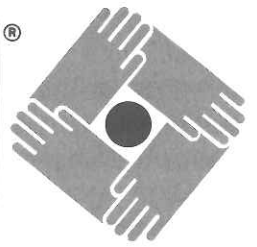# FOCAL POINT ®

DEVELOPING
# CULTURALLY COMPETENT ORGANIZATIONS

There is an increasing awareness of the role culture plays in the delivery of health and human services (10, 30, 32). One recent response in the area of children's mental health, has been the emergence of the Child and Adolescent Service System Program's (CASSP's) cultural competence model. This concept emerged as a response to the goal of providing culturally-appropriate services to children with mental, emotional or behavioral disorders and their families (18). The emergence of the cultural competence construct recognizes: (a) the increasing cultural and racial diversity of consumer populations (28); (b) the role culture plays in help-seeking behaviors (10, 23, 25); (c) the differential service utilization rates of various cultural and racial groups (8, 22, 31); (d) diverse perspectives on the origins or etiology of behaviors, emotions or thoughts that the dominant culture describes as mental health problems (14, 32) and, (e) culturally relevant services may differ from services that ignore cultural differences (9, 27, 29, 34).

Identifying the Target Population

One important concern involves the target of the agency's interventions. It is of little use to identify an agency's target population as the minority community.

The word "minority" has been so bandied about in recent years that it has lost some meaning. Is the reference to members of the *cultural groups of color*—African Americans? Asian Americans/Pacific Islanders? Native Americans? Hispanic- or Latino-Americans? Alternatively, Atkinson and Hackett (1) use the term *non-ethnic cultural groups* to refer to other minority populations such as lesbians and gays, elders, women, people with disabilities, religious minorities, and others.
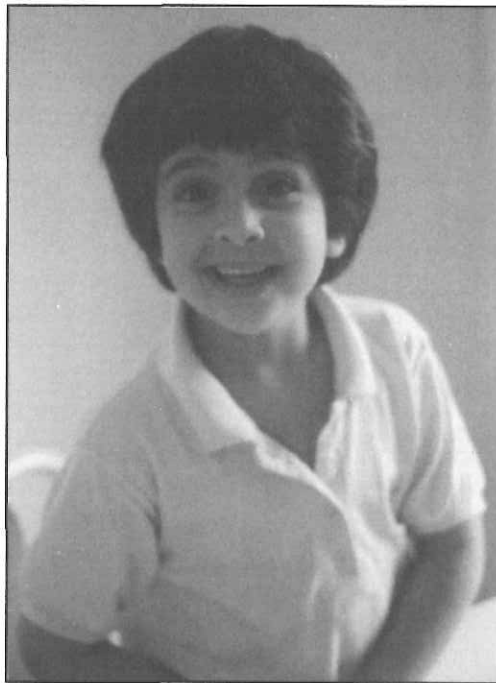
While cultural groups of color and non-ethnic cultural groups share some common ground, the distinctions between the two in terms of respective vulnerabilities is little understood. However, what is critical is that systems and organizations should specify who is the target of a given multicultural or minority initiative. Mixing the two groups may result in an initiative that serves neither well and ultimately deflates the concern for cultural diversity. In any event, differences *between* and *within* cultural groups of color and non-ethnic cultural groups must be considered.

For example, ethnic groups of color have historically been at the bottom of the economic, social, and political order. They are represented in disproportionate numbers among the poor, the uneducated, the unemployed, the sick, and the homeless (14). The U.S. President's Commission

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on Mental Health observed that children and youth of color were particularly at risk because of low socioeconomic status, residence in stressful environments, and lack of access to mental health services. Arguably, these conditions have not abated, and these children and youth are still vulnerable by virtue of their ethnicity, poverty, and social isolation (6). Other factors worthy of both consideration and assessment include educational attainment, teenage pregnancy, suicide, substance abuse, and out-of-home placements including psychiatric and juvenile detention facilities.

It is projected that children of color will approximate 30% of the nation's youth by the year 2000 (28) which heralds many challenges. However, one must endeavor to find good information as to how to serve these populations.

The motivation or value base to modify systems must also be developed. Ozawa (26) suggests the populations create an imperative that requires service system modification from the middle-class service orientation; Hodgkinson (15) ties the rationale for the changes to the professional's self-interest; and Cross, et al. (4) enumerate a list of systemic values that support such system changes.

Children and youth who are non-ethnic minorities *with* disabilities, *or* lesbian and gay, *or* poor, *or* female, of the dominant culture have different sets of issues to deal with than their peers who—respectively—do not have disabilities, are heterosexual, or are middle class, however, they *may* still derive the benefits of being "white" (12). Therefore, agency staff must attempt to discern how a given group is vulnerable in American society. By taking a broad brush approach, agency efforts to improve services to culturally diverse groups (whether groups of color or non-ethnic groups) can be bogged down. Certainly some agency

efforts will involve coalitions around overlapping issues, and culturally-specific approaches for problems facing a specific group.

As mentioned above, it is also important to pay attention to within-group diversity (27, 28, 32). The typical terms used to describe the four groups of color reveal very little in terms of important characteristics such as income, education, cultural identity, national origin, or social history. Agencies must avoid the propensity to re-stereotype the various groups based on new information that may reflect only upon a subset of a given group—for example—working class but not middle class Hispanics, urban and not reservation Native Americans, or refugee and not immigrant Asians. While the distinctions appear minor, they can be quite significant when providing services, advocating on behalf of a given client, and in promoting systemic changes.

James L. Mason (right) with John VanDenBerg.

On an ongoing basis it is important for agencies to stay abreast of changing demographics (28), ecological perspectives of problems and solutions (14), and the corresponding quality of life indicators (e.g., infant mortality, educational attainment, employment rates) by each cultural group. This is particularly relevant where agencies pursue community education, program development, or class advocacy efforts. When agencies and systems advocate on behalf of a given community for the necessary changes that will empower diverse communities they must pay attention to the environmental or psychosocial stressors that befall specific groups (17).

For example, the provision of mental health treatment is made difficult when children and their families are hungry, cold, besieged by urban crime, or are poorly portrayed in media accounts (6). Over-representation of children and youth of color in more restrictive settings is an issue (4, 18, 19). These circumstances highlight potential areas where agencies can play a viable role in community empowerment. Such efforts should be conducted in a spirit of collaboration and not well-intentioned yet inadvertent paternalism. A key goal is to develop leadership and self-determination as opposed to community dependence on external voices and leaders.

The Importance of Developing a Value Base

It is critical for the members of any given agency or system to know *why* they are embarking on the path towards cultural competence. The decision to move in this direction should not be solely a response to political correctness, or a marketing ploy to enhance utilization, or to comply with the requirements of an accrediting or funding body. The decision to proceed in this direction should be a collaborative effort—involving group-specific natural helpers and leaders, parents and family members, and advocates—to empower children, youth, families, and communities of color. Moreover, staff must recognize culture as a force in how problems are defined, including attribution of cause (10, 32), help-seeking (9, 23), how credible providers and services are defined (25, 34), and even how services are evaluated (29).
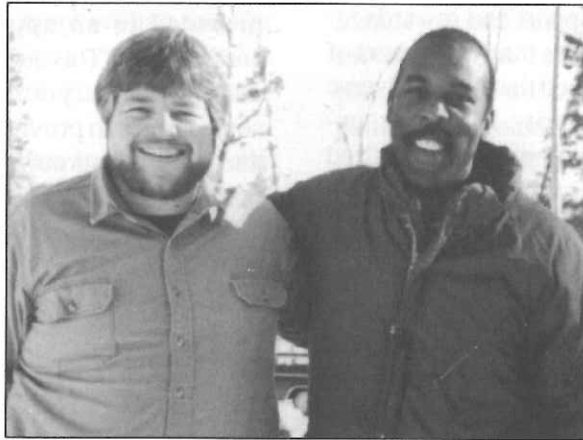
As a beginning step, Woody (33) outlines the following self-assessment questions concerned with developing a rationale for cultural competence:

1. What is the organization's responsibility in meeting the service needs of minorities? This area of self-study is the organizational foundation that moves an organization towards cultural competence. It is here that the respective target groups are identified. Additional discussions will establish for agency staff why it is focusing on cultural diversity and will simultaneously send a message to the community. It is at this phase that mission or goal statements and hiring or outreach policies may be revised. Similarly, the organization's advocacy strategies may shift. It is also an appropriate time to involve, or at least update, board members, volunteers, and program advocates.

To build such a framework, agency personnel (including board members and volunteers) may need to be made aware of: cultural differences as they concern changing demographics and demographic differentials between majority and non-majority cultures (28); culturally-specific perspectives of illness and health (10); culturally-specific program characteristics and components (17); and research concerning service delivery to culturally diverse communities (25, 29, 34).

2. How can the presence of minority and majority workers who are skilled in providing services to minority populations help an organization accomplish its mission? The benefits of culturally competent staff and agencies should be delineated in terms of their impact upon clients, professionals, the diverse communities and the community-at-large. This question invites sharing among staff in the form of brown bag discussions, sharing of

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continued from page 3

cross-cultural insights, and generally using the often over-looked *human* resources of a given agency or system. Bear in mind that cultural competence is a developmental process based upon the belief that all individuals can make progress with proper instruction, support and rewards.

Further, this area is very sensitive as many members of the dominant community are convinced that hiring diverse staff threatens their employment security. Moreover, existing staff may view new staff as less competent and hired to fill a quota requirement (7, 33). Win-win scenarios must

be developed and widely disseminated. While workers' apprehension about being displaced must be addressed—from an organizational change perspective—administrators, staff, and others must see the mutual benefits that can be derived from a diverse work force and a work environment conducive to diversity.

3. How might services necessarily be different when provided in an appropriate context to the minority community? This question recognizes that different groups may have slightly different needs. It may be appropriate for some groups to provide services in satellite offices (25, 34) and, for other groups, services may be provided in other languages (10). It may be necessary with some groups to

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CULTURAL COMPETENCE SELF-ASSESSMENT QUESTIONNAIRE

Minority Cultural Initiative Project staff at the Portland Research and Training Center developed the Cultural Competence Self-Assessment Questionnaire (CCSAQ) to assess cross-cultural training in human service agencies. The goal is to help social and human services agencies continue movement toward the positive end of the cultural competence continuum. A great deal of information has been learned since this document was first mentioned (*Focal Point*, Summer 1988, 2(4), p. 6) and, as a result, this tool has undergone several significant changes.

The tool involves an agency-based process of identifying training needs and, based on these needs, developing site-specific training or other interventions that enhance cultural competence. The CCSAQ also contains a sheet to collect demographic data on a given work force. Once this information is collected and aggregated, agencies often discover hidden cross-cultural attributes or experiences of their staff. For example, agencies might take advantage of this in-house resource to learn more about diverse languages, communication styles, belief systems, religions and other cultural information.

The CCSAQ was designed for programs that serve children and youth who have serious emotional disabilities. The questionnaire has been field-tested at various levels and among different service disciplines in widely diverse sites across the country. Various sites have used the tool including: a western state mental health division management team, a mid-western state multi-service agency (containing mental health and child welfare programs), a county juvenile justice system in a western state, an eastern region child and adolescent mental health system, a southern state mental health bureaucracy, and a county mental health system in a northeast-

ern state. In all instances, however, the assessment goal was to improve services to ethnic groups of color and other culturally diverse populations. The CCSAQ has also proven useful in workshops and consultation meetings in various states including: California, New York, North Carolina, Oregon, Pennsylvania and Washington.

