind

than it is a location in geographic space. In the realm of social comparison and envy, virtually any place can feel like the "boonies" relative to another place, or can be disparaged as the boondocks" by a place that is larger, and associated with higher status, than it.

From his word choice and admonitory tone of voice, he was not reporting about someone else's culture, but instead he was claiming its values as his own. To hear this was as culturally edifying as it was personally devastating. I felt as if my career and contribution had been reduced to rubble and feces. I wondered whether he could elevate his "urban," "academic" stature by identifying me with rural and community "boonies." What, I further wondered, was the current status of the early Family Medicine ideal as advocate for underserved groups? In his admonition, I felt not only that I had been relegated to the hinterland, but likewise the reformist philosophy of Family Medicine had been demoted if not banished. Clearly, from his position, there was little or no room for integration.

CLINICAL MEDICINE AS CULTURAL MEDICINE: FIVE VIGNETTES

The following five brief clinical vignettes illustrate how rurality-as-culture colors virtually any facet of clinical reality, and in turn how this fact merits consideration in any clinical case, rural or urban. Clinical (biomedical) examples will range from chest pain, to hospital discharge planning, the measurement of central venous pressure, performance and evaluation of "routine" laboratory tests, and the diagnosis and treatment of headache. Together, they will show how culture, identity, group, and sense of place play a central role in patient, family, and clinician values, decision-making, and health-related behavior.

VIGNETTE #5: RURALITY, SICK ROLE, AND GENDER

No "physical" symptom, however common, is without context. Consider the experience of chest pain. The "what" is part of the "who," which is in turn part of the "where" (context). A 51 year-old Euro-

pean American wheat farmer in northwest Oklahoma comes reluctantly to the hospital emergency room with chest pain. He comes at the insistence of his wife. There is an implicit treatment timetable to his delay in seeking medical treatment. Like many rural, European American men, when he experienced chest pain, he kept it quietly to himself, and waited for two days to tell anyone; he tried to "work it off" by mowing the lawn, driving the tractor, and other forms of work. After he told his wife about his chest pain, he finally agreed to go to the ER only because his wife insisted. She becomes his face-saving agent and pretext to seek medical care. His presenting complaint is that "My wife made me come in." In his own eyes and in others', he does not lose his sense of masculine pride (often called "macho").

There are cultural consequences for going "too early" to the doctor: e.g., shame from one's rural male peer group. Medical consequences often clash with cultural consequences. The choice often comes to losing face (pride) versus risking losing one's life. From the (often urban-trained) physician's viewpoint, medical consequences and restoration to health are the paramount cultural consequences, while for the rural wheat farmer patient, the fear of ostracism and the equation of health with the ability to work, are the paramount cultural consequences.

VIGNETTE # 6: RURALITY AND CLINICAL ROLE GENERALISM

This brief vignette is a lesson in rural and urban clinical epistemology and role assumptions. Rural and urban medicines are not and cannot be identical precisely because one cannot automatically transpose all contexts when one leaves one and enters another. I have learned a great deal about rural and urban Oklahoma culture less by asking questions than by being in, and observing, clinical situations where the distinction helps to make sense of the nature of the problem. For instance, in the early 1980's, a second year family physician resident who had completed his internship in Oklahoma City, approached me as he was preparing to discharge a hospitalized patient

back to her home in the community in Enid, Oklahoma, where he was receiving his residency training. He said urgently to me, "Tell me where I can get a medical social worker to do the discharge planning."

I said to him: "Here, like in a lot of rural medicine, you ARE the medical social worker. A rural doc has to be much more of a generalist than in cities. You need to get to know the town well enough either to do the planning yourself, or to develop some of those skills in nursing or other staff. Let's talk about what medical and social needs you've identified and what we can put together with the types of people who are here." He was rudely awakened – and displeased – by the differences in cultural reality between urban and rural practice. He had expected to be able to move on quickly to the next clinic patients, and not have to get "bogged down" in performing for himself roles that he did not feel should be his.

VIGNETTE #7: RURALITY AND ALTERNATIVES TO HIGH TECHNOLOGY

The following vignette, like the previous one, illustrates the confusion of urban with rural realms, and the possibility of utilizing context-specific clinical strategies to achieve similar clinical ends. A patient with an acute myocardial infarction comes to the emergency room in a rural Oklahoma hospital. The physician wants to find out the central venous pressure (CVP), requests a Swan-Ganz pulmonary artery catheter, or an echocardiogram, neither of which are possible to order here. The solution, a hospital nurse tells him, is to check the neck veins for jugular venous distension (JVD). That is, if the neck veins bulge, high blood pressure may be inferred.

The larger cultural-clinical lesson here is that in rural medicine, many high cost, high technology tests and procedures are not immediately available. In many cases, rural clinicians have developed alternate, low-cost means of approximating the kinds of biomedical data they seek.

VIGNETTE #8: RURALITY, MEDICINE, TIME, WEATHER, AND DISTANCE

Many American (including Oklahoman) physicians prefer to treat their patients in hospitals rather than in outpatient (ambulatory care) settings, because inpatient facilities offer the promise of greater control over the patient's medical condition. Yet that wished-for control is often illusory and elusive – and not only in rural locales. The following vignette illustrates how generically rural and specifically Oklahoman factors can intervene to complicate the course of hospital-based medical care, especially when only urban values and expectations are taken into consideration.

A patient is hospitalized with severe breathing problems, uncontrolled by outpatient treatment. Part of the medical work-up is to rule out the presence of tuberculosis. The test is performed in a rural Oklahoma hospital. The lab, however, that can determine the presence or absence of TB is in Dallas. The test takes place during a severe ice storm that plays havoc with the southern Great Plains. It will take at best 3-4 days to receive the test results. Treatment alternatives are sought based on the interplay of distance, travel, weather, time, loss of control, expectations, and frustration.

This scenario is frequently played out in Oklahoma and in many neighboring states where ice storms and treacherous winds bring to a virtual halt all ground and even emergency medical air transportation. On occasion, the ice storms will interrupt telephone and other communication networks. Perhaps more dramatically than any other cultural situation, these circumstances make explicit the clash between the wish to control nature (including disease) – the presumption that even it can be "managed" -- and the recalcitrance of nature, a duality more extreme in urban than in rural culture.

VIGNETTE #9: RURALITY, MEDICINE AND THE STATUS INEQUALITY OF DISEASES

This final vignette illustrates how even the seemingly most commonplace features of American medicine are not immune to rural-urban contextual considerations.

Consider the common symptom or "complaint" of a "headache." The context of a patient's "presentation" of a symptom to a physician in the office or hospital partially determines which diseases will be considered (that is, enter the physician's "differential diagnosis" list).

For the common symptom of "headache," urban and highly academic center-oriented physicians will tend to think of complex, rare diseases, often called "zebras." The detective search for these internal medicine entities is both exciting and high status (Stein 1990). More ordinary causes are of far less interest than unusual ones. In rural Oklahoma, both equine (horse) and bovine (cow) encephalitis often "present" with the symptom of headache. Yet, because many urban-oriented physicians tend not to think of these common, low-status, diseases, the correct diagnosis might be missed, or take longer to make and therefore correctly treat.

This vignette reflects a larger contextual issue in clinical methodology. If I may borrow from George Orwell's novel, *Animal Farm*, "Some diseases are more equal than others." That is, diseases are not alike symbolically. The etic/emic, official/unofficial distinction, helps to account for the social status of diagnoses. In making biomedical measurements, rural and urban physicians implicitly ask themselves: How do we measure? What do we think we should measure? What do we regard as worth measuring? What "units" count? What makes us feel good, competent? These universal issues become played out on the cultural landscape of the conflict-ridden relationship between rural and urban medicine in Oklahoma, and elsewhere as well.

CONCLUSIONS AND IMPLICATIONS

This paper has explored issues in Oklahoma rural health care insofar as they are governed by out-of-awareness differences in rural-urban perspectives. Specifically, I have explored rural and urban ideologies of place and the identities they express and sustain. I have argued that the rural/urban distinction is a bona fide cultural distinction and opposition, one that is driven by often-reciprocal group stereo-

types that safeguards the boundary between rural and urban identities.

Vignettes from my twenty-three years of clinically applied anthropology in Oklahoma have illustrated the operation and tenacity of this cultural oppositional system (Spicer 1971) within ostensibly "the same" state and national culture. I have argued specifically that psychologically and historically rooted stereotypes of the cultural "other" by urban-based academic health sciences centers and hospitals impede the delivery of culturally-sensitive health care to countless rural areas. Usually unstated assumptions about group, culture, identity, place, and sense of place are at least partly responsible for the intractability of problems that are more narrowly defined as issues in "rural health care delivery." Ideologies of place play decisive roles in rural health care decision-making on large and small scales alike.

The "lens" of ethnocentrism is one through which people commonly view and (mis-)understand "otherness." Its distortive potential increases with the anxiety that surrounds the subject matter. Rural-urban distinctions have long been emotionally charged and are heir to this human legacy, one that is usually associated with ethnicity, nationality, and religion.

In Oklahoma and elsewhere, proposed healthcare "solutions" in rurally underserved areas are constrained to the degree that they fail to recognize "rural" and "urban" to be inter-linked cultural systems. In Oklahoma and elsewhere, we -- an inclusive "we" -- can genuinely address, and perhaps solve, problems of rural health care only if we are willing and able to perceive rurally lived life on "its" own terms -- rather than as extensions of urban-based stereotypes steeped in ideologies of romanticism and condescension.

Attention to others' lived and experienced lives -- rural, urban, and otherwise -- can improve health care as we come to realize that much we had thought to be "pure" perception was heavily informed by prejudice -- that was in turn distorted by projection. A rural-urban health care dialogue might well begin with the basic question: "What is it like to be you?" Rural

health planning will best be served by approaches that acknowledge rural and urban "places" to constitute bona fide cultural groups, each having a distinctive identity tied to a sense of place.

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JOURNEY FROM DARK TO LIGHT AND THEN? THE LEGACY OF OKLAHOMA'S TERRY D. LAWSUIT

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Abstract

In 1978, Oklahoma's child welfare and juvenile justice systems were sued by Legal Aid of Western Oklahoma, the National Youth Law Center and the American Civil Liberties Union concerning conditions in the state's child care institutions. The suit alleged abuse of children and youth through extreme restraint practices, isolation, and physical punishment. It further alleged that the institutions were not properly staff, were located in isolated rural areas that made it impossible to find qualified professional staff, and sometimes the institutions housed deprived and delinquent children together. Specifically, it was alleged that deprived children were sometimes transferred, without due process protections, from non-secure, open settings to secure institutions designed to house delinquent youth. During the nearly twenty years of litigation, the state's juvenile justice and child welfare systems underwent extensive changes and the lawsuit was finally settled. At the final hearing, the Honorable Ralph J. Thompson, Federal Judge in the case, commented that the state had made a "journey from dark into light." This historical essay explores what happened, what changes were made, how settlement was reached, and what has transpired since federal court involvement ended. It explores the legacy of this litigation and the prospects for using such an event as an effective and lasting change agent.

Oklahomans have long prided themselves on being a caring and compassionate people. Following the Oklahoma City bombing of April 19, 1995 or the disastrous tornado of May 3, 1999 citizens from all walks of life pitched in to help not just their friends and neighbors but also total strangers. This caring way of life is thought to be a part of Oklahoma's heritage and is extended to providing for deprived and delinquent children as well.

From the earliest days of statehood, Oklahomans endeavored to provide for children who had no place to go or who found themselves in trouble. Over the years the state provided homes and services for children in a series of large public institutions. But as time went by something went wrong. The facilities which were intended to serve as a refuge for unfortunate children became isolated, antiquated and troubled. It was as if Oklahoma had forgotten a segment of its population and, if Oklahomans thought about it at all, were satisfied that the state's deprived and delinquent children were being taken care of in safe havens. Unfortunately, this was not the case (Durrill 1978:

1 & 15).

By the late 1970's, Oklahoma's children's institutions were an operational part of the Department of Human Services (DHS) and had a capacity of 1211 beds (Buckner 1987:1). The DHS had been headed by Director Lloyd E. Rader since the early 1950's. Mr. Rader and his chief subordinates believed that large congregate care facilities were fit and proper places to raise children. With one exception, the institutions were located in small rural communities such as Taft, Helena, Boley and Pryor. The lone exception was a new facility located near Tulsa (Trzcinski 1996: 92).

Despite his considerable administrative skill, Mr. Rader allowed the institutions to become isolated from the national children's services community. As a result, local practices developed that, when exposed, caused great controversy and consternation (Pearson 1994: 3). Rumors of extensive use of security cells and isolation rooms, even in institutions for deprived children, began to surface. The practice of "hog tying" (the shackling of hands and feet together behind one's back)

was alleged to be commonplace (Taylor 1998: 1).

At about the same time, the nation began to be exposed to allegations of systemic abuses of children residing in institutional care. Kenneth Wooden in his landmark book *Weeping In The Playtime Of Others* cites Texas' 1973 *Morales v. Turman* case as being one of the nation's first wake-up calls to constitutional issues involving children (1976: 4-7). Wooden detailed on a national scale abuses in a juvenile justice system he described as "a formidable fortress, built with the powerful forces of status quo and vested self-interest and reinforced by traditional thinking and political realities (1976: 232)." While Wooden's book only mentions Oklahoma one time, he could have been writing specifically of the Sooner State. Barry Krisberg later noted that juvenile correctional facilities were, generally speaking, "almost impervious to change (1996: 47)."

TERRY D. V. RADER

In January, 1978, lawyers from Legal Aid of Western Oklahoma, the National Center for Youth Law and the National Prison Project of the American Civil Liberties Union filed a lawsuit in Federal Court concerning unconstitutional conditions alleged to exist in Oklahoma's institutions. The case became known as *Terry D. vs. Rader* because Terry D. was the first name on a list of children who were seeking relief. The suit alleged that the state abused its youth through the use of extreme restraint practices, isolation, and physical punishment. The suit further alleged that the institutions were not properly staffed, were located in isolated rural areas that made it impossible to find qualified professional staff, and sometimes housed deprived and delinquent children together. Specifically, it was alleged that deprived children were sometimes transferred, without due process protections, from non-secure, open settings to secure institutions designed to house delinquent youth (Trzcinski 1990: 194).

In its twenty years of life, the lawsuit took all of its participants on a strange trip.

The first years of litigation were bitterly contested. Later, the lawsuit became less contentious and the two sides worked together with an attitude of cautious cooperation. The DHS went through six directors, seven juvenile justice administrators and five child welfare administrators. There was a similar number of lead attorneys for the state. The Plaintiffs' side was more stable with Stephen Novick leading their effort throughout the course of the suit. During the life of the lawsuit, the author of this article worked as a senior level staff person for both the DHS and the Office of Juvenile Affairs (OJA). In this capacity, the author served as the liaison to the Federal Court's Monitor for both the OJA and then the DHS. As such he was deeply involved in the eventual settlement of the case.

In 1984 a Consent Decree was signed by the parties. The Consent Decree established rules for the operation of the institutions including removal of deprived children from large congregate care. The Consent Decree also established parameters for the use of restraints and the use of isolation in the institutions. It required the state to seek accreditation of its juvenile justice programs from the American Correctional Association (ACA) and from the Council On Accreditation (COA) for its child welfare programs. Perhaps most significantly, the Consent Decree directed that the state develop a "balanced system" of community programs for custody youth, although it did not define what constituted a "balanced system" of community programs (1984: 8).

The Department worked diligently to implement its unofficial and non-court sanctioned understanding of the requirements of the Consent Decree. It closed its two large institutions which served deprived children and began developing a system of community placements. In addition, the Department closed three institutions which had served delinquent children. Secure operations were available at only two remaining sites that could house a total of 212 youth (Buckner 1987: 1).

The DHS actively pursued accreditation of its various programs. The Department's

child welfare system became the first state-wide program in the nation to achieve accreditation from the COA and the Department's programs for delinquents became accredited through the ACA. These significant achievements were not reached without resistance from some administrators and line staff. Some believed accreditation was a "paper process" that guaranteed little. Others wondered why the agency had to follow national standards. It was not uncommon to hear the comment, "Oklahomans know what is best for Oklahoma." Despite such resistance there was little room for hesitancy; both the Consent Decree and state statute required DHS programs to achieve and maintain accreditation (Trzcinski 1990: 196).

By 1992, the parties had agreed upon an implementation plan to delineate the actions necessary to end the suit. Judge Ralph Thompson appointed Paul DeMuro of Montclair, New Jersey, to serve as the Court's Monitor. DeMuro's task was twofold: to assure the parties remained in agreement and to monitor the implementation of the court approved plan.

Between 1992 and 1995 the DHS, with the support of the Governor and the Legislature, began active implementation of the plan. Perhaps the most significant part of the plan was the creation of the Oklahoma Children's Initiative (OCI), designed to assure compliance with that part of the Consent Decree which mandated "a system of balanced community services (1984: 8)." The OCI included independent living services, comprehensive home-based services, educational advocacy and other programs which had not previously existed in Oklahoma and were contracted to private service providers located throughout the state. The Legislature and Governor provided funding to assure that specific target levels of service could, over time, be met. This public and private sector collaboration was the largest partnership of its type in Oklahoma's history.

The implementation plan also required the Department adopt a philosophy of "strengths and needs based" assessments and case planning to assure that children,

youth and their families received individually designed services to assist them in meeting their goals. Previously, treatment plans, if they existed at all, had focused on simple assessments which typically stated only a broad goal (e.g., "The parents are required to stop drinking and abusing their children"). Under the philosophy of strengths and needs based assessments, treatment plans were to become much more detailed and specific in regard to how goals were set and how they were to be achieved. The new philosophy required the staff to increase the involvement of parents and children in developing and carrying out the plans (Beyer, DeMuro and Schwartz 1990: 59). Even with a massive training effort and top administrative support, the concept was not well received by the staff.

Two independent evaluations of the Department's progress in this area were conducted by the University of Oklahoma's School of Social Work. Despite intense training for line staff, the initial results were not encouraging. Generally, it appeared that staff were not adept at the new techniques and saw the increased family/client participation as having dubious value (Rosenthal, Baker and Atkinson 1993; Rosenthal and Greenwood 1996). This would be an area of concern for the Department and the Court Monitor until the final days of the suit (DeMuro 1997: 2).

In 1995, the changing political climate and the public's concern over a perceived rise in juvenile crime brought about the creation of a new state agency to take over the operation of Oklahoma's juvenile justice system. On July 1, 1995, the Office of Juvenile Affairs (OJA) took over the operation of the state's juvenile justice programs. All employees, programs and facilities in the state's juvenile corrections system were transferred from the DHS to the new agency. Child welfare programs remained with the DHS.

With the two service systems now operated by separate agencies, DHS and OJA re-negotiated their respective court approved implementation plans, but the Consent Decree remained applicable to both.

Each agency had its own legal team and from that time forward, there was very little coordination between the two. Both agencies desired to bring an end to the litigation but took different paths toward achieving this goal.

OJA'S EFFORT TO END THE LAWSUIT

The new Director of the OJA announced that his first and primary task was to "end Federal Court involvement" in the state's juvenile corrections programs; a position he reiterated numerous times (Lackey 1997). The new agency took an aggressive stance that the suit would end by negotiation or litigation. The OJA devoted a great deal of effort to complying with the letter of its implementation plan and the administration did a commendable job of marshaling its resources to achieve compliance. A new study of OJA's "strengths and needs based" service planning revealed that the agency had met this goal. Additionally, the specific numeric levels of services delivered to youth and their families under the OCI increased and eventually reached the levels of service contemplated under the implementation plan (DeMuro 1996: 10).

When the OJA administration felt certain that all target levels and other terms of the implementation plan had been reached, the parties began negotiation of a dismissal order. The OJA administration took the position that the terms of the plan had been achieved; the plaintiffs pointed to several possible shortfalls and did not agree that compliance had been reached. In a "land for peace" agreement the two parties reached a compromise. In exchange for the plaintiffs not opposing the dismissal, OJA offered to agree to several conditions which would be a part of the final settlement order (DeMuro 1996: 9-10).

The settlement included agreements on limiting the use of isolation and mechanical restraints in the juvenile institutions and continued accreditation of all programs by the ACA. It was agreed that mechanical restraints could only be used "to transport a violently out of control child to a place of confinement, but only after less restric-

tive methods of control have failed. When restraints are employed in this situation, they shall be removed as soon as the child regains control or is confined, whichever comes first (OJA *Terry D. v. Rader* Dismissal Order 1996: 9-10)." Additionally, it was agreed that placement in a security room can not exceed three hours and the child must be released when he or she has gained control of themselves (OJA *Terry D. v. Rader* Dismissal Order 1996: 9-10).

It was agreed that non-compliance with these requirements would allow the plaintiffs to move for a reinstatement of the lawsuit (OJA *Terry D. v. Rader* Dismissal Order 1996: 4). In summary, OJA achieved a much heralded dismissal of the suit and the plaintiffs received assurances that perpetual safeguards would remain to prevent the reestablishment of previous onerous practices.

The OJA portion of the lawsuit was conditionally dismissed in April, 1996. The parties agreed, and the Court ordered, that OJA would submit to six months of monitoring to assure that compliance was maintained. Court Monitor DeMuro certified compliance at the end of October, 1996 and final conditional dismissal was granted by Judge Thompson. At the final hearing for the OJA case, Judge Ralph Thompson commented that Oklahoma "had made a journey from dark to light" in the manner in which it treated its troubled children (Thompson 1997: 1).

DHS' EFFORTS TO END THE LAWSUIT

The administrative staff of the Department of Human Services appeared stung by the early dismissal of OJA and increased its efforts to end the case. Working with the plaintiffs' attorney and the Court Monitor, the DHS identified several critical issues requiring resolution. These included determining the status of the Department's commitment to implement strengths and needs based assessments and case planning, assuring that numeric target levels of services were being met through the OCI, and displaying continued progress towards resolving issues surrounding the DHS operated emergency

shelters in Tulsa and Oklahoma City (DeMuro 1997: 7-8).

