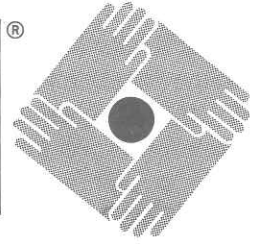




# FOCAL POINT



## SERVICES TO MINORITY POPULATIONS

### Cultural Competence Continuum

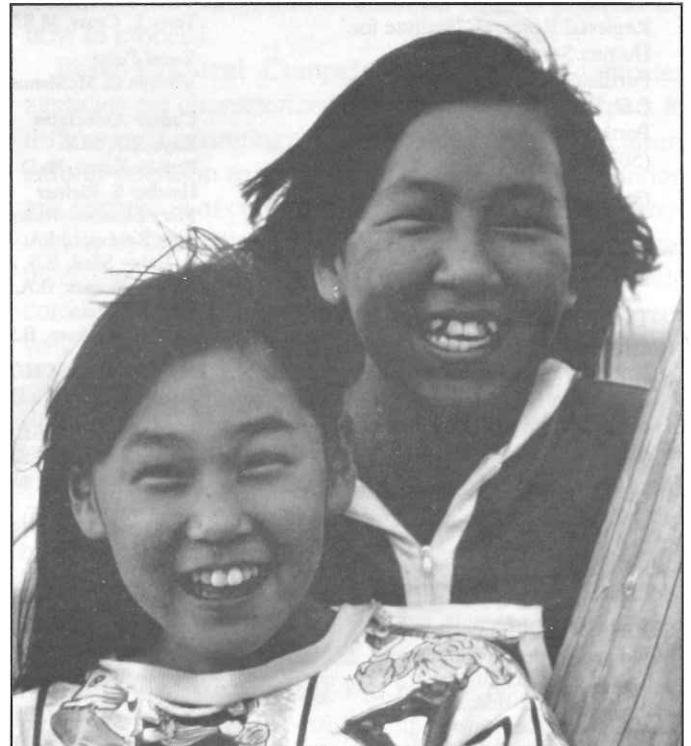
Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or professional and enable that system, agency or professional to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge and the adaptation of services to meet culturally unique needs.

Certainly this description of cultural competence seems idealistic. How can a system accomplish all of these things? How can it achieve this set of behaviors, attitudes and policies? Cultural competence may be viewed as a goal towards which agencies can strive. Accordingly, becoming culturally competent is a developmental process. No matter how proficient an agency may become, there will always be room for growth. It is a process in which the system of care can measure its progress according to the agency's achievement of specific developmental tasks. As the tasks are defined the system will be guided toward progressively more culturally competent services. First, it is important for an agency to internally assess its level of cultural competence.

To better understand where one is in the process of becoming more culturally competent, it is useful to think of the possible ways of responding to cultural differences.

Imagine a continuum which ranges from cultural proficiency to cultural destructiveness. There are a variety of possibilities between these two extremes. Here we describe six points along the continuum and the characteristics that might be exhibited at each position.

**Cultural Destructiveness.** The most negative end of the continuum is represented by attitudes, policies and practices which are destructive to cultures and conse-



*Photo courtesy the Alaska Division of Tourism*

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quently to the individuals within the culture. The most extreme example of this orientation are programs which actively participate in cultural genocide—the purposeful destruction of a culture. An example of cultural genocide is the systematic attempted destruction of Native American culture by the very services set up to “help” Indians (i.e. boarding schools). Equally destructive is the process of dehumanizing or subhumanizing minority clients. Historically, some agencies have been actively involved in services that have denied people of color access to their natural helpers or healers, removed children of color from their families on the basis of race or purposely risked the well-being of minority individuals in social or medical experiments without their knowledge or consent. While we currently do not see many examples of this extreme in the mental health system, it provides us with a reference point for understanding the various possible responses to minority communities. A system which adheres to this extreme assumes that one race is superior and should eradicate “lesser” 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 population.

**Cultural Incapacity.** The next position on the continuum is one at which the system or agencies do not intentionally seek to be culturally destructive but rather lack the capacity to help minority clients or communities. The system remains extremely biased, believes in the racial superiority of the dominant group and assumes a paternal posture towards “lesser” races. 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 support segregation as a desirable policy. They may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Such agencies are often characterized by ignorance and an unrealistic fear of people of color. The characteristics of cultural incapacity include: discriminatory hiring prac-

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*We invite our audience to submit letters and comments.*

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tices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients.

