DOCUMENT RESUME

ED 264 358 UD 024 634

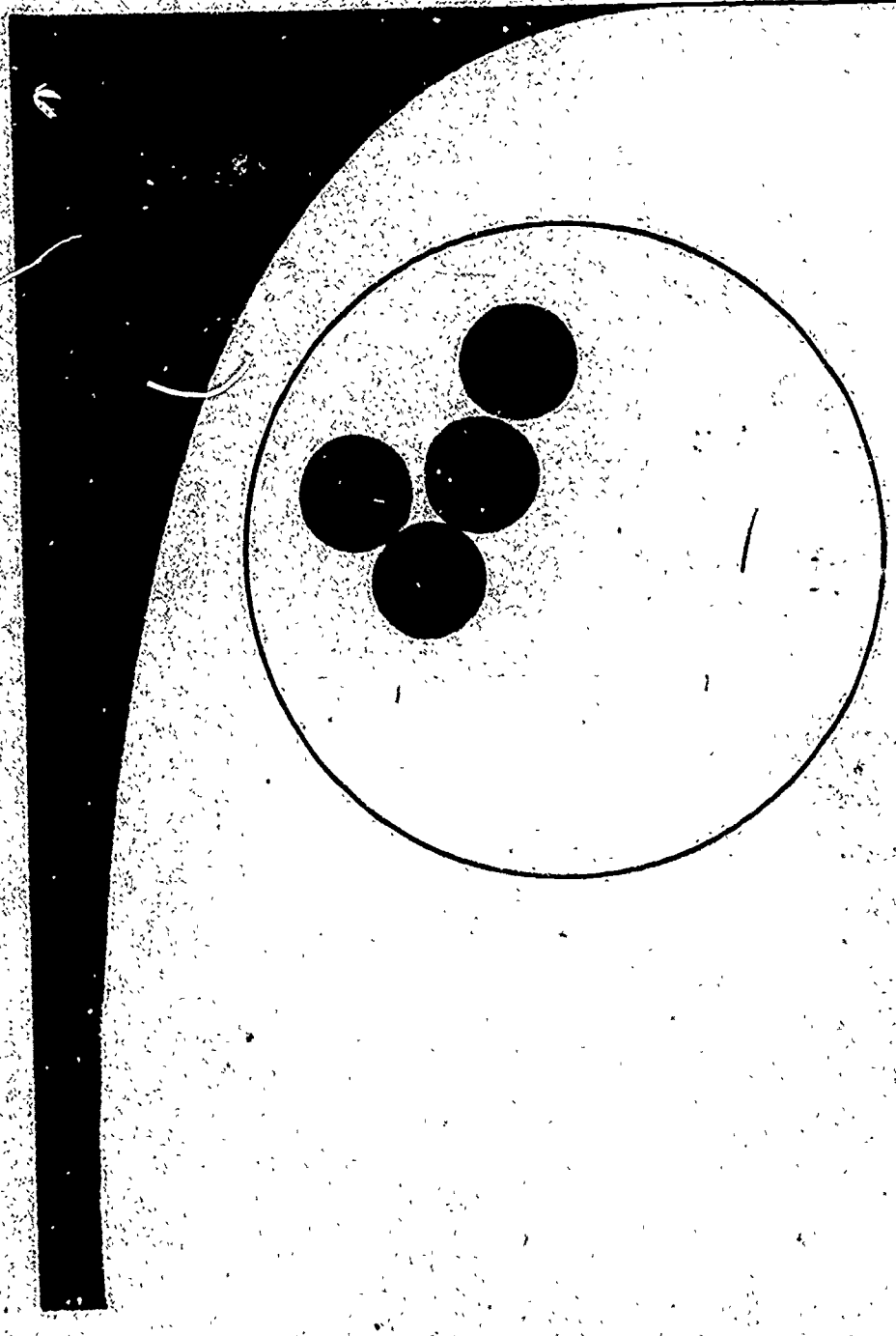
TITLE Minority Administrators in Community Mental Health Centers.
INSTITUTION Howard Univ., Washington, D.C. Mental Health Research and Development Center.
SPONS AGENCY National Inst. of Mental Health (DHHS), Rockville, MD. Center for Minority Group Mental Health Program.
PUB DATE 82
GRANT 1R01-MH-25551-05
NOTE 97p.
AVAILABLE FROM Mental Health Research and Development Center, Institute for Urban Affairs and Research, Howard University, 2900 Van Ness Street, N.W., Washington, DC 20008 ($3.00).
PUB TYPE Reports - Research/Technical (143) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Administrator Characteristics; *Administrator Role; Administrators; *Community Services; *Mental Health Programs; *Minority Groups; Social Services

ABSTRACT

The purpose of this study was to provide an overview of the problems confronting minority administrators of mental health agencies. Twenty-five minority directors of Community Mental Health Centers were given questionnaires asking for information about their backgrounds and the design, structure, and operation of their respective mental health centers. The major findings concerning the administrators were that the group was 88% male, 50% held masters degrees, and more that 37% had social work backgrounds. Concerning the agencies, it was found that most of them had a flexible service philosophy, that their future orientations were characterized by stress and scarce resources, and that the adequacy of the agencies was affected by lack of funding and the need for management and staff development. The directors were found to value the need for sensitivity to socio-cultural and political awareness among their treatment personnel. The centers were found to need special personnel, political support, adequate public transportation, and bilingual programs. The major community priority seen was a need for services for children and adolescents and community outreach programs. The resources needed by the agencies included staff development and technical assistance in the areas of finance, research, and grantsmanship. The study includes recommendations addressing the problems experienced by these agencies. The study questionnaire is appended. (CG)

Minority Administrators in Community Mental Health Centers



Mental Health Research and Development Center
Institute for Urban Affairs and Research
Howard University
Washington, D.C. 20008

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PREFACE

Minority Administrators in Community Mental Health Centers is part of a series of studies undertaken by the Mental Health Research and Development Center at Howard University to examine mental health issues confronting Black communities. This paper was prepared by Charles L. Sanders, Senior Research Associate, and Rita R. Foy, Research Associate, under the supervision of Lawrence E. Gary, who was the principal investigator for this project.

The authors wish to express their gratitude to the following individuals whose support and cooperation made this survey possible: James Ralph, Chief, Center for Minority Group Mental Health Programs, NIMH; Ford Kuramato D.S.W., Assistant Chief, Division of Mental Health Programs, NIMH; Richard Shapiro, Assistant Chief, Racism and Mental Health Programs, NIMH; Chester Jones, Executive Director and Lawrence Hylick, Assistant Director, Albert Einstein, Community Mental Health/Mental Retardation Center; and Eva M. Bell, Assistant Director of the Institute for Urban Affairs and Research, Howard University. Appreciation is also extended to those participants who took the time to respond to the questionnaire.

The research described in this report was supported by a grant from the Center for Minority Group Mental Health Programs of the National Institute of Mental Health (Grant Number 1R01 MH-25551-05). Reports of the Institute for Urban Affairs and Research (IUAR) do not necessarily reflect the opinion or policies of the sponsors of IUAR research.

* These were the affiliations of the individuals when this study was started.

TABLE OF CONTENTS

SUMMARY

Crucial to the quality of services provided in the mental health care system is the role and support of the administrator. Little is known, however, concerning the special problems of the minority administrators of mental health facilities. The purposes of this study were to provide an overview of the internal and external problems confronting minority administrators and to assess the management tools and other factors involved in the improvement of community mental health services delivery and program evaluation. Specific objectives were to:

1. Acquire a general profile of minority directors of community mental health centers.
2. Acquire a general profile of the agencies directed by minority administrators.
3. Ascertain the needs, problems and issues surrounding the national status of minority directors.
4. Provide a base of information on the problems of minority directed community mental health centers.
5. Provide information on corrective measures for problems encountered by minority directors.

Twenty-five minority directors who attended the 1977 National Conference of Minority Directors of Community Mental Health Centers were the study's participants. A two-part questionnaire was developed. The first part asked for information concerning the respondent's background and the second part focused on the design, structure and operation of the community mental health center the respondent directed. Questionnaires were administered through personal interviews and, in some cases, they were mailed. Content analysis was the data analysis technique used.

The major findings of this study were:

1. The group was primarily male (88%). The only female director among the majority was from the south.

2. The most frequently held degree (50%) was a Masters. More (37%) of the minority directors had background disciplines in "Social Work" than in other fields.

3. An average of 29% of the minority directors' time was spent in program planning and development, fiscal affairs, community relations, staff selection and supervision.

4. Most of the agencies surveyed, had a flexible service philosophy, and offered either treatment or prevention emphasis. The future orientation for these agencies was characterized by uncertainty, stress, and scarce resources; but still they provided a comprehensive range of services. The flexible programs did reflect special service consideration for client. Consequently, co-ordination with referral sources, was seen as a major strength among the agencies. The adequacy of the agencies was affected by a lack of funding and the need for management and staff development.

5. These minority directors valued highly the need for sensitivity to socio-cultural and political aspects among their treatment personnel.

6. The centers were considered to be in need of special personnel as well as, political support, adequate public transportation or mobile vans, and bilingual programs.

7. The major community priority was the need for more services for children and adolescents and community outreach programs.

8. Staff development and technical assistance especially in knowledge of finances, research and grantsmanship ranked high among the need for further resources among the agencies.

Based on the aforementioned conclusions, the following recommendations are made from this research survey:

1. This study revealed the apparent lack of female administrators among the minority directors. Increased affirmative action efforts might focus on more female directors in community mental health centers.

2. It is recommended that these directors give more attention to project evaluation and monitoring. The issue of time management is a recurring one for administrators.

3. It is recommended that the broad service orientation be re-examined if some of these directors' dilemmas are to be resolved. Broadly based programs may be inherently conflicting, thereby, resulting in more operational constraints.

4. It is recommended that continuing education and staff development training include such areas as project evaluation, fiscal and budget management, grantsmanship, technical assistance and staff development should commence immediately.