Preliminary assessment of the CCSAQ's psychometric properties has been very encouraging; the instrument will continue to be refined. Given the great demand for the CCSAQ from various systems, it will be published this fall complete with guidelines outlining its use. The tool allows an agency to measure its growth over time. Thus, by comparing pre- and post-measures, an agency can view how it has grown and in which areas continued growth is still needed. This is particularly important because achieving cultural competence involves a developmental process designed around the belief that given proper instruction, support, and motivation, agencies and professionals can change.

There are two versions of the questionnaire: one version for administrative personnel and the other version for direct service staff. Project staff have field-tested a version for consumers and family members and one for non-paid staff (e.g., board members, volunteers, advocates). While the initial responses are encouraging, these latter tools will not be published until further testing of psychometric properties is completed.

For additional information on the questionnaire contact: James L. Mason, A.B.D., Project Manager, Multicultural Initiative Project, Research and Training Center on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, Oregon 97207-0751; (503) 725-4040.

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work to overcome a history of distrust (32); while others may require class- or system-advocacy efforts (6, 19).

Generally, this is an opportune time to involve knowledgeable members of the various communities who can assist in developing a rationale for identifying group-specific needs and prospective interventions (16, 17). Once enlisted in the initial phases of activity, it is likely that these local key informants may be more willing to offer their support to the process. This is also a critical period to involve parents and family members who are often the most under-utilized resource (2).

4. What is the vision of services to the minority community? This is an opportunity to design system or organizational refinements. It is particularly important to involve members of the diverse communities in creating the vision. This is the key opportunity to both envision the system as it should be and to identify ways of funding such a system. Moreover, by involving natural helpers and leaders, parents and family members, key informants, and others, community-based supports and resources may be brought to bear. This may also yield greater support for the program in various ways such as: assisting with staff and board recruitment, encouraging in-kind donations, identifying advocacy resources, and promoting parent or community education and support groups.

This is a time to consider the concept of "culture" quite broadly. Accordingly, the planning group should have as members representatives of the targeted groups. Cultural diversity within a given group should be strongly considered. For example, it is hard for one member of any group to represent the wide range of beliefs, practices, and customs within that group. Empowering members of a specific cultural group to help envision or otherwise design system improvements should result in greater relevance of services and service delivery approaches. Thus, if the target population are groups of color, they may be a majority of the planning body. To use existing personnel with a few minorities sprinkled in may hint at tokenism. Similarly, simply identifying people of color may not be a guarantee that they represent or are aware of the cogent cultural issues. Hence, selecting cultural key informants for this process is a time-consuming yet critical step. Certainly parents, family members, and consumers need to be involved.

Attention to group processes such as problem-solving, decision-making, and conflict management is critical during this phase (35). A good group can be decimated by internal differences that remain unaddressed or by friction with other work groups that is ignored. Work with groups is often difficult. While diversity is a strength, untended, it can be a strain. Anti-bias and subsequently cultural competence training may be a primary activity that facilitates positive interaction among group members as well as ensures that interaction with other groups is respectful in nature.

5. How can one know if the goal of serving minority clients has been achieved? This remains the ultimate question for the cultural competence concept. As agency staff begin to develop plans, they must simultaneously identify measurable goals and objectives (24). Goals or milestones can be designed in measurable, incremental phases. While there are few standardized tools to measure cultural competency (5, 14, 21), staff can review those that are available and adapt them as necessary to meet agency needs. Task forces or work groups can be convened to review emerging scales and measures that might be used or adapted for more quantitative analysis. Exit interviews, focus groups, and consumer satisfaction measures may be employed to generate an initial data set that can be re-assessed over time to discern where the program has grown and where additional growth is needed.

The Cultural Competence Model: Planning Issues and Implications

Several areas of knowledge have been developed with respect to the CASSP cultural competence model. The theoretical foundation for the model is set forth in the monograph, *Towards a Culturally Competent System of Care* (4). A second monograph, *Towards a Culturally Competent System of Care: Programs Which Utilize Culturally Competent Principles* (17), identifies and describes several programs that exemplify various aspects of the model. As the latter publication demonstrates, there is no single approach to developing cultural competence. Even when the cultural group and service discipline are identical, programming may vary from site to site.

There are five basic principles that undergird the cultural competence model, namely: Valuing Diversity, Conducting a Self-Assessment, Understanding the Dynamics of Difference, and Adapting to Diversity. These principles undergird the model and the its application. Contained within the Adapting to Diversity principles are the following four primary elements: (a) attitudes; (b) practices; (c) policies; and (d) structures (4).

Attitudes refers to the thoughts, beliefs, and biases people have as they regard culturally diverse groups. This area responds to the issue that many people have been negatively influenced by news media accounts, public education and social learning, and cultural conveyances (movies, books, jokes, folklore) about culturally diverse groups. As a result, deficit models with respect to ethnic groups of color have resulted in very negative biases about the respective realities faced by groups of color (10). Shedding these biases is very hard even for the most well-

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intentioned individual. Often people are very unaware of their own cultural and racial biases, yet they must be acknowledged in order to be supplanted with cultural strengths perspectives. This element typically comes in the form of cultural sensitivity and awareness models, also some of the emerging anti-bias models can help set the foundation for learning more about cultural competence.

The **practices** element concerns clinical skills such as assessment, treatment planning, resource development, outreach, and advocacy for direct service staff; while for administrative personnel it will concern such things as recruitment and retention, networking with leaders from diverse communities, conflict management and mediation, program development, staff and board development, and program implementation and evaluation. The rapidly growing body of knowledge in the theoretical and research literature regarding service delivery practices for culturally diverse populations should prove helpful. With respect to this dimension, there exist two under-tapped resources that can be very helpful to consult: (a) research and theory describing programs that exemplify aspects of the cultural competence model (17), and (b) key informants such as consumers, family members, and parents of children with emotional or behavioral disabilities (20).

The **policy** element is an often overlooked—yet very important—area. While many programs have culturally competent characteristics, these may not be supported by policy. Given the possibility of budget cutbacks, staff turnover, or other occurrences, it is important that good practice become routinized by virtue of policy. Examples include such things as mission statements, program goals, hiring practices, outreach and advocacy efforts. Culturally competent staff attitudes and program practices need to be upheld by policy lest they ebb and flow on the trends of the times.

The **structure** aspect of the model is twofold: (a) it refers to the diversity and cultural competence of the agency's governing structures (e.g., board advisors, directors, consultants, and policy- or decision-making bodies generally); and (b) considers the cultural appropriateness of the physical plant (i.e., in terms of access, artwork and office decor, program name, location, even what is available in the waiting room to read).

Hence, cultural competence is a set of congruent attitudes, practices, policies, and structures that come together in a system or agency and enable professionals to work more effectively in cross-cultural situations. The model is best viewed in the context of a continuum with a negative and a positive pole. Because the model is developmental in nature, organizations must continually strive to work towards the positive end of the continuum with respect to specific populations. Moreover, since culture is a dynamic phenomenon and subject to change, arriving at the most positive end of the continuum is an ideal state requiring a lifelong commitment. The caveat, however, is that an organization's staff may be proficient with one given cultural group but may need to work on enhancing their abilities to work with emerging or other existing groups within their catchment area. Similarly, agencies with demonstrated credibility with a given population may need to consider the varying contexts in which group members reside. For example, programs that effectively serve Latinos in Houston may not be appropriate for serving Latinos in Omaha or Miami. Other considerations include such factors as national origin, socioeconomic status, social history, rural-urban continuum, levels of assimilation and acculturation. Simply put, the racial categories currently used often lack the necessary details to comprehend and effectively meet the needs of children, youth, and their families.

Planning Implications

In efforts to move an organization towards the positive end of the spectrum, staff must: (a) identify the target of the change efforts (e.g., one specific cultural group, groups of color, non-ethnic cultural groups, or others); (b) assess their cross-cultural training needs; (c) identify barriers to serving the identified groups effectively; (d) develop goals and implementation steps for achieving them; and (e) develop approaches for measuring success. Diversity should be considered in all aspects of the organization—not just clinical practice. Certainly parents and family members of children and youth of color who have serious emotional disabilities are an underutilized resource. Additional resources include natural helpers, elders, clan and tribal leaders, and members of spiritual communities.

Timing is important. Since planning groups need to have some sense of accomplishment to sustain momentum and interest, tasks should be: identified as short-, medium- or long-term in duration; divided into manageable incremental steps; and, described in terms of whether personal or organizational resources are needed. The persons responsible for specific tasks should be identified and the methods for measuring progress should be carefully delineated. As much as possible, local communities should be involved and empowered to have influence into a process which is ultimately for their benefit.

Conclusion

There are many culturally-informed service delivery models emerging in various fields. Most contemporary models are concerned with more than worker cognition of differences. Therefore, any approach adopted should include a focus on organizational attitudes, policies, and structures. The target population needs to be identified and barriers to effective service delivery addressed (language, access, trust, lack of diverse staff); environmental stressors should also be explored and ways to mitigate against such factors considered (e.g. poverty (6), institutional bias or racism (16)) culminating in a sense of mutual benefit; and, a value base for why this is being developed should be disseminated. In particular, this information should be widely disseminated to staff, volunteers, board members, and relevant members of the targeted community. Planning should be conducted in a spirit of collaboration utilizing as many culturally- or community-based resources as possible. The possibility of subcontracting with indigenous people may be an initial way of creating a symbiotic relationship (27). Lastly, one should recognize the years of mis-education with respect to diversity and how many services delivered to groups of color are steeped in deficit models (10, 27, 32).

There is enough work to go around. While much of the work in cross-cultural service delivery has focused upon clinical interventions, additional work is needed in such areas as: management information systems, recruitment and retention of diverse staff, community education and advocacy strategies, outreach techniques, and fund raising approaches. Ultimately, society will change and become darker in complexion. The challenges facing contemporary human service professionals are vast; however, so are the benefits to the children and youth with serious emotional disabilities, their families, and their communities.

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CULTURAL COMPETENCE: NEW FRONTIERS

The Child and Adolescent Service System cultural competence model emerged in the mid-1980's as many systems and agencies redoubled their efforts to enhance services to culturally diverse populations. This increased interest in improving services to culturally diverse groups is attributable to a variety of factors including: (a) changing demographics; (b) greater acknowledgment that culture is a factor in the helping process; and (c) recognition that many professionals are not trained to provide service to diverse populations. Accordingly, various child and youth service delivery systems have mobilized to provide specific activities to promote cultural competence.

Professionals in the child welfare field now recognize: the need for more foster and adoptive homes of color, that children of color often end up in more restrictive settings, and that children are allowed to drift in foster care and not be permanently placed (Edelman, 1987). The juvenile justice field is dealing with such issues as minority over-representation in that system, more violent offenses being perpetrated by youth (often involving firearms), and the increased prevalence of female offenders (Mann-Richey, 1993). Maternal and child health professionals are working to: lower infant mortality rates, reduce the abuse of alcohol and other drugs by expectant mothers and families, better understand culturally diverse help-seeking practices, eliminate recalcitrant childhood diseases (e.g., polio, tuberculosis), and acknowledge diverse perspectives of health and illness (Randall-David, 1989).

In children's mental health, the issues include: the development of culturally appropriate diagnostic and treatment approaches, identification of effective outreach efforts to culturally diverse communities and utilization of culturally diverse natural helpers, eradication of over-representation in more restrictive settings (including juvenile justice settings), and the evaluation of culturally competent services and programs. Clearly, everyone has their work cut out for them.

