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ABSTRACT

This paper presents the approach used by the Technical Assistance Center (TAC) of the University of Minnesota's Refugee Assistance Program in Mental Health for identifying successful and culturally sensitive mental health service delivery models. It divides these into four categories: the psychiatric model; the community mental health model; the primary health care clinic model; and the multi-service agency model. The functional and descriptive characteristics of each of these models are described and are illustrated by selected examples. General characteristics of effective programs are discussed, including the use of trained bilingual/bicultural staff, integration into the refugee community, awareness of the special cultural needs of refugees, integration into a larger system of refugee care, and cross-cultural expertise among the service delivery staff. The bulk of the paper consists of an appendix describing 11 exemplary programs that illustrate each of the four categories: 2 psychiatric models, 2 community mental health models, 3 primary health clinic models, and 4 multi-service agency models. A second appendix lists all the refugee mental health programs visited by the TAC staff. A selected bibliography is also included. (TE)

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UNIVERSITY OF MINNESOTA

REFUGEE ASSISTANCE PROGRAM - MENTAL HEALTH

TECHNICAL ASSISTANCE CENTER

PROGRAM MODELS FOR MENTAL HEALTH TREATMENT OF REFUGEES

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One of the primary tasks of the Refugee Assistance Program - Mental Health: Technical Assistance Center (TAC) during its first and second years of operation has been to identify successful and culturally sensitive mental health service delivery models. Consequently, members of the TAC, located at the University of Minnesota, visited approximately twenty refugee mental health programs during 1986 and early 1987. This paper is intended to present the approach used by TAC, to categorize the models, to summarize the general characteristics of effective refugee mental health programs, and to describe some programs visited.

Developing program models, especially for mental health services, is a difficult task. The biggest challenge is to present models that are neither too specific nor too complicated to be useful. In discussing models, it is very easy to be so simplistic as to be uninformative or, at the other end of the continuum, to be so over-inclusive that one becomes abstruse and virtually unintelligible. Perhaps it is so difficult to develop models because individual variation and contextual factors supersede commonalities. A case could be made that programs really can't be categorized and that "no model" is the ideal model. There are admittedly so many variables that affect the implementation of any program in a given setting that construction of models is useful only up to a point.

The sources of information for this paper are the TAC site visits to programs across the continental United States, additional information from TAC members and consultants, and a brief review of

the published and unpublished literature on refugee mental health service delivery programs and models. Programs visited were selected primarily using the "snowball" technique for sampling, often used in community surveys. In other words, individuals in programs identified as culturally sensitive and successful were asked to recommend additional programs which might be useful to visit. Recommendations by State Offices of Refugee Resettlement, State Mental Health Offices, the National Institute of Mental Health, the TAC staff, and others were followed. Other criteria included assuring that we visited most of the areas in which refugees were located in high concentration, programs which refugees actually used, and agencies that agreed to be visited. Consequently, programs visited are representative but not inclusive of all effective programs, and those selected to exemplify models in this paper are not the only quality programs. Definitions of "culturally sensitive" and "successful" were thereby circumvented using these site selection criteria, despite the fact that we struggled to define these terms.

Although existing models of prevention, diagnosis, and treatment are to be considered for improvement by TAC, this paper discusses programs for delivery of clinical mental health services.

Primary prevention programs are not categorized, although some primary prevention activities are conducted by the treatment programs discussed. The intricacies of diagnostic and treatment approaches, of primary use to clinicians delivering frontline services, are not considered here but will be discussed in subsequent TAC papers. Finally, the program models presented here are the components of mental health systems, but the models for developing larger systems,

such as on those on the state level, are not directly addressed in this paper.

Ideally, models can be described by either structure or function, and modified by philosophic, economic, geographic, demographic, and other contextual variables. Examples of such factors affecting programs include the severity of the illnesses treated, the acculturation of the refugee population, the geographic considerations of urban or rural location, the percent of the defined population which consists of refugees, the financial stability of the treatment program, and the availability of trained staff.

Models, by definition, are "patterns" or "examples" which are to be copied. The example is the actual model or program description, the approach most often used in published literature. The pattern is the ideal model or typology which is much more difficult to define because of the large number of possible variations in classification.

This paper defines four ideal or typological models (patterns), classified according to a structural approach. Actual or program description models (examples) from the sites visited will be used to illustrate each of the categories. The four models include: 1) the psychiatric model; 2) the community mental health model; 3) the primary health care clinic model; and 4) the multiservices or social services model. Certain functional or descriptive characteristics of these four structural models can be discussed by creating a matrix of structure and function (Table I). For example, there is a tendency for more severely ill patients to be served by the psychiatric or mental health center model and less severely ill patients to be served in the primary health clinic or multi-services

models. By service approach, the more direct service and medical model appear to be more common on the psychiatric end of the continuum and the case management and consultation liaison models more common toward the multi-services end of the continuum. The financing mechanism, whether it be private (fee for service or nonprofit) or publicly funded (state, county, or university) crosses all of these four models, but not on the same continuum as the severity of illness of the population served. The ways in which biling l/bicultural staff are used, as professionals, workers, or interpreters can differentiate programs. Other ways of discussing models are: 1) by ethnic groups served; 2) by targeted populations such as the chemically dependent, the elderly, children, torture victims, or the chronically mentally ill; or 3) by type of service such as transitional care or partial hospitalization. Appendix A includes more detailed examples of the four structural models which have been discussed above, and Appendix B lists all programs visited by TAC.

The programs described are predominantly found within "mainstream" agencies. Sometimes the entire program is devoted to serving refugees, sometimes a small program was created in an already existing structural model, such as a mental health center.

The psychiatric model includes examples such as the Indochinese Psychiatric Clinic at the Oregon Health Sciences University in Portland, Oregon, or the Asian Inpatient Program at San Francisco General Hospital, San Francisco, California (Appendix A). These programs tend to be in university teaching hospitals or in large medical centers located in urban areas, often near where refugees

live. Staffs tend to be quite multidisciplinary. There is a diversity of programs and therapies but, since the very severely ill tend to be treated, the reliance on medications and the medical model approach is often the central core of the program. Training is frequently emphasized, and access to research and other academic activities is good. The major risks of this sort of program are ivory tower isolation and barriers to access by refugees who are intimidated or just unable to negotiate a complex of large building.

The next model is the community mental health center such as Elahan in Vancouver, Washington, or New Horizons Mental Health Center in Miami, Florida (Appendix A). The Elahan program is a small refugee-specific program within a mental health center, but integrated into the program. New Horizons was organized to treat the many ethnic groups, mostly refugees, within the catchment area. There are many advantages to a community mental health center model. Historically, the concepts of community mental health have included developing a continuum of services, initially required under the Federally-funded Community Mental Health Services Act and Amendments, and have included inpatient, emergency outpatient, screening, follow-up care, partial hospitalization, transitional halfway house services, as well as specialized services to the children and elderly or chemically dependent. Individual treatment plans and continuity of care have been organizing principles of mental health centers. Accessibility has been a concern, community orientation and involvement important, and coordination with other mental health services a priority. Preventive activities, such as consultation and education, have generally been incorporated because of federal

requirements and philosophy of the organizations. Multidisciplinary staff, as with the psychiatric model, are the norm. Disadvantages sometimes include insufficient ties to general health services, unlike the psychiatric model or the primary health clinic model, but similar to the multiservices/social services model. For freestanding mental health centers, inpatient treatment access is often relatively difficult. The staff, although committed, often have extremely heavy service demands and, consequently, training and emphasis on inservice become secondary.