In an effort to resolve long-standing problems at the two DHS shelters (Bond and Moore 1982: 22-23), the Department agreed to establish a system of emergency foster care to assure that children under the age of six would not spend more than a few hours at the shelters. The Department also agreed it would not allow the population at either shelter to exceed its licensed capacity. Finally, the Department agreed to move all children in the shelters to alternate placements or home as quickly as possible. The DHS committed through its formal policies that under no circumstances would any child stay over sixty days in a DHS operated shelter. The policy included the designation of a representative of the DHS Director whose function would be to assure that no child remained in the shelters for over the agreed upon sixty days (DeMuro 1997: 6). Optimism was high that a problem in existence since the 1975 creation of the first DHS operated shelter would finally be corrected (Trzcinski 1997:1-2).

About the time that the OJA portion of the lawsuit was being dismissed, the DHS got another discouraging report about its strengths and needs based treatment planning (DeMuro 1996: 2-3). An internal report indicated the Department's staff had still not implemented the concept (Linam undated). As a result, the Department agreed to a massive training effort requiring participation by all child welfare line staff and supervisors. The parties agreed that following the training another study of the status of strengths and needs based assessment and planning would be conducted (DeMuro 1997: 7).

However, since the OCI numeric target service levels were being met, the agreements regarding shelter practices had been put in policy, accreditation had been achieved and other conditions of the implementation plan and Consent Decree had been met, the parties agreed to a dismissal of the suit prior to completion of the treatment plan study. Judge Thompson dismissed the lawsuit in January, 1998 (Taylor 1998: 1).

The treatment plan and assessment study was completed a few months later (Herrerias 1999). The training effort had been effective and the Court Monitor accepted the report that the Department had complied with the terms of the settlement agreement. The Terry D. lawsuit was over some twenty years after it was first filed (DeMuro 1998: 1-2).

Both state agencies had achieved their goals. The OJA in 1996 and the DHS in 1998. The most significant difference between the two Dismissal Orders was the existence of conditions which the OJA must continue to meet. No such "legacy conditions" existed for the DHS.

Following dismissal of any class action lawsuit, it is prudent to examine whether the changes brought about by the litigation have become an operational part of the agency's program culture. When the "scaffolding" of the Federal Court is removed, which court ordered programs will continue and which will not? Did the changes that came about through the efforts of so many persons survive; or, will the changes be dismantled and the agency move in a different direction?

THE DEPARTMENT OF HUMAN SERVICES: POST TERRY D.

The DHS has no legacy agreement with which it must comply. It now operates under the mandates of state and federal law, the rules and regulations which come with federal funding, its own policies and procedures, and the COA standards.

The current administrator for child welfare services stated in an interview with the author that the Department remains committed to the progress and changes which occurred as a result of the Terry D. lawsuit. In keeping with current social work thought, the administrator indicated that the agency is working to become less focused upon process matters and more on overall outcomes (Ballard 2000).

For example, during the lawsuit much effort was made to assure that case planning focused upon the strengths and needs of clients. While strengths and needs based training is still a part of the agency's new employee core training, the DHS is

now focusing its efforts on impediments that prevent the achievement of safety, well-being and permanence for children. The Department is working to determine what must take place to move children through the child welfare system in order to achieve family reunification, adoption, or in a few instances, placement in a long term setting or in independent living. Agency leaders state that rather than do another study of case planning, the agency is preparing to study its longest term cases to determine what needs to be done in order to achieve some sort of permanency for the child. The results of the study will influence the future planning of the agency (Ballard 2000).

The DHS has reorganized the Oklahoma Children's Initiative. It is now called the Oklahoma Children's Services (OCS). According to DHS officials, the services have been somewhat restructured to provide greater accountability for expenditures and results. While some of the basic components of OCI are still recognizable in the OCS, there is now increased monitoring of what actually happens to the families involved and the manner in which the money is spent separate from OCS. A "contingency fund" has been established which allows local staff to spend limited money to assist a family in overcoming problems which may hinder a child's return home. For example, up to \$750 per family can be spent for things such as automobile repair, bedding, utility deposits and so forth (Ballard 2000).

The DHS reports they have sustained a \$300,000 (4.3%) reduction in the amount of funding for the OCS during the Fiscal Year 1999-2000. The agency indicates that a recent round of general budget cuts were mandated by the Governor and Legislature and, since not all money earmarked for OCI/OCS had always been spent, the reduction was ordered. Ironically, the agency reports that service utilization has increased and they are now experiencing shortfalls in this area. The DHS also reports there is now a waiting list for services for some clients (Ballard 2000).

Two years following the dismissal of the lawsuit, the DHS acknowledges it still

experiences problems managing the populations of the two shelters and acknowledges that length of stay continues to be an issue. The agency reports that generally the shelters operate under their licensed capacities and children under the age of six do not typically spend more than a few hours at the shelters before going to emergency foster care (Ballard 2000). Speaking upon a guarantee of anonymity, several DHS shelter personnel commented to the author that teenagers, minority children and children with behavioral problems sometimes still experience unacceptable lengths of stay and small children sometimes stay longer than the DHS administration would care to admit. If true, the safeguards set in place at the end of the lawsuit have not been entirely successful in assuring that no child remains in shelter care over sixty days, and the Department is frequently in violation of its own policy concerning maximum length of stay.

Within the DHS, there seems to be no consensus on how to remedy the problems of shelter care and, thus, no effective action to correct the problem. Oklahoma state law (Title 10: 7004-1.1) clearly prohibits placement of deprived children in an institution operated by the DHS; the DHS shelters are, however, designated as "emergency shelters." When children stay beyond the sixty day maximum set by DHS policy, the shelters functionally become "public institutions." One of the fundamental tenets of the *Terry D.* case was that deprived children who cannot go home have a right to live in "home-like" community-based settings (*Terry D. v. Rader* Consent Decree 1984: 7). Failure to effectively deal with this issue creates a risk similar to that faced by children placed in public institutions prior to the filing of the lawsuit in 1978. While staff and administrators in DHS often speak of doing "what is in the best interest of the child," (DeMuro 1996: 7-8) they have not yet remedied this serious problem.

The DHS remains committed to accreditation by the COA. There is recognition among staff that the new COA standards mandating a system of "Continuous Quality Improvement" will be difficult to meet.

However, both the child welfare division head and the Director of Human Services support accreditation and will continue to maintain it (Ballard 2000).

THE OFFICE OF JUVENILE AFFAIRS: POST TERRY D.

The Director of the Office of Juvenile Affairs did not respond to requests for an interview to discuss what has happened within the agency since the dismissal of the Terry D. lawsuit in 1996. The agency did provide a copy of its latest annual report in which the OJA's "Promise Approach" to juvenile justice is explained. In *Future Focus: The Promise Approach, 1999 OJA ANNUAL REPORT*, then OJA Director, Jerry Regier wrote, "In this approach we tell the youth that there are certain and swift consequences for delinquent and criminal behavior. We will not tolerate his anti-social actions. We will not tolerate his disrespect and self-centeredness. He is responsible for his behavior and must change, and we will help him to change while he is in our custody by holding him accountable and providing tools to change (2000: 4)."

There has been a significant increase in secure and "staff secure" beds for juvenile offenders, including an increase of capacity at the existing facilities in Sands Springs and Tecumseh. Prior to the creation of the OJA, the legislature authorized the creation of a new state operated medium security institution at Manitou, Oklahoma. The new institution became operational during 1996 and added approximately 80 secure beds to Oklahoma's system. The OJA also contracted for a privately operated medium secure training school, with a capacity of approximately 80, located at Union City, Oklahoma. This facility became operational in 1998.

The OJA has become a leading proponent of boot camps for juvenile offenders. During the final days of the lawsuit, negotiations began with VisionQuest for the operation of a boot camp in Faxon, Oklahoma. These negotiations and plans were not discussed with the plaintiffs and Court Monitor. The OJA has also contracted for a second boot camp operated by the Okla-

homa National Guard in Pryor, Oklahoma, on the site of the former Whittaker Children's Home which was closed during the Terry D. lawsuit. The Terry D. issue of locating facilities in rural areas of the state where qualified staff are difficult to hire and retain seems to have been ignored.

In 1999, the OJA dismantled its Oklahoma Children's Initiative, which was a significant part of the "new" programs mandated under the lawsuit. The OJA has redirected much of the OCI funding into its State Transition and Reintegration System (STARS). STARS is operated through a contract with the Oklahoma Military Department and is described as a program to provide "accountability, control and disciplinary services for OJA youth returning to their home communities from juvenile justice system placements (OJA 2000: 17)."

Perhaps of greatest concern and most difficult to ascertain is the quality of life and conditions of confinement in the OJA's secure institutions. The Dismissal Order required that certain conditions in the institutions be maintained including restrictions on the use of solitary confinement and mechanical restraints. Solitary confinement is defined as "the involuntary removal of a child from contact with other persons by confinement in a locked room, including the child's room, except during normal sleeping hours (OJA Dismissal Order 1996: 8-9)" The Dismissal Order further states, "No child shall remain in solitary confinement in excess of three (3) hours. As soon as the child is sufficiently under control so as to no longer pose a serious and immediate danger to himself or others, the child shall be released from solitary confinement. The use of consecutive periods of solitary confinement to evade the spirit and purpose of this section is prohibited (1996: 9)." The Dismissal Order also addresses the use of mechanical restraints by the OJA. The Dismissal Order states mechanical restraints can be used. "Within OJA institutions, to transport a violently out of control child to a place of confinement, but only after less restrictive methods of con-

trol have failed. When restraints are employed in this situation, they shall be removed as soon as the child regains control or is confined, whichever comes first (1996: 9-10).”

However, regarding the use of restraints, the agency’s annual report states, “The Office of Juvenile Affairs has developed a Continuum for the Use of Force in Oklahoma’s juvenile institutions...The use of mechanical restraints and temporary monitored placement in a crises management room may be used in response to moderate and high levels of risk (2000: 17).” If, as the OJA 1999 Annual Report seems to indicate, mechanical restraints are used for any other purpose other than transporting a youth from one point to another there is significant concern about compliance with the Terry D. Dismissal Order. Similarly, if the use of solitary confinement is beyond that contemplated in the Dismissal Order, the Plaintiffs could ask for re-instatement of the Terry D. lawsuit.

THE FINAL LEGACY OF TERRY D.

Judge Thompson spoke of Oklahoma making “a journey from dark to light.” In the ensuing years following the dismissal of the Terry D. lawsuit there remain questions about the direction both of Oklahoma’s agencies have taken. The critical issue for Terry D.’s legacy is how well did the agencies learn the lessons of the past as evidenced by their program efforts following the lawsuit’s dismissal. What reforms have become systematized and what have disappeared?

For the Department of Human Services, there has clearly been an internalization of some of the fundamental issues of the case. The agency’s leadership appears to accept and affirm the basic principles which led to a resolution of the case and continue to be guided by a dedication to the spirit of the settlement. Community services are provided and accreditation is maintained. However, the Department has not resolved the significant issues it faces concerning its shelter operations. The agency appears to continue to allow long lengths of stay at its shelters in violation

of the agreements made at the end of the lawsuit and its own internal policies.

On the other hand, the Office of Juvenile Affairs has moved in an entirely different direction. The new direction is reliant upon the use of a growing number of residential programs and represents a turning away from the community programs that were created during the lawsuit. The agency’s latest annual report raises questions about the use of isolation rooms and mechanical restraints in its institutions. Today, Oklahoma’s juvenile justice system appears to be moving toward the system of the past by returning to a possible over-reliance upon costly secure and “staff secure” residential programs which are often located in rural and isolated areas of the state. Community services have been replaced by “accountability follow-up. (Regier 1999: 5)”

Can litigation be a meaningful change agent? In the short run, certainly. Despite being a painful and costly experience, a lawsuit can cause an otherwise dormant system to develop new resources and move forward. Such was clearly the case in Oklahoma. As one DHS administrator commented in 1990, “Mr. Rader loved his institutions. As painful as it was, it was the only way we would ever move forward (Gordon 1990).” Will the changes last? Certainly not all changes will last when the scaffolding of court oversight is removed. But if the significant changes are internalized into the system, some changes may stand the test of time. If the changes are not internalized or the management of the agency has a counter philosophy, the changes and improvements will likely disappear.

When settling a lawsuit that has brought about sweeping changes, the parties must consider the future and make an assessment of the probabilities of continuing the progress which has been made. This must include an assessment of the political climate of the jurisdiction and the people who will likely become decision makers in the foreseeable future. While no one can guarantee the future, every effort should be made to preserve the best of the progress which has been made.

Oklahoma's experience provides a case study of two different directions agencies can take following the dismissal of such an action. One agency is clearly working to move forward by preserving many of the gains made while under court supervision but still faces serious unresolved issues. The second agency seems to have turned its back on the lessons of the past and appears to be moving toward a return to the conditions which originally caused the lawsuit to be filed over twenty years ago; a phenomenon Barry Krisberg refers to as resembling the popular movie "Back To The Future (1996: 48)." Judge Thompson was correct when he commented that Oklahoma had made a "journey from dark to light;" however, the state's final destination remains unclear. Oklahoma appears to be unsettled in the direction it will take concerning helping its troubled children and youth. Lessons from *Terry D. v. Rader* may serve as a guide for the future or as a signpost to the past.

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DEINSTITUTIONALIZATION AND THE MEASUREMENT OF CONSUMER OUTCOMES: THE OKLAHOMA EXPERIENCE 1992-1999

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Abstract

The deinstitutionalization movement in the United States has taken on many forms and has had significant impact on individuals, governments, and communities. In response to government policy concerns, social scientists have investigated the theoretical and methodological tasks of conceptualizing and measuring the impact of deinstitutionalization. Procedures for examining the impact of community based correctional and mental health facilities have become well established, but far less attention has been paid to the deinstitutionalization of persons with developmental disability. This paper provides an overview of the deinstitutionalization movement as applied to persons with developmental disabilities and places the Oklahoma experience within the context of that movement. The analysis examined four indicators of quality of life (independence, integration, productivity, and satisfaction) drawn from the 1987 Amendments to the Developmental Disabilities Act. Results show higher mean scores on each indicator used to measure quality of life since community placement.

INTRODUCTION

The purpose of this paper is to provide an overview of the de-institutionalization movement as it applied to persons with developmental disabilities and to place the Oklahoma experience within the context of that movement. This analysis draws on information from several sources including Oklahoma State University Developmental Disabilities Quality Assurance Research Project.

BACKGROUND

The deinstitutionalization movement in the United States has taken on many forms and has had significant impact on individuals, governments and communities. Typically viewed as a social movement, its organizational phase dates back at least to the 1960s. The movement has as one of its primary goals the removal of individuals from total institutions such as prisons, asylums, and mental hospitals to community-based alternatives. Similar movements occurred (and are occurring) in other countries as well. Several studies for example document aspects of the movement in Canada and Britain. The success of the movement has led to the establishment of community alternatives to prisons, mental hospitals, and state schools. State schools, like mental hospitals, were large total institutions that housed persons who were then referred to as "mentally retarded". Public policy statements and plans paralleling this movement are concerned with assessment of the success of community placement for individuals as well as for the communities in which they are placed.

In response to governmental policy concerns, social scientists began to concern themselves with the theoretical and methodological tasks of conceptualizing and measuring the success of deinstitutionalization. Until recently (last 10 years) in the U.S., most of this effort was concentrated in the area of prison reform and eradication of many large mental institutions. Many of these were replaced with community correctional facilities and community mental health facilities. The procedures for establishing success, or lack of success, of the community based correctional and mental health facilities are well established in research. Far less attention has been paid to deinstitutionalization of persons with developmental disability. Of particular concern is how successful deinstitutionalization is conceptualized and measured for persons with developmental disabilities.

Several forces joined to contribute to broad-based shift in policy. First, the aforementioned deinstitutional movement, as an outgrowth of the civil rights movement, has altered society's perceptions about how people with developmental disabilities should be supported. There is a growing recognition among families, professionals, and policy makers that people with developmental disabilities can and should live in the community (Stancliffe & Hayden, 1998). Second, federal legislation such as the Omnibus Budget Reconciliation Act (OBRA: P.L. 100-203) has discouraged the use of congregate care settings, such as nursing homes, for people with developmental disabilities, favoring instead the use of smaller community based

services. Third, research on the quality of life has accumulated over the past two decades showing that individuals improve in several skill areas when placed in a community setting regardless of the severity of their disabilities (Larson & Lakin, 1989; Larson & Lakin, 1991). Finally, Oklahoma's increased commitment to community based programming was significantly promoted by the litigation that led to the closure of The Hissom Memorial Center in Sand Springs, Oklahoma.

OVERVIEW OF HISSOM MEMORIAL LITIGATION

In 1987, Oklahoma became one of the testing grounds for the rights of those with developmental disabilities when a lawsuit was filed on behalf of persons living in Hissom Memorial Center in Sand Springs. This lawsuit, *Homeward Bound vs. The Hissom Memorial Center*, was filed on July 24, 1987. The Northern District Court of Oklahoma, in response to the lawsuit, ordered the Department of Human Services to phase out services at Hissom. A similar lawsuit was filed in the State of Pennsylvania in 1979 on behalf of consumers living in the Pennhurst State School and Hospital. The result of that lawsuit was a federal court order mandating that residents of Pennhurst be moved into less restrictive environments outside of the facility. This was to be accomplished by placing consumers in the general community. In order to assure the well being of those who were deinstitutionalized, Temple University Developmental Disabilities Center and the Human Services Institute of Boston undertook a landmark study to track consumer progress through the process of deinstitutionalization. This landmark study is known as *The Pennhurst Longitudinal Study* (Conroy & Bradley, 1985). The Oklahoma experience shares many similarities with the Pennsylvania one.

The Oklahoma lawsuit stipulated that the State of Oklahoma place the Hissom residents in appropriate alternative care facilities around the state. "The court's central finding was that the State's attempt to create a specialized segregated center for the purpose of clustering quality services does not work" (Cook, 1987:350). Further, the court determined that, "...institutions were the least likely settings in which to achieve individual growth and development." (Cook, 1987: 351). Historically, institutions were created because there were no community services, and the development of segregated services through institutions only

further exacerbated the prejudices against "retarded people" by communities. The court concluded, "segregation and the separation from others leads to reduced learning, reduced freedom, and reduced growth" (Cook, 1987:352).

The *Homeward Bound* case is the first to have used Section 508 of the Rehabilitation Act— Disabled Person's Civil Rights Act — to find in general, the "right" to effective and integrated services. Prior to this decision, the courts used Section 508 to support community placements, but never determined a general "right". The *Homeward Bound vs. The Hissom Memorial Center* litigation evoked for the first time the enforcement of regulations mandated by the Social Security Act as administered by the U.S. Department of Health and Human Services. In particular, those regulations that pertain to "all-institutional" residents, and the opportunity to participate in community activities (Cook, 1987:355). The consent decree required the State of Oklahoma to develop discharge plans for all persons who do not need institutional settings. The *Homeward Bound* court order determined that there should be no room for the possibility for any segregated settings for any individuals. The court sought "the removal of the institution as a choice of living environment for such individuals" (Cook, 1987: 356).

As a result of the court's findings, "Nine Guiding Principals" were drafted to guide the parties as they sought to create community-based alternatives for persons with mental retardation in Oklahoma. "While the court acknowledged that this order could not require the citizens of Oklahoma to interact with their fellow citizens with mental retardation in a positive, supportive way, it can require the state to implement strategies designed to bring Oklahomans voluntarily to that same conclusion" (NASMRP:1987:360).

The suit initially filed on May 2, 1985 on behalf of the Hissom Class, sought to obtain relief from alleged unlawful treatment by the Department of Human Services. The class consists of the "focus class", which is made up of all those people who resided at Hissom prior to May 2, 1985 and at the time of the suit. And the "balance class", including all former residents. After several interim orders related to services provided at Hissom, the "court plan and order of deinstitutionalization" became effective on October 21, 1987. The court appointed a monitor in May 1988 to fa-

cilitate the implementation of the decree.

Two years later in 1989 the plaintiffs and the defendants mutually agreed to drop the litigation concerning care and treatment of the class, including the pending appeal. Both moved to an agreed upon structure for carrying out service that would provide appropriate relief for the class in a manner that is consistent with the 1987 order. On December 4, 1989, U.S. District Judge James Ellison, of the Northern District Court of Oklahoma, approved a consent decree that would substitute for the 1987 court plan and order of deinstitutionalization in the case of *Homeward Bound vs. the Hissom Memorial Center*. The consent decree establishes a framework (Nine Guiding Principles) for a community service system that would serve as an alternative to institutional care for current and former residents of Hissom. Thus the December 4 consent decree supercedes the 1987 order and all subsequent court orders.

PROVISIONS OF THE CONSENT DECREE

The Consent Decree consists of six sections, each divided into a series of provisions. The six sections are:

1. Provisions Related to the "Focus Class"
2. Provisions Related to the "Balance Class"
3. Provisions related to the Entire Class—the role of parents/families is outlined in the agreement; parents/guardians will be members of the Interdisciplinary Team (IDT) for their family member and involved in all team decisions. Clients and families will have the right to select service providers from a State approved list of providers. A system of safeguards is outlined in the decree, and DHS is directed to secure technical assistance from the outside to assist in the development and implementation of a quality assurance program, including compliance with ACDD standards.
4. Provisions Related to Oversight and Dispute — establishes Homeward Bound Review Panel, a panel of three individuals who will be assigned primary responsibility for assisting the court and the parties in the suit to carry out the decree. The panel will replace the court monitor whose role will be terminated.
5. Financial Provisions — shall not expend more funds on an average per capita basis to maintain and serve clients in the community than the amount required serving

them at Hissom.