**Cultural Blindness.** At the midpoint on the continuum the system and its agencies provide services with the express philosophy of being unbiased. They function with the belief that color or culture make no difference and that we are all the same. Culturally blind agencies are characterized by the belief that helping approaches traditionally used by the dominant culture are universally applicable; if the system worked as it should, all people—regardless of race or culture—would be served with equal effectiveness. This view reflects a well intended liberal philosophy; however, the consequences of such a belief are to make services so ethnocentric as to render them virtually useless to all but the most assimilated people of color.

Such services ignore cultural strengths, encourage assimilation and blame the victims for their problems. Members of minority communities are viewed from the cultural deprivation model which asserts that problems are the result of inadequate cultural resources. Outcome is usually measured by how closely the client approximates a middle class non-minority existence. Institutional racism restricts minority access to professional training, staff positions and services.

Eligibility for services is often ethnocentric. For example, foster care licensing standards in many states restrict licensure of extended family systems occupying one home. These agencies may participate in special projects with minority populations when monies are specifically available or with the intent of "rescuing" people of color. Unfortunately, such minority projects are often conducted without community guidance and are the first casualties when funds run short. Culturally blind agencies suffer from a deficit of information and often lack the avenues through which they can obtain needed information. While these agencies often view themselves as unbiased and responsive to minority needs, their ethnocentrism is reflected in attitude, policy, and practice.

**Cultural Pre-Competence.** As agencies move toward the positive end of the scale they reach a position we will call cultural pre-competence. We have chosen this term because it implies movement. The pre-competent agency realizes its weaknesses in serving minorities and attempts to improve some aspect of their services to a specific population. Such agencies try experiments, hire minority staff, explore how to reach people of color in their service area, initiate training for their workers on cultural sensitivity, enter into needs assessments concerning minority communities, and recruit minority individuals for their

boards of directors or advisory committees. Pre-competent agencies are characterized by the desire to deliver quality services and a commitment to civil rights. They respond to minority communities' cry for improved services by asking, "What can we do?" One danger at this level is a false sense of accomplishment or of failure that prevents the agency from moving forward along the continuum. An agency may believe that the accomplishment of one goal or activity fulfills their obligation to minority communities or may undertake an activity that fails and are therefore reluctant to try again.

Another danger is tokenism. Agencies sometimes hire one or more (usually assimilated) minority workers and feel they are then equipped to meet the need. While hiring minority staff is very important it is no guarantee that services, access or sensitivity will be improved. Because minority professionals are trained in the dominant society's frame of reference they may be little more competent in cross-cultural practice than their co-workers. Minority professionals, like all other professionals, need training on the function of culture and its impact on client populations. The pre-competent agency, however, has begun the process of becoming culturally competent and often only lacks information on what is possible and how to proceed.

**Basic Cultural Competence.** Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations. The culturally competent agency works to hire unbiased employees, seeks advice and consultation from the minority community and actively decides what it is and is not capable of providing to minority clients.

**Advanced Cultural Competence.** The most positive end of the scale is advanced cultural competence or proficiency. This point on the continuum is characterized by holding culture in high esteem. The culturally proficient agency seeks to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture and publishing and disseminating the results of demonstration projects. The culturally proficient agency hires staff who are specialists in culturally competent practice. Such an agency advocates for cultural competence throughout the system and improved relations between cultures throughout society.

In conclusion, the degree of cultural competence an agency achieves is not dependent on any one factor. Atti-



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tudes, policies, and practice are three major arenas where development can and must occur if an agency is to move toward cultural competence. Attitudes change to become less ethnocentric and biased. Policies change to become more flexible and culturally impartial. Practices become more congruent with the culture of the client from initial contact through termination. Positive movement along the continuum results from an aggregate of factors at various levels of an agency's structure. Every level of the agency (board members, policymakers, administrators,

practitioners and consumers), can and must participate in the process. At each level the principles of valuing difference, self-assessment, understanding dynamics, building cultural knowledge and adapting practice can be applied. As each level makes progress in implementing the principles, and as attitudes, policies and practices change, the agency becomes more culturally competent.

