# REFUGEE MENTAL HEALTH AND SOCIAL ADJUSTMENT: A STRATEGY FOR SYSTEM IMPROVEMENT

A Proposal by

The State of Minnesota
Department of Human Services

July 25, 1985

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RUDY PERPICH
GOVERNOR

# STATE OF MINNESOTA

OFFICE OF THE GOVERNOR

ST. PAUL 55155

July 15, 1985

Richard B. Cravens, Ph.D.
Acting Director
Cuban/Haitian Mental Health Unit
National Institute of Mental Health
Room 18A-33, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Cravens:

I enthusiastically support Minnesota's application submitted by the Department of Human Services for funds under the Refugee Assistance Program - Mental Health.

As the son of immigrant parents I started school unable to speak English. This experience has resulted in a very personal interest which I have had over the years in the successful adjustment of refugees and other immigrants into our state. The trauma of departure and the loss of country lead one to realize how vital it is that we recognize and support the needs of our new residents with appropriate services. It is therefore my pleasure to endorse the Minnesota application for refugee mental health services.

Recently I met personally with refugees to learn first hand of the problems they have encountered in Minnesota. I have also asked Leonard W. Levine, Commissioner of Human Services, to meet with leaders of the Hmong community to hear their concerns. When he did so access to culturally appropriate mental health prevention and treatment services was one of the top priorities. When the announcement of the Refugee Assistance Program - Mental Health arrived the timing could not have been better to assist us in improving our ability to provide the needed services.

Within the broader context of mental health services, I have just announced the creation of the Governor's Commission on Mental Health which will, among other things, address the mental health needs of refugees.

I have directed the Commissioner of Human Services to study the feasibility of a consolidated funding system for publicly supported services for people with mental illness problems. This study will address such approaches as prospective financing, capitation grants, and local agency responsibility and control in an effort to reduce eligibility barriers, fiscal disincentives, and varying matching ratios which impede cost-effective services for people who need them. Department staff will pay particular attention to the needs of refugees in this study.

We are fortunate that the state's Mental Health Division and the Office of Refugee Resettlement are both located within the Department of Human Services. Staff from the two units have worked closely together for over a year and will continue to collaborate in implementing the Refugee Assistance Program grant.

The State of Minnesota is combining concern with creative initiative to address the problems of people with mental illness problems, including refugees. Receipt of the federal grant will enable us to develop specific solutions for refugees by making systemic changes that will endure well beyond the duration of the grant. I urge your favorable response to our application and pledge my ongoing support in accomplishing its goals.

Thank you.

Sincerely,

RUDY PERPICH
Governor

OMB Approval No. 0348-0006

# FEDERAL ASSISTANCE

**SECTION I—APPLICANT/RECIPIENT DATA**

1. TYPE OF SUBMISSION (Mark appropriate box)
- ☐ NOTICE OF INTENT (OPTIONAL)
- ☐ PREAPPLICATION
- ☒ APPLICATION

2. APPLICANT'S APPLICATION IDENTIFIER
- a. NUMBER: NA
- b. DATE (Year month day): NA

3. STATE APPLICATION IDENTIFIER (NOTE TO BE ASSIGNED BY STATE)
- a. NUMBER: NA
- b. DATE ASSIGNED (Year month day): NA

Leave Blank

4. LEGAL APPLICANT/RECIPIENT
- a. Applicant Name: Minnesota Department of Human Services
- b. Organization Unit:
- c. Street/P.O. Box: Centennial Office Building, 4th Floor
- d. City: St. Paul
- e. County: Ramsey
- f. State: Minnesota
- g. ZIP Code: 55155
- h. Contact Person (Name & Telephone No.): James T. Sarazin 612/296-2710

5. EMPLOYER IDENTIFICATION NUMBER (EIN): 41-600-7162

6. PROGRAM (From CFDA)
- a. NUMBER: 8 5 . 1 0
- MULTIPLE ☐
- b. TITLE: Refugee Assistance Program-Mental Health

7. TITLE OF APPLICANT'S PROJECT (Use section IV of this form to provide a summary description of the project): Refugee Assistance Project - Mental Health.

To promote the positive social adjustment of refugees through system change and culturally appropriate services.

8. TYPE OF APPLICANT/RECIPIENT
A—State; B—Interstate; C—Substate Organization; D—County; E—City; F—School District; G—Special Purpose District; H—Community Action Agency; I—Higher Educational Institution; J—Indian Tribe; K—Other (Specify)

Enter appropriate letter: A

9. AREA OF PROJECT IMPACT (Names of cities, counties, states, etc.): State of Minnesota

10. ESTIMATED NUMBER OF PERSONS BENEFITING: 7,000

11. TYPE OF ASSISTANCE
A—Basic Grant; B—Supplemental Grant; C—Loan; D—Insurance; E—Other

Enter appropriate letter(s): A

12. PROPOSED FUNDING

| | |
|---|---|
| a. FEDERAL | $ 208,265 00 |
| b. APPLICANT | 00 |
| c. STATE | 103,284 00 |
| d. LOCAL | 00 |
| e. OTHER | 00 |
| f. Total | $ 311,549 00 |

13. CONGRESSIONAL DISTRICTS OF
- a. APPLICANT:
- b. PROJECT: Statewide

15. PROJECT START DATE (Year month day): 19 85 10 1

16. PROJECT DURATION: 12 Months

18. DATE DUE TO FEDERAL AGENCY (Year month day): 19 85 7 26

14. TYPE OF APPLICATION
A—New; B—Renewal; C—Revision; D—Continuation; E—Augmentation

Enter appropriate letter: A

17. TYPE OF CHANGE (For 16c or 16e)
A—Increase Dollars; B—Decrease Dollars; C—Increase Duration; D—Decrease Duration; E—Cancellation; F—Other (Specify)

NA

Enter appropriate letter(s):

19. FEDERAL AGENCY TO RECEIVE REQUEST: National Institute of Mental Health

a. ORGANIZATIONAL UNIT (IF APPROPRIATE): Cuban/Haitian Mental Health Unit

b. ADMINISTRATIVE CONTACT (IF KNOWN): Dr. Richard Cravens

c. ADDRESS: Parklawn Building, Room 18A-33
5600 Fishers Lane
Rockville, Maryland 20857

20. EXISTING FEDERAL GRANT IDENTIFICATION NUMBER: NA

21. REMARKS ADDED: ☐ Yes ☒ No

**SECTION II—CERTIFICATION**

22. THE APPLICANT CERTIFIES THAT: To the best of my knowledge and belief, data in this preapplication/application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the attached assurances if the assistance is approved.

a. YES. THIS NOTICE OF INTENT/PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE _____

b. NO. PROGRAM IS NOT COVERED BY E.O. 12372 ☒
OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW ☐

23. CERTIFYING REPRESENTATIVE
- a. TYPED NAME AND TITLE: Leonard W. Levine, Commissioner
- b. SIGNATURE: Leonard W. Levine

**SECTION III—FEDERAL AGENCY ACTION**

24. APPLICATION RECEIVED (Year month day): 19

25. FEDERAL APPLICATION IDENTIFICATION NUMBER:

26. FEDERAL GRANT IDENTIFICATION:

27. ACTION TAKEN
- ☐ a. AWARDED
- ☐ b. REJECTED
- ☐ c. RETURNED FOR AMENDMENT
- ☐ d. RETURNED FOR E.O. 12372 SUBMISSION BY APPLICANT TO STATE
- ☐ e. DEFERRED
- ☐ f. WITHDRAWN

28. FUNDING

| | |
|---|---|
| a. FEDERAL | $ 00 |
| b. APPLICANT | 00 |
| c. STATE | 00 |
| d. LOCAL | 00 |
| e. OTHER | 00 |
| f. TOTAL | $ 00 |

29. ACTION DATE (Year month day): 19

30. STARTING DATE (Year month date): 19

31. CONTACT FOR ADDITIONAL INFORMATION (Name and telephone number):

32. ENDING DATE (Year month date): 19

33. REMARKS ADDED: ☐ Yes ☐ No

FORM HCFA - 11P6 (10-84)

STANDARD FORM 424 PAGE 1 (Rev. 4-84)
Prescribed by OMB Circular A-102

## PHS SUPPLEMENTARY INSTRUCTIONS

## CHECKLIST

**NOTE TO APPLICANT:** Complete and forward this sheet with your application.

**Type of Application**

☒ **New** ☐ **Noncompeting Continuation** ☐ **Competing Extension** ☐ **Supplemental**

**CHECKLIST**

☒ Proper Signatures and Dates (Item 23 on face page)

☐ Human Subjects Certification (when applicable)

☒ Staff and Position Data (biographical sketch(es) with job description when required)

☐ State and areawide Clearinghouse Review (as requried by OMB Circular A-95) - Attach comments or evidence of submission to A-95 Clearinghouse(s).

☐ Health Systems Agency Review if required by Federal regulations - Attach evidence of submission to Health Systems Agency.

☐ Civil Rights Assurance on File with HEW (45 CFR 80)

☒ Assurance Concerning the Handicapped on File with HEW (45 CFR 84)

☐ Assurance Concerning Sex Discrimination on File with HEW (45 CFR 86)

A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence:

☐ (a) A reference to the organization's listing in the Internal Revenue Service's most recent cumulative list of organizations.

☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.

☐ (c) A statement from a State taxing body or the State Attorney General certifying that the organization is a nonprofit organization operating within the State and that no part of its net earnings may lawfully inure to the benefit or any private shareholder or individual.

☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date filed must be indicated.

Previously filed with: _____ on _____
(date)

Name, title, address and telephone number of official in business office to be notified if an award is made.

Kenneth E. Sommers, Budget Director
Department of Human Services
Centennial Office Building, St. Paul, MN 55155

Name, title, address and telephone number of official responsible for carrying out the proposed project.

Leonard W. Levine, Commissioner
Department of Human Services
Centennial Office Building
St. Paul, MN 55155 612/296-2710

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported; or (3) a negative certification.

## PART II

## PROJECT APPROVAL INFORMATION

**Item 1.**
Does this assistance request require State, local, regional, or other priority rating?
____ Yes X No
Name of Governing Body ____
Priority Rating ____

**Item 2.**
Does this assistance request require State, or local advisory, educational or health clearances?
____ Yes X No
Name of Agency or Board ____
(Attach Documentation)

**Item 3.**
Does this assistance request require clearinghouse review in accordance with OMB Circular A-95?
____ Yes X No
(Attach Comments)

**Item 4.**
Does this assistance request require State, local, regional or other planning approval?
____ Yes X No
Name of Approving Agency ____
Date ____

**Item 5.**
Is the proposed project covered by an approved comprehensive plan?
X Yes ____ No
Check one: State ☒ Local ☐ Regional ☐
Location of Plan State Plan for Refugee Services/State Mental Health Plan

**Item 6.**
Will the assistance requested serve a Federal installation?
____ Yes X No
Name of Federal Installation ____
Federal Population benefiting from Project ____

**Item 7.**
Will the assistance requested be on Federal land or installation?
X Yes ____ No
Name of Federal Installation ____
Location of Federal Land ____
Percent of Project ____

**Item 8.**
Will the assistance requested have an impact or effect on the environment?
____ Yes X No
See instructions for additional information to be provided.

**Item 9.**
Will the assistance requested cause the displacement of individuals, families, businesses, or farms?
X Yes ____ No
Number of:
Individuals ____
Families ____
Businesses ____
Farms ____

**Item 10.**
Is there other related assistance on this project previous, pending, or anticipated?
X Yes ____ No
See instructions for additional information to be provided.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to §84.5(a) of the regulation [45 C.F.R. 84.5(a)], the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other Federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance, including payments or other assistance made after such date on applications for Federal financial assistance that were approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which Federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in §84.5(b) of the regulation [45 C.F.R. 84.5(b)].

The recipient: [Check (a) or (b)]

a. (  ) employs fewer than fifteen persons;

b. ( x ) employs fifteen or more persons and, pursuant to §84.7(a) of the regulation [45 C.F.R. 84.7(a)], has designated the following person(s) to coordinate its efforts to comply with the HHS regulations:

Mary Jean Anderson

Name of Designee(s) (Type or Print)

| | |
|---|---|
| Minn. Dept. of Human Services | 4th Floor Centennial Bldg. |
| Name of Recipient (Type or Print) | Street Address or P.O. Box |
| 41 - 6007162 | St. Paul |
| (IRS) Employer Identification Number | City |
| | Minnesota 55155 |
| | State Zip |

I certify that the above information is complete and correct to the best of my knowledge.

1-24-85

Date

Signature and Title of Authorized Official Commissioner

If there has been a change in name or ownership within the last year, please PRINT the former name below:

**NOTE: If this form is not returned with the application for financial assistance, return it to DHHS, Office for Civil Rights, 330 Independence Avenue, S.W., Washington, D.C. 20201.**

# ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Minnesota Department of Human Services (hereinafter called the "Applicant")

Name of Applicant (type or print)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this Assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this Assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this Assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the Applicant.

Date 7-24-85

Minnesota Dept. of Human Services

Applicant (type or print)

By 

Signature and Title of Authorized Official

Commissioner

4th Floor Centennial Bldg.

Saint Paul, Minnesota 55155

Applicant's mailing address

**NOTE: If this form is not returned with the application for financial assistance, return it to DHHS, Office for Civil Rights, 330 Independence Ave., S.W., Washington, D.C. 20201**

## PART III – BUDGET INFORMATION

### SECTION A – BUDGET SUMMARY

| Grant Program, Function or Activity (a) | Federal Catalog No. (b) | Estimated Unobligated Funds | | New or Revised Budget | | |
|---|---|---|---|---|---|---|
| | | Federal (c) | Non-Federal (d) | Federal (e) | Non-Federal (f) | Total (g) |
| 1. Refugee Assistance | MH 85-10 | $ NA | $ NA | $ 208,265.20 | $ 103,284.00 | $ 311,549.20 |
| 2. Program – Mental Health | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. TOTALS | | $ | $ | $ 208,265.20 | $ 103,284.00 | $ 311,549.20 |

### SECTION B – BUDGET CATEGORIES

| 6. Object Class Categories | – Grant Program, Function or Activity | | | | Total |
|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) |
| a. Personnel | $ 66,879.00 | $ | $ | $ | $ 66,879.00 |
| b. Fringe Benefits | 13,376.00 | | | | 13,376.00 |
| c. Travel | 6,000.00 | | | | 6,000.00 |
| d. Equipment | 0 | | | | 0 |
| e. Supplies | 5,000.00 | | | | 5,000.00 |
| f. Contractual | 90,000.00 | | | | 90,000.00 |
| g. Construction | 0 | | | | 0 |
| h. Other | 19,000.00 | | | | 19,000.00 |
| i. Total Direct Charges | 200,255.00 | | | | 200,255.00 |
| j. Indirect Charges | 8,010.20 | | | | 8,010.20 |
| k. TOTALS | $ 208,265.20 | $ | $ | $ | $ 208,265.20 |
| 7. Program Income | $ 0 | $ | $ | $ | $ |

## SECTION C – NON-FEDERAL RESOURCES

| (a) Grant Program | (b) APPLICANT | (c) STATE | (d) OTHER SOURCES | (e) TOTALS |
|---|---|---|---|---|
| 8. Refugee Assistance Program - Mental | $ 208,265.20 | $ 103,284.00 | $ | $ 311,549.20 |
| 9. Health | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. TOTALS | $ 208,265.20 | $ 103,284.00 | $ | $ 311,549.20 |

## SECTION D – FORECASTED CASH NEEDS

| | Total for 1st Year | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter |
|---|---|---|---|---|---|
| 13. Federal | $ 208,265.20 | $ 52,066.30 | $ 52,066.30 | $ 52,066.30 | $ 52,066.30 |
| 14. Non-Federal | 103,284.00 | 25,821.00 | 25,821.00 | 25,821.00 | 25,821.00 |
| 15. TOTAL | $ 311,549.20 | $ 77,887.30 | $ 77,887.30 | $ 77,887.30 | $ 77,887.30 |

## SECTION E – BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

| (a) Grant Program | FUTURE FUNDING PERIODS (YEARS) | | | |
|---|---|---|---|---|
| | (b) FIRST | (c) SECOND | (d) THIRD | (e) FOURTH |
| 16. | $ | $ | $ | $ |
| 17. | | | | |
| 18. | | | | |
| 19. | | | | |
| 20. TOTALS | $ | $ | $ | $ |

## SECTION F – OTHER BUDGET INFORMATION

(Attach additional Sheets If Necessary)

21. Direct Charges: See Accompanying BUDGET DETAIL and BUDGET NARRATIVE

22. Indirect Charges: The Minnesota Department of Human Services computes these at .04% of total.

23. Remarks: Non federal resources include total from Supplement, Part III, Section F, plus some projects on additional Fiscal and Accounting time.