5. It is recommended that recognition of a broad range of skills, talents, and cultural sensitivities be encouraged when selecting treatment personnel.

6. It is recommended that specific resources, such as special personnel, bilingual programs, and transportation services be among the unique programmatic needs of minority community mental health centers.

7. It is recommended that directors give more attention to community support.

LIST OF TABLES

CHAPTER I INTRODUCTION

Background

The area of mental health manpower has been one of the crucial areas of interest in total mental health service delivery. Of continuing special interest is the area of minority mental health manpower. These factors were borne out by some work done by the Division of Special Mental Health Service Programs and Division of Manpower and Training Programs at the National Institute of Mental Health (NIMH).

It has been the consensus of the Planning Committee that community health centers in minority communities have an unique set of strengths, problems, and issues which could be referred to as "another country." Problems of funding and funding sources, interpretation of guidelines and policies, difficulties in the politics of community organization activities, and other factors represent a common set of circumstances among minority directors. Thus, the assessment survey used in this research was aimed at codifying some of these generic issues, and providing a better base point for furthering both service delivery and program evaluation.

Objectives

This research survey evolved from the National Conference of Minority Directors of Community Mental Health Centers (CMHC) held in Washington, D.C., on February 10-12, 1977. The aim of the assessment was to provide an overview of the internal and external problems con-

fronting minority administrators and also to provide a perception of the management tools and other factors involved in the improvement of community mental health services delivery and program evaluation.

The objectives of the study were to:

1. Acquire a general profile of minority directors of community mental health centers.
2. Acquire a general profile of the agency directed by minority administrators.
3. Ascertain the needs, problems, and issues surrounding the national status of minority directors.
4. Provide a base of information on the problems of minority directed community mental health centers.
5. Provide information on corrective measures for problems encountered by minority directors.

More specifically, the study addressed such questions as:

1. What are the characteristics of the minority directors and their agencies?
2. What is the role of the minority director?
3. What are the needs and problems?
4. What are the operational constraints in these agencies?
5. How can the CMHC serving minorities be identified as a "special" service delivery system?
6. What is the philosophical framework for overall service priority?
7. How do minority CMHC directors view the future of their programs?
8. Are there "special" service considerations to serve the clients?
9. Do minority CMHC directors perceive their facilities as being adequate?

10. Is there a specific kind of treatment personnel needed in these centers?

11. How are community priorities and needs perceived by these directors?

12. How effective are the community influences on services provided by the CMHC?

Indeed, many of these questions were aimed at getting a better view of the agency, the need for policy change, and role revision for better mental health services. Basically, these questions were answered in the study. However, while gross determinations and projections cannot be made, the study showed conclusively several important facets based on the small but representative sample surveyed.

Literature Review

Few attempts have been made to concentrate on the general problem of supply and demand among various areas of minority mental health professionals; for example, the emergence of data on recruitment (U.S. Civil Service Commission, 1977), training and education, and the increasing number of minority mental health professionals (Gary, 1978).

Little information, moreover, has emerged on the substantive issues such as the needs, roles, specific work settings, current work forces, career patterns, frustrations, or successes regarding Black administrators (Hunt and Howard, 1977; Sanders, 1977; Hennig and Jardin, 1977; Nason, 1972). Based upon the paucity of research on minority administrators, in general, this study will provide a landmark contribution on the largest ethnic minority group among mental health professionals (Spilerman, 1976; Lipset, 1955; Form, 1949). This

study focuses specifically on the needs and problems of minority mental health administrators.

In order for the problems of minority administrators to be better explored, there is a great need for the study of the research available on minority administrators. The literature review revealed several pertinent documents which had special reference to the needs assessment survey of minority mental health directors. Bramwell (1972) observed the multidimensional role of the Black professional. The minority mental health directors operate in a multiplicity of roles in order to meet requirements in community mental health centers which serve minority communities.

Reid (1976) observed the importance of the professional ideology among the helping professions, especially when it necessitates a Black perspective. She noted the conversion experience in becoming Black as well as the concept of ethnicity and self-identity in dealing with the Black community.

Nason (1972) wrote one of the articles with special reference to the problem of Black mobility in management. His article presents a descriptive analysis of the Black mobility problem. According to Nason, Black mobility is impeded by the legacies of racism in both overt and institutional forms. These subtle forms include: the employment, testing and screening criteria; inaccessibility to informal organization where subjective content and advocates are used for upward movement; Blacks in non-line jobs were placed in tangential and dead-end positions; and "Super-black" requirements for Blacks. Nason in essence summarized the various reasons for Black constraints on upward mobility. It is a fact that Blacks attain far fewer managerial positions and receive substantially lower remuneration. Solutions were offered to businesses, such as corporate insight (with governmental and private action), as well as national influence by business on government to shift priority toward ameliorating the deprivations of Blacks.

Statford's (1975) research on Blacks in public management as policy makers in New York City represents some of the most definitive data in recent years. Using the university setting as a basis, he revealed that despite the overt appearance of progress, Black policy makers, on the whole, were assigned tenuous roles in the hierarchies of universities. Blacks were included in policy-making positions because of external pressure (Black community, federal fundings sources), observed Statford. Essentially, these findings indicated that the most powerful organizations among corporations and public universities which formulate economic, political, social, and educational goals have been reluctant to deal with the conflict between inclusion of Black policy makers and whites' charges of favoritism. In terms of EEO, Black participation as policy makers has been low.

One of the most recent developments on the subject of "The Black Administrator in the Public Bureaucracy" was the Special Issue of the Journal of Afro-American Issues, (Spring, 1975). While most of these articles highlighted a theoretical and empirical discussion on Black administrators, Hunt and Howard (1977) noted their growing influences on public policy, their problems, and opportunities. Brown (1975) observed, specifically, the paucity of substahtive research on the 235 Black federal supergrade executives. Perhaps it can be viewed as progress when at least researchers are able to identify Blacks and their groups, but the quality of their experience, role demands, stress

factors, etc., needs more systematic examination. Brown called for "Blacks to carry out competent and dispassionate research on the "Black Tax," the intensive study of those who have reached the top. The Black ex-executive is essentially silent in the exhaustive professional and research literature. "Black researchers are essential if full negative dimensions of 'Black Tax' is to be understood. If advances are to be made, Blacks must publish their results, develop research competencies, and facilitate our collective advance..." Brown's current research in progress deals with the pathological and positive implications of the Black executive's stress.

Another recent work regarding minority professionals in the management field was done by Hennig and Jardin (1977). The authors stated: "The primary aim of this book is to help men and women understand the critically different beliefs and assumptions which they hold about themselves and each other, about organizations, and about a management career," The authors showed how the variable was one of the main forces for determining different styles, emphasis, and patterns of management among women and men. This book, then, provided some answers related to the job subject of career patterns and mobility among minority professionals from the perspactive of sex rather than ethnic minority.

In general, there has been an increase of Blacks in public employment. According to the U.S. Civil Service Commission (1977), Blacks hold 15.9% of all federal jobs, and 14.8% of non-federal government jobs. While there has been numerical progress, little is known about career patterns of the Black Administrator. This topic has been essentially ignored, according to the authors of this research.

Hunt and Howard (1977) surveyed 36 Black administrators' attitudes and career patterns. The study is qualified methodologically, because on the limited sample resulting from the inaccessibility of data on federal Black administrators. Black administrators were contacted at will. On the whole, they were alienated, young, highly trained, but poorly paid. Most Blacks (60%) were earning less than $ 20,000. Black females were considerably frustrated.

The survey assessed the administrators' sense of accountability, feelings about "good" organization, attitude toward Black perspectives of administration, willingness to delegate authority, their employment level and position (line of staff), and the nature of their responsibility.

This review provides a limited and illustrative examination of some of the more recent research developments on minority managers, including women, in the public sector. As stated before, due to the invisibility of Blacks in management, the literature reflects a paucity of research. This research reflects the daily practical needs rather than theoretical perspectives of minority directors in community mental health centers. It is hoped that this survey on mental health administrators will be only a beginning step for further substantive research inquiry on minority mental health professionals.

Methodology

Research Design

The experimental design of this descriptive survey was a one-shot case study. This methodological approach was designed to identify and obtain a quantitative description of the needs, problems, and accomplishments of minority community mental health center directors in the United States. The data needed to answer the questions asked in this research study were derived from a single two-part questionnaire designed for use by community mental health directors. This instrument was administered at the National Conference of Minority Directors of Community Mental Health Centers, held in February, 1977.

Observational and popular discussions revealed that directors of minority health centers experience a unique struggle and a set of inequities borne only in their work environment. This study attempts to present some of the findings on this group. Moreover, this study reveals how these administrators can diligently make use of these areas. The implications of this research are many for the delivery of public services and administration. Inherent in this study was the chance to review the practices, failures, training needs, problems and strengths of directors in minority community mental health centers. This research and further comparisons with the wider universe of mental health centers will let us know more about the politics, public policies, human relations, values, and the organizations as a whole.

Sample Size

The sample section involved the following steps:

1. Identification of community mental health centers existing in the United States.
2. Identification of minority directors of community mental health centers in the United States.
3. Nonprobability sampling.
4. Sampling of minority directors.

In the first step of the sample selection, five hundred and fifty (550) community mental health centers were identified as operational nationwide. These centers were identified from a list provided by the Center for the Study of Minority Group Programs.

The second step in the sample selection was to identify minority directors who were among the five hundred and fifty (550) directors of community mental health centers. Fifty-six (56) minority directors were identified as the result of a conference sponsored by the Division of Mental Health Services Programs (the National Institute of Mental Health) and the Center for the Study of Minority Group Programs. The conference was designed for minority directors representing Black and other minority communities throughout the United States. The conference was planned because it was felt that this group of directors had special needs or problems to be addressed. A list of these directors was developed by the Center for the Study of Minority Group Programs.