6. Miscellaneous Provisions — consent decree will terminate three months after the last client is transferred out of Hissom. (Excerpts taken from Reprinted Newsletter of the National Association of State Mental Retardation Program Directors, Inc.)

OKLAHOMA STATE UNIVERSITY QUALITY ASSURANCE LONGITUDINAL ASSESSMENT PROJECT (OSU-DDQA)

The project is a direct outgrowth of two federal lawsuits filed on behalf of persons with developmental disabilities. The first lawsuit being the aforementioned *Homeward Bound vs. The Hissom Memorial Center*. Under Section 3 of the 1989 Consent Decree, DHS is directed to secure technical assistance from the outside to assist in the development and implementation of a quality assurance program. Oklahoma followed a pattern that had already been established in the Pennhurst Study, the OSU Project was established to provide data on the Oklahoma population of concern.

CONTENT OF THE STUDY: SIX INDICES OF QUALITY OF LIFE OR CONSUMER OUTCOME

Modifications have been made to meet the specific monitoring requirements mandated by the consent decree; however, the "core indicators" of consumer outcome remain intact. These core indicators are: independence as measured by adaptive behavior and challenging behavior, integration or opportunities for interaction, productivity as measured by specialized work or educational opportunities, consumer satisfaction as measured by perceptions of community placement and choice making opportunities.

Over the years several sections within the instrument have been modified and/or eliminated, but the four basic consumer outcome indicators have remained constant throughout the years. The assessment has expanded to include all known individuals receiving services from The Department of Human Services, Developmental Disabilities Services Division. The actual study does not include all persons who are eligible to be a part of the study, and approximately 3700 attempted assessments are made each year.

The political milieu has significantly influenced the framework in analyzing quality of life outcomes. The pressure to desegregate services or deinstitutionalize individuals has directed the analysis toward a comparison be-

tween those persons who remain institutionalized (stayers) and those who moved out into the community (movers). The research is primarily concerned with assessing changes in indicators over time.

Variables

Of the more important variables in the study four core indicators were utilized as the primary indicators for consumer outcomes. These indicators were scaled and indexed items designed to assess important quality of life indicators identified in the 1987 amendments to the Developmental Disabilities Act and are a variant of the indicators used in the Pennhurst Study (Conroy and Bradley, 1985). The indicators included independence, integration, productivity and satisfaction. All of the consumer outcome indicators were examined longitudinally. There were two measures of independence — one set of indicators measuring an individual's adaptive skills and one set of indicators measuring the reported ability to control challenging behaviors. Information was obtained during a face-to-face interview with someone who knew the consumer well, usually the primary caregiver. The adaptive development scale was comprised of 32 items designed to measure adaptive skills in terms of physical capabilities, cognitive attributes, group interactions, and the ability to deal with complex instructions. Respondents were asked to reply based on skills and abilities the consumer displayed at least 75% of the time. The scale was scored from 1 to 100 with a higher score indicating more adaptive skills.

The ability to control behaviors that have been defined as challenging was assessed with a scale that measured across five dimensions: 1) inappropriate behaviors directed at others, 2) inappropriate behaviors directed at the self, 3) stereotypical behaviors, 4) acting out, and 5) general listlessness. The scale was scored from 1 to 100 with a higher score indicating a greater ability to control challenging behaviors.

Integration was operationally defined as the number of times consumers left the place of residence to interact in the community. Caregivers reported the number of times consumers visited friends or neighbors, went shopping, dined out, went places for recreation, and visited the bank. Responses were tabulated to show how many opportunities for social interaction individuals experienced each week.

Questions that comprised the consumer satisfaction scale were answered by the primary

consumer of DDSD services. The scale was scored from 1 to 100 with a higher score indicating greater satisfaction. The actual questions are specified below.

Measures of Independence

1. Adaptive Behavior Skills refers to a series of related life skills that focus on practical activities of daily living. Items contained within the 100-point scale address topics such as toileting, eating, dressing, bathing, and socialization. A higher score on this Adaptive Behavior scale suggests a greater competence in meeting the basic demands of life.
2. Challenging Behavior refers to various forms of socially unacceptable behavior. Such behavior includes assault, self-mutilation, and property destruction, along with a number of less significant behaviors as rocking, repeating words or phrases. The OSU-DDQA assessment instrument measures 16 specific challenging behaviors, and each behavior is rated for frequency: not observed in the past month (2), less than or equal to five times a week in past four weeks (1), more than five times a week in the past four weeks (0).

Measures of Integration

3. Community Integration was measured by seven indices of opportunities for social interaction. The seven indices represent seven distinct public domains where social interaction can occur. Responses represent the frequency of outings per week. The seven public domains are: banks, movies, malls, churches, restaurants, grocery stores, and friends. The questions were scored: never (0), not sure refused (1), less than once a month (2), once a month (3), two to three times a month (4), once a week (5), twice a week (6), more than twice a week (7).

Measures of Productivity

4. Productivity was measured as the number of hours each month consumers are engaged with school or work related activities. Educational activity included regular and special classes at public schools, special schools, private schools and homebound education. Work activity included prevocational services, sheltered workshops, supported employment and competitive employment.

Measures of Consumer Satisfaction

5. Consumer satisfaction was assessed directly by asking consumers several questions

about their lives. Findings are limited to those individuals who had the capacity to respond to the questions. The following questions were asked: Do you like living here? Do you like the people who work with you? Do you think the food is good? Do you have enough clothing? Do you have friends? Are the people who work with you mean or nice? Do you like your day activity?

Questions regarding the opportunity to exercise choice were included in the consumer interview. The six specific questions were: Do you choose what you eat? Do you choose the clothes you buy? Do you choose the clothes you wear? Do you choose your friends? Do you choose how your money is spent? All of the above questions were rated Yes (3), Unsure (2), and No (1).

PROCEDURES AND DATA

The OSU-DDQA procedures for collecting data involve visiting each person's home, or institutional setting, inspection of the person's records combined with collection of information from direct care staff, a tour and qualitative assessment of the home, and finally an interview with the consumer. Every effort is made to do direct interviews through alternative means of communication. These include signing, picture book, language board, or non-verbal gestures. For the people who cannot respond directly, there remains a wealth of

qualitative information gathered during the assessment. Trained interviewers conducted assessments, and each visit required 60 to 90 minutes per consumer to complete.

FINDINGS BASED UPON THE INDICATORS

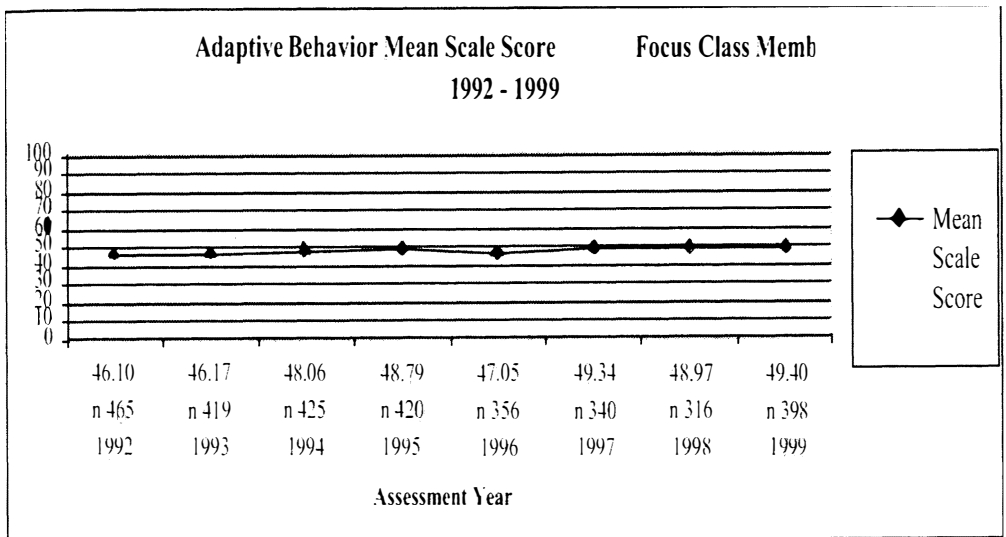
Adaptive Behavior Score

Direct care staff were asked to reply based on skills and abilities displayed at least 75% of the time. The scale was scored from 1 to 100 with a higher score indicating more adaptive skills. Figure 1 shows the mean scores for class members since 1992. In 1992, class members' average score on adaptive development scale was 46.10. There has been a steady increase in the mean scores measuring adaptive skills since 1992 except for one low mean in 1996. Further analysis of the data is needed in order to determine if the decrease is significant and what are the contributing factors surrounding the decrease. In general, the adaptive behavior skills of the focus class members have not exceeded 50 on a 100-point scale since deinstitutionalization with a mean score of 49.40 in 1999.

Challenging Behavior Score

The ability to control behaviors that are defined as challenging was assessed with a scale item that measured across five dimensions: 1) inappropriate behaviors directed toward the self, 2) inappropriate behaviors directed towards others, 3) stereotypical behaviors, 4)

FIGURE 1
ADAPTIVE BEHAVIOR SCORE



acting out, and 5) general listlessness. The scale was scored from 1 to 100 with the higher score indicating a greater ability to control challenging behaviors. Figure 2 shows the average scaled score for the ability to control challenging behaviors since 1992. Class members have scored relatively high on the scale, the lowest score, 87.93 was recorded in 1996, with variation in the scores throughout the years.

Social Integration

Integration was operationally defined as the number of times consumers left their place of residence to interact in the community. Such interactions included visiting friends or neighbors, shopping, dining out, going places for recreation, and visiting the bank. Responses

were tabulated to show how many opportunities class members had for social interaction each week since 1992. Figure 3 shows that in 1992, class members left the residence an average of almost 5 times a week. There have been relatively steady increases in the number of opportunities, and in 1999 class members left their residence more than 7 times a week. Class members experienced more opportunities for social interaction after deinstitutionalization.

Figure 4 shows the average number of hours per month class members over the age of 18 were active in work related activities has steadily increased over the years from 47 hours per month in 1992 to 60.83 hours per month in 1999. Mean scores are shown in Table 1. Most of these hours were worked in non-competi-

FIGURE 2
CHALLENGING BEHAVIOR SCORE

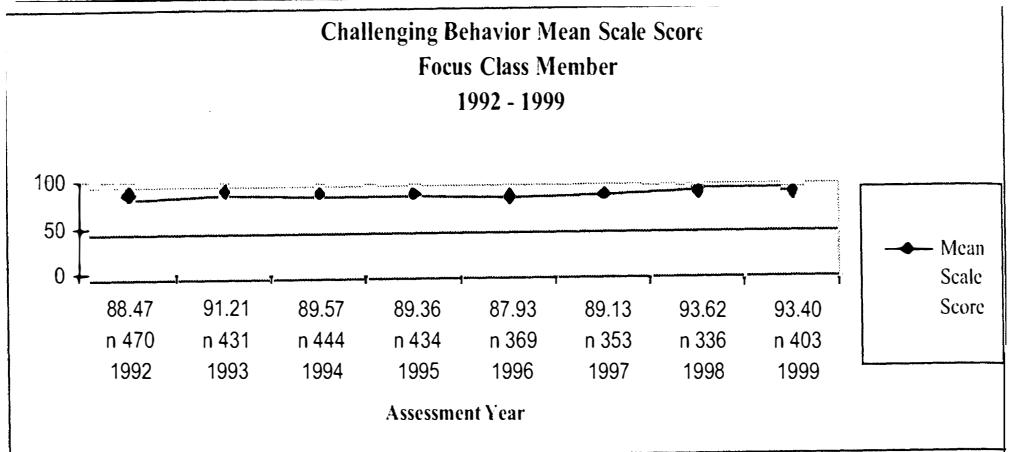
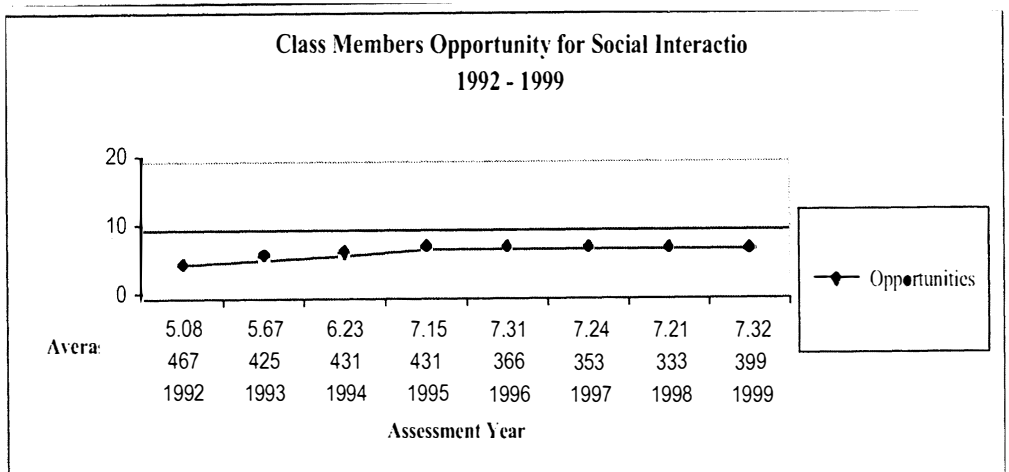


FIGURE 3
OPPORTUNITIES FOR SOCIAL INTEGRATION



tive positions which included hours spent in prevocational training and sheltered or supported employment. The average number of hours per month that class members between the ages of five and 18 were active in educational activities has steadily declined. Part of this decrease may be attributed to individuals aging out of the educational system. In 1992, there were 20 class members in school, and they averaged 118 hours a month of educational activities. In 1998, there were two class members attending school, and they averaged 10 hours of educational activities per month. In 1999 there were no class members attending school.

Consumer Satisfaction

Consumer Satisfaction was assessed with a scale that measured across two dimensions, individual satisfaction with the residential arrangement and satisfaction with the interactions that were available. The consumer an-

swered questions that comprised the consumer satisfaction scale. The scale was scored from 1 to 100 with a higher score indicating greater satisfaction. Figure 5 shows the average scores for class members since 1992. The consumer satisfaction scores through the years indicate that class members have indicated increased satisfaction, over the years, with their residential services and the interactions available to them. In 1992 the average score was 90.98. After a first year drop, there has been a steady increase in consumer satisfaction scores. Consumer satisfaction scores for class members increased to 91.37 in 1999.

SUMMARY AND CONCLUSIONS

Today, all persons at Hissom Memorial Center have been placed in the community¹. Oklahoma officials have extensively studied the closure of Hissom Memorial Center. The over-

FIGURE 4
WORK AND SCHOOL ACTIVITY/PRODUCTIVITY

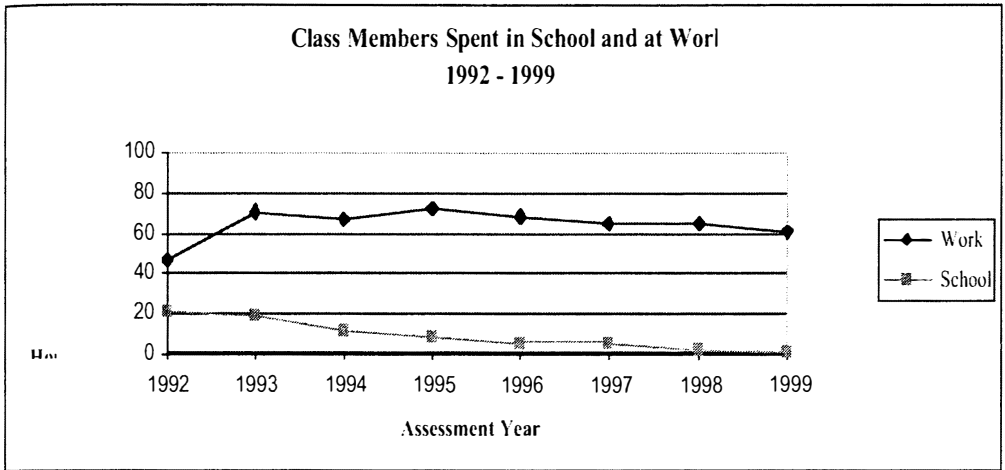
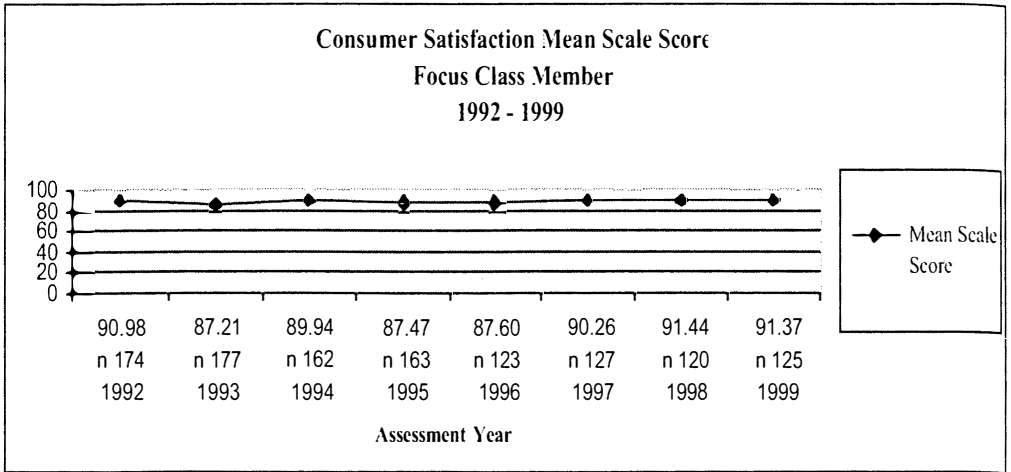


TABLE 1
MEAN SCORE ON WORK AND SCHOOL HOURS PER MONTH 1992 – 1999

	1992	1993	1994	1995	1996	1997	1998	1999
Work	47.32	70.51	67.26	72.14	68.46	65.10	64.47	60.83
n	470	431	444	434	369	353	336	403
School	21.17	19	11.24	8.61	5.48	4.81	1.68	.55
n	470	431	444	434	369	353	336	403

FIGURE 5
CONSUMER SATISFACTION



all findings indicate that the former Hissom Memorial Center residents averages increased on the quality of life indicators, subsequent to their placement in the community. The data have revealed that a consistent pattern of increased adaptive behavior skills, increased opportunities for social interaction with persons who are not developmentally disabled, increased opportunities to make choices about one's own life, increased satisfaction, increased family contact, and increased services are associated with those consumers discharged from Hissom and placed into community based services.

Public policy and the administration of community based services for the developmentally disabled have been concerned with the assessment of the success of individual placement. Of particular concern is how one conceptualizes and measures successful de-institutionalization for persons with developmental disabilities ranging from the mildest to the most severe.

Measures of success have come to be defined and based on the premise that the ultimate goal is to utilize specialized services and "mainstream" the entire population of persons formerly classified as mentally retarded. Successful community based services operates under the premise that this group of people could (or should) become productive interacting members of communities in which they were placed thereby enhancing the quality of life of the individual (Schlalock, 1994; White and Dodder, 1996).

This line of reasoning ties the success of deinstitutionalization to social integration and quality of life. The problem for conceptualization is one of being able to clearly delineate the characteristics and criteria for judging the social integration of a person within developmental disability.

Social integration and quality of life are, to some extent, a function of sociability. However, the concept of social functioning usually emerges in developmental research as containing several dimensions. These include interaction with others, social participation, independence and ability to adapt to the environment. On the surface these social and behavioral domains appear to be logical prerequisites for becoming "attached" to one's social and physical environment. What is methodologically troubling is how these domains have become conceptualized and measured in the literature on deinstitutionalization.

There is evidence that the current quality assurance assessments capture individual level profiles of basic physical, psychological, and social functions. There is some concern that they may not capture other important factors such as the quality of the community-based service delivery systems, the quality of community participation, or degree of attachment to the community. For example, the research does not examine the host community and or resident perceptions and/or reactions to their new members of the community. The various service providers, from residential to medical, are also not included in the assessment process. A further examination of the processes

of community-based services is needed in order to help explain the variations that are occurring in consumer outcomes at the individual level of analysis.

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NOTES

[1] There remain two State operated institutional settings that refuse to "go away". They are the Southern Oklahoma Regional Center (SORC) and the Northern Oklahoma Regional Center (NORC).

CHILD CARE IN OKLAHOMA: THE REACHING FOR THE STARS PROGRAM

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Abstract

Child care is one of the most pressing issues facing working parents with children under the age of 13 years in the U.S. This article sets a historical context for child care at the national and state level with a focus on Oklahoma. It discusses issues of affordability and accessibility and quality of care, as well as describes the Reaching for the Stars Program, a progressive initiative that addresses affordability and quality criteria of child care services

INTRODUCTION

Child care is one of the most pressing issues facing working parents with children under the age of 13 years in this country. According to the Carnegie Corporation, only 17 percent of the mothers of one-year-olds were in the work force in 1965 compared with 53 percent in 1991 (Carnegie Task Force 1994). Between 1977-1993, the number of children under age 5 years with an employed mother more than doubled (Council of Economic Advisors 1997). According to the Children's Defense Fund (2000a), 6 out of 10 children under the age of six years and 7 out of 10 children from six to thirteen years have both parents or their single parent in the labor force. Each day at least 13 million preschoolers, which include six million infants and toddlers, spend some part of their day in child care (Children's Defense Fund, 2001). In the U.S., 3 out of every 5 young children are in child care and millions more are cared for in after-school programs (Blassingame 2001).

What about some of the children that need child care yet do not receive it? An estimated 21 percent of children between the ages of 6-12 years with mothers employed outside of the home—about four million youths—are regularly without adult supervision when *not* in school (Child Welfare League of America 2000; The Urban Institute 2001). According to the Children's Defense Fund (2001) nearly 7 million children 5-14 years regularly care for themselves without adult supervision. About 35 percent of 12-year-olds provide their own care after school hours when parents are working (Corder 2000). This is alarming given that the rate of juvenile violence is greatest between 3-7 p.m., that most unintentional injury-related deaths occur when children are out of school and unsupervised, and that nearly 45 million

children under 14 years old are injured in their homes annually (Children's Defense Fund 2001). Children need not only a sensitive and responsive "parent" but also good supervision with an ability to set appropriate limits (Chira 1998).