*Terry L. Cross, M.S.W., is on the staff of the Portland Minority Project and is Director, Northwest Indian Child Welfare Institute.*

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## Revisiting the Ethnic Dilemma

One of the primary goals of the Child and Adolescent Service System Program (CASSP) has been to deliver culturally relevant services to minority children and youth with serious emotional handicaps and their families. This goal recognizes that our country is made up of racial, cultural and religious minorities; and further, that children's mental health is steeped in many of the same racial and cultural biases and prejudices that affect our nation's other institutions. The goal also acknowledges that insufficient attention has been paid to understanding the culture-specific characteristics of racial and ethnic minority groups as a means of identifying mental health needs and planning mental health services<sup>1</sup>.

The term "minority" in itself can be confusing. In a global context, non-white people constitute a majority of the world's population and not a minority. Thus, the term can rob many American minorities of a sense of cultural heritage and achievement, as well as potential sources of emotional or spiritual strength, and human dignity. The term was originally used to refer to Blacks and other people of color who were victims of overt racial discrimination in this country. However, as Jenkins<sup>2</sup> notes: "The term has been broadened to include a variety of groups who have been disadvantaged in one way or another who all receive the minority designation to the consternation of other groups who feel hard won gains achieved through civil rights legislation being eroded and diffused."

Irish, Jews, Italians, and Poles are among America's many ethnic groups; yet they also belong to the dominant population and are not considered minority groups in contemporary parlance. Therefore, the criteria for minority status should include groups that are both powerless and relatively few in number<sup>2</sup>. Such groups are characterized by the absence of power as opposed to the misuse of

power which makes the minority group subject to the values and goals of the dominant group<sup>3</sup>.

The CASSP Minority Initiative focuses upon America's four sociocultural groups of color: African-Americans, Hispanic-Americans, Native Americans, and Asian-Americans/Pacific Islanders. These groups were targeted because historically they have had limited access to economic or political power and have been unable or not allowed to influence the structures that plan and administer children's mental health service systems.

Efforts to improve services to minority children and youth with serious emotional handicaps and their families will be tied to our ability to understand and empower minority families and communities. In order to work productively with racial and cultural communities, partnership must replace paternalism. This notion embodies the concept that minority people and communities must be enabled to determine their own destinies. Many earlier attempts to plan services and make policy for minority communities have been rooted in a push toward assimilation typically based on a pathology model rather than on cultural pluralism. In the sixties for example, the major barriers to racial integration were viewed as based in the sociocultural characteristics of Blacks themselves, rather than based on the dominant society's own racism<sup>4</sup>. Gary<sup>5</sup> admonishes against using what are essentially pathology models to understand cultural dynamics and environmental strengths of Black people and communities.

Because of our history and survival skills inherent to minority communities, we may encounter some understandable resistance on the part of some communities as we begin on our path to improved services. However, within the CASSP family and extended family exists considerable wisdom and expertise that can facilitate our ability to work with various minority communities. We

must be committed, and must understand why this goal is important. Perhaps the distinguishing feature of empowering people is respect and faith in the capacity of a specific constituency to help themselves. When empowered, minority communities are up to the challenge. Our challenge as professionals is to develop the understanding and commitment necessary to embark on such an ambitious journey.

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## CASSP National Workshop Identifies Culturally Specific Needs of Minority Children with Emotional Handicaps

The Child and Adolescent Service System Program (CASSP), housed within the National Institute of Mental Health's Child and Family Support Branch, sponsored a national workshop in which participants identified and explored the culturally specific needs of minority children with emotional disorders and their families. The 1986 workshop brought together professionals representing the four major minority population groups in the United States (Blacks, Hispanics, Asians and Native Americans).

The most significant cultural barrier identified was the issue of assimilation into the majority culture. Conflict between cultures creates a natural tension between the majority and minority groups which is often stressful for a child or adolescent, especially one who is bused to a school in another district or who is biracial or bicultural.

A second sociocultural issue is the difference in family structure between the minority and the dominant culture. This is reflected by heavy reliance on extended family structures in all four major minority groups, the authority and deference given to male heads of household in Asian families, and the need for special support of single parent and teenage families within the Black community.

The impact of the use and abuse of alcohol and drugs, especially among Native American and Black youngsters and their families, is another issue. Substance abuse complicates the environmental and sociocultural problems minority children face and is recognized as a major con-

tributing factor to their difficulties in school and their overrepresentation in the juvenile justice system.