The primary health care clinic model includes the Community-University Health Care Center (CUHCC) in Minneapolis, Minnesota, the Windsor Neighborhood Health Center in Cambridge, Massachusetts, and the South Cove Community Health Center in Boston, Massachusetts (Appendix A). Some of the advantages of this approach include a much tighter linkage between physical and mental health care, including better communication between primary health care professionals and mental health professionals. Refugees also find, as with the multi-services model, that there are fewer barriers due to the stigma of mental health found in many of the cultures. Although there is more diversity of staff than in a primary mental health setting, there is probably less of a range of mental health staff available. The range of mental health services is usually less than in the first two models discussed.

Examples of a multi-services/social services model include Asian Community Mental Health Services (ACMHS) in Oakland, California; Richmond Area Multiservices (RAMS) in San Francisco, California; Asian Pacific Center for Human Development (APCHD), Denver, Colorado;

and Asian Counseling and Referral Services (ACRS) of Seattle, Washington (Appendix A). The major advantage of this approach is that refugees can be offered more than just mental health services in this setting and are consequently more easily brought into the system. They can see the results of getting additional services in the same setting, and such concrete results are seldom achievable so quickly in the mental health treatment area. Problems can be identified early. As in the primary health model, the stigma of mental illness is less of a barrier to receiving services. Some of the disadvantages are that funding is often precarious which jeopardizes long-range planning of programs, and level of training of some of the staff is at times inadequate.

General characteristics of effective programs include: 1) use of trained bilingual/bicultural staff; 2) integration into the refugee community; 3) awareness of the special needs of refugees and an attempt to recognize these needs by using special approaches, such as herbal medicine, acupuncture, and supportive "psychotherapy" by spiritual leaders or traditional healers; 4) integration into a system of refugee care so that a continuum of services can be provided, even if the individual program does not; and 5) the quality of leadership and of direct service delivery staff who, if not bilingual/bicultural, have cross-cultural awareness, training and/or expertise. The final characteristic, although not required for good programs, is a critical mass of both refugees and of refugee service providers in a community. Obviously, this is an advantage, but would not be possible in states where smaller pockets of refugee settlement have been the norm. Concepts and ideas from the programs

with this critical mass can be adapted to areas without it and quality services can still be provided.

In Appendix A, we have used the program description approach to describe models by providing examples of each of the four structural typologies. Basic information included in these descriptions consists of identifying information such as the name of the agency and/or program, address, telephone number, and contact persons. An overview section includes information related to structure, philosophy, purpose, goals, facility, location, historical data, funding sources, and administration. The personnel section briefly discusses the ethnicities and disciplines represented and other potentially useful information. Finally, a services section discusses the populations serviced by ethnicity and proportion of refugees, the range of services, and any special culturally relevant services for other programs to emulate. These program descriptions are not meant to provide complete information, but to provide enough information for a program manager to decide whether additional information should be sought from the agency's contact person.

The approach to categorizing ideal or typological program models in admittedly arbitrary and somewhat simplistic but, for the sake of discussion, four structural models were selected: 1) Primary Psychiatric; 2) Mental Health Center; 3) Primary Health Care Clinic; and 4) Multi-Services/Social Services. Functional characteristics of programs vary depending upon the model. Actual examples or program descriptions of each of the four typologies have been included. Neither the approach to describing models nor any

program is flawless. However, this should provide a useful basis for a discussion of improving mental health services to refugees.

TABLE 1

CHARACTERISTICS OF MODELS

	TOTAL REFUGEES SERVED	SEVERITY OF ILLNESSES TREATED	SERVICE APPROACH
PSYCHIATRIC	LEAST	MOST ILL	MEDICAL
MENTAL HEALTH CENTER	SOME	MORE ILL	CASE MANAGEMENT
PRIMARY HEALTH CARE CLINIC	MORE	MORE ILL	CONSULTATION-LIAISON
MULTI-SERVICES/SOCIAL SERVICES	MOST	LEAST ILL	PSYCHOSOCIAL - PREVENTION

APPENDIX A

MODEL: PSYCHIATRIC

Indochinese Psychiatric Clinic
Oregon Health Sciences University
Department of Psychiatry
3181 S.W. Sam Jackson Park Road
Portland, Oregon 07201
(503) 225-8145 or 220-5651

Contact person: David Kinzie, M.D., Director or
Marie Ades, M.S.W., Coordinator

Overview/Personnel

The Indochinese Psychiatric Program is located at Oregon Health Sciences University in the Department of Psychiatry. This medical location fits within the conceptual framework of the Indochinese and works to facilitate acceptance of treatment.

The program receives funding from the State Mental Health Division and the State Alcohol/Drug Division, Oregon Health Sciences University, and patient fees. The program has been in existence since 1978 and transitioned one year ago from federal funding to state funding.

The program is directed by David Kinzie, M.D. and is staffed by four part-time psychiatrists, three senior Indochinese mental health counselors, four Indochinese counselor trainees, a part-time psychiatric nurse practitioner, and a coordinator. The counselors represent four main groups of Indochinese: Laotian, Mien, Cambodian, and Vietnamese. These are the groups served by the program.

The purpose of the Indochinese Psychiatric Program is to provide culturally appropriate psychiatric or alcohol treatment for Southeast Asians who are chronically mentally ill or who suffer from substance abuse.

Mental illness/alcoholism are complex biopsychosocial disorders and we believe treatment requires a thorough medical and psychiatric evaluation, with an understanding of the patient's culture. Treatment requires a broad-based approach with medical, individual, family, and group therapies all needed, depending on the specific problems of the patient.

The program's goals are to improve the functioning level of the patients psychiatrically and to support them in their adjustment to American society, while encouraging them to respect their traditional values.

Services

Treatment is provided in the patient's own language, with the psychiatrist, i olving the mental health counselor, during a psychiatric clinic visit, and in separate counseling sessions with the specific mental health counselor. Treatment is through individual, family, or group method.

The major types of disorders the program sees are: schizophrenia, major affective-depressed type, post traumatic stress disorder, organic brain syndrome, and substance abuse/dependence.

The psychiatric clinic operates once a week. Each week, the clinic sees one or two new patients and conducts a follow-up visit of an additional 25 patients. The clinic's current caseload is about 300 patients, and demand is constantly increasing. Patients are extensively evaluated during their first visit. Afterward, most patients visit the clinic once a month for medication management and supportive psychotherapy. Between visits, many patients receive counseling from the mental health counselors, who also serve as case managers. Most patients in the program either have a chronic psychiatric disorder or complicated social problems which add to their distress. Therefore, a long-term therapeutic relationship is needed and encouraged.