Child care is clearly a necessity, yet its price tag is akin to a luxury item. Many parents can scarcely afford it full-time—especially single parents who are the hardest hit financially. In 1999, 30 percent of all mothers in the labor force who had children younger than age 6 were single parents whose earnings were vital to their children's support. Data from the Federal Interagency Forum on Child and Family Statistics (2000) reported that in 1999, 27 percent of children lived with one parent, and of these 4% lived with a single father. Moreover, 54 percent of children from birth through third grade received some form of non-parental child care on a regular basis.

Single working parents share a keen concern with child care given that in most instances they may receive minimal to no help from the absent noncustodial parent (Lengyel 2001). When a child becomes ill in child care or at school, the single parent has no back-up support. The situation is compounded when the parent's health suffers, and there is neither support nor a secondary income source to buffer the effects.

The Carnegie Corporation describes the child care situation as a crisis and claims that the well-being of infants and toddlers is jeopardized by lack of affordable care, the existence of poor quality care, and a fragmented system of delivery and high turnover among providers due to the inadequacy of salaries and working conditions (Carnegie Task Force, 1994). They indicate that many parents have limited child care choices and are plagued by inconsistent day care providers, lack of continuity of care, and con-

stant disruptions to work schedules—that for optimal development and well-being, children are best cared for by a small number of familiar caregivers in their early years.

Clearly a number of convincing issues confront consumers and/or providers of child care, such as accessibility for poor and working poor parents, licensing requirements, staff compensation, training for child care providers, regular program monitoring and evaluation, quality of care, and the effects of extended child care to both the child and the parent-child relationship. A discussion of all salient concerns facing child care is beyond the scope of this paper.

This article accomplishes three purposes. It sets a historical context for child care at the national and state level with a focus on Oklahoma. It discusses two of the compelling issues faced by child care consumers and providers: (1) affordability and accessibility and (2) quality of care. Finally, it describes the Reaching for the Stars Program, a progressive initiative that addresses the issues of affordability and accessibility, and serves to enhance quality child care services for all of Oklahoma's children.

HISTORICAL CONTEXT OF CHILD CARE

CHILD CARE AT THE NATIONAL LEVEL

New York City was the site of one of the first child day care centers in this Country as early as 1854 (Kadushin, Martin 1988). It was set up in a hospital for employed mothers who were patients and had left their children in the care of nurses when they returned to work following their recovery. A more permanent day nursery was established in 1863 to allow for the care of the children belonging to women that were employed in the manufacturing of soldiers' clothing and to provide housekeeping services in hospitals. This was apparently so successful that in 1898 the National Federation of Day Nurseries was created. Kadushin and Martin (1988) postulate that by the turn of the century, an estimated 175 similar child care centers had emerged throughout U.S. cities.

By the mid-1920's, day nurseries saw great expansion in numbers, as well as a shift from protective care to a growing recognition that children were unique, malleable beings in need of early [childhood] education (Kadushin, Martin 1988; Trattner 1994). The Great Depression slowed the growth in the day care

movement, although vis-à-vis the Works Progress Administration (WPA), day care centers were established throughout the country as a large-scale demonstration that touted some of the values of child day care. Kadushin and Martin (1988) write that:

Such centers were established by the program throughout the country to provide employment for teachers, nurses, nutritionists, and so on. The service they offered was primarily designed not to meet the child-care needs of the working mother but to provide a healthier environment for children from low-income families. Only children of parents who could not afford the tuition of privately operated nursery schools were eligible for admission to the WPA centers (176).

The day care programs continued during World War II with the support of the federal government during which time more than three million married women many of whom had preschoolers entered the labor force. A Department of Labor report cited by Kadushin and Martin (1988) highlighted problems of juvenile delinquency and high absenteeism in some of the workplaces as a result of inadequate child care services. At the end of the war, federal funding for the day care programs was terminated with the rationale being that the child care funding had been directly related to "...recruitment and retention of workers for war production and essential support services" (Kadushin, Martin 1988, 177).

By the 1960's, there was a renewed interest in child care that was partly an outcome of the 1962 and 1967 amendments to the Social Security Act whose provisions included day care funding for welfare recipients (Kadushin, Martin 1988). Head Start, which combined elements of early childhood education and development, began in early 1965 as an outgrowth of President Johnson's War on Poverty (Mills 1998). Since its inception, Head Start has served more than 15 million children, and its budget has increased from \$96.4 million (Mills 1998) to \$6.2 billion for fiscal year 2001—its highest yet (Children's Defense Fund 2001). Still far from being fully funded, the dollars for Head Start serve almost one-half of those children eligible. In the State of Oklahoma, funding for Head Start serves only 20.9 percent of the eligible children (Children's Defense Fund 2000a).

Funding for child care has been provided to the states since 1975 through Title XX dollars

(Social Services Block Grant), which represents the most significant categorical expenditures in this social service program. Title XX funds were decreased for fiscal year 2000 and the Children's Defense Fund has been in the forefront of the lobbying effort to have its funding restored to \$2.4 billion (Children's Defense Fund 2000a, 2001).

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193) brought the former Aid to Families with Dependent Children (AFDC) to an end and authorized a new focus of public assistance to families now known as Temporary Assistance to Needy Families (TANF). Initially, AFDC exempted single parents with preschool aged children from employment activities. The Family Support Act of 1988 altered that to make economic self-sufficiency its primary goal for single parents (Sonenstein, Wolf 1991). The revamped AFDC required work participation for parents with children over 2 years old and guaranteed child care subsidies to working parents for up to 12 months after leaving welfare. Under TANF, the employment-related activities go a step further by more specifically outlining required employment and training activities for parents with children of any age, by setting forth sanctions for failure to meet work requirements, and by establishing a lifetime maximum eligibility of 60 months of cash assistance (Knitzer, Caughen 1999). Child care subsidies are not guaranteed. The bottom line is that recipients of TANF need child care in order to achieve self-sufficiency by leaving and staying off welfare. At the same time, all children need high quality child care as a means of enhancing their emotional, cognitive, and language development.

Since the advent of welfare reform created by P.L. 104-193, families who are transitioning from welfare into the job market must utilize child care out of necessity. The connection between welfare reform and child care is obvious. The goals of welfare reform—successful movement of welfare recipients from public assistance to work—cannot be realized without affordable and accessible child care.

There was significant progress at the federal level for 2001 with historic gains in funding for child care (Children's Defense Fund 2001). The discretionary funds of the Child Care and Development Block Grant (CCDBG), later changed to the Child Care Development Fund (CCDF) were \$2 billion with an increase of \$817 million. The mandatory component of

the grant was raised by \$200 million, which makes the FY-2001 total CCDBG \$4.567 billion. Four percent of this amount must be spent on enhancing quality of care.

CHILD CARE IN THE STATE OF OKLAHOMA

Allsup (1991) details the beginnings of day care and licensing in a publication about the events that led to the enactment of the 1963 Oklahoma Child Care Licensing Law. Around the time of enactment, the responsibility for child care, which included licensing, was assigned to the Department of Public Welfare (presently the Oklahoma Department of Human Services). The State's initial attempt at creating a child care licensing law pertaining to facilities was accomplished at the time that the 1953 Oklahoma Children's Agency Licensing Act, Title 10, Chapter 18, was enacted by Senate Bill 338 (Oklahoma Department of Human Services 1981). Allsup (1991) elaborates:

The Act represented an effort to establish a licensing authority in Oklahoma to protect three or more children placed for full-time care in any home, agency or institution. Unfortunately, omissions and exemptions in this law placed more facilities outside the jurisdiction of the law than in it. The result was the level of care that the children received depended entirely upon the individuals and the sponsoring organization. No minimum requirements were enforced by any state agency (5).

Minimal regulations and lack of enforcement by the state created a climate conducive to the establishment of children's congregate and/or child care facilities throughout Oklahoma. Existing facilities, such as the American Legion Home in Ponca City, Tulsa's Sand Springs Home, and homes or orphanages operated by faith-based or fraternal organizations were explicitly exempted from the licensing requirements of the Act and continued to function undisturbed (Allsup 1991). A new children's home was opened in 1961 called Miracle Hill and was located just outside of Wewoka, Oklahoma in an abandoned high school situated on ten acres. Miracle Hill was intended to accommodate 500 children, substantial farm animals, and the potential for growing the necessary produce to feed its residents (Allsup 1991). An estimated 245 children between the ages of 11 months and 20 years old were housed at Miracle Hill between 1961 until its closure in 1964. Miracle Hill depended entirely on donations for its existence; federal and state assistance were

neither sought nor accepted.

A series of complaints from neighbors and other community residents eventually led to a series of articles in the *Daily Oklahoman* that began May 17, 1964. Cited were issues of inadequate food, clothing, medical attention, and supervision; substandard structural facilities, excessive and inappropriate discipline; inexperienced, untrained, and insufficient staff; and a lack of structured activities for the children. Miracle Hill was closed just days preceding the enactment of an amended licensing law in the state. In 1998, DHS produced a video entitled “Miracle Hill, The Legacy” that represents a documentary about the beginning of Oklahoma’s child care laws and how one tragic episode in the state’s history became the watershed event to improve the lives of Oklahoma’s dependent children (Miracle Hill 1998; Office of Child Care 1998).

The Oklahoma Child Care Facilities Act was signed into law on May 23, 1963. Essentially there was no formal child care programming prior to enactment of the law (vonBargen 2001). The Act allowed existing children’s homes and child care facilities until June 30, 1964 to apply for licensing from the Department of Public Welfare (DPW). Allsup (1991) searched Oklahoma’s Department of Libraries State Archives and found that: “The House passed an amendment which provided for an exemption from the law to institutions furnishing full-time care for children for 10 years prior to the effective date of the law” (29).

While a series of child care-related initiatives may have begun as early as 1964, publication of these were significantly overshadowed by the increased activity, multiple changes, and added responsibilities assigned to DPW (Murphy 1976; Department of Institutions, Social and Rehabilitative Services 1977; Oklahoma Department of Human Services 1980 1981 1987). Among the numerous changes, the organization’s name was changed in 1976 from DPW to the Department of Institutions, Social and Rehabilitative Services (DISRS), and changed again in 1980 to DHS, as it is known currently.

It was not until 1989 that the State of Oklahoma reached its next milestone in the history of child care when Senate Joint Resolution 39 created the Joint Advisory Task Force on Child Care (1989). This task force was comprised of legislative members and child care professionals. It was charged with both studying and making recommendations that would address

the rapidly growing and widespread need for safe, affordable, and quality child care for families of all incomes. As part of the Task Force’s efforts, a series of public hearings were held during September and October 1989 in Enid, Lawton, McAlester, Oklahoma City, and Tulsa. The five most significant areas of concern expressed by the estimated 300 participants in those public hearings include:

1. Greater financial assistance needed for child care
2. Licensing be required for all child care facilities
3. Facilities are needed that will accept children with special needs
4. Increasing the number of licensing workers to DHS since current staff were reportedly overworked and could not complete licensing studies timely nor provide more than superficial technical support to child care providers and facilities
5. Increasing the quality of child care

The Task Force encouraged parents to seek licensed child care, saying that unregulated child care represented the greatest amount of potential risk to children in care outside of their own homes. Moreover, the Task Force agreed that all facilities in the business of providing routine care for children should be licensed because:

- 1 Regulations prevent unscrupulous competition from offering grossly substandard services and assure some consumer protection;
- 1 Licensing assures an acceptable level of care and can help raise the level over time;
- 1 Licensing educates the community as to the necessary components of acceptable care; and
- 1 Exemptions weaken the entire regulatory structure (Joint Legislative Advisory Task Force on Child Care 1989, 11).

The Task Force recommended that DHS child care assistance program be revised. The rate schedule recommendations included reflecting the actual costs of providing child care; indexing rates by the age of the child; including a rate for children with special needs; providing rate adjustments to address parents working non-traditional hours; and including a weekly rate allowing for a reasonable number of absences. The Task Force also recommended developing and implementing criteria for quality child care, including using peer and self-review processes and establishing a grading system that recognized superior programs based on specific criteria known to improve quality (Joint Legislative Advisory Task Force on Child

Care 1990).

In April 1991, Senate Bill 177 established the Office of Child Care (Oklahoma Department of Human Services 1992). The Licensing Services Unit was assigned to the Office of Child Care in September 1991. The Office of Child Care was situated for three years in the Division of Children and Family Services and became a freestanding division in 1999 in order to more effectively carry out its mission and continue its development and implementation of progressive initiatives. The Division of Child Care has responsibility for the direct administration and implementation of all programs funded by the CCDF (Oklahoma Department of Human Services 2000a).

One of the Division's more progressive initiatives has been the Oklahoma Child Care Resource and Referral Association (OCCRRA) that in 1999 recorded over 14,000 calls from parents, 90 percent of who were seeking child care services for children ages birth to 3 (Pyeatt, Johnson 2000a). The OCCRRA's mission is "...to achieve a quality child care system accessible to all Oklahoma families through community-based resource and referral services" (Office of Child Care 1999 13). Referrals provided to inquiring parents aid the timely filling of vacancies in child care facilities. Parents are given information on three to five licensed or exempt facilities that most closely approximate criteria of cost, location, size, and/or curriculum requested. The OCCRRA also offer or sponsor a range of trainings throughout their service areas, as well as help facilitate access to resources (Oklahoma Department of Human Services 1992, 1994, 1995 1999b; Office of Child Care 1999).

A selected number of other initiatives of the Division of Child Care include:

1 Contracting with public and private schools at numerous sites for before- and after-school care (Oklahoma Department of Human Services 1992; Pyeatt, Johnson 2000b);

1 Contracting for provider training for owners and staff of family child care homes and child care centers (Oklahoma Department of Human Services 1993, 1994, 1995; Office of Child Care 2000);

1 Awarding enhancement grants to child care providers for expanding child care especially to those targeting low-income families, children ages birth-two years, children with special needs, school-age children, and/or children of adolescents (Oklahoma Department of Human Services 1993, 1994; Office of Child Care

1999, 2000; Division of Child Care 2001);

1 Providing classes on child care careers to potential providers and center directors (Office of Child Care 2000);

1 Developing and funding six pilot Family Child Care Home Networks, three each serving urban and rural areas (Office of Child Care 1999); and

1 Developing and piloting *Access Oklahoma*, first in the nation child care payment system that uses an electronically-coded debit card to allow for payments to child care providers by subsidy-eligible families (Johnson 2000).

At Governor Frank Keating's request, the Director of DHS, Howard H. Hendrick, and representatives from the Division of Child Care became part of a specially convened Governor's Task Force on Early Childhood Education whose principal focus was to work collaboratively with private citizens, state officials, and an array of parent and community stakeholders to strengthen their commitment to Oklahoma's children from birth to 5 years old (Governor's Task Force on Early Childhood Education 2000). This group identified four key strategies for an effective early childhood education initiative that would lead to stronger, healthier children, parents, and community. The strategies are:

1. Enact a strong public policy promoting early child care and education

2. Create a statewide public-private early childhood partnership

3. Implement a comprehensive public engagement campaign

4. Mobilize communities to provide environments that support children and families

An initiative that has had the most transformative effect on child care in the state in recent years is the implementation of the Reaching for the Stars Program, which will be described in the latter part of this article.

CHILD CARE ISSUES

There are a myriad of forceful issues confronting the field of child care today. For the purpose of this article, two primary issues are addressed: (1) affordability and accessibility and (2) quality of care. The focus of this paper is on *formal* child care provided in child care centers or family child care homes that are currently licensed by the State of Oklahoma. Formalized child care is part of an organized system of caring for children that includes a series of tasks and activities aimed at helping to ensure the safety and well-being of children. In

years past, child care was perceived as little more than *babysitting*, where a child was 'dropped off' to play, eat, nap, and if old enough, to watch television while parents worked or spent varying amounts of time away from their children. Today's child care is a child development program similar to Head Start and public or private school pre-kindergarten programs (Carter 2001). References to center-based programs generally include "...day care centers, pre-kindergarten, nursery schools, Head Start programs, and other childhood education programs" (Federal Interagency forum on Child and Family Statistics 2000 10). The evolution of this formalized system of child care in recent years has received increased attention in the professional literature and print media (Lowenberg 2000, Newsweek 2000, USA Today 1999). There is a distinction between formal or regulated forms of child care and unregulated kith and kin care that is largely provided by relatives or close acquaintances who may care for a small number of children in their own homes (Collins, Carlson 1998).

AFFORDABILITY AND ACCESSIBILITY

The cost of child care is expensive for the average parent, but for low-income parents, the cost of child care can consume more of a family's resources than even rent or food (The Urban Institute 2001). Frequently, a single mother's earnings are insufficient to support her family *before* child care is paid for (Children's Defense Fund 2000a). While in working families with children costs for child care may consume a significant portion of the family's budget, it is an even greater challenge for the large numbers of low-income families that have recently left welfare rolls for employment since 1995 (Giannarelli, Barsimantov, 2000). Not all low-income working families receive aid since child care subsidies are no longer an entitlement. The main source of federal funding for subsidized child care comes from the Child Care and Development Fund (CCDF), and it only serves 10-15 percent of the eligible children.

Gong et al (1999) cited a finding by the U.S. Government Accounting Office that offering child care subsidy to poor mothers increased the likelihood that mothers would work by 15 percent. These researchers also cited a study by the Child Care Law Center who found that one-fifth of those leaving public assistance for work returned to the welfare rolls since they could not afford child care costs without subsidi-

dized aid. Irrespective of income level, parents of infants and toddlers face the likelihood of waiting lists due to an inadequate number of child care slots for this age group.

Many working-poor and low-income families struggle to find and afford quality child care environments for their children. In some cases, full-day child care easily costs \$4,000 to \$10,000 per year—as much if not more than college tuition at a public university (Children's Defense Fund 2000b, 2001). For example, in Kansas City, Kansas, child care averages \$5,200 annually, whereas public college tuition costs \$2,223 (Children's Defense Fund 1998).

In order to obtain an approximate sense of what different providers charge for full-time infant care in the Oklahoma City area, the senior author conducted a telephone survey of 10 local child care centers representing the major sections of the city. Telephone calls were all made on 6/8/01, and the centers were randomly selected from the Southwestern Bell Greater Oklahoma City Yellow Pages. Providers were asked for their weekly rates for infants and toddlers. The rates ranged from \$85 to \$147 per week for birth to 12 months of age, with an average rate of \$116 weekly. Toddler care costs \$20 less weekly on average.

Based on the data gathered, the annual cost of child care for an infant in Oklahoma City ranges from a low of \$4,386 to \$7,585, reflecting an average of \$6,048 or \$504 monthly. Tuition for an entering freshman at the University of Oklahoma for two semesters calculated using 16 credit hours a semester as a full-time course load costs \$2,532 for the year. Hence, the cost of child care for an infant for one year costs 73 percent *more* than tuition for a full-time public university student in Oklahoma during the same time period. Comments made by two providers reflected that "child care does not pay for teachers" and that the cost of child care "...does not pay for the care of the infant."

In 1999, there were 882,062 children under the age of 18 living in Oklahoma, with 29 percent or 255,798 of those children under 13 residing in low-income families with working parents (Child Care Bureau 2000). At the same time, there were a total of 5,734 child care licensed facilities with a capacity of 120,240 (Oklahoma Department of Human Services 1999a). However, the capacities of facilities with a DHS contract reflect the potential capacities for children receiving child care subsidies and that number is lower—4,626 facilities with a capacity of 95,628.

The Bureau of Labor Statistics projects that the number of children enrolled in part-or full-time child care will continue to increase (Blasingame 2001). Overall, there is a shortage of licensed infant and toddler child care in Oklahoma, and in turn, this creates a stressful situation for working parents and providers. Several providers said that they were considering decreasing the number of DHS-referred children because they were becoming unable to “break even” financially. The challenges do not end there. When one looks at the numbers of children 0-13 years of age *needing* child care, the crisis is heightened. Schumacher and Greenberg (1999) note that the lack of child care was consistently identified as one reason for non-employment among welfare leavers who responded to surveys—a sample of 142 Oklahomans were among those respondents. Kickham et al (2000) found that those transitioning from welfare were at substantially greater risk relative to disruption, change, or loss of child care arrangements. Even the most motivated worker can be seriously hampered when faced with problems of child care arrangements or transportation that are beyond their control (Regenstein et al 1996).

Table 1 depicts the combined number of licensed child care centers and homes by year beginning in 1981. The numbers of child care centers and family care homes shown in 1981 and 1983 appear inordinately high and the annual reports for three of the years did not contain comparable data. The numbers of child care centers and family care homes from 1986 forward show a steady increase with few exceptions. The greatest increase in child care centers and homes was in 1988 with 21 percent. From 1997 to 1998, there was a 3.9 percent increase in child care centers and family child care homes, then between 1998 and 1999 there was a 5.6 percent decrease. In 2000, there was a modest increase of 1.7 percent. Thus while the numbers of child care facilities have increased with few exceptions, the need for child care has outpaced the availability. Projections by the Census Bureau estimate almost 45,000 Oklahoma children less than one year of age by year's end. In contrast, there are about 10,000 licensed child care slots for children of that same age (Pyeatt, Johnson 2000). This is of particular significance given that more TANF (73.3%) than general population (64%) parents' use licensed child care in Oklahoma (Kickham, Bentley, Effendi, Harnden 2000).