## PART IV PROGRAM NARRATIVE (Attach per instruction)

## Budget Detail

a. Personnel

Supplement to Part III, Section F

| | Requested | Donated | Total |
|---|---|---|---|
| DHS, MDE, other agencies Staff Salary | $ | $ 60,000.00 | $ 60,000.00 |
| Task Force members, 8 hours a month (averaged hourly wage at $15.50) | | 22,320.00 | 22,320.00 |
| GRANT FUNDS REQUESTED FOR PROJECT STAFF | 66,879.00 | | 66,879.00 |
| b. Fringe Benefits | | | |
| DHS, MDE and other agencies | | 12,000.00 | 12,000.00 |
| Task Force members | | 4,464.00 | 4,464.00 |
| Grant funds for project staff | 13,376.00 | | 13,376.00 |
| TOTAL GRANT FUNDS REQUESTED FOR PERSONNEL COSTS | 80,255.00 | | |
| c. Travel | | | |
| DHS staff | | 1,000.00 | 1,000.00 |
| In-State (staff and task force) | 3,000.00 | | 3,000.00 |
| Out-State (includes 4 round trips, hotels $60.00 a day, meals $25.00 a day) | 3,000.00 | | 3,000.00 |
| TOTAL GRANT FUNDS REQUESTED FOR TRAVEL | 7,000.00 | | |
| d. Equipment | | | |
| No equipment will be purchased | | | |
| TOTAL GRANT FUNDS REQUESTED FOR EQUIPMENT | | | 0 |
| e. Supplies | | | |
| Office supplies, postage, training and workshop support materials | 5,000.00 | | 5,000.00 |
| TOTAL GRANT FUNDS REQUESTED FOR SUPPLIES | 5,000.00 | | |
| f. Contractual | | | |
| Includes workshops, training, technical consultation, assessments, evaluations | 90,000.00 | | 90,000.00 |
| TOTAL GRANT FUNDS REQUESTED FOR CONTRACTS AND CONSULTANTS | 90,000.00 | | |

| | Requested | Donated | Total |
|---|---|---|---|
| g. Construction | | | |
| No construction will be done | | | |
| TOTAL GRANT FUNDS REQUESTED FOR CONSTRUCTION | | | |
| h. Other | | | |
| 1. Reproduction cost (training materials and newsletter costs included) | $ 6,000.00 | | $ 6,000.00 |
| 2. Telephone | 3,000.00 | | 3,000.00 |
| 3. EDP costs (includes programming) | 10,000.00 | | 10,000.00 |
| 4. Office space | | $ 3,500.00 | 3,500.00 |
| TOTAL GRANT FUNDS REQUESTED FOR OTHER | 19,000.00 | | |
| i. Indirect Costs | | | |
| DHS indirect costs | 8,010.20 | | 8,010.20 |
| TOTAL GRANT FUNDS REQUESTED FOR INDIRECT COSTS | 8.010.20 | | 8,010.20 |
| TOTAL PROJECT COSTS | | | $311,549.20 |
| TOTAL GRANT FUNDS DONATED | | $103,284.00 | |
| TOTAL GRANT FUNDS REQUESTED | $208,265.20 | | |

# BUDGET NARRATIVE

This proposed budget is composed of modules in Item f. Subparts 1 and 2 of this item are in priority order. (Goals and Objectives cited are contained on pp. in the text.)

The proposed Refugee staff would be:

a. 1 Mental Health Program Consultant - 12 months
   1 Mental Health Program Advisor - 9 months
   1 Clerk-Typist II - 12 months

   The donated salaries are estimates.

b. Fringe benefits were computed at 20% of base salaries.

c. Travel - Mental Health Advisory Committee and Task Force members not otherwise reimbursable would be covered by this item.

e. Supplies - Should underwrite some training materials.

f. Contractual - Items include the following:

   (1) Training - (a) To agencies, departments and providers for cultural awareness/sensitivity; to ethnic practitioners for skill acquisition; to natural support networks for knowledge and skill building (cf. Goal I, Objective B, Goal II, Objectives C and D) - $35,000.

   (b) To educators in Limited English Proficiency, Adult Basic Education and Vocational/Technical Schools. This will be a statewide workshop (cf. Goal II, Objective D) - $10,000.

   (c) To University of Minnesota to provide professional development in mental health to S.E. Asian students (cf. Goal II, Objective A) - $5,000.00.

   (2) Evaluation - (a) Study of the existing natural helper network to assess effectiveness in referral, prevention and support provision (cf. Goal III, Objective D) - $15,000.00.

   (b) Assess feasibility of a culturally appropriate diagnostic tool (cf. Section VI, Part F) - $5,000.00.

   (c) Assessment and evaluation of employability of identified "problem" clients (cf. Goal IV, Objective B) - $5,000.00.

   (3) Consultants - (a) Provide technical consultation to Refugee Office for evaluation of treatment modalities, systemic interventions and formulations and assessment instruments - $5,000.00.

   (b) Provision of cultural and professional orientation and training - $10,000.00.

g. Other - Reproduction and phone costs should be self explanatory. EDP costs will include runs on University and Wilder Foundation equipment plus design reformulation time.

h. Indirect Costs - DHs costs are computed at .04%.

SUPPLEMENT TO PART III, SECTION F
KEY PERSONNEL

| NAME AND POSITION TITLE | | ANNUAL SALARY RATE | NO MOS BUDG | % TIME | TOTAL AMOUNT REQUIRED |
|---|---|---|---|---|---|
| | | (1) | (2) | (3) | (4) |
| Full time DHS Employees who will work on Refugee Mental Health Program. | | | | | |
| Margaret Sandberg, Assistant Commissioner | est | 45,000.00 | 12 | 10 | 4,500.00 |
| Jerri Sudderth, Management Analyst | est | 38,000.00 | 12 | 10 | 3,800.00 |
| Al Hanzal, Assistant Commissioner | est | 45,000.00 | 12 | 02 | 900.00 |
| Mel Harris, Assistant Commissioner | est | 45,000.00 | 12 | 02 | 900.00 |
| James T. Sarazin, Director, MHPD | | 41,927.00 | 12 | 20 | 8,385.40 |
| Jay Bambery, Supervisor | | 40,423.68 | 12 | 10 | 4,042.00 |
| Elmer Pierre, Supervisor | | 30,471.60 | 12 | 15 | 4,571.00 |
| John Sauer, MH Program Advisor | | 28,668.24 | 12 | 10 | 2,867.00 |
| Jerry Storck, Research Analysis Specialist | | 28,000.00 | 12 | 15 | 4,200.00 |
| Jane Kretzmann, Supervisor, Refugee Office | | 30,471.60 | 12 | 20 | 6,095.00 |
| Sandra DuVander, Specialist, Refugee Office | | 28,000.00 | 12 | 20 | 5,600.00 |
| Clerk Typist III - 1 MHPD, 1 Refugee Office | | 15,000.00 | 12 | 10 | 3,000.00 |
| Research Analysis Specialist (2), Refugee Office | | 28,000.00 | 12 | 10 | 5,600.00 |
| SALARIES TOTAL | | | | | 54,460.40 |
| BENEFITS (Rate 20%) | | | | | 10,892.08 |
| | | | | CATEGORY TOTAL | $ 65,352.48 |

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ev. 3 79)

SUPPLEMENT TO PART III, SECTION F
KEY PERSONNEL

| NAME AND POSITION TITLE | ANNUAL SALARY RATE | NO MOS BUDG. | % TIME | TOTAL AMOUNT REQUIRED |
|---|---|---|---|---|
| | (1) | (2) | (3) | (4) |
| Full time employees to staff Refugee Mental Health Office | | | | |
| VACANT - Director | 31,161.52 | | 100 | 31,161.52 |
| VACANT - Mental Health Program Advisor (Note: Hired in 4th month of project) | 27,035.84 | | 66 | 18,717.12 |
| VACANT - Clerk Typist II | 17,000.00 | | 100 | 17,000.00 |
| TOTAL | | | | 66,878.69 |
| BENEFITS (Rate 20%) | | | | 13,375.72 |
| | | | CATEGORY TOTAL | $ 80,255.00 |

## I. PURPOSE AND INTRODUCTION

The State of Minnesota, through its Department of Human Services is applying for federal funds to assist it in its efforts to foster and promote the mental health of refugees and their access to such services as they may need to function effectively within this new and foreign culture.

This proposal reflects the mental health services already available in the metropolitan Twin City area and likely to be available soon in Rochester. These communities include over 90 percent of the state's refugee population. Because needs assessments have already been done in those communities, this proposal will primarily address: 1) systems changes needed to improve refugees' access to mental health services, 2) improved culturally appropriate diagnostic capability, 3) training of mainstream and bicultural staffs, and 4) evaluation of outcomes. This document builds upon the countless hours of work already done by public and private organizations, voluntary associations, and numerous individuals. It is to these people that we gratefully dedicate this grant proposal.

## II. GENERAL REFUGEE EXPERIENCE

### A. Earlier vs. Later Refugees

An understanding of refugees requires making a distinction between "earlier" refugees and "later" refugees. From experience, we have learned that ease and success of adjustment to American life is strongly related to three factors:

(1) the language, educational, and skill level of the refugee at the time of arrival in the United States.

(2) the length of time spent in the United States.

(3) the existence of a support system.

On both counts, the "earlier" refugee (1975 and before) is at a distinct advantage. The earlier refugees, as a group, were better educated, were more likely to speak English or French upon arrival, and tended to have lived in the urban areas. Having been in Minnesota for a longer period of time they were more skilled and ready for Western economic and technological life and hence, have had more time to learn new skills, to retain and be reeducated, to accumulate assets, and to stabilize family and social relationships. For some, passage of time has helped to heal the personal and family wounds and trauma associated with atrocities in the homeland and the dangers of the flight.

### B. The Unique Circumstances of the Refugee

These are those who resist distinguishing between the refugee and earlier immigrant groups. They argue that earlier immigrant groups did not require special attention and programs and eventually were assimiliated successfully. Why, they wonder, can't the same be true of the current refugees? Such arguments fail to recognize critical differences between current refugees and earlier groups of immigrants.

The large earlier waves of immigration (from mid-1880s to 1900s) occurred at a time when the United States economy was expanding in the unskilled and semi-skilled occupational areas, which accommodated or required a rapidly expanding unskilled labor pool. Today, however, the situation is vastly different, as there is a shrinking need for unskilled labor. The economic adjustment problems of today's refugees are greater.

In addition, the United States is currently facing unprecedented immigration (legal and illegal), with most of today's arrivals coming from countries vastly dissimilar from the United States. Unlike earlier immigrants, today's refugees are coming in larger numbers than ever and typically from non-Western and underdeveloped countries. This creates a much more difficult acculturation and adjustment. Today's

refugees are more likely to:

- speak a language other than English. This is especially true of the later refugees, some of whom come from a preliterate culture;

- be unskilled for the United States economy. The later refugees, especially, tended to be peasants and/or farmers from a primitive and predominantly agricultural economy. This makes the transition to an industrialized or post-industrial economy much more difficult.

- be uneducated and/or have had education seriously disrupted.

Finally, the more severe nature of the refugee experience should not be overlooked:

(1) The refugee is forced to leave his/her homeland, often without money or possessions. The move is sudden and unplanned. The future is unknown. In contrast, immigrants generally chose to leave their homeland, planned the move, took along possessions and, maybe, some savings, and usually expected to move to a better situation in the new country.

(2) The refugee's flight is much more traumatic. Whereas the immigrant probably chose the country to which to immigrate, the refugee experience stands in stark contrast as:

  - involuntary and without options; while refugees may have preferences as to where they want to settle, they are essentially at the mercy of the world community.

  - stressful; it is likely that family members/relatives/friends have been murdered and/or raped.

(3) The refugee will probably spend time in a refugee camp in a state of privation. The experience is even more traumatic if the refugee is held in a prisoner-of-war camp.

The refugees have lived in a constant state of fear.

  - disruptive because many families have been destroyed and family life and traditional roles have been disrupted.

The education of youth has been interrupted.

Refugees face lack of employment over prolonged period of time.

  - characterized by severe hunger/malnutrition/starvation and serious health problems from forced relocation, flight, and/or refugee camps.

(4) Refugees cannot return to their homeland, even though many yearn to do so. Nor can the refugee return to visit any remaining family, relatives, or friends. There is considerable remorse attached to the move and often guilt about having escaped while others were left behind and/or were imprisoned or killed.

(5) Upon arrival in the new country, the situation facing the refugee is typically harsher than that of the immigrant. Whereas the immigrant typically moved into a community with relatives/friends or with a concentration of people from the same ethnic group and could live among people with the same or similar culture/language/religion, the refugee usually is "placed" initially in a community. A federal policy of dispersion tends to place refugees in communities with low or no concentration of people from the same culture. There is considerable isolation from the old culture.

It is inaccurate to treat refugees as merely another immigrant group and to assume that they are as capable of acculturation without special attention and programs, as earlier groups.

C. The Resettlement Process

The process by which refugees leave their homelands and arrive in a new host country is long, arduous, often dangerous, complex, and, sometimes, affected by chance. It is important to understand this process.

The earliest groups of refugees from Vietnam (usually persons who were associated with and/or cooperated with the United States government) were evacuated by the United States military to receiving stations in the Philippines and Guam. From there, they were flown to four relocation centers in the United States, from which they were assigned to 10 voluntary agencies to find sponsors. This system operated in 1975, and was the last time that refugee resettlement resembled anything like a planned process.

Since that time, the refugee process has been characterized by hazardous flight from the homeland, assignment to refugee camps in country of first asylum, prolonged confinement, and eventual assignment of some to a host country of resettlement. Once in the country of resettlement, the process can continue to be confusing, disorganized, difficult, and traumatic.

D. The Flight

It is difficult to fully describe the struggle and trauma associated with the flight from the home country. In Vietnam, families often had to purchase both their right to flee and the flimsy fishing vessel used to sail, often disposing of all family assets. Once this was done, they still had to face the hazards of the sea, hunger, drowning, sickness, and attacks by pirates (where they were robbed, raped, mur-

dered or kidnapped). In other Southeast Asian countries, escape usually took the overland route through rugged jungles, again facing countless dangers to life and health.

While the flight itself was fraught with terror and danger, it must be understood in the context of the many horrors left behind - persecution, forced relocation and reeducation camps in Vietnam and Laos, poision-gas attacks on Hmong mountain villagers in Laos, and in Cambodia, a holocaust that murdered millions, relocated entire cities, destroyed an economy, and created widespread famine.

Vietnam: It is estimated that more than 350,000 "boat people" have reached such ports as Hong Kong, Malaysia, and Thailand since 1975. Thousands have perished at sea. In recent years, the flow of boat people has been curtailed, in response to Hanoi action, the awareness of the perils, and the introduction of the Orderly Departure Program a negotiated agreement in which Vietnamese can request exit permits and emigrate in an orderly fashion. Also, more than 250,000 ethnic Chinese fled or were pushed across the border into China.

Laos: More than 200,000 Hmong and ethnic Laotians have fled the persecution of the Pathet Lao and the Vietnamese, ending up in refugee camps in Thailand.

Cambodia: Nearly 500,000 Cambodians have huddled into camps on both sides of the Thai-Cambodian border, having fled the excesses of the extremism of Pol Pot. Recently, attacks by the Vietnamese on camps on the Cambodian since have forced thousands more across the border into Thailand.

E. Refugee Camps

Since 1975, Thailand has become the nation of first asylum for over 600,000 refugees. At the end of 1983, approximately 150,000 Southeast Asians remained in refugee camps in that country. The great majority of these refugees are currently from Cambodia; most are rural and uneducated peasants. The conditions in the camps are deplorable, and the health of the survivors has been damaged by both the severity of the flight and the camp conditions.

Other refugee camps are found in Malaysia, Indonesia, Hong Kong, Indonesia, and Australia - primarily serving Vietnamese "boat people".

Refugees often spend up to three or more years in refugee camps before being accepted by another host county. Many do not survive camp conditions.

F. Refugee Camp Process

Once refugees arrive in the country of first asylum, they are sent to camps under the supervision of the United Nations High Commissioner for

Refugees. At some point in time, refugees who wish to be considered for admission to the United States are interviewed by United States embassy refugee officers, Immigration and Naturalization Service (INS) officials, or voluntary agency staff hired for that purpose. A biographical sheet is developed for the refugee, and INS determines the category or acceptance to the United States, according to priorities for resettlement:

(1) family reunification;
(2) previous employment by the United States government and corporations;
(3) educated in the United States;
(4) a determination that life is in danger, there are no hopes of resettlement elsewhere, and that the flight is not as an "economic migrant".

If approved, the refugee biographical sheet is sent to the American Council of Voluntary Agencies in New York, where it is assigned to a voluntary agency (volag). Then the volag finds a sponsor in the country and sends assurance of sponsorship to United States authorities in the refugee camp.

This process often takes a long time. It frequently takes months and years; some cases have taken up to three years for the appropriate paperwork and bureaucratic decisions to be made.