One exciting development in the area of cultural diversity is the growing number of journal articles and books that address the topic. Agencies and organizations are beginning to develop their own libraries, as well as bibliographic and other instructional materials that promote greater competence.

For example, the **Office for Substance Abuse Prevention** has launched the first in a series of cultural competence publications "to promote the development and dissemination of a scientific knowledge base that assists prevention program evaluators and practitioners in working with multicultural communities" (Orlandi, Weston & Epstein, 1992, p. iii).

In the field of child welfare, the **Child Welfare League of America** developed and published the *Cultural Competence Self-Assessment Instrument* (Child Welfare League of America, 1993) to help agencies assess their own progress. Once 100 assessments are completed by member agencies, an analysis of aggregate data will be published (Child Welfare League of America, 1994).

With respect to training, the **Maternal and Child Health Bureau** has convened training activities that are very responsive to the cultural realities and needs of mothers and young children of color. The **Juvenile Justice and Delinquency Prevention Office** has initiated demonstration projects and other activities to inform both professionals and non-professionals alike in how one begins to reclaim children leaning toward youth gangs or otherwise delinquent activity.

In many communities across the country little-known resources exist in the form of Pow Wows, Cinco de Mayo celebrations, Martin Luther King holiday observances, and Asian New Year festivals. Moreover, places of worship are also key locations at which good information and expertise about a given cultural group can be sought.

The caveat, however, is evident in the acknowledgment that cultural competence is not new. It still needs to be infused into the fabric of many of America's key institutions. For example, there are few mandatory courses on diversity at colleges and universities at either the under-

graduate or graduate levels. Many systems are still struggling to recruit, hire and retain workers of color. And, research has only scratched the surface with respect to groups of color in terms of within group diversity. Much of our thinking about diversity is based on media portrayals of pathology in families and not empirically validated strengths and coping techniques.

There is a great deal of work to be done as this society enters the twenty-first century. Beyond the many systemwide or disciplinary-specific activities, many local opportunities exist to promote cultural competence. Some agencies have initiated efforts that can involve natural helpers and leaders, as well as diverse professionals, consumers and family members to further this agenda. Agency- or bureau-based task groups and cultural competence committees are emerging offering those interested a role to play.

Lastly, we all have to remain vigilant in assessing our personal biases in the organizations and institutions in which we work. While conditions for groups of color and other cultural groups are arguably at a critical juncture, we all have a role to play in assuring that the issues do not get lost or trivialized. Now is a good time to develop the commitment and dedication needed to eliminate barriers to culturally competent service delivery to children, youth and their families that assures that their culture, race and class are taken into account. Becoming more aware of service delivery issues affecting diverse populations is a way of staying both profes-sionally ethical and personally employable as America grows ever more diverse.

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WHY NOT?

As society becomes more diverse there is increased concern over the diversity of decision-making bodies. One, two, or—occasionally—more people are added to an existing board to give it the representation necessary. The debate as to what is tokenism and what is critical mass related to diversity has not been concluded (maybe not yet even convened). Some argue that two new members are needed, suggesting if one new member could not attend a meeting the other one will be available; others say three, indicating that if one cannot attend there are still two people attending for mutual support—a minimum of three makes sense. Yet, the token issue may still be with us.

Given our diverse and democratic society, board membership should reflect the diverse interests. Why not think of boards in terms of multiples of five, given that there are five major cultural groups in our society (European-, African-, Asian-, Hispanic-, and Native American)? Diverse groups can then be equally represented, this is perhaps more reflective of our democratic principles. Voting may emerge around common interests and not so much around a sense of group survival. Disproportionate power will not always accrue to the same group—the dominant population. If equity and good ideas irrespective of their origin is a concern, why not consider equal representation in this manner? Coalitions can develop around issues and not cultural groups; thus, in addition to the board having divergent views perhaps around cultural lines, it will also have convergent views as well. Moreover, it eliminates any concerns about tokenism. Similarly, around parent representation, we want parent and professional interests being met, this requires we add two more or seek people who can wear multiple hats. In some cases an individual might represent a culturally diverse group, a parent or family member, and even a specific service discipline. It certainly sounds weird, but is this not one group, one vote? J.L.M.

Editor's Note: *Readers are invited to submit contributions, not to exceed 250 words, for the Why Not? column.*

OUTREACH EFFORTS TO INVOLVE FAMILIES OF COLOR IN THE FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH

A key long-term goal of the Federation of Families for Children's Mental Health has been for its membership to reflect the cultural and economic diversity of families who have children with mental, emotional and behavioral disorders. Traditionally, national organizations primarily serve white, middle-class families. We wanted the Federation's membership to more accurately reflect the population. From the very beginning, we have strived to have a diverse board of directors. We have consistently asked ourselves, "What changes can we make within our organization that will expand the participation of families of color in the national children's mental health family support and family advocacy movement?"

Our receipt of a grant from the Annie E. Casey Foundation gave us a prime opportunity to introduce people of color to the national network of resources—including the Federation—available to families and their children with mental health needs. The Casey Foundation's Mental Health Initiative for Urban Children project has targeted locations in five states (Colorado, Florida, Massachusetts, Texas and Virginia) to receive grants to develop healthier neighborhoods, families and children. The grant money is being used to expand and create new services, and for training to fill service gaps and maintain children in their neighborhoods. The initiative addresses issues of jobs, safety, violence prevention, and after-school programs. In addition to her other Federation duties, Mary Telesford serves as a site advisor to the Casey Foundation project locations.

Using focus groups to identify areas for materials development.

Federation staff members planned to use some of the Casey Foundation money to develop materials for families of color and scheduled a series of focus groups in various parts of the country for the purpose of receiving the advice of families of color with respect to specifically what type of materials they would like the Federation to develop. The first focus group was pulled together by two African-American women and was composed predominantly of African-American families. The Federation provided child care, transportation expenses and meal expenses for the families who participated in the group. Additionally, we paid the group organizers for their time.

Planning for the second focus group was a real eye-opening experience. We were shocked to learn how little we actually knew about the difficulties families experience—difficulties that limit their opportunities to access and participate in the activities of organizations such as the Federation. Once again, in a large urban community, we asked for assistance in pulling a group composed of African-American families together.

We were advised that the families who planned to attend the group meeting had no transportation. The coordinator's solution was to take a taxi cab to deliver bus tokens to the families. We sent the coordinator a check to cover the cost of providing food for the meeting. She replied by telling us that they were in a "red line area" and that she couldn't cash the check. Barbara Huff responded by going to Mary Telesford and asking, "What's a red line area?" We learned that residents of red line areas have no banks and thus no checking accounts. They have no way to cash checks. The meeting coordinator arranged for culturally appropriate food to be served and for child care.

This focus group meeting was a wake-up call for the Federation. With guidance from Mary Telesford we have learned that we cannot assume anything about families. They may not have: (1) an address; (2) a telephone; (3) access to banking services; or (4) transportation. They may have cultural or religious food requirements. We have learned not to ask people, "What's your address?" or "What's your phone number." Instead, we ask, "Do you have an address or telephone number?" "Are there ways we can get in touch with you?" We have also learned that we have to schedule meetings in the areas where families live because there may be no public or other transportation available to them.

One of Mary's key contributions to the Federation has been her ability to translate the circumstances of some communities of color for the Federation—to help point us in the right direction and give us a roadmap for getting from Point A to Point B.

Building trust among local organizations.

In addition to introducing members of diverse communities to the services available from a variety of national, state and local resources, Federation staff members have an additional goal: We are striving to build the necessary trust of people of color involved in local organizations with the hope that they might choose to affiliate themselves formally with the Federation as a local chapter.

One strategy was to identify local level family organizations that serve minority populations and to ask them to write a paragraph describing—if they were to receive $2,000—what they would do with the money. Pretty uniformly, the responses from each of the nine identified

organizations were that they would use the money to fund the expenses of holding meetings—child care, transportation and food expenses. We were able to give each of these organizations a one-time monetary gift with the hope of building up their trust in the Federation and keeping them interested in us. Frankly, money talks and this was a way of saying to them, "You are important to us."

Another strategy has been to involve local organizations in our materials development activities. For example, we paid Washington, D.C.'s Family Advocacy and Support Association, Inc. (FASA) an honorarium to assist us in the development of a manual entitled *Find-ing Help: Finding Hope*. FASA's family members have worked side-by-side the authors sharing their family stories, and reviewing drafts to ensure that they are both sensitive to and readable for families. This is a win-win strategy: the Federation gets guidance in developing materials for distribution through our national organization; FASA members get an opportunity to influence the materials development, as well as to work elbow-to-elbow with us and thereby learn more about what the Federation is about. This strategy gives local organizations a more informed basis upon which to answer questions such as: "What does it mean to become a

TIPS FOR ACCESSING AND INVOLVING FAMILIES OF COLOR IN A SIGNIFICANT WAY

1. Identify Community Leaders. These natural leaders may be found in churches, schools, public housing project resident councils, Head Start programs, day care programs, senior citizen centers, teen parent programs, or the homes of Good Samaritans (individuals who watch out for the children and elderly in the neighborhood or who participate in community crime prevention programs).

2. Respect Geographic Neighborhood Boundaries. Work with the community leaders to identify geographic boundaries residents respect. While one community might regard its boundaries as extending five or six blocks, a public housing complex may regard the boundaries of its neighborhood as the boundaries of the housing facility.

3. Meeting Sites, Times and Dates. Hold meetings within each of the identified geographic neighborhoods in a location accessible by walking or public transportation. Families fear muggings after dark. Many prefer meetings between 4:30 and 7:00 P.M. Due to church activities, Sunday is often not a good day to schedule meetings.

The best turnouts to meetings are usually between the 2nd and the 15th of the month. For those on public assistance, people have more money during this time of the month, are in better spirits, and are more likely to be receptive to hearing about something new.

4. Publicity. For those who have them, telephones and regular mail delivery are good methods for publicizing upcoming meetings. For those who do not have those resources, fliers announcing meetings should be posted in laundromats, clinics, churches, grocery stores, public transportation stops and day care centers. Fliers can be given to children at school to take home and announce-ments can be made at PTA, church, Head Start and resident council meetings. Public service announcements can be placed on local radio and television stations and individuals can be encouraged to spread the word.

5. Incentives. Publicity fliers should announce that child care and food will be provided.

6. Prompt Follow-Up and Identification of Issues Group Will Address. Follow-up the first meeting with a second meeting within the next month. Do not let time pass or the momentum will be lost. The sooner family members can begin to address identified issues (such as learning more about the Individualized Education Plan (I.E.P.)), the sooner they will develop an appreciation of the group and an investment in its success.

7. Empowerment. Many families feel that they are at the mercy of others: the welfare system, the transportation system, their social worker, the education system or the public housing system. It is the challenge of the empowerment process to help parents and other family members educate themselves about various children's mental health issues, and thereby feel good about themselves and channel that positive energy into action that will improve their lives and the lives of their children.

8. Collaboration. Lastly, out of families' increasing sense of empowerment will hopefully come collaborative working relationships with professionals serving children and families and participation in community-based decision making about children's mental health services.

Mary C. Telesford, *Casey Foundation Site Advisor, Federation of Families for Children's Mental Health, Arlington, Virginia.*

Outreach Efforts Involve Families

chapter of this organization?" "Do we lose our own identity if we take that step?"

Encouraging the participation of diverse communities in the Federation's annual meeting.

