If you have issues viewing or accessing this file contact us at NCJRS.gov.

Developing Mental Health Programs for Minority Youth and Their Families

A Summary of Conference Proceedings

124121

CASSP Technical Assistance Center
National Center for Networking Community Based Services
Georgetown University Child Development Center

Developing Mental Health Programs for Minority Youth and their Families

A Summary of Conference Proceedings

124121

U.S. Department of Justice
National Institute of Justice

This document has been reproduced exactly as received from the person or organization originating it. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the National Institute of Justice.

Permission to reproduce this [redacted] material has been granted by
Public Domain/NIMH/U.S. Dept. of Health and Human Services

to the National Criminal Justice Reference Service (NCJRS).

Further reproduction outside of the NCJRS system requires permission of the [redacted] owner.

Funded through an interagency agreement between the
Child and Adolescent Service System Program,
National Institute of Mental Health
and the
Division of Maternal and Child Health,
Bureau of Health Care Delivery and Assistance,
U.S. Department of Health and Human Services

1986

ACKNOWLEDGEMENTS

The major author and contributor to this document was Mareasa R. Isaacs, Ph.D., Associate Commissioner for Children and Youth, New York State Office of Mental Health. Dr. Isaacs took a leadership role in planning the Atlanta conference on "Mental Health Program Development for Minority Youth and their Families," in preparing all background materials, surveying the states for minority program nominations, identifying experts in the field to participate in the project and in coordinating initial follow-up activities. Other contributors include Ira S. Lourie, M.D., Director, NIMH, CASSP; Judith Katz-Leavy, Deputy Director, NIMH, CASSP; Margaret Beale Spencer, Ph.D., Associate Professor of Developmental and Educational Psychology, Emory University; Sybil K. Goldman, M.S.W., Director of Policy Planning, Georgetown University Child Development Center; and, Roxane Kaufmann, Director of Special Projects, Georgetown University Child Development Center.

Special thanks are extended to Lemuel Clark, M.D. who was the motivating force in initiating and conceptualizing this project. His ongoing support, perseverance and commitment have insured the success of this project.

TABLE OF CONTENTS

PREFACE

This monograph is published with the hope that it will promote among advocates, providers, and minority families a better understanding of the myriad of complex issues that influence the development, delivery and effectiveness of mental health services provided severely emotionally disturbed minority children.

The document Developing Mental Health Programs for Minority Youth and Their Families represents the confluence of three important events: the development of an organized minority strategy within the Institute, strong and consistent leadership from the Director of the Division of Education and Service Systems Liaison, and the involvement of an excellent primary consultant. The convergence of these three factors created a climate and a capacity that enabled dedicated program staff to conceptualize, plan and produce this monograph, and proceed confidently with the implementation of many of its recommendations.

The effort builds on a sequence of technical assistance resources prepared for CASSP by the Georgetown Technical Assistance Center and focuses on: external and internal factors affecting the mental health of minority youth; predominant perceptions about "mental health" which determine the utilization of services in minority communities; incorporating social and cultural factors in the development of services for emotionally disturbed minority children and their families; and identification of those age groups and subpopulations within minority communities most in need of mental health programs and interventions. In addition, this monograph seeks first to explore, then to integrate concerns about the economic status and the mental health and wellness of minority children.

Lemuel B. Clark, M.D.
Associate Director
Division of Education and Service
Systems Liaison
National Institute of Mental Health

INTRODUCTION

On January 30 through February 1, 1986 the CASSP (Child and Adolescent Service System Program) Technical Assistance Center of the Georgetown University Child Development Center sponsored an invitational workshop in Atlanta, Georgia, on Mental Health Program Development for Minority Youth and their Families. Funding support for this workshop was provided through the National Institute of Mental Health.

This report includes the background papers developed for this workshop as well as a summary of the recommendations made and actions to be taken. Section I presents an overall framework and an overview of the issues which were explored in greater depth at the workshop. The material for this section was developed through a survey of key professional representatives of the major minority groups in this country: Asian American, Blacks, Hispanics, and Native Americans. Section II summarizes the workshop recommendations, which are grouped according to seven different areas: policy, research, training, access, assessment, family involvement and community education and resource development. Section III delineates activities to be undertaken through the CASSP Technical Assistance Center at Georgetown University and the National Institute of Mental Health, CASSP program, to begin to address some of the issues identified. In Section IV there are brief descriptions of a sample of programs that serve minority youth and their families; these were developed from a survey conducted prior to the workshop. And, finally, the appendices include a copy of the presentation on "Minority Children and Mental Health: Old Perspectives and New Proposals" which was delivered by Margaret Spencer, Ph.D., at the Atlanta conference, a listing of the workshop planning committee members and staff, respondents to the questionnaire, major issue areas discussed at the workshop, a list of workshop participants, a copy of the agenda, and a listing of state CASSP projects.

I. AN OVERVIEW OF ISSUES AND CONCERNS

In preparation for this workshop, a group of minority professionals were asked to respond to a set of ten questions. These questions were centered around major areas of concern identified by the workshop planning committee (see Appendix I). The responses to these questions were utilized to develop a framework for the workshop, to provide a common focus for the larger issues to be addressed and to stimulate other ideas and thoughts to be shared during the workshop.

This overview is an attempt to synthesize the various thoughts and ideas submitted by respondents representing the four major ethnic groups who were the subject of the workshop: Blacks, Hispanics, Asians and Native Americans. Although the respondents were asked to address many different issues, this paper will focus on only the following:

- o External and internal factors affecting the mental health of minority youth;
- o Predominant perceptions about "mental health" which determine the utilization of services in minority communities;
- o Incorporating social and cultural factors in the development of mental health programs for minority communities; and
- o Identification of those age groups and subpopulations within minority communities most in need of mental health programs and interventions.

As noted above, this paper is an attempt to synthesize rather than analyze responses. Some issues were raised by a specific ethnic group, although common concepts and issues may exist across ethnic groups. Since the answers from respondents differed in format and style, this paper is an attempt to cull out key concepts, rather than present responses in their totality. However, in some instances, direct quotes from respondents are included, but the specific respondent remains unnamed.

Finally, it should be stated clearly that no minority population is homogeneous. Although the questions presume a certain amount of generalization, there are clearly intracultural differences within groups that must be kept in mind. For example, the term Asian American covers "...at least 23 ethnic groups, speaking over a thousand different languages and dialects, spanning enormous geographical origins and coming from the most primitive stage of civilization to the highest sophistication of electrotechnology". The same diversity exists within the other ethnic groups. It is noted that "the word, 'Hispanic', is a generic term used to refer to people of Spanish heritage. There are various groups that are called Hispanic

that are identifiable by their origin, e.g., Puerto Ricans, Cubans, Mexicans, and people from various parts of Central and South America. These groups have in common the Spanish language and heritage, but many of the similarities end there." Consequently, the responses noted in the following pages should be examined within the framework of the great diversity that exists within all ethnic minority populations.

EXTERNAL AND INTERNAL FACTORS AFFECTING THE MENTAL HEALTH OF MINORITY YOUTH

The respondents were asked to review a list of external and internal factors generated by the Planning Committee for this workshop as well as to list additional factors not included. The Planning Committee list was viewed as rather exhaustive by most respondents; however, additional comments were offered. Further, the respondents, as a group, tended to mention certain factors with greater frequency than others. The external factors mentioned most often by respondents are described below. They are:

1. The impact of institutional racism. Institutional racism usually begins to be significant when minority children first encounter the education system as preschoolers or gradeschoolers. Many respondents viewed the educational system as inadequate and the principal institution perpetuating stress for minority youth. For instance, one respondent noted that Black and Hispanic children are over-enrolled in classes for the mentally retarded and the seriously emotionally disturbed, while being underrepresented in gifted/talented programs. Another noted that schools fail to provide multicultural education, thus "minority children are expected to assimilate as rapidly as possible toward the Anglo American culture, and to learn at the same rate and with the same teaching methods as the Anglo American child". Such oversight leads not only to over-representation in special education classes, but also to "...failure, delinquency and school dropout in proportions that far exceed representation in the U.S. population". For instance, in New York City, 70 percent of Black youngsters and 55 percent of Hispanic youngsters drop out of high school. Indian children also experience an inordinately high rate of dropout in the various educational systems available to them. It should be noted that there is a reverse principle operating with Asians, who are often considered "model" minorities. One respondent states that "personal observations and dialogues with the few Asian Americans in special education and related fields suggest that Asians are underrepresented and therefore underserved in all special education programs, especially those for the behavior disordered and emotionally disturbed."

2. The urban environment itself. Crime, poverty, drug and gang activities associated with inner cities tend to threaten minority youths' mental health. Furthermore, due to housing patterns, certain

inner city areas are becoming increasingly poor, as minority professionals relocate to other areas of the city or surrounding suburban areas. This creates an inability to provide positive role models within many urban environments. Also, while crime and the legal system are "...undoubtedly linked to socioeconomic variables, they assume a large enough role in the lives of children and adolescents that they can be said to be independent stressors affecting minority youth." For example, statistics indicate that homicide is the leading cause of death for Black males between the ages of 18 and 25.

3. The strain of acculturation. The impacts of acculturation are experienced differently by various Hispanic and Asian/Pacific groups. The strain of acculturation, for many of these groups, includes a "migration" or refugee experience, which is often traumatic and difficult. Many refugee children are carrying the effects of war experiences -- these youth have witnessed an inordinate amount of violence, atrocities and death of loved ones. Thus, many youth experience accumulative - trauma that can persist over long periods of time.

4. Language/communication problems. Communication difficulties exist both for new immigrants and refugees as well as other minority youth. One respondent notes that "it is also necessary to consider language in the case of subgroups of American-born Black populations. For example, there is sufficient evidence to suggest that regional dialects and ethnic dialects are diverging significantly from mainstream or standard English in such a manner as to cause potential problems with comprehension for youth and families using the variant dialects."

5. The impact of geographic isolation and resource-poor environments. These situations are a particular stress for American Indians that remain on or near reservations and for rural Blacks. Geographic isolation and resource-poor environments also create special and unique problems in service delivery.

6. The impact of the American sociopolitical environment. Since minority groups are more dependent on government policies and programs, differing sociopolitical environments create greater stress on minority families. For example, federal policies have tended to break down the natural helping and support systems among American Indian tribes and have created pervasive out-of-home placements in non-Indian settings; this in turn creates cultural identity issues for Indian youth. Another respondent noted that "changes in the sociopolitical environment can bring about the creation of new programs and the expansion of the budgets of old programs, or bring about the termination of old programs and the reduction of budgets ....the political climate in and of itself will affect resource availability" in minority communities.

7. The economy and the availability of employment. These factors, closely related to the sociopolitical environment, also place greater stress on minority populations than on the majority culture. For example, the "...loss of historic tribal economics and the accompanying loss of traditional adult roles coupled with unemployment" diminish role models and lead to feelings of powerlessness among American Indian youth and families. Given the large unemployment rate among Black youth, one respondent notes that it "...affects the opportunities for adolescents to find part-time or even full-time employment." The lack of "legitimate" opportunities to be productive members of society and to participate in the "work ethic" is a primary factor in delinquency and other antisocial behavior among minority youth.

8. The impact of the media. This is a particularly important factor when viewed from a minority perspective -- "the average teen spends approximately 40 hours a week in front of a television and when positive role models are missing from television shows, for the most part, the socializing impact is prodigious." An Asian respondent suggested that "extraordinary emotional stress and inferiority complexes could be induced when Asian American youngsters are often greeted with distorted, stereotypic or insensitive portrayals of their group members in the printed media. Furthermore, they have to live with and deal with erroneous perceptions of themselves perpetuated by such portrayals....there is also a dearth of verbal and pictorial portrayal of Asian Americans in children's literature and instructional materials....This may create identity crises for Asian youngsters residing in rural or non-metropolitan areas, where there are few Asians. The lack of identity and role models of one's own origin may induce emotional disturbance, self-or group-denial, and, in some cases, surfaces as overeagerness towards acculturation or assimilation."

9. Inter- and intra-group conflicts. The racial tension that is being experienced within certain urban areas must be examined from a minority-minority perspective -- "...namely, Black and Latino youth acting out racial/ethnic hostilities." A Black respondent further states that there are also intragroup conflicts, such as "...conflicts between Caribbean Blacks and American-born Blacks, which create substantial stress, especially for that Black group in the minority. A similar problem may exist between Cuban, Puerto Rican, Mexican or other Latin American groups."

10. The loss of the most highly skilled/competent members of minority groups to the larger society. This drains minority communities of those who could serve in leadership and direct service delivery roles.

The internal factors mentioned most often by respondents were centered around one overriding concept -- assimilation. A respondent notes that "the experience of being treated as an uninvited guest in one's own country is a demoralizing one that creates tremendous stress and distress for minority children. Expectations established by the society for minority children are embedded in stigmas that greatly inhibit their potential for assimilation into the larger society. The context is one of dysfunction, not normal adjustment." Assimilation creates a number of internal stresses and problems for minority populations including:

1. Conflict of cultures. There is a natural tension between the majority culture and minority culture that is often stressful for a child or adolescent, especially one who is bussed or who is biracial or bicultural. Another respondent stated that the "failure to effectively integrate the African culture and world view with the majority culture and Eurocentric view is a continuous source of psychological stress for African-Americans. The majority culture does not support the attainment of psychological Blackness, and the historical response of the Afro-American community, in general, has been confusion, self-deprecation and feelings of inadequacy. Further, the majority of legitimate Black differences have been misinterpreted to reflect Black deficits." Another respondent notes that the amount of cultural conflict is dependent upon where one is on the cultural identity continuum, ranging from very assimilated to very traditional. It is also very important to clarify the values underlying a particular culture, if interventions are to be sensitive and effective. Besides intergroup cultural conflicts, there also exists cultural conflicts between generations, as the younger generation tends to acculturate at a faster rate than the older generations who migrate. In speaking of Asian Americans, a respondent states that "the differential degree of acculturation, compounded by the developmental tasks of the teenage years, set the stage for many and varied conflicts and confrontations, sometimes leaving emotional scars to both generations. Thus, there could be role reversal for some Asian youngsters who, due to greater capacity for acquisition and assimilation of language, skills and adaptive behavior, may assume the role of teaching, supporting or counseling their parents....sometimes youngsters may learn to appreciate the American values, such as independence, self-determination and self-fulfillment that may be opposite to the cultural values that the older generation is still clinging to."

2. Family structure differences. These differences must be taken into account. They include extended family structures, which may be either positive or negative factors, and single-parent and teenage families (especially among Blacks).

3. Greater use and abuse of alcohol and drugs. This is particularly true among American Indian and Black youngsters and their families. Substance abuse creates "...substantial secondary difficulties such as problems in school and criminal activity." Alcohol is viewed as a key factor in the high incidence of suicide and accidental death of American Indian youth. Finally, the children of alcohol and drug users have "...both psychological and biological problems attributable primarily to the use of substances by their parents."

All of these factors have a tremendous impact on the development of positive self-concepts and feelings of efficacy among minority youth.

Respondents reported a number of programs and efforts to minimize the detrimental effect of both internal and external factors on minority youth. Several mentioned positive education programs that stress cultural enrichment, including the Yale-New Haven Primary Prevention Project and the Marva Collins' Westside Preparatory Academy. Judith Kleinfeld (University of Alaska) has reported on the characteristics of a school serving Indian children, which supported a "sense of community", "belonging", "participation", and "set of well-defined values and standards." Headstart and other preschool programs, operated by American Indian tribes, have also encouraged positive self-image and cultural identity.

Programs emphasizing strengthening and educating parents, as well as clinical intervention, have also been useful in mitigating some of the detrimental effects on minority families. For example, one innovative approach in dealing with alcoholism is the Women's Center operated by the Native American Rehabilitation Association (NARA). In this program, NARA provides residential alcohol treatment for women and their children. Children continue to live with their mothers in an apartment-like setting and receive care and treatment while the mother receives both alcohol treatment and parenting education. The approach also includes a strong cultural component to deal with identity issues and is referred to as "Indian Self-Actualization."

Finally, one respondent noted that the list of external/internal factors were all focused on the identified victims of racism and not on the perpetrators. He suggested that the "cumulative effects of racism on the psyche and behavior of the oppressor class must also be addressed and treated if there is to be a satisfactory resolution" of minority mental health problems. The focus of mental health intervention on the minority community alone is helpful but incomplete.

Another respondent suggested that the external and internal factors could be more helpful to mental health professionals if they were further classified according to two different axes, namely: a) whether they bear a direct effect on the etiology or causes of mental disorder in minority youth or whether they contribute to the exacerbation of these disorders, and b) whether they impede access to mental health services. The respondent noted

that there is a real dearth of data establishing the normal incidence of psychiatric disturbance for third world populations both within and outside the United States.

PREDOMINANT PERCEPTIONS ABOUT "MENTAL HEALTH" IN MINORITY COMMUNITIES

The perceptions about "mental health" and "mental illness" determine the utilization and efficacy of services for individuals and minority communities. In general, minority populations are underrepresented in community-based mental health settings, while being somewhat overrepresented in the more restrictive public mental health institutions. In order to develop effective programs, a knowledge of dominant perceptions and attitudes about mental health must be addressed and understood. Most respondents agree that "mental health" services have negative connotations in most minority communities.

Asian American respondents state that the Asian community either does not perceive the need for mental health services or views such services as negative and stigma-ridden. A respondent states: "Besides being a rich man's illness and fancy, to some Asians it may also be synonymous with 'craziness'. Mental illness is viewed variously as being a result of biological, moral or spiritual infirmity. This is particularly true for Asian cultures that are heavily influenced by Confucianism, such as China, Japan, Korea and Vietnam. For countries, such as the Philippines, which are not profoundly influenced by Confucianism, there is a widely accepted belief that mental illness can result from possession or influence by fairies or spiritual beings. Thus, care is commonly sought from folk or faith healers who incorporate appeasement of these spirits or deities in their rituals." In general, mental health services are usually viewed as being only for the severely disturbed. It is also ego-alien to most Asians and Pacific Islanders to discuss personal and intimate matters with strangers, even doctors. For many Asians, the loss of "mental health" only reaches conscious awareness when physical problems are triggered, such as headaches, sleeplessness, loss of appetite, etc. However, people then consider it as physical illness and seek medical treatment.