Socialization groups were begun in July, 1986, and are working very well. Groups are also being used in the alcohol treatment program. The socialization groups are led by an ethnic counselor and an American-trained staff: a social worker, nurse, or occupational therapist with involvement of the psychiatrist. The alcohol groups are led by the ethnic counselor.

Socialization groups are organized according to ethnic status and diagnosis: depressed, schizophrenic, and post-traumatic stress disorder. The groups are held once a week. Education about the illness, teaching of English and survival skills in American, and promotion of traditional activities, such as cooking or the telling of folk stories, are a major emphasis in the groups.

More recently begun are the once-a-month group therapy sessions conducted by the psychiatrist and the ethnic mental health counselor. These focus primarily on the traumatic experiences suffered by the refugees.

Other aspects of treatment are the provision of emergency and inpatient treatment through the OHSU hospital, patient advocacy with local social service and legal agencies, education of the patient about the United States society, and involvement of the family.

The program also has a priority of engaging in research projects. The Vietnamese Depression Scale, a self-rating scale for detection of depression among Vietnamese according to their conceptual framework, was developed several years ago.

Other research projects currently underway involve the study of post-traumatic stress disorder among Cambodians, and the development of an alcohol self-rating scale to detect the degree of alcohol abuse among Lao and Vietnamese.

MODEL: PSYCHIATRIC (INPATIENT)

Asian Pacific-American Inpatient Psychiatric Program
Department of Psychiatry
San Francisco General Hospital
1001 Potrero Avenue
San Francisco, California 94110
(415) 821-5077

Contact person: Evelyn Lee, Ed.D., Program Director
Francis Lu, M.D., Senior Attending Physician

Overview/Personnel

A description of the program is found in "Inpatient Psychiatric Services for Southeast Asian Refugees" in Southeast Asian Mental Health, DHHS #85-1399, 1985, pages 307-327.

The program utilizes a bilingual/bicultural model which staff considers superior to using well-trained interpreters assisting well-trained clinicians. The General hospital inpatient unit is the first such program in the United States designed especially for Asian-Americans. Southeast Asian refugees comprise 22% of the Asian-American admissions. Over twenty staff members and trainees are Asian-Americans, and two out of the three attending psychiatrists involved in the program are Asian. When the program opened in 1980, only 5% of the patients were Asian, but currently 60% are Asian. Of the program's on-site staff, Vietnamese is the only Southeast Asian refugee language spoken, but interpreter services for Cambodian and Laotian are available throughout the hospital. The program attempts to use a single interpreter for each cultural group on the inpatient unit.

Major referral sources include community mental health centers (21%), other psychiatric hospitals (18%), the police (15%), and medical units (8%). Sixty-nine percent are involuntarily committed as dangerous to self/others or gravely disabled.

Services

Diagnostic breakdown includes 97% with an Axis I diagnosis, excluding alcohol or drug abuse (37% of the refugee population carries a primary diagnosis of affective disorder, and 20% schizophrenic disorder).

The approach to treatment is that of an acute short-term inpatient service. Rapid stabilization with medication is the major form of treatment. After diagnosis with the "ethno-medical model," specific treatment techniques include symptom reduction through medication, supportive individual and family therapy, and a structured milieu. Family assessment rather than individual therapy is emphasized in the program. Among the concepts used are: energy systems theory, the

family life cycle theory, and alternative forms of treatment and acupuncture treatment. We only provide this at the outpatient mental health clinic. Physical examination is considered to be an important part of the evaluation and treatment, especially since many refugee patients have multiple physical complaints. The milieu program is designed to provide multi-lingual and multi-cultural services. Special attention is paid to the food offered on the unit, which includes rice and tea with regular meals. Family members can bring in home-cooked meals and staff often cook Oriental food on the weekends. Small group discussions are available among refugee patients who share the same language, and bilingual staff members attempt to manage the patients from the admission procedures and orientation to the unit through many aspects of the milieu and therapy. This tends to reduce the refugee concerns about confidentiality and improves continuity of the entire admission and treatment process. Herbal medicine is used, but for external use only. Seclusion for refugee patients is discouraged since this often exacerbates symptoms by eliciting memories of confinement in the homeland.

Community linkages have been developed carefully over several years, and those patients who improve are referred to community mental health centers, day treatment programs, residential care facilities, and board and care homes. If long-term hospitalization is needed, the patients are referred to Napa State Hospital and other locked facilities outside of San Francisco. Whenever possible, Asian refugees are placed in community settings where bilingual and bicultural mental health staff are available. Weekly visits by the inpatient staff to an outpatient clinic and treatment program in Chinatown are conducted to provide progress reports on the inpatient and receive input for discharge planning. Weekly inpatient hospital visits are also conducted by outpatient staff in these agencies, and outpatient therapists are encouraged to visit their hospitalized patients and attend case conferences. Pre-placement visits to treatment facilities are encouraged prior to a patient's discharge, and bilingual staff are available to escort the patients to other agencies.

MODEL: COMMUNITY MENTAL HEALTH CENTER

Elahan Center for Mental Health and Family Living
1950 Fort Vancouver Way, Suite A
Vancouver, Washington 98663
(206) 695-3416

Program Title: Southeast Asian Refugee Program
Contact person: John C. Magnano, A.C.S.W., Coordinator

Overview

Elahan is a traditional community mental health clinic with a specialized program for Southeast Asian refugees. The Center is a freestanding facility on a campus with education, public health, and social services. It is located in a small community of 40,000+ within a few miles of a medium sized metro area (1.5 million) with a medical school. It is convenient to the refugee community. About 2,000 Vietnamese, Laotian, and Khmer live in Clark County and the two adjacent counties which together have a total population of over 200,000.

The program was started in 1983-84 with the impetus from local service providers with federal block grant dollars that were targeted for minority services. The program is based on the belief that intensive case management services, combined with the coordination of services across the community and use of culturally specific treatment will attract clients and will reduce symptoms of major mental illness in the refugee population. The administrator of the Community Mental Health Center is a non-refugee, minority, Master's level social worker.

Personnel

A non-refugee Master's level social worker supervises three bilingual staff who are located organizationally within the case management unit of the mental health center. They utilize home visits, outreach, resource development, and heavily emphasize folk medicine and healing ceremonies. The role of the bilinguals includes therapy but also much social service intervention. They are viewed as members of the clinical staff as well as case managers.

The bilingual workers assess the client's psychiatric status and make the referral decisions as to whether or not a client needs to be seen by a psychiatrist. The psychiatrist, in the mental status exam, does an assessment with the bilingual worker and depends heavily upon behavioral observation and upon the worker for establishing cultural congruence.

The psychiatrist supervises the bilingual workers about half an hour each month and on an informal and as-needed basis. The child psychiatrist at the Center meets with the bilingual workers twice a

month to deal with family and child issues. The Case Management Coordinator runs an ethnic minority session three times a month and, in addition, meets with county case workers (including the bilingual case managers) once a month to discuss refugee cases.

Skill development workshops for both the bilingual and mainstream staff help to insure more culturally sensitive and appropriate services.