The third step in the selection was the nonprobability sampling procedure. Because minority directors constituted a diminutive portion

of the population, it was decided that it would be more advantageous to conduct person-to-person interviews with those minority directors attending the conference. This group appeared to constitute a measurable sample for the assessment of management tools and other factors associated with the improvement of service delivery and program evaluation in minority communities.

Data Collection Procedure

Finally, a data collection instrument was developed for use with minority directors that contained variables pertaining to descriptive information about each respondent and agency and problems encountered at the centers. In the initial interview, a total of twenty-five (25) minority directors completed either the person-to-person interview or returned the questionnaire by mail. No follow-up was conducted because this return rate represented slightly less than half of the sample.

Questionnaire Construction

A survey instrument in the form of a questionnaire was developed for use in the formal interviewing of this sample of minority directors. The instrument included questions relative to the design, structure, and operation of community mental health centers. The questionnaire was divided into two sections. The first section provided descriptive data that defined the agency or facility that each director represented. Items such as the organizational structure, service scope of the agency, population served and staffing patterns were also included. The second

section consisted of questions to provide data on those factors pertaining to the background and educational training of the directors, service philosophy, and community relations. In order that continued service delivery by minority directors be provided, information obtained from this portion of the questionnaire would aid in designing a model for assured continuation and growth of mental health care service in minority communities.

Data Limitations

This study provides basic information on minority mental health directors in community mental health centers which serve minority communities. Although the study provides basic information, several limitations have been noted. A major limitation was that this was a single group case study. Additional study phases might include a comparison group. Other limitations of the study might be attributed to the lack of clearly defined research problems. The study, however, has merit because it was a descriptive exploratory study, which was undertaken to identify and describe the needs, problems, and accomplishments of minority community mental health directors. Little or no information had been documented on this group. Essentially, the study will help to improve the administrators' effectiveness in service delivery, and to provide a better overview so that funding sources, and public policy sectors can better understand these special units.

A study on needs assessment in and of itself is broadly based. Consequently, it deals with numerous concerns. These numerous concerns

on areas such as minority mental health directors, adequacy of physical facilities, perception of community priorities, and special qualities among treatment personnel, each comprising a single study, leads to still another limitation of the study.

Organization of the Report

The format for presentation of this report entails "Major Findings" in Chapter II. In this chapter, basic results of the survey are offered.

Chapter III provides a discussion and analysis of the data. In addition, the chapter gives the major conclusions and recommendations as outcomes of the study.

CHAPTER II MAJOR FINDINGS

Chapter II provides the substantive overview of the Report. Major findings are presented on the various concerns of the study. A profile of personal and social characteristics of the directors; description of the facilities, including organizational structure; basis of operation; staffing patterns; uses of time; size of client population; charts of ethnic distribution; types of psychiatric diagnosis; referral services; funding level; and the reimbursement patterns are covered in this section of the report.

Profile of Directors

Twenty-five minority directors responded to this survey. The findings revealed that the majority of directors came from the "West" and "South," a total of seven (28%) respectively. Six (24%) came from the "East", and five (20%) came from the "Midwest." Among the twenty-five directors, there were three women. One woman was from the "South" and two were from the "Midwest." See Table 2.1.

Professional Discipline and Educational Background

Mental health administration has become very complex, demanding a high level of managerial knowledge and skill. Feldman (1975) observed that mental health organizations are generally run by mental health professionals with little administrative knowledge and training. Moreover, an essential part to this is the ability to understand the substance of both mental health and administration, as well as their interaction.

Table 2.1

NUMBER AND PERCENT OF MINORITY COMMUNITY MENTAL HEALTH CENTER DIRECTORS BY SEX AND GEOGRAPHIC LOCATION

GEOGRAPHIC LOCATION	SEX		TOTAL	PERCENT
	MALE	FEMALE		
North	-	-		-
South	6	1	7	28
East	6	-	6	24
West	7	-	7	28
Mid-west	3	2	5	20
Total Number	22	3	25	100

In an attempt to determine the extent of managerial knowledge and skill of minority directors, respondents were asked about their professional background and training. A majority of the respondents, nine (37%), had professional disciplines in "social work." Eight (33% had "multi-discipline" degrees, meaning several of the respondents had combined their professional degrees with such areas as counseling, psychology, law, internal medicine and social work. Of the remaining figures, three (13%) had disciplines in "psychiatry" and "psychology," respectively; one (4%) had a discipline in "urban planning." Consequently, the findings revealed that the majority of minority directors were not primarily trained in administration but had completed disciplines in social work or multi-discipline areas. See Table 2.2.

The highest degree obtained by the majority of directors was a "Master's," twelve (50%), followed by seven (29%) with "Doctoral" degrees. Four (17%) had "Doctor of Medicine" degrees; while one (4%) respondent stated that he had a "Master's" and a "Special" degree in Mental Hygiene. See Table 2.3.

Background in Mental Health

To indicate the amount of professional experience directors had in the field of mental health service delivery, the survey revealed that seven (29%) had been in the field for "3 to 6 years," "7 to 10 years," and "15 years or more," respectively. Additionally, there were two (9%) who had been in the field for "11 to 14 years," and one (4%) who had been in the field for "2 years or less." See Table 2.4.

As shown in Table 2.5, the survey revealed that a majority of the

Table 2.2

NUMBER AND PERCENT OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS PROFESSIONAL DISCIPLINES

PROFESSIONAL DISCIPLINE	NUMBER	PERCENT
Social Work	9	37
Psychology	3	13
Psychiatry	3	13
Multi-discipline*	8	33
Urban Planning	1	4
Administration	-	-
Total	24	100

*Multi-discipline combination of professional disciplines such as counseling, psychology, law, education, internal medicine, and social work.

Table 2.3

NUMBER AND PERCENT OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS HIGHEST DEGREE OBTAINED

DEGREE	NUMBER	PERCENT
Doctor of Medicine (M.D.)	4	17
Doctoral	7	29
Master's	12	50
Bachelor's	-	-
Special (specify)	1	4
Total	24	100

Table 2.4

NUMBER AND PERCENT OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS PROFESSIONAL EXPERIENCE IN THE DELIVERY OF MENTAL HEALTH SERVICES

YEARS OF PROFESSIONAL EXPERIENCE	NUMBER	PERCENT
2 years or less	1	4
3 to 6 years	7	29
7 to 10 years	7	29
11 to 14 years	2	9
15 years or more	7	29
Total	24	100

Table 2.5

NUMBER AND PERCENT OF YEARS AS MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

LENGTH OF TIME	NUMBER	PERCENT
2 years or less	9	37
3 to 6 years	10	42
7 to 10 years	5	21
11 to 14 years	-	-
15 years or more	-	-
Total	24	100

directors had directed their particular agency for "3 to 6 years," ten (42%). The remaining portion had directed their agencies for "2 years or less," nine (37%); and "7 to 10 years," five (21%). More than half of the group of directors had been at their particular agency for stable periods of time over a three-year period. It should be noted that among this group, there were several "newcomers" represented. Reasons for this representation were not indicated.

Organizational Structure and Facilities

In order to provide an adequate description on the type of center (facility) respondents represented, it was necessary to gather descriptive data on staffing patterns, utilization and need of resources, time management, population served, referral sources and funding sources. This information was useful in painting a picture of the various kinds of facilities administered by minority directors.

Staffing Patterns

Staffing of a mental health center was thought to be important to the successful overall operation of a center. As a result, respondents were asked about the number and kind of staff employed by their facility. The staffing pattern of mental health centers are shown in Table 2.6. In this table, a total of 259 positions were filled by both full-time (190) and part-time (69) employees. The employees included psychiatrists, physicians, psychologists, social workers, other mental health providers, nurses, mental health workers, administrative, clerical, and other personnel.

Table 2.6

NUMBER AND PERCENT OF FULL-TIME AND PART-TIME PERSONNEL EMPLOYED BY DIRECTORS OF MINORITY MENTAL HEALTH CENTERS

STAFF	FULL-TIME NUMBER	PERSONNEL PERCENT	AVERAGE PER FACILITY	PART-TIME NUMBER	PERSONNEL PERCENT	AVERAGE PER FACILITY
Psychiatrists	21	11	4	16	23	5
Other physicians	7	3	2	3	4	1
Psychologists	19	10	3	9	13	1
Social workers	24	13	8	10	15	2
Other mental health providers	21	11	18	7	10	1
Nurses	22	12	7	8	12	3
Mental health workers	21	11	7	6	9	3
Administrative personnel	22	12	6	3	4	2
Clerical personnel	22	12	8	6	9	1
Other personnel	11	5	7	1	1	-
Total	190	100	70	69	100	19

Psychiatrists:

There were twenty-one (11%) " psychiatrists " employed by the mental health centers. Of this percentage, there was an average of four full-time psychiatrists per facility and sixteen (23%) employed part-time psychiatrists. Of this percentage there was an average of five part-time "psychiatrists" per facility.

Physicians:

Mental health centers employed seven (3%) full-time "physicians." Of this percentage, there was an average of two full-time physicians per facility. There were three (4%) part-time physicians with an average of one part-time "physician" per facility.

Psychologists:

Nineteen (10%) of the "psychologists" were employed full-time. Of this percentage, there was an average of three full-time psychologists per facility. Nine (13%) employed part-time psychologists. Of this percentage, there was an average of one part-time psychologist per facility.

Social Workers:

There were twenty-four (13%) full-time "social workers" employed. Of this percentage, there was an average of eight full-time social workers per facility. Ten (15%) employed part-time social workers. There was an average of two part-time social workers per facility.

Other Mental Health Providers:

On a full-time basis, there were twenty-one (11%) "mental health providers" employed. Of this percentage, there was an average of

eighteen mental health providers per facility. Mental health providers were those having a bachelor's degree or above. For example, an occupational therapist would represent a "mental health provider." Seven (10%) employed part-time "mental health providers." Of this percentage, there was an average of one part-time mental health provider per facility.