In the Black community, according to respondents, seeking mental health services is equated with "craziness". Also, mental health services are not perceived as beneficial or effective in dealing with the problems of Blacks. For instance, in one study, it was discovered that a little more than half of those who felt that they were at the point of a nervous breakdown did not seek professional help. A 1982-83 Survey of Mental Health Needs, conducted by the Chicago Community Mental Health Council, Inc., reflects the perceptions of Chicago's minority community, that mental health programs are needed primarily for adolescent and adult Black males who are alcohol and drug abusers, homicidal or suicidal. Community residents also felt that there is a need for mental health services to deal with depression, nervous breakdowns and teenage pregnancy. According to the survey, "embarrassment"

was overwhelmingly given as the reason people do not utilize mental health services. It was found that community residents are resistant toward seeking and continuing treatment because of their lack of understanding about mental health, their fear of being labeled, and fear of self-disclosure. As a respondent noted, "mental health remains very much a private matter among African-Americans." In general, African-Americans seek relatively more direct and immediate types of services from the mental health system. Another related attitude is that Blacks tend to strongly prefer Black therapists who, they feel, can understand and relate to them. Finally, the Chicago survey also revealed that "unawareness of services" was often cited as a reason why mental health services were not utilized. One respondent felt that these attitudes were shifting towards more positive manifestations as more Blacks become involved in mental health professions.

For American Indians, respondents note that there is an historic distrust of the dominant society's approach to dealing with mental health and a belief that formal mental health services are an extension of the dominant society, particularly when the services are under the auspices of non-Indian agencies. There is a concurrent belief that formal mental health services tend to be judgmental, demanding and inconsistent. Finally, there are strong beliefs, among American Indians, that non-Indian service providers do not understand Native American cultures, retain stereotypic images of that group, and utilize approaches and techniques designed for the dominant society.

As is the case with other people of color, Hispanic respondents state that mental health services are viewed as either "...irrelevant or oppressive and are eschewed at all costs." It must be kept in mind that there are many Hispanics who have never been in contact with mental health professionals. When they do come into contact, generally they are forced to seek services as a result of mandates from some governmental agency (courts, welfare, etc.). Consequently, the experiences with the mental health system have generally been negative. Further, another respondent indicated that American mental health programs are in conflict with Hispanic culture in that they stress individuation as an indication of normalcy. Involvement in a mental health program is, therefore, viewed as a step closer to pathology, not mental health, by many Hispanics. In addition, mental health services are perceived by Hispanics to be incongruent with the family system. "Among first generation Hispanics, the family is the source for problem solving. An elder functions in the role of problem solver and within the hierarchy of the extended family, sufficient supports should be available without having to resort to mental health programs. Involvement in such a program, therefore, is viewed by the family and the client as an affirmation of serious dysfunction. It is an affirmation that the client is cut off from the family support system, which is an embarrassment to the family."

Since mental health services are underutilized, respondents were asked to identify resources that are more frequently utilized in seeking solutions to emotional/mental health problems. All of the respondents felt that "informal" support systems were predominantly used to deal with mental health

problems. Even when the formal mental health system is utilized, this is often augmented by other support systems. Every respondent indicated that spiritual centers, churches and clergymen were often utilized to handle emotional and mental difficulties, although the formal mental health system tends to overlook these important resources. However, churches are among the strongest institutions in many minority communities and can be extremely valuable allies. In Chicago, for example, "Project Image" is an ecumenical, community-based effort designed to stimulate church-based programs that can meet the recreational, social, educational and spiritual needs of boys growing up in homes without positive male role models. Programs are centered in participating churches of various denominations located in the Black community.

Other resources outside the mental health system, which are utilized in seeking solutions to emotional/mental problems, include:

- Extended family members (all groups)
- Tribal elders, grandparents or other elders in the community who are viewed as having "wisdom"
- Folk healers (mediums, santeros, curanderos, herbalists, antiguadores, astrologers, medicine men, shamans, seers, et al)
- Friends (and "as if" relatives)
- Community ceremonials and rituals that are either family-specific or adopted from the homeland
- Merchant/social clubs (botanical shops, grocery stores, medium centers, hometown clubs, fraternities and sororities, etc.
- Clan mothers
- Self-help organizations
- Social service agencies
- Hospitals and/or family doctors
- Community leaders

It was also mentioned that, out of desperation, the Black community has begun to turn to the courts for help in meeting its mental health needs. Parents, children, spouses, relatives, friends and neighbors have sought assistance for themselves or for a loved one by petitioning a legal source for help.

INCORPORATING SOCIAL AND CULTURAL FACTORS IN THE DEVELOPMENT OF MENTAL HEALTH PROGRAMS FOR MINORITY COMMUNITIES

Given the social and cultural factors affecting minority populations and the perceptions and attitudes held by minority groups, respondents were asked to identify those factors that must be taken into account in the development of mental health programs. The responses covered a variety of factors, many of which had been mentioned in previous answers, such as spirituality, the extended family system, language and communication variables, family structure, etc. However, specific suggestions were made about how to incorporate social and cultural factors into program development. These suggestions included:

1. Awareness of environmental factors and the influence they have on intrapsychic conflicts;

2. Awareness of the level of acculturation (defined as a process of adjustment to the dominant culture), a factor that may have a great impact on the type of mental health programs needed;

3. Clarification of definitions of particular mental illness or disorders and development of consensus between parents, agency, community and treatment staff. Similarly, the goals and specific methods for ameliorating problems must be agreed upon;

4. Awareness of the minority culture's patterns of communications, language, values, morality and learning;

5. Confidentiality as basic and prerequisite to any successful program;

6. Cognizance of the view that mental distress can have physical manifestations — thus, linkages with local medical doctors, children's clinics and hospitals, and other facilities that might treat the young are important. Treatment must be based on a holistic approach that deals simultaneously with the mental, physical and spiritual components of the individual, rather than separating them;

7. Maintaining and incorporating the network of support systems that recreates the feeling of community for the client. Services must allow for a validation of the client's self and his respect for his community;

8. Outreach, networking and linkages with churches and indigenous healers in the community, including linking lay referral services with professional ones;

9. Development of neighborhood-based services that are geographically accessible;

10. Provision of a wide variety of services -- advocacy, education, training, counseling, etc. in a single site, such as multiservice centers;

11. Focus on concrete problems identified by the clients and use of directive techniques;

12. Provision for a continuum of available services from primary prevention to intensive treatment and aftercare;

13. Linking service delivery with other systems, such as education, child welfare, alcohol and drug programs, to meet the multi-needs of many minority youth;

14. Supporting community ownership of the problem and self-determination of the solution;

15. Involvement of grass roots constituency of community members in planning, monitoring and acting as advisors for programs. For example, the support of tribal elders and tribal leadership is essential for services to American Indians;

16. Provision of services by bilingual and bicultural staff, or by same culture staff.

There are also certain factors that are more important for some minority groups than others. For example, program development responsibility for American Indians must be clarified since there are a number of groups -- state and local agencies, the Bureau of Indian Affairs, Indian Health Services, urban Indian organizations and tribal governments responsible for various services. For African-Americans, an understanding and assessment of the family structure, the current stressors on the unit, and the roles and responsibilities of various members (especially Black males) are important determinants of needed programs. Among Asian Americans, the shame and guilt often associated with mental illness is an additional factor that should be taken into account. Often family therapy, group therapy, and confrontive techniques are contraindicated with Asian American clients. In addition, the traditional client-therapist relationship must be modified to accommodate Asian Americans' preference for lasting interdependence. For Hispanics, supporting the network of intimate personal relationships and the family is of critical importance in treatment. A respondent notes that "the traditional psychotherapy model describes motivation, self-will and the ability to control one's behavior as a prerequisite to behavior change in therapy. Thus, a cultural value system that emphasizes interdependency and the Latin's spiritual beliefs must be taken into account when developing mental health programs."

IDENTIFICATION OF THOSE AGE GROUPS AND SUBPOPULATIONS WITHIN MINORITY COMMUNITIES MOST IN NEED OF MENTAL HEALTH PROGRAMS AND INTERVENTIONS

Finally, given limited resources, respondents were asked to identify the age group and youth subpopulations most in need of mental health programs and interventions. Needless to say, there was no overwhelming consensus. Four respondents indicated that, given limited resources, emphasis should be placed on the development of mental health programs for adolescents. The reasons given for focusing on adolescents were:

- Adolescents appear to have more urgent and serious problems, given the number of cases in clinics and other agencies;
- Adolescents are at a crucial impasse stemming from the polarity of the oppositional cultural demands confronting them at this stage;
- Adolescents, in many ways, bear the brunt of society and face very difficult issues -- drugs, young families, dropping out of educational systems, incarceration, etc.
- Adolescent pregnancies, which are high among Blacks, have a major impact on the life of the teenager as well as the unborn child.

The types of programs and interventions suggested for adolescents include: outreach programs; psychosocial counseling; vocational guidance and career counseling; parenting education; peer counseling; after school recreation programs; programs with an employment/work focus; cultural exchange programs; and, interventions that focus on empowerment rather than self-pity.

Three respondents identified preschoolers as the population towards whom resources should be focused. The reasons for focusing on preschoolers were:

- Based on knowledge of the effects of racism and products of racism, such as poor education, it is necessary to begin as early as possible to prepare children with the social, academic, and coping skills necessary to survive in a monocultural Anglo American society;
- Research and clinical practice (Berlin, 1982-83) suggest a link between early developmental issues and emotional problems. Focusing on preschool children, infants and first time parents can nurture networks, improve parenting and enhance self-esteem.
- Focus on preschoolers is cost-effective, allows for prevention as well as intervention, and lends itself to multiservice models.

The types of programs and interventions recommended for preschoolers include: identification of high risk children and families; teaching "survival" skills in educational settings; primary prevention (prenatal

care); preschool and Headstart for early stimulation and enhanced social skills; workshops and groups for parents; parent support groups; extended family intervention and treatment approaches; advocacy for the family with other agencies and institutions; and helping families cope, maintain their confidence, and nurture their family unity, ethnic identity and culture.

Three respondents indicated that latency-age youth (7-12) should be the focus of mental health services and interventions, given scarce resources. The reason given for focusing on the latency-age youngsters were:

- Latency is the time that most emotional problems become apparent For Asians, the high value placed on education makes this period of identification more amenable to therapeutic intervention.

- Latency-age and preadolescent focused programming would help to structure the nature, quality and configuration of adolescent peer groups, which have great strength and potential for mobilization in positive directions.

- Latency-age youngsters are amenable to prevention techniques. At these ages, youth are still available for emotional contact and their behaviors are not as set as adolescents. They are still responsive to adult supervision and guidance. In all likelihood, they have not as yet complicated their lives with sex and drugs; although they can understand the meaning of various life experiences.

The types of programs and interventions mentioned as important for latency-age youth include: Concerned Black Men (Big Brother) programs; structured psychosocial recreational outlets; organized competitive events; beginning experiences with the world of work; therapeutic interventions combined with action/education programs; and interventions that emphasize close collaborations with the school system.

CONCLUDING REMARKS

During the course of answering a variety of questions, the respondents also mentioned issues that were not directly addressed by the questions. One of the issues consistently mentioned was the need for ongoing research related to the mental health issues of minorities; the need for epidemiological data; and, the need for applied research regarding the effectiveness of clinical interventions and modalities.

Further, several respondents provided additional comments that address other generic issues or concerns. One respondent addressed the dearth of statistical information available about minority youth -- in particular, American Indians:

"One further issue which deserves comment is the current state of affairs of available statistical information regarding emotionally disturbed Indian youth. Recently, the Regional Research Institute at Portland State University, through its Research and Training Center for Improved Services to Seriously Emotionally Disturbed Children and their Families, in cooperation with the Northwest Indian Child Welfare Institute, conducted a preliminary study regarding the current state of affairs regarding emotionally disturbed Indian children. The results of that study are presently being compiled into a report.

One of our findings was that none of the states studied (Oregon, Washington, and Idaho) keep statistics on emotionally disturbed Indian children. Two states indicated that producing such statistics would require substantial effort and computer reprogramming.

The Indian Health Service representatives report that it is still undetermined if they could produce such statistics. Further, they would only have information on children served by IHS clinic mental health staff.

The Bureau of Indian Affairs also has no such statistics, but tribal programs gave estimates based on the memory of workers and their understanding of emotional disturbances. Some tribes reported no cases, while others reported as many as 20 percent of the youth population. This diversity seems to suggest very different definitions or attitudes about emotional disturbance.

Certainly, the task of learning the extent of the problem is going to be difficult. However, given the prevalence of school failure, adolescent suicide, alcoholism, involvement in the juvenile justice system, and out-of-home placement rates, one might expect the numbers to be substantial. Careful effort will be necessary in the design of any research intended to study the extent of this problem in the Indian community."

Two respondents addressed the need to empower minority families and better understand natural support systems in minority communities. One stated:

"The most critical issue must be a shift in attitudes by legislators, mental health practitioners, and members of academia away from the traditional 'melting pot' notion to one which understands behavior in its social and environmental context. Specific cultural issues of minority groups must be considered when tailoring services to meet needs. Systems approaches and network intervention are much more congruent with the experiences of minority families. A systems perspective permits one to deal with minority responses and family structure as different rather than pathological.

The concept of empowerment is crucial in the treatment of minority families. Traditionally, families have felt powerless to overcome the oppression of the larger society. Societal issues of scapegoating the minority group for their failure to assimilate into the larger culture have served to reinforce their sense of helplessness and isolation. Empowerment focuses on the strengths of the individual and family to

effect change in systems as opposed to other approaches which reinforce a sense of helplessness and a tendency towards self-pity.

Central to the concept of circumstances of poverty, empowerment can assist in establishing a more cohesive system for delivery of concrete services to minority families. Housing, educational and vocational services, day care, job placement, recreation and cultural activities, etc., have traditionally been out of reach for minority families to a large degree. In addition, services which have been made available fail to take into account the value systems of the minority family structure and, instead, impose the values of the larger society as a condition for eligibility."

Speaking to natural support systems, another respondent added that:

"It is imperative that services be based upon a thorough understanding of natural support systems. There is a need to integrate formal mental health services with Hispanic natural support systems. The use of natural support systems is greatly influenced by a group's beliefs and traditions pertaining to helping themselves rather than obtaining assistance from outsiders, and by the lack of available resources from outside the group. When focusing on Hispanics, a group that is experiencing dramatic increases in numbers, and is facing formidable barriers in receiving culturally sensitive services, natural support systems increase in importance. Consequently, there is a need to utilize the strength of the community in meeting the needs of its troubled youngsters and their families. Collaboration between formal agencies and natural support systems represents an important strategy in attempting to meet the needs of Hispanics."

Finally, one respondent indicated how important it is to be realistic about what changes governments and mental health programs can effect in minority communities. Speaking specifically of Black communities, he concluded:

"Programs are no substitute for culture and cultural expectations. Programs are no substitute for the power of history and heritage. Where in programs can Black people find the power to effect change within their culture, changes which will reduce many of the psychosocial problems affecting Black youth and adults, leaving only those organic problems, and their psychosocial sequelae, which affect the generic human organism?...

Despite the weakness of their overall sociopolitical posture on the failure of Blacks to compete within the majority culture framework, Black conservatives raise a valid point when they argue that Blacks cannot expect the government to define the parameters of Black culture and to provide the glue to pull that culture together. Despite the horrors, past and present, of racism, there are things that Blacks can and must do to alter the calculus of the cumulative trauma of racism.

It is clear from the fact of this conference and from the works that have recently appeared in the literature that a new strategy of intervention is required. Mental health programs are limited in what they, by definition, can do to heal the pain of the Black community. There are already notions of what must be done to 'save' the Black community from the ego enervating effects of racism, poverty, crime or alcohol and drug abuse. There have been experiments within the Black community that have ultimately been inadequate or have failed, in part, due to the sociopolitical nature of those efforts; witness should be given to some of the early Black Muslim attempts at bringing together a healthy Black community which operated on traditional values, concepts of self-sufficiency, and concepts of self/group sacrifice.

If there can be no Black community participation in the functional recovery from racism, then all the efforts of mental health workers are at best stopgap and inadequate. If the mental health system cannot facilitate a group process for recovery, then the limits of programs will continue to haunt mental health workers, accelerating 'burn out', bitterness and frustration; this will dilute the effectiveness of even the most committed individuals who are concerned about the mental health of Black youth and the Black community."

II. WORKSHOP RECOMMENDATIONS

Recommendations were made in the following seven areas:

POLICY

- States with large minority populations should develop a state-level focus on minority youth and their families.

- State licensing boards, for mental health professionals, should include material about minority youth and their families as a part of the knowledge base needed for licensure.

- Mental health services for minority youth should focus on early intervention in environments that are accessible to minority youth and their families (i.e., churches, schools, day care centers, etc.). Stronger links should be forged with education, maternal and child health, welfare and the media in efforts to reach minority populations.

- Federal and state programs should focus on the coordination of mental health and substance abuse programs, especially when addressing the needs of minority youth and their families.

- Likewise, federal and state policies should encourage greater coordination of physical health and mental health services for minority youth and their families. There should be guaranteed prenatal health care for all mothers.

- States should be encouraged to develop in-home services and other family-based programs to address the mental health needs of minority youth and their families.

- States should adopt a policy of permanency planning for all youth, including those in the mental health system. All efforts should be made to place minority youth in homes of similar background, but not at the expense of the child remaining in temporary placement for long periods of time.

- Federal and state governments should examine latent or overt policies that cause minority youth to be overrepresented in the juvenile justice system in comparison with majority youth. Efforts should be made to offer mental health and other less stigmatizing services to these youth.

RESEARCH

- On all advisory boards, NIMH should have minority members to insure sensitivity to research on or for minority members. NIMH research panels must be sensitized to acceptable research topics and practices for minority group members. Minority representation on federal/state advisory groups should be selected by minority group coalitions or networks.

- The CASSP Technical Assistance Center or other technical assistance centers should develop training programs for review panelists focused on minority issues and concerns.

- All research on children and youth must include samples from minority populations. Analysis of such research should include generic findings, as well as separate findings for each minority group, when possible. This would provide a method to determine the validity and reliability of research instruments as well as provide normative data on minority youth that is currently unavailable.

- Research focused on the mental health of minority youth and their families should be encouraged, at both the state and national levels.