In addition, the perceptions of "mental health" and "mental illness" held by all four major minority groups determine whether minority families will seek mental health services or use them for their children. In the Hispanic community mental health services are viewed as either irrelevant or oppressive. Many Hispanics come in contact with a mental health professional only when forced by the court, welfare department or other government agency to accept services. Consequently, their experiences with the mental health system have generally been negative. Furthermore, because they stress individualization as an indication of normalcy, American mental health programs are perceived to be in conflict with Hispanic culture. Many Hispanics view mental health services as incongruent with the Hispanic culture, in which the family is seen as the source of problem solving while individual values are de-emphasized. Sufficient supports are expected to be available within the hierarchy of the extended family without having to resort to mental health programs. Involvement in such a program is therefore viewed by the family and the client as an affirmation of serious dysfunction and as evidence that the client is cut off from the family support system, which is an embarrassment to the family. Similar views are also held by many Asians, Blacks and Native Americans.

In attempting to overcome these barriers, "informal"

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support systems have developed in many communities. However, the formal mental health system tends to overlook these culturally relevant resources, which can be valuable allies. Informal resources outside the mental health system which are used in seeking solutions to mental health problems include churches, extended family members, friends, folk healers, older persons who are viewed as having wisdom, community ceremonials, merchant/social clubs, and self-help organizations.

Accordingly, in order to facilitate the development of mental health services, programs and systems relevant to minority populations, policymakers and program planners should be aware of the following:

1. environmental factors and the influence they have on intrapsychic conflicts;
2. the level of acculturation or adjustment to the dominant culture which may influence the type of mental health programs needed;
3. the minority culture's patterns of family systems, communications, language, values, morality and learning; and
4. the view that mental distress can have physical manifestations (Asians, for example, tend to deny the existence of emotional problems and often manifest these as headaches or stomach problems).

Other principles to observe in developing services for minority populations include:

- maintaining and incorporating the client's network of natural support systems;

- outreach, networking and linkages with churches and indigenous healers in the community;
- development of neighborhood based services which provide a wide variety of services in a single site;
- linking service delivery with other systems, such as education, child welfare and substance abuse programs;
- supporting community ownership of the problem and self-determination of the solution by involving a grassroots constituency of community members in planning, monitoring and acting as advisers for programs; and
- provision of services by bilingual and bicultural staff, or by staff from the same cultural background.

[Note: Adapted from Katz-Leavy, J., Lourie, I.S. & Kaufmann, R. (1987). Meeting the mental health needs of severely emotionally disturbed minority children and adolescents. *Children Today* 16(5), 10-14.]

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## Service Delivery to Indian Children with Emotional Handicaps

An exploratory study to increase the understanding of issues involved in providing services to Indian children with emotional disorders was conducted in Oregon, Washington, and Idaho. In these three states there are thirty-seven federally recognized tribes and several other tribes without federal recognition which range in size from 61 to 8,500 members. Findings included the following:

- Given the prevalence of school failure, adolescent suicide, alcoholism, involvement in the juvenile justice system and out-of-home placement rates, an estimated 11% to 20% of Northwest Indian children suffer some degree of emotional impairment.

- Indian children with emotional handicaps are served by a complex variety of systems with overlapping responsibilities and jurisdictions. Given that so many systems are involved and that no single system has assumed primary responsibility for this population, only those children whose behavior absolutely demands intervention actually receive services. Even then, the service provided is more likely to be what is available, rather than what is needed.
- Barriers to service delivery were identified. Primary *system barriers* include diffuse responsibility, lack of funding, and isolation. The need for increased awareness, improved attitudes, and training were identified as *community barriers*. Lack of knowledge of etiology



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and the lack of a theory base that reflects cultural beliefs and practices were viewed as primary *practice barriers*.

- Exemplary programs serving Indian children with emotional handicaps were identified. Both the Confederated Tribes of Warm Springs and the Muckleshoot Tribe have developed group homes which offer an alternative to off-reservation treatment. The culturally based Warm Springs program designates members of the tribe to serve as teachers and disciplinarians. Realizing that sexual abuse is a major source of emotional problems, the Skokomish Tribe has developed a sexual abuse prevention program. The Quinault Indian Nation brings together traditional elders, tribal

government, service providers and parents to find solutions to child welfare and mental health problems unique to that community. The Native American Rehabilitation Association in Portland, Oregon uses an approach known as Indian self-actualization in its treatment of alcoholism and related mental health issues. Clients examine their own identities, clarify values and develop skills to cope with cultural differences.