Nurses:

There were twenty-two (12%) full-time "nurses" employed. Of this percentage, there was an average of seven full-time nurses per facility. On a part-time schedule, there were eight (12%) "nurses" employed.

Mental Health Workers:

Twenty-one (11%) employed full-time "mental health workers." Of this percentage, there was an average of seven full-time mental health workers per facility. Mental health workers were those having less than a bachelor's degree. Six (9%) employed part-time "mental health workers." Of this percentage, there was an average of three part-time mental health workers per facility.

Administrative Personnel:

Twenty-two (12%) employed full-time "administrative personnel." Of this percentage, there was an average of six full-time administrative personnel per facility. Three (4%) employed part-time administrative personnel. Of this percentage, there was an average of two part-time "administrative personnel" per facility.

Clerical Personnel:

There were twenty-two (12%) full-time "clerical" personnel employed. Of this percentage, there was an average of eight full-time "clerical personnel" per facility. Six (9%) employed part-time "clerical personnel" per facility.

Other Personnel:

There was an average of eleven (5%) personnel classified as "other" employed full-time. Of this percentage, there was an average of seven "other" full-time personnel per facility. Only one respondent's facility employed "other" part-time personnel.

It is significant to note that more facilities employed "social workers" than any other personnel. Although the survey did not ascertain the reasons for this, the majority of the directors were also social workers. It can be inferred that the skills of a social worker, such as casework counseling, coordination, resource development, and referrals, seem to be parallel with the smooth operation of a community mental health center.

Criteria for Hiring Personnel

Respondents were asked to state the special selection criteria required in hiring treatment personnel to serve their client population. There were 41 responses to this question because more than one response was given. Eight (20%) indicated that among the criteria required was "a sensitivity to patient/social/cultural needs"; scene (17%) showed that the criterion required was "education and training"; six (15%) indicated the criterion required was "experience"; four (10%) indicated the criterion they required was compliance with the "State Civil Service Law" in that they

consider each applicant equally; three (7%),respectively,indicated that the applicant must have a "knowledge of a language other than English," "an ability to relate to the community," and emphasis on "recruitment of minority clinical staff"; two (5%) indicated that they required "competency"; and five (12%) stated several different reasons. The reasons were: (1) community residency, (2) knowledge of institutional racism, (3) a rational approach to a mental status examination, (4) an understanding of the philosophy of community mental health center services,and (5) knowledge of demography of the catchment area. See Table 2.7.

Staffing Assets for Minority Clients

As a follow-up to this question, respondents were asked if the personnel employed by their agency had special characteristics that would not be required if the client population were not minority. Of the respondents answering this question, nineteen (82%) stated " yes"; four (18%) stated "no." The respondents who answered "yes " were then asked to state what these characteristics were. There were 20 responses. Thirteen (65%) responded that the personnel employed by their agency should have an understanding and acceptance of racial/cultural differences; two (10%) indicated that personnel should have had bilingual skills; four (20%),however, stated several other characteristics that personnel should have. These characteristics were (1) competency, (2) ability to conceptualize "people's problems" and utilize treatment modalities that were not inherent in the medical model, (3) emotional stability, reliability, commitment and dedication, and (4) freedom

Table 2.7

NUMBER AND PERCENT OF CRITERIA FOR HIRING TREATMENT PERSONNEL FOR CLIENT POPULATION OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

CRITERIA	NUMBER	PERCENT
Sensitivity to patient/social/ cultural needs	8	20
Education/training	7	17
Experience	6	15
Knowledge of language other than English	3	7
Competency	2	5
State Civil Service Law	4	10
Ability to relate to community	3	7
Recruitment of minority clinical staff	3	7
Other	5	12
Total	41*	100

*Based on a total of 41 responses to the question.

and respect for all.

Staff Training and Development

Respondents listed and described the three most important areas in which each agency needed staff training and staff development. The nineteen responses were categorized as follows: nine (47%) indicated the need for "development of programs" (to include program planning and evaluation) to cover all segments of the community; six (32%) showed a need for "knowledge of the dynamics of human behavior" in order to work effectively with clients; four (21%) indicated "general in-service training" to update skills and develop professionally. See Table 2.8.

Adequacy of Facility

The directors were asked to rate the competency of their facility in certain identified areas on a scale from one (least) to ten (most). The highest rated area was "coordination with referral resources" (8%), followed by "support services," "physical structure", and "staffing" with (57%) respectively. It was significant to note that although "funding" was extremely important in operating mental facilities, that area was rated least with (4%).

Table 2.9 shows the directors' facilities organizational structure. The majority of respondents, seven (29%), stated that their organizational structure was "community center based"; while six (25%) indicated that their facility was "completely freestanding"; three (13%) stated that their facility was "hospital based"; one (4%) stated that his

Table 2.8

NUMBER AND PERCENT OF THE AREAS OF NEEDED STAFF TRAINING AND STAFF DEVELOPMENT BY MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

AREAS	NUMBER	PERCENT
Development of progress (including program planning and evaluation)	9	47
Knowledge of dynamics of human behavior	6	32
General in-service training	4	21
Total	19*	100

*Based on a total of 19 responses to the question

Table 2.9

NUMBER AND PERCENT OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTER FACILITIES' ORGANIZATIONAL STRUCTURE

ORGANIZATIONAL STRUCTURE	NUMBER	PERCENT
Completely freestanding	6	25
Hospital based	3	13
Outpatient clinic based	1	4
Community center based	7	29
All services contracted	1	4
Other	6	25
Total	24	100

facility was "outpatient clinic based"; another one (4%) stated that all of his "services had been contracted"; and six (25%) implied that their facilities had "other" types of organizational structure. For instance, one stated that all services except "inpatient" were "freestanding"; one (4%) indicated his facility was a D.C. Government Agency; and three (13%) stated that their facility was both "completely freestanding" and "community center based."

Resources Needed for Clients

Respondents were also asked, other than personnel what resources were required by their agencies that they considered unique to the client population they served. There were 23 responses. Four of these responses (17%) indicated several different resources "other" than personnel. These resources were (1) non-attack by white systems, (2) local and state political support, (3) adequate public transportation and (4) understanding of ghetto language. Three (13%) indicated that respondents needed "fiscal support" and "sensitivity to cultural differences," respectively; two (9%) indicated a need for a "bilingual program," "physical facilities," "community support," and "extensive outreach delivery." See Table 2.10.

The responses to these questions seem to suggest that respondents were mainly concerned about communication with their communities. In addition, they seemed to realize that the roads to effective communication was the understanding and acceptance of racial/cultural differences.

Table 2.10

NUMBER AND PERCENT OF THE UNIQUE RESOURCES TO THE CLIENT POPULATION OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

RESOURCES	NUMBER	PERCENT
Bilingual program	2	9
Fiscal support	3	13
Physical facilities	2	9
Community support	2	9
Extensive outreach delivery	2	9
Sensitivity to cultural differences	3	13
None	5	21
Other	4	17
Total	23*	100

*Based on a total of 23 responses to the question.

Utility of Resources

Forty-seven respondents indicated if they had unlimited resources the following types of adequate mental health services would be rendered. Thirteen (28%) would concentrate on "staff development"; nine (19%) on "broadening social services" in the line of housing, income maintenance, creation of jobs, and structure of a new system of education; eight (17%) would concentrate on "extending treatment services" such as psychiatric half-way houses, services to adolescents and Day Treatment Programs; four (9%) would emphasize "organization of health services"; three (6%) respectively would "improve transportation"; "improve facilities"; improve "planning, priorities and governing body"; and "improve community relations"; and one (3%) stated they would "emphasize the prevention of mental illness rather than treatment or rehabilitation of mental illness." See Table 2.11.

Need for Technical Assistance

As shown in Table 2.12, the respondents were asked to list and describe the three most important areas of needed technical assistance by each agency. The fourteen responses to this question were categorized as: seven (50%) stated assistance in seeking "financial sources, both governmental and private;" four (29%) indicated "staff development" in order that efficiency could be increased; and three (21%) stated "accounting/fiscal management" because of the extremely complex budget.

Survival Funding

In terms of "Survival Funding" (the level of funding required to continue providing quality mental health care services to the treat-

Table 2.11

NUMBER AND PERCENT OF PROVISIONS OF ADEQUATE MENTAL HEALTH SERVICES TO POPULATION BY MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

Resources	NUMBER	PERCENT
Improved transportation	3	6
Broadened social services	9	19
Organization of health services	4	9
Staff development	13	28
Improved facilities	3	6
Planning, priorities and governing body	3	6
Improved community relations	3	6
Extension of treatment services	8	17
Other	1	3
Total	47*	100

*Based on a total of 47 responses to the question

Table 2.12

NUMBER AND PERCENT OF THE AREAS OF NEEDED TECHNICAL ASSISTANCE BY MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

AREAS	Number	Percent
Funding (governmental and private)	7	50
Staff development	4	29
Accounting/fiscal management	3	21
Total	14*	100

*Based on a total of 14 responses to the question

ment population), respondents were asked about the major factors needed to obtain and continue the operation of the agency. Out of the thirty-three responses, twenty-six (79%) indicated "more resources" such as money, facilities, qualified staff and equipment; five (15%) stated a need for "community support and involvement" in order for the agency to continue; and two (6%) needed "more political influence." See Table 2.13.

Evaluation of Services

In providing services to the community, the respondents were asked to state their source of data for evaluating the services. Of the thirty-four responses, ten (29%) stated "client's feedback"; nine (26%) indicated "feedback from community," which included the Multi-State Information System; three (9%) stated that the evaluation, came from "the state/county"; two (6%) evaluated the services provided by information from "questionnaires"; and two (6%) responded "other" means were used to evaluate. The "other" means stated were community acceptance and external/internal evaluation.