- NIMH should sponsor longitudinal research on minority children and youth. Such research should be focused on system development and special areas of particular interest to minority populations such as juvenile offenders with emotional problems; coordination of service system; day treatment program evaluation; home-based care, etc.

- Research studies should focus on innovative and other successful delivery of mental health services in minority communities.

- NIMH should encourage minority researchers by making grants and training more available. NIMH should offer workshops and provide a mentor system for minorities interested in developing greater research skills.

- NIMH or the CASSP Technical Assistance Center should develop a document that synthesizes all current research on minority youth or their families and disseminate it to minority researchers and clinicians. There is also a need for more clinical and program information to be available.

- NIMH should develop an ongoing, accessible, free computerized annotated bibliography that contains information on all research conducted on the mental health needs of minority youth and their families. A similar computerized file should be available on all programs that specifically address the mental health needs of minority populations.

- NIMH and states should make funding available to community-based minority programs to hire a person to conduct research and to make linkages between data and program. A portion of research funds currently available should be shifted from academic to community-based programs.

- NIMH should establish a five or ten-year research agenda on minority populations. Experienced minority researchers, clinicians and program directors should be utilized to develop such an agenda.

TRAINING

- NIMH should identify and support institutions of higher education in targeted multicultural communities to serve as centers for research and training on minority child mental health issues.

- NIMH should support training programs that improve mental health services to minority children and their families through empowering local minority communities to participate in the development and implementation of mental health services. States should provide training to communities in multi-system approaches to properly identify, serve and/or refer mentally disturbed minority youth.

- NIMH should encourage the use of paraprofessionals, including parents, in the delivery of services to minority communities and should support the development of community-based paraprofessional training programs (and career development), including parental empowerment and advocacy.

- NIMH should, through training and research, examine the role of indigenous resources in minority communities (i.e., folk healers, herbalists, etc.) and their influence in maintaining mental health and preventing mental illness. NIMH should also encourage natural mechanisms (such as spirituality) to be incorporated in training of professionals and the promotion of mental health in minority communities.

- In training programs, NIMH and states must provide incentives for minority professionals to stay and work in minority areas or with minority populations.

- NIMH should strongly encourage states to mandate that staffing patterns of providers reflect the community's cultural diversity. NIMH should continue and expand the training programs for mental health professionals working with minority youth and their families.

- Universities must be encouraged to incorporate, in their training curricula, understanding of multidisciplinary roles as well as the diversity of "cultures" and values.

- NIMH should require training grantees to develop curricula that contain substantial content about services to diverse cultures, emphasizing multicultural competence (ethnic competency).

- Innovative training grants, available through NIMH, should focus on interdisciplinary training for those working with minority youth and their families.

ACCESS

- All mental health facilities and programs should be located within reasonable proximity to the communities they serve.

- NIMH should direct states to use block grant funds to develop non-traditional services and states should be monitored. In addition, no person should be denied mental health services due to an inability to pay.

- Confidentiality should not be a deterrent to the availability and accessibility of appropriate mental health services.

- NIMH and states should ensure that youth transitioning out of the child mental health system have access to culturally appropriate transitional and adult services.

ASSESSMENT

- A comprehensive initial evaluation should identify a client's strengths and problems in a way that is sensitive to cultural diversity.

- NIMH should continue to support the development of culturally relevant instruments for use in assessing minority group members. For example, such instruments should be sensitive to the degree of acculturation, group identity, cultural values, etc.

- NIMH should support staff development and training in culturally relevant assessment and testing practices, both at the university and community levels.

FAMILY INVOLVEMENT AND COMMUNITY EDUCATION

- Minority families should be involved in all aspects of state and local planning, program development and treatment of the children.

- NIMH and states should provide funding for research and evaluation of parent training and its effectiveness with diverse populations.

- NIMH and states should provide funding for community-based programs to train professionals and paraprofessionals in effective outreach techniques for minority youth and their families.

- NIMH or the CASSP Technical Assistance Center should develop and disseminate a document that describes existing operational programs for minority youth and their families. The document should address such areas as parenting and family involvement, community education, avoiding burnout, staff training, etc.

- NIMH and states should help ensure that community education programs directed to minority communities be supported that focus on, a) dispelling myths about mental illness, and b) clearly stating the benefits of mental health services and interventions.

- Efforts should be made to sensitize the media (television, radio, and print) to the needs of minority communities. Such efforts should be culturally sensitive as well as educate the general public.

- Through technical assistance, efforts should be made to educate federal/state policymakers and legislators about the mental health needs of minority populations. Education should focus on how to address these needs and the development of legislation that facilitates the implementation of effective programs rather than making implementation more difficult.

- Advocacy is an important element in the development of programs and community education. Every effort should be made to include and educate existing community groups about the needs of, and resources available for, minority youth and their families.

RESOURCE DEVELOPMENT

- A continuum of services for minority youth and their families should be developed. Given limited resources, the types of services developed initially should depend on the needs of the individual community. The continuum should include not only mental health services, but integration and interaction with other agencies. The continuum must include publicly and privately funded programs. The public sector should be encouraged to contract for services to improve creativity and flexibility and to increase citizen involvement.

- Services to culturally different youth and families should be delivered through a comprehensive service network rather than through programs that simply address an individual symptom, such as teenage

pregnancy, alcoholism, etc. Programs for minority children and families must be more flexible and multiservice oriented.

- NIMH and states should find a way to encourage development of innovative programs for minority youth and their families. Experimentation and coalition building should be integral aspects of such programs.

- A computer based national information system about minority programs, services, research and resources should be established, either through an existing child care organization or some other mechanism. This information center should identify resource people (such as those at the workshop); materials on programs, ongoing research, etc. NIMH should provide seed money for such an undertaking.

- NIMH, through its technical assistance centers, should make available technical assistance to states, counties and local agencies on how to maximize public funding (S.S.I, Medicaid, etc.) for services to minority children and their families.

- NIMH and states should study and encourage changes in reimbursement policies to allow for funding of outreach, in-home services, case management and other services that are not currently reimbursable.

- Individual program goals should be articulated in a way that makes it possible to evaluate effectiveness. Program evaluation should be an integral part of program development and not an afterthought.

- The resource persons available through this workshop should be utilized to train and educate state and local agencies. CASSP/NIMH should provide some funds for such efforts, as well as states themselves.

- Seed money should be made available for technology transfer in the reverse -- namely, funding should be available for minorities to develop training packages based on a holistic model of child services for culturally diverse populations.

- NIMH should provide funding to study new methods for disseminating information to and about minority populations -- such as greater use of films, videotapes and other more visual efforts. This should also include peer-to-peer information sharing.

III. DEVELOPMENT OF NATIONAL FOCUS FOR IMPROVING MENTAL HEALTH SERVICES FOR MINORITY YOUTH AND FAMILIES

In response to the recommendations from the Atlanta the conference, the National Institute of Mental Health (NIMH) CASSP program and the Georgetown University T.A. Center have initiated a number of action steps. In March, 1986 CASSP project directors from 24 CASSP States (See Appendix VII) were given an opportunity to review and discuss these recommendations during their project directors' meeting in Washington, D.C. States were instructed to select one or two areas to pursue during the next year and to include these as clearly delineated objectives in their continuation applications. These objectives were submitted to NIMH during the summer of 1986. They reflect a broad spectrum of interest areas ranging from research on the characteristics and service system contact histories of minority children in out-of-state placement to the development of state-level task forces charged with recommending policy changes to more effectively deliver services in minority communities. These objectives are currently being reviewed by the NIMH, CASSP program and progress will be tracked over the next two years. A list of some of these objectives by state follows on page 24.

In addition, the Georgetown University CASSP T.A. Center has initiated an interactive process with the CASSP states in order to identify the states' needs for technical assistance in pursuing their objectives related to mental health program development for minority children. Technical assistance will be provided by the Georgetown T.A. Center in a variety of ways. Periodic mailings will be sent sharing relevant materials and information. Individual consultation will be provided in an effort to problem-solve and identify helpful providers and trainers. As each CASSP states further develops its projects and expertise, status updates will be shared with other states. In a post-conference communication, Georgetown solicited nominations from all conference participants of individuals who would be interested in and qualified to serve as resources to the states in their work with minority communities. These individuals will be called upon as state technical assistance needs are defined. A list of these providers has been sent to all CASSP states. This listing will be updated and added to as warranted.

Finally, the Georgetown University CASSP Technical Assistance Center together with the NIMH, CASSP program planned, in response to several of the Atlanta conference recommendations, a working group composed of conference participants, recommended professionals and CASSP project directors. This work group focused on: mental health/special education linkages for minority emotionally disturbed children. The first meeting of the group was scheduled for the beginning of March, 1987. Many recommendations generated by the group are pragmatic and will be useful to mental health professionals and/or school systems. The recommendations and strategies impact upon research, policy, service delivery and/or training and will provide a framework for future exploration.

State Initiatives

This is a list of some of the initiatives CASSP states are taking in addressing the special needs of minority populations.

ALABAMA

Minority issues are being addressed through the CASSP Minority Issues Task Force which is an ongoing resource group. They are trying to develop a method to recruit and maintain minority staff and unique methods for attracting minority clients (rural churches, housing project sites)

ALASKA

CASSP has funded a special project called "Ikaiyurluki Mikelnguut," which means "helping our children" in the Yupik Eskimo language. This project is aimed at developing village controlled, integrated services for Yupik Eskimo youth in the Yukon-Kishkokwim Delta region of Alaska. The project has had strong initial success and will be replicated in Southeast Alaska during 1986 and 1987 in Tlingit and Haida Indian villages. CASSP is working with both the CSP and HRD projects to examine further how the special needs of these minority youth can be met.

DELAWARE

Delaware is providing training to minority workers to work with minority youth and their families: professional development for community youth workers. These workers are from a coalition of 5 neighborhood houses serving troubled youth.

They are also providing training and technical assistance to the Latin American Community Center. There is a 98% Puerto Rican population. They are bringing in a Hispanic psychiatrist to conduct case conferences. The results of the case conferences will determine training programs.

GEORGIA

Five private non-profit agencies have been funded by CASSP to develop parent support groups spread among the 8 regions of the state. One to three groups will target minority parents and families. Educational materials for parents of emotionally disturbed children, including minority families will be developed.

HAWAII

Hawaii has developed a series of training modules for multi-system professionals. One of these modules focuses on how to appropriately serve children and adolescents from non-dominant cultures. As part of its focus on Native Hawaiians, CASSP is a member of the Department of Health Hawaiian Programs Advisory Committee. Membership on the statewide core planning group includes representation from the Refugee Assistance Program of the Mental Health Division.

IDAHO

Idaho is in the process of identifying needs of minority SED children and determining the level of services currently delivered. Approaches to improved effectiveness of delivery include utilizing existing Native American and Hispanic groups and service providers. Paid child citizen companions will be used with Native American SED children.

ILLINOIS

Illinois is starting a Spanish speaking parent support group for parents of emotionally disturbed children. They are coordinating with County Health Department, hospitals and churches. They are also planning a conference which will focus on the needs of minority youth.

INDIANA

Indiana has selected 6 counties that have a large minority population to set up residential placement review teams. The effort is just beginning.

IOWA

Iowa is in the process of identifying the needs of its minority constituency. In Des Moines there is a large Asian immigrant population receiving mental health services.

KANSAS

Last year Kansas had a major project which focused on the urban black population. They provided case managers to the Martin Luther King Urban Center which operates a children and youth program. Several important recommendations came about as a result of the experience which Kansas wants to share with other CASSP states.

This year they are in the beginning stages of developing a summer day program for SED minority youth. They will include the community at large in all stages of the project planning.

KENTUCKY

Kentucky is focusing on two populations: Appalachian and Black. They will form a task force to help define needs and plan strategies. CASSP has planned two regional conferences:

January, 1988 - Urban Black
May, 1988 - Appalachian

They want this to dovetail with parent initiative.

LOUISIANA

The state has a large mental health task force that is presently struggling with identifying the special needs of minority SED children. They are now hiring a new staff member for CASSP and are recruiting minority personnel.

MAINE

Maine has two minority populations: Franco-Americans and Native Americans. CASSP is trying to document barriers to service provision.

MISSISSIPPI

CASSP sees the necessity for data collection and an assessment of needs. They have initiated a literature search and are beginning to collect data from census information. Half of Mississippi's population is composed of minorities.

NEBRASKA

Nebraska has a low minority population (less than 2%). They have two initiatives directed at this population: 1) assisting a school district in applying for a grant to improve Hispanic parent participation and 2) identifying a school with a high minority population and working with local mental health centers to consult with the teachers.

NEW JERSEY

CASSP's focus in the demonstration counties has included looking at the delivery system to minority youth. Within this context, CASSP has identified the need to remove systematic barriers and sensitize mental health professionals to the diversity of culture and values of minority youth. Focus will be given to decreasing the more restrictive inpatient units through the development of community-based programs. CASSP will also support the development of parent support groups for SED minority youth and explore specific outreach to Asian-American families who tend not to utilize our service system. The state has an adolescent suicide prevention project and CASSP has been asked to adapt the curriculum to address the needs of urban, minority youth.

NEW YORK

One aspect of New York's focus on minority youth is through its Brooklyn CASSP grant. Plans exist to build a psychiatric hospital in Brooklyn and CASSP wants to plan and develop a system that provides a range of community-based services prior to the construction. Upstate New York will coordinate an interagency collaborative group to focus on the needs of SED children and an issue to be addressed is improved services to minorities.

OHIO

The state has an Interdepartmental State Cluster for Services to Youth which CASSP is a part of. They are conducting a study to examine the characteristics of children and youth in out-of-home care. CASSP will develop a focus on examining the needs of minority groups and assess the availability and utilization of mental health services by minority families.

OKLAHOMA

The state is initiating a Fetal Alcohol Prevention Program which is focused on American Indian youth. This is a collaborative health/mental health project involving the Indian Health Service. They will also be working with the public schools on a suicide prevention program.

PENNSYLVANIA

Pennsylvania has a task force of minority professionals who will advise the Office of Mental Health.

CASSP will provide training and technical assistance to counties to increase sensitivity and skills of professionals in working with minorities. They are in the process of conducting a literature search and refining their focus on minorities.

TENNESSEE

All of the minority efforts in Tennessee are based in Memphis. They have a home-based therapeutic infant intervention program, a day treatment program for 6-12 year olds and they are just starting a parent group.

VERMONT

Vermont has only a 1% minority population so they are not focusing on minority children as a separate issue.

VIRGINIA

They have a task force that is looking at foster care and social services for minority youth. This task force has prepared recommendations for Department of Social Services relating to minority issues.

VIRGIN ISLANDS

Since the majority of the population is composed of Blacks, all of their efforts are directed at this population.

WASHINGTON

This is a new CASSP program and these are the areas that they will focus on: 1) Having the Minority Consortium appoint someone to the CASSP Council; 2) assuring the needs assessment tool is ethnically sensitive; 3) establishing families as allies; 4) recognizing the limited resources of the minority community and 5) recruiting minority or etnnically sensitive personnel.

WEST VIRGINIA

West Virginia is geographically located in the central Appalachian region. This has resulted in a focus on Appalachian families and the effects that Appalachian culture have on accessibility and utilization of mental health services to families and children.

West Virginia and Kentucky are in the process of planning a conference which will address Appalachian issues.

WISCONSIN

CASSP staff have provided consultations and technical assistance to two Indian tribes who were awarded Mental Health Block Grant funds to serve children and adolescents with severe emotional disturbance living on the reservations. One tribe formed an advisory committee to address the mental health needs of the children/adolescents from a broader perspective than the scope of the actual project which focuses on after-school activities for the youngsters, and family support for their parents. The other tribe increased their counseling services to severely emotionally disturbed youth, after entering into a collaborative agreement with the local school district to identify all Indian children in need of mental health services within that school district.

IV. DESCRIPTION OF SELECTED PROGRAMS SERVING MINORITY YOUTH AND FAMILIES

The programs described here responded to a survey developed under the auspices of the CASSP Technical Assistance Center as background for the workshop on "Developing Mental Health Programs for Minority Youth and Their Families". For those wishing further information about a particular program, an address and contact person is provided. THIS SHOULD NOT BE VIEWED AS A COMPLETE COMPILATION OF PROGRAMS SERVING MINORITY YOUTH AND THEIR FAMILIES.

ADA S. McKINLEY INTERVENTION SERVICES
2717 W. 63rd Street
Chicago, Illinois 60629
(312) 434-5577
Contact Person: Marjorie Sullivan

Ada S. McKinley Intervention Services has been in operation for three and one half years. This program offers services for individuals, families, and adolescents. Twenty-four hour crisis intervention services are available as well as parent education, psychiatric evaluation/consultation, psychological testing/ consultation, court advocacy, activity therapy (life skill training), community linkage, after school tutoring, and employment/referral services. The program serves 80 clients annually utilizing a team approach with a client-staff ratio of ten to three (10:3). Youth and their families stay in the program between 12 and 18 months. The program serves youth up to age 18; 63 percent are Black, 28 percent are white, and 9 percent are Hispanic. The major presenting disorders of youth are emotional illnesses, developmental disabilities, delinquency, and family discord.

Ada S. McKinley Intervention Services has adopted a family treatment modality, which is predicated on the basic premise that youth should be placed in a setting most closely approximating the religious, ethnic and cultural background of their natural families. The program is intent on avoiding cultural displacement of their youth and proving that these youth can function successfully in their own communities. Children and adolescents are helped to function in their communities through intensive in-home services that eliminate the need for residential and other restrictive placements. The program has managed to stabilize children and adolescents in their communities and to reverse the trend of youths and their families not having a healthy understanding of the discrepancies of cross-cultural dynamics (i.e., minority vs. dominant culture). These accomplishments have been achieved by: teaching families the impact of traditional society on the family system (e.g., court, public welfare, medical and educational systems); and, helping clients identify and utilize strengths and resources that are available within their cultural setting.

The program's 90 percent success rate is attributable to youth and families actually practicing learned behaviors, the intensive treatment team approach,and the twenty-four hour on-call service of community workers.

Funding for Ada S. McKinley Intervention Services is provided by the Department of Mental Health and the Department of Children and Family Services. Twenty-four FTE staff are employed by the program; 58 percent are minority. Administrators of the program recognize a need for an after school tutoring program and a drop-in recreational program for clients and their families. These programs are currently under development. In addition, plans are currently being formulated to implement a family respite program.