For information on ordering the study's full report, entitled *Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children*, see page 11.

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## State and Local CASSP Activities

Each Child and Adolescent Service System Program (CASSP) project is committed to improve the delivery of services to minority children with emotional handicaps and their families. We summarize selected state and local CASSP efforts here as examples of approaches individuals and agencies may undertake to guide the system of care toward the provision of progressively more culturally competent services.

**Alabama.** A minority issues task force composed predominantly of Black professionals was launched in July 1986. The task force found that Black youth were underrepresented in residential mental health care and overrepresented in the juvenile justice system. CASSP staff developed a six day training curriculum with the University of Alabama Child Psychology Program which was provided to mental health center staff statewide. Task force members created modules that focus on issues concerning children of color and serve as co-trainers on the testing and minority issues modules. Each mental health center will receive a copy of the revised curriculum for staff development and juvenile justice personnel will be offered a one day training session.

**Alaska.** Alaska CASSP seeks to serve children locally, rather than placing them outside their homes, villages, or state. Alaska Native children are most at risk of inappropriate placement. In 1986 the Alaska Youth Initiative began to return children from out of state placements. Native villagers develop plans for returning children with the schools and relevant agencies. These plans rely heavily on each child's natural helping system. CASSP pro-

vides flexible funding so that dollars follow children. Schools may receive extra funding to provide the child with special help. Local caregivers, including relatives, are trained and hired to provide for local youth.

**Brooklyn.** Brooklyn CASSP staff conducted a literature review that helped them develop both historical and theoretical perspectives to identify and understand the specific issues and problems of minority children and adolescents that prevent them from taking full advantage of mental health services. Community forums and informal meetings were held which enabled community leaders to articulate their thoughts and concerns about delivering services to minority groups. An intensive needs assessment was conducted to identify: (1) the necessary elements of a culturally relevant system of care and (2) how the community could best be served by the mental health system.

**Delaware.** The Delaware CASSP Project provided technical assistance funds to a Latin American community center to obtain the services of an Hispanic clinician. In addition to direct services, the clinician works with the schools to encourage referrals. Community center staff are assisting CASSP staff in translating a manual for parents of children with emotional handicaps into idiomatic Spanish. The Division of Children's Mental Health Services has an ethnic advisory committee comprised entirely of people of color whose responsibilities include recommending system changes to CASSP. The Division is working to coordinate outpatient mental health providers, drug and alcohol programs, and community centers to

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serve youth at risk in community settings more effectively. A priority for each of these programs is to have bilingual/bicultural counselors.

**District of Columbia.** Prior to 1987 the District had few mental health services specifically targeted for children and youth with serious emotional handicaps. In 1987, however, the District established a separate budget for children and youth and immediately addressed the issue of interagency coordination and collaboration. As a result of these efforts CASSP has established agreements with other systems including: juvenile justice, education, and alcohol and drug. Efforts are underway to develop and test a model of intervention for latency-age Black males. Additionally, CASSP staff are contemplating adapting the Homebuilders (in-home, intensive intervention) model to enhance its effectiveness with minority children and families.

**Georgia.** A regional task force that includes Black and Hispanic parents was formed to identify barriers to service delivery and develop a regional plan for services. A conference held this spring included a workshop on minority issues, and an upcoming conference will focus on drafting a state plan for improving services to children of color. Eight regional Families As Allies workshops will be held this year and CASSP staff will emphasize the inclusion of Black and Hispanic parents and providers.

**Hawaii.** Hawaii CASSP efforts seek to increase provider awareness of Native Hawaiians, Polynesians, and immigrant and refugee Southeast Asian peoples and thereby enhance their service delivery. The Immigration and Refugee Services Division of the Department of Health and CASSP are adapting a parent leadership training program for Southeast Asian immigrant and refugee parents. CASSP staff developed a training handbook and a half-day workshop with the assistance of Native Hawaiians for providers concerning services to Native Hawaiian and Polynesian peoples. Two CASSP staff members are on the Native Hawaiian Task Force of the Department of Health.