The Federation's November 1993 annual conference specifically targeted issues of concern to minority families and communities. Entitled *Diversity, Direction and Dedication* conference sessions addressed such topics as organizing families in urban multicultural neighborhoods and promoting and supporting diversity in family groups. Conference entertainment included an African-American children's choir, a Paraguayan dance troupe, a gospel choir and a Polynesian dance group.

Moreover, the Federation offered a number of parent scholarships to attend the conference. Many of these scholarships were earmarked for parents of color. Never before had our annual conference been so diverse. Although it was challenging, we experienced great successes in bringing people of color from remote locations to our 1993 conference. For example, we assisted a family member who had never before been outside of her community to travel to our conference. We arranged to pay someone to drive her from her home to other transportation and, from there, to the airport. Once at the airport, we were able to figuratively walk her thru the rest of her journey. Similarly, we have made cash payments to other parents to enable them to pay a neighbor, take a bus, catch a cab or do whatever they needed to do to get to an airport.

Just as the generally accepted definition of "family support" is "Whatever it takes!"—we have made "Whatever it takes!" our motto for pursuing various strategies to involve families of color in the national, as well as local level, children's mental health movement.

Barbara Huff, *Executive Director, Federation of Families for Children's Mental Health;* **Mary C. Telesford,** *Casey Site Advisor, Federation of Families for Children's Mental Health, Alexandria, Virginia.*

PARENTS' PERSPECTIVE

In 1988, our twelve year old son Steve, Jr. (one of eight children) had his first psychiatric hospitalization, resulting in an eight month residential placement. We ran out of insurance in ten days and were never advised of our entitlements under Public Law 94-142, (now known as the Individuals with Disabilities Education Act or IDEA).

Over the next four years, we bounced around in public schools and in Tennessee Department of Mental Health (TDMH) schools. During this time my son was placed on three separate occasions into TDMH residential schools, spent eleven months in a group home, and also spent two years in a separate day school.

We were illegally billed almost $200,000 for my son's special education placements. In most of these programs, Steve Jr. was the only child with bona fide psychiatric disabilities (atypical schizophrenia). He was continually teased, taunted and assaulted.

In Fall 1990 we stumbled upon special education law. At that time Steve Jr. was stuck in another TDMH residential school, and the schools refused to refer him to a more appropriate program unless we gave up custody of our son. We refused to give up custody.

We hired an attorney and filed the first of three Due Process hearings. We won in each instance. The schools and TDMH appealed, lost the appeals, re-appealed, etc. We have faced twelve well-paid attorneys, and we are still in Federal court.

In 1992, we gave up on local programs, and successfully sued the schools for placement in Grove School in Madison, Connecticut, where Steve has been for the past two years.

Yesterday (June 30, 1994), we filed our fourth Due process, invoking the "Stay Put Rule" when the local schools (Hamilton County, Tennessee) refused to renew Steve's contract with Grove School.

Steve Daugherty, Sr., Hixson, Tennessee.

Editor's Note: *Parents are invited to submit contributions, not to exceed 250 words, for the Parents' Perspective column.*

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCE PLAN

Similar to a number of other states, South Carolina is experiencing changes in the race and ethnicity of its consumer groups. Demographic patterns indicate that African Americans make up 30% of the population, Hispanic/Latinos constitute 1% of the population and a number of Native Americans and Asian Americans reside in the state. 1990 census data reveals that these four groups of color are represented in each of South Carolina's 46 counties. The groups as a whole are expected to grow at a much higher rate than people from European-American backgrounds.

The South Carolina Department of Mental Health (SCDMH) initiated a cultural competence survey of 105 of the top leaders within the state system in August 1993. James Mason, project manager of the Multicultural Initiative Project, Research and Training Center on Family Support and Children's Mental Health, Portland State University, conducted the survey. The survey data clearly demonstrated that the leaders of South Carolina's mental health system, needed to expand their knowledge of and skills concerning the diverse groups residing within the state.

The SCDMH developed a multi-level thrust to address the needs outlined from the survey data. The statewide Cultural Competence Committee was formed and a new program, the Cultural Action Management Program was created.

The Cultural Action Management Program was established with the following goals and objectives:

1. To develop a statewide plan to ensure that mental health professionals who work in the public mental health system will be prepared to provide the range of services needed by African American, Latino, Native American and Asian American clients and their families;

2. To examine, comprehend, explain and focus on suffering and unmet service needs experienced by people of color;

3. To develop resources that are required to maximize our system's effectiveness through cultural competence and proficiency;
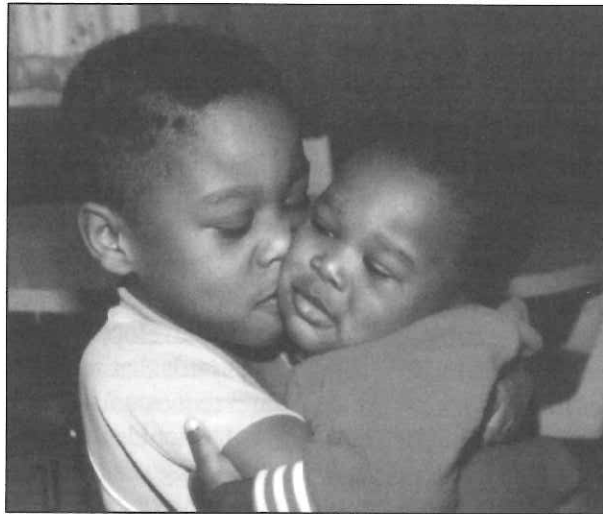
4. To establish training programs focusing on cultural competency for all staff;

5. To develop policies and procedures to make mental health services accessible, acceptable, and available to people of color who are in need of services;

6. To access and evaluate the composition of governing boards, to assure that they reflect the demographics and cultures of the service area;

7. To develop policies that facilitate ongoing collaboration with South Carolina's institutions of higher education to assure that clinical training and residency programs include culturally sensitive and relevant training in the curricula content, internships and externships;

8. To develop methods to evaluate progress toward cultural proficiency for individuals, organizational units and the system as a whole;

9. To develop, implement and monitor culturally relevant standards, that would apply to all programs, grants, contracts, and requests for proposals. Develop methods that integrate cultural competence standards, issues and programs to other departmental programs, such as Continuous Quality Improvement, Budget Development, State Plan and Continuity of Care; and

10. To assess the fiscal impact of not having culturally competent staff.

The Cultural Competence Plan was developed through a comprehensive process. The Cultural Competence Committee began the process by studying the cross cultural literature, reviewing other state programs and reviewing data from the survey. The Ohio Department of Mental Health's program seemed closest to the model we wanted to develop. A representative from the Ohio program came to South Carolina and provided consultation after we had completed the first of seven plan drafts. The fifth draft of the plan was circulated for review by the leadership within the system. The final plan was developed, priorities established, and it was approved in March 1994.

The Cultural Competence Plan of SCDMH makes specific recommendations regarding policy, administration, clinical services, human resources development, com-

South Carolina Plan

munity relations/public education, and research. Each recommendation is given with a suggested time-line and potential identification of the person or persons responsible. There are a total of fifty-five recommendations with a time frame of completion ranging from three months to five years. Recommendations for time frames of one year or longer will require updates every six months.

All employees will receive a copy of the executive summary by September 30, 1994. People with leadership responsibility have received the full plan. Implementation strategies with measurable outcomes will be submitted to the cultural competence committee no later than November 1994.

The Cultural Competence Plan recommendations are clustered in six areas: policy, administration, clinical services, human resource development, community relations and public education, and research.

Policy

Policy is an expression of the Department's value that cultural competence will form the foundation of all its works. As such, cultural competence will be reflected in its operating principles, positions, procedures, guidelines, standards, legislation, regulations and service delivery system. The twelve policy recommendations include the following:

A. revision of the Department's mission statement;

B. assessment and review of departmental policy manuals to ensure that mental health services are accessible, acceptable and available to people of color;

C. establish policies to mandate the inclusion of representatives of target groups when deciding location of facilities, establishing service hours, design and interior decorations of facilities, size (to allow for extended families), and provision of culturally appropriate literature in waiting rooms;

D. develop marketing strategies designed for specific groups of color served by the agency;

E. develop policies and procedures that reward facilities and staff who make progress towards cultural competence;

F. include issues of cultural competence in job descriptions, evaluation procedures and staff orientation training programs;

G. develop policies that facilitate ongoing collaboration with South Carolina's institutions of higher education to assure that clinical training and residency programs include culturally relevant training in the curricula content, internships and externships; and

H. establish policy mandating that all consumer surveys include questions related to culturally appropriate service.

Administration

Administration refers to the transforming of policies into practices. Administration has the responsibility to plan, assign, coordinate and evaluate all cultural competence initiatives. Included among the twelve administration recommendations are the following:

A. develop a standing Cultural Competence Committee to provide consultation, oversight and leadership;

B. revise affirmative action plan guidelines to reward compliance;

C. develop, implement and monitor culturally relevant standards that will apply to all programs, grants, contracts and requests for proposals;

D. include assessment of progress toward cultural competence goals in all annual reports;

E. conduct an annual needs assessment at each facility to identify the cultures present in their catchment area and develop knowledge of their prevalence, belief systems, natural health systems and community leaders; and

F. explore the possibility of establishing a Cultural Competence Resource Center for the Department of Mental Health and other state human resource agencies.

Clinical Services

Clinical services refer to those direct client services that provide interventions with individuals, families and groups. These services include studying the problem presented, assessing and diagnosing the client situation and directly helping the client achieve the desired goals. The five clinical recommendations include:

A. securing resources to develop and pilot culturally appropriate diagnostic assessment tools and replicate effective treatment modalities;

B. providing ongoing cultural competence training to staff;

C. providing mental health services in a manner that makes them *accessible, available, appropriate and acceptable* to people of color. *Accessibility* includes issues related to hours of operation, geographical location and transportation; *availability* includes effective communication skills and providing culturally responsive treatment; *acceptability* includes being aware and responsive to cultural differences, promoting freedom of choice among therapeutic alternatives, while allowing that clients will not be denied access to other services for refusing to accept other services recommended; *appropriateness* indicates a practice of providing services in the least restrictive environment, delivery of services in the natural environment of the person receiv-

ing services as appropriate, continuity of therapeutic relationships, and culturally appropriate assessments.

Human Resources Development

Human Resources Development can be organized into four major categories: planning/evaluation, education/training, workforce management and sanctions/regulations. The twelve recommendations include:

A. address the need to reduce anxiety/discomfort associated with cultural competence initiatives;

B. regularly assess the proficiency of staff in the cultures of each catchment area and include an objective related to improving their cultural competency on employee performance appraisals;

C. develop tuition assistance programs that target under-represented ethnic populations in the workforce;

D. develop and train staff throughout the system to focus on ethnic, interracial conflict resolution associated with the implementation and management of diversity programs; and

E. establish mechanisms to facilitate clinicians participating in cultural events and informal interactions at community activities.

Community Relations and Public Education

Community relations and public education refer to larger systems efforts to facilitate and develop cultural competence initiatives in other human service agencies. The five recommendations in this section include:

A. support the development and adoption of statewide legislation and policies for state government that enhance cultural diversity initiatives and move the state to a position of cultural competence;

B. inform governmental bodies and other state human service agencies of plan and progress toward cultural proficiency; and

C. explore the development of joint relationships and cooperative cultural diversity projects with private industry, state agencies' constituency groups, formal and informal community organizations.