ASIAN COMMUNITY MENTAL HEALTH SERVICES
310 8th Street, Suite 201
Oakland,California 94607
(415) 451-6729
Contact Person: Rodger G. Lum, Ph.D.

The Asian Community Mental Health Services is a comprehensive program serving the entire age range, from young children to the elderly. The program offers outpatient; prevention; developmental disabilities case management and parent education training; refugee business development; sexual assault treatment and prevention; and an expanded children's mental health center. Bilingual and bicultural services are provided to Chinese, Japanese, Korean, Filipino, Vietnamese, Laotian, Mien, Cambodian (Khmer), and to a more limited extent, Afghani, Black and the racially mixed. All of the Vietnamese, Laotian, Mien, Cambodian and Afghani clients are refugees. For the large percentage of Asian children in Alameda County, English is not their primary language -- in fact, 53 percent of those age five to 17 speak a language other than English in the home.

The most prevalent presenting problems for these youth center around adjustment-related disorders. An interrelated phenomenon is the high incidence of conduct disorders among many Asian youth as they attempt to discharge much of the torment and anguish they experience through behaviors unacceptable in the new culture. There are also much depression and anxiety disturbances among refugee youth. Families and parents present a more mixed diagnostic picture. There is a high prevalence of severe psychiatric disturbances; post-traumatic stress disorders and affective disturbances are particularly prominent. The program serves approximately 250 persons annually,with an average stay of eleven months.

The treatment approach is based on sound principles of intervening in minority communities: utilizing staff who are primarily immigrants or refugees themselves (i.e., bilingual and cultural); utilizing community leaders or youth peer leaders as volunteers wherever appropriate; undertaking periodic needs assessments and key informant interviews to keep abreast of changing needs; providing conflict mediation training to youth groups at local high schools; and, providing on-site counseling and guidance in the local schools.

The program has a staff of 14 FTEs, all of whom are minority. Some paraprofessionals are included. The program has been successful in increasing utilization (through community education, outreach, information and referral, training, and client advocacy efforts); increasing parental and family participation in treatment; improving the adaptive functioning of Asian children and adolescents; increasing utilization of sexual assault services; and, promoting community coalitions and interorganizational efforts in addressing interracial conflict between youth. The administrators would like to expand services to include day treatment, more extensive child abuse and child sexual abuse treatment services, and a child drop-in program. Currently, the program receives funding from county Short-Doyle funds; county revenue sharing; United Way; Regional Center of the East Bay; Medi-Cal reimbursements; and, other third party payers.

ASIAN HUMAN SERVICES
4753 N. Broadway, Room 818
Chicago, Illinois 60640
(312) 728-2330
Contact Person: Jennifer Bower or Stanley Luke

Asian Human Services (AHS) provides outpatient, prevention and education programming. The program has been operational for three years. During its period of operation, it has developed five specific services to offer its client population: high school counseling, individual psychotherapy, family therapy, translation services, and crisis intervention. The program serves all Asians in the Chicago area, regardless of national origin. Program staff attend to a wide range of psychopathology such as depression, teenage gang violence, culture conflict, psychosis, post-traumatic stress disorder, family conflict and school dropouts Career or education counseling is also provided. In addition, consultation is provided to hospitals that have Asian youth in their care who are experiencing psychiatric dysfunctioning.

Given the resistance and lack of understanding of psychotherapy by Asian youth, Asian Human Services attempts to espouse a treatment model that emphasizes the cultural conflict experienced by Asians in the U.S. Usually, therefore, clients are educated in order that they might be prepared for therapy.

AHS receives funding from the Illinois Department of Mental Health and the United Way. There are five FTE staff; 90 percent are minority. Most are either mental health counselors or social workers. Consultants are retained for various services and include psychiatrists, psychologists and physicians. The program seeks to inform Asian parents of the services available to encourage greater utilization of their services.

BAY AREA INDOCHINESE MENTAL HEALTH SERVICES
3632 Balboa Street
San Francisco, California 94121
(415) 668-5911/5955
Contact Person: Nguyen-Van Dinh, Program Director
Herbert Wong, Executive Director

Bay Area Indochinese Mental Health Services is an outpatient mental health program serving Asian adolescents. The adolescents served are Cambodian, Laotian, ethnic Chinese from Vietnam, and Vietnamese. The program has been operational for approximately seven years and treats 40 to 50 persons per year. The average youth is seen for three to six months. Problems that are addressed by the mental health center include family conflict; suicide; drug abuse; violence and other criminal activities; and school problems, such as truancy and poor academic performance. The program offers counseling services to youths/families; outreach to school sites for detection/prevention purposes; consultation to teachers and counselors working with these youth; and related services to youth such as referrals to education and employment services.

The Bay Area Indochinese Mental Health Service Center employs 3.5 FTE staff, most of whom are paraprofessionals. The staff are bilingual and bicultural, often refugees themselves, who are trained to work with and impact upon the problems of other refugees who have difficulty adjusting to the new lifestyle facing them in this country. Unfortunately, the program has had little success in meeting the goals established for its client population. Lack of staff time and limited training and experience have prevented the program from meeting the needs of the population being served.

CHILD/ADOLESCENT PSYCHIATRY CLINIC,
L.A. COUNTY/UNIVERSITY OF SOUTHERN CALIFORNIA
Graduate Hall; 1937 Hospital Plaza
Los Angeles, California 90033
(213) 226-5309
Contact Person: William Arroyo, M.D.

The Los Angeles County/University of Southern California Child/Adolescent Psychiatry Clinic is an outpatient mental health program that has been operational for 20 years, and serves 1,500 clients annually. At least 75 percent of the client population is minority, consisting of Asian, Black and Hispanic youths (birth through adolescence), and increasingly, Mexicans and Salvadorans. Presenting problems for the youth served include abuse and all childhood mental disorders; further, youth are often violently victimized and come from families in which poverty, mentally disordered parents and generally chaotic family life patterns prevail. Treatment offered these youth include individual, family, and group therapies; psychotropic medication; behavioral programs (group and family); parent training and consultations.

The clinic has a general philosophy that is considered unique -- it provides culture-sensitive mental health services to clients in their primary languages. The clinic is not able to measure its success rate, but feels the benefits are extensive.

Funding to support the Child/Adolescent Psychiatry Clinic come from the state (Short-Doyle), Medi-Cal and other third party payers. Eleven FTEs are employed by the clinic; six FTEs are minority members. Additional program needs are considered to be improved coordination of mental health services with other human service organizations; more staff; and systematic evaluations of the clinic programs to measure their efficiency and effectiveness.

CHILDREN'S SERVICES TREATMENT PROGRAM
Central Community Health Board
530 Maxwell Avenue
Cincinnati, Ohio 45219
(513) 559-2002
Contact Person: Betti J. Hinton

The Children's Services Treatment Program is a multifaceted program operated by the Central Community Health Board. For eleven years, the program has provided outpatient, adolescent day treatment, prevention and education services; a Summer Enrichment Program has been offered for the past two summers. Inner city Black children and adolescents, birth through 18 are 95 percent of the program's caseload. Major presenting problems center around the home, school and the community. Problems include poor academic achievement, poor social skills, cultural deprivation, depression, adjustment problems and the lack of jobs. Services offered the youth include: counseling; family, group and psychotherapies; behavior modification; psychological and psychiatric evaluations; day treatment; Summer Enrichment Program; outreach, case management and tutoring services; structured recreation; services to the hearing impaired; and consultation and education.

Because many of the youth served by the Children's Services Treatment Program have problems functioning at home, in school and in the community, the program gears its intervention at whichever place and point the service is necessary. The program serves as the stabilizer for youth and as support for the parents, as well as school personnel. The success of the program is apparent from school and home responses about the children. Ninety percent of the adolescents in the day treatment program graduate from high school and several have attended colleges and trade schools. Eighty percent of the youth referred to the program from the state mental hospital have been able to remain at home and in school. There has also been a considerable decrease in the number of youth referred to the state mental hospital from the catchment area. Additionally, many children and adolescents have improved social skills and have thus been freed to receive more from the educational learning process.

The program receives funding from the state, the county, from a levy imposed on mental health services, from Title XX and from Medicaid. The program employs 15 FTE staff, 80 percent of which are minorities. In order to be more successful, the program projects a need for a school setting that employs the existing Children's Services staff. A research staff person is also needed.

CHINATOWN FAMILY CONSULTATION CENTER
Hamilton-Madison House
50 Madison Street
New York, New York 10038
(212) 349-3724
Contact Person: Susan Chan

Hamilton-Madison House is a settlement house serving the poor and immigrants in many ways for over 80 years. In 1980 the Asian-American Mental Health Project was initiated. This is a state-funded multifaceted project which consists of four Asian populations: Chinese, Koreans, Japanese and Filipinos. The goal of the project is to develop and implement a demonstration project for improving mental health services for the Asian-American populations by providing bilingual, bicultural services consistent with the Asian-American culture. The project has three components: 1)a continuing treatment program to serve the chronically mentally ill Chinese population; 2)a case-finding network for the Koreans, Japanese and Filipinos; and 3)a consultation and educational program to educate mental health professionals.

In addition to offering services to adults, the Hamilton-Madison House also operates the Chinatown Family Consultation Center, which was established in 1974. The Center is a state-licensed outpatient clinic that offers prevention and treatment services including psychiatric consultation and evaluation; psychological testing; individual therapy; marital counseling; group and psychopharmacological therapies; community networking; and, education and referral services. The Center has an average annual caseload of 230 persons, with an average treatment period of one year. The client population is 100 percent minority: Chinese, Korean, Japanese,Filipino and Vietnamese. The major presenting problems for the youth served by the Chinatown Family Consultation Center are behavioral, truancy and other school adjustment problems, relationship problems, depression, anxiety disorders, affective disorders and schizophrenia.

The Center has a unique approach to treating clients. First, they employ a psychosocial as opposed to a psychological approach; two, a directive rather than a non-directive approach is used; third, treatment goals and plans are family centered; fourth, an individual approach prevails over a group approach; and finally, the client's cultural and religious values are employed in treatment. Improving functioning levels and behavior changes support the Center's success with the population. Further, funding sources, the community and the agency's internal evaluation speak to the success of the Center.

Funding for the Center is provided by the New York City Department of Mental Health, Mental Retardation and Alcoholism Services, the New York State Office of Mental Health, and private foundations. The Center has a staff of 21 FTEs, 95 percent of whom are minority. The current program needs to be expanded in order to meet the growing needs of Asian-Americans. Due to limited resources, a waiting list is maintained. It is also difficult to maintain a stable staff for the program due to the lack of trained bilingual professionals and the noncompetitive salaries offered by the agency. In order to more fully meet the needs of clients, the program requires more funding for current services, more training opportunities for bilingual workers, and a more responsive mental health system to the needs of Asian-Americans.

CIRCLE OF PAIN
Cahaba Region Mental Health Center
1017 Medical Center Parkway
Selma, Alabama 36701
(205) 875-2100
Contact Person: Dr. David W. Schell

Circle of Pain is an outpatient mental health program established to serve children and youth who are abused and neglected; it functions within the Cahaba Pegion Mental Health Center. The program has been operational for four years and serves youth from birth through age 18. Fifty percent of the client population is minority; Black, indigent and from rural communities. The program serves 125 young persons each year; each client has an average stay of six months in the program. Services offered include individual, group, family and play therapies; multidisciplinary collateral coordination of resources and services; emergency services; and consultation and education with a focus on the needs of minority victims and the development of effective parenting skills. Major presenting problems include all forms of abuse and neglect, major breakdowns of family life, paucity of mental health resources and personnel, and chronic poverty and minority disenfranchisement.

In providing services to the largely Black client group, a minority consultant is employed and performs as a fully qualified child abuse and neglect therapist. That consultant addresses the unique needs of victimized minority children and youth. The program has demonstrated success by noting a drop of reported incidences of abuse from 1,000 in 1982 to 650 in 1984. Following the exhaustion of federal funding for the program, and subsequent staff reductions, incidences of abuse are again approaching the 1982 level.

Funding for the program has been provided by the State Department of Mental Health, United Way, and community contributions. The program now employs 1.6 FTE staff, none of whom are currently minority. Program improvement needs include additional staff, and improved travel accommodations, given the rural nature of the counties in the region.

CUMMINGS-ZUCKER CENTER
123 22nd Street
Toledo, Ohio 43624
(419) 241-6191
Contact Person: Errol Kwait

The Cummings-Zucker Center provides a comprehensive range of services and programs for children and adolescents in the Toledo area. The community-based program focuses on the primary institutions that have an influence on youth and families and schools. The major goals of the program include preventing school failure and promoting healthy families. The Early Intervention Center is a data-based, early intervention service offering parenting education, behavior management training, child development classes and home management training. The program is offered to families with children under six years of age. The Center also has an extended day treatment program, a chemical dependency program and a family teaching home program.

The Center just recently developed neighborhood liaison services to high risk youth in public housing, the majority of whom are Black. The service is an attempt to reduce repeat juvenile offenses and to prevent the occurrence of first-time offenses. Paraprofessionals, living in the neighborhood, are trained to provide in-neighborhood support to families and children. They are trained to establish a daily schedule of structure and activity, create positive recreational experiences and negotiate conflicts between parent and child. The project will provide these services to 50 selected probationers of Juvenile Court seen to be at high risk of repeat offenses as determined by probation counselors and to 25 youth who have been expelled from neighborhood schools.

EARLY INTERVENTION PROGRAM
Geneva B. Scruggs CMHC
295 Corlton Street -- Futures Academy
Buffalo, New York 14204
(716) 856-4940
Contact Person: Cassandra Jakes-Beasley

The Geneva B. Scruggs Early Intervention Program is a prevention/education type of effort. It has been in operation for two years, and has an average annual caseload of 40 students. Children, through age 12, are served and 75 percent of those served are Black. Young people spend approximately 15 weeks in the program. Services provided by the program include individual and group counseling for youth; and, training and skill-building courses for parents, in addition to parent support groups.

The Early Intervention Program focuses on children, who at an early age, have experienced stress, depression, or discomfort that has influenced their self-concept and affected their academic and personal potential. The program provides children "at risk" of developing mental illnesses a necessary foundation for good mental health by helping the youngsters recognize, explore, understand, and cope with the feelings, emotions, and experiences they encounter. Through various therapies, the program enhances self-concepts and teaches children to view themselves as valuable persons deserving respect. The program also provides didactic training and skill-building services, as well as support groups for the parents of the youth enrolled. Through consultations and a series of mental health workshops, the program also provides teachers and other school personnel an avenue to recognize and become more sensitive to the needs of these children and parents.

The Geneva B. Scruggs program receives funding from the State Office of Mental Health. Three FTE staff are employed by the program, 95 percent of which are minority. In order to better serve the target population, the program has need of an additional staff person -- one who would visit the children's homes and assist parents with the treatment, as well as with home and budget management. However, the program has been quite successful. Since January 1984, 108 "at risk" children and 90 families have participated in the program. Of those served, 84 percent have required no further health or special education services.

ECONOMIC OPPORTUNITY FOUNDATION, INC.
1542 Minnesota
Kansas City, Kansas 66102
(913) 371-7800
Contact Person: Rosemary Davis Kelly

The Economic Opportunity Foundation, Inc. serves youth ages six through 21 in Wyandotte County. The average workload is 400 children/youth per year. The client population is largely made up of low income families, basically minority. Services are offered through Educational Assistance and Employment Assistance programs. The Foundation's programs are directed to children and youth to develop their talent and skills, with a special emphasis on life enrichment. The program provides a process for children and youth to learn to compete in the marketplace.

The Foundation operates 13 early childhood centers for low income families; youth services, which include tutorial assistance, career counseling, recreation, financial assistance; housing services; and, employment-related transportation. The Foundation has worked cooperatively with a number of community and state agencies to provide meaningful work and learning experiences for the youth in Wyandotte County.

THE FAMILY CENTER
23 Aspen Place
Passaic, New Jersey 07005
(201) 779-7454
Contact Person: Barbara Eichner

The Family Center is an outpatient mental health program serving Black and Hispanic youth, ages five to 18. The catchment area is predominantly populated by the urban poor: Southern and Northern Blacks; Hispanics (first and second generation) from Puerto Rico, the Dominican Republic and South America (Peru, Ecuador, Colombia). The major problems of the youth and families referred to the Center are child abuse and neglect, poverty, chaotic family systems, learning disabilities and emotional problems. For the last nine years, the Family Center has offered a number of services including home visits, family therapy, individualized therapy, toddlers' groups, mothers' group, advocacy, liaison to community resources, phone contact, clinical evaluations and family visits for children in foster care. The Center serves approximately 70 families per year. Each family is involved in treatment for an average of 18 months.

The Family Center has based its intervention strategy with minority youth around family-oriented and home-based services. Intensive efforts are made to provide services that will actually meet the child's needs in whatever milieu is indicated -- home, school, court, street or foster home. With this intervention strategy, the Center has been rather successful in meeting its goals. In all cases served beyond the initial intake assessment, there has been significant reduction in the incidence of child abuse and neglect. In the infants and toddler group, significant reduction in developmental lags has been noted. Among the school age children and adolescents, there has been more age appropriate behavior, improved social skills and improved school functioning.

The Family Center receives funding from the Social Services and Community Development Block Grants. In addition, the program can receive Medicaid reimbursement. Presently, the Center employs six FTE staff, 50 percent of whom are minority. The Center sees the need for more recreational opportunities, summer and after school programs with recreation.

FATHER FLANAGAN HIGH SCHOOL
2606 Hamilton School
Omaha, Nebraska 68131
(402) 341-1333
Contact Person: Rev. James E. Gilg

The Father Flanagan High School is an alternative program offering prevention, education, and child care services to adolescents. Seventy-five percent of the population are minority -- mostly Black high school age students and their infant children. The program has been operational for 17 years and offers: a quality alternative high school program leading to an accredited diploma; child care for infants of teenage parents and academic classes in parenting for all students; chemical dependency counseling and on-site AA and Alateen meetings; emergency assistance and referral services; and, volunteer legal assistance for those involved with the juvenile justice system. The program serves 300 students a year; most youth spend two to three years in attendance.