Time Management

Feldman (1975) asserted that a director of a community mental health facility is both responsible and accountable for the entire program of the facility. This includes the facility's fiscal affairs, internal management, quality of services, and overall focus and direction. Ideally, he or she has a knowledge of administration and of program substance and is sensitive to the reciprocal reltionships between the two.

Table 2.13

NUMBER AND PERCENT OF MAJOR FACTORS NEEDED FOR CONTINUED OPERATION OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

MAJOR FACTORS	NUMBER	PERCENT
More resources	26	79
Community support and involvement	5	15
More political influence	2	6
Total	33*	100

*Based on a total of 33 responses to the question

Because of this dual responsibility, the respondents were asked to indicate the percentage of time they spent at their various tasks. The respondents stated that they spent an average of 31 percent on "program planning and development"; 18 percent on "fiscal affairs"; 17 percent on "staff selection and supervision"; 16 percent on "community/client relations"; 13 percent on "project evaluation and monitoring"; and an average of 4 percent on "service delivery/treatment." These findings revealed that the respondents were more concerned with "program planning and development" than with any of the other various tasks. See Table 2.14.

The normal business hours for these facilities operated on an average of 7.19 hours a day. Four (18%) had twenty-four hour service; ten (43%) had eight-hour weekday services only; and nine (39%) had special hours (evenings and Saturdays, in addition to eight-hour weekdays).

Funding Level

Because of the importance of funding in maintaining a community mental health facility, the respondents were asked to supply data on the proportionate funding level of their agencies. Only eight of the respondents answered this question correctly. Of this number, an average of forty-five percent of the respondents funds was provided by the "state government"; twenty-one percent of the respondents funds was provided by the "local government"; and an average of twenty percent of the respondents funds was provided by the "federal government." In only one case was the respondent's funds provided by "other federal grants."

Table 2.14

AVERAGE TIME SPENT IN VARIOUS TASKS BY MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

TASKS	AVERAGE TIME PER WEEK
Program Planning and Development	31.0
Staff Selection and Supervision	17.0
Fiscal Affairs	18.0
Community/Client Relations	16.0
Service Delivery/Treatment	4.0
Project Evaluation and Monitoring	13.0

It was significant to note that there was a shift away from national to local power in shaping human services. This proved to be somewhat of a problem since the local tax base was insufficient to support expensive programs. In addition, local government was often more conservative, and therefore less responsive tc groups interested in social change and human services.

Reimbursement

When asked about reimbursement for services, four respondents stated that they received reimbursement from "medicaid" and "patient fees"; three received "medicare"; two received reimbursement from insurance" and "patient fees."

When asked about other types of income, two respondents received funds from "philanthropy"; one received funds from "other fund raising"; and another received funds from "other receipts." Most of the respondents seemed to have had difficulty answering this question.

Thus, the findings revealed that respondents got most of their funds from the government. Feldman (1975) observed that mental health services are dependent upon public funding, and as such, are subject to high degrees of government regulation. This posed the issue of how responsive can a minority community mental health center be to the needs of the community when it has been subjected to government intervention. These centers tend to overlook the lack of public accountability to minority representation.

The average budget of respondents' facilities was $1,705,237. This dollar amount ranged from $270,000 to $7,000,000.

Description of Client Population

The size and the racial/ethnic composition of the client population, along with the primary diagnosis and referral services of these minority-directed community mental health centers,are discussed as follows:

Size of Client Population

The average size of the client population was 13,983 units of service. The client population ranged from 320 to 87,906 units of service. The average population of their catchment area, on the other hand, was 157,464. The latter population ranged from 1,500 to 240,000.

Racial/Ethnic Composition

The racial/ethnic composition of the minority mental health centers averaged thirty-eight (38%) percent Black; nineteen (19%) percent were Spanish-speaking; five (5%) percent were Asian-Americans; and two (2%) percent were Native Americans. A large percent (30%) of the client population were Anglo-Americans.

Primary Diagnosis.

In response to the directors' primary diagnosis of their client population, an average of twenty-six (26%) percent of the clients were "schizophrenic"; twenty-one (21%) percent had "depressive disorders"; nineteen (19%) percent had "other

psychiatric mental disorders"; eleven (11%) percent had "non-psychiatric disorders"; seven (7%) percent were drug abusers"; seven (7%) percent had alcohol disorders"; and five (5%) percent reported as having "other kinds of diagnoses." Included in this category were environmental, organic brain syndrome, transient situational disturbances, and behavioral disorders of children and adolescents. An average of three (3%) percent reported mental retardation and a remaining twelve (12%) percent was unknown. On the whole, the facilities' client populations were suffering from serious psychological impairment as evidenced by the "schizophrenic," "depressive disorders," and "other psychological mental disorders."

Referral Sources

The respondents were asked about the referral sources of their current client population. It was interesting to note that the majority of their referral sources, thirty-six (36%) percent, were from "self, family, or friend," followed by ten (10%) percent from "other psychiatric facilities." The "social or community agencies" had nine (9%) percent; the "school system" six (6%) percent; "unknown" sources five (5%) percent; the "court, law enforcement, or correctional agencies four (4%) percent; "medical facilities" three (3%) percent; the "private practice mental health professional" three (3%) percent; and "other sources" referred only one (1%) percent of the client population.

These findings tend to be consistent with a recent IUAR study titled "Dimensions of Positive Mental Health From A Black Perspective" (Gary, et al., 1978). A major finding showed that the informal support

system (family and friends) played a major role in getting people to mental health services.

Service Philosophy

To focus on problems encountered by the agencies, it was necessary to determine the community mental health center's overall service priorities. The findings outlined in this section pertain to the service philosophy of these facilities and their relationship to the community. Some of the questions asked were given more than one response, resulting in a large number of responses throughout this section.

Service Philosophy of Agency

When respondents were asked about the overall service philosophy of their agency, the majority fourteen (45%) indicated the thrust of their agency's service priority was "treatment" of mental illness. "Prevention" of mental illness was indicated by seven (23%) of the minority directors. Five (16%) stated that their overall service priority was "rehabilitation" of their patients who were mentally ill. There were still three (10%) who stated that "short-term care and expediency of appointments" required clients to be seen when they came to the center or within twenty-four hours of the call; and two (6%) stated that they had "general community services" as priorities. See Table 2.15.

Over the years, due to the immediacy of problems and the shortage of resources, much energy had been directed into secondary and tertiary prevention. In other words, the early diagnosis and treatment of mental disorders, and when possible rehabilitation, were focal

Table 2.15

NUMBER AND PERCENT OF SERVICE PRIORITIES FOR MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

SERVICE	NUMBER	PERCENT
Prevention	7	23
Treatment	14	45
Rehabilitation	5	16
Short-term care/ appointments	3	10
Other	2	6
Total	31*	100

*The respondent had an opportunity to give more than one response to this question; therefore, the total number was larger.

points of the energy directed to preventive efforts. These efforts proved significant in the findings of this report. However, the major frustration in most preventive efforts, apart from the ever-urgent competition of both human and fiscal resources, has been the identification of the causative agent in mental disorders (NIMH, 1976).

Relationship of Priorities to Agency Origin

In relating the priorities of the agency to those of historical beginnings of each agency, the directors responded in the following manner. Seven (59%) indicated that there had been little or no change in either the present priorities or those at the beginning of their agency. Three (21%) stated that their priorities were quite similar to those at the time of origin of their particular agency except for (1) reduction of crisis and emergency functions, (2) improvement of the quality and availability of services and (3) expansion of services. Another three (21%) reported that their priorities had changed because of a different funding agency and its priorities. There was only one (7%) that indicated its agency had changed from a voluntary religious-based program to an independent community-governed agency.

With respect to the funding agency and priorities, some of the respondents felt that there was conflict between the funding source priorities and the needs of the community. For many of the minority directors, it appeared that federal priorities were based on inadequate local needs assessment as opposed to any of the rationales.

Future Projections

It was interesting to note that seven (17%) of the minority directors indicated that they had "no" future projections because of budget limitations, time, space, and lack of private funding sources. These findings were significant because they tended to emphasize a problem basic to the existence of minority community mental health centers, that problem being a lack of adequate financial resources. There were six (14%) who stated their plans to develop and/or expand children's and adolescent's services; another six (15%) reported their plans were to be become more oriented toward comprehensive health care service delivery. Still another five (12%) indicated plans to develop a program for the elderly. Three (7%) planned greater work in the area of prevention. While two (5%) indicated their plans to develop a day treatment program, a halfway house, and a consultation, research and education program, respectively. There were nine (21%) who had several different projections; for instance, comprehensive physicals for clients, development of a patient advisory board, psychiatric emergency services, satellite centers, development of a follow-up program, expansion of service populations and program focus, and increasing services in the area of alcoholism.

Special Services

Due to the client population served by minority community mental health centers, special service considerations were required. In Table 2.16, the majority of minority centers, sixteen (41%), indicated they provided an "extension of their treatment" methods through services to

Table 2.16

NUMBER AND PERCENT OF SPECIAL SERVICE CONSIDERATIONS TO THE CLIENT POPULATION OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

SERVICE CONSIDERATION	NUMBER	PERCENT
Special population	11	28
Transportation	2	5
Staffing	4	10
Facilities	1	3
Extension of treatment	16	41
Broadened social service	5	13
Total	39*	100

*The respondents had an opportunity to give more than one response to this question; therefore, the total number was larger.

long-time patients, consultation and education, full outreach systems, and alternatives to hospitalization. There ware eleven (28%) that stated their development of services were geared to a "special population" of the elderly, children/adolescents, Mexican-Americans, deaf, blind, and the physically impaired. Five (13%) indicated they had to "broaden their social services" to include cultural orientation, work with board and care houses, and programs that removed people from the ghetto. Still another four (10%) stated they offered special services through increased quantity and quality of their "staffing" by hiring bilingual workers and social workers; two (5%) indicated improved "transportation" for their clients; and one (3%) reported improved "facilities."