**Idaho.** Idaho plans to use specially trained bilingual paraprofessionals as mental health aides or "treatment extenders" within two migrant Head Start programs serving approximately 150 three-to-six year old Hispanic children and their families. Initial training and ongoing clinical supervision and consultation will be provided by a consortium of Hispanic human services professionals from a local community mental health center, an elementary school, the Casey Family Foundation, and other local community settings. CASSP staff will provide program

monitoring, technical assistance, and program evaluation services. Paraprofessionals may provide in-home consultation and training to family members in areas of developmental education and parenting skills or may provide respite to family members. The goal is to provide training, supervision, and funding for an ongoing cadre of Hispanic paraprofessionals to be used as bilingual and bicultural mental health treatment extenders within the migrant and Hispanic communities.

**Kentucky.** Kentucky CASSP convened a meeting of parents, community leaders, and child-serving professionals with an interest in Black children and youth with serious emotional problems to identify issues related to the needs of such children and to recommend appropriate training and education activities. The group proposed culturally specific training which should address: diagnosis and assessment, behavioral and social dynamics of Black families, and service models and interventions for Black children and youth. Community education activities should address: accessing community resources, improving communication skills (parent/child and parent/professional), advocacy skills, parent education (e.g., discipline techniques, building self-esteem, and identifying respite and child care resources). One training has been held and a second is scheduled. Similar efforts to improve services are underway with the Appalachian community.

**Louisiana.** The Louisiana CASSP Project studied children in the mental health system and found that a significant percentage were children of color. CASSP is hiring a cultural diversity specialist who will develop a corps of cultural consultants for programs to use and will provide technical assistance to CASSP staff on cultural issues.

**Mississippi.** Mississippi CASSP convened an interdisciplinary planning team to identify issues, establish priorities, and develop action plans to better serve Black, Native American, and Southeast Asian minorities. A cross-cultural training manual for use by professionals working with minorities will be developed. CASSP staff identified minority community leaders who could be instrumental in helping to develop plans and objectives that more accurately reflect the issues faced by minority children and youth with mental health needs. Some minority children with unmet mental health needs, currently being served by other systems, have been identified.

**Nebraska.** CASSP staff met with consumers and providers of children's mental health services to identify staff training and development needs for serving minority populations. In conjunction with the University of Nebraska CASSP staff are identifying curricula and training



approaches aimed at enhancing cultural competence in service delivery. Natural leaders in local minority communities who can participate in the service system planning process have been identified.

**New Jersey.** New Jersey efforts are primarily aimed at improving services for the Black, Hispanic, and Asian/Pacific Islander communities. An interdisciplinary group planned a conference entitled *Affecting Change in the Delivery of Mental Health Services for Minority Youth and Their Families*, which was held in December 1987. The planning group sent a letter articulating their concerns to the state's mental health planning body. Commu-

nity education efforts seek to empower consumers by enhancing advocacy skills, suggesting approaches for accessing decision making bodies and encouraging non-stigmatizing views of mental illness.

**Ohio.** Ohio CASSP is focusing their efforts on Black and Asian/Pacific Islander populations. CASSP staff obtained input from providers and consumers of children's mental health services as well as from the state's 53 mental health boards which will enable Ohio to improve services based on current data. Ohio is also examining cross-cultural training approaches that can make their service system more sensitive to racial and ethnic minority needs.

## Why Not?

In the last decade the changing character of the American racial and ethnic mix has contributed to changes in the way we think and behave. Nowhere is this more evident than in the way we eat. For years, nutritionists have been educating us about our dietary needs. Almost everyone can name the four basic food groups. As tacos, red beans and rice, and stir fry—to mention only a few—have become part of the American diet, we have learned that dietary needs can be met in a variety of ways. As human beings we share the same needs but our styles of meeting those needs are as varied as our cultures. *Why not* take a lesson from our society's experience with food?

By accepting the uniqueness of each culture's cuisine American culture has been enhanced. Likewise, by learning about and accepting various cultures' preferences for meeting emotional needs, mental health services can be enriched for all people. Family loyalty, extended family nurturing systems, role flexibility, and spiritual harmony and strength are all preferred ways of meeting emotional needs in various cultures in America today. *Why not* place them on the menu of the system of care? We can start by reaching out to those who have knowledge of these diverse preferences whenever we have a client whose emotional dietary preferences are different than our own.