Services

The three Southeast Asian refugee populations that live in the catchment area (Vietnamese, Laotian, and Cambodian) have provided a challenge to the Mental Health Center to offer mental health services in such a way that would combat the traditional reluctance of the Asian population to receive service through a designated mental health agency. The stigma of the mental health label kept refugees away from the Center. however, the great emphasis on the use of the bicultural staff as "co-counselors", the use of home visits, case management to deal with social adjustment, coordination with other service providing agencies, and the use of traditional spiritual healers in a culturally appropriate setting together with a sensitive Western staff has largely overcome the mental health stigma label.

Services include outpatient, emergency services, community support, residential, vocational, and day treatment programs. Outreach is carried out in an individual/family model and education of the refugee community and consultation services to other health and human services providers is emphasized.

A crucial element of the project is consultation, training, and public education. Strong linkages are maintained with the wider refugee provider community in the areas of social, educational, and health needs of the refugees. Elahan staff are particularly involved in addressing the service area evaluation and planning process that overlaps with mental health concerns.

MODEL: COMMUNITY MENTAL HEALTH CENTER

New Horizons Community Health Center
1469 North West 36th Street
Miami, Florida 33142
(305) 635-0366

Contact person: Evelena Bestman, Ph.D., Director

Overview

New Horizons is a community mental health center in an ethnically diverse community. It started operation in 1974 as the University of Miami-Jackson Memorial Community Mental Health Center. Formal ties to the University were severed in 1981 but several staff members continue to have informal ties as well as adjunct positions with the University.

The original program model was developed in conjunction with the Health Ecology Project directed by Dr. Hazel Weidman. In that project, the needs, attitudes, and resources of the various ethnic groups with respect to medical and mental health care in Dade County were studied. Based upon the findings of this report, an approach was taken to improve access, utilization, and acceptance of the mental health center among surrounding ethnic populations.

In the original model, separate ethnic-specific teams were created to serve each of five ethnic groups (Haitians, Cubans, American Blacks, Bahamians, and Puerto Ricans). Each team consisted of mental health and social science professionals as well as paraprofessional neighborhood workers. As much as possible, team members were from the ethnic group being served. The teams were led by a social science professional of the targeted ethnic group, who served as a "culture broker" between the community and the agency. Eventually, seven teams were developed to serve a variety of groups and needs. This approach led to a well-documented increase in utilization of services by members of the target groups.

In addition to the team approach, the initial service model strongly emphasized prevention in the form of community education, organization, and advocacy. Additionally, activities frequently took place within the community rather than at the center. Activities included organizing community support groups, generating funding for important community projects, and assisting people with legal concerns.

Apparently for funding reasons, this team approach is no longer used. Instead, there is a centralized organization with sensitivity and responsiveness to different ethnic groups maintained by having the ethnic mix of the staff at all levels, reflecting the populations served.

Personnel

The director of New Horizons, Dr. Evelena Bestman, is a child psychologist with clinical licensure. She has been with the program since its inception and worked with Dr. Weidman at Jackson Memorial Hospital in developing the original program model. The Director of Clinical Services is a licensed clinical social worker. Programs are staffed by representatives of the ethnic groups served. In most instances, clients are served by a professional or paraprofessionals from their own ethnic group without the use of interpreters.

Staff with associate degrees in mental health technology do some patient interviewing, plan and lead craft and socialization groups, meet with family members, record observations and progress notes, and as part of the treatment team help plan and enact treatment plans. They do not conduct psychotherapy, psychiatric or psychological assessments. Bachelor level social workers perform a variety of tasks including enlisting services of surrounding agencies, determining eligibility for service, assisting patients in obtaining service at the clinic, providing some ongoing individual and family counseling, assisting in outside placement in residential or other facilities.

Services

New Horizons provides a full range of mental health services including: crisis emergency services with screenings and evaluations as well as medication maintenance and crisis counseling; day treatment, inpatient services, aftercare, linkage services, outpatient services including psychiatric, psychological evaluations, individual, family and group therapy, vocational counseling, court screening, specialized services for Cuban and Haitian entrants, substance abuse counseling, specialized services for children, youth, and the elderly; consultation, education and training programs, research and evaluation.

MODEL: PRIMARY HEALTH CARE CLINIC

Community-University Health Care Center (CUHCC)
2016 - 16th Avenue South
Minneapolis, Minnesota 55404
(612) 627-4774

Program Title: Refugee Mental Health and Social Adjustment Program
Contact Person: Marjorie Habenicht, RN, MSN, Coordinator

Overview

The Community-University Health Care Center is an outpatient clinic of the University of Minnesota Hospital. It is a freestanding, family centered, comprehensive health and human service agency located in a low-income neighborhood with a significant Southeast Asian population. Mental health and social services are an integral part of the primary health care service delivery.

The Refugee Mental Health and Social Adjustment Program at CUHCC addresses the problems of mental illness, severe trauma, grief and loss, and stress and adjustment in the Southeast Asian population. Recently, special emphasis has been given to the issues of sexual assault, battering, and chemical dependency. CUHCC first began providing refugee mental health services in 1981 with a small foundation grant. Funding continues under a combination of public and private monies. CUHCC is the primary agency in the county that provides mental health services to this target population. The number of opened mental health cases has more than doubled in the last two years. Fifty-four percent of the clients come from within Hennepin County, with the remainder coming from neighboring counties in the metropolitan area. Phone conversations come from counties beyond the metro area and from neighboring states. Occasional trips are made to outlying areas for case consultation and inservice programs.

Many of the clients served in the program receive their primary health care at the center, but this is not a prerequisite for service. Approximately 25,000 Southeast Asian refugees live in Minnesota, with the majority concentrated in the greater metropolitan area. The ethnic groups served in the Refugee Mental Health Program at CUHCC are broken down as follows: 45% Hmong, 17% Vietnamese, 14% Laotian, and 13% Cambodian.

The leaders from the four ethnic groups have input into program planning through ethnic group meetings with the administrative staff. They have an opportunity to share in planning but also are made aware of issues and problems related to service delivery to their respective communities.

Personnel

The Refugee Mental health and Social Adjustment Program uses the services of a psychiatrist one day per week. A Master's level psychiatric nurse with experience in refugee camps is the supervisor of the bilingual staff. An MSW is also assigned part-time to the project. The permanent bilingual staff includes representatives from the four Southeast Asian groups. Their educational levels range from no college education to Master's degrees. Two additional refugee workers are graduate social work students. The bilingual workers carry the major responsibility for the ongoing treatment. Each carries a heavy caseload and, in addition, is responsible for some support groups and community education.

Services

Refugee mental health services include: assessment and diagnosis, treatment plan development, individual and family therapy, medication and acupuncture clinics, involvement with traditional helpers, consultation to referring agencies, advocacy, and social services. Linkages with employment projects, sponsors, American volunteers, schools, and MAAs are supported/facilitated. A group support program offers therapeutic and educational group sessions for adults, children, and youth. Groups are held at schools, in apartment buildings, and at the clinic. The bilingual staff have primary responsibility for the groups, but leadership is often shared with an American professional or a worker from another agency. Community education is offered in a wide variety of settings, both to American and refugee providers.