Research

Research efforts will be directed toward the development of systematic procedures to use in seeking acts, principles and effectiveness of cultural competence initiatives. The goals of the research will include, but not be limited to, dissemination of information, knowledge building, and clinical skill development. The nine recommendations in this section include:

A. all major intervention strategies will be evaluated for their cultural value, appropriateness, usefulness and impact;

B. all cultural competence training programs will incorporate evaluation components for trainers, instructors, representatives of the targeted ethnic groups, trainees and consumers;

C. a database will be established to include the kind of ethnic-specific service and research being conducted, identification of researchers interested in multi-cultural research, identification of possible research projects and development of a clearinghouse of relevant minority mental health-related materials; and

D. complete a minimum of one research and/or evaluation project every two years.

For additional information on South Carolina's Cultural Competence Plan of Action please contact the authors at the South Carolina Department of Mental Health, 2414 Bull Street, P.O. Box 485, Columbia, South Carolina 29202; (803) 734-7766.

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CULTURAL COMPETENCE: BUILDING A STATE LEVEL SYSTEM OF CHANGE IN PENNSYLVANIA

Based on the principles of the national Child and Adolescent Service System Program (CASSP), the Bureau of Children's Services in the Pennsylvania Office of Mental Health began almost a decade ago to develop the statewide infrastructure for improving mental health services to children and adolescents in Pennsylvania. The staff soon realized that in order to build the infrastructure, they would have to integrate cultural competence into the design for a comprehensive mental health system for children and adolescents and their families. We agreed with the national CASSP Minority Initiative that, historically, insufficient attention has been given to the needs of African Americans, Asian Americans, Latinos and Native Americans for culturally specific, accessible,

Building Change in Pennsyvania

available, and acceptable mental health treatment and services to families and children of color.

The Pennsylvania CASSP minority initiative began in October 1989. A Minority Initiatives Subcommittee of the statewide CASSP Advisory Committee consisting of parents, professionals and advocates was convened and supported by the Bureau of Children's Services. Five years later, the committee is a strong and effective voice for cultural competence.

The main reason we have been successful in maintaining our committee is because—in the early stages of our development—we were able to define our purpose and limit our goals to ones that seemed reasonable to achieve. We were clear about what we believed the child-serving systems in Pennsylvania needed to do in order to be culturally competent.

To work cooperatively as a team, we had to develop a spiritual oneness. We soon recognized that respect for the individual was not enough; we had to respect individual and group differences as well. This meant that committee members had to acknowledge that cultural values and beliefs are valid for each group. With the broad range of experiences that each member brought to the committee came the need to increase efforts to understand and value our differences as well as our similarities.

We learned that cultural competence is not just a fad, or feelings of warm fuzzies, or being sensitive to each other's needs. It is more than caring and professing love for each other. We learned the richness both individually and as a group that comes with understanding and awareness of the totality of cultural competence.

Definition

Most of the time we were able to put aside our personal agendas and develop a process for becoming culturally competent as a committee. Because several different cultures are represented on the committee, we needed to think holistically and learn to understand the values each person brought to the committee. To isolate a component of any one culture's values or beliefs was to ignore the point of our being together. This process was often uncomfortable because it meant a constant shifting of paradigms. To help us in our ultimate goal of developing an agenda for cultural competence in Pennsylvania, we also had to create a support system to increase the morale of committee members.

Our first challenge, after learning to work together as a team, was to develop a five-year plan. To do this, we divided the committee into task forces. This method helped to minimize some of the conflict we continued to have because of our individual differences and it increased our effectiveness because we were working on specific tasks. When we met as a full Minority Initiatives Subcommittee, time was devoted to the task force reports by committee co-chairs.

The first major project we undertook was to plan the Pennsylvania CASSP statewide conference in March 1990. We wanted to give our audience (people from Pennsylvania's child-serving systems) the experience of interacting with culturally diverse parents, professionals and advocates, and to think about how to develop a culturally-specific agenda for meeting the treatment needs of minority children and their families.

The conference was attended by 200 parents and professionals from the child-serving systems (mental health, mental retardation, child welfare, education, health, drug and alcohol, juvenile justice and vocational rehabilitation). The information shared by participants helped the committee to plan strategies for completing the following tasks: (1) producing a concept paper entitled *The Pennsylvania Model Toward a Culturally Competent System of Care*; (2) developing a regional training program on cultural competence that would aid in the recruitment of parents of color into the mental health system; (3) planning an annual training on cultural competence for parents and professionals; (4) holding annual retreats for the committee to work on major tasks and to do conflict resolution with committee members; (5) developing a set of training modules for cultural competence to be incorporated into existing program designs and policies; and (6) strengthening the commitment of the Bureau of Children's Services to support Pennsylvania's county-based mental health system's efforts in becoming culturally competent.

The Minority Initiatives Subcommittee has also assisted in the creation of additional forums for incorporating cultural competence into Pennsylvania's child-serving systems. For example, as an outgrowth of our trainings in cultural competence, we convened a state-level Interde-

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partmental Cultural Competence Committee, consisting of representatives of the child-serving systems. This committee has been available to the state Children's Coalition to give input on statewide initiatives as they relate to the development, provision and implementation of services to children of color and their families. We have also helped the coalition to formulate a collaborative agenda for cultural competence. As a result, the coalition has begun a cross-systems training initiative that has named cultural competence as its first priority.

Another important initiative for our committee was sponsoring focus groups in the twelve counties in the state with the highest percentage of people of color. The goal of these focus groups, led by committee members and CASSP coordinators, was to bring together parents from the respective counties to discuss their perception of available services for their children. Based on the information gathered in these focus groups, a parent questionnaire will be developed and distributed to determine what parents of color see as their treatment issues in Pennsylvania.

Woven into the fabric of our entire process has been an effort to incorporate an understanding of the dynamics of diversity through a knowledge-based agenda into all the initiatives of both our committee and the mainstream mental health system. The questions most often asked is this: "We've always had minorities in this country. What is the difference now?" The difference is that the numbers have changed; the numbers have increased to the point that people can no longer ignore people of color. There will continue to be more people of color in need of mental health treatment and services. Therefore, issues relating to minorities will continue to be a challenge for child-system workers into the 21st century.

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RESEARCH FRONTIERS IN BUILDING A CULTURALLY COMPETENT ORGANIZATION

It is widely acknowledged by experts in the field that the organizations and structures in the system of care should be culturally competent. If we are to be successful in building culturally competent organizations, then it is imperative to develop culturally competent research strategies to inform service delivery decisions and to implement new methods of research that involve the community from planning to dissemination. Equally important is the need to identify and increase the number of researchers with culturally-based knowledge in order to formulate appropriate research questions and to develop methodologies congruent with the populations studied (Benjamin 1993, p. vii). Recognizing the importance of research in building a culturally competent organization, the Child and Adolescent Service System Program Minority Initiative convened a distinguished group of minority researchers, child mental health administrators, clinicians, academicians and consultants on April 16-17, 1992 at Georgetown University to begin to address some of the pertinent research issues. A monograph entitled *Child and Adolescent Service System Program Minority Initiative Research* was one of the results of this meeting. The remaining content of this article is based upon this meeting and monograph.

What is a culturally competent organization and what are some of the research frontiers to consider in building such an organization? Cultural competence is a set of congruent behaviors, attitudes, policies, and structures which come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in the context of cultural differences (Cross et al, 1989, p. 13). Indeed, effective service delivery is a combined function of cultural attitudes, service parameters, and delivery processes. It includes the particular "chemistry" that develops between the client/family and the organization itself (Chavez, 1986, p. 145).

If an organization does not adequately address these functions in its service delivery system, then that organization may be providing inappropriate, ineffective and potentially damaging services (Spriggs, V. 1991, p. v). One of the problems that contributes to inappropriate service delivery is the lack of culturally competent research. For the most part research studies do not include culture as a variable that must be considered and measured in the research design. Even when culture is considered as a variable, researchers need to overcome gaps such as poor conceptualization. Poor conceptualization may be seen in such areas as the "tricultural experience" of minority group members, environmental risk factors, the description of study samples, the coping styles of minority youth, culturally relevant research instruments and the philosophy and orientation

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of the researchers themselves (Benjamin 1993, p. 9). This means that research frontiers must be expanded in order to overcome such gaps. Furthermore, in building a culturally competent organization, research frontiers must also be expanded to address important research issues such as the support of community-based research projects by minority researchers. Other important research areas that must be expanded include bi-cultural identity development for ethnic minority youth, the characteristics, structure, function and uniqueness of minority families, the help-seeking behavior of minority clients, the nature and efficacy of treatment, and the quality of treatment follow-up. Research must go beyond simple labels of good and poor outcome to that of providing a better understanding of how, why, and in what situations a particular intervention works well. An understanding of how an intervention works allows further improvements and refinements (Szapocznik et al., 1990). "This type of research requires greater conceptual clarity, multi-disciplinary research approaches, and cooperation among academicians and service delivery professionals" (Jackson, 1988 p. 19).

While it is recognized that research methodology should include multi-source and multi-method techniques it is especially important to utilize case study and ethnographic methods in conducting research involving minority populations. Areas to study include existing culturally relevant programs as well as the treatment approaches that are currently being implemented. This could then lead to the development of a more comprehensive model for describing culturally relevant treatment. In conducting mental health research, researchers should be aware that the range of disorders, the manner in which such disorders are presented, and the extent to which treatment services are utilized are quite varied in multi-cultural communities. For example, findings of a University of Miami research project conducted on the health systems, practices, and beliefs of African Americans suggest that a community mental health center established along traditional lines would be neither maximally effective nor optimally utilized (Bestman, 1986). In addressing issues such as cultural uniqueness, Neighbors et al. (1992) suggest that "rigorous research which can provide clear empirical documentation of ethnic differences in under-utilization, misdiagnosis, or poor outcome is a good means to ensure the development and maintenance of nontraditional mental health service delivery programs" (p. 55). These authors believe that researchers must place increased emphasis on

designing and conducting research studies that take cultural uniqueness into consideration if they are to be successful in making research findings useful to service providers of multi-cultural populations.

Indeed, research should be a collaborative partnership between researchers, practitioners, policymakers and the community—all of whom should recognize each others' unique roles and expertise. Domains measured in research projects should include strengths as well as weaknesses and should include community risk and resiliency factors. Moreover, measurements should be valid for study samples. For example, in conducting research involving minority populations, "healthy" minority children should be used in comparison groups rather than children from the majority culture. Likewise, it is important to recognize that there is as much variability and diversity within any minority group as there is between a minority and majority group.

In conclusion, utilizing different research paradigms and methodologies may assist researchers in making recommendations that could lead to better service delivery to minority populations. These may range from ethnographic approaches to complex data modeling. When researchers talk about methodology, they need to conserve the distinction between the desire to use state-of-the-art approaches and the need to take into account the problems associated with doing research related to different cultures. Finally, in building a culturally competent organization, some of the issues that must be more adequately addressed include cultural uniqueness, overcoming gaps such as poor conceptualization, supporting community-based minority researchers and developing collaborative partnerships between researchers, practitioners, policymakers and the community.

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CULTURAL COMPETENCE AND THE JUVENILE JUSTICE SYSTEM: IRRECONCILABLE DIFFERENCES?

There are many professionals of color who look with increasing alarm and dread at recent developments in the juvenile justice system in this country. It seems that, more and more, justice simply means "just us," as the overrepresentation of youth of color in juvenile confinement continues to soar in direct proportion to the fears of violence and crime that grip the minds of those dominant culture Americans who are least likely to be its victims.