Regarding special service considerations, the large number of minorities being treated at community mental health centers required the middle-class professionals to have a greater familiarization with the client's life style. It is a truism that communication is the necessary basis for psychotherapy. Communication involves processing information. If information is not received, interpreted and processed appropriately, then no meaningful communication has occured. However, in order for meaningful therapy to occur, the professional must communicate with his clients. This group of respondents seemed to have made an effort to communicate with their clients through the consideration of hiring bilingual workers and the development of a cultural orientation for the staff. Therefore, more effective communication was an underlining factor to special services.

Special considerations was another area considered crucial to special services in minority mental health centers. There were six (22%) who

indicated that these considerations were identified by the consistent use of the service provided. Five (18%) responded that considerations were identified by needs assessment; while four (14%) stated that considerations were identified through demographic profiles, census tracts, and utilization data. Still another two (7%) indicated considerations were identified through waiting lists and the time lag which resulted in a high dropout rate; another two (7%) indicated that these considerations were identified through the advisory board. There were four (14%) that indicated several different ways of identifying these considerations. The different ways were (1) Public Law 94-63, (2) inadequate public transportation, (3) client participation in program planning, and (4) modification of social service agencies. However varied the method, these findings suggest that respondents made an effort to find out what the community's needs were.

Community Relations

The information reported in this section describes the priorities and needs of minority clients served by minority-directed community mental health centers. The influence of the community, professional sensitivity as a prerequisite, and major barriers to providing services are discussed as major findings of this section.

Community Priorities and Needs

As previously stated, minority directors have the desire to communicate better with the community. These minority directors seem to realize that communication is needed to effectively treat their clients. A large

portion of the directors, five (14%) perceived the community's priorities and needs relative to their client population as being "children's and adolsecent's services" and "improved community outreach," respectively. Yet, four (11%) named "services to the aged" as a community priority. There were three (8%) that indicated "emergency services"; while two (6%) respectively, indicated that the community needed "follow-up care," "accredited mental health education programs" and "more jobs." Nevertheless, the majority of the directors, thirteen (36%), indicated that the community had several other needs; for instance, services in occupational mental health, better housing, and improved transportation were mentioned. See Table 2.17.

It would be significant to note that these needs (improved transportation, better housing, etc.) were basically outside the control of respondents even though these items were factors in the development of the community's mental health.

Community's Effect on Services

Respondents were asked to state the extent to which the "community" influence dictates the services orovided by their agency. It was expected, after the responses were given to the previous questions, that the respondents would say that the community influences the services a great deal. However, nine (37%) stated that the community influences the services to some extent; four (17%) stated the community influences the services only marginally, but none of the respondents stated that the community did not influence them at all.

Table 2.17

NUMBER AND PERCENT OF THE NEEDS AND PRIORITIES OF THE CLIENT POPULATION SERVED BY MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

NEEDS AND PRIORITIES	NUMBER	PERCENT
Children's & adolescents' services	5	14
Follow-up care	2	6
Service to aged	4	11
Improved community outreach	5	14
Accreditation of Mental Health Education Programs	2	6
More jobs	2	6
Emergency services (i.e., services for acutely disturbed)	3	8
Other	13	36
Total	36*	100

*Based on a total of 36 responses to the question

Directors' Perception of Community

When respondents were asked why did they feel the community influenced them a great deal, five (83%) felt that this was so because the community was capable of articulating its needs; one respondent (17%) explained that the community was relied on in general but the client's input was paramount in shaping the type of services provided.

Of those respondents who stated that the community influenced them to some extent, four (67%) explained that the community organizations and advisory boards identified the needs of their constituency and then communicated these needs to their agency. Two (33%) of the respondents explained that local community input was diluted because: (1) funding at the local level was a political decision, and (2) the program was part of a larger administrative umbrella responsible to one board. Of those respondents who stated the community influenced them only marginally, three (75%) of the respondents stated that a combination of influences dictated the services provided; for instance, community/state, and community/state/county mental health plans. One (25%) of the respondents stated that because of retarded growth due to apathy, the community advisory board had not been effective.

Critical Professional Sensitivities

Respondents were asked to state the necessary or critically important professional sensitivities required to provide mental health services in their community. A total of twenty-four respondents stated that because of previous responses, certain other responses might be expected at this point. The majority of the respondents nine (37%), indicated that

the professional should have a "knowledge of language and understanding of cultural differences"; and four (17%) stated that professionals should have the ability to work with "poor minorities and young clients"; three (13%) stated the professionals should have been "competent via professional experience and training." There were two (8%) of the respondents that indicated the professional should be the one who has the "ability to listen" to a client; still another two (8%) indicated that the professional should "understand the connection between mental health and the social environment." Another large group, four (17%), indicated several different requirements. Those requirements were (1) the professional should have the ability to design mental health programs, and (2) the professional should have an understanding of the problems of the elderly. See Table 2.18.

Major Barriers to Providing Services

In Table 2.19 the respondents' major barriers to providing mental health services in their community are shown. Due to previous responses, the results were not unexpected. Out of thirty-five responses, thirteen (37%) indicated "a lack of funds" from both governmental and private funding sources as a major barrier; five (14%) stated " a lack of competent personnel"; five (14%) named "resistance to the idea of mental health services" because of the social stigmas attached; three (9%) indicated "poor communication linkage between groups, agencies and organizations"; two (6%) cited a "lack of control of health care systems"; and seven (20%) listed several different barriers. Among the different barriers

Table 2.18

NUMBER AND PERCENT OF PROFESSIONAL SENSITIVITIES REQUIRED TO PROVIDE MENTAL HEALTH SERVICES TO CLIENT POPULATION OF MINORITY DIRECTORS OF MENTAL HEALTH CENTERS

SENSITIVITIES	NUMBER	PERCENT
Ability to listen	2	8
Knowledge of language and understanding of cultural differences	9	37
Competency (i.e., professional experience and training)	3	13
Ability to work with poor minorities and young clients	4	17
Understanding the connection between mental health and the social environment	2	8
Others	4	17
Total	24*	100

*Based on a total of 24 responses to the question

Table 2.19

NUMBER AND PERCENT OF MAJOR BARRIERS TO PROVIDING MENTAL HEALTH SERVICES TO CLIENT POPULATION OF MINORITY DIRECTORS OF COMMUNITY MENTAL HEALTH CENTERS

BARRIERS	NUMBER	PERCENT
Lack of funds	13	37
Poor communication linkage between groups, agencies and organizations	3	9
Lack of control of health care system	2	6
Lack of competent personnel	5	14
Resistance to the idea of "mental" health services (e.g., social stigma)	5	14
Other	7	20
Total	35*	100

*Based on a total of 35 responses to the question

listed were the absence of a clear priority for programs by funding sources; private funding sources that promoted research and training rather than services; and a lack of transportation for clients.

In the first section, the findings concluded that the agencies on an average were rated low in funding on a scale of one (least) to ten (most). This was confirmed when the majority of responses (37%) indicated that a major barrier to providing mental health services to the community was a lack of funds. Thus, the findings suggest that respondents need assistance in generating funds for their particular agencies.

CHAPTER III DISCUSSION AND CONCLUSIONS

Based on the findings presented in this study, a broad range of results provided a better overview of minority directors of community mental health centers. The findings in this report consisted of descriptive data, in addition to information regarding the needs of the minority community mental health administrator, job problems, training needs, agency priorities, staffing criteria, special needs of staff in working with minority populations, community dynamics affecting service delivery, technical assistance, and data on evaluative measures.

Basically, the questions posed in this study were answered. The study revealed several important points based on the small but representative sample of minority directors.

Profile of Directors

Professional Background

The majority of the directors were from the West and South, and were trained in social work. The next largest number were trained in more than one profession, such as law and social work, or medicine and psychology. Few had been trained in administration, which was consistent with Feldman's (1975) findings on the education and background of mental health administrators. The majority of the interviewees had been in the field more than six years, or seven to ten years. A significant number had been in their agencies for two years or less. Within the group several "newcomers" were represented.

Organizational Structure and Facilities

Staffing

Most of these Centers were "community-center-based," while the next largest number were "completely freestanding," with weekday and special hours of operation.

The staffing pattern reflected full-time social workers, psychiatrists, and psychologists. The largest group of employees included the mental health providers, mental health workers, and those in social work categories.

The majority of the directors felt that sensitivity to the clients' social and cultural needs was the paramount prerequisite for working with minority clients. There appeared to be a major emphasis on education, training, and experience. There was a larger response among the group who gave varying criteria for staff selection. Among the criteria were: living in the community, knowledge of institutional racism, identification with the philosophy of CMHC, and knowledge of the demography of the community.

It would seem that the directors considered the minority CMHC a unique service system, and in order to be useful and efficient "caretakers" they may differ from those of other systems through their sensitivities to cultural differences, necessity for education, training and experience, and community knowledge. These findings on the criteria for staffing seem to be quite different from those of other middle-class, non-minority mental health centers. It was indeed evident that directors felt these special characteristics represented prerequisites.

While staff training and development were listed high among the needs of directors, program planning and evaluation were considered as the key areas for development. The second most important area for consideration in staff training was human growth and behavior. Emphasis on these areas might have been anticipated in view of the fact that few clinically-oriented mental health professionals had dealt with the knowledge and skills of program development, management and coordination. One might also consider that a majority of the CMHC staff were paraprofessionals, which would necessitate training in this area.

Adequacy of Facility

The issue of adequacy of the facility was considered a crucial index for examining the common elements in the operation of a community mental health center. A large number of directors participating in this survey saw each agency's greatest adequacy in the area of "coordination of referral sources." While this could be a positive strength, this response seems to indicate that many of these agencies may also spend time "referring or coordinating." President Carter's recent Commission on Mental Health reported a preliminary finding as a shortcoming in the lack of coordination of services. The community mental health centers in minority communities may be somewhat ahead of other mental health systems. Yet, no agency takes the sole responsibility for a disposition with the mental health clients.