MODEL: PRIMARY HEALTH CARE CLINIC

Windsor Neighborhood Health Center
105 Windsor Street
Cambridge, Massachusetts 02139
(617) 498-1098

Program Title: Latino Mental Health Program
Contact Person: Mauricia Alvarez, MSW, Psy.D., Director

Overview

This program is an outpatient community-based clinical program established by the Department of Psychiatry at Cambridge Hospital located within a neighborhood health center. The Center is in the heart of a largely Latino community in the area and is close to transportation. It serves largely a Hispanic clientele. Most of the medical and support staff are bilingual; many are bicultural.

A largely Latino multi-service agency is also housed at the Center, with an array of social services: information and referral, outreach and social advocacy, adult education, vocational and occupational assistance, substance abuse counseling, and family service.

The medical and support staff of the clinic were instrumental in advocating for the establishment of the program, as were Latino advocacy groups who wanted a more accessible and integrated approach to physical health, mental health, and the social service needs of Latinos.

Initially, medical clinics were the primary referral source along with many referrals from the psychiatric emergency room service in the hospital, and from multi-service agencies in the community. As the knowledge and acceptance of the program has become more widespread, the emphasis in referrals has shifted to self-referral and referral by clients, family, and friends.

Program Goals

- To provide culturally sensitive and effective mental health services to Latinos.
- To maintain ongoing liaison with psychiatric services at the community hospital and community mental health center.
- To provide consultation services to other mental health and social service programs and community agencies.
- To advocate for further development of bilingual/bicultural services in mental health and social service systems.

- To attract and train bilingual/bicultural mental health professionals/paraprofessionals.

Administration

The Program Director is responsible to the Director of Outpatient Services of the Department of Psychiatry of Cambridge Hospital. She is Latino, a social worker and a psychologist, and is employed 25 hours per week. She also functions as a community organizer, advocate, activist, fundraiser, program planner, supervisor, and clinician.

Personnel

The program staff is multi-disciplinary, made up of clinicians, trainees, and post-doctoral fellows. They work with consultants from psychology, social work, psychiatry, clinical anthropology, and social psychology. Most consultants and all of the staff have extensive clinical experience. All of the staff have graduate level degrees except for masters level trainees in social work. All clinical staff and trainees receive a minimum of two hours of individual supervision per week and all participate in seminars, group supervision and workshops within the Department of Psychiatry. The trainee programs in social work, psychology, psychiatry, and community mental health provide a heavy emphasis on training and ties with the Medical School and universities.

Services

All of the clients are Latino and about 65% are refugees. Services are limited to adults and families. When the child is the identified client, he/she is referred to the Cambridge Child Guidance Center. Collaboration with the Child Guidance Center is maintained. Primary services are diagnostic evaluation, psychological and psychiatric assessments, trauma and crisis intervention, short and long term counseling with individuals and groups, supportive and group psychotherapy, behavioral therapy, psycho-educational workshops, information, referral, advocacy, outreach and home visits.

All staff and trainees are engaged in providing consultation and training (both clinical and programmatic) to numerous programs and agencies in the larger hospital system as well as in the community. In addition, there is a strong participation in various advocacy groups, collaborations and coalitions at multiple levels including the community, city-wide, regional and state levels. Several members of the staff as well as two post-doctoral fellows are also conducting research studies through their involvement with the Latino Mental Health Program.

MODEL: PRIMARY HEALTH CARE CENTER

South Cove Community Health Center
885 Washington Street
Boston, Massachusetts 02111
(617) 498-7555

Program Title: Metropolitan Indochinese Children and Adolescent Center (MICAS)
Contact Person: Holly Lockwood, Program Coordinator
302 Broadway
Chelsea, Massachusetts 02150
(617) 889-2760

Overview

The South Cove Community Health Center, a neighborhood-controlled center, was established to serve the Chinese community but now has expanded to serve Southeast Asian refugees and Asians from all over metropolitan Boston.

The Metropolitan Indochinese Children and Adolescent Services (MICAS) was established in 1983 as part of the Community Health Center to provide mental health and social services to children, adolescents, and families from Cambodia, Laos, and Vietnam. About one-sixth of the caseload is made up of Amerasian children. The present coordinator of the program, an education specialist, was instrumental in organizing and advocating for its establishment.

The program uses the social outreach rather than the medical model. Emphasis is on self-referral by adolescents with concrete living problems with later mental health interventions as necessary. Parents of adolescents over sixteen years of age are not contacted without the consent of the teen unless a serious crisis warrants. Most cases, however, are either identified through the outreach activities of the MICAS staff or by other providers (e.g., school personnel, health providers, court and police personnel, refugee resettlement staff) who make referrals for MICAS.

Personnel

Staff include a part-time child psychiatrist, a clinical psychologist (eight hours per week), and a part-time protective services consultant, in addition to the full-time staff of clinical social workers, education specialists, and bilingual/bicultural workers. The staff work together in counseling teams which meet at least once a week for an hour for "team consultations", a time to plan counseling sessions, share information, and coordinate activities with a given client. An American social worker (usually an individual with a degree in education or social work) is paired with a bilingual worker called a caseworker. Each member of the

counseling team also meets with the Clinical Services Coordinator weekly for individual clinical supervision. Training as well as supervision of the teams is the responsibility of the Clinical Services Coordinator.

Services

MICAS services include individual, group and family counseling; career and educational counseling; diagnostic evaluation; special education evaluation; activity groups; summer school; summer youth employment; information and referral; advocacy; crisis intervention; agency consultation and education. MICAS clients have access to the full array of health and allied health services offered at the Health Center site. Clients are frequently met at home, in the school, in coffee shops, or in other non-clinical settings.

MICAS has satellite programs in several high schools. A bilingual caseworker and a MICAS social worker provide counseling, crisis intervention, and social service, consultation, and education for school personnel. This team does not generally work with school social workers, since many schools do not have social workers and school social workers usually have little or no contact with the Southeast Asian students. This school outreach program targets students with poor attendance, motivation or conduct, and those with educational, psychological, family, or health problems. The MICAS staff maintains close contact with students and school staff with the goal of enabling students to benefit more fully from their school experience.

Specific objectives of the school satellite program include: increasing student access to and utilization of school and community services, addressing the special cultural orientation, educational, emotional, and social needs of the target population by supplementing school services and offering mental health services in an accessible, culturally appropriate setting.

MICAS is in the initial implementation stage of a project providing hospital diversion and inpatient psychiatric support services to Cambodian children and adolescents ages 10-21 living in eastern Massachusetts. This two year project is supported by the United Way of Massachusetts Bay and the Massachusetts Department of Mental Health and operated by South Cove/MICAS and the Massachusetts Association for Mental Health.

MODEL: A MULTI-SERVICE AGENCY

Asian Community Mental Health Services (ACMHS)
310 - 8th Street, Suite #201
Oakland, California 94607
(415) 451-6729

Contact person: Rodger Lum, Ph.D., Executive Director

Overview

The history of ACMHS is well-documented in the California RAP Grant, 1985. A current description of the population served and the structure and staffing of mental health services is noted in "A Community-Based Mental Health Service to Southeast Asian Refugees" in Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research, DHHS #85-1399, 1985, pages 293-299. The Program began in 1974, largely providing mental health promotion services to the existing Alameda County Asian community, but also provided limited clinical services at that time. In 1980, the clinic was licensed and the shift in recent years has been from the initial focus on prevention services to far greater emphasis on provision of clinical services. Although most services have been provided in Alameda County, the agency is also contracting with Contra Costa County to provide service to Southeast Asian refugees.