In response to the overwhelming confinement of youngsters of color, the Office for Juvenile Justice Delinquency and Prevention (OJJDP), in 1989, issued regulations requiring states that participated in their Formula Grants Program to determine the existence of disproportionate minority confinement and to design strategies to reduce the problem where it exists. As of February 1993, 42 states had completed the required data analyses, with all but one determining that juveniles of color were overrepresented in secure facilities (*Federal Register*, Vol. 59, No. 134, July 14, 1994, p. 35993). Despite these data collection activities, the problem continues to worsen and few, if any, states have developed comprehensive strategies to reduce or counteract this trend.

Thus, it is an accepted fact that most juvenile justice systems tend to be culturally biased from the initial assessment through the course of placement disposition. These systems have proven to be inflexible when assessing or serving youth of different racial and cultural orientations. Their programs and staffing seldom reflect any real commitment to cultural competence or diversity.

In the cultural competence model developed by Cross et al., (1989) in *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children who are Severely Emotionally Disturbed* (Vol.

1), the authors state that cultural competency is a developmental process and, as such, propose a cultural competence continuum as a useful tool to illustrate the possible ways organizations (and individuals) can respond to cultural differences. They identified six points along this continuum that describe characteristics that might be and are often exhibited by agencies—from those that are least culturally competent to those that are highly developed in the cultural competence context.

The least culturally competent points of the continuum are cultural destructiveness and cultural incapacity. Culturally destructive agencies are those at the most negative end of the continuum that exhibit attitudes, policies and practices that are destructive to cultures and consequently to members within the culture. A system that adheres to this extreme assumes that one race is "superior" to the other and has the right to eradicate "lesser" races or cultures because of their perceived subhuman position. Bigotry, coupled with vast power differentials, allows the dominant group to disenfranchise, control, exploit, or systematically destroy the minority group and its culture. At the next step of the continuum is cultural incapacity. At this level, the system or organizations do not intentionally or consciously seek to be culturally destructive; rather, they lack the capacity to help persons or communities of color. The organization remains extremely biased, believes in the racial superiority of the dominant group, and assumes a paternal posture towards "lesser" races and cultures. These agencies may disproportionately apply resources, discriminate against people of color on the basis of whether they "know their place" and believe in the supremacy of dominant culture helpers. Such agencies may overtly or covertly support segregation as a desirable policy. They may act as agents of oppression by enforcing

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racist policies and maintaining stereotypes (Cross, et al., 1989).

From the perspective of this author, most juvenile justice agencies currently fall within these two levels of the continuum. The very attitudes, policies, structures and practices of these organizations devalue individuals and cultural diversity. For example, there are problems with the fact that:

- One is most likely to be a "client" of this system if African American, male and poor (race/class biases);
- Once in the system, there is a significantly lower probability that the individual will go to college or find a decent job; in fact, there is a greater probability that the individual will graduate into the adult criminal justice system (the juvenile justice system becomes a feeder for adult jails and prisons);
- Despite well-documented and high correlations between juvenile justice and emotional disabilities, substance abuse, child abuse and learning disabilities, one is unlikely to receive adequate assessment or treatment for these problems upon entering the system;
- The attitudes and knowledge that discretionary decisionmakers within the juvenile justice system hold about people of color (i.e., police officers, probation officers, prosecutors, etc.) are often based upon strong and deeply embedded racial biases and stereotypes;
- There is little room for input and little respect for parents, family members, members of communities of color, or for the youth themselves;
- There are consistent and pervasive power differentials within the system and that those with power and authority are almost always dominant culture persons (i.e., police officers, judges, attorneys, government law enforcement agents, etc.) since the justice system has notoriously poor records when it comes to affirmative action and equal opportunity for advancement; and
- Juvenile justice is increasingly becoming a system of punishment (control agent) and not treatment/rehabilitation.

Thus, some of the most salient characteristics of juvenile justice agencies lead to a level of cultural incompetence and insensitivity that is having devastating impact on youth of color, their families and their communities.

The growing question is whether there are ways to redirect current trends in the juvenile justice system so that it can fulfill its mission without destroying cultures of color or whether there are truly irreconcilable differences between the concept of justice and cultural competence. It seems that the solution lies in reversing many of the characteristics that plague the current system. Attitudes and knowledge need to be addressed through cultural competency training and practice; families and communities of color need to have a greater voice and greater mechanisms for being heard and respected within the system; the discretionary and arbitrary decisionmaking processes of those with power and authority need to be limited and closely monitored; and, cultural competence action plans and strategies need to be developed and implemented throughout all aspects of the system.

Although the current $600,000 appropriation for developing strategies directed at reducing minority confinement available through OJJDP is a small part, there has to be a greater "will" and commitment among those who have the power and authority to change the current incentives within the system. There must be greater recognition that juvenile justice is failing children and adolescents of color through an inability to recognize, understand, or provide adequate prevention, assessment, treatment and rehabilitation due to the lack of culturally appropriate and competent policies, staff, and programs—and not because children and adolescents are inherently "bad" or undeserving of humane approaches. We have to reverse the fact that: "(R)ace emerges as the single best predictor of arrest, incarceration, and release, even when the influence of other variables are controlled....This is not only true for Black youth, but also Hispanic youth, Native Americans and Japanese Americans" (Krisberg et al., 1987, pp. 174-175).

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MY GRANDMA'S HOUSE:
REACHING OUT TO UNDERSERVED FAMILIES OF CHILDREN AND YOUTH WITH NEUROBIOLOGICAL, EMOTIONAL OR BEHAVIORAL DIFFERENCES

Reaching out to under-served families of children and youth with neurobiological, emotional or behavioral differences — What does that statement mean? Why do we do it? Aren't all families the same? Are we? We have children with similar symptoms. We face the same difficulties negotiating the mazes. Why do we need to separate it out? We understand each other. Do we?

The times I have been asked to speak about working with Hispanics with disabilities, it has been difficult because I did not grow up as an Hispanic or as a Mexican-American. I am Mexican-American, but my family identified themselves as Mexicanos and Anglos as Americanos. I came from a small community of 3,000 people in southern New Mexico that relied on mining to survive. I never thought of myself as coming from a low income household, but I have pictures that tell a different story. I remember seeing family pictures and saying "I don't remember being poor." I remember my great-grandmother always telling us how rich we were because we had food, clothes, shoes, love and discipline.

My growing up consisted of living with my great-grandmother, grandparents, parents, aunts, uncles, cousins, sons and daughters of friends of the family and neighbors. My grandmother's house could have easily been certified as a residential treatment center. We all lived between my great-grandmother's and grandmother's house (both homes on the same lot). The cousins, sons and daughters of friends of the family, and neighbors who were having difficulties with adolescence, were all sent to my great-grandmother for lessons in living (boot camp). My cousins all visited during the summer because it was expected. It was a well-organized summer respite program.

My great-grandmother, Doña Julia, was four feet tall and weighed about ninety pounds. Doña Julia was born in Casas Grande, Chihuahua, México. She was a friend of Pancho Villa's mother, married to a territorial judge, was the cousin of a woman general in Zapata's army, and lived through the Mexican Revolution. In other-words, my great-grandmother was one tough cookie. Doña Julia ruled the neighborhood with a look. She never raised her voice nor a hand, but because of that look of total confidence and authority, we all knew that some horrible fate awaited us if we made this woman angry. She was also a behavior management specialist. So we all towed the line, well almost.

I grew up on ghost stories, visits from spirits, and La Llorona. La Llorona is a legend. Rumor had it that she drowned her children in the arroyo, killed herself and then her restless spirit roamed the arroyos evermore searching for her children. Every night we played kick the can and the prime hiding places were usually in the arroyo because only the bravest of souls would hide there. At least once a month some "kick the can" player would come out screaming from their hiding place claiming they saw a vision in white crying for her children. So at least once a month the legend lived in our hearts, minds and trembling knees.

No one celebrated more than I when a paved road was built over the arroyo because every other night when it was dark, somebody in the house needed something from the corner grocery store and I had to go with the Marquis de Mexicans—my uncle—to get it. The problem was we had to cross the arroyo to get to the store. My uncle, being only four years older than me, felt it was his duty to torture me on the way back. We'd get to the bottom of the arroyo and he would take off running, while yelling, "La Llorona is waiting for you!" How I hated him, but I never turned down the chance to go to the store with him. Forget the ropes courses and Outward Bound to build character. There is nothing like being so scared you can't move to build character. I highly recommend Arroyo Therapy. I won't get into Cemetery Therapy where you go to the cemetery late at night and wait for spirits and balls of fire to appear.

Our medical needs were taken care of by a curandera and sobadora (herbalist and masseuse of sorts). Doña

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Camila came to my grandma's house every day for a cup of cafe and conversation. To this day I rarely complain about anything that ails me. When we complained, Doña Camila was brought to cure us. The cure ritual began at 7:00 A.M.—if not earlier—with a shot of cod liver oil and a leg massage that would bring screams to the strongest of humans. This was quickly followed by a back massage and a snapping (picking up the skin with the thumb and index finger) of the pressure points. AND, if this didn't work, you could count on a cup of yerba buena (wild spearmint) tea AND an enema. Today, when the cousins all get together, we laugh about how quickly we learned to keep our ailments to ourselves and how we prayed no one would notice us doubling over with pain.

There are other memories that are not so fond, but, nevertheless, memories. My grandfather worked the coal mines and when his lungs were so deteriorated that he couldn't mine anymore, be delivered propane. I usually went with him on his propane runs. There I learned about racism.

My home town was divided into three sections: (1) Chinatown (there were only three Chinese families in our community); (2) Dogpatch; and (3) Middletown (where we lived). Middletown was further subdivided by east and west. East is where we Mexicans lived. The few restaurants and diners in my community had signs posted "No Spics, Coloreds, or Dogs Allowed." Given that the town had a Mexican-American population of 51%, this policy displayed some pretty poor business acumen.

Mexican-Americans usually ate at home or gave their business to Mrs. Hightower's restaurant. The Hightowers were one of three African-American families living in the community. Students were not allowed to speak Spanish at school, because, after all, we were living in the United States. If students were the least bit different, they were not allowed to attend school. Their families, who could not speak English and were brought up to respect teachers, did not question the administrative decisions. Unfortunately, forty years later these kinds of decisions are still being made.

My hometown is a desert town. It seemed that our teachers must have come from cooler climates where there was sparkling water, one race of people, and entertainment galore. I know this because I had to stay after school (only the Mexican-American children had to do this) and listen to the teachers complain about the heat and dust, our dirty water, our podunk town, and the dirty Mexicans. I agreed with them about the heat, dust, and our lack of entertainment. The other complaints built character.

So, the two key words of wisdom I have to share with anyone trying to reach out to underserved families of children with mental, emotional or behavioral disorders are the following: **respect** and **commitment**. To show respect you must have commitment. My seven basic steps to promote identifying and serving underserved minority families are the following:

1. Know the community. Meet the people in the community. Know what the community does to survive. What are the languages of the community? Meet the community leaders. Pay attention to favorite politicians, tribal leaders, religious leaders, teachers, administrators, employers.

2. Know what families need and want to learn. Learn from individual families. Listen and respect what families say about the cultural things they do for their family members. Put your ego in your back pocket and leave it there. If you think you have a better, more acceptable way of doing things, keep it to yourself until you have gained trust and a better understanding of the family's cultural ways. Are they traditional, non-traditional or a combination? Make home visits and personally invite families to attend meetings or trainings. Seek out the perspective of community leaders and community agencies.