The next largest group indicated that a rather diverse offering of social services such as housing, board and care were necessary. Minority

directors also felt that support services, physical structure, and staffing were the next respective areas of major sufficiency. Funding was the category with the least adequacy. Although funding resource was the most troublesome area, directors had some creative future projections, and were continuous in the development of specific and unique services for their population.

These directors overwhelmingly felt that special talents and criteria were needed for the staff more than were other special resources for the agencies. There were almost similar responses regarding the issue of agency resources. Some felt that few resources were required, while systems, adequate public transportation and ability to understand "ghetto language" were regarded as necessary resources. The respondents were rather evenly distributed in their responses to a number of other required resources such as bilingual programs, community support and extensive outreach services. These variations and the preponderance of responses to a number of others would show, however, that minority CMHC's do require other specific complements when compared to other centers.

Resources

The concluding evidence of this survey seems to point out that directors in minority community mental health centers are severely handicapped by a lack of funds. The other shortcomings varied according to directors, but were usually matters beyond their control. Given an abundance of resources, the majority indicated that they would emphasize staff development, broaden social services (housing and income maintenance) and treatment approaches.

Most of these efforts reflected the strong service orientation of these directors. There were a few similar responses indicating a focus on planning, staff priorities, improving community relations, and improving facilities. Only one emphasized the prevention of mental illness.

Technical Assistance

At least half of these directors considered financial assistance or grantsmanship to be the main area in which they needed technical assistance. The next major need was staff development, and then more assistance in fiscal affairs and budget management. On the whole, there was a need to increase efficiency and make easier the complex budget operations of the centers.

Minority directors were perhaps more in need of all of these technical services, especially since grantsmanship, research, and financial administration were historically scarce skills in these communities. Indeed, they had been scarce among the mental health disciplines which were primarily clinical and treatment oriented.

Survival Funding

In order to continue the minim level of operation, directors considered money, facilities, qualified staff, and equipment to be germane elements. Community support, followed by political influence, were given as the next major factors for continued operation of these centers. These essentials might tend to be those described by most administrators if any agency were to continue.

Evaluation of Services

The majority of the directors used the client's and community's feed-back as the main sources of data for evaluating their services to the community. Several seem to participate in the multi-state information system.

It seems that these directors had some awareness regarding evaluation. Consumers were the best source of feedback and would probably be used by any other service system. This survey showed that minority directors were indeed responsive to their clients' needs.

Time Management

Directors tend to spend most of their time on tasks related to program planning and development, fiscal affairs, community relations, staff selection and supervision, and finally, in project evaluation. This would seem to be the normal task load for the administrator. Perhaps, the returns on the use of a major portion of time in fiscal affairs was rather unrewarding. Many continue to have to deal with money issues.

Funding Level

As to funding levels, the study concluded that state and federal governments were the primary sources. Community Mental Health Centers in minority communities were reimbursed primarily from "medicaid," "medicare," "patient fees" or "insurance" in this descending order.

The average budget for these centers was estimated at $1,705,237. The highest amount given to any one center was $7,000,000.

Description of Client Population

The average size of the client population was 14,650, resulting from an average range of 320 to almost 88,000 people. The catchment area averaged at least 157,500 people.

Centers in the survey tend to serve a large Black, Anglo-American, and Spanish-speaking clientele whose primary diagnosis was schizophrenia, depressive disorders, or other psychiatric mental disorders. Most of the clients were referred by family or friends. The largest number of the remaining referrals were from public psychiatric hospitals, or other psychiatric facilities.

Service Philosophy

The majority of the agencies surveyed reported that their essential mission was to treat mental illness, while the next largest number indicated their thrust was prevention of mental illness. Most of the directors perceive each center's function as residual, preventative, and rehabilitative, respectively. The data would tend to show that the chief emphasis was placed on treatment, although much of the legislative intent emphasized prevention, consultation, and educational services by these centers. Most of these agencies have operated since their beginning under this framework. However, almost half of them had reflected a change in priorities necessitated by the funding source.

As to future projection, most of these directors reflected the precarious and muddling atmosphere surrounding their agencies. Their rather dismal

view was attributed to limited funding, lack of spatial, and time resources. There were, however, a sizeable number of agencies that sought expansion of services for children, the elderly, and broader health services. Another large group had rather individual projections such as patient advisory boards, satellite centers, and increased services for alcoholics.

The spread and differences in the responses about the future reflected the varying patterns of operation and future potentials among this set of centers.

Special Services

The majority of these directors reported that the special service gave a longer range of treatment methods. Among these services were such elements as alternatives to hospitalization, follow-up service to long-time patients, and special approaches to serving the elderly, handicapped, and special ethnic groups.

A major portion of the respondents used needs assessment as a baseline for defining special services to the community they served. Other directors used census tracts and demographic profiles as the primary means for developing special services to their catchment area.

Certainly, these findings tended to indicate the vast need for coordination of services, which was a major activity for these centers. On the other hand, these special considerations showed that minority community mental health centers provided a group of services, rather than any single, traditional or therapeutic approach.

Directors saw major priorities in their community as being, the need for children's-adolescents' services and more community outreach. The group as a whole felt that there was not any one category of needs, but multiple needs for their communities such as jobs, an improved transportation system, better housing, and occupational mental health.

At this point, the question arises as to how the perception of this group of directors might differ from that of any other mental health director on community priorities and needs. Directors, such as those interviewed in this study, were usually service-oriented and would tend to perceive the community needs as: more services to children, extensive outreach, emergency services, follow-up care, and mental health education programs. This reflected the comprehensive need for the centers' involvement in community planning and community organization.

On the whole, the directors saw the "community" to some extent, influencing services. Given the variety of needs in these centers' communities, it could be assumed that the response "a great deal" might in-

dicate the lack of community participation or difficulty in the center's capability for organizing community pressure and priority and value given to mental health service in the minority community.

The majority of directors attributed the moderate level of influence on the advisory boards and community organizations to the continuous exchange of information on community needs.

Almost half of the directors felt that knowledge and understanding of social and cultural differences was critical and important professional sensitivity for the provision of mental health services in minority communities. Working with poor minorities and young clients were examples of this sensitivity. Even though the other responses seemed to be specific about the design of programs and the groups to be served, respondents consistently agreed with the view of the importance of ethnic content as part of professional tools. The conclusion provided strong evidence of this group's sensitivity.

Major Barriers to Mental Health

On the whole, most of the barriers to the provision of services were considered financial. The next largest group of barriers were either incompetent personnel or the stigma associated with the use of mental health services.

Conclusion

The following conclusions were made based on the findings reported in this survey.

1. The group was primarily a middle- aged male population, primarily trained in the clinical area among mental health disciplines. The majority of their duties necessitated involvement in program planning and fiscal matters.

2. Most of the agencies surveyed, had a flexible service philosophy, and offered with treatment a prevention emphasis. The future orientation of these agencies was characterized by uncertainty, stress, and scarce resources; but yet they provided a comprehensive range of services. The flexible programs did reflect special service considerations for clients. Consequently, coordination with referral sources, was seen as a major strength among the agencies. The adequacy of the agencies was affected by a lack of funding, and the need for management and staff development.

3. These minority directors valued highly the need for sensitivity to socio-cultural and political aspects among its treatment personnel.

4. The centers were considered to be in need of special personnel, as well as, political support, adequate public transportation or mobile vans, and bilingual programs.

5. The major community priority was seen as more services for children and adolescents, and community outreach programs.

6. Staff development, and technical assistance, especially in the knowledge of finances, research, and grantsmanship, ranked high among the need for further resources for the agencies.

Recommendations

As a result of the aforementioned findings and conclusions of this research survey, the following recommendations can be made.

1. This study revealed the apparent lack of female administrators among the minority directors. Increased affirmative action efforts might focus on employing more female directors in community mental health centers.

2. It is recommended that these directors give more attention to project evaluation and monitoring. The issue of time management is a recurring one for administrators.

3. It is recommended that the broad service orientation be re-examined if some of the dilemmas facing directors are to be resolved. Broadly-based programs may be inadvertently conflicting, resulting in more operational constraints.

4. It is recommended that continuing education and staff development training include such areas as project evaluation, fiscal and budget management, grantsmanship, technical assistance, and staff development.

5. It is recommended that the broad range of skills, talents, and cultural sensitivity be encouraged among selecting treatment personnel.

6. It is recommended that special resources, such as special personnel, bilingual programs and transportation services, be among the unique programmatic needs of minority community mental health centers.

7. It is recommended that directors give more attention to community support.

8. It is recommended that revised policies and guidelines for these centers be considered by NIMH. Such areas as "organization of services, resource utilization, staff development, and technical assistance" may require special examination.

9. Finally, it is recommended that these administrators examine their professional attitude toward research in addition to acquiring more research knowledge and skills.

In the final analysis, this study has implications for filling the void in research and manpower literature with regards to substantive data on minority mental health professionals. The outcome of this study could be useful in developing better manpower utilization for women and minorities. The findings should be applicable to improving affirmative action programs, and other public personnel practices. Although the actual utilization of research in the mental health field is a recruiting issue, there appears to be a readiness to use this data as indicated by a major Advisory Panel at ADAMHA.

It is hoped that the findings of this research can project a quantitative and qualitative basis for the survey of several other ethnic and sex minorities, such as Hispanic, Oriental, and females in mental health administation. Moreover, the data reported have further implications for comparison with other professional disciplines besides those in mental health settings. Considering the diverse implications of this study, timely and practical application of the data should be made.

APPENDIX

APPENDIX A

Date _____

Code # _____

Questionnaire

NATIONAL CONFERENCE
OF
MINORITY DIRECTORS OF COMMUNITY
MENTAL HEALTH CENTERS

RESPONDENT'S NAME: _____

AGENCY (Facility): _____

_____

Mental Health Research
and Development Center
Institute for Urban
Affairs and Research
Howard University
Washington, D.C.