The DHS administers the State Plan that includes the child care subsidy program, and as such subsidizes child care monthly for over 28,000 children ages birth to 6 years old. Less than 10 percent is available for infant care, with a total of 20 percent available for birth to 3. Eighty-two percent of the families on waiting lists for child care have children under 2 years of age. The availability of child care subsidies for children from infancy to 13 years of age whose family meets income and employment or educational requirements is intended to help parents stay off welfare and maintain self-sufficiency (Pyeatt, Johnson 2000b).

Approximately 34 percent of children in Oklahoma's licensed child care facilities receive child care assistance through DHS. The subsidy program assures that child care is available to children whose families live at or near the poverty level and are moving toward self-sufficiency through employment, training, or education. The program uses a sliding fee scale based on family size, family income, and the number of children in a family. The eligibility ceiling is 164 percent of the poverty level. The program ensures that co-payment fees, paid by parents, increases gradually, so that child care expenses do not dramatically surge when the

TABLE 1. NO. OF CHILD CARE CENTERS AND HOMES BY YEAR*

Year	Total No.
1981	5,386
1982	No Info
1983	4,800
1984	No Info
1985	No Info
1986	2,715
1987	2,850
1988	3,451
1989	3,137
1990	3,510
1991	3,835
1992	4,507
1993	5,078
1994	5,599
1995	5,546
1996	5,586
1997	5,845
1998	6,071
1999	5,734
2000	5,829

*Taken from Oklahoma Department of Human Services' Annual Reports for each year shown.

family rises above the eligibility maximum and must pay the full cost. Licensed child care providers contract with DHS and are reimbursed for the care provided to children at the rates approved by the DHS Commissioners.

Table No. 2 shows the number of children receiving child care subsidies between 1981 and 1999. Notably, child care services have expanded by 183 percent over nearly two decades as a direct benefit to those both transitioning from welfare to work and the working poor.

TABLE 2. NO. OF CHILDREN RECEIVING DAY CARE SUBSIDIES AT THE END OF EACH FISCAL YEAR*

Year	Total No.
1981	16,444
1982	No Info
1983	No Info
1984	13,700
1985	20,666
1986	24,000
1987	No Info
1988	15,800
1989	16,500
1990	18,500
1991	20,500
1992	28,500
1993	30,000
1994	31,000
1995	37,289
1996	37,626
1997	40,231
1998	40,413
1999	46,471
2000	47,436

*Taken from Oklahoma Department of Human Services' Annual Reports for each year shown.

Child care assistance is available under circumstances other than for poor working parents. One of these is for protective or preventive child care services provided for up to 30 days as an early intervention strategy in certain situations as a means of enhancing family functioning or stabilizing a crisis situation (Oklahoma Department of Human Services 2000b). Another one is to provide child care assistance to children in foster or kinship care when the foster parent or kin caregivers are employed, in training or schooling similar to the need criteria for single parents or caretaker families

mentioned earlier. Child care services must be provided in a licensed center- or family care-based environment, or in a foster parents' own home by a licensed child care provider (Oklahoma Department of Human Services 2000c). The collective number of these is small by comparison to the numbers of parents moving from welfare to work.

QUALITY OF CARE

Early childhood practitioners understood the positive effects of developmentally appropriate care for children in all settings (Anderson 2001). The recent research on brain development provided an additional impetus for increased child care funding and scientific inquiry (Greenwood 1999; Karoly et al 1998; USA Today 1999). Research on child care quality has been conducted on both family day care settings (Galinsky et al 1994) as well as child care centers (Helburn et al 1995). Constructs for measurement have included the ratio of children to staff; providers' education, training, and experience; and relational aspects of the interaction between provider and child (Henly 2000).

Researchers indicate that the quality of licensed child care irrespective of setting is frequently inadequate, but child care in unregulated settings is potentially of even lower quality and unsafe (Council of Economic Advisors 1997, Federal Interagency Forum on Child and Family Statistics 2000, Henly 2000). Exposure to negative responses from caregivers can be a hindrance to children's attempts to develop a sense of competence and success (vonBargen 1991). This is particularly troubling given that low-income parents without child care assistance tend to utilize unregulated child care at higher levels. The most common child care providers for employed parents who left welfare are informal ones—family or friends (Schumacher, Greenberg 1999). According to these researchers, a survey of N=147 Oklahomans found that 22 percent use relatives and 7 percent use friends. Along the same lines, a study completed by Kickham et al (2000) reported that TANF leavers were more likely to obtain child care from a grandparent or other adult relative (63%) compared to current TANF recipients (50.5%) or non-TANF working parents in the general population (44.2%). These researchers believe that it is the *instability* of these arrangements that lead to difficulty on the job for those leaving TANF especially.

Informal child care has been suggested to be

of lower quality than licensed center-based and family child care, yet it may also offer parents easier access by being located in more convenient sites, as well as more flexible to the working hours of low-income parents who are have a greater tendency to work odd or off-peak hours (Henly 2000). Since subsidized child care serves a small number of the children who are eligible—about 15 percent—informal care is usually an affordable, albeit not preferred, child care arrangement (Giannarelli, Barsimantov 2000). Low earning families are less likely than higher earning ones to pay for child care. Also, kin-provided child care is less often financially compensated than non-kin child care (Brandon 2000).

Gallagher (1998) cites a 1995 national study that found only 8 percent of child care centers that serve infants and toddlers provide high quality child care. The care in 40 percent of the centers was reportedly so poor as to potentially place young children's psychological and cognitive development at risk. Quality measures have been associated with group size, caregiver training, staff-child ratios, and provider credentials (Henly 2000). Moreover, some child care professionals equate quality child care with eliciting the same emotional processes as that found between mother and child (Gallagher 1998). This is characterized by nurturing, appropriately stimulating, responsive care that is attentive to both the child's verbal and non-verbal communication. Child care providers face a formidable challenge to address these issues without sacrificing quality of care in the process.

How do child care facilities fare in the State of Oklahoma? An externally done study found that 80 percent of Oklahoma's child care facilities were rated as mediocre at best when it came to providing quality care for children (Helburn et al 1995). This is in keeping with questions of quality of child care voiced by consumers, advocates, and researchers (Child Care Bureau 1997b; Children's Defense Fund 2000b; Council of Economic Advisors 1997). Some barriers to participation experienced by providers and licensing representatives include a lack of qualifications, low subsidy rates, expensive training or lack of training opportunities, and less than positive perceptions about child care as a career.

Dunn (1995) found in a study about the status of the Oklahoma child care work force that few family child care providers had education beyond high school. Of those that had taken

courses beyond high school, most had attended vocational technical training courses rather than two- or four-year institutions of higher education. Just over 7 percent had Child Development Associate credentials. None had state certification in early childhood education. Child care staff typically had one year of education beyond high school. About 67 percent reported having attended some form of higher education; however, few graduated from programs related to early childhood education or child development. Directors of child care centers were found to average two years of formal education beyond high school, and only 20 percent had any form of teacher certification. The study also found that 75 percent of child care center-based teachers earned less than \$11,000 annually (Dunn 1995). This is corroborated by other findings that show child care workers are among the lowest paid in the U.S. (Child Care Bureau 1997a; Council of Economic Advisors 1997; Twombly et al 2001).

vonBargen (1991) cited an annual turnover rate of 44 percent in child care facilities. Springen (2000) found a turnover rate at child care centers nationally to be nearly 40 percent largely attributable to low pay, which averages an estimated \$6 per hour. The Children's Defense Fund (2001) says that on average child care workers earn less than bellhops, funeral attendants, and garbage collectors. The mounting challenges to child care professionals are to provide high quality care to children simultaneous to competitive wages and benefits to workers (Blassingame 2001). Low wages and poor benefits lead to high staff turnover, not to mention maintaining child care workers among the ranks of the working poor.

Quality early care programs have been shown to have a significant effect on a family's economic independence, and eventually, such programs can provide a solid foundation for children's future success (Rand Corporation 1998; Whitney 1999). Research also shows that quality of care carries a lasting impact on children's well being and can be key in helping to overcome obstacles to children's learning (Child Care Bureau 1997b; Children's Defense Fund 2000a, 2001; Greenwood 1999). Children in high quality child care centers consistently outperform children in the development of cognitive and language skills as compared to children in other quality care settings (Greenberg, Springen 2000; Kantrowitz 2001). Wisen's vision was that "...by providing safe, quality programs at the earliest age possible,

we will be able to nurture each child to develop to his or her full potential as well as install values, positive self-esteem, and pride in our cultures” (1999 12).

Early in 1996, the Office of Child Care identified several issues for improvement and incorporated the issues as part of the market rate survey conducted the following year. Then in 1997, DHS via the Office of Child Care contracted with the Center for Economic and Management Research (CEMR) at the University of Oklahoma to conduct a market rate survey. A market rate survey is required every two years by the federal government. The rates established must be based on survey results and consistent with CCDF requirements (Gong et al 1999). The contracted survey found that DHS subsidy rates were below current market rates (e.g., rates charged to private-paying families) especially in urban areas (Penn 1997). As a result of the low rate, few providers offered infant and toddler care because of the high staff-to-child ratio requirements for appropriate care. This is consistent with some of the information shared with the senior author during the ad hoc survey she conducted of local child care providers.

The market rate survey (Penn 1997) found that there were differences in rates charged for child care across different counties in Oklahoma. In response to this, the Office of Child Care, in conjunction with the Office of Finance, Field Operations, and Division of Family Support formulated more realistic reimbursement rates that would be provided as child care subsidies. At the same time, the Oklahoma State legislature encouraged DHS to tie quality care indicators to an increase in the subsidy reimbursement rate received by the provider. The most recent market rate survey report was completed September 1999 and resulted in an increase in child care assistance rates effective December 2000 (Office of Child Care 1998). The rates are based upon several factors: age of the child, child care setting, geographic location of child care provider, and the child care facility’s star designation. Another rate increase is anticipated pending the results of the market rate survey to be conducted in 2001 (Oklahoma Department of Human Services 2001b).

The Divisions of Child Care and Family Support have discussed the need for a differential rate for the care of special needs children (Anderson 2001). Following an extensive study there was a new rate established to provide for child care assistance in support of children with

disabilities. Thus should a child be determined to have a moderate to severe disability, a special rate is authorized for reimbursement to the child care provider above the regular rate as a means of ensuring accessibility to needed services (Oklahoma Department of Human Services 2001b).

The National Conference of State Legislatures (1997) posits that what results in quality child care are smaller group sizes of children, higher teacher-child ratios, and greater staff wages. Further that children’s outcomes measurably improve when participating in developmentally-appropriate early childhood education provided by credentialed staff and when there is a degree of parental involvement in curricular programming. The Reaching for the Stars Program addresses all of those issues.

REACHING FOR THE STARS PROGRAM

Reaching for the Stars became effective February 1, 1998 (Office of Child Care 1998). This program provides financial incentives for child care centers and family child care homes as a means to enhancing the quality of care. Reaching for the Stars is a tiered system, which was recommended by the Welfare Reform Block Grant Advisory Committee. Numerous states utilize tiered systems as a differential for reimbursement (Child Care Bureau 1997c).

The Reaching for the Stars program addresses the issues of affordability and accessibility, quality of child care, and proactively furthers the development and implementation of early childhood education and intervention to benefit all infants, toddlers and preschool age children in licensed facilities in Oklahoma. Revision of the reimbursement rates under this initiative raised the rates payable to child care centers and family child care homes as an essential support to facilitate low income parents currently in the labor force continue to work toward self-sufficiency (Oklahoma Department of Human Services 1999c). Standards for providers in the areas of basic education requirements, related work experience, and the completion of mandatory annual training hours directly influence the quality of care. The program was also created to ensure, enhance, and expand the critical role of early childhood experiences with regard to school readiness and the child’s subsequent success as an adult.

Linked to the child care subsidy program, the Reaching for the Stars Program accomplishes three goals: (1) regularly evaluates the child care reimbursement rate with approved in-

creases as appropriate in order to generate additional slots for children whose families receive child care assistance (2) improves the level of competency and salaries of child care providers that impacts overall quality of care and (3) provides a mechanism whereby parents can systematically assess the quality of Oklahoma's child care programs (Division of Child Care 2000).

The program was first developed with two tiers designated as one-star and two-star. The one-star category included those child care centers and family child care homes that met the basic licensing requirements (Office of Child Care 1998). The basic licensing requirements are not included here due to space limitations. **One-star child care facilities** receive the current reimbursement rate for those eligible children whose care is subsidized by DHS.

Two-star child care centers and family child care homes are required to meet criteria exceeding the basic licensing requirements. **Two-star child care centers** are accredited by an approved national accrediting body (there are four currently) and meet state licensing requirements. In non-accredited centers, the directors must complete 40 hours of formal training in administration and management annually. Two-star centers also employ master teachers (e.g., 2- or 4-year degree in child development, Child Development Associate, or Certified Childcare professional credential) who, along with all staff, must complete 20 hours of formal training annually. Further, two-star centers have an established salary scale with increments based on years of early childhood experience, education, credential, and training. Lesson plans are developed weekly that are developmentally appropriate and activities for children are structured to enhance cognitive, language, and motor development for those two years and older. Parental involvement is another component of two-star child care centers.

Two-star family child care homes must document 20 hours of annual training from a DHS-approved source in each 12-month period

(Office of Child Care, 1998). Additional training required includes pediatric first aid training provided by the American Red Cross or an equivalent approved source. The provider in the two-star family child care home must have a Child Development Associate credential, a 2- or 4-yr degree in early childhood education or child development, or any 2- or 4-yr degree with a minimum of 12 credit hours in early childhood education, child development or a closely related subject.

Three-star child care centers must meet the two-star center criteria in addition to having been accredited by a Division of Child Care-approved national accrediting entity. **Three-star family child care homes** must meet the two-star home criteria, as well as being accredited through the National Association of Family Child Care. The three-star designation was implemented in July 1999.

On July 1, 2000, a new level of care became effective and is designated **one-star plus** (Oklahoma Department of Human Services 2001a). Child care centers and family child care homes at this level must meet the basic licensing requirements similar to one-star facilities, and at the same time, demonstrate the potential for achieving two-star status at the end of the 24-month period. It is expected that the one-star plus category of care will be an impetus toward further improvement of quality child care.

Record increases were posted in total licensed capacity, as well as in the numbers of two- and three-star facilities. Table 3 shows the number of children receiving care in one-, two-, and three-star rated child care centers over the course of 13 months from July 1998 to August 1999. During this time frame, there was a 5 percent increase in the number of children receiving child care services in one-star centers. There was an impressive 319.6 percent increase in the number of children being cared for by centers achieving two-star designation. Within one month of the implementation of the three-star rating, 110 children were being served at the highest designated level of care.

TABLE 3. NUMBER OF CHILDREN CARED FOR IN
STAR-RATED CHILD CARE CENTERS
JULY 1, 1998 – AUGUST 30, 1999

Rating	Jul 1998	Oct 1998	Jan 1999	Apr 1999	Aug 1999
One-Star	39,041	40,867	39,092	39,816	40,984
Two-Star	1,061	1,539	1,991	3,538	4,452
Three-Star*	N/A	N/A	N/A	N/A	110

*Three-Star Child Care Center rating was implemented 7/1/99

Table 4 depicts the number of child care centers and family child care homes at both the two- and three-star ratings as well as the county where the designated facilities are located. One-star and one-star plus child care centers and family child care homes are geographically seated in every county across the state and not represented here. The increase of two- and three-star facilities from the end of January 2000 to May 2001 has been remarkable. Three-star child care centers and family child care homes increased by 60 and 33.3 percents, respectively (vonbargen 2001). Two-star child care centers increased by 57.6 percent, and two-star family child care homes increased by 83 percent during the same time period.

Parental choice can be significantly influenced by the reimbursement rates authorized by DHS that are payable to child care providers (Gong et al 1999). Rates must be sufficiently high to afford equal access to comparable child care received by non-subsidized children. One of the CCDF requirements is that states must establish a system of co-payments that is based on income and family size. States, however, have the ability to waive co-payment fees for families whose incomes fall below poverty level. Six states charge co-payments to TANF recipients including Louisiana, Maine, Mississippi, Missouri, **Oklahoma**, and Wyoming. At the same time, the State of Oklahoma is only one of five states that invests a higher than average amount of funding per child for child development programs for children ages 0-6 (National Center for Children in Poverty 2000). The five states are: California, Geor-

gia, Massachusetts, North Carolina, and **Oklahoma**.

A comment relative to monitoring and compliance is worth mentioning, albeit briefly. Frequently new initiatives are implemented without the necessary resources with which to help ensure their success. This was not the case with Reaching for the Stars. Thirty-eight licensing staff were added to the Office of Child Care (1998) for a total of 107 statewide professionals to evaluate providers' compliance with two-star quality criteria, as well as to improve monitoring of child care programs overall. This allowed for caseloads to decrease to an average of 58 cases per worker. In Fiscal Year 1999, there were 110 licensing representatives, 21 supervisors, and three state office staff responsible for monitoring child care programs and evaluating facilities for compliance with two-star designated centers and homes (Office of Child Care 1999). Presently, 114 licensing representatives monitor 1,936 child care centers and 4,169 family child care homes at least three times annually for compliance from DHS' six service areas across the state (Oklahoma Department of Human Services 2001b). To determine the impact of quality of care upon children, DHS and the provider will evaluate two- and three-star programs annually using the Early Childhood Environment Rating Scale.

The Division of Child Care has also planned for regular external evaluations of the Reaching for the Stars Program. Two initial evaluations were conducted by the Bureau of Social Research (1998a, 1998b) at Oklahoma State University concerning the implementation of

TABLE 4. NUMBER OF TWO- AND THREE-STAR CHILD CARE CENTERS AND HOMES*

Star Rating	No. of Facilities	County Where Facilities Are Located
Two-Star Center	118	Adair, Caddo, Canadian, Cherokee, Cleveland, Comanche, Creek, Garfield, Johnston, Kay, Logan, Major, Marshall, McCurtain, Muskogee, Noble, Oklahoma, Payne, Pittsburg, Pontotoc, Pottawatomie, Seminole, Sequoyah, Tulsa, Wagoner, Washington
Two-Star Home	88	Caddo, Canadian, Cherokee, Cleveland, Coal, Comanche, Cotton, Creek, Garfield, Garvin, Grant, Kay, Logan, McCurtain, Muskogee, Noble, Oklahoma, Okmulgee, Osage, Payne, Pittsburg, Pottawatomie, Rogers, Tulsa, Wagoner, Woodward
Three-Star Center	25	Caddo, Cleveland, Creek, Delaware, Hughes, Oklahoma, Pittsburg, Tulsa, Washington, Woods
Three-Star Home	3	Tulsa

*Data are accurate as of 1/31/2000

the Stars Program through surveys of child care centers and family child care homes in the state. Future evaluations will focus on both process and outcomes.

The Division of Child Care recently established a Facilities Fund Committee whose members include representatives from DHS, business, and philanthropy. In order to facilitate the expansion and improvement of high quality center-based child care programs, the committee is developing an initiative that will provide training, technical assistance and financing to those facilities (Oklahoma Department of Human Services 2001b). Details of the licensing requirements, child care reimbursement rates, the Reaching for the Stars Program, or any current child care initiatives can be found on the DHS web page at <http://www.okdhs.org>.

CONCLUSIONS

Undoubtedly, there is a need to help increase the capacity of Oklahoma child care providers to serve greater numbers of children while their parents are engaged in employment- or education-related activities. The Division of Child Care is actively recruiting individuals to work toward licensing either home- or center-based child care using grants as an incentive. In 1998, 157 child care centers and family child care homes received improvement grants to either expand capacity or improve quality of care to 5,439 children, nearly half of who were from low-income families (Office of Child Care 1998). In 1999, 145 applicants were awarded similar grants (Office of Child Care 1999). A strategic plan to transform the Oklahoma child care industry from care giving facilities into developmentally appropriate learning centers for young children was implemented during the prior fiscal year (Oklahoma Department of Human Services 2001a).

The range of issues confronted by child care policy makers, providers, and consumers are greater in scope than any single article, and certainly limited in the present discussion. Recommendations and strategies for strengthening child care programs and services abound. At the state level, legislators have recognized some of the salient reasons to be concerned about affordability and availability of quality child care. In the state of Oregon, for example, legislators are addressing the high cost of child care by making their child care credit refundable for those families whose incomes are up to 200 percent of the poverty level (Sheketoff, Lewis 2001). At the present time only a small

number of states have refundable child care tax credits for eligible families: Arkansas, Hawaii, Iowa, Minnesota, New Mexico, and New York (National Women's Law Center 1998).

Whitney (1999) says that good quality "...early care and education programs can have a significant effect on state economies, families' self-sufficiency and welfare reform" (12). Moreover, quality care is foundational for later success in all areas of school, employment, and community living. Ridley et al (2000) evaluated what children did while they were in child care environments to determine development and contextual appropriateness. Results showed that engagement levels were related to independent measures of program quality. Researchers moreover found that engagement levels differed as a function of licensing level.

Carnegie Corporation (1994) addresses employers of working parents by recommending they adopt *family-friendly* workplace policies including flexible work hours and subsidized child care and developing networks at the community level that link the range of child care programs in order to offer working parents a continuum of child care choices. Litt et al (2000) expressed that for the success of welfare reform, "...barriers to childcare and family support systems need to be lifted and policies to increase social supports need to be created and maintained" (83).

By developing and implementing the Reaching for the Stars Program, DHS has taken significant steps in integrating child development and family support with welfare reform. They have worked to tailor statewide child development and family support programs to meet the needs of families affected by TANF. They have convened and continue to work collaboratively with the Child Care Advisory Committee, a 22-member interdisciplinary public-private advisory group in maintaining minimum requirements and desirable standards for the state, as well as to create community approaches toward improving child care. Moreover, DHS through the Division of Child Care, has provided leadership and outreach to the early childhood community. Partnerships with the Division of Family Support have aided significantly in bridging the gap toward helping families who are coping with substance abuse, domestic violence, or other risk factors. Finally, and most important, this approach has increased the accessibility and affordability of child care for increased TANF recipients transitioning from welfare to work, as well as has significantly

elevated the quality and quantity of child care for Oklahoma's working parents and their children with credibility and accountability by all concerned.