3. Choose the training sites and times carefully. Be aware of community pride and rivalries. Provide safe, neutral meeting places. Go where people feel comfortable. Hire staff or provide volunteers who know the community or the language. Be sensitive to local customs. Be respectful of alternative healing practices such as medicine men, healers, curanderas, el mal ojo, brujo(a)s. Schedule meetings so that they do not conflict with feast days and other religious observances. Be aware of transportation problems. Don't ever say: "If they really cared about their children, they'd find a way to the meeting." Even though a community may be ten miles away from another, some families may not want to go "out-of-town." Make sure the site allows children and food. Provide child care and food. Discard your need for high numbers of participants. If only two people show up—then you have reached two people. Don't give up. Trust takes time.

4. Invite speakers who will address the families' information needs in a culturally sensitive manner.

Provide speakers who are fluent in the group's native language. If you can't find native speakers, be sure that trained translators are available ahead of time. Allow for the extra time for translators to do the job effectively. Break down information to accommodate learning styles.

5. Check your own comfort zone. Can you communicate with the families you are trying to reach? Can you respect the families and their beliefs? Can you keep an open mind? If you find yourself saying, "Yes, I understand, but...," you need to find someone who knows the language of that community and is trusted by members of that community. Don't give up, just find a different approach.

6. Set a two to five year goal for your outreach planning. Invite culturally diverse people to serve on your board of directors and advisory boards. Discard the programming need for high numbers of participants in the trainings (trainings should not be the only service provided). Allow for the development of support networks (remember that support has many faces and families seek support in many ways). Plan activities that include home and school visits, potluck dinners and other community activities.

7. Seek other Funding Sources. Establish the need to serve the targeted group by finding studies/surveys conducted by federal, state, and local agencies. Identify government agencies that serve the targeted groups such as University Affiliated Programs (UAPs); state departments of health, developmental disabilities divisions or mental health divisions; and states' departments of education. Identify private corporations that provide grants to serve minority groups. Identify national and/or state private organizations that serve the ethnic group you wish to serve, such as LULAC , NAACP, or the Council of Churches. Tap into what your state's parent training and information center is doing for culturally diverse families with children with neurobiological, emotional or behavioral differences. Establish the priority of reaching underserved families with children and youth with neurobiological, emotional or behavioral differences in everything your organization does. It has to be important enough to your organization to make minority outreach a part of the budget.

Keep the following eight things in mind when planning outreach efforts:

1. Don't put conditions on families. Just because you provide individual support, don't automatically expect families to attend meetings or training, or to want to be advocates.

2. Keep in mind the family energy it takes to do anything when you have a child with neurobiological, emotional, or behavioral differences.

3. Don't expect everything to go exactly as planned. Also don't expect to begin on time, have a good crowd or

for promised child care workers to show up. Have a contingency plan.

4. Remember that not everyone has a car or a telephone. Be creative in supporting families and in keeping them informed.

5. Remember community dynamics. People in small communities have developed telephone trees that rival the best of political campaigns. You need to know who is related to whom, who is talking to whom, and who will carry back stories.

6. Throw your organizational agenda away. Put the needs of the families first and you can't go wrong. Remember that not all families want to hear about the Individuals with Disabilities Education Act (IDEA). They might want information on day care programs, CPR, problem-solving, and how to get their basic needs met.

7. Remember that families have basic fears about speaking out or being perceived as speaking out. Assertiveness can bring retribution at home as well as in school, community programs, delivery of social services, and resolution of immigration matters.

8. Learn about family dynamics. Find out who the leader is and talk to that individual first. In Native American communities this approach is particularly important. There are wonderful organizations that provide training on reaching out to Native American families. One such organization is EPIC (Education for Parents of Indian Children with Special Needs). EPIC's director, Martha Johnson, may be reached at (505) 867-3396.

So the answer to "Aren't we all the same?" is a resounding "NO!" We may face the same challenges, but how we perceive them and how we deal with them is where we differ. The individual culture of each family must be acknowledged and respected. My community was very traditional in that it respected my great-grandmother's age and therefore her status in the neighborhood, but with new generations came new traditions and variations in the traditional Mexican culture. I was blessed to have my great-grandmother for so many years. She lived to be 98 and died when I was a senior in high school. My grandmother died two months age at the age of 92. I was lucky to have such wonderful, strong women as role models. I was lucky to have such a large extended family to teach me survival skills, and I was lucky to live near the arroyo that taught me that fear is healthy and to run like the wind.

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EXCERPTS FROM AN INTERVIEW WITH PROFESSOR JAMES LEIGH

James Leigh is an associate professor emeritus at the University of Washington, School of Social Work in Seattle, Washington. Mr. Leigh has written and lectured extensively on cultural competency issues and has trained many social workers in the ethnographic interview model for cultural competency. Ethnographic interviewing is a cross-cultural communication skill. This interview process assumes that language is the window into the reality that is known and experienced by others.

Q: Let's talk about cultural competence.
A: Certainly the focus on the implications of the concepts of diversity, multiculturalism, bi-culturalism should continue. I see no reason to drop the issues that have arisen in the past 20 years in regards to the delivery of social services to people of color....I see no reason why we should give it up, even though there are now groups—women, gay and lesbian, people with disabilities—a variety of other groups saying also that they need to be looked at in terms of services that are delivered to them....

We first began to look at [social work with African-Americans in the late 1970's] in the area of practice. I think the first time we talked about this it was, oh, "ethnic effectiveness" and "service competence," and people began to pick it up and it came out as cultural competency, which people are using now.

There has been nothing that I can see that has changed, we need to continue talking about the issues at all of the levels—administrative, supervision, practice, agency organization—including the aspects of empowerment that we are getting into. I think Doman Lum, in his book, incorporates empowerment as a practice modality in working with—as he says—"ethnic minorities of color." I don't think Doman has even dropped the color piece. He really still focuses on people of color in his book.

Q: The group-specific perspectives are also of interest. For example: How is feminism defined and viewed within a given community of color? Or culturally-specific perspectives on homosexuality? Aging? Disability? Often the groups have been studied in ways that limit the group variations.

A: [I] think you have a point there—if people are really looking at the cultural materials more in terms of comparison to other cultural groups, rather than looking [at] the variations within the ethnic culture or people of color themselves.

Q: If you are talking about empowering women and you use a category as large as "women," you may miss the nuances or implications such a focus would have on, say, a working class African-American, a rural Hispanic, or urban Native American female. It is a fundamentally different issue for the diverse communities.
A: Well, it is. There you get into the class issues that we really don't address very much in social work anyway. We don't talk about what is class-wise, or from where the majority of people that come into the social welfare system are from....Which is different than saying, "How do I understand the problems that this person is having or presenting and the issue of race? [H]ow do you look at mental illness? How do you look at child welfare through the lens of race?

This may be an assessment issue, which I think a lot of people don't want to deal with specifically. It's much easier to ask, "Okay, what do I need to learn about this person culturally to help them?" without considering what is the impact of race on the problem that people are having.

Those are two different issues. It depends on your own view of the world and how you think things come about and the kind of world you want. The empowerment people would say, essentially, "The problem is caused by the environment." Now in terms of an individual family—and we are talking about practice—how do we help the family understand that? How do we help a family understand the social and economic basis for their presenting problem?

Q: Often we culturally impose values upon people. A person of color walks into the room, but one should not presuppose where they are on a cultural identity continuum. So by imposing a new cultural stereotype one may inadvertently mis-judge or mis-serve the client.
A: That becomes the issue when we get to variations within the group. You know, there may be a visible sign of

identification and you don't have a cultural or emotional identification with it at all. The worker, again, makes an assumption, even though the assumption may be a positive assumption—I'm not saying it's negative—but out of that assumptive stance, they begin to operate in certain ways.

How do we deal with that? How do you know who is in front of you, really? We...came up with the interviewing model that we sort of adapted from James Bradley for ethnographic interviews. That is the only how-to-do-it that I have seen in the literature, so far, that relates to what workers actually do in the interviews to deal with this.

We have to figure out how do we begin to let people tell us who they are without our having to have a questionnaire that we check off things or a scale that we look for certain things and put them on a scale and make the inferences about who they are from that data anyway. I mean, [a] person might say, "You make the inference about where they are, and since we are mostly into very short-term stuff, a lot of workers don't have a lot of time to do this." They have to do things pretty fast and they don't have time to really know who is in front of them before they have to make some sort of decision. Typically it comes from within the area of meeting immediate needs and dealing with emergency issues.

Q: Most agencies use an efficiency model that is essentially impersonal for people who are relationship oriented. How important is the relationship and how is it expedited?
A: If you don't think the relationship is that important to the service you have to deliver, then you would not do certain things. If you think the relationship is important to the service that you are about to deliver, then you will do other things. If you have been trained that you walk in, you get certain information, out of that information you make a check on a DSM III chart, then all the power is in your hand out of what the person presents to you [in] maybe half an hour, an hour, two hours at most. But the issue is not on building a relationship with a person, and we know in a lot of our cross-cultural stuff, this is even material that comes out when they do training for people going overseas to work in various cultures that are distinctly different from theirs. They emphasize the necessity of beginning to form a relationship before you do anything. I think that is certainly true today here in our social services where we are dealing with people who represent many cultural and racial groups....

We say, "The client doesn't communicate very well."

Well, what they are saying is, "The client doesn't take to me," or "Somehow or another something didn't click." But it's always "the client didn't communicate." It isn't "I didn't communicate." So that is the power issue, because we have the power to say where the cause of the failure lies and it generally lies in the other person. Very seldom do we say "I was a rotten worker on this case and I really failed. It was because of my failure that I couldn't do anything."

Q: Now that goes back to your ethnographic interview. It almost, by its very nature, reverses the balance of power for at least a few minutes.
A: In fact it does, and it's almost a power that you cannot go back to once you've done it because you set it up so soon that it sets the tone for a different kind of relationship rather than mutuality....I am struggling with various names for it because it isn't truly ethnographic interviewing, but it is an adaptation of that model—ethnographic interviews and ethnographic research interviews....It's a data gathering technique, but it's gathering data in a different way and for different purposes and, within an empowerment framework, a person fully participates in the whole thing.....We have to be together and we have to share and we have to talk before we really begin to progress and, hopefully, the worker will make the right cultural moves. Now they may make some wrong cultural moves, but those are okay because the person sees the struggle to enter into their world. So, you can make faux pas using this model, where sometimes you make [cultural mistakes or false moves] with somebody and you are out of there. But within the context of setting up a relationship, you can, you know, people laugh at you, you can struggle and make mistakes and people laugh at you. They use humor, which is the best way that you can have in this area, when two people are contrasting, trying to form a relationship....[T]he saving thing is humor. And we rarely talk about humor in this thing. I put a lot of humor in myself. People just don't talk about it.

Q: In closing, what's good? What have you seen?
A: [T]here are more people, as I go around, that are very open to talking about these issues. Even some agency administrators are more open to talking. Now I don't know what the motivation for that is. I don't do enough administrative work to know, why do all these agencies want to get so culturally competent all of the sudden?....With respect to race, culture and ethnicity I am all for continued dialogue. Let's talk about it and then let's decide.