NEEDS ASSESSMENT FOR THE NATIONAL CONFERENCE OF MINORITY MENTAL HEALTH CENTER DIRECTORS

The following questionnaire has been designed to identify and collect data on several factors related to the design, structure and operation of Community Mental Health Centers (CMHC) directed by and for minority group members. The purpose of the Assessment will be to provide a base of information on the problems encountered, or anticipated to be encountered, by your agency(ies) so that developmental efforts might be implemented to provide assistance in the design of corrective measures.

The Assessment questionnaire has been divided into two sections. The first part requests descriptive data that will provide a definition of the agency (facility) that you represent (i.e., staffing patterns, service scope and population served, etc.). The second part consists of questions that will provide data on those factors that are important for the continued service delivery by minority operated CMHCs.

Your assistance in providing the data requested will aid all of us in designing models for assuring the continuation and growth of this vital mental health care service to our communities.

Thank you for your help!

PART A

(The back of the page should be used if the answers go beyond the space allowed).

1. What is your facility's organizational structure? (Describe multiple structure.)

   a. Completely Freestanding _____
   b. Hospital-Based _____
   c. Outpatient Clinic-Based _____
   d. Community Center-Based _____
   e. All Services Contracted _____

   _____
   _____
   _____

2. What are the normal business hours? _____

3. What is the number of staff employed by your facility? (By Position).

	FULL-TIME	PART-TIME
a. Psychiatrists	_____	_____
b. Other Physicians	_____	_____
c. Psychologists (Ph.D's only)	_____	_____
d. Social Workers (Master's or above)	_____	_____
e. Other Mental Health Providers (B.A. or above)	_____	_____
f. Nurses	_____	_____
g. Mental Health Workers (Less than B.A.)	_____	_____
h. Administrative	_____	_____
i. Clerical	_____	_____
j. Other	_____	_____
TOTAL		

4. Indicate the percentage of time (approximate) you spend as an administrator in the following tasks:

   a. Program Planning and Development _____
   b. Staff Selection and Supervision _____
   c. Fiscal Affairs _____
   d. Community/Client Relations _____
   e. Service Delivery/Treatment _____
   f. Project Evaluation and Monitoring _____

5. What is the size of your client population? (Per Annum).

_____(Units of Service)

6. What is the population of your catchment area?

_____

7. Please identify the racial/ ethnic composition of your client population (as a percentage).

	PERCENTAGE
a. Black	_____
b. Spanish - Speaking	_____
c. Asian	_____
d. Native American	_____
e. Anglo	_____
TOTAL	100.0%

8. What is the primary diagnosis of your facility's client population? (As a percentage.)

a. Alcohol Disorders	_____
b. Drug Abuse	_____
c. Mental Retardation	_____
d. Depressive Disorders	_____
e. Schizophrenia	_____
f. All Other Psych./ Mental Disorders	_____
g. Nonpsych. Disorders	_____
h. Other (Specify)	_____
i. Unknown	_____
TOTAL	100.0%

9. What is the referral source of your current client population? (As a percentage.)

	PERCENT
a. Self, Family or friend	_____
b. Clergy	_____
c. Private Practice Mental Health Professional	_____
d. Nonpsychiatric Physician	_____
e. Public Psychiatirc Hospital	_____
f. Other Psychiatric Facility	_____
g. Social or Community Agency	_____
h. Medical Facility	_____
i. School System	_____
j. Court, Law Enforcement, or Correctional Agency	_____
k. Other	_____
l. Unknown	_____
TOTAL	100.0%

10. The following question requests data on the proportionate funding level of your agency; therefore a percentage breakdown of your present annual funding level is requested:

GOVERNMENT FUNDS:	APPROXIMATE PERCENT
a. Federal	%
b. Other Federal Grants	
c. State	
d. Local	
e. Other (Specify):	
_____	
_____	
_____	

REIMBURSEMENT FOR SERVICES:	
a. Patient Fees	%
b. Insurance	
c. Medicare	
d. Medicaid	
e. Schools	
f. Other Receipts from Services	

OTHER TYPE OF INCOME:	
a. Consultation and Education	%
b. Philanthropy	
c. Other Fund Raising (i.e., United Appeal, etc.)	
d. From Other Receipts (Specify):	
_____	
_____	
_____	
_____	
TOTAL FUNDING LEVEL	100.0%

11. What is the total budget (in dollar amount) of your facility?

_____

PART B

1. What is your professional discipline?
Special field: _____
_____
_____

2. What is your highest degree?

a. M.D. _____
b. Doctoral _____
c. Master's _____
d. Bachelor's _____
e. Special (specify): _____

_____
_____

3. How long have you been in the mental health services delivery field?

a. Two years or less _____
b. 3 to 6 years _____
c. 7 to 10 years _____
d. 11 to 14 years _____
e. More that 15 years _____

4. How long have you been directing this particular agency (facility)?

a. 2 years or less _____
b. 3 to 6 years _____
c. 7 to 10 years _____
d. 11 to 14 years _____
e. More than 15 years _____

THE FOLLOWING QUESTIONS RELATE TO THE SERVICE PHILOSOPHY OF YOUR AGENCY (FACILITY)

5. What is the thrust of the agency's overall service priorities?

_____

_____

_____

_____

6. How would you relate these priorities to the origins and historical beginnings of this agency?

_____

_____

_____

_____

7. What are your projections for future service?

_____

_____

_____

_____

8. What, if any, special service considerations have been required due to the client population that you serve? (In terms of outreach, intake, treatment, special supportive services, etc.).

_____

_____

_____

_____

9. How were these special considerations identified?

_____

_____

_____

_____

THE FOLLOWING QUESTIONS RELATE TO STAFFING AND PROGRAM RESOURCES OF YOUR AGENCY

10. On a scale of 1 (least) to 10 (most), how sufficient do you rate your facility in the areas identified below? (Circle one item for each).

a. Funding	1	2	3	4	5	6	7	8	9	10
b. Staffing	1	2	3	4	5	6	7	8	9	10
c. Physical Structure	1	2	3	4	5	6	7	8	9	10
d. Support Services	1	2	3	4	5	6	7	8	9	10
e. Coordination With Referral Resources	1	2	3	4	5	6	7	8	9	10
f. Other (identify):										
_____	1	2	3	4	5	6	7	8	9	10
_____	1	2	3	4	5	6	7	8	9	10
_____	1	2	3	4	5	6	7	8	9	10

11. What are the special selection criteria required in hiring treatment personnel to serve your client population?

_____

_____

_____

_____

12. Should personnel employed by your agency have special characteristics that would not be required if the client population were not minority?

a. Yes _____
b. No _____

If "Yes", what are these characteristics? _____

_____

_____

_____

13. Other than personnel, what resources are required by your agency that you consider unique to the client population you serve?

_____

_____

_____

_____

THE FOLLOWING QUESTIONS RELATE TO COMMUNITY RELATIONS AND COORDINATION

14. What are the community's priorities and needs as you view them relative to your client population?

_____

_____

_____

15. To what extent do "community" (the client population's peer group) influences dictate the services provided by your agency?

a. Not at all _____
b. Only marginally _____
c. To some extent _____
d. A great deal _____

16. Why do you feel this way? _____

_____

_____

_____

17. What are the necessary or critically important professional sensitivities required to provide mental health service in your community?

_____

_____

_____

_____

18. What are the major barriers to providing mental health services in your community?

_____

_____

_____

_____

THE FOLLOWING QUESTIONS ARE MORE GENERAL AND IN SOME CASES MAY REQUIRE RESPONSES THAT ARE SIMILAR TO THOSE PREVIOUSLY GIVEN. TO THE EXTENT POSSIBLE, RESPOND TO THE QUESTION OR REFER TO PREVIOUS ANSWERS.

19. Given all of the resources you could want, what would you do to provide adequate mental health services to your community?

20. In terms of "Survival Funding" (that level of funding required to continue providing quality mental health care services to your treatment population), what are the major factors that are needed to continue the operation of your agency -- and what is required to obtain them?

21. Please list and describe the two (2) most important areas in which you believe your agency needs technical assistance

a.

WHY?

b.

WHY?

22. Please list and describe the three (3) most important areas in which you believe your agency needs staff training and staff development.

a. _____

WHY? _____

_____

_____

b. _____

WHY? _____

_____

_____

c. _____

WHY? _____

_____

_____

_____

23. What are your sources of data for evaluating your services to the community?

_____

_____

_____

24. Please provide other comments you consider helpful.

_____

_____

_____

_____

IUAR
Institute for Urban Affairs and Research

March 20, 1977

APPENDIX B

Dear_____:

Enclosed is a copy of the questionnaire that was distributed at the National Conference of Minority Directors of Community Mental Health Centers held on February 10-12, 1977,in Washington, D. C.

This questionnaire has been designed to identify and collect data on several factors related to the design, structure and operation of community mental health centers directed by and for minority group members.

Since we are now in the process of analyzing the returned questionnaires, your immediate attention would be appreciated.

If there are any questions, please contact me on 686-6770 or 6744.

Sincerely,

Charles L. Sanders, DPA
Project Director

CLS:hp

Follow-up Letter

Howard University
2935 Upton Street, N.W., Washington, D.C. 20008
(202) 686-6770

IUAR
Institute for Urban Affairs and Research

May 5, 1977

APPENDIX C

Dear _____:

The Mental Health Research Center of the Institute for Urban Affairs and Research is currently conducting a research survey on Minority Mental Health Administrators in Community Mental Health Centers.

The purpose of this survey is to provide a base of information on the encountered or anticipated problems in community mental health agencies. Hopefully, developmental efforts might be implemented to provide assistance to minority directors.

We would appreciate your assistance in completing the enclosed questionnaire. Please forward return to the above address.

If there are any questions, please contact me on 686-6770, or 6744.

Sincerely,

Charles L. Sanders, DPA
Project Director

Howard University
2935 Upton Street, N.W., Washington, D.C. 20008
(202) 686-6770

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