When a sponsor is found, the United States State Department arranges for transportation to the United States and for health screening. Upon arrival in the United States, the refugee is met by the sponsor or relative.

Many refugee families already in the United States apply to have their relatives rejoin them in their community. Currently, Ramsey County (which includes St. Paul) is designated as "impacted area" by the Department of State, so that very few "open cases" (persons/families without relatives in the United States) will be resettled directly from camps in Ramsey County in the future.

G. Arrival in the United States

Ideally, upon arrival in the local community, the refugee is met by the local sponsor, who works with the refugee in getting a complete health examination, registering for Social Security, applying for Medicaid and public financial assistance (if needed), getting housing, enrolling in an English as a second language (ESL) course, finding employment, and other assistance as needed.

In reality, the quality of sponsorship assistance varies depending upon the particular sponsor. The sponsorship process is not always carried out as planned. Many times the needs of the refugees are so great that

it is difficult to meet these needs. The sponsor potentially provides guidance and assistance that is critical to the initial adjustment of the refugee. Where such sponsorship is not available, the resettlement process may be much more difficult and not nearly as successful overall.

In some cases, the refugee is sponsored by a relative who has already settled in the community. Many times relative sponsors may not speak English or understand American systems and, thus, may have limited ability to help new arrivals become acculturated.

H. Secondary Migration

A significant amount of secondary migration occurs after the primary resettlement, because of family reunification, dissatisfaction with climate or community, search for employment, attempts to join other clan members or communicate with large concentrations of fellow countrymen, or other reasons.

Whatever the reason, secondary migration of refugees is significant. Minnesota, particularly, has experienced large amounts of secondary migration, especially of Hmong who have come to be near leaders and social services.

It should be noted that most official statistics of refugee resettlements and population figures rely upon primary migration data. The chief exception is the secondary migration data gathered by the Federal Office of Refugee Resettlement for time-eligible public assistance recipients. Thus, the estimates of numbers of refugees in certain parts of the country are significantly shy of the actual numbers, because of secondary migrations. This is especially true of Minnesota.

It should also be emphasized that secondary migration is typically a more difficult process for the refugee, because he/she arrives in the new community without the support of a local sponsor. It is possible that secondary migrations result in a much higher proportion of "problem" resettlements and is more costly, in the long run, to the local community. Large amounts of secondary migrations have thwarted the national policy of refugee dispersal, an outcome not entirely negative since refugees often desire to live among family and countrymen.

Refugees tend to settle initially in inner city neighborhoods with low cost rental housing and close to other similar families (see Appendix A).

The culture shock and dislocation first experienced by refugees may be due to such factors as the the breakdown of the sponsor relationship, hostile neighbors, and secondary migration.

## III. MINNESOTA TARGET POPULATION

### A. Background

An estimated 26,000 persons now living in Minnesota originally came to the United States as refugees, giving the state the eighth largest refugee population in the country. Approximately 87 percent of these refugees reside in the Twin Cities metropolitan area, most within the boundaries of St. Paul and Minneapolis.

A recent population assessment estimates the total refugee population of 26,000 to consist of 9,500 Hmong, 6,500 Vietnamese, 5,000 Cambodian, 4,100 Laotian, 300 Ethiopian, and 500 other non SE Asians (this does not include Soviet Jews).

A chart which estimates the total number of refugees residing in the state is contained in Appendix B.

The first significant groups of Southeast Asian refugees arrived in Minnesota in 1975, after the collapse of the South Vietnamese government. For the most part, these refugees were from South Vietnam, with a sprinkling of Cambodians. They typically had been members of the military, were employed by the U.S. government in Vietnam, and/or were highly educated business and professional people. This group of refugees was evacuated by the U.S. government in the last days of the South Vietnamese government, as they had cooperated with the United States. Many of them spoke English, had excellent occupational skills, and were already somewhat used to Western life. They had large extended families, who were also evacuated.

Since 1976, Indochinese refugees have constituted the largest group to come to Minnesota. This later group of refugees has been much less prepared for American life. At the peak of refugee influx in 1979 and 1980, approximately 1,200 refugees per month were entering Minnesota, including both primary and secondary refugees. For the last four years Minnesota refugee arrivals have averaged about 150 people per month. Current projections are that the Minnesota refugee population will continue to grow at the rate of 100 per month during Federal Fiscal year 1986 (October, 1985 - September, 1986).

The refugee population in Minnesota has become very stable in its ethnic composition. The rank order of ethnic groups has not changed in the last four years.

Approximately 6,000 or 23 percent of the total are time eligible refugees (those who have been in the United States 36 months or less). This includes new arrivals and secondary migrants.

Appendix C shows the distribution of the new arrivals throughout the state. During 1983 and 1984, the ethnic distribution of the new arrivals (primary migrants) was as follows:

| Year | Cambodian | Vietnamese | Hmong/Lao | Polish | Ethiopian | Others |
|---|---|---|---|---|---|---|
| 1983 | 39% | 31% | 12% | 6% | 3% | 9% |
| 1984 | 31% | 27% | 27% | 3% | 3% | 8% |

The state does not track intra-state migration.

B. Differences

Refugee resettlement in the state of Minnesota can be distinguished from the national pattern of refugee characteristics in the following ways:

(1) Size: Minnesota has received a very large number of refugees. It currently ranks eighth in the nation in terms of number of refugee settlements since 1975. Some contend that, if secondary migrants were counted, Minnesota would rank behind only California and Texas.

(2) Secondary Migration: Secondary migrants are still a major factor in the flow of refugees to Minnesota. In 1984, 27 percent of all time eligible refugees on public assistance were secondary migrants. An earlier Minnesota study had shown that 36 percent of the time expired (those in the United States more than 36 months) were also secondary migrants.

(3) Size of Hmong Population: By 1981, the Twin Cities metropolitan area had become the largest urban concentration of Hmong in the nation. This represents the largest single concentration of pre-literate persons in the country. Today, Minnesota's Hmong concentration is exceeded only by California.

(4) Time Expired Population: Over 75 percent of Minnesota's refugee population is time expired, that is, the people have resided in the United States for over 36 months. Many have remained on public assistance because of their difficulties with the English language and because it is difficult for them to earn incomes adequate to support their large families. Over 90 percent of the Hmong population is time expired.

(5) Special Characteristics: of the Minnesota refugee population are:

- Refugees with severely limited English language competencies, little or no education in their homeland, inability to read and write in their native language, limited or no prior wage or salaried work history in the United States and who have experienced or can be expected to experience highly restricted employment opportunities.

- Refugees, who because of family size, face extreme disincentives to accepting entry level employment.

- Refugees age 45 and older who have a combination of language deficiencies and limited or nonapplicable prior work experience and can be expected to experience highly restricted employment opportunities.

- Refugees with emotional/psychological or medical impairments which restrict the range of employment available to them.

- Refugee nonheads of households, including spouses, youths, and other eligible was earners who have the same characteristics as those listed.

Throughout the United States, refugees with these characteristics have been recognized as having a very difficult time achieving self-sufficiency. More resources are needed to assist these clients to achieve self-sufficiency. These are frequently those individuals and families less able to cope with the new and complex society and the demands created by intergenerational conflicts. These people are at risk for social adjustment problems. In Minnesota, a majority of clients currently served by all agencies are from these groups. Examples are:

- 63 percent of the language development (ESL) slots in the first three quarters of 1984 were filled by preliterate students, who had little or no education in their own countries.

- In March, 1985, 12,887 or 49 percent of all Minnesota refugees were eligible for cash and medical assistance. This included adults and children.

- 40 percent of all current refugee AFDC cases in Ramsey and Hennepin Counties (the two most impacted counties) have four or more children.

- 25 percent of all current refugee AFDC cases in Ramsey and Hennepin Counties are over 45 years of age.

- 54 percent of all current AFDC cases in Ramsey and Hennepin Counties have children under six years of age.

- 55 percent of all refugees placed in jobs in the last 16 months, through refugee social services funded employment projects, required three or more placements during the period.

- 1,600 of the adult population were seen in special social adjustment/mental health projects during 1984. The number needing that service is estimated to be twice that number.

- Over 300 unaccompanied refugee minors live in Minnesota. This young group is at high risk for social adjustment problems due to trauma, loss of family and culture shock.

See chart of population estimates (Appendix D)

IV. RAP-MH GOALS

The Department has established the following objectives for the first year of the project to achieve the major goals of the Refugee Mental Health Program. In succeeding years it will implement those goals specified in the RFP so that they will be accomplished during the term of the project and endure beyond that time. The objectives reflect the state's intention to foster and promote the mental health of refugees and provide access to services they may need to function effectively in this culture.

**GOAL I.** To assure the availability of a highly coordinated system of essential and appropriate mental health services for refugees:

Objectives

A. The Department will establish its office of Refugee Mental Health hire staff and will have completed a formal work plan between the Mental Health Program Division and the Refugee Program Office and other divisions by November 15, 1985. These divisions may include the Hearing Impaired, Quality Assurance, Social Services Residential Services (state hospitals) and Chemical Dependency Divisions.

B. By January 1, 1986, the Department will begin its training of central office mental health, chemical dependency, social services staff, and key state hospital mental illness treatment staff, which will be ongoing and which will be completed by July 1, 1986.

C. By January 15, 1986, the Commissioner of DHS will appoint and convene its Refugee Mental Health Advisory Committee, which will act as the project's steering committee to assure the achievement of the project's goals.

D. By February 1, 1986 the Department will determine the appropriate number of task forces and work groups to address the priority issues and will have appointed those groups, giving them specific charges and time frames for their work.

E. By September 30, 1986 the task force charged with analyzing the state's refugee population and its mental health service needs will complete its work and submit its recommendations to Commissioner of Human Services Leonard W. Levine and Governor Rudy Perpich.

F. By September 30, 1986 the task forces will identify the major program, funding, policy, and cultural barriers to a highly coordinated system of high quality essential and appropriate mental health services and will make written recommendations to the Commissioner and Governor for the reduction or elimination of those barriers. Primary initial concerns include the policies and practices of the Medicaid program, the Community Social Services Act (the state block grant law), and health maintenance organizations, as well as cultural factors which inhibit service access and delivery.

**GOAL II.** To promote strong linkages among the various existing agencies and services.

Objectives

A. The Department will continue its working relationships with the University of Minnesota and Mayo Clinic to obtain training opportunities for refugee students interested in careers which provide mental health services to refugees. In addition, the Department will review other possible opportunities in public and private two and four year colleges and in area vocational technical schools. A plan for this purpose will be developed by January 1, 1986.

B. By July 1, 1986, the Department will negotiate an agreement with the Disability Determination Section of the Minnesota Department of Economic Security to assure that refugees who apply for Social Security disability benefits are evaluated by professionals who are culturally sensitive.

C. By September 30, 1986 the Department will have completed a training and technical assistance plan for community mental health and social service providers, with assistance from refugees and from faculty at the University of Minnesota.

D. By September 30, 1986 the Department will have completed orientation and training for other agencies with whom linkages should be formalized, which in Minnesota will include at least the Department of Health, the Department of Education, the Division of Vocational Rehabilitation, and the housing authorities in Minneapolis and St. Paul.

**GOAL III.** To incorporate mental health services for refugees within the state system of care.

Objectives

A. By October 1, 1985, the Department will award at least two grants from federal ADM Block Grant funds for refugee services. One grant will be administered by the Mental Health Program Division and will be designed to demonstrate the effectiveness of culturally appropriate services. The other will be administered by the Department's Chemical Dependency Division. Priorities for the second grant are for prevention, education and for treatment services.

B. By October 1, 1985 the Department will have notified counties and community mental health centers of the availability of additional state funds for community support services for people with chronic mental illness problems. The notice will identify refugees among the priority groups eligible for the new funds and will encourage appropriate applications for them.

C. By December 30, 1985 the Department will complete a feasibility study of consolidated public funds used to pay for mental health services. The study will assess the costs and benefits of consolidating various funds to eliminate the various eligibility requirements and matching ratios to increase the likelihood that funds will be available to pay for needed services. Special attention will be paid in this study to the needs and problems of refugees.

D. The Department will, by April 1, 1986, complete a study of other resources which may be used for refugee mental health services.

**GOAL IV.** To promote refugee self-sufficiency:

Objectives

A. By February 1, 1986, the Department will create a task force to address the issue of promoting refugee self-sufficiency and by September 30, 1986 this task force will make its recommendations to the Commissioner of Human Services and to the Governor.

B. By July 1, 1986, the project will address the issue of repeated job failure, and its implications for the mental health of refugees, and will assess the impact of additional services in reducing the problem. The Department will contract with the Community University Health Care Center (CUHCC) to provide counseling services to test the hypothesis gained from the review of employment data that significant mental health problems impact repeated job failures. A close relationship will be established with the Division of Vocational Rehabilitation in the Department of Economic Security to increase the likelihood of successful outcomes of future job placements for this group of people.

The recommendations resulting from all goals and objectives will be included in the 1987 legislative development and biennial budget process of the Department of Human Services and of other appropriate state agencies.

Goal Statements
For Years 2 and 3

| Year 2 | Year 3 |
|---|---|
| 1. Refugee MH Office attached to Assistant Commissioner. | 1. Model standards currently in existence will be modified to make them culturally appropriate. (Examples: DHS Rule 29 sets standards for out-patient CMHC services qualifying for insurance reimbursement; |
| 2. Refugee MH Office meets regular with the Department's Executive Staff and the Governor's sub-cabinet on Human Resources. | |

Year 2

3. Grants awarded for refugee mental health and chemical dependency services from ADM Block Grant and state CSP (Rule 14) funds.

4. Department's budget proposal for next biennium shows evidence of attention to needs of refugees.

5. Legislation introduced providing for improved supervision of unaccompanied minor refugees.

6. Agreements negotiated with refugee services agencies for crisis intervention (this exists already with CUHCC and the Wilder Foundation).

7. Training and technical assistance of Department central office and state hospital staff accomplished (see Goal I, Objective 13).

8. Training and technical assistance to local providers accomplished according to plan developed in Year 1 (see Goal II, Objective C).

9. Scholarship funds for refugee students in University mental health programs used appropriately.

10. Plan for promoting training opportunities for refugee students accomplished (see Goal, II, Objective A).

11. Formal working agrements developed with other state agencies (see Goal II, Objectives B and D).

Year 3

Rule 36 is a program licensing rule for residential facilities serving adults with MI problems; Rule 14 sets standards for funding of community support programs.)

2. See #3, Year 2.

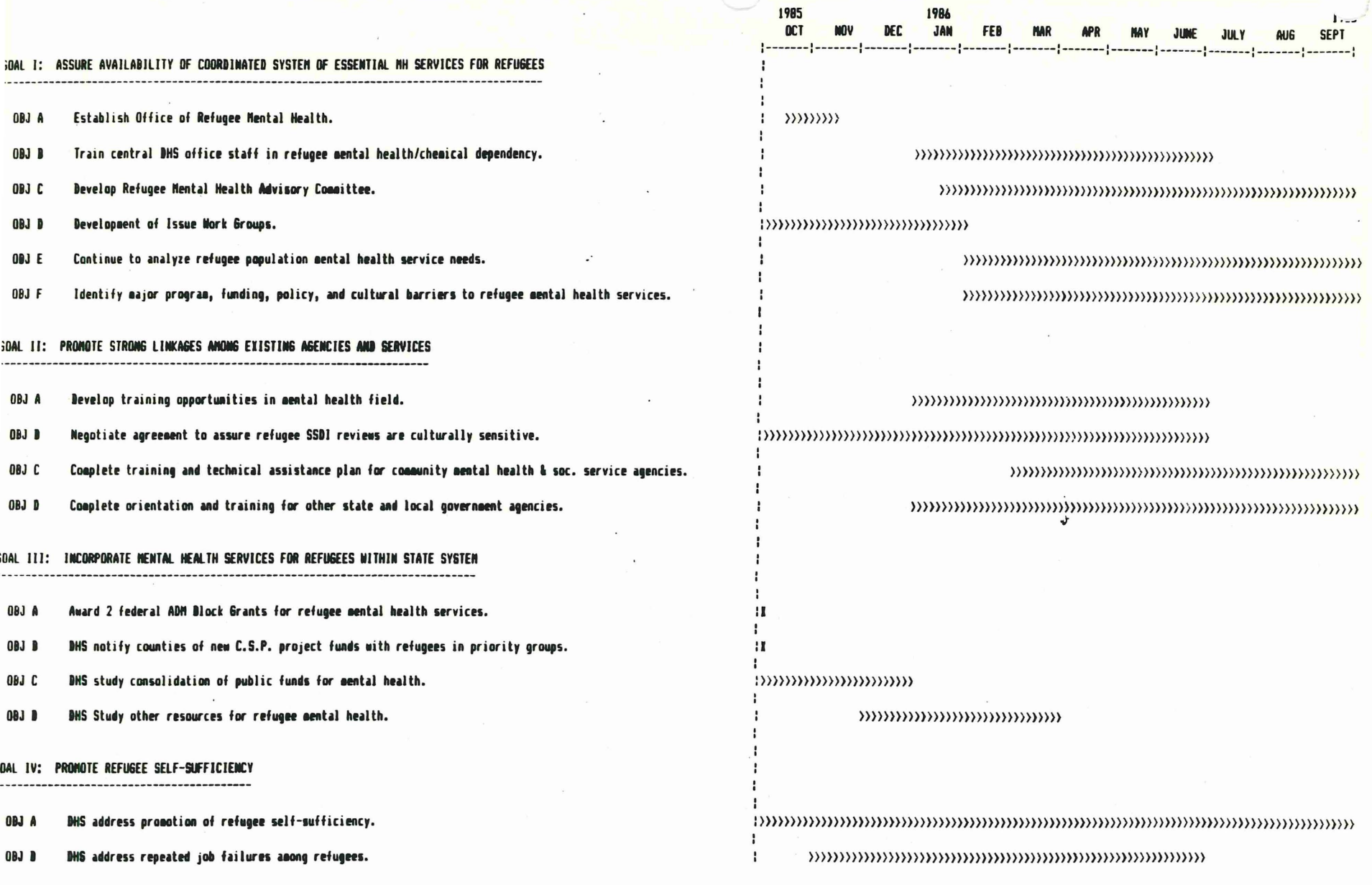
3. Formal agreement completed with the University of Minnesota clinical training programs to accept refugee students (see Goal II, Objective A).