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CLANDESTINE LABORATORIES, DYNAMIC SYSTEMS, AND THE DEEP SOCIAL IMPACT OF METHAMPHETAMINE ABUSE IN OKLAHOMA

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Abstract

Ranking third behind California and Missouri on the total number of clandestine laboratories seized by law enforcement officers, Oklahoma has the highest number of illegal methamphetamine laboratories per capita in the United States. This paper examines the deep social impact of the recent outbreak of clandestine laboratories in Oklahoma and the corresponding rise in methamphetamine abuse. Because methamphetamine genetically restructures the human brain, neurophysiological morbidity associated with chronic abuse reveals damage to the limbic system, which, in turn, is associated with correlative behavioral problems in abusers that has been characterized as clinically indistinguishable from paranoid-schizophrenia. A useful way of describing how these structural and functional changes in the brain (as a dynamic system) can have overarching effects, both in the individual and society, is the form of analysis known as 'chaos theory'. From this perspective, the behavioral changes are analogous to 'strange attractors' of a chaos theory model, which vividly illustrates the overall impact of methamphetamine abuse on both the individual's quality of life and the lasting effect on the social world.

INTRODUCTION

During the past five years there has been an exponential increase in the number of illegal methamphetamine laboratories seized by law enforcement officers in Oklahoma. In 1995, 34 labs were seized as compared with 781 in 1999. Over 700 illegal methamphetamine laboratories have been seized in the state the first nine months of 2000, with a projected year-end total of 1200 (OSBI, 2000). Only California and Missouri had more lab seizures, than Oklahoma who ranks third in the nation. Moreover, Oklahoma ranks highest per capita in the United States in the reported occurrences of clandestine methamphetamine laboratories. The problem of methamphetamine laboratories in Oklahoma provides an index to an array of deeper social and neurophysiological issues associated with chronic methamphetamine abuse. These problems transcend law enforcement concerns, impacting health care, substance abuse treatment, drug courts, education, and the correctional system.

This article overviews methamphetamine abuse in Oklahoma. This article

also discusses chronic methamphetamine abuse causes actual damage to the limbic and meso-limbic areas of the brain—those parts associated with emotional stability—and other behavioral manifestations which spread to other dimensions of the social life-world. A demographic area undergoing increased methamphetamine abuse can expect a collateral increase in domestic violence and other crimes involving violence. This article finally suggests that a comprehensive multi-disciplinary approach is the only viable solution to this outbreak of chronic methamphetamine abuse in Oklahoma.

BACKGROUND OF METHAMPHETAMINE LABORATORIES

Methamphetamine was first discovered in 1913, yet the first documented case of illegal manufacture in the United States occurred in California in 1963. At that time, an individual wanting to synthesize the drug needed to understand complex chemical equations in order to successfully translate the technical literature into a process (Duncan, 1991). Hence, early clandestine laboratories tended to be operated

by advanced chemistry students. Within only a few short years, complex technical formulae were written into simple “recipes” that anyone could follow (Duncan, 1991). Initially, these recipes were closely guarded secrets and only passed on through apprenticeship.

It is speculated that historical connections between families in California and Oklahoma, as a result of great ‘dust bowl’ days, recipes for manufacturing methamphetamine emerged in Oklahoma in the late 1970’s. Consequently, in the early 1980’s, there was a severe outbreak of clandestine methamphetamine laboratories in Oklahoma which lasted until 1990 (Duncan, 1990). In fact, Oklahoma was fourth in the United States on law enforcement seizure of clandestine laboratories in the 1988-89 period.

These early laboratories were usually very large, with a minimum of one and often up to a dozen 22-liter reaction flasks operating at once. Each of these laboratories had an average production capacity of about 27 pounds of methamphetamine per week. The main precursor chemical used was phenylacetic acid, purchased in bulk quantities from chemical distributors. Since the recipe required about 36 hours to complete, and because phenylacetic acid was extremely odorous, these laboratories were usually found in rural areas of Oklahoma. Typically, the finished product, which was around 70 percent pure d,l-desoxyephedrine, was transported to the larger metropolitan areas of Tulsa and Oklahoma City where it was then ‘cut’ (i.e., adulterated to a purity level of approximately 12 percent for street level consumption) and sold at various levels to drug dealers. Clandestine laboratory operators were a primary source of illegal drugs and were at the top of a ‘pyramid’, the base of which was the user (Duncan, 1990).

The Oklahoma law enforcement strategy was to push for legislation that would control the availability of certain bulk chemicals (such as phenylacetic acid), increase the criminal penalty for illegal manufacturing from two to 10 years to 20 years to life, and provide law enforcement train-

ing programs for local officers in the how-to’s of recognition and investigation of clandestine laboratories. This strategy was passed in the legislative year 1989 and implemented in 1990. The results were immediate – clandestine laboratory activity in Oklahoma dropped from 73 labs in 1989 to only 15 in 1990 (Duncan, 1990). While it appeared that the methamphetamine laboratory problem in Oklahoma had passed, it was clear that the street availability of methamphetamine had not changed: a 1 gram bag of roughly 12 percent pure methamphetamine was still easily purchased for between \$100 and \$125 (OBND, 1990).

A ‘new’ recipe from California then emerged in Oklahoma, with a newer, simpler manufacturing method. It was now possible for a non-chemist to manufacture virtually pure methamphetamine (d-desoxyephedrine, which is stronger than the d,l variant), in only four hours using supplies available at local grocery and hardware stores, and without producing the tell-tale odors that were inherent in the older, more cumbersome method (Duncan, 1991). This new recipe, unlike previous ones, was readily available through publications and, more recently, over the Internet. There had been a paradigm shift within the world of clandestine laboratories – information was ubiquitous.

Consequently, law enforcement officers in Oklahoma witnessed a rapid increase in clandestine methamphetamine laboratory activity. Contrary to their ancestors, these laboratories were generally small, comprised of household appliances (hotplates, crock-pots, and pickle jars) and ordinary chemicals (ephedrine and pseudoephedrine – common sinus medications – were the main precursors). Since odors associated with operating these labs were virtually nonexistent, the bulk of clandestine laboratory activity appeared in cities, such as Tulsa and Oklahoma City.

Not only did the recipe and demographics of clandestine laboratory activity change in Oklahoma, there was a more telling change in the very nature of the methamphetamine distribution network. The old pyramid structure, although still

in place with drugs smuggled in from Mexico, became more of a 'rhizomatic' structure, characterized by the remarkable decrease in social distance between production and consumption. These small labs are easy to operate and can produce small quantities of nearly pure methamphetamine in a shorter period of time. Even though lab numbers dramatically increased, production capacities for each lab dropped from 27 pounds per week in 1989, to about one to six ounces per cook in the late 1990's.

In 1989 the average clandestine laboratory operator was a 34 year old white male, about with little or no college education. In the late 1990's the description of a laboratory operation was expanded to include females, Hispanic males, and college educated individuals (OBND, 1990), (OBND, 1999). Typically in Oklahoma, chronic methamphetamine users now produce their own product. The user and producer are often the same person, similar to the lower-level marijuana growers in Oklahoma.

RISE OF METHAMPHETAMINE ABUSE IN OKLAHOMA

An increase in methamphetamine laboratories alone might not imply that there is a corresponding increase in chronic methamphetamine abuse in Oklahoma. There are, however, other indications that this is the case. A recent study conducted by the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) showed that "the rate of stimulant use in Oklahoma is 42% higher than the national rate (Dixon, 2000)." In comparing Oklahoma to the overall United States, an analysis of lifetime stimulant use shows significantly higher percentages, with the largest difference in ages in the 26 to 34-year-old category. Accordingly, while the national average for stimulant use in this age group is 7.7 percent of the population, in Oklahoma that number is 13.7 percent. The next highest age group is between 18 to 25 year-olds, where the national average is 6.5 percent and the Oklahoma mean is 9.3 percent (Dixon, 2000).

The number of methamphetamine users in treatment in Oklahoma is also significantly higher than the national average. From slightly more than 500 patients in 1992, Oklahoma has seen an increase to roughly 3,400 patients receiving treatment for methamphetamine abuse currently (Dixon, 2000). This is significant, particularly since the national average is higher than the Oklahoma average in all other controlled drug categories (e.g., marijuana, cocaine, opiates, inhalants, hallucinogens, and sedatives) (Dixon, 2000). Furthermore, there is a significant treatment gap in Oklahoma - about 76.7 percent of those in need do not receive treatment (Dixon, 2000).

These figures, coupled with the increases in methamphetamine laboratory seizures, indicate that there is an outbreak of chronic methamphetamine abuse in Oklahoma. Because of the nature of the drug itself, and the kinds of changes that it can bring about in the central nervous system of a chronic user, it is likely that other areas of social concern will be impacted by this outbreak. Moreover since neurological damage caused by chronic methamphetamine abuse is most often permanent, the overall social impact of this phenomenon will linger. For this reason, it is important to examine the effects of methamphetamine on the brain and its resultant adverse behavioral manifestations.

BASIC NEUROPHYSIOLOGICAL EFFECTS OF METHAMPHETAMINE ABUSE

There are many reasons why a person may become a chronic drug abuser. Genetic propensity for addiction, pre-existing psychiatric problems (bipolar, depression, anxiety disorder), influences of the social life-world (economics, social values, peer pressure, etc.), and fundamental existential conditions (e.g., Heidegger's being-toward-death, forlornness, and angst) (Heidegger, 1996). These characteristics are often a feature of the human condition, thus every person who becomes a chronic drug abuser likely had one or more of these influences before using drugs. In fact, some medical professionals contend that up to 80 percent of chronic

drug abusers are really dually diagnosed patients seeking drugs due to an existing brain chemistry problem (Holloway, 1999). However, while there may be underlying brain chemistry problems prior to methamphetamine abuse, chronic use of the drug will certainly change some fundamental aspects of overall brain chemistry. Through understanding these changes and articulating the corresponding behavioral manifestations, the long-term impact of chronic methamphetamine abuse will become more apparent.

The action of methamphetamine upon the central nervous system can best be understood from the perspective of two fundamental processes: dopamine and norepinephrine neurotransmitters. The methamphetamine molecule is shaped very much like these two important neurotransmitters and has a serious effect upon the parts of the brain that are specific to these systems (Snyder, 1996). Methamphetamine molecules metabolize and cause the release and re-uptake of dopamine to speed up in an unnaturally vicious cycle that impairs the normal function of the neuron. This cycle peaks in only a few minutes, gradually diminishing over approximately 18 hours. During this cycle, the neuron is highly overworked, progressively diminishing the ability of the neuron to function properly, thus permanently damaging the dopamine and norepinephrine systems of the brain (NIDA, 2000). To understand the social impact of this change in brain chemistry, it is useful to look first at how this change most often leads to the aberrant behavioral patterns associated with chronic methamphetamine abuse.

Dopamine is a catecholamine neurotransmitter that acts on the limbic system of the brain, which has been associated with the initial appraisal of the safety or danger inherent within immediate spatial proximity (Snyder, 1996; Carpenter, 1991; Julien, 1998; Carter, 1998). Deficiencies in dopamine are usually accompanied by corresponding anxieties about personal safety and self-control. This can manifest itself in many ways, but usually does so as an intense paranoia about the world and personal relationships. Dopamine

is also a critical component of the pleasure-reward systems of the brain. As a result, malfunctioning of the system frequently leads to emotional instability and to an alteration in incentive salience (Robinson and Berridge, 1998).

Norepinephrine, like dopamine, is associated with the limbic area of the brain. It is released in large quantities when immediate danger is perceived. Typically, norepinephrine causes an increase in blood pressure, heart rate, and bronchodilation. It is also associated with aggressive behavior resulting from an immediate emotional trigger (Snyder, 1996). The heightened effects of dopamine and norepinephrine produced by chronic methamphetamine abuse cause both permanent brain damage and specific behavioral changes that are manifested as paranoia, emotional instability, aggression, violent reactions, and inappropriate response to environmental stimuli.

The impact of methamphetamine abuse upon the dopaminergic and norepinephrine systems of the brain causes serious and permanent neurological damage. Consequently, a major characteristic of a serious outbreak of methamphetamine abuse is a corresponding increase in occurrences of problems resulting from neurological damage. Primarily, these cognitive-behavioral changes will affect mostly the immediate family, gradually reaching into other areas of the social world. It is useful to examine the manner in which a small change in brain functioning ability, particularly one that affects emotional stability can manifest large changes in the overall behavioral system of an individual suffering from methamphetamine damage.

BUTTERFLIES AND BEHAVIOR: CHAOTIC SYSTEMS

Although the mind resists reduction to brain states, it is clear that there is at least some correlation between brain activity and cognitive life (Carter, 1998; Churchland, 1989). Furthermore, different parts of the brain when damaged show consistent behavioral changes in patients (Carter, 1998). Given these parameters, it is likely that the neurophysiological ef-

fects of chronic methamphetamine abuse have some corresponding impact upon behavior.

One innovative model of human behavior has been proposed by Ben Goertzel, a leading figure in the emerging realm of 'chaos theory' (Goertzel, 1995). Chaos theory examines the qualitative patterning of nonperiodic dynamic systems. Chaos theory offers a valuable way of illustrating the deeper impact of chronic methamphetamine abuse on the larger universes of individual behavior and social reality. First, it will be useful to examine some of the fundamental features of this modeling method.

For purposes of analysis, any deterministic, dynamic, nonperiodic system, such as the weather, can be reduced to a single point in a representative field known as 'phase space' (Williams, 1997). As the entire system changes, the phase space representation traces a series of non-intersecting curved orbits, which, in nonperiodic systems, have come to be known as 'strange attractors'. Sublime phase space portrayals of strange attractors are extremely aesthetically pleasing, leading many thinkers to believe that what on the surface appears as random and uncoordinated may actually reveal a deeper logic in some complex pattern. The overall shape of the strange attractor changes dramatically when a slight modification is made to any aspect of the initial condition, a phenomenon is known as 'sensitive dependence upon initial conditions', which demonstrates how, in these systems, a small change can have a large effect (Gleick, 1988). The well known example, stemming from Lorenz' experiments upon turbulent weather systems, is that a butterfly flapping its wings in one part of the world might have a huge effect upon the weather in a vastly different part of the world (Gleick, 1988). Goertzel applies this understanding of the overall dynamics of complex systems to human behavior (Goertzel, 1995).

People live in circles, and as such each one has certain behavioral responses that, although not fully deterministic, tend to resemble 'semi-regular' patterns. The but-

terfly effect observed by Lorenz in weather systems can be applied as a metaphorical model to the qualitative analysis of human behavior. This model reveals that slight changes in an underlying feature of the overall system can bring with it dramatic changes in the behavior of that system. In the case of methamphetamine abuse, neurophysiological damage to the limbic system can lead to larger changes in the behavioral patterns of the abuser.

It is well known by both law enforcement officers and neuro-psychologists that methamphetamine users exhibit very wild behavior (Yui, et al, 1999). Typically, a methamphetamine abuser lives within a sphere of intense paranoia—they think that they are being followed, tend to distrust those with whom they have relationships, and frequently collect and intensely ideate about weapons and violence. Furthermore, they often manifest inappropriate emotional responses to environmental stimuli. For example, methamphetamine abusers tend to become highly aggressive and violent without provocation. Cases abound of methamphetamine associated crimes against persons, including brutal murders. As 'strange attractors', these behavioral patterns are qualitatively dissimilar to the general shape of 'normal' behavior.

Behavioral patterns, when manifested as a part of ongoing daily existence, tend to reinforce and create corresponding belief systems. Not surprisingly, bonding frequently occurs between those living in and experiencing the same behavioral patterns. Methamphetamine abusers tend to associate with other abusers, and a cycle of reinforcement of behaviors within the matrix of a social life-world emerges. This cycle, far from stable, operates as a chaotic system iterating in a nonperiodic manner based upon progressive and varying feedback from the social landscape.

ITERATIONS INTO THE DIMENSIONS OF SOCIAL REALITY

The dynamic system of individual behavior is itself a part of a larger social reality. There is a 'ripple effect' that tends to destabilize deeper areas of social dy-

namics. The destructive behavioral patterns associated with methamphetamine abuse affect family, friends, co-workers, and progressively impacts society. For example, Oklahoma Department of Human Services statistics reveal that in 1999, at least 21 percent of child abuse cases involved substance abuse by a caretaker and 4.2 percent of children removed from the mother at birth were born drug-exposed (DHS, 1999). It is not known how many domestic violence incidents in Oklahoma involved either methamphetamine abuse or resulted from emotional instability caused by methamphetamine-related brain damage.

Chronic methamphetamine abusers have a real need for the drug. They are addicted, both physiologically and psychologically, to the stimulant effects that bring their neurological system into a state where they can avoid the major depression and anxieties associated with low levels of dopamine and norepinephrine. The neurons producing these neurotransmitters have become exhausted and only function with added influence of strong stimulants. Burned out and desperate, methamphetamine addicts will do anything to obtain their 'lifeline' drug.

Prostitution, stealing, robbery, murder, drug dealing, and illegal drug manufacturing are only a few of the more common methods that chronic methamphetamine abusers use to fulfill their endless hunger for their drug of choice. Society responds by increasing criminal enforcement—more police officers, more prisons, and stiffer penalties; substance abuse providers are overwhelmed with unfulfilled treatment needs; and the educational system is charged with the responsibility of making sure that every child understands that drugs are dangerous. Drug courts are established as a way to link law enforcement, prosecution, and substance-abuse treatment in the hope of breaking the cycle of progressive iterations of increasingly menacing social catabolism. Yet, the solution is nowhere in sight. Social problems with deep neurobiological roots, manifested in the chaotic destabilization of acceptable behavioral patterns, that, in

turn, change fundamental relationships such as family and friends, and spurring criminal activity resulting in long-term incarceration—coalesce into a problem with no simple solution.

TOWARD A SOLUTION

Clearly, methamphetamine abuse in Oklahoma is a multidimensional problem. We are highest per capita in the law enforcement seizure of illegal methamphetamine laboratories; we exceed the national average in both treatment, unfulfilled need for treatment, and lifetime use of methamphetamine; and, we are groping with partial solutions such as increased law enforcement resources, longer jail sentences, and drug courts. Oklahoma is caught in a chaotic system that cannot return to a previous place where methamphetamine abuse had a lesser, more controllable, impact.

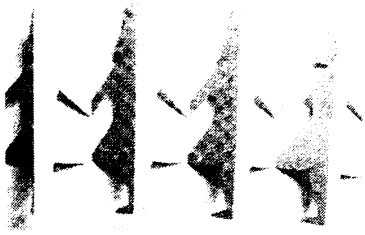
This article has demonstrated evidence of a significant outbreak of chronic methamphetamine abuse in Oklahoma. It has moreover shown that this outbreak can be seen as an 'index' to matters of deep social concern. Specifically, an often-overlooked aspect of this problem is its corollary long-term effect upon individuals suffering from methamphetamine brain damage. This functional impairment is frequently manifested as emotional instability, domestic violence, and child abuse.

These features of the methamphetamine problem in Oklahoma will require a commitment on the part of the citizens of this state to adopt a comprehensive strategy that addresses deeper social issues. Any solution to this problem must be comprehensive and multidisciplinary. It must involve law enforcement, treatment providers, domestic violence workers, health care professionals, child welfare workers, educators, and the community at large. Citizens of Oklahoma must realize that methamphetamine abuse is a nemesis that demands full attention. There is only one hope—a change in the mentality of our society—the reinvention of social practices that would give back more than they take. With such a change in the socio-aesthetic paradigm, the reinvention of shared un-

derstandings, and the honest recognition of a serious problem, methamphetamine abuse and its pernicious deep social impact may be ameliorated.

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Positive Impact of Neighborhood Policing in Ponca City*

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ABSTRACT

A descriptive review is brought to an early exploring of the effectiveness of a neighborhood community policing structure in place in a community district comprising part of southwest Ponca City, Oklahoma. Several dimensions comprise this analysis for determining the program's effectiveness, including items measuring public fear of crime, neighborhood conditions and problems, public opinion of police services in the neighborhood, and other quality of life indicators. The findings show the structure of neighborhood community policing to provide a broad and positive effect for Westside residents in reducing public perception of their risk of crime, in improving public perception of neighborhood conditions, in the decline in public perception of neighborhood problems, as well as in the increased positive opinion of the police and police services. Implications are identified for communities and police departments either anticipating the adoption of or having a strong interests in establishing community policing initiatives of their own.

INTRODUCTION

For the past two decades, community policing has been the prevailing wind of change among police agencies across the United States. Currently, progressive police departments throughout the United States are assessing the necessary changes in orientation, organization, and operations within police agencies implementing community policing philosophies, and the benefits such change bring to the communities they serve. Although the concept of community policing has sometimes been challenging to always thoroughly comprehend, its key principle reflects a change in the overall direction of policing. Neighborhood centered policing and other community policing strategies would appear to constitute a fundamental shift from traditional incident driven and reactive policing to proactive and/or problem oriented crime control strategies. Community policing further represents collaboration between the police and community residents involving both the identification and solving of neighborhood problems. The ultimate goal is to identify and help eliminate those conditions that cultivate crime and threaten the quality of neighborhood life.