Overall, the school offers youth a very personalized supportive atmosphere that breaks through the sense of alienation and hopelessness that their many problems have caused. Such problems include school failure and truancy; teen pregnancy and parenthood; chemical dependency and alcohol abuse; unemployment and lack of career planning; personal and family health problems; and juvenile delinquency. The school has a staff of 32 FTEs, of which 15 FTEs are minority.

Although most people do not view a high school as a primary provider of mental health services, the comprehensive program of Flanagan High offers just such services in a normalized setting that is free of any negative labeling. The on-site social services, within the setting of a regular high school, allows students with specialized problems to receive help and at the same time participate in the kinds of activities that are part of a normal growing up. The high school has been quite successful in meeting the needs of these youth through this approach. The high school receives funding from Father Flanagan's Boys' Home, the U.S. Office of Adolescent Pregnancy Services; contributions from corporations and individuals; per diem expenses for infant day care and small tuition payments from students.

HISPANIC FAMILIES MENTAL HEALTH PROJECT
Children's Aid, East Harlem Center
130 East 101 Street
New York, NY 10029
(212) 348-2343
Contact Person: Linda J. Nessel, MSW

The Hispanic Families Mental Health Project provides prevention and education services to its client population. The project has been in operation for two years and aims to prevent mental illness in vulnerable Hispanic children. The target population is Hispanic families where one parent or child has had a recent psychiatric illness. The project then works with the entire family, including extended families and significant others, to decrease the risk of mental illness in children who have not yet been identified as having serious emotional problems. In addition, many of these families face the problems of living in poverty, compounded by language barriers and immigration status issues. Services offered program clients are home-based, structural family therapy; case management; systems and family advocacy; recreation groups; and referral and networking. The annual caseload is 20 to 22 families; each family remains with the program for approximately two years.

The Hispanic Families Mental Health Project is predicated on the assumption that minority youth can be helped best by a truly comprehensive approach -- looking at both the dynamics of their families and at structural problems in their environment that increase their vulnerability. Therefore, it is necessary to look at the entire system affecting youth,which may well include extended family in another country, or boarders or other non-relatives who are important to the family. This philosophy requires home visits, effective crisis intervention, and staff availability 24 hours per day. Although it is difficult to prove preventive success, the project has prevented family breakdown in several situations and has prevented the institutionalization of youth through case management. In addition, parents are hospitalized less frequently before the interventions.

Funding for the Hispanic Families Mental Health Project has been provided by the New York State Office of Mental Health, New York City Office of Mental Health, and the parent agency, Children's Aid Society. The project employs three and one-half FTE staff; the three direct service staff are minority. Noting the extreme isolation of their families, administrators of the project would like to provide additional social supports. The goal this year is to form groups for clients and identify family members who can begin to take over certain advocacy activities for the families. The project would also like to find additional methods to empower clients and to build on strengths within the family system. Relocating to a community center could help in achieving these goals.

HISPANIC HEALTH AND MENTAL HEALTH ASSOCIATION
425 Broadway Street
Camden, New Jersey 08103
(609) 541-6985
Contact Person: Amilcar Torres, Executive Director

The Hispanic Health and Mental Health Association is an outpatient mental health center. It has been in operation for eight years, serving young people from birth through 18. The average length of time spent in the program is eight to 12 months. The Center offers information and referral services; psychiatric and psychological services; individual, group and family therapy; emergency food and social services; and a youth summer recreation program. The major problems of youth entering the program include: depression,family violence, sexual issues, marital problems, homicide, emotional problems, school problems, psychosomatic problems, suicide and self-mutilation, discipline management, hyperactivity, and financial problems that lead to stress.

The Hispanic Health and Mental Health Association has adopted a unique philosophy for the treatment of their client population -- they have as a minority-serving organization, incorporated the cultural needs of Hispanics within their treatment approach. The program states that it has not been entirely successful in meeting its goals since there is a waiting list for services.

Funding for the Center is provided by the City of Camden; the New Jersey Department of Health; the New Jersey Division of Youth and Family Services; the New Jersey Division of Mental Health and Hospitals; and United Way. Ten FTE staff are employed by the program, all of whom are minority. The Center needs additional funding to expand and better serve those seeking services.

HOGARES, INC.
P.O.Box 6342
Albuquerque, New Mexico 87197
(505) 842-8275
Contact Person: Nancy Jo Archer

'Hogares, Inc. has been in operation for 14 years and offers a range of services to adolescents in New Mexico. The services offered include: outpatient counseling; drug/alcohol residential treatment (14 beds); therapeutic group homes (50 beds); mental health residential treatment (14 beds); community corrections (10 beds); independent living (12 beds); parenting groups; information and referral. Approximately 800 adolescents per year are served -- 38 percent of these adolescents are Hispanic, seven percent are Native American and three percent are Black. The average length of time an adolescent spends in the program is eight months. The program offers services to families and over 80 percent of the families participate in family therapy. The major problems of the youth and families referred are emotional disorders; abuse and neglect; drug and alcohol abuse; and delinquency.

Hogares, Inc. receives funds from many different sources including human services (Title XX), mental health and substance abuse, corrections, United Way, the City of Albuquerque, and Bernalillo County. The program has 75 FTE staff; 30 percent are minority. The program believes that it has been successful in meeting the needs of the adolescents it serves. Follow-up studies indicate a 70 percent success rate using the variables of living arrangements, school/employment and staying out of difficulty with the law. Program staff state that day treatment, therapeutic foster care services and an adequate funding base are the major program improvements needed to better serve the population.

MARTIN LUTHER KING URBAN CENTER, INC.
1418 Garfield Street
Kansas City, Kansas 66104
(913) 321-8042
Contact Person: Rev. Nelson L. Thompson

The Martin Luther King Urban Center provides day treatment and a latch key program to Black youth, ages birth to 18. The client population comes from low income families and includes youth who suffer from neglect, lack of guidance, and lack of educational and economic opportunities. The day treatment program offers skills enrichment, personal enrichment, nutritious meals, transportation, field trips, social activities and youth employment, training and motivation. The program has a Parent Council, composed of family members of youth involved in the program. In operation for 13 years, the program annually serves 70 to 100 clients -- about 20 percent are seriously emotionally disturbed.

In order to assist youth, the program stresses self-development and self-motivation based on cultural appreciation and awareness. The Center has concrete evidence that the approach works, based on the young people who have completed the program and are now working and holding responsible positions in the community. The program employs five FTEs, all of whom are minority. According to the program administrator, the program needs more funding for better facilities, and would like to have a residential facility available. In addition, the program could benefit from better transportation and better qualified staff. The program would like to offer more opportunities for out of town events and other alternative means of education.

THE PAUL ROBESON SCHOOL FOR
GROWTH AND DEVELOPMENT
North Community Mental Health Center
125 Spring Road, N.W.
Washington, D.C. 20010
(202) 576-7154
Contact Person: Paul Worthy

The Paul Robeson School for Growth and Development is a five day a week psychoeducational program for children between the ages of six and 12. Opened in September 1973, the Robeson School now serves 32 students, the majority of whom are Black and Hispanic. From its founding, the Robeson School has been a center for treating children who have been diagnosed as having behavioral-emotional problems and/or learning disabilities. The primary guiding philosophy of the program is to promote the maximal development of the genetic and constitutional potential of each child in spite of all obstacles to that development which may be posed by the surrounding environment. More specifically, the staff works to promote both the child's self-respect, as reflected in his or her behavior and emotional controls, and his or her academic achievement. Parents are included as full participants in the treatment program. The program currently has 17 FTE staff, most of whom are minority.

PRESSLEY RIDGE YOUTH DEVELOPMENT EXTENSION (PRYDE)
Pressley Ridge School
530 Marshall Avenue
Pittsburgh, Pennsylvania 15214
(412) 321-6995
Contact Person: Dr. Pamela Meadowcroft

PRYDE is an institutional alternative for emotionally disturbed youth in need of out-of-home treatment. The program recruits skillful, highly committed couples and professionally trains them to serve as "treatment parents" to a troubled youth placed in their home for short-term treatment or long-term care. The PRYDE professional staff closely supervise treatment parents and the daily implementation of a treatment plan in the PRYDE home. Since 1981, the program has served 150 youth -- 55 percent have been Black. The current population is 72 youth of which 55 percent are Black. Youth between the ages of five and 18 are eligible; each youth spends ten to eleven months in the program.

The youth enrolled in PRYDE have at least one significant behavior problem -- 75 percent are aggressive (toward adults or children); 65 percent have emotional reactions (depression, tantrums); and 57 percent have a high activity level. Many of these youth are in families that abuse their children or have an alcoholic/drug abusing family member. In addition, 90 percent of the families face economic hardships. PRYDE offers the following services: foster placement in home of "treatment parents"; daily treatment implemented by the PRYDE parents; additional intervention strategies; professional supervision of the treatment parents; 24 hour on-call service; psychiatric/psychological assessment; and, educational liaison.

PRYDE is committed to developing a model of youth treatment that is not only more humane, but more effective than residential services. PRYDE had had noteworthy success in recruiting excellent Black families to provide treatment homes to troubled/troubling Black adolescent boys and girls. Of the 90 couples PRYDE has trained and certified, 50 to 60 percent have been Black. Of the 22 professional staff employed by the program, 14 percent are minority.

The program conducts research evaluation and development activities for this effort. To date, 72 to 75 percent of the youth discharged from PRYDE have been successful in returning home or moving to independent living. Through 1984, of the youth successfully discharged, only one had reentered the "system" (i.e., required out-of-home placement). Youth served and their biological families consistently report high levels of satisfaction with program services. The Black community in Pittsburgh also supports the program's efforts. The program administrators would like to increase follow-through services. i.e., services to the youth and his/her natural family <u>after</u> he/she leaves the PRYDE treatment home. Currently, there is no funding for this component and, thus, follow-through is not consistently achieved.

RICHMOND MAXI CENTER OUTPATIENT &
PREVENTIVE SERVICES
3626 Balboa Street
San Francisco, California 94121
(415) 668-5955
Contact Person: Lorena Wong, Acting Director

The Richmond Maxi Center is an outpatient mental health center that provides prevention and education to Asian children, ages birth through adolescence. The program, which has been in existence for ten years, has at least a 75 percent minority client population. The program serves the immediate neighborhood, and while mainly Asian ethnic groups are served (i.e., refugees, Chinese, Korean, Filipino and Japanese), Black and Hispanic children are also served. Annually, 250 unduplicated clients are seen; each child or adolescent remains in the program approximately six to eight months. Services to the youth include evaluations, with psychological assessments in various Asian languages; individual, family and marital therapies; child and adolescent groups; outreach; consultation to schools and other child-serving agencies; and liaison to all public schools in the immediate area. Presenting problems of the youth include the entire spectrum of mental disorders, but most are experiencing academic and behavioral problems of a mild to moderate degree. Refugee children have major difficulties associated with their new location and cultural differences (e.g., psychotic episodes, major depressive episodes, severe antisocial behavior).

The Richmond Maxi Center is unique in that it has a multilingual, multicultural staff who provide culturally-responsive treatment strategies. These treatment strategies include on-site consultation and counseling at schools and other community sites; community organization; and advocacy services to the targeted community.

The Center receives funding from the following sources: Short-Doyle; the Department of Mental Health; Medi-Cal; direct fees; third party reimbursements; and city and county real estate taxes. Fourteen FTE staff are employed; 50 percent of this staff is minority. In order to better serve their client population, the Center feels they need to continue to develop expertise and personnel for serving the newly emerging Asian communities, and must continue to develop models of prevention and treatment that are responsive to the needs of Asian youth.

SCHOOL TRANSITION PROGRAM (Filipino Counseling Services)
712 North School Street
Honolulu, Hawaii 96817
(808) 533-7263
Contact Person: Teresita Aquino and Regina Junasa

The School Transition Program is a prevention/education program for recently-arrived Filipino immigrant adolescents. The program, which has been in operation for one year, provides individual and peer group counseling to these students in the school environment. Group sessions for parent-child communications are also offered, but time constraints have limited outreach to parents. Fifty students are served by the program.

The basic assumption of the program is that mental health problems of immigrant students arise out of their adjustment and assimilation to a new environment, particularly to a new school. Therefore, the School Transition Program is mostly an education program aimed at providing social and emotional support to this high risk group of students. The program employs two part time staff -- a nurse and social worker, with consultative services from a child psychiatrist. Since the program is just beginning, little data are available about its effectiveness.

UNIVERSITY OF NEW MEXICO,
SCHOOL OF MEDICINE
Division of Child and Adolescent Psychiatry
Department of Psychiatry
2400 Tucker Avenue, NE
Albuquerque, New Mexico 87131
(505) 277-4002
Contact Person: Irving N. Berlin, M.D.

The Division of Child and Adolescent Psychiatry provides a comprehensive program for youth of all ages. Approximately 40 percent of the youth served by various programs are minority -- primarily, Hispanic and Native American. The division serves Hispanics without regard to when and how they arrived in New Mexico. It also serves all the Pueblos and reservations in the state, including the Navajo Nation and urban Native Americans. In operation for five years, the division provides: inpatient care for children and youth up to age 20; individual, family and group therapies; pharmacotherapy; adjunctive therapies (primarily in inpatient setting); therapy for children or youth involved in sexual abuse; school consultations; and, parent group therapy. The division has an annual outpatient total of 4,500 visits and an average caseload of five inpatients. The major presenting problems of youth admitted to services are depression and suicide efforts; drug and solvent addiction; alcoholism; acting out behavior; conduct disorders of all kinds; psychoses and other schizophrenic reactions.

The division has adopted a treatment philosophy and intervention strategy that attempts to understand and empathize with different cultures and to spend time learning about the various cultures' concerns and attitudes toward mental health. For instance, the programs work with clergy in urban areas, especially Catholic clergy in Hispanic communities. With Native American youth, program staff visit various reservations and provide community education for juveniles and youth on suicide, drug, alcohol and inhalant abuse. With the Black community staff meet with community leaders around problem issues. In both work with Native Americans and Hispanics, wherever possible, native healers are involved in using their influence to support family therapy. On the Navajo and Hopi reservations, consultation is provided to Native American mental health workers who work with families.

The division has met with only tentative success in its efforts. There has been increased access to native healers, religious leaders and other community leadership. However, there is a need for more mental health professionals and mental health workers able to speak Spanish and some basic Indian languages of nearby pueblos. Of the 150 inpatient staff, 20 percent are minority; only ten percent of 18 FTE outpatient staff are minority. Further, program administrators feel increased outreach is needed -- expanded outpatient capability to work with families in their homes and more community mental health facilities with their own workers and control. The division's programs are currently supported by State funds, city-county tax levies, Medicaid, private insurance, private contracts and client fees.

YANKTON SIOUX TRIBE
Child Welfare Services
Box 248
Marty, South Dakota 57361
(605) 384-3609
Contact Person: Vince Two Eagles

The Yankton Sioux Tribe provides child protection and family services to all Indian children and their families within the boundaries of the reservation. Over the past five years, the program has provided protective services; foster/group care licensure services; family counseling; parent training; intensive placement prevention services; drug and alcohol abuse counseling and referral services; and, family crisis intervention counseling. The major focus of all developed intervention services is to maintain the family unit. All remedies are sought to effect that end before placement in any sort of residential facility is considered. Programs are offered with the recognition that the key to future survival lies within the enhancement of the existing culture while at the same time ensuring that the future generation is well educated in the ways of the dominant culture. The primary issues affecting youth and their families are alcoholism, drug abuse, sexual abuse, child neglect, physical abuse and juveniles out of control. The average caseload is 360 cases annually; the average length of intervention is six months.

The Child Welfare Services program employs social workers, counselors and reality therapists. Preference for employment is given to tribal members and other Indian people. The program depends on the grants from the Bureau of Indian Affairs, Indian Child Welfare and Health and Human Services for funding. A very limited amount of private funding is also available.

Program success is measured by the number of children who have been able to secure permanent living situations either with the extended family, with their primary caregivers or some other alternative. Better than 90 percent of the caseload meet this criteria for success. However, program staff believe that more effective prevention efforts are needed.

YOUTH DEVELOPMENT, INC.
1710 Centro Familiar, S.W.
Albuquerque, New Mexico 87105
(505) 873-1604
Contact Person: Chris Baca

Youth Development, Inc. has been serving the community of Albuquerque since 1971. The program serves youth between the ages of 6 and 21. The majority of youth are low income, Hispanic youth; most are from Mexican-American descent. Youth Development Inc. consists of 14 programs to provide comprehensive services to meet the needs of youth and their families. Much More Residential Treatment Program is offered for those youth whose behavioral, emotional or physical problems cannot be remedied in their own home. A local businessman donated the home. In early 1977, Amistad, a youth crisis and runaway facility, was established. The Institutional Diversion Program provides sentencing alternatives to the courts and correctional institutions for nonviolent and non-habitual juveniles who might normally be institutionalized. Youth Development Inc.'s Concerned Parents Volunteer Program was established to help prevent or reduce the incidence of adolescent premarital sexual activity, including adolescent pregnancy, by organizing and mobilizing groups of volunteer parents and other family members around this critical issue at the local level and by fostering local networks supportive of these groups. Several employment-related programs are available, including Job Development Services, Community Pride-Educational Enhancement, Prep-Entry Employment Experience and the Helping Hands Program. An outreach counseling and after school recreation program are also offered. The Alamosa Community Center, located in a city housing project, provides a structured youth program for those residing in this highly volatile area.

Youth Development Inc. receives funds from many different sources, including the State Department of Corrections and the State Department of Health and Environment. Forty-seven FTE staff are employed, of which 58 percent are minority. The programs offered to youth have been somewhat successful. However, the programs need increased funding and expanded outpatient, follow-up, individual and group/family therapy for discharged clients.

APPENDIX I

Key Note Speech

MINORITY CHILDREN AND MENTAL HEALTH: OLD PERSPECTIVES AND NEW PROPOSALS

Margaret Beále Spencer, Ph.D.[1,2]

Emory University

Workshop presentation sponsored by the National Institutes of Mental Health, "Minority Children and Mental Health," Atlanta, Georgia, January 30, 1986.

[1]The research reported was funded by an NIMH (PHS-1-rol-MH 31106) awarded to the author.

[2]The author is especially grateful to the Project Coordinator, Ms. Dena Swanson, to Dr. Fleta Jackson who served as Project Director during a portion of the second phase, and to the other research assistants. Most of all, sincere gratitude is owed the children and their parents who agreed to participate.