Personnel

The frontline delivery of mental health services is provided by five refugee mental health workers: two Vietnamese, two Laotians, and one Cambodian. Refugees who are also fluent in Chinese are given the option of seeing a Chinese-speaking social worker or mental health worker. In addition, there are two part-time psychiatrists, one Chinese and one Vietnamese. An Afghani is on staff as an interpreter/translator.

Services

The primary mode of treatment is individual therapy but groups are also used and families are almost always involved in the treatment process. Psychiatric care is usually medication evaluation and supportive therapy only. A very eclectic approach is used towards treatment, and the client needs seem to outweigh the particular orientation of the therapist. Most refugee treatment is supportive only, but some behavioral and cognitive approaches are used. Supportive therapy is most commonly used amongst the Cambodian, Laotian, and Mien populations. Occasionally, the most acculturated or educated Vietnamese are seen in dynamically oriented or cognitive-behavioral psychotherapy. The agency has a large population (more than 50%) of severely disturbed clients. Staff view themselves as seeing relatively more disturbed clients than a

comparable outpatient agency in the mainstream because the refugees are often unaccepting of mental health concepts and do not seek treatment early. Biofeedback is offered as part of the prevention services and is one of the ways of attracting client attention into the treatment portion of the center. Although most referrals do occur from other agencies, the preventive efforts of ACMHS have encouraged many people to seek clinical attention at the center. More recent emphasis at the Center is on sexual abuse, child abuse, family violence, and substance abuse prevention.

Staff feel that basically ACMHS can handle virtually all outpatients using treatment modalities which include not only individual therapy, but family, group, and play therapy. There is an interest in incorporating traditional healing practices in the treatment approaches. The number of clients per staff member is gradually increasing and supervisors feel that this is largely due to an increasing efficiency on the part of staff members. The family is virtually always involved in treatment, even if the patient is overtly psychotic, and outside agencies are used for advocacy as well as referral.

Research and teaching are important components of ACMHS. The agency received a grant for a state-wide mental health needs assessment. A survey of about 4000 Southeast Asian refugees in the ten counties most heavily impacted by refugees is being completed and a state grant has been received for the provision of technical assistance and training to counties in the delivery of refugee mental health services.

MODEL: A MULTI-SERVICE AGENCY

Richmond Area Multi-Services Agency (RAMS)
3626 Balboa Street
San Francisco, California 94121
(415) 668-5955
Contact Person: Herbert Z. Wong, Ph.D., Executive Director

Southeast Asian Mental Health Services
Contact Person: Dinh Van Nguyen, MSW, Program Director

Overview

The Southeast Asian Mental Health Services, one of four programs of the Richmond Area Multi-Services, Inc. (RAMS), started in 1979 as a Social Security Administration-funded training program. Although the original intent was to train Southeast Asians to become paraprofessional Community Mental Health Workers for their communities, clinical services were by-products of the RAMS training program. And, these services were extended to Southeast Asians in all five Bay Area counties (Alameda, Contra Costa, Marin, San Francisco, and San Mateo).

In its first year, the Southeast Asian Mental Health Services focus was on preventive activities such as organizing community meetings and block parties, referrals for clinical services were received after the agency was in operation for four months. In the early history of the agency, referrals were mostly from health clinics and resettlement agencies. Currently, referrals were either from families, friends, clients themselves, or from numerous agencies serving the Southeast Asian communities, including schools, English-as-a-Second-Language programs, and psychiatric inpatient units.

Since 1983, Southeast Asian Mental Health Services has become a contract agency, under the RAMS, Inc. umbrella, serving the Southeast Asians living in the City and County of San Francisco only.

Personnel

Staffing pattern is based on the composition and size of the Southeast Asian communities here in San Francisco. Workers are recruited within the communities. Due to their direct contact with their clients from their own communities, workers are required to have bicultural, bilingual, and biliterate capabilities in their native languages. Ideally, the agency would have two Vietnamese-speaking, one Cambodian-speaking, and one Laotian-speaking worker, to provide clinical services and mental health promotion services to the communities. Currently, it has two Vietnamese workers and one Cambodian worker, and hopes to fill the Laotian-speaking position in the next few months.

Southeast Asians who had been working at the agency were from various backgrounds. Some were professionals in their countries. However, none of them had any training or experience in mental health upon joining the agency. Thus, the RAMS training program aimed to provide its workers with such basic skills in mental health services as: interviewing, assessment and evaluation, medication issues, and therapy techniques for individuals, couples and families. In addition, workers were introduced to different theoretical orientations for treatment.

Clinical supervision and consultation are provided to workers by a licensed clinical social workers and the Southeast Asian Mental Health Services staff psychiatrist, on a weekly basis. Ongoing training is provided through inservice and workshops sponsored by San Francisco Community Services, and other social service/health/mental health service agencies in the Bay Area.

Service

The primary mode of treatment by the bilingual workers is individual weekly therapy. The family and other agencies are involved in the treatment process, and the family, in particular, is involved with case management. The therapeutic context is used to educate family members about mental health. No groups are available at Southeast Asian Mental Health Services. A women's group was attempted, but attendance was not good and this was discontinued. The director feels a single women's group and an elderly group would be extremely helpful, but has not found a way of incorporating these into the program.

Medications are managed by the staff psychiatrists at RAMS. The primary approach is supportive, in the context of providing follow-up for medications. The psychiatrists use interpreters and employ a "generalist approach" rather than a culture-specific approach towards treatment and assessment. For many of the patients (estimated between one-fourth and one-third of the Southeast Asian Mental Health Services caseload), psychiatrists manage the patients with the bilingual mental health workers, and these patients are usually seen on a weekly basis with the bilingual mental health workers for individual therapy.

The general treatment approach is problem-solving and support by both the psychiatrist and the mental health workers, and there is very little classic psychotherapy done. Only a few Vietnamese clients are appropriate for intensive therapy according to the director. The average length of stay within Southeast Asian Mental Health Services is six months to one year, but some chronic patients, managed medically, have been in the program since 1979.

Adult Day Treatment Program (RAMS)

The other major treatment modality used for refugees is the adult day treatment program at RAMS. About 20-25% of the day treatment clients are refugees, with 30-40 clients seen in day treatment per month. The day treatment program, in existence since 1980, treats predominantly Chinese, then Vietnamese, Caucasian, and "others." It

meets five days per week. The average age is 29 years and the patients are younger, more active, and tend to have more resources than many of the Southeast Asian Mental Health Services clients. Day treatment is staffed by bilingual professionals, but none of these belong to the Southeast Asian cultures. Instead, translators are used when Southeast Asians are in the program.

Staff work closely with halfway houses and other residential facilities including the inpatient Asian unit at General Hospital. There is also a case management system in San Francisco, and continuity of care is provided through this mechanism. Referral sources to the day treatment center include hospitals and the Southeast Asian Mental Health Services outpatient clinic. Day treatment does take into account cultural considerations such as the stigma of mental health, the predominance of somatic complaints expressing psychological distress, and the culture-specific nature of delusional material.