4. Agreements negotiated with refufee service agencies for crisis interventing referral, and prevention services (this exists already with CUHCC and the Wilder Foundation).

5. States and service needs report and recommendations to Governor and Commissioner diseminated widely to legislators, Governor's Refugee Council, county commissioners, the media, agencies, MAA's, etc.

6. Department's plan for training and technical assistance will include ways of meeting refugee MH needs in smaller communities without specialized refugee MH staff units (see Goal II, Objective C).

| Year 2 | Year 3 |
|---|---|
| 12. Access to resources of other state agencies demonstrated in biennial budget making process and in in-kind contributions of staff time. | |
| 13. Strategic planning meeting held to set direction for Years 2 and 3 (see Evaluation Section). | |
| 14. Poly-techno committee meetings held regularly re culturally appropriate diagnostic instruments, training sessions, ongoing needs assessments. | |
| 15. Local agencies informed of availability of state and federal (ADM) funds to make their services to refugees more relevant (see Goal III, Objective B). | |
| 16. Training of local providers and of other state agency staff re more relevant services completed (see Goal II, Objectives C and D. | |
| 17. Status and service needs report and recommendations submitted to Governor Perpich and Commissioner Levine (see Goal I, Objective E). | |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GOAL I: ASSURE AVAILABILITY OF COORDINATED SYSTEM OF ESSENTIAL MH SERVICES FOR REFUGEES
OBJ A Establish Office of Refugee Mental Health.
OBJ B Train central DHS office staff in refugee mental health/chemical dependency.
OBJ C Develop Refugee Mental Health Advisory Committee.
OBJ D Development of Issue Work Groups.
OBJ E Continue to analyze refugee population mental health service needs.
OBJ F Identify major program, funding, policy, and cultural barriers to refugee mental health services.
GOAL II: PROMOTE STRONG LINKAGES AMONG EXISTING AGENCIES AND SERVICES
OBJ A Develop training opportunities in mental health field.
OBJ B Negotiate agreement to assure refugee SSDI reviews are culturally sensitive.
OBJ C Complete training and technical assistance plan for community mental health & soc. service agencies.
OBJ D Complete orientation and training for other state and local government agencies.
GOAL III: INCORPORATE MENTAL HEALTH SERVICES FOR REFUGEES WITHIN STATE SYSTEM
OBJ A Award 2 federal ADM Block Grants for refugee mental health services.
OBJ B DHS notify counties of new C.S.P. project funds with refugees in priority groups.
OBJ C DHS study consolidation of public funds for mental health.
OBJ D DHS Study other resources for refugee mental health.
OAL IV: PROMOTE REFUGEE SELF-SUFFICIENCY
OBJ A DHS address promotion of refugee self-sufficiency.
OBJ B DHS address repeated job failures among refugees.

## V. STATE LEVEL FOCAL POINT

### Current Organization of the Mental Health Delivery System and State Mental Health Agency

#### A. The System Overview

The mental health system in Minnesota is a complex network that involves the state agency (Department of Human Services), eight state hospitals, 26 community mental health centers, 87 county social service departments, human service boards, and a variety of private agencies. Public sector involvement in the delivery of mental health services is organized around three inter-acting systems--the state hospital, county social service department, and the community mental health center. In addition to service traditionally assumed or ascribed within the local area, each of these systems has certain legally defined responsibilities. The private sector involvement usually occurs through purchase of service agreements, other third-party payments, and involvement in the Mental Health Bureau's ongoing planning process.

The system for the delivery of mental health services has been an evolutionary process. While components of the system remain fairly constant, roles, responsibilities, and funding patterns have varied. No event has had a greater impact on the system in recent years than the passage of the Community Social Services Act (CSSA) in 1979. The Act has significantly shifted the responsibility for planning and implementing human service programs (social services and mental health) from the state level to the local (county) level. The stated purpose of the Act was to establish "a system of planning for and providing community social services administered by the boards of county commissioners of each county under the supervision of the Commissioner of Public Welfare." The CSSA basically consolidates a wide range of programs and services, which used to be planned and funded separately into a single "community social services" system. It clearly decentralizes planning, funding and administrative responsibility to the 87 boards of county commissioners, thus giving local elected officials greater control and flexibility.

Three specific effects of the Act on the mental health system should be emphasized. First, the authority for community mental health programs was transferred from the Department of Human Services to the counties. Second, with the exception of funding for residential mental illness facilities for adults and for community support programs, there was a change in the funding pattern from a state grant-in-aid formula to the community mental health centers to a block grant to county boards of commissioners which includes social services, mental health, mental retardation, and chemical dependency funds.

The boards may, in turn, choose to contract for programs and services with a community mental health center, other public and private agencies, or may choose to offer similar programs and services through

the county board's own employees, or through or a mixture of these options. Boards may, however, choose to make shifts in funding patterns with in the overall mental health budget. Third, there is a clear mandate to county boards of commissioners to assess the needs of the target population and identify the means available to meet those needs.

The CSSA legislation represents a significant change in responsibilities and funding patterns for both social services and mental health services. Under the CSSA, the county welfare/social service agencies must prepare biennial plans showing:

(1) How intergovernmental coordination of planning and service delivery will be ensured;

(2) How the plan relates to all other federal, state, and locally financed human service programs;

(3) How it relates to comprehensive social, physical, and environmental plans of the Metro Council and Regional Development Commissions; and including

(4) An evaluation of the effectiveness of each social service program in relation to measurable goals and objectives.

The State Department of Human Services must also supervise the new social services system through:

1. Standard setting;
2. Technical assistance;
3. Approval of county plans;
4. Evaluation of community social service programs;
5. Preparation of the state biennial plan;
6. Distribution of public funds.

And finally, the State Department of Human Services must:

1. Provide forms and instructions for preparation of county plans;
2. Revise or eliminate all rules as necessary;
3. Provide training and technical assistance in needs assessment, planning, implementing, and monitoring social service programs;
4. Monitor and evaluate community social service programs;
5. Produce an annual report on community social services complete with program evaluations and recommendations for changes; and
6. Request federal waivers where necessary.

B. <u>The Department of Human Services</u>

The Minnesota state mental health agency is the Department of Human Services (DHS), which operates under the direction of the Commissioner, Leonard W. Levine. Formerly known as the Minnesota Department of

Public Welfare (DPW), the state legislature mandated a title change as of July 1, 1984. The function of DHS is to develop, administer, and supervise a public welfare program that will be responsible to the basic needs of persons in Minnesota. The Department provides financial assistance, social services, and rehabilitative services to the mentally ill, mentally retarded, chemically dependent, and physically handicapped as provided in federal regulations and state law.

Medical consultation for the entire system is provided by the Medical Director. The Personnel Office and Policy Analysis and Planning Office report directly to the Commissioner. Legal services are provided by staff assigned to the Department by the Attorney General. Training and development activities are carried out to DHS and welfare system staff by the Staff Development Office.

Prior to December, 1984 the Department was structured under the Commissioner and Deputy Commissioner, with four bureaus under the direction of assistant commissioners. Commissioner Levine presented an organizational change proposal, as shown in the accompanying chart, which was designed to meet three challenges:

- To flexibly administer day to day operations.
- To respond to short-term issues while providing a context for innovation and change.
- To resolve major initiatives and issues which are at the core of the Department's mission.

C. Mental Health Program Division

The Mental Health Program Division (MHPD) has responsibility for designing, organizing and coordinating the statewide program for mentally ill persons; identifying the nature and extent of mental illness; developing and maintaining a comprehensive mental health plan; initiating participation in the formation of policies relating to mental health; and reviewing and approving plans and services in mental health programs. The Director of the Mental Health Program Division is James (Terry) Sarazin.

The MHPD also administers the mental health share of the federal ADM Block Grant. Under another DHS rule, Department staff review community mental health centers and private clinics for approval which allows them to collect insurance reimbursement under the state's insurance mandates.

Until the 1980's the staff of MHPD have concentrated their efforts on providing mental health program consultation and technical assistance, primarily to the network of community mental health centers. However, with the addition of staff through federal funding for the Community Support Project located in the MHPD, and two new state funded positions, the MHPD has increased its ability to direct planning and the

expenditure of funds throughout the state. Currently, the MHPD approves and administer grants to 123 residential and nonresidential programs serving an estimated 7,000 chronically mentally ill adults.

MHPD staff have responsibility under the CSSA legislation to review and approve the mental health portion of the county plans and to carry out the mandates of the CSSA to provide technical assistance and training, establish standards, and to monitor and evaluate mental health programs.

The Mental Health Program Division has established relationships with community mental health centers, county social service agencies, state hospitals, private clinics, professional associations, the professional schools at the University, some general hospitals, the Association of Minnesota Counties (representing local elected officials), the Division of Vocational Rehabilitation, 20 local community support projects, and 90 groups homes for adults with mental illness problems, (one group home now serves five Southeast Asian refugees) and human service-related policy and appropriation committees in the Legislature. These relationships will also be enhanced under the federal grant.

The Division also has over three years of experience with culturally appropriate mental health services through its grants to Indian reservations. These grants have been funded with ADM Block Grant funds and a matching grant which it obtained for this purpose from the McKnight Foundation.

D. Refugee Program Office

The Minnesota Department of Human Services is the designated single state agency for the state-administered refugee resettlement program. Since September, 1977, the Refugee Program Office (RPO) has existed as one of the program units within the Assistance Payments Policy and Operations Division (APPOD) of the Department. The State Refugee Coordinator also serves as director of RPO, and provides direction and coordination of the entire refugee resettlement program, including cash and medical assistance, and social services, and unaccompanied minors, which are administered through the county welfare departments and multi-county purchase of service contractors. As an independent unit of the APPOD Division, RPO has direct policy linkages through the regular state supervision system with the 87 counties for purposes of conveying policy instructions and directions for cash and medical assistance. See Appendix E for RPO/APPOD organization chart.

In addition, the RPO contracts directly with a wide range of service providers for refugee across the state. The providers include voluntary agencies, mutual assistance associations, school districts, and other public and private agencies. The majority of the more than 40 contracts are for the delivery language instruction (ESL) and employment. However, RPO also purchases social adjustment, cultural orientation, and supportive services.

Central to the effectiveness of the Refugee Program in Minnesota is the capability of the staff of the RPO to administer the policies and programs serving refugees. Planning, monitoring and evaluation, policy development, fiscal analysis, contract administration, program management, and capability in utilizing management information systems describe the current skill areas in the Refugee Program Office.

Of special note was the creation of a special team, within the RPO, of three highly trained professionals in monitoring and evaluation. They have the capabilities and expertise to design instruments, conduct evaluations and train vendors in both the completion of data instruments and the use of data as a management tool. The monitoring and evaluation staff use quarterly information filed by all vendors (except social adjustment) on individual client data sheets. These forms gather data on client demographics and service activities leading to certain measurable outcomes. For cultural orientation, social adjustment, and support services, vendors file program narrative reports. Monitoring includes site visits, case file reviews, and verification of agency reports.

The RPO has access to two IBM PCs (the XT and AT), as well as the state's main frame computer. Available software includes data management, word processing, communications and statistical packages.

The contracts maintained by the RPO are competitively procured according to state and federal guidelines. These "purchase of service agreements" are performance-based contracts, which include specific service outcomes, such as language levels for ESL, and retention rates for employment. Outcome criteria, reporting requirements, and the corrective action plan process are among the elements of the state vendor relationship delineated in the contract.

In addition to the mainstream federal refugee funding awarded to the state based on time eligible population (social services) and public assistance utilization (cash and medical assistance), the state has administered other federal refugee program funds. Among them, Targeted Assistance, Highland Lao Initiative, MAA Incentive Grant, and Enhanced Skills Training are the current programs.

The RPO has successfully secured private grants for a variety of services from McKnight, Blandin, Bremer, St. Paul, Northwest Area, and Ordean foundations.

For several years, the RPO has maintained interagency agreements with three other state agencies: the Departments of Economic Security, Health, and Education. While each agreement differs in its scope and intent, each provides a formal structure for dealing with refugee issues, ensures proper tracking of federal funds, an builds refugee services into a broader base of service delivery. Staff from Education and Health attend the RPO staff meetings.

The RPO provides staff support to the Governor's State Advisory Council for Refugees (see Appendix F for membership list). In addition, staff regularly attend the Minnesota Consortium for Refugee Resettlement (see Appendix G), and participate on coordinating councils, such as the East/West Metro Health Coordinating Committee (see Appendix H).

The RPO expect to collaborate closely with the new Office of Refugee Mental Health. Through regular weekly joint staff meetings, the full exchange of resources, information, program tends, and staff expertise will strengthen each office's capability.

In the State of Minnesota the Refugee Program Office and the Mental Health Program Division are both located in the Department of Human Services, thus facilitating close working relationships. They have anticipated the current federal request for proposals and have collaborated to develop this proposal.

E. Creation of State Level Focal Point

To provide the highest level of visibility and influence the Office of Refugee Mental Health will be attached to the Office of Assistant Commissioner, Margaret Sandberg, who reports directly to the Department Commissioner, Leonard W. Levine, as shown on the organizational chart.

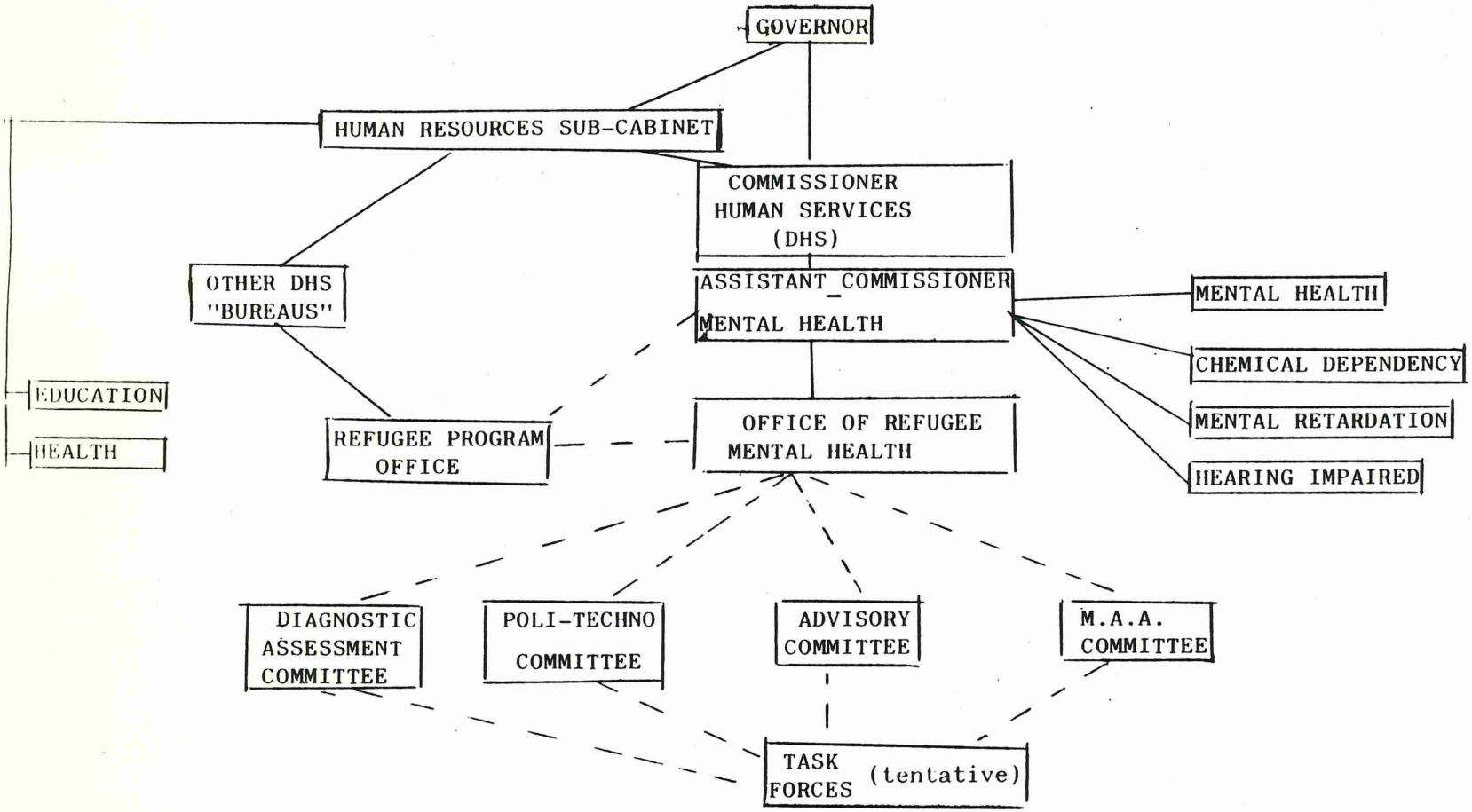
The Mental Health Program Division reports directly to Assistant Commissioner Sandberg. It will work closely with the project staff, and with the Refugee Program Office.