Minority Children and Mental Health: Old Perspectives and New Proposals

Margaret Beale Spencer, Ph.D.

Emory University

Research and theory are expected undergirdings for mental health programs. Unfortunately, the developmental study of minority status children and families remains in its infancy which highlights some inherent inadequacies of mental health programs for them. Research efforts involving African Americans, in particular, suggest specific recurrent themes in the areas of personality and intellectual functioning. These themes and the traditional, i.e., old perspectives concerning minority group membership have significant implications in the assessment of the ideas and thoughts contributed by the minority workshop participant respondents around which this conference has been organized.

In the time available, my presentation will highlight and delineate some of the external and internal factors affecting the mental health of minority youth. The first section offers general interpretations of mental health and adaptational processes. The second section describes the oftimes (sic) short-sighted conclusions drawn from the traditional research on minority group children and families generally and on African American children specifically. And finally, the third section presents empirical, theoretical and demographic statistics which should suggest new proposals for maximizing the mental health of minority status children.

Part I. Conceptualizations of Minority Mental Health and Adaptational Processes

As used by social scientists, the notion of adaptation suggests an adjustment process to novel or new conditions. People of color in North America have experienced a unique legacy of conditions. As such, the survival of the group into the current period implies the use of effective coping mechanisms. However, requiring an explanation is the psychological costs of such coping mechanisms or adjustments to minority child competence formation and mental health.

Historically (see Kellam et al., 1975), an investigator's research focus has generally impacted his/her definitions of mental illness or mental health. As reported in the literature during this century, psychoanalysts developed the dominant concepts of mental health and illness. Later, ego

psychologists dominated our conceptualizations.

When the focus shifted to ego function, the concepts of mental illness shifted to the nature of psychological defenses and their adequacy in dealing or offsetting intrapsychic conflict (see Kellam et all, 1975). More recent analyses by ego psychologists have defined mental health and illness by emphasizing the interaction between the external environment and intrapsychic structures and the impact of this interaction on the growth of personality and the formation of symptoms.

According to some theorists (see Kellam et al., 1975, p. 7) a social adaptational status is a societal judgement of the individual's performance and is therefore external to the individual. The contradistinction to one's social adaptational status, then, is the individual's own feelings on the inside or his psychological well being. According to the literature, these two components--social adaptational status (i.e., the societal judgement) and psychological well-being (i.e., the personal view)--together represent the two major dimensions of mental health. The mental health implications of the individual/environment interface have been further clarified by more recent contributions (see Ogbu, 1983; Garbarino, 1983 & Muga, 1984). John Ogbu's typology aids this process by differentiating minority status. The term caste-like minority is different from either autonomous or immigrant minority status. In castelike stratification (e.g., Native Americans, Afro Americans, Hispanics), people are assigned to their particular groups by birth--i.e., according to skin color. There are few opportunities to escape the derogation associated with the stratification. Children's derogating experiences are often demonstrated by group or cultural identity research findings--these studies of very young children suggest group rejection.

Unlike castelike minorities, immigrant minorities (e.g., Koreans, Vietnamese) usually enter the host society more or less voluntarily. Although initially lacking power and a clear comprehension of the menial value associated with their status, the relevant other for evaluating current experiences is "the homeland." Autonomous minorities (e.g., Jewish Americans, Polish Americans or Mormons), according to the typology do not experience stratification although they may experience some prejudice. Most importantly, their separateness is not based on a degraded, specialized economic or political status. They occupy a minority status by choice; they are ordinarily less identifiable unless they choose to be identified. They also experience a different degree of intrapsychic conflict and associated mental health problems. Obgu's typology suggests a broadened perspective of mental health for historically diverse minority status groups.

Part II. Old Perspectives in Need of Revamping

There are five (5) traditional themes which represent old perspectives inferred from the empirical and theoretical literature available on minority children and family life generally and on African American children specifically.

(1) The interpretation of research findings generally neglect a developmental perspective. Research findings on children are interpreted from an adult psychological perspective.

(2) Too frequently, a careful analysis of the ecosystem is not offered. The buffering role of parental child rearing practices, in particular, is generally inadequately conceptualized.

(3) Ordinarily, all minority status members are assumed to cope with equally devastating environmental experiences. A view which takes into account the unique perceptions and experiences of specific minority status members is seldom considered. That is, homogeneity of perceptions and experiences is generally assumed. Very little is made of the impact of skin tone which further "colors" interpersonal relationships and subsequent intrapsychic conflict.

(4) The interpretations of data are heavily laden with a priori assumptions of psychopathology. This is particularly the case for discussions concerning childrearing. There is generally an inability to acknowledge, support, and in fact, to use family strengths. And finally,

(5) The overall interpretation of empirical data is generally atheoretical. To illustrate, cognitive processing or a cognitive-developmental interpretation of affective data is infrequently employed.

More current research and theoretical contributions have improved formulations or have afforded new proposals for enhancing mental health of minority status children.

Part Three: New Proposals Regarding Minority Children and Mental Health

A cognitive-developmental perspective has greatly aided our interpretation of research. The assumptions made from group identity findings (e.g., beginning with the early "black self rejection" work by Clark & Clark 1939, 1940), would have been interpreted differently if a cognitive-developmental perspective had been used. It would appear that interpreters of the large collection of studies did not understand that very young children (i.e., cognitively egocentered children) processed information differently as a consequence of occupying a different cognitive developmental status than older youth or adults. The so-called "self rejection" findings for very young children actually demonstrated group rejection and had no relevance for personal identity (i.e., self esteem or self concept) which is a critical element of ego processes. Instead, the findings offered important information about the prevalence of negative imagery or stereotypes which abounds in the environment for specific caste-like minority children. African American children and youth are socialized in a Europeanized context. An identity associated with this context--i.e., a pro-white evaluative bias would be expected unless an intervention occurred,i.e., unless there is a compensatory cultural focus which emphasizes the strengths of castelike minority members. Castelike minority group members may have developed cognitive structures which vary from those used by groups whose status reflects "an act of will." Black children, by and large, do not perceive America as an open opportunity structure. As members of a caste-like minority group, they often see that the role for self is not full of possibilities but instead is a locked room.

Native Americans, subgroups of Hispanic Americans and African Americans share several characteristics as unassimilated Americans who have remained outside the mainstream. Not only are they racially different and did not "become" Americans by choice, but each has attempted to maintain aspects of their own cultural heritage. In research conducted by this researcher, findings suggest that young minority status children continue to perceive negative imagery of the group's status. The data were consistent for children living in the Midwest, North and South: personal identity which involve ego processes (i.e., self esteem) and group identity (i.e., knowledge of the group's devalued status) were independent.

As early as 1941, in fact, Frazier noted that all components of the ecosystem were important to the process by which Black children learn to know themselves in relation to opportunities and limitations of their social world. Race and color, in particular, remain unavoidable issues when one considers identity formation. The production of negative images surrounding people of color continues to abound although its origin is seldom explored.

The media has also supported a view that minority children are better cared for by white parents (e.g., the TV programming of Webster and Different Strokes). These issues are important to those mental health professionals who are particularly concerned with policies having to do with the preferential placement of caste-like minority children outside of the tribe and/or race. The parental role is clearly critical for the transmission of culture and the child's identity formation. It is generally accepted that parents and families occupy the most powerful position of influence for each generation. As the agents of socialization, parents can apply human development knowledge to the greatest social and mental health advantage and thereby elevate the quality of life and general competence of its members (see Jordan, 1980). In transmitting the culture through child rearing, parents pass on attitudes, values, ways, and skills which permit the child's development and psychological well being from a state of complete dependency to a more or less independent adulthood status.

From a mental health perspective, parents are most successful in their social roles when they are an accepted and valued part of society (see Comer and Poussaint, 1975). Thus, for the minority parent, the developmental task of successful parenting takes on added stress as a consequence of the group's ascribed societal role. Thus, any support for minority children must be undergirded by parenting support. Since childrearing is risky, uncertain and difficult under the best or most supported of conditions, then the problem is intensified for minority parents.

The Atlanta crisis of the missing and murdered children represents an unusual stressor or a condition of risk and allows for an empirical examination of risk and resilience as an adaptational process. Garbarino (1983) defines risk as the impoverishing of the child's world of the basic social and psychological necessities of life. Institutional practices which unnecesarily or unfairly limit the opportunities of individuals are a threat to development. As indicated by the following quotes, the children of Atlanta experienced a period of acute trauma for a 2 1/2 year period solely as a consequence of their castelike minority status and institutionalized practices which result in vulnerability and risk. The following quotes are

from children who were attending one of the schools where the NIMH sponsored research to be reported was conducted. Many of the study's children lived in areas where bodies were found and weekend searches conducted.

> I wasn't scared for myself. I just feel kinda sorry for all them little children that was killed. I wasn't scared 'cause when I be outside I be with a lot of people. When the people start going in the house, I go in the house.
>
> I be scared to go to sleep by myself. I be scared 'cause I didn't have nothing with me...like a gun.
>
> My mamma was so nervous she burned everything she cooked... I ain't had no decent supper until that Wayne Williams case got off. She'd go in there to cook and the news would come on and the next thing you know the frying pan was burning.

The NIMH funded research findings to be reported demonstrate alternative perceptions of ego processes and developmental variations in African American children and youth as affected by parental cultural value transmission.

Procedures

Multiple measures were obtained for nearly 400 black male and female children between the ages of 3- and 9- years in 1978-79. Towards the end of the acute period of the Atlanta crisis (1981-82), 150 of the original children were relocated, tested and interviewed; parents were also interviewed and completed the Achenbach and Edelbrock Child Behavior Checklist (CBCL). These were parental ratings of their children's (stress assumed) clinical symptoms. Parents in four (4) distant cities, Philadelphia, Chicago, Nashville and Washington, D.C., also completed the checklist for their own children.

MAJOR FINDINGS

PRECRISIS PHASE

(1) The data supported two earlier studies completed in two different regions by this author which demonstrated that preschool children children show a positive evaluation of the color white, have more positive attitudes concerning white persons and show a greater preference for white persons as friends.

(2) These early cultural values and attitudes are not related to young children's personal esteem or ego developmental processes. However, this is not the case for older subjects who have moved into the primary grades and more mature levels of cognitive processing.

Primary grade pupils who perform best on intellectual or competence related tasks are children who show both positive personal regard and have an Afrocentered or own cultural group bias. That is, thinking highly of one's castelike minority group is related to improved performance on competence related measures. Mental health is promoted and less conflict is apparent when cultural heritage is stressed. Parents appear critical in this process.

(3) Only 1/3 (or 36%) of the sample parents interviewed during the precrisis phase indicated that racism and discrimination were issues in the rearing of black children. Thirty-three percent (33%) noted that there was no discussion of race unless the child asked specific questions. In fact, 50% noted that teaching children about race is unimportant; 47% indicated no discussion of civil rights.

Given that the conditions and very survival of black males, in particular, have worsened in school and in the family system, (i.e., an unusually high black male school drop-out rate and a high young adult black male suicide rate), the findings suggest that black youth are not prepared for unchanging institutionalized caste-related practices. The findings also indicated child rearing links with children's competence.

(4) For all youth, pro-white or Eurocentric values were significantly predicted (46% of variance) by three parental values: (a) a lack of parental teaching concerning civil rights, (b) children's inadequate knowledge about civil rights, and (c) a lack of parent/child discussion of race discrimination. The child's cultural beliefs or degree of group acceptance before the crisis were significantly related to the children's expression of competence following the acute phase of the crisis.

(5) Children who expressed positive regard for the group at Time 1 (i.e., showed a more Afrocentric orientation) before the crisis performed significantly better on the competence related tasks at Time 2 or after the crisis. For the older black males, an own group orientation before the crisis was related to greater feelings of internal control.

(6) Children, independent of age group, who demonstrated greater cultural identification at Time 1, showed significantly fewer clinical symptoms at Time 2.

(7) Children from families with fewer economic resources (i.e., lower socioeconomic status or SES), manifested more clinical symptoms.

POST CRISIS FINDINGS

(8) Since the city's black male youth appeared most at risk during the crisis, in addition to testing, each of the 78 adolescents were also interviewed. The responses indicated a critical role of identity for the expression of more general psychological well-being. When assessed on a measure of locus of control, older youths indicated a greater sense of being internally controlled. The pattern was the same for middle income males. However, lower income and younger youths indicated greater external controls.

(9) A general trend for adolescent males suggested active defenses against perceptions of "the self" as vulnerable. To illustrate, 91% of the adolescents sampled noted that being black does not affect life chances although 58% were unable to list any advantages in being black (45/78). The issue of empowerment is important generally but has special salience for young black males who are proposing solutions to life course issues. These same youths are also consciously aware of the unemployment rates and

opportunity structure. It has been widely shared that by the year 2,000 the unemployment figure for black males is estimated to be 70%!

(10) Consistent with the Time 1 or Precrisis parental interview data, 55% of the youth at Time 2 noted that there is no discussion of race with parents. Explanations for race discrimination, in fact, were most often mentioned as the type of information needed from parents.

(11) Although males were the primary victims of kidnap and murder, all males reported a male identity preference. Only one child (of 78) noted a preference to change race (1%). At what cost to mental health are these adaptations made? To maintain a male gender preference, perhaps short-term ego supporting devices are employed. Given the black teen pregnancy rate and the black on black homicide rate, some of the short-term ego-saving methods appear obvious. Of course such solutions only result in concretizing certain negative prophesies for the group.

(12) Relatedly, when asked to identify the male who was most important, all youth identified a black male. Names most often listed were: father (75%), brother (10%), and grandfather (4%). Most important about this finding is that the black father, although often unable to perform his instrumental role (which is not surprising given the group's unemployment rate) is still well regarded by his son who, it would appear, understands the father's "predicament" in North America during the current century and--given demographic statistics, the son's identification, and the unemployment projections--appears destined to follow suit.

(13) Almost 60% of the adolescents believed that "the law" would have acted differently if the youths killed had been white; 56% noted their belief that the crisis was not over although the suspect had been arrested; importantly, relative to an ongoing state of stress, 96% believed that the killings could happen again.

POST CRISIS: CITY VS. NON-CITY COMPARISONS

As noted, parents of the sample in Atlanta along with parents of similarly aged children in four other cities (Philadelphia, Chicago, Nashville, Washington, D.C.), completed the CBCL rating form which asked about the presence or absence of 118 clinical symptoms.

The quotations above which were made by Atlanta children living in communities where victims were found suggest an unusual stressor. However, there was no main effect for the city vs. non-city comparisons on the composite score for manifested symptoms. That is, Atlanta children did not show significantly more symptoms than did children living in distant cities. However, SES differences were apparent.

(14) Lower-income children showed significantly more clinical symptoms than middle income children independent of city of residence. The findings of significant relationships between social class, educational attainment for parents and the manifestation of clinical symptoms have implications for the oft reported demographic characteristics of Afro-American. The statistics which list the disproportionately high adult black male and youth

unemployment rates appear linked with the current proportions and projections of female headed households. A man's potential to become a spouse and an effective, constructive paternal role model are significantly reduced if employment opportunities, male role modeling, or supportive adult socialization practices are not adequate. A less than viable or stable family system undermines the protective or supportive functions expected of the family for the positive ego functioning and mental health of its members.

PART IV. Discussion and New Proposals

In summary, precrisis and postcrisis findings indicate that the environmental experiences of castelike minority children and adolescents still promote biased perceptions of castelike minority status. Environmental conditions which primarily present favorable connotations of whites still exist 40 years following the initial empirical findings in 1939 by Mamie and Kenneth Clark. The data suggest that parents who confront the issues more directly and promote more positive group imagery, in fact, reared children with improved ego functioning, greater behavioral competence and greater perceived locus of control. Children from lower-income families obtained self esteem scores and locus of control findings which suggested greater vulnerability than those of MI black youth. The discrepancy suggests that castelike minority status LI children must cope simultaneously with the consequences of caste and class, most often, without significant parental input while continuing to confront biased, institutionalized beliefs concerning their reference group. Without parental or other intervention, the older children's and adolescents' more mature cognitive structures make the implications for "self" exceedingly clear.

To conclude, the role of parental child rearing strategies along with external sources for inculcating positive values concerning cultural group membership was significantly related to children's competent performance --especially with increasing age. These data imply that with more mature cognitive processing, castelike minority youth are able to process: (1) the environmental constraints more effectively, and (2) the perceptions of racism and its undermining effects on the self. It would appear that coping is promoted by parental inculcation of positive cultural images and direct teaching. The parental defensive style--which was to ignore cultural heritage issues and to assume successful assimilation--may well be adaptive for themselves in the short run, but obviously is not positive for their children's development and more general ego functioning in the long run.

References

Clark, K.B. and Clark, M.P. (1939). The development of consciousness of self and the emergence of racial identity in Negro children. Journal of Social Psychology, 10, 591-599.

Clark, K.B. and Clark, M.P. (1940). Skin color as a factor in racial identification of Negro preschool children. Journal of Social Psychology, SPSS Bulletin, 11, 156-169.

Comer, J. and Poussaint, A. (1975). Black Child Care, N.Y.: Simon and Schuster.

Frazier, E.F. (1941). Negro Youth at the Crossroads. Washington, D.C.: American Council on Education.

Garbarino, J. (1983). Children and Families in the Social Environment, N.Y.: Aldine Press.

Jordan, D. (1980). Development universals and their implications for parent competence. In M. Fantini and R. Cardenas (Eds.), Parenting in a Multicultural Society, N. Y.: Longman.

Kellam, S. G., Branch, J.D., Agrawal, K.C. & Ensminger, M.E. (1975). Mental Health and Going to Schools, Chicago: University of Chicago Press.

Muga, D. (1984). Academic sub-cultural theory and the problematic of ethnicity: A tentative critique. Journal of Ethnic Studies, 12 (1), 1-51.

Ogbu, J. (1983, October). Crossing cultural boundaries: A comparative perspective on minority education. In Race, Class, Socialization and the Life Cycle-Symposium in honor of Allison Davis, John Dewey Distinguished Service Professor Emeritus, University of Chicago.

APPENDIX II

WORKSHOP PLANNING COMMITTEE

Workshop Coordinator: Mareasa R. Isaacs, Ph.D.