T.L.C.

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

## Parents' Perspective

I am the parent of an attention deficit disorder (ADD) child. He is now five years old, has been in a private school for two years, and will enter public school and the first grade in September. At my request the public school tested him for special education services. He did not qualify for any services. I explained my feelings as the mother of an ADD child to the principal and special education teachers and hoped they would understand that the normal classroom environment they were suggesting may not be appropriate even though he was not in a special education position. I was ready for battle.

Much to my surprise, they not only understood, they came up with solutions that I didn't know were available. My son will enter Cochiti Elementary School next year in a regular classroom with a special task force in place to monitor him. His teachers will be chosen by a special team.

So many parents of special needs children have to fight the entire way. I felt it important to share this story of a wonderful school and a wonderful staff. This is not to say the fight is over for my son and I, but one battle has been won. For the moment that is enough for celebration.

Jackie C. Lawrence. Albuquerque, New Mexico.

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

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**Oklahoma.** Oklahoma CASSP is addressing mental health needs of Native American children and youth with emotional handicaps and their families. CASSP staff recognize that plans to improve services to this population must acknowledge the considerable diversity that exists among Indian tribes. Oklahoma convened a conference entitled *Encircling Our Forgotten: A Conference for the Emotionally Disturbed North American Indian Child and Adolescent* in June 1988 which addressed mental health issues related to health care, cultural integrity, and the family. This multi-tribal conference stimulated the development of an interagency task group to examine issues affecting Oklahoma Indian populations. One important issue is the presence of Fetal Alcohol Syndrome in many Indian communities. The group began to push other Indian serving organizations to examine their sensitivity when serving Native Americans. CASSP staff have conducted extensive research and literature reviews. Interviews and discussions with community leaders, consumers and providers of mental health services guide Oklahoma's planning process.

**Pennsylvania.** Pennsylvania has a significant Black and Hispanic population. Minority parents are included on a statewide advisory committee. A statewide task force on minority issues comprised of minority professionals, and representatives from state, local and regional organizations will be assembled. CASSP staff will coordinate the task force. Two county level CASSP projects have been funded to examine accessibility patterns in service delivery and to examine the use of natural support systems as the basis for serving children.

**Washington.** Washington CASSP staff met with representatives of minority communities, consumers and providers of mental health services, and a coalition of minority service providers to identify concerns and needs in delivering services to minority populations. As an outgrowth of these meetings, CASSP has issued "requests for qualifications" in an effort to identify persons and agencies qualified to develop and provide minority-specific approaches to service delivery.

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## NOTES & COMMENTS

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### Louisiana Parent Conference

Louisiana's upcoming parent conference will be held October 20-22, 1988 in New Orleans. Conference participants will explore approaches to parent/professional collaboration and methods of maintaining parent support groups. A parent panel will discuss their experiences in obtaining services for their children. The Louisiana Child and Adolescent Service System Program (CASSP) Project has announced the availability of parent scholarships to fund expenses. For additional information contact: Liz Sumrall, CASSP Office, P.O. Box 4049, Baton Rouge, Louisiana 70821 or telephone (504) 342-2540.

### Research and Training Center on Families and Disabilities Launched

The University of Kansas received a United States Department of Education's National Institute on Disability and Rehabilitation Research grant to open the first federally funded national rehabilitation research and training center on families and disabilities. The Beach Center on Families and Disability will engage in research, training and dissemination of information relevant to families

who have members with developmental disabilities or serious emotional disturbances, members who depend on technology for life support or members who are disabled and elderly. For further information on the center, or on the work done relative to a specific disability population or issue, contact: Gary Brunk, The Beach Center on Families and Disability, The University of Kansas, Lawrence, Kansas 66045 or telephone (913) 864-4950.

### Next Issue: Creating Positive Change

The next issue of *Focal Point* will focus on ways of bringing about positive change for children with serious mental or emotional disorders and their families. In addition to discussing the philosophy, theory, and strategies for creating change, we will offer examples at the case, program, community, and state system levels. Readers are invited to offer descriptions of successful advocacy efforts, examples of change efforts initiated by or involving parents, or other examples of positive change for inclusion in the next *Focal Point*.

Please use current order form for Research and Training Center resource materials.



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