Family members are involved closely in day treatment. The program plans to restart parent and family education and they hope by this means to overcome the resistance that families have to therapeutic instructions by RAMS or Southeast Asian Mental Health Services staff. For example, families often feel that they should determine how much medication the patient will take or how much use of the traditional healing system is required. The RAMS program uses culture-specific family therapy techniques for Asians developed by Evelyn Lee and Sung Kim.

MODEL: A MULTI-SERVICE AGENCY

Asian Pacific Center for Human Development
1825 York Street
Denver, Colorado 80206
(303) 393-0304

Program Title: Outpatient Mental Health Program
Contact Person: Sumiko T. Hennessy, Ph.D., Executive Director
Richard Onizuka, Ph.D., Clinical Director

Overview

The Asian Pacific Center for Human Development is a non-profit multi-service agency that serves refugees, immigrants, and native born Asian and Pacific Island populations in Colorado. It was founded in 1980 by a group of professionals (mostly Asian-Americans) who had been working in a traditional community mental health center. Certification by the Colorado Division of Mental Health came in 1982.

The goals of the Center are to deliver culturally sensitive services to the Asian/Pacific Island communities through the use of trained bilingual/bicultural clinicians. These clinicians help clients learn to cope with psychological and emotional problems as well as to develop life skills to aid in their assimilation into American society and to become self-sufficient, contributing residents of Colorado. In addition, the Center's aim is to provide assistance and consultation to other organizations who provide services to the Asian/Pacific Island populations.

About 60% of the Center's mental health services are to Southeast Asian refugees. The remainder are delivered to non-refugee Asians, Asian-Americans, and Eurasians.

The Asian Pacific Center for Human Development is located in Denver but has an interagency agreement to serve Southeast Asians at the San Juan People's Clinic in Boulder.

Funding for the chronically, acutely, and seriously mentally ill is provided by state funds with the provision that at least 75% of the caseload must serve that group. Additional funding is derived from a variety of sources for special projects and for services.

The Center is governed by a Board of Directors which meets every other month for large meetings with the bulk of the work accomplished by special committees: Executive, Finance, Mental Health, Vocational Programs, Nomination, and Long-Term Planning.

The Executive Director of the Asian Pacific Center for Human Development is an Asian professional with a Ph.D. Her administrative responsibilities include a heavy emphasis on fundraising.

Personnel

The Director of Clinical Services is Asian-American and has a Ph.D. in Clinical Psychology. He sees every client (adults and the occasional child) on admission and at some later date reviews every case.

The major responsibility for the ongoing work with refugee clients is accomplished by bilingual Southeast Asian workers who are called "clinicians." The clinicians work under the direct supervision of the Director of Clinical Services. Most have a V.A. degree and received their mental health training through in-service and on-the-job training. The senior clinicians have M.A. degrees and serve mainly the non-refugee clients who are Korean, Japanese, Chinese (either immigrant or American born), or Euroasian.

Each clinician carries a caseload of between twenty to thirty cases and are given a high level of responsibility in patient assessment, development of treatment plans, and provision of care. Psychiatrists serve as consultants and see each patient at least once in six months and must approve treatment plans. Clients on medication are seen more frequently. The total psychiatric consultation time amounts to about ten to twelve hours per week.

Emphasis is placed on in-service training of the clinicians with a minimum of one day a week set aside for that activity. These include sessions with a clinical psychologist and with a psychiatrist. The latter has in her sessions addressed the needs of the clinicians who have experienced many of the same traumatic events and suffer from many of the same conditions as their clients. Case review is considered a part of in-service and cases are reviewed in conferences once per month. Peer review is scheduled one session per month and the clinicians review each other's cases for treatment and follow-up. The Clinical Director is responsible for the in-service training programs.

Services

Approximately 12,000 refugees live in Colorado, with the majority residing in the Denver metropolitan area. About 78% of these are Asian, with Vietnamese being the predominant group. The remaining non-Asian refugees include Soviet/Eastern Europeans, Ethiopians, and Afghans. About 2,000 refugees live in surrounding rural counties.

The Center staff provides outpatient services that include individual, family, and group therapy, day treatment programming, psychological evaluations, and 24-hour emergency services. Psychiatric hospitalization is provided when needed through contracts with community mental health centers and inpatient facilities. Priority is given to the seriously, critically, and chronically mentally ill.

Special activities provided are: consultation and education services to hospitals, mental health agencies, schools, colleges,

universities, social service agencies, and law enforcement agencies. A training division partly funded by the United Way coordinates the education and training for the public and for professionals in the community. In-service training workshops are presentations on Asian cultures and mental health issues are offered. Alcohol and substance abuse treatment services and pre-vocational programs are also provided. The Center has a state funded rehabilitation program specializing in the production of Asian foods and utilizing chronically mentally ill and refugee clients. Special funding has also been obtained for youth at risk and domestic violence programs.

In addition to those services specifically related to mental health, the Center provides many other services including: leadership training and education; job search skills workshops; English language classes; translation of professional pamphlets and material into Asian languages; Oriental massage; and Asian cooking, language, and dance classes. The Business Management section is of special interest to refugees and offers on-the-job training in clerical, data management, and business management skills.

MODEL: A MULTI-SERVICE AGENCY

Asian Counseling and Referral Service (ACRS)
409 Maynard Street
Seattle, Washington 98104
(206) 447-3606

Contact Person: Theresa Fujiwara, MSW, Director
Jerry Sera, MSW, Mental Health Program Manager

Overview

The Asian Counseling and Referral Service is a large multi-service agency located in an Asian community in a large metropolitan city. It had its inception in 1973, when a group of Asian professionals with impetus from the University of Washington, School of Social Work, became concerned that Asians were not using mental health services in proportion to their population and that clients dropped out of treatment. From the beginning, its primary emphasis has been mental health care and an integrated pan-Asian rather than an ethnic-specific approach. It was the first Asian minority organization in the country to provide mental health care to the Asian community. It maintains strong ties to the University of Washington School of Social Work.

The agency is housed in a freestanding facility that serves as an Asian community center and is across the street from a community health clinic. The outpatient mental health program of ACRS has been state certified since 1976 as a mental health service provider.

The agency goals are to provide a wide range of mental health services that are linguistically, culturally, and therapeutically appropriate to client needs, and which result in the improved functional and emotional well-being of the clients.

It is governed by a Board of Directors with the assistance of a Clinical Advisory Committee. The Executive Director, an Asian MSW social worker, has responsibility for overall administration. The ACRS has an overall budget of about 1.3 million dollars with government funds making up 72% and the remainder coming from the United Way and community support. The clinical mental health portion of the program consumes about one-third of the overall budget.

With the influx of Indochinese refugees beginning in 1975, the Center hired the first bilingual/bicultural community mental health therapist to work with Indochinese refugees. This was the first such effort in the nation and was the beginning of an expanding mental health program of service and training to the Indochinese community. Since that time, it has become the major provider of mental health care to Indochinese refugees in the state.