Workshop Planning Committee

- Barbara J. Bazron, Ph.D.
- Freida Cheung, Ph. D.
- Lemuel Clark, M.D.
- Lillian Comas-Diaz, Ph. D.
- Michael Fishman, M.D.
- Judith Jacobs, Ph.D.
- Ellen Kagen
- Judith Katz-Leavy
- Ira Lourie, M.D.
- Damien McShane, Ph.D.
- Phyllis Magrab, Ph.D.
- Dana Mattison
- Sherman Ragland
- Arturo Rangel
- Jeanne Spurlock, M.D.
- Herbert Z. Wong, Ph.D.

Workshop Staff:
Gail Saunders
Lisa Myers

APPENDIX III

RESPONDENTS TO QUESTIONS

Martha Bernal, Ph.D.
Department of Psychology
University of Denver
Denver, Colorado

H. Westley Clark, M.D., J.D., M.P.H.
Department of Psychiatry
Veterans Administration Medical Center
San Francisco, California

Terry Cross, M.S.W.
National Indian Child Welfare Institute
Portland State University
Portland, Oregon

Melvin Delgado, Ph.D.
School of Social Work
Boston University
Boston, Massachusetts

Jandyra M. Fontenelle-Velazques
The Children's Village
Dobbs Ferry, New York

Ton He Koh, Ph.D.
Bureau of Child Study
Chicago Board of Education
Chicago, Illinois

Esther Leung, Ph.D.
Department of Special Education
Eastern Kentucky University
Richmond, Kentucky

Damien McShane, Ph.D.
Department of Psychology
Utah State University
Logan,Utah

Frederick B. Phillips, Psy.D.
Progressive Life Center
Washington, D.C.

Karen Taylor-Crawford, M.D.
Community Mental Health Center, Inc.
Chicago, Illinois

Jocelyn Yap
Asian/Pacific Treatment Center
Los Angeles, California

Herbert Z. Wong, Ph.D.
Richmond Area Multi-Service Community Mental Health Center
3626 Balboa Street
San Francisco, California

APPENDIX IV

MAJOR AREAS AND KEY ISSUES TO BE ADDRESSED
(FROM PLANNING MEETING)

1. External Factors (Stresses) Affecting Minority Children and Adolescents

   A. Impact of racism: implications for psychosocial interventions; self-concept and efficacy; self-validation; implications of racism in educational system (early write-off of minority youth).

   B. Impact of mass media: how minorities are portrayed.

   C. Strain of acculturation: Asians, Latin Americans and other bicultural/multicultural groups; effects of migration.

   D. Legal constraints and strategies for circumvention: issues on reservations or with refugees and "illegal aliens."

   E. Influence of socioeconomic status: differences of social class; impact of poverty.

   F. Influence of established minority communities versus support systems for newer immigrants.

   G. Perception of mental health system as "alien" and not meeting needs of minority populations.

   H. Rural/urban differences and impact on services and treatment, as well as regional differences.

   I. Can mental health practices in the country of origin be helpful in developing strategies in this country for those populations?

2. Internal Factors Impacting on Minority Youth

   A. Impact of racism: self-concept; development of failure that becomes self-fulfilling prophecies (self-efficacy).

   B. Physical health problems (more among minority youth?).

   C. Lack of knowledge about services available and how to access them.

   D. Cultural attitudes and preconceptions about mental health that determine outlook and utilization of services, especially reluctance and resistance among Black families and Southeast Asians.

   E. Family structure: single-parents, teenage mothers, immigrant and migrant status, domestic violence and abuse; also families that work and families that don't work -- what makes them different?

   F. Informal or natural support systems (however, must not strengthen or rely on at expense of competent treatment programs).

G. Changing lifestyles in minority communities and impact of intergenerational differences (especially important for Asian and Hispanic populations).

3. Treatment and Outreach

A. Assessment of minority children -- are there any tools, techniques or parameters that can enhance assessment efforts? How to identify important factors and undertake total environmental assessments?

B. Defining and understanding specific cultural aspects of treatment modalities -- what works and what doesn't work?

C. How to take assessment data and develop realistic and appropriate treatment plans and interventions?

D. Importance of outreach: helping family members cope; outreach across child-serving systems.

E. Given limited resources, where should treatment efforts be focused: prevention, preschool, adolescence, supporting parents and parent education,etc.?

F. Identification of effective treatment modalities.

4. Education and Training

A. Development of programs and curricula to sensitize professionals in the treatment of minority populations.

B. Development of incentives for the training of minority professionals -- should they be expected to treat minority populations? Do they enhance treatment effectiveness? Once trained, do they differ substantially from other professionals?

C. Training of families around advocacy and gaining access to system; education of parents and community about what services are available.

D. Training and utilization of paraprofessionals and natural support networks.

5. System Structure and Community Linkages

A. Linkages with physical health facilities, schools, courts, child welfare agencies, etc., especially with educational agencies -- how to develop and integrate.

B. Linkages and utilization of indigenous healers and cultural institutions.

C. Structure of existing mental health system that exacerbates problems of minority youth -- access issues: when/where minority youth enter system.

D. How to avoid two-tiered systems of care (i.e. separate minority programs vs. integrated programs and also the issue of public sector/private sector domains)?

E. Initial contact with minority youth -- why and how they are "routed" into system streams -- i.e. disproportionate representation in juvenile justice system; special educational programs; more restrictive mental health facilities.

F. Comprehensive one-stop multiservice approach vs. multiple settings/programs.

G. Identification of community leadership and legislative advocacy activities.

H. Identification of system incentives/disincentives to provide services to minority populations.

6. Program Development

A. Focus on existing programs that illustrate specific principles and issues for delivery of services -- how they developed.

B. Program components: overcoming obstacles/barriers; financing; staffing; services offered; evaluation, etc.

C. Circumstances that make states/local communities begin to focus on minority populations -- is it large percentages of minorities, charismatic leadership, crisis situations, legislation, special grants, advocacy by professional groups, elected politicians, etc.?

APPENDIX V

WORKSHOP PARTICIPANTS

William Arroyo, Ph.D.
Clinical Assistant Professor
L.A. County/University of
Southern California
Graduate Hall
Los Angeles, California 90033
(213) 226-5308

Jo Anne E. Barr
Assistant Director
Indian Health Board of
Minneapolis, Inc.
1315 E. 24th Street
Minneapolis, Minnesota 55404
(612) 721-7425

Barbara J. Bazron, Ph.D.
Executive Director
PACE School
200 South Beatty Street
Pittsburgh, Pennsylvania 15221
(412) 441-1111

Irving N. Berlin, M.D.
Director, Division of Child &
Adolescent Psychiatry and
Children's Psychiatric Hospital
University of New Mexico
School of Medicine
Department of Psychiatry
2400 Tucker Avenue, N.E.
Albuquerque, New Mexico 87131
(505) 277-4002

Martha Bernall, Ph.D.
Professor of Psychology
Department of Psychology
University of Denver
Denver, Colorado 80208
(303) 871-3306

Evelina W. Bestman, Ph.D.
Executive Director
New Horizons Community Mental
Health Center, Inc.
1469 N.W. 36th Street
Miami, Florida 33142
(305) 635-0366

Nancy A. Boxill, Ph.D.
Atlanta University School of
Social Work
223 James P. Brawley Dr., S.W.
Atlanta, Georgia 30314-4391
(404) 681-0251 ext.292, 302

Samuel Q. Chan, Ph.D.
Director of Training in Psychology
& Program Director of the Multi-
Cultural Training of Trainers
University Affiliated Program
Children's Hospital of Los Angeles
P. O. Box 54700
Los Angeles, California 90054
(213) 660-2300

Susan Chan
Assistant Executive Director for
Mental Health Programs
Hamilton-Madison House
50 Madison Street
New York, New York 10038
(212) 964-9240

Freida Cheung, Ph.D.
Deputy Chief
Center for Studies of Minority
Group Mental Health
Division of Special Mental Health
Programs
National Institute of Mental Health
5600 Fishers Lane, Room 18-101
Rockville, Maryland 20857
(301) 443-3724

H. Westley Clark, M.D., J.D., MPH
Psychiatry Fellow
Department of Psychiatry, 116E
V.A. Medical Center
4150 Clement Street
San Francisco, California 94121
(415) 221-4810 ext. 3085

Lemuel Clark, M.D.
Associate Director
Division of Education and Service System Liaison
Room 11-C-18, Parklawn Drive
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-1760

Dale Cochran
Youth Services
P. O. Box C
Warm Springs, Oregon 97761
(503) 553-1161 ext. 209

Pamela Colorado, Ph.D., Four Worlds Project, University of Lethbridge
4401 University Drive
Lethbridge, Alberta, CANADA 6T1K31274
(403) 329-2435

Lillian Comas-Diaz, Ph.D.
Administrative Officer
American Psychological Association
1200 17th Street, N.W.
Washington, D.C. 20036
(202) 955-7764

Giuseppe Costantino, Ph.D.
Clinical Director
Sunset Park Mental Health Center Of Lutheran Medical Center
514 49th Street
Brooklyn, New York 11220
(718) 854-1851

Pamela Coughlin, Ph.D.
Administration for Children, Youth and Families
Head Start Bureau
400 6th Street, S.W.
Washington, D.C. 20201
(202) 755-7782

Terry L. Cross
Director
Northwest Indian Child Welfare Institute
c/o Regional Research Institute
P. O. Box 751
Portland State University
Portland, Oregon 97207
(503) 229-3038

Jane L. Delgado, Ph.D.
National Executive Director
National Coalition of Hispanic Mental Health & Human Services Organizations
1030 15th Street, N.W., Suite 1053
Washington, D.C. 20005
(202) 371-2100

Charles F. Desmond
Vice Chancellor for Student Affairs
University of Massachusetts-Boston
Harbor Campus
Boston, Massachusetts 02125
(617) 929-7700

Aaron Favors, Ph.D.
Division of Maternal & Child Health
5600 Fishers Lane, Room 7A-23
Rockville, Maryland 20857
(301) 443-2350

Michael Fishman, Ph.D.
Associate Director
Office of Policy Analysis and Coordination
Room 17-C-17, Parklawn Building
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-5480

Michelangelo Florence
Clinical Therapist
Community Mental Health Council
1001 E. 87th Street
Chicago, Illinois 60619
(312) 734-4033

Jandyra M. Fontenelle-Velazquez
Coordinator, Family Center
Echo Hills
Dobbs Ferry, New York 10522
(914) 693-0600 ext. 317

John Gates, Ph.D.
Director
Division of Mental Health & Mental Retardation
878 Peachtree Street
Atlanta, Georgia 30309-3999
(404) 894-6300

Charlotte Goodluck, M.S.W.
Child Welfare Specialist
3825 Montgomery, N.E. #105
Albuquerque, New Mexico 87109
(505) 884-7596

Bernadette Gray-Little, Ph.D.
Professor, Director of Clinical Psychology
Davie Hall
University of North Carolina
Chapel Hill, North Carolina 27314
(919) 962-5035

Maureen Hart, Ph.D.
Director of Research Evaluation & Training
Community Mental Health Center
Meharry Medical College
1005 D.B. Todd Boulevard
Nashville, Tennessee 37208
(615) 327-6255

Aminufu Harvey, D.S.W.
Chief Executive Officer
Maat Institute for Human and Organizational Enhancement
1914 9th Street, N.W.
Washington, D.C. 20001
(202) 265-0296

Betty Hinton
Director, Children's Services
Central Community Health Board of Hamilton County, Inc.
530 Maxwell Avenue
Cincinnati, Ohio 45219
(513) 559-2002

Janice Hutchinson, M.D.
Senior Scientist
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-4523

Mareasa R. Isaacs, Ph.D.
Associate Commissioner for Children and Youth
Office of Mental Health
44 Holland Avenue
Albany, New York 12229
(518) 474-8394

Crystal Jackson
Tehnical Assistant
Department of Mental Health/ Mental Retardation
P. O. Box 3710
Montgomery, Alabama 36193
(205) 271-9258

Judith Katz-Leavy
Deputy Director, CASSP
Division of Education & Service System Liaison
Room 7-C-14, Parklawn Building
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-3667

Roxane Kaufmann
Georgetown Child Development Center
Marcus J. Bles Bldg., CG-52
3800 Reservoir Road, N.W.
Washington, D.C. 20007
(202) 625-6745

Paul T. Kayye, M.D.
Director
Division of Mental Health/Mental Retardation & Substance Abuse Services
Department of Human Resources
325 No. Salisbury Street
Raleigh, North Carolina 27611
(919) 733-7011

Evelyn Lee
Assistant Clinical Professor & Program Chief
Department Psychiatry
San Francisco General Hospital
1001 Potrero Avenue, 7G22
San Francisco, California 94110
(415) 821-5065

Esther Kau-To-Leung, Ph.D.
Associate Professor, Special Education
Department of Special Education
Wallace 245
Kentucky University
Richmond, Kentucky 40475
(606) 622-1868

May Kwan Lorenzo
Acting Director, Mental Health/
Social Services
South Cove Community Health Center
885 Washington Street
Boston, Massachusetts 02146
(617) 482-7555

Ira Lourie, M.D.
Director, CASSP Program
Division of Education & Service
System Liaison
Room 11-C-14, Parklawn Building
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-3667

Percilla Lynch
PRYDE Program Supervisor
Pressley Ridge
530 Marshall Avenue
Pittsburgh, Pennsylvania 15214
(412) 321-6995

Damian McShane, Ph.D.
Associate Professor
Department of Psychology
Utah State University
Logan, Utah 84322-2810
(801) 750-1251

Phyllis R. Magrab, Ph.D.
Director, CASSP Technical Assistance
Center and Georgetown Child
Development Center
Marcus J. Bles Building, CG-52
3800 Reservoir Road, N.W.
Washington, D.C. 20007
(202) 625-7033

Dana Mattison
Chief, Office of Children's and
Educational Services
Department of Mental Health
30 East Broad Street, Suite 2475
Columbus, Ohio 43215
(614) 466-9961

Pamela Meadowcroft, Ph.D.
Director, Pressley Ridge Youth
Development Extension (PRYDE)
530 Marshall Avenue
Pittsburgh, Pennsylvania 15214
(412) 321-6995

Judith Meyers, Ph.D.
Assistant Professor of Psychology
University of New Hampshire
130 Horton Social Science Center
Durham, New Hampshire 03824
(603) 862-2342

Pam Miller
Counselor for Project Hope
Youth Development, Inc.
1710 Centro Familian, S.W.
Albuquerque, New Mexico 87105
(505) 877-0371

Barbara Minton, Ph.D.
Mental Health Education
Coordinator
Department of Mental Health
Pouch H-04
Juneau, Alaska 99811
(907) 465-3370

Linda J. Nessel
Project Director
Hispanic Families Mental
Health Project
East Harlem Center, Children's Aid
Society
130 E. 101st Street
New York, New York 10029
(212) 349-2343

George Osakoda
Instructor
Leeward Community College
2825 Daw Street
Honolulu, Hawaii 96817
(808) 455-0360

Delores L. Parron, Ph.D.
Associate Director for Special
Populations
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2847

Frederick B. Phillips, Psy.D.
President/Director
Progressive Life Center
1123 Eleventh Street, N.W.
Washington, D.C. 20001
(202) 842-4570

Sheila A. Pires
Child/Youth Services Coordinator
D.C. Mental Health System
Reorganization Office
1825 Connecticut Avenue, N.W.
Suite 411
Washington, D.C. 20009
(202) 673-7773

Bonnie Politz
Special Assistant to the Commissioner
of Social Services
Randall Building
1st and Eye Street, S.W.
Washington, D.C. 20024
(202) 727-5930

Maxine N. Robbins
Director, Social Services/
Mental Health
Indian Health Service
Yakima Indian Nation
Route 1, Box 1104
Toppenish, Washington 98948
(509) 865-2101

Audrey Rowe
Commissioner
Commission on Social Services
Randall Building
1st and Eye Street, S.W.
Washington, D.C. 20024
(202) 727-5930

William H. Sack, Ph.D.
Director of Child Psychiatry
Oregon Health Sciences University
3181 S. W. Sam Jackson Park Road
Portland, Oregon 97201
(503) 225-8615

Sharon W. Shaw
Director, Special Services
Tennessee Division of Alcohol &
Drug Abuse
J. K. Polk Building, 4th Floor
505 Dederick Street
Nashville, Tennessee 37219
(615) 741-3862

Sheila Smith, Ph.D.
Research Fellow
Bush Program in Child Development
and Social Policy
3415 Mason Hall
University of Michigan
Ann Arbor, Michigan 48109-1027
(313) 763-3717

Margaret Spencer, Ph.D.
Associate Professor of Developmental
and Educational Psychology
Division of Educational Studies
Fishburne Building #201
Emory University
Atlanta, Georgia 30322

Jeanne Spurlock, M.D.
Deputy Medical Director
American Psychiatric Association
1400 K Street, N.W.
Washington, D.C. 20005
(202) 682-6093

James Stockdill
Director, Division of Education &
Service System Liaison
Room 11-C-26, Paklawn Building
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-3606

Alma Y. Takata
Coordinator, Service Support Section
Mental Health Division
Department of Health
45-710 Keaahala Road
Kancohe, Hawaii 96744
(808) 235-6489

Leonard Tate
Consultant
Georgia Division of Mental Health/
Mental Retardation
Department of Human Services
878 Peachtree Street
Atlanta, Georgia 30309-3999
(404) 984-6554

Karen Taylor-Crawford, M.D.
Associate Director of Family
Systems Program
Community Mental Health Council, Inc.
1001 E. 87th Street
Chicago, Illinois 60619
(312) 734-4033

Jewelle Taylor-Gibbs, Ph.D.
Acting Associate Professor
School of Social Welfare
University of California at Berkeley
Berkeley, California 9472-
(415) 643-6662

Charlotte Thompson
Social Service Consultant
Child & Adolescent Mental Health
Division of Mental Health/
Mental Retardation
878 Peachtree Street, Room 315
Atlanta, Georgia 30309-3999
(404) 894-6561

Rev. Nelson Thompson
Director
Martin Luther King Urban Center, Inc.
1418 Garfield Street
Kansas City, Kansas 66104
(913) 321-8042

Judith Tolmach, M.S.W.
Executive Director
City Lights
7 New York Avenue, N.E.
Washington, D.C. 20002
(202) 682-0818

Mary T. Tripp
CASSP Project Coordinator
Bureau of Children's Services
New Jersey Division of Mental Health
CN 700
Trenton, New Jersey 08625
(609) 987-2005