Placement of the project at this level will assure access to other Department divisions including Income Maintenance/Medical Assistance; Social Services, Services for the Hearing Impaired; the Board on Aging; Services for the Blind; Chemical Dependency; state hospital mental illness and chemical dependency units; and such services as child protection and access, when needed, to the protections of the state's Vulnerable Adults Act.

As the chart on the following page indicates, there will be numerous committee formed to accomplish the various objectives of the program. The committee structure is explained below:

State Level Focal Point

The Office of Refugee Mental Health (ORMH) will have two professional and one support staff. Copies of proposed job descriptions are included in Appendix I. The chief responsibilities of the office concern training, analysis information and distribution of planning, providing support to committee structures, and collaborating with the RPO and other key agencies.


GOVERNOR
HUMAN RESOURCES SUB-CABINET
COMMISSIONER HUMAN SERVICES (DHS)
OTHER DHS "BUREAUS"
ASSISTANT COMMISSIONER MENTAL HEALTH
MENTAL HEALTH
CHEMICAL DEPENDENCY
MENTAL RETARDATION
HEARING IMPAIRED
EDUCATION
HEALTH
REFUGEE PROGRAM OFFICE
OFFICE OF REFUGEE MENTAL HEALTH
DIAGNOSTIC ASSESSMENT COMMITTEE
POLI-TECHNO COMMITTEE
ADVISORY COMMITTEE
M.A.A. COMMITTEE
TASK FORCES (tentative)

## HUMAN SERVICES SUB-CABINET (Chair = Levine)

| DEPARTMENT | MEMBER | PHONE | ADDRESS |
|---|---|---|---|
| Corrections | Orville Pung | 642-0200 | 300 Bigelow Bldg. |
| Corr. Ombudsman | John Poupart | 296-4500 | 894 Nalpak Bldg. |
| Economic Security | Barbara Beerhalter | 296-3711 | 390 North Robert |
| Education | Ruth Randall | 296-2358 | Capitol Square Bldg. |
| Health | Sister Mary Madonna Ashton | 623-5460 | 717 Delaware Street N.E. |
| Human Rights | Linda Johnson | 296-5665 | 5th Floor - Bremer Tower |
| Human Services | Leonard Levine | 297-4040 | 4th Floor - Centennial Bldg. |
| Mediation Services | Paul Goldberg | 296-2525 | 205 Aurora |
| Military Affairs | General James Sieben | 296-4664 | 4th Floor - Veterans Bldg. |
| Public Safety | Paul Tschida | 296-6642 | Department of Transportation Bldg. |
| State Planning | Linda Sutherland | 296-3983 or 296-4852 | 100 Capitol Square Bldg. |
| Veterans Affairs | Bill Gregg | 296-2783 | 2nd Floor - Veterans Bldg. |

Advisory Committee - The project's central steering committee is comprised of representatives from the major coordination and information networks, and includes both practitioners and administrators. The committee who will provide members to the advisory committee are:

- East/West Metro Health Coordination

  All major health providers in Hennepin, Ramsey, and Olmsted Counties including public health nurses, screening clinics, homemaker education projects, acute care, statewide voluntary resettlement agencies. This committee provides input to the state Health Department, and has been deeply concerned with mental health for several years.

- Metro Mental Health/Social Adjustment Coordination Committee

  Convened by the Wilder social adjustment project, this committee addresses coordination, training, service gaps and emerging issues in mental health. Representative agencies on this committee include Family Service of St. Paul, CUHCC, Capitol Community Services, University of MN Day Treatment Clinic, St. Paul Schools, American Refugee Committee, Catholic Charities, Lutheran Social Service.

- MN Consortium for Refugee Resettlement

  The "Consortium" is the oldest refugee coordinating body in the state. Composed of all voluntary resettlement agencies and representatives from Hennepin and Ramsey Counties its purpose is to provide statewide information sharing concerning refugee resettlement at home and abroad. As a first line resource, this network of agencies has ability to convey information to a wide variety of service providers, sponsors and refugees.

- Sub-Committee on Health and Social Adjustment of Governor's State Advisory Council for Refugees

  The role of the State Advisory Council is to advise the Department of Human Services in its conduct of the refugee program. Overall committee membership is drawn from refugee community, business, private sector, voluntary agencies, education, counties. The Subcommittee is one of several the council maintains.

- MAA Committee

  There will be representation from the new MAA Committee (described below) on the Advisory Committee.

- The State Department of Health and Education will each provide one representative to the Advisory Committee.

The second "advisory" group to be formed for this project is the MAA (Mutual Assistance Association) Committee. The organization and design of this committee is based on the following plan:

(1) Core MAA Committee staff will be the eight-ten (8-10) refugee representatives on the Governor's State Advisory Council. Additional membership is anticipated from bilingual/bicultural staff and, MAA agency service providers.

(2) The committee will advise on project direction and issues, with emphasis on cross cultural implications, and barriers to services.

(3) The committee will address mental health consumer issues, education of the concept of mental health, strengthening the network of MAAs within the array of mental health services. This will require educational strategies.

Therefore, inservice training will be a key element in the relationship between the ORMH and the MAA Committee.

The "Poli-Techno" Committee is the third group to relate to the new office. Policy and technical experts form the department, county human service/mental health agencies, advocate organization, and other appropriate agencies will address the policy, regulations and political barriers which affect refugee access to mental health services. Resource control, policy change, legislative initiatives, county level public resource identification will be among the issues address by the committee. Short and long-term appointments to the committee will be made by the Commissioner of Human Services, and the Governor for the time limited tasks. In some instances the committee will provide direction to the ORMH staff work; in other, the committee will conduct its own research and writing. Training recommendations will emanate from this committee. Consultants will also assist.

Diagnostic Assessment Committee - A frequently expressed need of mental health provider organizations is for culturally appropriate diagnostic tools. While year two of the project would have greater activity in validating instruments, a group of Minnesota practitioners and researchers will meet regularly to discuss developments in their own research and review instruments identified by ORMH steps and themselves. Preliminary commitments from St. Paul Ramsey, Mayo Clinic, CUHCC, the University of Minnesota, the Wilder Foundation and a clinical psychologist in private practice doing extensive work with unaccompanied refugee minors, and in the field of learning problems. The committee will also discuss the educational evaluations needed for the limited English proficient, learning disabled, hearing impaired, and other multiply disabled refugee people and the developmental activities that will be needed.

## VI. THE PLANNING PROCESS

The initiation of the planning process for the current application began in 1975. The outline in Appendix J indicates Minnesota's present system of refugee mental health/social adjustment services is the result of the efforts of a number of individuals and agencies.

Various Minnesota practitioners and agencies have completed or are in the process of conducting needs assessments of refugee social adjustment/mental health problems. This application draws on those needs assessments already done in the state's major counties; where the vast majority of refugees reside. Hennepin (which includes Minneapolis); Ramsey (which includes St. Paul); and Olmsted (which includes Rochester). Included with this application are brief summaries and abstracts of work by Holtan (Appendix A) and Westermeyer (Appendix L).

### A. National Background

The mental health needs of refugees have been repeatedly described in terms of the delayed stress reaction (often several years after resettlement), high incidence and levels of depression, frequency of health symptoms with no organic basis, severe and unresolved grief reactions, and high rates of family conflict and break-up. The fact that refugees do not readily utilize western-style mental health services compounds the difficulty of addressing the problems. Continued difficulty in achieving economic self-sufficiency exacerbates mental health problems. Refugees are vulnerable to special stresses such as anxiety over sudden unexpected death, racism, rumors of harrassment, rumors of diseases which are very dangerous and very contagious, and isolation due to inadequate skills.

The International Institute of San Francisco reports that, "...after an initial period of adjustment during which basic needs predominate, refugees' psychological problems related to loss begin to appear with increasing frequency" (Robinson, 1980: 33).

Court Robinson in a "Special Report: Physical and Health Care Needs of Indochinese Refugees" (1980), lists the problems identified in a 1976 study by the mental health task force for Indochinese refugees in order of frequency; depression; anxiety reactions; marital conflict; intergenerational conflict: school adjustment problems; psychosomatic illness including fatigue, dizziness, weight loss, nausea, headaches, chest pain and insomnia. The National Mental Health Needs' Assessment of Indochinese Refugees sponsored by DHEW, IRAH (July, 1979) also lists depression as the most frequently reported problem among refugees. Anxiety and marital conflict are other frequently cited presenting problems among refugee clients.

B. Needs of Refugees in Minnesota

Minnesota's refugee population is diverse with significant numbers of Hmong, Cambodian, Lao and Vietnamese people. This diversity compounds the difficulty of serving the mental health needs of refugees. The different national/ethnic groups vary widely in their culturally based attitudes toward health practices, family structure, religious/ spiritual aspects of health, acceptance of western practices and social support structures.

Studies suggest that 25-50 percent of the refugee population in Minnesota are at risk for dysfunction due to emotional distress or mental disorders. In contrast the incidence of such dysfunction in the general state population is 10-15 percent, a dramatic difference in problem density. Inadequate resources to address emotional and adjustment problems could easily become the single greatest obstacle to the achievement of refugee self-sufficiency. Anywhere from 7,000 to 12,000 refugee people in Minnesota are likely to need emotional or psychological support (cf. Sutherland and Westermeyer in Bibliography).

Mainstream mental health services are not readily utilized by most refugees and in most cases service providers are not prepared to serve them if, in fact, they did seek help. The shortage of trained bi-cultural workers in mental health and social service staff positions hinders the use of services by those in need. There are currently only 8.5 (full-time equivalent) bi-cultural social adjustment/mental health workers serving the metropolitan Twin Cities area and outside communities as well.

The St. Paul Foundation recently sponsored a study of refugees in Ramsey County. The study examines the problems and prospects of the readjustment process with particular focus upon Southeast Asian refugees. The 'most prevalent problem' this study concludes is 'depression'. This study also cites an increase in psychosomatic problems with national statistics suggesting a dramatic increase in such problems. Also noted are memory losses and mental fatigue, because of emotions, stress and overstimulation.

The St. Paul Foundation's study also states that 57 percent of the Indochinese population of Ramsey County is under the age of 18. Wilder staff believe that mounting levels of stress and tension between two generations will be seen. One group consists of adults or older folks who may have gone through a number of traumatic experiences and are having a difficult time making adjustment in the new land. The younger 57 percent of the population, many of whom were born and brought up here, may be alienating themselves from the old tradition/culture. Early marriages, parenting responsibilities at an early age, changing traditional roles and patterns are some other factors affecting the adjustment process.

Several Mutual Assistance Associations (MAAs) were consulted before the inception of Wilder's Social Adjustment Project. Refugee individuals, including identified natural helpers/leaders and MAA staff, are consulted on an ongoing basis to assess and review the needs of their communities. This has been an important aspect in identifying the needs and problems in the refugee communities and continues to point to the above listed problems.

One of the major concerns shared by various service providers is that even though many refugees are undergoing an overwhelming amount of stress, which is affecting their functioning in other programs offered in the process of resettlement, most refugees do not seek any help for their social adjustment/mental health needs from western professionals. There are several myths about mental health services. Mental health problems are assumed to be synonymous with being "crazy", and cure may not be possible. Admitting to such a problem is a disgrace to the whole family and also to extended networks. "Problems" are resolved within families and friends and not, as a rule, shared with "strangers". A helper is a respected and knowledgeable person who is expected to provide answers.

Large numbers of refugees have lost their resources for problem solving in their families and extended networks. Even where those networks are present, they are not equipped to provide the same level of support, as they themselves may be "lost" in this new land.

C. Needs Identified By Individual Programs

Both the needs assessment and case records of the two funded programs in Minnesota, the Community University Health Care Center (CUHCC) and the Wilder Foundation, are also indicative of the level of need.

1. CUHCC

The refugee mental health social adjustment program at CUHCC addresses two problems, mental illness and stress and adjustment, within the target population of Indochinese and Ethiopian refugees at risk for or experiencing such dysfunction.

Problems of stress and adjustment are defined here as impaired or strained ability of individuals, couples and/or families to cope with stressful problems in their daily lives.

620 refugee people received screening and intervention for stress and adjustment problems at CUHCC in 1984. Presenting problems included:

- Unmet basic living needs due to ineffectiveness of problem-solving skills and inappropriateness of employment skills for American culture resulting in self-doubt, loss of esteem, and feelings of shame.

- Apparent inability to learn English due to high anxiety, resulting in distractibility and poor concentration.

- Reluctance to use the English language for fear of being shamed in front of, embarrassed by, or offensive to Americans (or to fellow refugees or their children).

- Death and family separation causing feelings of grief, loss, and guilt, and creating severe financial pressure due to the need to support relatives left behind and find ways to reunite living family members.

- Cultural void, particularly among adolescents whose native cultural value orientation is lost but who have difficulty adapting to American cultural values; drifting instead into delinquent patterns including drug and alcohol abuse, fighting, absenting from home, male and female prostitution, etc.

- Cultural dissonance related to adolescent women's issues. Adolescent women in refugee families assume major responsibilities at home at an early age. Parents may keep girls home feeling that formal education is less important than home responsibilities. Girls may be encouraged to wed and start a family at very young ages. Adolescent pregnancy is common. Cultural dissonance is particularly acute for young women as they struggle to grow up in two cultures with very different expectations of them. Frustration often leads to depression and/or delinquent behaviors.

- Widening cultural disparity within families emerging in women's/couple's issues and parent/child relationship issues.

Mental illness is defined by CUHCC as long-term, severe and episodic psychiatric disorders that impair the refugee person's ability to function independently. The years of war which preceded flight from their homelands and the refugee experience itself created sustained stress conditions putting refugees at high risk for mental illness.

During 1984, one hundred ninety-eight (198) Indochinese clients were seen in the refugee psychiatric assessment project at CUHCC. Diagnoses for these 198 cases covered the entire range of DSM III categories, with affective disorders (33 percent) and adjustment reactions (35 percent) most predominant. Eight percent of these clients had previous histories of hospitalization, another 6 percent were hospitalized during the course of treatment, and in 26 percent of these cases use of medication was recommended. Of those clients receiving medication, 4 percent received anti-psychotics and 96 percent received antidepressants. Significant complicating case characteristics included:

- In 40 percent of all cases either physical abuse, sexual abuse, dangerousness to oneself or to another was a complicating factor.

- 26 percent of all cases reported having no personal support system.

- 75 percent of all cases were not fluent in English.

- 12 percent of all cases had chronic medical problems or physical handicaps due to war injuries.

- 6 percent of all cases were complicated by chemical use problems.

Symptomatic problems frequently associated with these cases include appetite and sleep disturbance, depression, anxiety, distractibility, unexplained body pains, and other somatic complaints. A major difficulty in treating these cases is the lack of access to the existing continuum of treatment services for the mentally ill.

As has been the case in previous months, CUHCC's mental health caseload consists primarily of individuals who present symptoms of depression which are expressed through and/or accompanied by complaints of bodily pain. Some persons have been to several physicians who have not satisfactorily "helped" them with their pain. Persons also come to CUHCC who, despite their chronic pain, have had no contact with a physician since their initial public health visit when they arrived in the state.

2. Amherst Wilder Foundation

In the 12-month period ended July 1, 1985, the Amherst Wilder Foundation's Social Adjustment Project for Refugees, served 222 cases. Case records show increasing levels of severity of problems including depression, psychophysiological illness, domestic violence, incapacitating grief or family separation issues (see Appendix M for sample quarterly report).