One of the great challenges brought particularly to poor communities today is having to overcome a variety of neighborhood ills, including higher crime, neighborhood disorder, street gangs, and other problems directly tied to high poverty, unemployment, and other conditions found in communities ravaged by high amounts of economic and social strain. Neighbor-

hood-oriented policing as a form of community policing would appear a promising remedy to such social disorder and other problems of rural low-income, inner-city, and other economically challenged communities today. Neighborhood policing has been found to function well and successfully where the dynamics of violent crime in communities have been brought to light and problem-solving strategies adopted. Elliott Currie has presented the value in applying problem-solving philosophies to some of the most important sources of community violence — guns in the possession of violent drug gangs who concentrate their presence mostly in a handful of high-crime neighborhoods. Much gun violence in inner-city neighborhoods has been reported as being defensive in nature, with the young carrying guns because they believe that arming themselves will protect them against potential assault. In a 1996 poll, two out of five teenagers living in high-crime neighborhoods reported that they carried a weapon for protection. Applying problem-solving remedies where the police will work with federal and local agencies and community organizations to disarm the young in such communities have brought relief to communities whose history had been one of escalating rates of gun violence (Currie, 1998).

Other community policing initiatives have specifically targeted the assisting of school age children to stay away from drugs and gangs. Both the Drug Awareness and Resistance Education (D.A.R.E.) program, and the Gang Resistance Education and Training (G.R.E.A.T.) pro-

gram found in communities throughout the United States, are educational programs to prevent drug use and violence among young people. Community policing officers involved with the D.A.R.E. program have emphasized assistance in the form of helping school age children recognize and resist the pressures from peers to experiment with alcohol, marijuana, tobacco, and other drugs (Palmiotto, 2000). Strategies focus on building self-esteem, assertiveness, interpersonal and communication skills, decision-making skills, and awareness of positive alternatives to drug use and gang involvement. Community policing officers involved with the G.R.E.A.T. program have emphasized assistance in the form of teaching young people the value of establishing goals for themselves as a means of resisting the pressures of gangs, along with educating the young on resolving conflicts without violence (Palmiotto, 2000).

Other research has pointed out the value of community policing philosophies in recognizing that youth violence, substance abuse, and other similar problems cannot often be separated from the larger social and physical environment in which they typically occur (Trojanowicz and Bucqueroux, 1990). Research has shown inner-city children to be routinely exposed, often repeatedly, to serious violence. Forty percent of sixth, eighth, and tenth graders in high-crime neighborhoods, in a 1992 survey, reported witnessing a least one violent crime in the preceding year (Currie, 1998). At the same time it is rare where a child will receive any systematic attention to offset its impact when such violence happens. Researchers have reported how exposure of a child to violence on a regular basis, including identifying with the power and excitement of delinquent and violent role models, may become a chronic hedge against feeling helpless and afraid (Currie, 1998). Community policing philosophies open up the thinking in having police officers recognize the broader context for such youth related violence. The opportunities for positively addressing the negative impact on the lives of such children through constructive social interventions is made possible as these principles are applied in addressing youthful violence and other problems tied to poverty and other adverse conditions impacting the lives of this nation's low-income and poor.

Other research reminds us likewise of youthful violence and other crime and its connections to larger social and economic forces en-

demic to the lives of many of this nation's poor. High rates of robbery, homicide, theft, spousal battering, and drug abuse are much more associated with high poverty areas, and with unemployed and subemployed men and other low-income persons in the nation's urban communities (DeKeseredy and Schwartz, 1996; Siegel, 2001). Such problems when born out of poverty and other social and economic strain, breed crime and other problems by denying people a sense of purpose, while simultaneously contributing to the weakening of families, and the eroding of community life (DeKeseredy and Schwartz, 1996).

The conditions of high crime, youthful violence, drug abuse, street gangs, poverty, and other problems community policing principles seems poised to address is not just an inner-city problem. Crime, violence, and poverty are also problems common to many cities and communities like Ponca City here in Oklahoma, and as well as communities throughout this state, region, and elsewhere. Small cities and rural communities experience many of the same problems as larger cities in the rates of drug abuse, crime, violence, and poverty. At the same time, small cities like Ponca City experience other problems common to larger cities, including competition between citizens for adequate housing, the widening gap between the privileged and the poor, the distrust of citizens toward the police and other public officials, much of which the latter find a cause in a public's increasing alienation tied to a growing sense of social and economic inequality. Neighborhood police versed in community policing principles would appear a promising remedy to many such problems born out of community conditions high in the amount of social disorganization tied to economic and social strain (Siegel, 1986:194). Progressive policing initiatives today found in the application and practice of neighborhood-oriented policing philosophy would appear to provide an important complement to the traditional police effort to control serious crime and other social disorder in low-income neighborhoods (Decker, 1981; Currie, 1985:254; Kratcoski, Dukes, and Gustavson, 1992: 219; Guido, 1993). Community policing principles which hold the potential in successfully controlling crime and social disorder in neighborhoods challenged by the high incidence of social and economic strain, is brought to bear on a study of the effectiveness of a neighborhood community policing structure in a neighborhood community district in

Ponca City, Oklahoma. Several dimensions comprise this analysis for determining the program's effectiveness, including items measuring public fear of crime, neighborhood conditions, problems, and other quality of life indicators.

THE WESTSIDE NEIGHBORHOOD PROJECT

Neighborhood-Oriented Policing will describe the more specific program which is in place in this group of neighborhoods. Two Ponca City police officers are assigned to this project and operate of a community resource center known as Lincoln Center within the Westside neighborhood community. The Westside Neighborhood Community include two separate neighborhood areas: a North Area group of neighborhoods and a South Area group of neighborhoods. One officer is assigned to the North area neighborhoods, and the other to the South area neighborhoods. Major Clayton Johnson of the Ponca City Police Department describes the responsibilities of the two officers as working with merchants and residents in the project neighborhoods to identify potential problems and solutions (Johnson, 1999). A further responsibility is for developing and maintaining partnerships within the neighborhoods, businesses, referral agencies and other organizations to improve the quality of life in the project areas (Johnson, 1999). A survey of activities performed by the two police officers over an 18 month period, further illustrates their responsibilities as described above:

focus code enforcement and fire marshal resources on problem locations; dine with children in neighborhood schools on a regular basis; visit preschool and day care facilities to interact with young children weekly; provide the Municipal Juvenile Court with pre-sentence information on neighborhood youth; secure food and recreational donations from businesses inside and outside of the project area; conduct misdemeanor property crime investigations; provide mentors for neighborhood youth; enforcement of city ordinances and state statutes on a daily basis; provide tutors for neighborhood youth; plan and conduct after school and summer recreational programs; arrange neighborhood clean up projects (Johnson, 1999).

The group of neighborhoods selected for the Westside Project contained households, which in 1995 was reported as having had a very high demand for police services. Internal documents

provided by the Ponca City Police Department showed Southwest side neighborhoods having reported the highest occurrence of disturbance calls (465) in the City of Ponca City for that year. Southwest side neighborhoods also had the highest burglary rate, the highest amount of prowler complaints and the second highest amount of reported fights in 1995 (Johnson, 1997). The neighborhood will include a mix of retail businesses as well as a residential area that is quite diverse. The residential property varies from apartment buildings, to duplexes to single family dwellings (Johnson, 1997). The area contains further a significant amount of rental property. Finally, an internal document prepared in 1997 reported strong evidence of a neighborhood in decay (Johnson, 1997).

The neighborhood area for the Westside Project is located in the southwest part of Ponca City and comprises about ten percent of the City of Ponca City. Businesses in the research study include all merchants owning or operating businesses in the Westside Project group of neighborhoods who elected to return surveys that were given to them for completing. Between 55 and 60 businesses were operating within the Westside group of neighborhoods over the course of the three years of the present survey. Thirty-three merchants completed and returned surveys in the 1997 year, while 25 merchants both in 1998 and 1999 completed and returned surveys. For each of the three-survey period, 160 residents were interviewed for the data and analysis generated for this study.

Survey data collected by the two authors of this research show income levels among North area residents within the Westside neighborhood district at well within the poverty range among a large proportion of residents. We found 41 percent of residents reporting annual household incomes of less than \$14,000 in 1997. An additional ten percent reported an annual household income of less than \$20,000 in 1997. Fifteen percent of North area residents reported being unemployed at the time of the survey in 1997. Similarly, residents living in the South area group of neighborhoods reported in substantial numbers income levels falling within the poverty range. Some 23 percent of southside residents reported annual household income of less than \$14,000 in 1997. While an additional 22 percent reported an annual household income of less than \$20,000 in 1997. Among South area residents at the time of the survey in August of 1997, ten percent reported being unemployed.

DATA AND METHODS

Survey interviews provided the principal research methodology. Two population pools, including residents from separate neighborhoods within the Westside community district, comprised the sample group for this analysis. For the residents, survey questionnaires were administered through face-to-face interviews carried out by the two authors and others hired as Graduate Research Associates over the first three years of the study. Data were collected over three separate periods: August 1997, August 1998, and August 1999. Systematic sampling methods were brought to selecting household respondents for interviewing for the three years. We report the findings below.

RESULTS

Table 1 presents the reported frequency among a combined sample of North Area and South Area respondents on their fear of crime across the three survey years. Reductions are observed over the three years in North and South Area residents' registering of fear of crime. For table 1, personal fear of crime is down (for several indicators quite dramatically) in 1999 compared to 1997. The largest reduction is among those reporting that they are more afraid of crime than they have ever been (down to 25 percent among North and South residents in 1999, compared to 48 percent in 1997). The next highest reduction is among those reporting that fear of crime is high in this neighborhood, and that there is a good chance I will be

a victim of a property crime this year (down to 26 and 38 percent, respectively, in 1999 compared to 38 percent and 50 percent in 1997). Each of the other measures for 1999 show a reduction from 1997. Residents' fear of being a victim of a personal crime shows a reduction from 17 percent in 1997 to 10 percent in 1999. Residents' fear of going out after dark shows a reduction from 30 percent in 1997 to 22 percent in 1999. Also, five of the seven measures of fear of crime show reductions between 1998 and 1997.

Table 2 presents the reported frequency among a combined sample of North and South Area respondents on their attitudes toward the police and police services across the three years. Gains are observed in North and South Area residents' positive perception of police and police services. For table 2, perception by residents that police are knowledgeable about the needs in my neighborhood has increased to 81 percent in 1999. This is up from 56 percent among North and South residents in 1997. Perceptions by residents that they see police officers on patrol in this neighborhood, and that the police department does the best job it can against crime in this neighborhood have both increased by some 21 points to 86 percent and 81 percent in 1999, from 65 percent and 60 percent, respectively, in 1997. A large increase in North and South residents' positive perception of police and police services are also present where residents in much fewer proportions report that the police hassle people too much in their neighborhood (down to six per-

TABLE 1. PERCENT FREQUENCY OF ITEMS MEASURING PUBLIC FEAR OF CRIME BY SURVEY YEAR

	NORTH AND SOUTH RESIDENTS		
	Percent Agree or Strongly Agree		
	1997	1998	1999
I often avoid going during the daytime because I am afraid of crime.	6	8	3
I often avoid going out after dark because I am afraid of crime.	30	29	22
My fear of crime is very high.	32	35	26
I am more afraid of crime than I ever have been.	48	35	25
Fear of crime is very high in this neighborhood.	38	28	26
There is a good chance I will be a victim of a property crime this year.	50	47	38
There is a good chance I will be a victim of a personal crime this year.	17	10	10
Base(N)	160	160	160

TABLE 2. PERCENT FREQUENCY OF ITEMS MEASURING PUBLIC ATTITUDES TOWARD THE POLICE AND POLICE SERVICES BY SURVEY YEAR

	NORTH AND SOUTH RESIDENTS Percent Agree or Strongly Agree		
	<u>1997</u>	<u>1998</u>	<u>1999</u>
I regularly see police officers on patrol in this neighborhood.	65	83	86
The police hassle people too much in this neighborhood.	23	6	6
The police department does the best job it can against crime in this neighborhood.	60	80	81
I must admit that I tend to view the police as an enemy rather than a friend.	13	6	6
My own impression of the police is that they cannot always be trusted.	31	23	14
The police are more interested in giving tickets than in solving crime.	26	8	13
MY OPINION OF PONCA CITY POLICE IS THAT THEY:			
Show concern.	73	81	88
Are generally quite helpful.	75	86	88
Are Knowledgeable about the needs in my neighborhood.	56	80	81
Puts you at ease.	67	82	84
Always exhibit professional conduct.	74	81	87
Base(N)	160	160	160

TABLE 3. PERCENT FREQUENCY OF ITEMS MEASURING NEIGHBORHOOD PROBLEMS BY SURVEY YEAR

	NORTH AND SOUTH RESIDENTS Percent Agree or Strongly Agree		
	<u>1997</u>	<u>1998</u>	<u>1999</u>
One big problem in this neighborhood is disorderly youth gangs and/or groups.	42	30	25
One big problem in this neighborhood is teenage crime.	50	40	39
One big problem in this neighborhood is frequent street fights and/or people loitering on corners.	29	20	16
One big problem in this neighborhood are the abandoned car and trucks.	15	13	11
One big problem in this neighborhood is poor street lighting.	40	32	31
One big problem in this neighborhood is run down buildings that are fire and other hazards.	46	38	23
One big problem in this neighborhood is litter and trash that don't ever seem to be cleaned up.	32	30	38
One big problem in this neighborhood is tall grass that don't ever seem to be cut.	40	31	20
Base(N)	160	160	160

cent in both 1998 and 1999, from 23 percent in 1997), that the police are more interested in giving tickets than in solving crime (down to 14 percent in 1999, compared to 31 percent in 1997), and that the police puts you at ease (up to 84 percent in 1999, compared to 67 percent in 1997). Each of the remaining measures shows similar increases between 1997 and 1999 in residents' positive perceptions of police and police services. The general pattern of increased positive opinions of police and police services observed in 1999 is showing a similar pattern among North and South residents for 1998 as well.

Table 3 presents the reported frequency among a combined sample of North and South Area respondents on their perceptions of neighborhood problems across the three survey years. Declines are observed over the three years in North and South Area residents' registering of neighborhood problems. The largest decline is among those reporting a big problem in this neighborhood is run down buildings that are a fire and other hazards (down to 23 percent among North and South Area residents in 1999, compared to 46 percent in 1997). The next highest reduction is among those reporting tall grass that don't ever seem to be cut as a problem (down to 20 percent in 1999, compared to 40 percent in 1997). Also, significant are the declines by residents' in problems related to disorderly youthful gangs/groups (down to 25 percent in 1999, compared to 42 percent in 1997), teenage crime (down to 39 percent in 1999, compared to 50 percent in 1997), and frequent street fights/people loitering on

corners (down to 16 percent in 1999, compared to 29 percent in 1997). Two of the other three measures for 1999 show a decline from 1997. Abandoned cars and trucks as well as poor street lighting show a decline in 1999 compared to 1997. Also, all eight of the measures of neighborhood problems show a decline between 1998 and 1997.

Table 4 presents the reported frequency among a combined sample of North and South Area respondents on quality of police contact across the three survey years. Gains are observed in North and South Area residents' perception of the quality of police contact. Perception by residents that police officers have generally cared about me as a person has increased to 80 percent in 1999. This is up from 59 percent among North and South residents in 1997. Perceptions by residents that officers who patrol my neighborhood are generally polite to me, and that police officers have generally taken their time to understand my particular problem have both increased some 16 points and 15 points, respectively, to 93 percent and 81 percent in 1999. This is up from 77 percent and 66 percent in 1997. Gains are observed as well in North and South residents' perception of police being generally helpful in matters where I have required their assistance. Further, all five of the measures of quality of police contact show gains between 1998 and 1997.

DISCUSSION

Our research sought to determine how successful policing initiatives found in neighborhood centered policing philosophy positively

TABLE 4. PERCENT FREQUENCY OF ITEMS MEASURING QUALITY OF POLICE CONTACT BY SURVEY YEAR

	NORTH AND SOUTH RESIDENTS		
	Percent Agree or Strongly Agree		
	<u>1997</u>	<u>1998</u>	<u>1999</u>
Officers who patrol my neighborhood are generally polite to me.	91	93	77
Officers have generally been helpful to me in matters where I have required their assistance.	80	86	87
Police officers have generally taken their time to understand my particular problem.	66	75	81
My experience is that police officers have generally cared about me as a person.	59	74	80
I will do anything possible to work with the police to make my neighborhood a better place to live.	93	96	93
Base(N)	160	160	160

impact low-income neighborhood quality of life. Insights brought to policing strategies where neighborhood policing and other adoptions of community policing philosophy are constructed in accomplishing important community safety goals, see much promise in such principles positively impacting quality of life for low-income and other socially and economically strained neighborhood members. Policing philosophies embracing the social and environmental basis for many of the problems affecting low-income neighborhoods and residents find a promising remedy to the problems inherent to low-income neighborhoods in the broader principles of problem-solving, crime prevention, and citizen-input that have come to shape community policing philosophy and practices today.

Our findings showed the structure of neighborhood community policing to provide broad and positive effect for Westside residents in improving community members' perception of neighborhood conditions and other assessments of their overall quality of life. In the items measuring fear of crime, our findings showed an overall decline among Westside community members' perception of their risk of personal and property victimization, neighborhood general fear of crime, and other assessments of personal and community level fear of crime. Similarly, in assessments brought to community members' perceptions of police, and police services to the community, findings from the study showed consistent gains in favorable opinions regarding important services brought to neighborhood life. Further, in the assessments of neighborhood problems, the findings point, likewise, to important gains in community member's perception of neighborhood problems being successfully addressed. Finally, our study found community members to express an overall, increasingly strong positive attitude toward the quality of personal contact they usually have with the police.

The findings appear to invite the important value of neighborhood policing as containing the seeds to positively impact overall quality of life in neighborhoods besieged by significant social and economic strain. Indeed, such principles where community centered problem-solving, crime prevention, citizen input, and the placing of neighborhood problems within a broader context of social and economic disadvantages prevail, that such principles appear to contain the ingredients to neighborhood life rich in the bounty of a reassuring and highly

contented sense of strong social order and an equally highly valued neighborhood life.

In addition to this study presenting the findings of a clear benefit neighborhood policing strategies bring to enhancing neighborhood conditions and quality of life in communities where such community policing strategies have been put in place, the research contains important implications that may prove quite enlightening in facilitating the accomplishment of local goals for communities and police departments anticipating the adoption of community policing initiatives of their own. First, the pilot study demonstrates quite effectively the value that an active research monitoring of a project involving neighborhood police officers can provide. The first author has been the principal investigator in supervising several assessments of the neighborhood police officers stationed in the Westside Community District in Ponca City. The reports developed from the annual assessments have provided an important evaluation component to the administration of the Ponca City Police Department in allowing for the determination of the project's success, and for making informed decisions in regards to the future of neighborhood policing in that part of the city. Police departments and communities planning the adoption of neighborhood policing and other similar community policing initiatives would benefit immensely from having in place at the start such a structure of research monitoring, similar to the Westside Project assessment reports that have been carried out over the course of the activities involving the presence of neighborhood community policing in this group of neighborhoods.

Secondly, the pilot study demonstrates the immense importance to the successful outcome of neighborhood community policing of support among local police administrators and police personnel for the structure of an annual assessment in evaluating the effectiveness of a neighborhood community policing presence. The active support among Ponca City Police Department senior administrators, and in particular the Police Chief and Deputy Chief officials have been a key factor for the success of the neighborhood policing presence in the Westside community. The initial concept paper developed by Major Clayton Johnson of the Ponca City Police Department contained statements inviting the clear value as the Westside Project is being planned to adopt an assessment component, which will also func-

tion as one of a number of key elements central in the administering of the project (Johnson, 1997). This interpretation by the senior administration of the benefit of putting in place the structure of research monitoring of the project's success would be the basis for Major Johnson's initial contacting of my department at Oklahoma State University, and my subsequent agreement to serve this role for the efforts being planned for the Westside community in the city. Finally, the two police officers assigned to the project were individuals highly supportive of the principles and goals of citizen involvement, the establishment of community partners, problem identification, problem-solving, and other similar values brought to community policing neighborhood designs. This was also key to the success of the project.

There is an important need for this type of research in rural and small city communities throughout this region and the country as communities increasingly adopt community policing approaches to enhance neighborhood conditions and safety. The efforts in Ponca City should then stand as a model for other communities in the heartland of rural, small town, and big city America. Barriers for conducting this kind of research is obviously found in not being aware of communities having a potential to benefit from such research. Possible strategies to overcome such barriers include constructing proposals for presentation to city police administrators as well as local public officials where one clearly conveys in an effective manner the clear benefit such research can provide for local communities in facilitating their goals to establish in neighborhood communities, a successful neighborhood community policing presence.

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COMMUNITY WORK CENTERS (CWC): OKLAHOMA'S EXPERIMENT IN PUBLIC WORKS¹

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Abstract

As an alternative to incarceration, Oklahoma Community Work Centers (CWCs) from their beginning have been a cooperative venture in which legislators and local communities and their leaders play a significant role. Based on interviews with Department of Corrections professionals, the researcher found that higher level of professional commitment and innovative structures kept the costs down. CWCs cost less to operate because the host DOC facilities provide many administrative services that are not then duplicated at the community level. Thus organizational clusters require fewer professionals to operate them. CWCs do alleviate overcrowding in prisons and jails and provide jobs within Oklahoma communities. These facilities showed cost savings, benefited the communities economically, and provided an overall economic benefit to Oklahoma. In an era of increased accountability, scarcity of resources, and prison overcrowding, state legislators and the public welcome cost savings. Thus CWCs allowed for a win-win situation where all the players win—professionals, communities, inmates, and the public. From a regional and national perspective, the researcher found a cross-fertilization of new ideas that has implications for others. Oklahoma now has enough working CWCs to attract national attention. CWC staff often get requests from other states, as well as Oklahoma communities, inquiring about CWC programs asking about how well they work, how much they cost, how they operate. As this study shows: CWCs are not only effective programs, they are also cost effective. What we find is that *Community Work Centers (CWCs) are indeed Oklahoma's experiment in public works.*

The community work center concept first emerged as taxpayers became frustrated with the failure of prisons to rehabilitate inmates. The ground swell grew more urgent; however, when 15 years ago Oklahoma faced a growing population of long-term convicts and an imbalance of facilities. Those most directly affected—judges and correctional officers—fully endorsed community corrections because it gave them more alternatives. Through these alternatives “hard beds” in the state’s main prisons were kept available for violent and career criminals. Both Oklahoma Advisory Commission (1973) and the National Advisory Commission (1973) on Criminal Justice Standards advocated three criteria of implementation: community-based (humanitarian), work-related (restorative), and shared-costs (inexpensive) arrangements.