Personnel

The bilingual staff consists of twelve mental health specialists, a mental health program manager, a mental health supervisor (social worker), a psychiatric nurse, three part-time psychiatric consultants, and social work students. The bilingual staff is supervised by a master's level social worker. With one exception, the minimum education of the bilingual workers is a Bachelor's degree, with some having Master's degrees.

The bilingual staff is responsible for the initial basic data-gathering as well as the initial diagnostic formulation. This is done under the supervision of the psychiatrist or the mental health supervisor. Individual therapy is conducted by the bilingual workers with the psychiatrist as the primary supervisor. Traditional healers are used as part of the treatment process using a small group approach with the bilingual workers coordinating the treatment. The bilingual staff is trained during in-service sessions at ACRS. They attend weekly grand rounds at the medical Center, meet with the psychiatrist for two and one-half hours per week, and spend an hour and one-half with the clinical supervisor. In addition, each bilingual worker is seen on an individual basis every other week by the clinical supervisor. Each worker is allotted $200 per year for travel to conferences or workshops outside the agency.

Services

Washington State's refugee population numbers approximately 36,000, with 89% being Southeast Asian and the remainder Ethiopians, Rumanians, Polish, and Afghans. The majority are concentrated in the metro area.

ACRS has become the major provider of Indochinese mental health services in the state. About 86% of the refugee case load are state priority clients with increasing numbers of severely dysfunctional individuals. The most acute and difficult cases are seen by the staff and the remainder are seen as space is available or referred to other agencies, with consultation provided by ACRS staff if necessary. A community mental health center provides day treatment services and a crisis clinic provides backup 24-hour emergency service.

Services provided by ACRS include individual and family therapy, supportive therapy, and case management. Traditional healers or herbalists are employed when appropriate, with services coordinated by the bilingual staff. All age ranges are served.

Outpatient services include: bilingual/bicultural intake and assessment; individual, family, marital and couples therapy; psychiatric evaluation; medication monitoring; crisis intervention; activities therapy; and case management. Patients are admitted to service on the basis of priority according to severity of illness. Preference is given to clients who are discharged from an inpatient

unit or the county emergency program, and to clients who need bilingual/bicultural services.

Service to Indochinese clients is based upon traditional help-seeking patterns and the ACRS mental health staff utilize and work with "accepted" healers including family members, elders, community leaders, spiritual leaders, and folk practitioners.

In addition to the mental health program, ACRS provides a wide range of social and support services including an information and referral telephone line, an Asian elderly project, vocational training for refugees, emergency food and shelter programs, interpretation and translation for agency clients, and employment referral.

Consultation and education is provided to Indochinese social and health service providers, community groups, Western health and mental health professionals and paraprofessionals within the state of Washington and other states. These services are budgeted at almost $70,000 and include formal, structured training (conferences, staff in-services), and community education (group and individual).

APPENDIX B

REFUGEE MENTAL HEALTH PROGRAMS VISITED BY TAC STAFF*

CALIFORNIA

Asian Community Mental Health Services*
310 - 8th Street, Suite #201
Oakland, California 94607
(415) 451-6729
Director: Rodger Lum, Ph.D.

Asian Pacific Counseling Center
Los Angeles County
3407 West 6th Street
Los Angeles, California 90020
District Chief: John Hatakeyama, M.S.
Indochinese Counseling and Treatment Unit (satellite of the Asian Pacific Counseling Center
1920 West Beverly Boulevard
Los Angeles, California 90057
(213) 738-4231
Supervising Psychiatric Social Worker: Que Le, L.C.S.W.

Metropolitan State Hospital Asian Inpatient
Unit I
Norwalk, California
(213) 863-7011
Program Director: Randolph Stone, Ph.D.

Orange County Department of Mental Health
1623 W. 17th Street
Santa Ana, California 92702
(714) 834-2268
Minority Services Coordinator: Mai Cong

Richmond Area Multi-Services (RAMS)*
3626 Balboa Street
San Francisco, California 94121
(415) 668-5955
Executive Director: Herbert Z. Wong, Ph.D.
Program Director of Southeast Asian Mental Health Services: Dinh Van Nguyen, M.S.W.

San Francisco General Hospital*
Asian Pacific-American Inpatient Psychiatric Program
Department of Psychiatry
1001 Potrero Avenue
San Francisco, California 94110
Program Director: Evelyn Lee, Ed.D.

COLORADO

Asian Pacific Center for Human Development*
1825 York Street
Denver, Colorado 80206
(303) 393-0304
Executive Director: Sumiko T. Hennessy, Ph.D.

FLORIDA

Miami Mental Health Center
2141 Southwest First Street
Miami, Florida 33135
(305) 643-1660
Executive Director: Olivia Martinez, M.S.W.

New Horizons Community Mental Health Center*
1469 North West 36th Street
Miami, Florida 33142
(305) 635-0366
Executive Director: Evelina Bestman, Ph.D.

ILLINOIS

Travelers & Immigrants Aid
Refugee Mental Health Program
1046 West Wilson Avenue
Chicago, Illinois 60640
(312) 271-1073
Coordinator: Gail Cohon Stein

MASSACHUSETTS

Dorchester Counseling Center
590 Morton Street
Boston, Massachusetts
(617) 282-1511
Clinical Services Director for Mental Health: Dick Woy, Ph.D.
Riverside Clinic

Haitian Mental Health Program
5 Callender Street
Cambridge, Massachusetts 02139
(617) 498-1109
Director: Michelle Klopner, Ph.D.

South Cove Community Health Center*
Metropolitan Indochinese Child and Adolescent Services Program (MICAS)
302 Broadway
Chelsea, Massachusetts 02150
(617) 889-2760
Program Coordinator: Holly Lockwood

Windsor Neighborhood Health Center*
Latino Mental Health Program
105 Windsor Street
Cambridge, Massachusetts 02139
(617) 498-1098
Director: Mauricia Alvarez, M.S.W., Psy.D.

MINNESOTA

Community-University Health Care Center*
2016 - 16th Avenue South
Minneapolis, Minnesota 55404
(612) 627-4774
Refugee Mental Health and Social Adjustment Program Coordinator: Marjorie Habenicht, M.S.

Wilder Foundation
Refugee Social Adjustment Program
92 Arch Street
St. Paul, Minnesota
(612) 642-4000
Director: Tom Rogers, M.A.

OREGON

Oregon Health Sciences University*
Indochinese Psychiatric Clinic
Department of Psychiatry
3181 Southwest Sam Jackson Park Road
Portland, Oregon 97201
(503) 225-8145
Director Indochinese Refugee Program: J. David Kinzie, M.D.

WASHINGTON

Asian Counseling and Referral Service (ACRS)*
409 Maynard Street
Seattle, Washington 98104
(206) 447-3606
Director: Theresa Fujiwara, M.S.W.

Elahan Center for Mental Health and Family Living*
1950 Fort Vancouver Way, Suite A
Vancouver, Washington 98663
(206) 695-3416
Coordinator, Southeast Asian Refugee Program: John Magnano, A.C.S.W.

International District Community Health Center
416 Maynard South
Seattle, Washington 98104
(206) 622-9650
Executive Director: Gail Tanaka, M.S.W.

* Programs described in the report

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