The Wilder focus of service continues to be on social adjustment/mental health needs related to:

a. Individual

Depression/sadness, psychosomatic complaints; guilt of having survived; hopelessness; anxiety/worry; feelings of loss and grief; post-traumatic stress; isolation; loss of status; other socialization problems; diagnosed mental illness.

b. Family

Marital problems; intergenerational problems; child neglect and abuse; domestic violence; abandonment/separation/divorce problems; issues with being a single parent.

c. Community

Work and school related problems; problems with health and human service systems; conflicts with nonrefugee communities; unavailability of traditional support systems.

3. Olmsted County

The third largest concentration of refugees in the state is in Olmsted County. In preparation for a grant application to the Department for mental health funds from the ADM Block Grant, the Zumbro Valley Mental Health center in Rochester prepared the following needs assessment:

Olmsted County has become a major center for refugee relocation in southeastern Minnesota. At the present time there are approximately 1,450 southeastern Asian refugees residing in Olmsted County. Of that number approximately 900 are Cambodian, 450 Vietnamese, and 100 Hmong/Lao. This group is an extremely high risk group for mental health/social adjustment problems because of the traumatic experiences they have witnessed or experienced. The adjustment problems of a new country with the attendant language, vocational, housing and financial difficulties also contribute to additional emotional difficulties.

It is difficult to specifically identify numbers, age and sex of persons who will need mental health services, due in part to lack of prior services. The information concerning persons who are of extremely high risk of needing services has been compiled based on the experience and knowledge of the Rochester IMAA staff with input from the Mayo Clinic, and public health, and social service agencies.

| Projected Numbers | Target Groups |
|---|---|
| 12 - 15 | Attempted suicide |
| 20 | Psychiatric emergencies - depression/psychosis |
| 50 | Family crisis - individual crisis child/spouse abuse, marital problems, unwed and teenage pregnancies |

| Projected Numbers | High Risk Groups |
|---|---|
| 150 | Fatherless children |
| 30 | Single, unattached Vietnamese men |
| 15 | Single, unattached Cambodian men and women |
| 40 | Widows (90 percent Cambodian) |
| 15 | Refugees suffering from permanent and/or terminal illnesses |

The Mayo Clinic receives "priority immigration cases." The Department of State designates this classification for cases which there are severe or complex physical or mental/emotional problems listed in Appendix N are the type of cases May has treated in 1984-1985. Listed below are the psychiatric or related diagnoses of cases treated by Drs. Franz and Messer.

95 active files

22 Psychiatric or related diagnoses:

Depression - 7
Chemical Dependency - 1
Psychosis - 2
Child Abuse - 2
Other - 10
  behavioral problems
  counseling
  mental retardation

D. Minnesota Refugee Mental Health Services

Two agencies are currently under contract with the Minnesota Refugee Program Office to provide refugee mental health/social adjustment services and leadership in the coordination of resources. They are the Community University Health Care Center (CUHCC) in Hennepin County (Minneapolis) and the Amherst Wilder Foundation in Ramsey County (St. Paul).

The two coordinating agencies each function with their own particular program emphasis appropriate to the predominant needs in their respective areas. They represent an integrated system in that services and staff composition are closely coordinated to fill as many gaps as possible. Referrals and resources are exchanged freely to find the best match of service and need. In-service training and coordination with other agencies/systems are often done jointly. Both agencies respond to the needs of refugees in non-Twin Cities metropolitan communities insofar as possible - sometimes with direct assessment or treatment services, sometimes with back-up training and/or consultation for the first-time agency handling a problem.

1. CUHCC

The Community University Health care Center is an outreach clinic of University of Minnesota Hospitals, and is located in a Minneapolis neighborhood in which many refugees live.

CUHCC has utilized two full-time bi-cultural workers plus four Southeast Asian work-study university students under supervision of a psychiatric nurse (plus interdisciplinary case consultation) to provide counseling, support groups and case findings. Staff have received in-service training and provided consultation and community education for other providers and refugee community groups.

The mission of Community University Health Care Center is to provide cost-effective family-centered comprehensive health and human services; delivered in a manner acceptable, accessible and affordable to a high risk target population. High risk indicators include those families with incomes below poverty, corridor families (those with incomes below 200 percent of poverty), and minority and/or refugee families.

The American mental health outpatient service has been operational at CUHCC since 1973. That program is funded through a purchase of service agreement with Hennepin County. In 1984, 1,000 people received intervention for stress and adjustment problems and 800 people received treatment for mental illness. Forty percent of those served in 1984 had minority status. Outreach and culturally adapted service for minorities is a program trademark. Of those terminating from treatment in 1984, 70 percent had successful outcomes.

In the west metro (Minneapolis) area, the refugee population has a large proportion of Vietnamese and most of the ethnic Lao population in the Twin Cities. There are also smaller numbers of Hmong and Cambodian refugees. CUHCC is located in a multi-ethnic neighborhood and began serving refugees when refugees walked into the center seeking medical care. CUHCC had been serving American Indians for several years as part of the Community Support Program for minority persons.

The refugee client population at CUHCC has increased steadily since early in 1979, going from none to 1,500 by January of 1985. The presence of bicultural and bilingual staff enabled CUHCC staff to develop first a psychiatric assessment project for refugees, and later social adjustment and mental health treatment services. The dominant approach to meeting refugee mental health needs is the integration of refugee paraprofessionals into the mainstream mental health system. Social adjustment services provided by CUHCC include a variety mutual help support groups and efforts to utilize refugee natural social support systems. The Center first

began providing refugee mental health and social adjustment services in 1981 under the auspices of a small grant from the Minneapolis Foundation. In 1982 the Mental Health Division of the Hennepin County Community Services Department began funding a mental health assessment and evaluation service for refugees, as part of its community support program minority strategy. In the fall of 1983, the Minnesota DHS/ORR Office began funding social adjustment programming at CUHCC, plus mental health assessment for non-Hennepin residents.

A serious difficulty for the mental health assessment project, however, continued to be the absence of treatment alternatives.

In 1983-1984 CUHCC was awarded, under a subcontract with the Wilder Foundation, a Refugee Mental Health Demonstration Project grant for a program of integrating refugee paraprofessionals into the mainstream mental health system. In that project, CUHCC developed refugee mental health treatment services which were integrated with the regular mental health services provided at CUHCC, but which also emphasized network clan therapy as the primary interaction modality (see Appendix O). Therapeutic intervention with both the clan and the clan member in a mental health crisis, emphasized resolution of grief and loss and evaluation of the dynamics of cultural dissonance, cultural void and integration.

Although demonstration project funds expired November 30, 1984, the United Way of Minneapolis assumed up 80 percent of the funding for the CUHCC program in 1985.

Notable program accomplishments to date include:

- Apparent acceptability of these services among a population strongly correlating shame with the need for emotional assistance - CUHCC provided service to over 1,200 refugee people in 1984.

- Establishment of the natural helper friendship group network - 18 friendship groups were started in 1984.

- Effective utilization of volunteers, provided by the American Refugee Committee, in aiding refugees with serious adjustment problems. In 1984, 19 refugees (and 72 family members) referred by CUHCC were assigned to volunteers.

- Establishment of staffed support groups including parent groups, adolescent women, and Hmong/American war veterans.

- Of those cases completing mental health treatment in 1984, 74 percent terminated successfully, showing marked improvement.

- Almost all cases presented appetite problems and sleep disturbances, including night terrors, experience improvement.

- Establishment of the refugee parents group to address concerns about their children's school performance and confusion about how the American educational system works.

- Providing community education services to American providers to facilitate access for refugee people to a wider range of services.

2. Amherst Wilder Foundation

In the east metro (St. Paul) area of the Twin Cities the refugee population has been predominantly Hmong with a large (Minnesota's largest) population of Cambodian and a smaller but growing Vietnamese population. The east metro area is the site of the headquarters of the strong Lao Family Community Association, a large mutual assistance association serving the Hmong population.

The Wilder Foundation became involved in serving refugees because of the need to reach out to Hmong and Cambodian populations with bi-cultural workers, who could provide culturally appropriate services while receiving back-up consultation and supervision from Western- trained mental health professionals. Wilder staff had experience with alternative forms of mental health service delivery such as training of lay or paraprofessional caregivers and developing mutual aid, self-help groups of many kinds.

Most refugees, particularly Hmong, would be unlikely to utilize typical clinical mental health services and, if they did, few professionals are available and prepared to offer helpful care. Wilder's refugee social adjustment/mental health services therefore were developed to reach out to clients in home visits, to seek out natural helpers who could assist other refugees, to form mutual help support groups, and to link and refer clients to skills professionals if necessary.

Wilder's services have sought to tap indigenous resources within the refugee community to the fullest extent possible. A primary method has been to identify refugee natural helpers and reinforce them in their role as helpers. These people may be friends, relatives, neighbors, associates from mutual assistance associations, sponsors, religious leaders, healers, shamans or community leaders. In order to understand these helpers as fully as possible, an anthropological consultant was employed to work with Wilder staff to identify and to document the helping activity and role expectations of such natural helpers in the different ethnic communities. This study helped staff to consider how best to work with natural helpers.

Two primary approaches to work with natural helpers have been followed. One originates with an individual case referred to the program for service. The refugee worker attempts to identify active or potentially active natural helpers already linked with or at least known to the refugee in need. With approval of the one in need the helper is contacted and offered the support and assistance of the staff for their continued or proposed helping role. The worker then attempts to maintain contact with both the client and helper while encouraging as much helping activity to occur in that relationship as possible.

The second approach to work with natural helpers involves identifying natural helpers known to be helping other refugees on regular basis, but not necessarily currently linked to a refugee in Wilder's caseload.

These natural helpers are invited to meetings with Wilder staff for the purposes of (a) building a relationship of trust and mutual respect, (b) identifying ways they are providing help and obstacles or frustrations they encounter, and (c) offering them consultation, support, assistance, and encouragement for the helping they do. In some cases these helpers are asked if they would be available to assist a refugee who has been referred to Wilder. If so, Wilder staff provide ongoing coordination, support, and monitoring of the relationship and help given. In all cases the refugee natural helpers are offered additional consultation, either individually or in a group setting.

In the three-month period April through June, 1984, 41 natural helpers were identified in the 56 new cases referred into the project in the same period. Most of these are identified as members of extended families and friends. Examples of such natural helper activity are as follows:

a. A 55 year old Hmong who sponsored the client's family has been identified as a natural helper. The client, a single mother is disappointed about her teenage children's misbehavior towards her. The natural helper, an older man, is well-respected. He frequently visits the family and is working on resolving the family conflict and provides emotional support to the mother who feels powerless and inadequate in her parenting role.

b. A 40 year old Cambodian, who is a client's cousin, is identified as a natural helper. He is providing direction and encouragement to the client for continuing his education and employment search when the client want to quit because of frustration.

c. A 45 year old Vietnamese who is a friend to the client is identified as a natural helper. He is providing client with emotional support. The client's wife and children were left behind in Vietnam. The natural helper visits client frequently, helping him in the process of bringing his wife and children to this country. He also has the client come to visit his family and makes efforts in having the client be a part of his family while the client's family is away.

Efforts to examine and evaluate this natural helper activity and the work of refugee social adjustment staff are needed in order to determine its effectiveness, its impact and how it could be modified to enhance the services provided to those in need.

Another major emphasis of Wilder's social adjustment services has been to assist in the formation and operation of mutual help support groups for refugees of similar backgrounds or ones experiencing similar difficulties. Attempts have been made to form at least five different groups over the last six-month period. These include: Hmong women's groups (2), Cambodian women's group, Vietnamese men's group and Hmong men's group.

Results of these efforts have been mixed. Most group sessions have been conducted in the native language and are faciliated by Wilder's refugee workers. Group facilitation is new to these workers. Efforts have been made to convene the groups around some theme of interest, educational topic or common interest/activity. The women's groups appear to have been more successful. Efforts with men's groups are continuing at this time with one focused on military veteran's issues. Efforts to thoroughly examine and evaluate these support groups experiences and approaches are needed.

In 1983-84 Wilder received a Refugee Mental Health Demonstration grant to train refugee natural helpers and refugee community services workers. Again, because of high numbers and level of needs among the Hmong population, a group of Hmong natural helpers was recruited for the core training experience. Forty hours of training were provided to this group in order to expand their capacity to be of assistance to other refugees. Sessions included presentations and discussions such as the following:

- Basic Health Concepts and Hmong Health (Bruce Bliataut, presentor via video tape)
- The American Health Care System and Hmong Health in America
- The American Social Service Welfare and Education Systems
- The Family
- Leadership and Advocacy
- Helping People with Emotional and Social Adjustment Problems
- The Work Place
- Loss and Grief

Throughout the course of the demonstration project, staff of the Refugee Social Adjustment Project continued to identify, meet and link clients with refugee natural helpers. Meetings with these helpers have been opportunities to hear of their frustrations, exhaustion, motivations, successes, and needs for help and support in their helping activity. Following the formal training provided by the demonstration project, ongoing mutual consultation sessions will be provided to those persons who participated and other refugee natural helpers.

Overall, the emphasis of the Wilder Refugee Social Adjustment Project and the Refugee Mental Health Demonstration Project has been to develop effective, culturally sensitive approaches to address refugee mental health needs, while capitalizing on the resources indigenous to the refugee community. This is done as an alternative to referring the increasing numbers of refugees with severe problems to mainstream mental health agencies which do not have personnel available to handle these needs. There are or the well-trained Western professionals needed to effectively serve refugee mental health needs.

These new mutual help and natural helper methods being utilized by paraprofessional refugee bi-cultural workers are so new in this type of application that another project to enhance, examine, evaluate and document such approaches is needed.

3. International Clinic University of Minnesota

Dr. Joseph Westermeyer supervises the International Clinic at the University of Minnesota. The International Clinic is targeting former opium addicts who have gone back to using the substance. Opium use among refugees is frequently seen as a form of self medication. Another target group are teenagers, especially where there are substance-induced psychoses. The clinic will be conducting assessments. The clinic is also a place for secondary assessments.

The clinic's bilingual staff will also do case management. Assessment and treatment for dual disability (chemical dependency and mental illness) will also be provided for patients.

Day Hospital will be used as one mode of treatment.

The International Clinic, CUHCC and Wilder have developed a plan to improve coordination, to avoid duplication of services, have a better flow of information on referrals, and to avoid overlap of services. International Clinic staff participate in the Social Adjustment/Mental Health Coordination Meetings.

E. Nature and Components of Systems of Care

As described in the following chart, treatment services must include health care and social service agencies which provide services and are involved in counseling and treatment approaches.

F. Goals and Priorities

Minnesota's RAP/MH program goals and strategies are described in Sections III and VII. The following paragraphs describe in greater detail aspects of the state's plan for program improvement which are referenced also in the budget.

## REFUGEE MENTAL HEALTH - THE ARRAY OF SERVICES

This chart shows the array of services from the least formal to the most formal assistance in a residential treatment setting.

Least Formal → Most Formal

| Volags | Referrals from Social Services | Referrals from Health/Patient Care | MAAs | American Refugee Committee and CUHCC with ARC Volunteers | Outpatient Services CUHCC - Wilder | Inpatient Services |
|---|---|---|---|---|---|---|
| Provide resettlement services<br>Early support referrals | English as a second language<br>Employment<br>Case management<br><br>Often provide the first identification of possible social asjustment/mental health problems | | Provide orientation<br>Early support<br>Natural helper networks<br>Ongoing support services/problem identification<br>Resource identification<br>Values clarification | Provide friendship support<br>Assistance with basic living skills<br>Case management | Wilder provides direct intervention through a natural helper network.<br>↓<br>More formal outpatient services are provided at Community University Health Care Center and Wilder.<br>↓<br>A day treatment program is also available at the University through Dr. Westermeyer's efforts.<br>↓<br>Outpatient services are being developed in Olmsted County at the Zumbro Valley Mental Health Center. | Family Style has set up one home for use by refugees in their Rule 36 facility (halfway house).<br>↓<br>More formal inpatient services are available at:<br>St. Paul Ramsey Hospital<br>Hennepin County Medical Center<br>The University of Minnesota<br>Olmsted County Hospitals<br>Mayo Clinics<br>↓<br>Some refugees have also admitted to the state hospital system (as a last resort). Anoka State Hospital is most likely to provide this resource since they service the metropolitan area where a majority of the refugees reside. |

# REFUGEE MENTAL HEALTH - CONTINUUM OF CARE GAPS

This chart shows some of the current gaps in the service system arranged in the order of the least formal to the most formal assistanc service options.

| Volags | MAAs | American Refugee Volunteers Linked With CUHCC Outpatient Services | Outpatient Services | Inpatient Services |
|---|---|---|---|---|
| Time limits on service provision and funding shortages limit what can be done. | These programs don't have trained personnel to address all of the identified problems. Referral networks are not fully developed. | | Funding Refugee Mental Health Services can only address a part of the need. Current mainstream resources cannot be effectively used because of cultural and language gaps. Traditional service providers need to learn which behaviors are the result of cultural norms and which are symptoms of dysfunction. Cultural barriers often inhibit refugee use of any mental health services until a crisis stage is reached. | |

1. Mental Health Intervention Project: Addressing the problem of Reported Refugee Employment Placements.

Refugee employment programs are identifying an emerging problem, the revolving door placement. Some refugee people return to employment projects two, three, four, five, and more times looking for jobs. These people, when placed in jobs, appear not to be able to keep them; in some instances they are fired, but in many cases they quit their jobs. The hypothesis of this project is that underlying factors related to cultural and emotional distress eaffect the ability of some refugee people to maintain jobs.