The first criterion addressed the public’s frustration (U.S. National Advisory Commission, 1973) over prisons’ “inhumane” treatment of inmates. Could those serving time stay better connected to their com-

munities and families? That issue was partly solved by moving low-risks inmates into community-based facilities. As for the second criterion, it was also addressed. Since work-related projects promote public health and/or welfare, inmates reintegrate not only into former communities but also gain community acceptance. One example occurred ten years ago after a severe Oklahoma storm. After that storm a private Oklahoma chicken farm was a public health hazard (dead chickens). Oklahoma inmates disposed of them and won public support for their deeds. Whether community work is private or public does not matter. The assumption is that through their work inmates give something tangible back to Oklahoma communities.

Finally, the Oklahoma model required shared-costs of incarceration. During the sixties and seventies penologists suggested that inmates in community corrections live in already existing facilities. This practice would save not only construction costs but also on program demands. Most Okla-

homa communities share costs of CWC start-up (an old building or money) as incentives. Because Altus paid \$120,000 for a renovated building, the Oklahoma Department of Corrections (DOC) located a facility in there. The start-up price for community work centers is approximately \$200,000, which includes food, clothing, vehicles, furniture, facility renovation, and kitchen equipment. The community that deposits \$20,000 is able not only to house 100 inmates but also to get top listing on DOC's priority list. With a backlog of interested communities, only those who have the money will likely have their own CWC.

The purpose of the research was to conduct an historical and qualitative analyses of professionals most directly involved. After notification of project funding the researcher selected the Western Oklahoma Region as the most representative place for the study. At the time of this study only one public and one private CWC existed outside this geographical region. Initially, he set up interviews with Administrative Officers, Correctional Officers, Wardens, Regional Administrators, former Administrative Officers, and others (PIO officer, Administrative Assistants, Researcher). Interview sites included Weatherford, headquarters for the Western half of Oklahoma Department of Corrections, and the Oklahoma City metropolitan area. Additionally, the researcher collected and evaluated articles and other documents in order to examine community program effectiveness and efficiency.

HISTORY OF COMMUNITY WORK CENTERS

The basic concept of community work centers began at Lake Murray in January 1989. The first renovation project on the State Park extended into a second project (February through April). By September Waurika established the first CWC prototype. Inmate work crews at Lake Murray State Park continued working through May 1990. They worked at the State Park until the second site, the Ardmore Industrial Airport, established the second CWC prototype.

From its beginnings the CWC concept has been a cooperative venture in which

legislators and local communities played a significant role. Early in CWC developments, legislators became involved by legislating where inmates could work. In 1989 legislators authorized CWC crews to work on projects not previously addressed by amending Title 57 authorizing the establishment of community work centers, as money became available (Oklahoma DOC, 1989).

What still remained, however, was an implementation procedure for the next community applicant, Waurika. Neither this legislation nor government-lease procedures provided specific guidelines about cooperative arrangements. Although Waurika wanted to start a private prison, they did not have money for renovation. This dilemma forced DOC administrators to consider alternatives. Thus they wanted to purchase materials for renovation or lease the structure for the amount needed. At that particular time, however, the Standard Government Lease contract made no such provisions. When, however, the Attorney General ruled that a one-year DOC lease could substitute for renovation costs, the implement stage of this and other CWCs began.

Although the basic concept began at Lake Murray and Ardmore, the prototype that later followed began at Waurika, a 45,000-foot structure that would house 75-80 inmates. By housing the inmates in a room just behind City Hall and having a reasonably free work force, citizens of Waurika received the equivalent of a half million-dollar grant each year in labor costs. The inmates have worked with the Oklahoma Department of Transportation, various county commissioners, and other regional city government officials. They were able to extend their 25 full time employees to include those 80 inmates housed at the CWC. Such an arrangement gave the community a return on their investment.

From the beginning local community leaders asked DOC professionals to house inmates in their facilities so they could employ inmates in public works projects. The process of extending the CWC Model to other communities had begun. In the

years following DOC staff never engaged a community unless that particular community asked them to come. Many city leaders (city managers, mayors, commissioners, and sheriffs) were quite enthusiastic because legislators promoted the CWC model.

The CWC legislation allowed inmates to work in communities where they had never lived. On the one hand public projects sounded great; on the other hand, people worries. Free laborers and community improvements versus risky business and security issues. Communities became polarized over these issues. Not surprisingly, many community town hall meetings lasted several hours. Some communities endorsed the CWC Model; others did not. In communities with strong constituency-based correctional philosophy, leaders took these initiatives. Upon request DOC staff visited privately with key community leaders. Depending upon the interests, these community leaders established a town hall meeting. Only later did DOC staff attend these meetings to answer questions.

These creative interactions between professional officers and local citizens produced an unintended consequence. Popular images of DOC changed from negative to positive. Perceptions of corrections changed from those perceptions of the sixties and seventies. During these years people ranked corrections and prison sites as undesirable much lower than hazardous waste sites or landfills or sewage systems. So too in Oklahoma citizens thought of DOC professional as having "cool hands" and potbellies. They knocked unruly inmates over the head with clubs. They were overweight and fat. According to correctional officers these perceptions changed. As local citizens became aware of Public Works Crews who worked for county commissioners or sheriffs, they supported these and their own projects. As one correctional officer stated: "Before we had miles of guard rails and few workers. We not only supplemented our crews with CWC inmates; we also changed public perception of correctional officers as well." From the original three sites in 1989

the number of communities participating has grown six times as shown in the section below.

LOCATIONS IN OKLAHOMA

Although one facility is in Oklahoma City (private), the Oklahoma DOC has placed most of the public facilities in the least populated areas of the states (primarily the southwestern and western areas of the state). Currently 15 CWCs exist in Oklahoma: Two CWCs—1. Carver (66 inmates located in Oklahoma City), 2. Idabell (80 inmates)—are located in the Central and Southeastern Regions. The other 13 CWCs are located in the Western Region. 3. Healdton (37 inmates), 4. Ardmore (86), 5. Madill (45 inmates, Host at Lexington CCC), 6. Walters (67 inmates), 7. Waurika (77), Lawton CCC, Host Facility), 8. Frederick (30), 9. Altus (93), 10. Hollis (40), 11. Mangum (50), 12. Hobart (49), 13. Sayre (55), 14. El City (17), (Host Oklahoma State Reformatory), and the newest is 15. Beaver CWC (19 inmates, Host, William Key Minimum Security at Fort Supply, Oklahoma)

Most of the CWCs listed above are located in small towns with limited resources. These communities see this Model as providing some type of economic transfusion by providing jobs, increasing the resident base, funneling wages into the local economy, and providing service projects that otherwise would cost the community money. The support of these and surrounding communities has been positive. These community experiments captured the attention of legislators and community leaders.

UNIQUE APPROACH TO COMMUNITY CORRECTIONS

What is unique about Community Work Centers? Based on the researcher's investigation and interviews, these are the nine categories of collective responses. 1) Many communities view CWCs as types of economic development, especially true in the small town and isolated counties where economic disparity works the greatest. 2) CWCs are an entirely new venture with Oklahoma communities. Oklahoma

Department of Corrections (ODOC) can personalize corrections in a favorable light. 3) CWCs represent a trend line pattern of moving from institutions. Now inmates are living in the community. 4) CWCs are cooperative ventures in which the communities own the buildings and control the work assignments. 5) CWCs mean good DOC public relations. The department has gone from being the "bad" people to being the "good" people who have a worthwhile service to offer. 6) This approach means that, for the first time, taxpayers get some return on their investments. It is also a tax benefit for those communities that get involved and form partnerships. 7) Where else but with CWCs do communities get a tangible service where needed. DOC has had work crews, but this is different. Work crews from a facility work where the community directs. This is different from road crews where inmates pick up beer cans and trash. 8) CWCs cause community leaders to look at inmates as a resource. And that fact, in turn, puts inmates back into the system. Now decisions are evaluated based on how beneficial inmates are to communities. 9) CWCs create healthy dialogue between DOC and community leaders. DOC has a chance to talk about inmate families, their kids and wives. Once personalized, inmates get jobs at the police station, a mayor's office, and city hall. And it is hoped that they find employment once they return to their communities, like the one who afforded them dignity.

Community involves social interaction of people living within a geographical region. Those citizens hope that business and industrial groups occupy their community and provide jobs, which, in turn produce strong community organizations and health and welfare councils with strong social work emphasis. Needless to say community development projects could include prisons especially in regions suffering economic depression. Those who advocate this approach believe that new correctional institutions can revive economically failing communities. Thus prisons have become an alternative to more traditional means of economic de-

velopment. Prisons do offer plentiful of long-lasting jobs because once located correctional facilities are not likely to move. Thus they are stable source of employment.

Not everyone in the community, however, sees prisons as a community development Mecca.

Several issues emerge. These include but are not limited to issues surrounding property values, crime rates, limited public resources, and public safety issues, especially because some of the old images of prison workers as marginal. Neither these newcomers nor inmate family members are wanted in these isolated rural communities. Community opponents believe those inmates' spouses, girlfriends, boyfriends, and children too often become involved in criminal activities themselves.

Pragmatically speaking, professionals saw CWCs as cost effective housing alternatives to overcrowded prisons. The CWCs allow inmates to work and reduce inmate idleness in the system. In turn, work centers enhance understanding and support of corrections in their community. They also allow for the completion of many worthwhile projects that benefit the local community and state. According to interviews such meaningful work give inmates a sense of pride and improved self-esteem, and dignity that they never achieve in warehouse operations making leather belts. In communities an inmate carpenter works with his tools on public facilities. They often work side-by-side with local carpenters who supervise them. It's a more normal, community life atmosphere where rehabilitation is more likely to occur. Finally, CWCs impact both the community and state economies.

Based on community studies, the economic impact of the CWC on Altus totaled \$1.5 million. It is estimated that for every 100/inmates the economic impact totals one million dollars. As a precaution, working inmates never replace city workers. Rather, they work along side them and increase their capacity for work. The relations are straightforward: the more inmates involved, the more work gets accomplished. Each community has a garri-

son of inmates who can be mobilized to remodel the old city hall at a fraction of the labor costs than would otherwise be the case.

COMPARATIVE COSTS

According to seven interviewed state legislators and 17 DOC staff, the driving force behind the CWCs comes from their lower costs. On several scales the CWCs costs less than is the case for other institutional operations. The evidence for that claim comes from evaluating the comparative costs per year. The average annual cost for housing inmates at CWCs in comparison with other incarceration costs is lower. CWCs cost \$11,000 per inmate compared with \$12,032 for Community Corrections Centers (e.g., Kate Barnard CCC, Oklahoma City CCC and Lawton CCC), with \$12,032, Minimum Institutions (e.g., William S. Key, Jess Dunn, Eddie Warriors), with \$12,829, Medium Institutions (e.g., Mabel Bassett, O.S.R., Lexington A & R) \$12,784, Maximum Institution \$20,361 (Department of Corrections, Research Division, 1996).

Just as the average annual inmate costs for each type of incarceration vary, so do the average per diem costs. The average CWC per diem costs amount to \$30.14 per day. That same figure for the Community Corrections comes to \$32.96 per day. For Minimum Institutions, the average inmate per Diem costs equal \$35.15 per day. For Medium Institutions, the figure equals \$35.03 per day. And finally, for the Maximum Institution the per diem figures equal \$55.78 per inmate per day. Each of these figures comes from the actual costs divided by the average inmate count per year (Department of Corrections, Research Division, 1996).

Based on conducted interviews, the researcher found five advantages to these CWCs. First, as is evident from above, CWCs cost the taxpayers less money whether calculated on an annual total cost basis or on a per diem basis. Second, the community receives something in return. They receive free labor for community and county projects, ones controlled by the local community. Third, a cross sectional

representation of community organizations requests inmate services. Based on DOC staff interviews, requests have come from local politicians, State representatives and senators, the parole board for DOC, service organizations (Rotary, Lions, Salvation Army), Oklahoma Historical Society, church groups, Chambers of Commerce, museums, public and county schools, and others. Inmates have taken on special projects: Special Olympics, Run Against Child Abuse, and other similar organizationally or community based projects. Fourth, CWCs can alleviate overcrowding. It is an alternative to total confinement, especially for those low risk inmates. Fifth, and finally, it can be argued that CWCs provide more jobs within the communities. As inmates work along side the community leaders and workers, they have, in working with community residents, better role models and guidance than would otherwise be the case in the prison system.

In summary, then, while the costs compared to other community-based or institutional-based facilities are cheaper, the benefits seemingly are greater. Yet the American Civil Liberties Union and their attorneys argue that by not paying the inmates for the work done dehumanizes them. It is true that this cost could be a repayment for the damage to society, not for their work. However, if CWCs can be viewed as an attempt to reintegrate inmates back into the community, it might make sense to pay them some salary, perhaps minimum wage. As communities make decisions about using inmates as resources, will they forget inmates' needs? They need employment at a minimum wages. A Southwest Iowa trailer-manufacturing firm recently hired 160 inmates. They opened a factory near Clarinda State Prison where inmates are paid an average starting wage of \$9.50 per hour. That money then can help pay for taxes, victim restitution, child care/support, and personal items (Harry, 2000).

EXPRESSED CONCERNS

During interviews with DOC professionals, several classifications of concerns

came up. These fell into two categories: 1. Facility concerns 2. Community concerns. The first item concerned where these communities are located and how far it is to staff meetings and training functions. Since professional officers and staff are required to attend staff meetings with counter parts and supervisors in Oklahoma City, they must travel long distance. Moreover, even between communities the distances are often several hundred miles. Staff members wondered why something could not be done about the frequency of these required meetings and training events.

Another facility concern dealt with personnel. Just about everyone agreed that working at one of the CWC sites required a certain type of professional. When asked about job requirements, interviewees gave the following rankings for Administrative Officer: Public Relations (75 percent) to include presentation of self, people skills, public speaking, expressing opinions), Administrative Rapport with the staff and Operational Concerns—Security, Food Supervision and Case Management (25 percent).

The facilities did not contain secure quarters for troubled inmates. Ideally, these sites should not house high-risk inmates those who had a troubled past. Practically speaking, though, questionable inmates came through these facilities. When that happened, neither the facilities nor those responsible could cope with them. Not having confined quarters created community problems. Since CWCs profiles of inmates have high visibility, violations affect community residential security. As a result of having inadequate quarters, staff wanted Restricted Housing Units (RHU) on CWC site. Were there areas of confinement for escapees, drunkard, and those not willing to work the facilities would work better.

Then there were community concerns. Community relations have a high priority and profile with the staff at CWCs. They work directly with the public, answer to an Advisory Committee, and form cluster groups around certain geographic regions. CWC professionals need to train commu-

nity leaders as they take responsibility for inmate workers. They certainly need good public relations and people skills.

They should be tactful, articulate, and confident. They present a "new face" to citizens of Oklahoma. At the same time they are on their own, isolated somewhat from the main facilities of DOC. Their territory is new; their clusters are remote satellites from major facility operations.

SIX RECOMMENDATIONS

It was only after extensive interviews with 57 DOC staff (those at CWC sites) and examining 113 documents (articles, reports, and DOC documents), that the researcher formulated the seven recommendations listed below:

1. When possible, reduce travel time. Since the CWCs are isolated satellites often located in remote geographic areas, meetings should both be limited to significant issues or located at half way sites. Perhaps remote phones would be a worthy investment for these roaming CWC professionals. It takes time and energy to drive to regional or state meetings that often have agendas not relevant to them.

2. Hire professionals who can promote CWCs. Just about everyone agreed that working at a CWC site demands unique skills. When asked about job requirements, DOC interviewees gave the following rankings for Administrative Officers job requirements: Skills in Public Relations (75 percent) to include presentation of self, people skills, public speaking, expressing opinions), Skills in Administrative Rapport with the staff and Operational Concerns—Security, Food Supervision and Case Management (25 percent). Since few women serve as correctional officers, staff wanted to have more women employees. Perhaps, according to those interviewed, they relate better with local citizens many of who are women.

3. Develop a philosophy of community security. For some, the ability to override classification systems has created serious security problems. Why put troubled, high-risk inmates in these facilities, especially when there is no segregated housing. It could be argued that the real issue

might be overcrowded facilities. Overcrowding leads to early release of many first-time offenders and those with less than two years to serve. These were classifications of inmates that CWCs typically received. Things have changed in just a few years. Some DOC staff believe that security develops from relationship and trust officers have with inmates and community. They believe correctional officers should not carry weapons, wear no uniform, and worry about rulebooks and more about interpersonal relations and communications.

4. Train community volunteers and supervisors to assume more responsibility. Since community relations has such a high priority and profile, training skills of DOC professionals are crucial for these professionals work directly with the public, answer to Advisory Committees, and form geographic clusters. These clusters of CWCs could be the forces for more constructive community dialogue about crime and the prevention of crime, about inmate's families—their kids and wives, about how the community could empower inmate families so that they succeed in spite of the odds against them.

5. Train the trainers. Train CWC administrative and correctional officers in the refinement of communication skills, of interpersonal skills, and of the art of being tactful, articulate, and confident. Then they will be more able to present a "new face" to community residents. This is especially important since these professionals are on their own, isolated somewhat from the main facilities of DOC. Training of these key DOC staff should be given a high profile and priority in the DOC training budget. As several Correctional Officers said, "Dealing with both the community and inmates is more difficult at CWCs than it is at other more secure DOC facilities. Consequently, it seems imperative to give more time to training these CWC staff in the use of community development skills.

6. Finally, Oklahoma legislators and DOC staff could implement more CWC arrangements. Oklahoma's resources are limited. CWCs cost less to operate. They

reduce overhead and related service costs. They require fewer professionals to operate them. And finally, many Oklahoma communities now view inmates as resources.

RESEARCH FINDINGS AND CONCLUSIONS

The community work centers began in 1989 with a renovation project at Lake Murray State Park. Former DOC Director Gary D. Maynard advocated establishing work center in each of Oklahoma's 77 counties. Whether that happens, implementation for such facilities has already begun. Since the majority of the communities with work centers are located in the Western half of Oklahoma, this regional was the focus of study. Based on qualitative and historical research findings, the researcher found that CWCs offer not only a unique approach of community involvement but also a cheaper way of housing inmates. Yet here as elsewhere it is necessary to balance community projects against security issues and inmate control.

From a practical perspective, this alternative approach to incarceration allows for a win-win situation in a professional field that offers few of these opportunities. All players win—DOC professionals, participating communities, and inmates. As this method of inmate incarceration evolves, the researcher expects a cross-fertilization of new ideas leading to other innovations. Perhaps communities will, in time, take on greater responsibility for criminals as they find more humane ways of extracting retribution for crimes, while, at the same time, they find ways to rehabilitate and re-integrate inmates back into their own communities once released from these Oklahoma CWCs.

Oklahoma has established CWCs. The staff often gets requests from other states inquiring about how the CWC Model works, and about what the program evaluations suggest. In an era of increased accountability, scarcity of resources, and prison overcrowding, the CWC Model should get wide publicity. State legislators and the public welcome prisons cost savers. The topic of CWCs is certainly both timely and worthy of continued fund-

ing. No other state has any correctional approach similar to the Oklahoma CWC Model; it is truly unique and innovative.

From their beginnings CWCs have been a cooperative venture in which legislators and local communities and their leaders play a significant role. Many communities (city managers, mayors, commissioners, and sheriffs) have been quite enthusiastic about the CWC model because legislators such as Senator Roberts (Ardmore) promoted CWCs. By amending Oklahoma Title 57 legislators authorized the establishment of Community Work Centers that allowed inmates to work in communities. This had never been done before. Even more encouraging, communities shared the up front costs with the Oklahoma Department of Corrections.

Based on interviews with DOC professionals, the researcher found that higher level of professional commitment and innovative structures kept the costs down. CWCs cost less to operate because the host DOC facilities provide many administrative services that are not then duplicated at the community level. Thus organizational clusters require fewer professionals to operate them.

CWCs do alleviate overcrowding in prisons and jails and provide jobs within Oklahoma communities. It is believed, however, that inmates who work beside community leaders have better role models than would otherwise be the case in the state's prison system. These community role models raise the level of decision making and skill development for community offenders. It is believed that as communities assume greater responsibility for offenders they will practice more humane ways of extracting retribution for crimes and rehabilitating inmates back into communities once released from CWCs. These facilities showed cost savings, benefited the communities economically, and provided an overall economic benefit to Oklahoma. In an era of increased accountability, scarcity of resources, and prison overcrowding, state legislators and the public welcome cost savings. Thus CWCs allowed for a win-win situation where all the players win—professionals,

communities, inmates, and the public.

In summary, then, the researcher concludes that CWCs have legislators' support, community commitment, cost sharing, professional commitment, and organizational resourcefulness. They provide both community benefits and state economic benefits. From a regional and national perspective, the researcher found a cross-fertilization of new ideas that has implications for others. Oklahoma now has enough working CWCs to attract national attention. CWC staff often get requests from other states, as well as Oklahoma communities, inquiring about CWC programs asking about how well they work, how much they cost, how they operate. As this study shows: CWCs are not only effective programs, they are also cost effective. What we find is that *Community Work Centers (CWCs) are indeed Oklahoma's experiment in public works.*

END NOTE

¹ This project required the cooperation of key Oklahoma Department of Corrections' staff, including Western Regional Director—Gary Parsons and his Deputy Director, Justin Jones. Jones arranged meetings. Others included these units: Research Division, PIO, Accounting, The Oklahoma Criminal Justice Consortium, and Host Facility Wardens.

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