Mr. Vince Two Eagles
Yankton Sioux Tribe's Child
Welfare Services
P. O. Box 248
Marty, South Dakota
(605) 384-3609

John VanDenBerg
Administrator, Child and Adolescent
Mental Health Services
506 North State Office Building
Topeka, Kansas 66612
(913) 296-3774

Herbert Z. Wong, Ph.D.
Executive Director and President
Richmond Area Multi-Services (RAMs)
& Asian American Psych. Assn.
3626 Balboa Street
San Francisco, California 94121
(415) 668-5955

Harry H. Wright, M.D.
Assistant Professor
William S. Hall Psychiatric Inst.
University of South Carolina
P. O. Box 202
Columbia, South Carolina 29202
(803) 758-5007

Joselyn G. Yap
Director, Child & Youth Division
Asian/Pacific Counseling &
Treatment Center
3407 W. Sixth Street, Suite 510
Los Angeles, California 90020
(213) 974-7386/382-7311

City Lights
7 New York Avenue, N.E.
Washington, D.C. 20002
(202) 682-0818

APPENDIX VI

AGENDA

MENTAL HEALTH PROGRAM
DEVELOPMENT FOR MINORITY
YOUTH AND THEIR FAMILIES

A Workshop Sponsored by the
CASSP Technical Assistance Center
Georgetown Child Development Center

Westin Peachtree Plaza
Peachtree at International Plaza
Atlanta, Georgia

January 30, 1986 - February 1, 1986

WEDNESDAY, JANUARY 29, 1986

		ROOM
6:30 p.m. - 9:00 p.m	Workshop Reception	Spanish Room

(An opportunity to informally meet other participants)

THURSDAY, JANUARY 30, 1986

(All general sessions in Peachtree Park and Place)

8:30 a.m. - 9:00 a.m. Registration

(Continental Breakfast will be available)

9:00 a.m. - 9:30 a.m. Welcoming Remarks and Introductions

- James Stockdill, Director
  Division of Education & Service System Liaison
  National Institute of Mental Health

- John Gates, Ph.D.
  Director, Division of Mental Health and Mental Retardation
  Georgia Department of Human Resources

- Paul Kayye, M.D.
  Director, Division of Mental Health/ Mental Retardation & Substance Abuse Services
  North Carolina Department of Human Resources

9:30 a.m. - 10:00 a.m. Overview of Workshop

The CASSP Program

- Ira Lourie, M.D.
  Director, CASSP Program
  National Institute of Mental Health

Workshop Objectives

- Mareasa R. Isaacs, Ph.D.
  Associate Commissioner for Children and Youth
  N. Y. State Office of Mental Health

10:00 a.m. - 11:00 a.m. — Presentation: Minority, Children and Mental Health--"Old" Perspectives and "New" Proposals

- Margaret Spencer, Ph.D.
  Associate Professor of Developmental and Educational Psychology
  Division of Educational Studies
  Emory University

11:00 a.m. - 11:15 — Break

11:00 a.m.- 12:30 p.m. — Panel Discussion: Cultural and Social Factors Affecting Mental Health Services to Minority Youth

Moderator: Lillian Comas-Diaz, Ph.D.
Administrative Officer
American Psychological Association

Panel Members:

- Damien McShane, Ph.D.
  Associate Professor
  Department of Psychology
  Utah State University

- Martha Bernal, Ph.D.
  Department of Psychology
  University of Denver

- Evelyn Lee, Ph.D.
  Assistant Clinical Professor & Program Chief
  Department of Psychiatry
  San Francisco General Hospital

12:30 p.m. - 1:30 p.m. — Lunch — Southern Cafe

1:30 p.m. - 3:15 p.m. — Panel Discussion: Conceptual Frameworks for Developing Programs for Minority Youth

Moderator: Mareasa R. Isaacs, Ph.D.

Panel Members:

- o Jandyra M. Fontenelle-Velazquez
  Coordinator, Family Center
  The Children's Village

- o Frederick B. Phillips, Psy.D.
  Director and President
  Progressive Life Center

- o Pamela Colorado, Ph.D.
  Four Worlds Project
  University of Lethbridge

3:15 p.m. - 3:30 p.m. Break

3:30 p.m. - 5:30 p.m. Panel Discussion: Improving Access to Mental Health Services: Interfaces with other Systems

Moderator and Respondent:
- o Jeanne Spurlock, M.D.
  Deputy Medical Director
  American Psychiatric Association

Panel Members:

Education - Esther Leung, Ph.D.
Associate Professor
Department of Special Education
Eastern Kentucky University

Social Services - Audrey Rowe
Commissioner of Social Services
Washington, D.C.

Substance Abuse - H. Westley Clark, M.D., J.D., M.P.H.
Psychiatry Fellow
San Francisco V.A. Medical Center

Juvenile Justice - Charlotte Goodluck
Child Welfare Specialist
Albuquerque, N.M.

6:00 p.m. - 8:00 p.m. Social Hour — The Flag Room

Dinner (on own)

FRIDAY, JANUARY 31, 1986

8:00 a.m. - 8:30 a.m. Continental Breakfast — Georgian/Spanish Room

8:30 a.m. - 10:30 a.m. Concurrent Sessions

A) Assessment of Minority Youth: Issues and Techniques — Tower Suite 14

Moderator: Damian McShane, Ph.D.

Discussants:

- Giuseppe Costantino, Ph.D.
  Clinical Director
  Sunset Park Mental Health Center
  of Lutheran Medical Center
- William H. Sack, M.D.
  Director of Child Psychiatry
  Oregon Health Science University
- Joselyn G. Yap
  Director, Child & Youth Division
  Asian/Pacific Counseling & Treatment
  Center

B) Training Staff to Work with Minority Youth and Families — Tower Suite 13

Moderator: Harry H. Wright, M.D.
Assistant Professor
William S. Hall
Psychiatric Institute

Discussants:

- Evelina W. Bestman, Ph.D.
  Executive Director
  New Horizons CMHC, Inc.
- Herbert Z. Wong, Ph.D.
  Executive Director
  Richmond Area Multi-Services, Inc.
- Terry Cross
  Director
  Northwest Indian Child Welfare
  Institute

C) Strengthening and Empowering Minority Families

Tower Suite 16

Moderator: Mary T. Tripp
CASSP Project Coordinator
New Jersey Division of Mental Health

Discussants:

- Jewelle Taylor-Gibbs, Ph.D.
  Acting Associate Professor
  School of Social Welfare
  University of California at Berkeley

- Linda J. Nessel
  Project Director
  Hispanic Families Mental Health Project
  Children's Aid, East Harlem Center

- Maxine N. Robbins
  Director, Social Services/Mental Health
  IHS-Yakima Indian Tribe

D) Developing Efective Models of Delivering Services to Minority Populations

Tower Suite 17

Moderator: Jane L. Delgado, Ph.D.
National Coalition of Hispanic Mental Health and Human Services Organizations

Discussants:

- Irving N. Berlin, M.D.
  Director, Division of Child & Adolescent Psychiatry & Children's Psychiatric Hospital
  University of New Mexico, School of Medicine

- Evelyn Lee
  Assistant Clinical Professor and Program Chief
  Department of Psychiatry
  San Francisco General Hospital

- Karen Taylor-Crawford, M.D.
  Associate Director of Family Systems Program
  Community Mental Health Council, Inc.

10:30 a.m. - 10:45 a.m.	Break	
10:45 a.m. - 12:15 noon	Program Sessions: Learning About Existing Programs	Georgian/Spanish Room; Tower Suites 13,14, 16 17
	(During this time period, each workshop participant will have the opportunity to talk with three program representatives concerning their programs for minority children and youth. It is anticipated that twelve to 14 programs will participate in this session).	
12:15 noon - 1:30 p.m.	Lunch	French Room
1:30 p.m. -2:30 p.m.	Lessons Learned from Existing Programs	Georgian/Spanish Room
	Discussion Leader: Barbara J. Bazron, Ph.D Executive Director PACE School	
2:30 p.m. - 2:45 p.m.	Instructions to Small Groups	
	o Mareasa R. Isaacs, Ph.D.	
2:45 p.m. - 3:15 p.m.	Break	
3:15 p.m. - 5:30 p.m.	Small Work Groups	
A)	Defining Principles for Access to Services and Assessment of Minority Youth	Tower Suite 13
	Facilitator: Dana Mattison Chief, Office of Children's and Educational Services Ohio Department of Mental Health Recorder: Judy Katz-Leavy	
B)	Professional Training and Utilization of Indigenous "Therapists"	Tower Suite 14
	Facilitator: Lemuel Clark, M.D. Associate Director Division of Education & Service System Liaison National Institute of Mental Health	
	Recorder: Lillian Comas-Diaz, Ph.D.	

C) Key Research and Policy Issues — Tower Suite 16

Facilitator: Judy Meyers, Ph.D.
Assistant Professor of Psychology
University of New Hampshire
Recorder: Roxane Kaufmann

D) Strategies for Developing Resources for Minority Communities — Georgian/Spanish Room

Facilitator: Mareasa R. Isaacs, Ph.D.
Recorder: Sheila Pires

E) Strengthening Family Involvement and Community Education — Tower Suite 17

Facilitator: Aminufu Harvey, D.S.W.
Progressive Life Center
Recorder: Barbara J. Bazron, Ph.D.

6:00 p.m. - 7:30 p.m. Social Hour — The Flag Room

Dinner (on own)

SATURDAY, FEBRUARY 1, 1986

(All sessions in the Georgian/Spanish Room)

8:30 a.m. - 9:00 a.m. Continental Breakfast

9:00 a.m. - 10:15 a.m. Report Back and Recommendations from Small Groups

Moderator: Mareasa R. Isaacs, Ph.D

10:15 a.m. - 10:30 a.m. Break

10:30 a.m. - 12:00 noon Formulation of Work Plan and Strategies for Implementation

Facilitator: Phyllis R. Magrab, Ph.D.
Director, CASSP Technical Assistance Center
Georgetown Child Development Center

12:00 noon - 12:30 p.m. Responses from Federal Staff

Moderator: Lemuel Clark, M.D.
Associate Director
Division of Education
Service System Liaison
National Institute of
Mental Health

- Delores Parron, Ph.D.
  Associate Director for Special Populations
  National Institute of Mental Health

- Michael Fishman, M.D.
  Associate Director, Office of
  Policy Analysis and Coordination
  National Institute of Mental Health

- Ira Lourie, M.D.

12:30 p.m. Adjournment

APPENDIX VII

List of State CASSP Projects

Alabama

Charles Day, M.S.
CASSP Coordinator
Department of Mental Health/Mental Retardation
P. O. Box 3710
200 Interstate Park
Montgomery, AL 36193
(205) 271-9261

Alaska

John Van Den Berg, M.A.
Child and Adolescent Mental Health Coordinator
Division of Mental Health/Developmental Disabilities
Box H-04
Juneau, AK 99811
(907) 465-3370

Delaware

Jeanne Dunn
CASSP Coordinator
Department of Services for Children, Youth,
and Their Families
Division of Child Mental Health
First State Executive Plaza
330 East 30th Street, 4th Floor
Wilmington, DE 19802
(302) 571-2651

District of Columbia

Sheila A. Pires
Child, Youth Services Coordinator
DC Mental Health System Reorganization Office
1875 Connecticut Avenue, N.W., Suite 1130
Washington, D.C. 20009
(202) 673-7773

Georgia

Lucy W. Bigham
CASSP Project Director
Dept. of Mental Health/Mental Retardation
878 Peachtree Street, Suite 315
Atlanta, GA 30309
(404) 894-6563

Steven Tanner
Project Director
Southeast Regional Troubled Childrens Committee (SERTCC,Inc.)
516 Drayton Street, 4th Floor
Savannah, GA 31401
(912) 234-0130

Hawaii

Richard Behenna, M.P.H.
CASSP Coordinator
Department of Health
3627 Kilaueau Avenue, Suite 101
Honolulu, HI 96816
(808) 735-5242

Idaho

Jody Lubrecht, Ph.D.
CASSP Project Manager
Department of Health and Welfare
Division of Community Rehabilitation
Bureau of Mental Health
450 West State Street
Boise, ID 83720
(208) 334-5531

Illinois

Kenley Wade
Director, Office of Children and Adolescents
Department of Mental Health and Developmental Disabilities
Institute for Juvenile Research
907 South Wolcott Avenue
Chicago, IL 60612
(312) 413-1893

Donna Simonson
Children and Family Services
1 North Old State Capitol Plaza
Springfield, Illinois 62706
(217) 785-2561

Indiana

Jim Killen, A.C.S.W.
CASSP Coordinator
Indiana Department of Mental Health
117 East Washington Street
Indianapolis, IN 46202
(317) 232-7834

Iowa

Jim Chesnik
CASSP Project Coordinator
Division of Mental Health/Mental Retardation/
Developmental Disabilities
Iowa Department of Human Services
Hoover State Office Building, State Capitol Complex
Des Moines, Iowa 50319
(515) 281-8908

Kansas

Acting Director
Mental Health and Retardation Services
Department of Social and Rehabilitation Services
State Office Building, 5th Floor
Topeka, KS 66612
(913) 296-3472

Carolyn Hill
Representative, Wichita Coalition, CASSP Project
Department of Social and Rehabilitative Services
P. O. Box 1620
Witchita, KS 67212
(316) 261-8436

Kentucky

William Scott, M.S.W.
CASSP Director
Department of Mental Health/Mental Retardation
Division of Mental Health
275 East Main Street
Frankfurt, KY 40621
(502) 564-7610

Barbara Thomas
CASSP--Children's Program Specialist
Division of Mental Health
275 East Main Street
Frankfurt, KY 40621
(502) 564-7610

Louisiana

Ronald F. Boudreaux, Ph.D.
CASSP Project Director
Office of Mental Health
P. O. Box 4049
Baton Rouge, LA 70812
(504) 342-2534

Jo M. Pine
CASSP Project Coordinator
Mental Health Association in Louisiana
P. O. Box 4049
Baton Rouge, LA 70821
(504) 342-2540

Maine

Rachel Olney, Ph.D.
Director CASSP
Department of Mental Health & Mental Retardation
State House Station #40
Augusta, ME 04333
(207) 289-4251

James Harrod
CASSP Project Coordinator
Department of Mental Health & Mental Retardation
State House Station #40
Augusta, ME 04333
(207) 289-4251

Mississippi

Tumutual Edwards
CASSP Project Director
Department of Mental Health
1500 Woolfolk Building
Jackson, Mississippi 39201
(601) 359-1568

Lucy Leslie,Ph.D.
Director, Division of Children and Youth Services
Department of Mental Health
1101 Robert E. Lee Building
Jackson, MS 39201
(601) 359-1568

Nebraska

Jose Soto, J.D.
CASSP Manager
Department of Public Institutions
Office of Community Mental Health
Box 94728
Lincoln, NE 68509-4728
(402) 471-2851, ext. 5293

New Jersey

Mary Tripp, M.A.
CASSP Project Director
Division of Mental Health and Hospitals
Bureau of Children's Services
13 Roszel Road
Princeton, NJ 08540
(609) 987-2005

Joyce Wale
Acting CASSP Project Coordinator
Division of Mental Health and Hospitals
13 Roszel Road
Princeton, NJ 08540
(609) 987-2005

New York

Mary Armstrong, M.S.W.
CASSP Program Manager
Office of Mental Health
44 Holland Avenue
Albany, NY 12229
(518) 474-8394

Maxwell Manning, M.S.W.
Brooklyn Children and Family Services Network
Department of Mental Health/Mental Retardation
Alcoholic Substances
16 Court Street, Suite 610
Brooklyn, New York 11241
(718) 643-7741

Ohio

Susan Ignelzi, Ph.D.
CASSP Director
Ohio Department of Mental Health
30 East Broad Street, Suite 2475
Columbus, OH 43215
(614) 466-9961

Oklahoma

Rock Richardson
Director CASSP
Department of Mental Health Programs Division
P. O. Box 53277, Capitol Station
4545 North Lincoln Boulevard
Oklahoma City, OK 73152
(405) 521-0044 or (405) 364-9004

Pennsylvania

Connie Dellmuth, M.S.W.
Director, Bureau of Children &
Youth Services
Office of Mental Health
Health and Welfare Building, Room 309
Harrisburg, PA 17120
(717) 783-8335

Lenora N. Stern
CASSP Coordinator
Office of Mental Health
Department of Public Welfare
Room 309, Health and Welfare Building
Harrisburg, PA 17120
(717) 783-8335

Tennessee

Duane Doidge
Director, Office of Children &
Adolescent Services
CASSP Director
Division of Mental Health Services
505 Deaderick Street
Nashville, TN 37219
(615) 741-3708

Vermont

John Pierce
Director
Planning & Program Development
Division of Mental Health Programs
103 South Main Street
Waterbury, VT 05676
(802) 241-2609

Gary De Carolis
CASSP Coordinator
Department of Mental Health
103 South Main Street
Waterbury, VT 05676
(802) 241-2609

Virginia

Janet Lung, L.C.S.W.
Director, CASSP
Department of Mental Health/Mental Retardation
Office of Mental Health Services
P. O. Box 1797
Richmond, VA 23214
(804) 786-2994

Gary Macbeth, M.S.W., M.Ed.
Director of Children and Adolescent Mental Health Services
Department of Mental Health/Mental Retardation
P. O. Box 1797
Richmond, VA 23214
(804) 786-2991

Virgin Islands

Corrine Allen, Ph.D.
Director
Division of Mental Health/Alcohol and Drug Dependency
Department of Health
6,7 Estate Diamond Ruby
Christiansted, St. Croix, VI 00820
(809) 773-1992

Washington

Richard Westgard
Director
Child and Adolescent Service Program Administrator
Mental Health Division
Department of Socialand Health Services
Mail Stop OB-42F
Olympia, WA 98504
(206) 586-3775

West Virginia

Susan Mann
CASSP Coordinator
West Virginia Division of Health
Office of Behavioral Health Services
1800 Washington Street, East, Rm. 451
Charleston, WV 25305
(304) 348-0627

Wisconsin

Dagmar Plenk
Project Associate -- CASSP Coordinator
Office of Mental Health
1 West Wilson Street, Room 433
P. O. Box 7851
Madison, WI 53707
(608) 267-2255