This project will accept referrals from refugee employment programs of clients who have returned more than two times for a job placement. Intervention will begin with an assessment, the purpose of which is the determination of those factors influencing the inability of the refugee person to maintain employment. The assessment phase will be followed by development of an intervention plan and the coordination of an appropriate intervention team. For example, in some instances language may prove to be a factor affecting the person's ability to keep a job. In addition, there may be intergenerational family stress, or the refugee person may be experiencing depression, a cultural void difficulty getting along with co-workers, or discrimination. In each instance, those helping agencies most able to identify the support and remedial services needed by the referred refugee client will be identified and mobilized as the intervention team. In addition to service agencies, other key team members may be the refugee person's personal support network, his or her family, or the appropriate mutual assistance association. Where mental health intervention is needed, services will be made available either through CUHCC or another alternative appropriate facility. Each referred refugee client will be assigned a bicultural case manager who will coordinate the team intervention effort and who will maintain a supportive role with the client. Support groups will be developed where possible on the job; when not possible, support groups of refugee people in different employment situations, all with a history of difficulty in maintaining employment, will be pulled together. The goal of the project will be to provide successful job placements of twelve months or more through assessment, intervention, and the development of ongoing support services.

This demonstration/project expects to serve 300 refugees within the first twelve months of operation, with an interim findings report due August 1, 1986.

2. <u>Unaccompanied Refugee/Minors</u>

The Department of Human Services supervises the unaccompanied refugee minors program that is administered through county contract with voluntary resettlement agencies. Currently the

Assistance Payments Policy Operations Division (funding and policy) and Social Services (reports) share responsibility for the program, which is one of the country's largest. Over 300 minors, veteran the ages of 4 and 21, reside in 32 counties. The ethnic breakdown is 103 Vietnamese; 66 Cambodians; 27 Amerasians; 2 Ethiopians; and 3 Iranians. Various reports suggest that as least some of these young people are at risk due to their traumatic experience, loss of family ties, and isolation.

The Department will promote the collaboration of the two existing Department divisions with mental health in order to better assess the situation of the minors, and identify service strategies and approaches. The collaboration will also involve mental health professionals who have dealt with this population, voluntary agencies, psychological testing consultants, and the office of Refugee Resettlement, Region V.

Systematic approaches to early detection of emotional and cognitive limitations will be emphasized to promote early remedy or treatment. If mental illness is suspected, collaboration on a state level (including the Department of Education) will facilitate identification of existing resources or consultation to promote culturally sensitive services. This is especially important in rural Minnesota where such special needs are more rarely encountered.

The state will work with and train county human services staff dealing with the minors program. The long-term goal of technical assistance to counties will be to ensure prevention, early detection and treatment services are systematically available to this special population.

3. Wilder Evaluation of Effectiveness of Natural Helpers and Mutual Support Groups for Refugee Mental Health.

One of Minnesota's newest innovations is the establishment of the Wilder Social Adjustment Project described in the previous section. Evaluation of the effectiveness of this approach is critical. The following paragraphs briefly describes the activities of the evaluation:

Activities

1. Evaluation of involvement of natural helpers with refugee clients will address the following issues:

   i) What is the amount and type of help provided by natural helpers?

   ii) Who are the refugees served by natural helpers and what is the nature of their problems?

iii) What is the impact of the involvement of the natural helper on the problems of the refugee client?

Data will be collected through existing or supplementary management information/evaluation systems on the following:

i) Client characteristics (demographic and presenting problems);

ii) Natural helper characteristics (demographic and helper role definition);

iii) Type of help provided;

iv) Ratings of effectiveness of natural helper by bi-cultural worke, client, natural helper;

v) Status of presenting problem as rated in follow-up interview.

2. Evaluation of mutual help group experiences for refugees will address the following issues:

i) What is the pattern of the participation on the part of th refugees.

ii) Who are the refugees who participate.

iii) What other forms of social support and social service help are participants seeking and reviewing.

iv) What is the impact of the group experience on the needs of the refugee participant?

Data will be collected through existing or supplementary management information/evaluation systems on the following:

i) Participant characteristics (demographic, support needs, other social support available).

ii) Participant ratings of need for and use of other participant forms of social support.

iii) Participant ratings of need for and use of other forms of social support.

iv) Participant ratings of leadership effectiveness.

v) Participant ratings of severity of problems, needs in relation to group experience.

Procedures and Personnel for Evaluation

Direction of program evaluation activities will originate from the Office of Research and Statistics of the Wilder Foundation. Final design of evaluation instruments will occur through collaboration of research staff and staff from the project. The Office of Research and Statistics is a 23 person research office with responsibility for developing information systems for human service programs, conducting program evaluation studies, unndertaking community needs assessments, and consulting with human service agencies on research tasks. It is comprised of: five Ph. D - level social scientists; five computer/programmers and data operations specialists; and other support staff. Data processing is conducted both on the University of Minnesota's Cyber computer and on Wilder's mini-computer.

4. Training of Bilingual/Bicultural Mental Health Agency Personnel

One objective to be pursued during the three years of the grant will focus on developing the availability of bilingual and bicultural capability in mental health service agencies. This objective will also be addressed taking full advantage of the faculty of the University of Minnesota. The following core faculty are involved in this objective: Deinard, Mackenzie, Dunnigan, Westermeyer, Hoshino, List, Brysky, and Habenicht. They will work together but will also work in conjunction with the Technical Assistance Center.

In general, the existing service delivery systems which provide service to the general population are needed by the refugee population as well. The problem is that the mainstream services are generally not culturally sensitive to particular refugee groups, or are not accessible because of cultural or language barriers. Hence, there is a need to develop refugee professionals and paraprofessionals who are competent bilinguals and who possess a bicultural focus, to work in service agencies to act as a bridge between the mainstream providers and the refugee population and, intramurally between the agency staff who serve the refugees.

In order to begin to understand the problem, it will be necessary to interview providers, to find out what their perceptions of the existing delivery system are and what shortcomings they can identify in that system. Secondly, it will be necessary to ask the same questions of the consumers, in order to learn whether the consumers' perceptions and the providers' perceptions are similar or different and, if different, to what extent would addressing successfuly the deficiencies identified by one side be compatible with the solution for the other side.

Once the shortcomings have been identified, the next question to be addressed is how to identify, within the refugee population, professionals or paraprofessionals who would be interested in becoming trained bilingual, bi-cultural providers. Once they have been identified, the next issue to be addressed is how to get them trained. If training is to occur in a University setting or in a vocational school, curriculum must be developed. This will require input from faculty in the School of Education who are skilled at developing curricula. Input from clinical psychologists will also be essential. Although they may not be skilled in the theory of curriculum development, they certainly are knowledgable about what the content of the curricula should be. In addition, it will be necessary to involve individuals who can address the question of financial support for students so that those individuals who express an interest to be retrained can go to school with minimal financial worries, thereby allowing themselves the greatest opportunity to achieve scholastic success. The opportunity to work while in school should also be addressed so that the students need not be totally supported by scholarships but may have the opportunity to be involved in, for example, a work-study program in order to earn some of their needed financial support. Finally, the input of employers who will actually hire the retrained providers in a larger service delivery system (e.g., an HMO) must be sought, to ensure the availability of jobs once individuals are satisfactorily trained and certified.

5. Development of Culture-Specific Mental Health Diagnostic Criteria

Appendix P contains a proposal and plan to develop culturaly appropriate diagnostic criteria for the Minnesota Refugee population. Staff for this project will be from University of Minnesota Hospitals and CUHCC.

## VII. STRATEGIES TO PROMOTE SYSTEM IMPROVEMENT

The charts on the following pages describe the strategies Minnesota will use to meet the objectives outlined in Section IV of the proposal.

Code of Abbreviations:

DMH - Division of Mental Health

DHS - Department of Human Services

ORMH - Office of Refugee Mentla Health

MAA - Mutual Assistance Associations (refugee community organizations)

RPO - Refugee Program Office

SAC - Governor's State Advisory Council for Refugees

DVR - Division of Vocational Rehabilitation

ES - Department of Economic Security

GOAL I: To assure availability of a highly coordinated system of essential and appropriate mental health services for refugees.

| Objective | Strategy | Who | Time Line | Outcome |
|---|---|---|---|---|
| A. Establish Office of Refugee Mental Health | Provide close, joint collaborative duties-RPO through working agreements, regular staff meetings, administrative reviews, collaborate on data collection. | RPO<br>DMH<br>DHS | Initiate by October 15, completed by December 15, 1985. | Working areements and staff hired. Work plan developed. |
| B. Develop Refugee Mental Health Advisory Committee | 1. Broaden participation into ongoing planning for refugee mental health services.<br>2. Provide a mechanism for communication on issue identification and resolution. | Existing mental health and mental health coordinating committees, refugee voluntary agencies, Refugee State Advisory Council, State Dept. of Health, State Dept. of Education. State Deptartment of Corrections. | Initiated by January 15. Monthly meetings. | On-going correlation/ review of projects direction and progress, development of a constituency for impacting the political process, educating, decision making. |
| C. Development of Issue Work Groups | To assemble experts on a short-term basis to address priority issues. | Selected professionals, indigenous refugee groups. | Initiate February 1 - ongoing. | Recommendations to Advisory Committee and Office of Refugee Mental Health on specific priority issues. |
| D. Continue to analyze refugee population and mental health service needs | Refine and improve data collection methodology for long-term systematic distribution to key decision makers. | RPO<br>DMH/ORMH<br>Advisory Committee<br>Poli-Techno Committee<br>MAA Comittee | September 30, 1986 | Report for Governor, Commissioner and Legislature. |

GOAL (cont.d)

| Objective | Strategy | Who | Time Line | Outcome |
|---|---|---|---|---|
| E. Identify major program, funding, policy, and cultural barriers to refugee mental health services | Effect permanent change in mainstream response to refugee mental health system through strategic targeting of barriers. | RPO<br>DHM/ORMH<br>Advisory Committee<br>Poli-Techno Committee<br>Sub-Cabinet on Human Resources<br>MAA Committee | September 30, 1986. | Written analysis and plan to remove specific barriers in year II.<br><br>Commitment from responsible agencies through written agreements. |
| F. Train Central DHS office staff in refugee mental health/ chemical dependency, etc. | Cost effective means of integrating refugee mental health needs at policy and planning levels. | RPO<br>DMH/ORMN<br>Refugee Mental Health Agencies<br>Consultants | Initiate by January 1, 1986, complete by July 1, 1986. | Training package for state staff to be used at local level. |

GOAL II. To promote strong linkages among the various existing agencies and services.

| Objective | Strategy | Who | Time Line | Outcome |
|---|---|---|---|---|
| A. Complete plan for training and techinical assistance to comunity mental health and social service agencies | Improve referral networks, sensitize to cultural difference through cost effective group consultation and work with organizations representing broad agency constituencies. | RPO<br>DHS/ORMH/<br>Central DHS staff<br>Advisory Committee<br>Refugee MH Agencies<br>MAA's<br>U of M | Initiated March 1, 1986, completed September 30, 1986. | Training package and schedule including trainers and target audiences.<br><br>Publication of resource directory. |
| B. Develop training opportunities in mental health field | Provide long-term bilingual/bicultural presence in mainstream agencies through strategic plan to identify programs, potential students, and barriers of funding, cultural, and/or educational nature. | RPO/ORMH<br>Dept. of Education<br>Service agencies who are potential employers<br>Refugee students now enrolled in higher education<br>University faculty, financial aids/work study personnel, and other educational support staff<br>Bilingual staff from mental health/social service projects<br>Refugee community representatives<br>Mayo Clinic | Initiated January 1, 1986, completed July 1, 1986. | Meetings organized around specific disciplines or careers in mental health. |
| C. Complete orientation/training for Depts. of Health, Education, Vocational Rehabilitation and local housing authorities | Develop curriculum to make trainees aware of refugee needs, cultural issues project goals. | RPO/ORMH<br>Refugee<br>MH Agencies<br>MAA's | Initiated January 1, 1986, completed September 30, 1986. | Trainees aware of refugee needs, cultural issues, project goals. |

GOAL II: (cont.d)

| Objective | Strategy | Who | Time Line | Outcome |
|---|---|---|---|---|
| D. Negotiate agreement with Disability Determination Section re refugee Social Security disability applicants | Identify MH professionals who can provide evaluation/ diagnosis with awareness of refugees' cultural background. | ORMH<br>Department of Economic Security | Initiated by April 1, 1986, completed by July 1, 1986 | Pool of qualified MH professionals identified, agreement in effect. |

GOAL III: To incorporate mental health services for refugees within the state system of care.

| Objective | Strategy | Who | Time Line | Outcome |
|---|---|---|---|---|
| A. Award two (2) federal ADM Block Grants for refugee services | To supplement limited federal refugee funds for mental health. | RPO<br>DMH<br>CDD | Award by October 1, 1985. | Increased mental health services to MN refugees. |
| B. DHS notify counties of new C.S.P. project funds with refugees in priority groups. | Expand services to refugees through county-administered mental health programs. | DHS/DHM and CD<br>RPO | Initiate October 1, 1985. | Inclusion of refugees in one C.S.P. project. |
| C. DHS study consolidation of public funds for mental health | Remove policy restrictions to improve access to mental health services and simplify funding of programs;<br><br>Create awareness of refugee mental health needs. | DHS<br>DMH<br>ORMH<br>RPO<br>Poli-Techno Committee | December 30, 1985. | Written feasibility study for Commissioner of DHS. |
| D. DHS Study other resources for refugee mental health | Secure a broader funding base for refugee mental health services through identification of related service needs and resources. | ORMH<br>RPO<br>Advisory Committee<br>Poli-Techno Committee | April 1, 1986 complete. | List of public resources: agency, eligibility, time<br><br>Review private foundation funding interests. |

GOAL V: To promote refugee self-sufficiency.

| Ojjective | Strategy | Who | Time Line | Outcome |
|---|---|---|---|---|
| A. DHS promotion of refugee self-sufficiency | Create task force to analyze all possible factors which promote or discourage self-sufficiency among refugees. | RPO<br>ORMH<br>Advisory Committee<br>SAC<br>Commissioner of DHS<br>MAA Comittee<br>Designated state staff and consultants | Initiate December 30, 1985, complete September 30, 1986. | Report on scope of problem and its causes with recommendations to Governor and Commissioner of DHS. |
| B. DHS address repeated job failures among refugees | Through systematic evaluation of clients to improve service system response. | CUHCC<br>RPO<br>ORMH<br>Advisory Committee<br>DVR<br>ES | Initiate November 1, 1985; interim report August 1, 1986; final report December 15, 1986. | Written recommendation to Governor for 1987 Legislature and Biennial Budget. |

VIII. COLLABORATION WITH OTHER AGENCIES AND SYSTEMS

A. Assessment of current planning, policy, and underlying processes and structures.

Minnesota has analyzed its administrative structure relative to refugee mental health. The resulting changes are described in the description of the State Level Focal Point.

The thrust of the organization plan is to ensure that the appropriate constituencies will be adequately involves with the critical decisions in the RAP/MH program.

B. Improve Ongoing Refugee Decision Making Processes

The creation of the project's advisory committee, as well as MAA Advisory Committee, the Diagnostic Assessment Group, and the Poli-Techno Committee will improve the decision making processes in refugee mental health service planning and delivery.

Clearly, refugee service providers and refugee leaders, voluntary agencies, health and mental health providers, and county welfare agency personnel all agree the problem and incidence of mental health/social adjustments is increasing. The design seeks to focus energies, coordination, and information into a centralized and visible location: The Office of Refugee Mental Health.

The state plans to publish a quarterly newsletter, organize conferences and training sessions in conjunction with the advisory committees. Additional surveys and needs assessments will be accomplished as necessary or recommended by the various groups.

C. Establish a Broad-Based Constituency

The intent of the Department's organization plan in establishing the state Office of Refugee Mental Health is to ensure establishment of a broad-based constituency. As described in an earlier section (V), agencies participating on one of the committees are:

1. The Refugee Program Office.
2. The Department of Health.
3. The Governor's Subcabinet on Human Services.
4. Local Mental Health Agency Representatives.
5. Health Agency Coordination Representatives.
6. The Governor's State Advisory Council for Refugees.
7. Health and Mental Health Professionals.
8. Mutual Assistance Associations.