NOTES & COMMENTS

Coming This Fall on PBS
Crisis of Care: Helping Families Help Children

This fall, a new prime-time public television documentary, *Crisis of Care: Helping Families Help Children*, will examine the mental health delivery system for children and their families. *Crisis of Care* is funded through a major grant from the Robert Wood Johnson Foundation. The documentary's major goal is to increase the knowledge and understanding of what must be done to adequately serve the ever-increasing numbers of children and adolescents suffering with serious mental, emotional and behavioral disorders. *Crisis of Care* will profile nationally recognized programs and systems of care in Michigan, North Carolina, Ohio, Oregon and West Virginia and will feature a variety of child mental health advocates. The project is being administered by The Nicholas Group, a special committee of the American Re-EDucation Association, and produced by N.A.K. Production Associates. For additional information contact: Dee Newman, 1302 Narrows of the Harpeth, Kingston Springs, Tennessee 37082; (615) 952-4884; (615) 952-3242 (fax).

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Portland Research and Training Center Schedules Spring 1995 Conference and Issues Call for Papers

The Research and Training Center on Family Support and Children's Mental Health will sponsor its annual national research conference *Research, Advocacy, and Partnership in Support of Children and Their Families: Building on Family Strengths*, June 1-3, 1995 at the Hilton Hotel in Portland, Oregon. This conference is a forum for the examination and dissemination of state-of-the-art research findings and issues in the areas of family support and family-centered care. The conference will address such research issues as: developments in family research and evaluation methods, family member/consumer involvement, family support services research, family diversity, and other topics related to improving services for families and children.

Proposals are invited in the form of paper presentations, poster sessions or symposia. Preference will be given to abstracts that report on research results. For submission applications, general conference registration materials, or further information, please contact: Conference Coordinator, Research and Training Center on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, Oregon 97207-0751; (503) 725-4040.

Federation of Families for Children's Mental Health Schedules Sixth Annual Conference

The sixth annual meeting of the Federation of Families for Children's Mental Health will be held November 11-13, 1994 at the J.W. Marriott Hotel in Washington, D.C. Entitled *United We Stand - A Common Vision*, the conference will address the membership's common goal of obtaining appropriate, accessible, and affordable services and supports for all children and families. Approximately 600 families and professionals are expected to attend. A limited number of scholarships to enable family members to attend the conference are available. For additional information contact: Federation of Families for Children's Mental Health, 1021 Prince Street, Alexandria, Virginia 22314-2972; (703) 684-7710.

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Farewell Richard!

Richard Hunter, director of training for the Research and Training Center on Family Support and Children's Mental Health in the 1989-94 funding cycle, recently left his position with the Center to assume a new position. Richard served as a valued member of the Research and Training Center's staff from April 1987 through June 1994. In addition to his duties as director of training, Richard has served on the following projects: Families as Allies, Families in Action, and Inter-Professional Education. Through his work at the Center, Richard has been responsible for the development of training curricula and activities to promote parent-professional collaboration on behalf of children with mental, emotional and behavioral disabilities.

In his new position Richard serves as coordinator of Oregon's Partnership for Children program. This is a collaborative effort between Oregon Children's Services Division and Portland State University's Graduate School of Social Work to provide advanced training and education to Children's Services Division employees and to individuals training for future employment with Oregon's state child welfare agency. Students in the program will receive a master's degree in social work and specialized training to enhance their abilities to provide services to children in out-of-home placements.

In addition to his new duties, Richard is continuing his work as a student in the Graduate School of Social Work's doctoral degree program and continues to serve as an instructor in the School's masters level program. We wish Richard the best of luck in his new position and will miss his presence here at the Research and Training Center.

Research and Training Center Resource Materials

☐ *Annotated Bibliography. Collaboration Between Professionals and Families of Children with Serious Emotional Disorders.* Contains 136 entries addressing family-professional collaboration, establishing collaborative relationships, collaboration in early intervention and education, advocacy, and empowerment. $6.00.

☐ *Annotated Bibliography. Parents of Emotionally Handicapped Children: Needs, Resources, and Relationships with Professionals.* Covers relationships between professionals and parents, parent self-help, support groups, parent participation. $7.50.

☐ *Annotated Bibliography. Youth in Transition: Resources for Program Development and Direct Service Intervention.* Transition needs of adolescents: educational and vocational issues, programs and curriculum, research overviews, interpersonal issues, skills training. $6.00.

☐ *Brothers and Sisters of Children with Disabilities: An Annotated Bibliography.* Addresses the effects of children with disabilities on their brothers and sisters, relationships between children with disabilities and their siblings, services and education for family members. $5.00.

☐ *Building a Conceptual Model of Family Response to a Child's Chronic Illness or Disability.* Proposes comprehensive model of family caregiving based on literature review. Causal antecedents, mediating processes and adaptational outcomes of family coping considered. $5.50.

☐ *Changing Roles, Changing Relationships: Parent-Professional Collaboration on Behalf of Children With Emotional Disabilities.* Monograph examines barriers to collaboration, elements of successful collaboration, strategies for parents and professionals to promote collaborative working relationships, checklists for collaboration, suggested resources. $4.50.

☐ *Child Advocacy Annotated Bibliography.* Includes selected articles, books, anthology entries and conference papers. $9.00.

☐ *Choices for Treatment: Methods, Models, and Programs of Intervention for Children With Emotional Disabilities and Their Families. An Annotated Bibliography.* Literature on the range of therapeutic interventions used with children and adolescents with emotional disabilities is described. Includes innovative strategies and programs. $6.50.

☐ *Developing and Maintaining Mutual Aid Groups for Parents and Other Family Members: An Annotated Bibliography.* Topics addressed include organization and development of parent support groups and self-help organizations, professionals' roles in self-help groups, parent empowerment in group leadership, and group advocacy. $7.50.

☐ *Families as Allies Conference Proceedings: Parent-Professional Collaboration Toward Improving Services for Seriously Emotionally Handicapped Children and Their Families.* April 1986. Delegates from thirteen western states. Includes: agenda, presentation transcriptions, recommendations, worksheets, and evaluations. $9.50.

☐ **NEW!** *Family Advocacy Organizations: Advances in Support and System Reform.* Describes and evaluates the development of statewide parent organizations in 15 states. $8.50.

☐ **NEW!** *Family Caregiving for Children with a Serious Emotional Disability.* Summarizes a family caregiving model employed in survey of families with children with emotional disabilities. Includes review, questionnaire, data collection and analysis procedures and findings. $8.00.

☐ *Family Research and Demonstration Symposium Report.* Summarizes recommendations from 1992 meeting for developing family research and demonstration agenda in areas of parent-professional collaboration and training systems, family support and advocacy, multicultural competence, and financing. $7.00.

☐ *Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children.* Findings from Idaho, Oregon, and Washington, covering current services, successes, service delivery barriers, exemplary programs and innovations. $4.50.

☐ *Glossary of Acronyms, Laws, and Terms for Parents Whose Children Have Emotional Handicaps.* Glossary excerpted from *Taking Charge.* Approximately 150 acronyms, laws, and words and phrases commonly encountered are explained. $3.00.

☐ *Interagency Collaboration: An Annotated Bibliography for Programs Serving Children With Emotional Disabilities and Their Families.* Describes local interagency collaborative efforts and local/state efforts. Theories of interorganizational relationships, evaluations of interagency programs, and practical suggestions for individuals contemplating joint programs are included. $5.50.

☐ *Issues in Culturally Competent Service Delivery: An Annotated Bibliography.* Perspectives on culturally-appropriate service delivery; multicultural issues; culturally specific African-American, Asian-American/Pacific Islander, Hispanic-Latino American, Native American sections. $5.00 .

☐ *Making the System Work: An Advocacy Workshop for Parents.* A trainers' guide for a one-day workshop to introduce the purpose of advocacy, identify sources of power and the chain of command in agencies and school systems, and practice advocacy techniques. $8.50.

☐ *The Multnomah County CAPS Project: An Effort to Coordinate Service Delivery for Children and Youth Considered Seriously Emotionally Disturbed.* Process evaluation of an interagency collaborative effort. The planning process is documented and recommendations are offered. $7.00.

☐ *National Directory of Organizations Serving Parents of Children and Youth with Emotional and Behavioral Disorders, Third Edition.* Includes 612 entries describing organizations that offer support, education, referral, advocacy, and other assistance to parents. $12.00.

☐ *Next Steps: A National Family Agenda for Children Who Have Emotional Disorders Conference Proceedings.* December 1988. Includes: development of parent organizations, building coalitions, family support services, access to educational services, custody relinquishment, case management. $6.00.

☐ *Next Steps: A National Family Agenda for Children Who Have Emotional Disorders (booklet).* Briefly summarizes Next Steps Conference and recommendations made by work groups. Designed for use in educating administrators, policymakers and advocates about children's mental health issues. Single copy: $2.50. Five Copies: $7.00

☐ *Organizations for Parents of Children Who Have Serious Emotional Disorders: Report of a National Study.* Results of study of 207 organizations for parents of children with serious emotional disorders. Organizations' activities, program operation issues, training programs described. $4.00 .

☐ *Parent-Professional Collaboration Content in Professional Education Programs: A Research Report.* Results of nationwide survey of professional programs that involve parent-professional collaboration. Includes descriptions of individual programs . $5.00.

☐ *Parents' Voices: A Few Speak for Many* (videotape). Parents of children with emotional disabilities discuss their experiences related to seeking help for their children (45 minutes). A trainers' guide is available to assist in presenting the videotape. Free brochure describes the videotape and trainers' guide and provides purchase or rental information.

☐ *Respite Care: A Key Ingredient of Family Support.* Conference proceedings. October 1989. Includes speeches and panel presentations on topics such as starting respite programs, financing services, building advocacy, and rural respite care. $5.50.

☐ *Respite Care: An Annotated Bibliography.* Issues discussed include: the rationale for respite services, family needs, program development, respite provider training, funding, and program evaluation. $7.00.

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☐ *Respite Care: A Monograph.* Monograph describes: types of respite care programs, recruitment and training of providers, benefits of respite services to families, respite care policy and future policy directions, and a summary of funding sources. $4.50.

☐ *Statewide Parent Organization Demonstration Project Final Report.* Describes and evaluates the development of statewide parent organizations in five states. $5.00.

☐ *Taking Charge: A Handbook for Parents Whose Children Have Emotional Handicaps.* Addresses issues such as parents' feelings about themselves and their children, labels and diagnoses, and legal issues. Second edition includes post-traumatic stress disorder and mood disorders such as childhood depression and bipolar disorder. $7.00 .

☐ *Therapeutic Case Advocacy Trainers' Guide: A Format for Training Direct Service Staff and Administrators.* Addresses interagency collaboration among professionals in task groups to establish comprehensive systems of care for children and their families. $5.75.

☐ *Therapeutic Case Advocacy Workers' Handbook.* Companion to the *Therapeutic Case Advocacy Trainers' Guide.* Explains the Therapeutic Case Advocacy model, structure of task groups, group process issues, evaluations. $4.50.

☐ *Transition Policies Affecting Services to Youth With Serious Emotional Disabilities.* Examines how state level transition policies can facilitate transitions from the child service system to the adult service system. Elements of a comprehensive transition policy are described. Transition policies from seventeen states are included. $8.50.

☐ *Working Together: The Parent/Professional Partnership.* A trainers' guide for a one-day workshop for a combined parent/professional audience. Designed to identify perceptions parents and professionals have of each other and obstacles to cooperation; as well as discover the match between parent needs and professional roles, and practice effective listening techniques and team decision making. $8.50.

☐ *Youth in Transition: A Description of Selected Programs Serving Adolescents With Emotional Disabilities.* Descriptions of existing youth transition programs provided. Residential treatment, hospital and school based, case management, and multi-service agency transition programs are included. $6.50.

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