Consumer advocacy groups will be represented on the Poli-Techno Committee and task forces. Judicial personnel and housing authorities

are already involved on mental health coordination committees. In addition, thee are representatives of the mayor's offices of Minneapolis and St. Paul on the State Advisory Council for refugees. These offices work closely with police and housing officials. Training has already taken place. More will occur.

Of special note are the two interagency agreements, maintained for several years, of the Department with Health and Education for refugee services and program coordination. Both agreements will be amended to incorporate refugee mental health concerns through the larger and viable networks supervised by these agencies.

The Department of Health has the capability to reach public health nurses, physicians, and other health providers throughout the state. Strategies include the use of statewide newsletters and conferences, and collaborating in the development of culturally appropriate diagnostic tools.

The State Department of Education and the Board of Vocational Education have expressed their eagerness to participate in the mental health program.

The Department of Education programs include K-12 Limited English Proficient (LEP) program; early childhood (pre-school); school guidance; and Adult Basic and Continuing Education, including ESL.

The Department of Education and the Refugee Program office have identified several areas for strategic joint efforts.

The concerns include:

1. Prevention;
2. Incorporate of "mental health" in a holistic approach;
3. Problems in families due to intergenerational stress; and
4. Parenting strategies.

The Board of Vocational Education has taken an active role in assisting in refugee adjustment strategies. One effort is the Adult Homemaker Program, which is located in different sites throught the metro area, including public housing projects. This program has developed a refugee-specific guide, "Practical Living Skills." Among the strategies under consideration are:

- Additional section in "Practical Living Skills" on what is mental health and how to access services.

- Give inservice training to school social workers and guidance counselors.

- Educate teachers about refugee mental health through the statewide LEP newsletter.

- Rochester has a model comprehensive refugee early childhood program: share with other schools.

- Collaborate on special education diagnostic criteria.

- Share resource information systematically (publish).

A statewide conference in the fall of 1987 is planned on refugee mental health needs. (See Budget.) Both interagency agreements will be completed by October 30, 1985.

D. Participating in National and Regional NIMH-RAP Conferences

The response to the RAP-MH initiative from Minnesota agencies and individuals concerned for long-term services to meet refugee mental health needs has been phenomenal. The Department is fully committed to participated in national information sharing conferences, and will work to ensure the broadest representation possible in these meetings. It is our plan to draw particpants from the advisory committees and other key agencies.

E. Develop Collaborative Efforts

The entire thrust of the Minnesota plan is to bring together individuals and agencies with the goal of collaboration, resource sharing and system development. The tasks of the new staff in the office of Refugee Mental Health as well as of the various committees are to improve coordination, identify obstacles to service and system development, and to develop strategies to more effectively use available resources. Minnesota has many creative and hard working people in the field of mental health who have frequently worked alone and without knowledge of others' efforts. The project provides a focal point from which to move forward in policy revisions, expanded training strategies, and formal collaboration.

IX. DOCUMENTATION, ANALYSIS, AND EVALUATION OF RAP/MH ACTIVITIES OUTCOMES

Documentation and evaluation activities will focus on:

1. Participation in the national data collection and evaluation;

2. Documentation of the local systems development;

3. Design of program outcome measures; and

4. Development of mechanisms for the dissemination of documention/evaluation results.

National Evaluation - Appropriate department staff will participate in the national evaluation design process. Local documentation and data collection methods will be developed which accommodate national evaluation needs.

Documentation of Local Systems Development - Existing systems will be described and goals for system modifications will be specified. Activities and timelines for the implementation of system changes will be designed and monitored. Progress will be monitored monthly by Refugee Program Office and Mental Health Program Division staff.

Program Outcome Measures - Project staff will define measurable outcomes for program objectives. Data collection methods and instruments will be designed to collect data to measure these outcomes. When possible existing data sources or instruments, such as the CUHCC and Wilder Foundation data and instruments, will be used.

Evaluation requirements and performance measures will be specified in all contracts for service.

Dissemination of Results - Procedures to disseminate both interim and final project results will be designed. Project staff will identify a variety of audiences for documentation and evaluation results. These include, but not be limited to, local Mental Health and Refugee service staff and administrators, State Refugee Program Office and Mental Health Program Division Staff, and ORR and Nimh staff.

A major local use for the documentation and evaluation information (in conjunction with existing data and task force input) will be planning for years two and three of the project.

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# APPENDIXES

# LETTERS OF SUPPORT

# AND

# RESUMES

# INDOCHINESE REFUGEE HOUSEHOLDS
# in the TWIN CITY METRO AREA, DECEMBER 1980

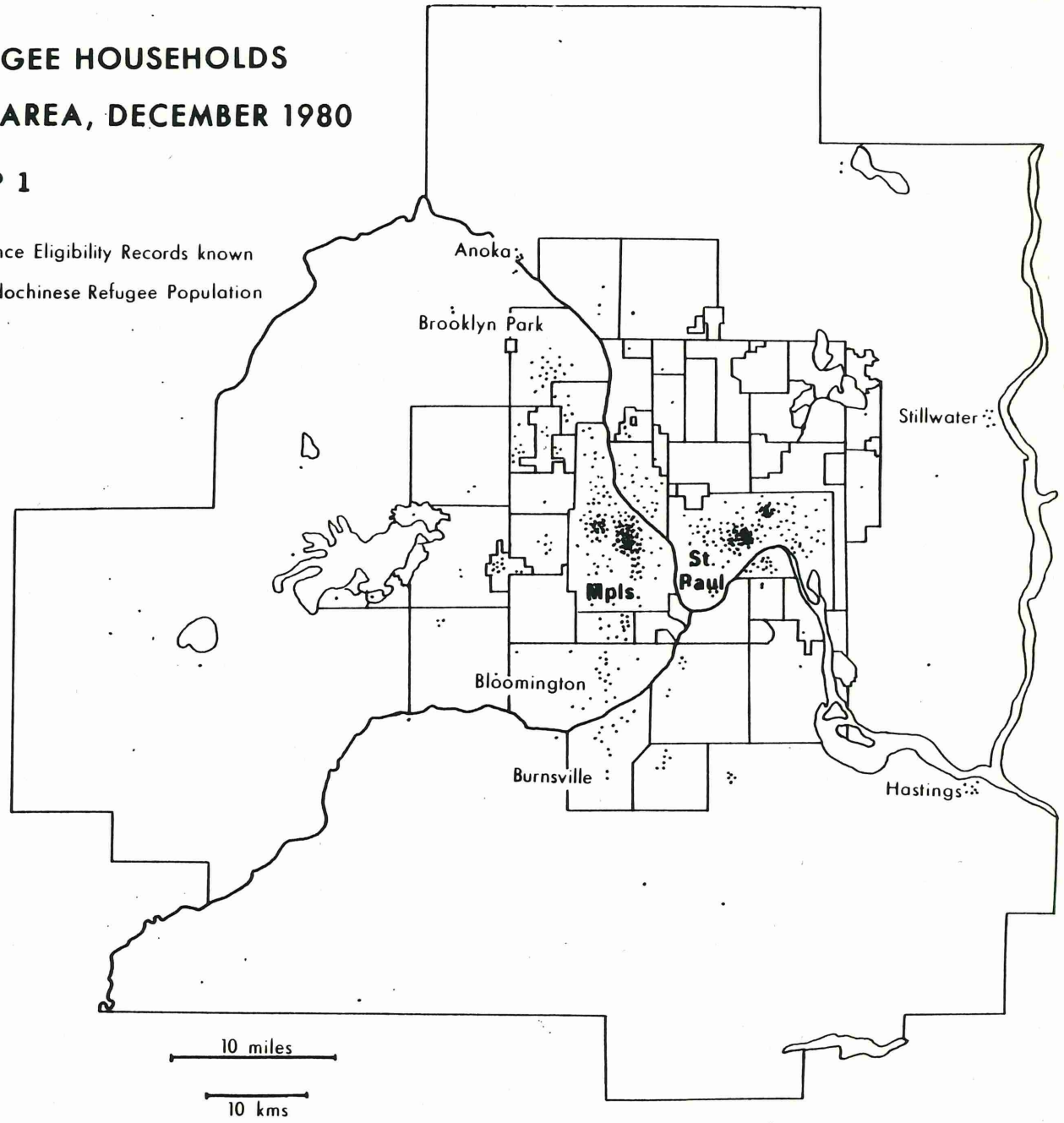
## MAP 1

Based on Public Medical Assistance Eligibility Records known to cover roughly 75 percent of the Indochinese Refugee Population

*One Dot = Three Families*

*Average Family Size = 3.6 Persons*

*In sparsely settled areas the dot may represent only one or two families*

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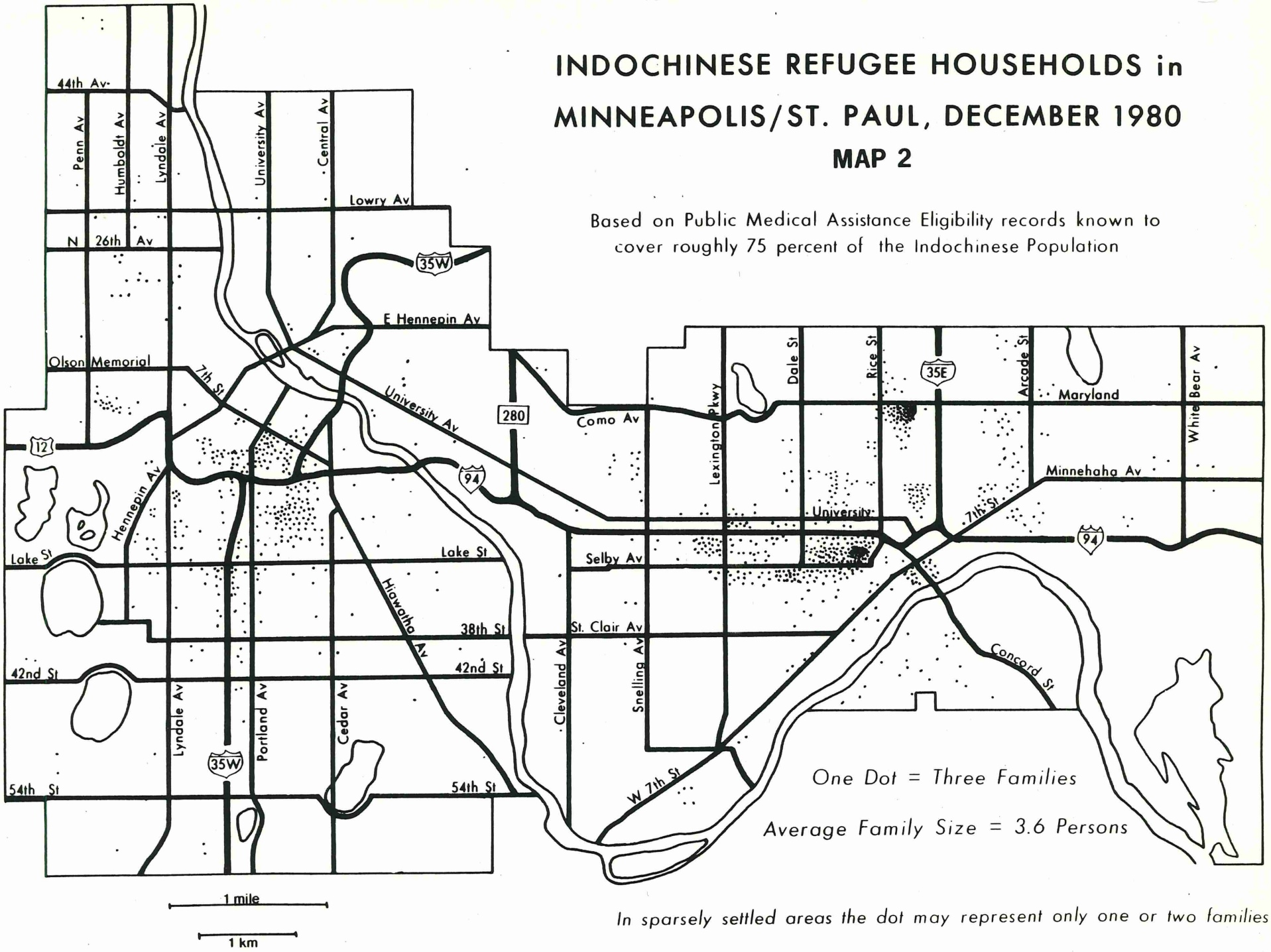
# INDOCHINESE REFUGEE HOUSEHOLDS in MINNEAPOLIS/ST. PAUL, DECEMBER 1980

## MAP 2

Based on Public Medical Assistance Eligibility records known to cover roughly 75 percent of the Indochinese Population




*In sparsely settled areas the dot may represent only one or two families*

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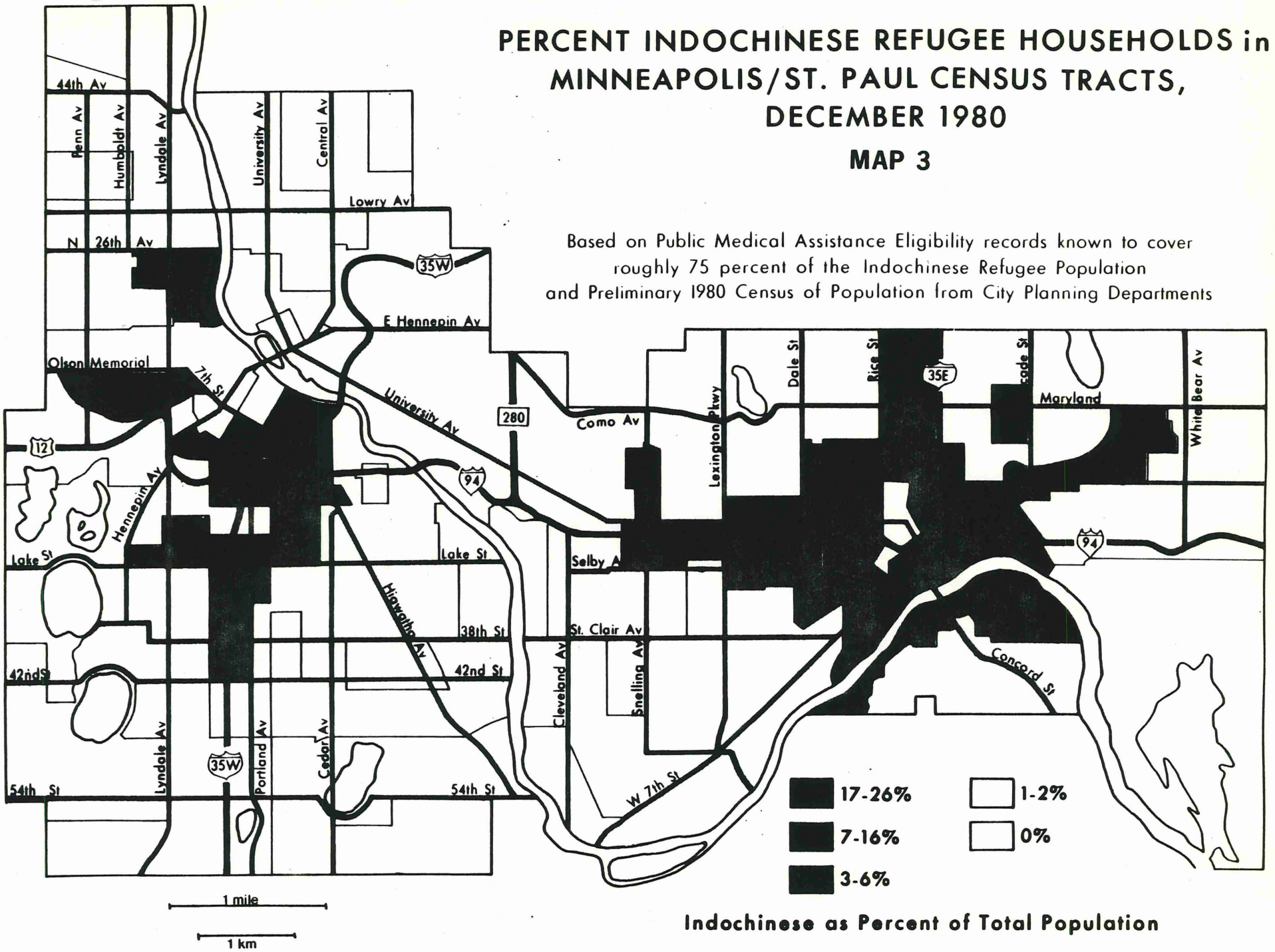
# PERCENT INDOCHINESE REFUGEE HOUSEHOLDS in MINNEAPOLIS/ST. PAUL CENSUS TRACTS, DECEMBER 1980

## MAP 3

Based on Public Medical Assistance Eligibility records known to cover roughly 75 percent of the Indochinese Refugee Population and Preliminary 1980 Census of Population from City Planning Departments




**Indochinese as Percent of Total Population**

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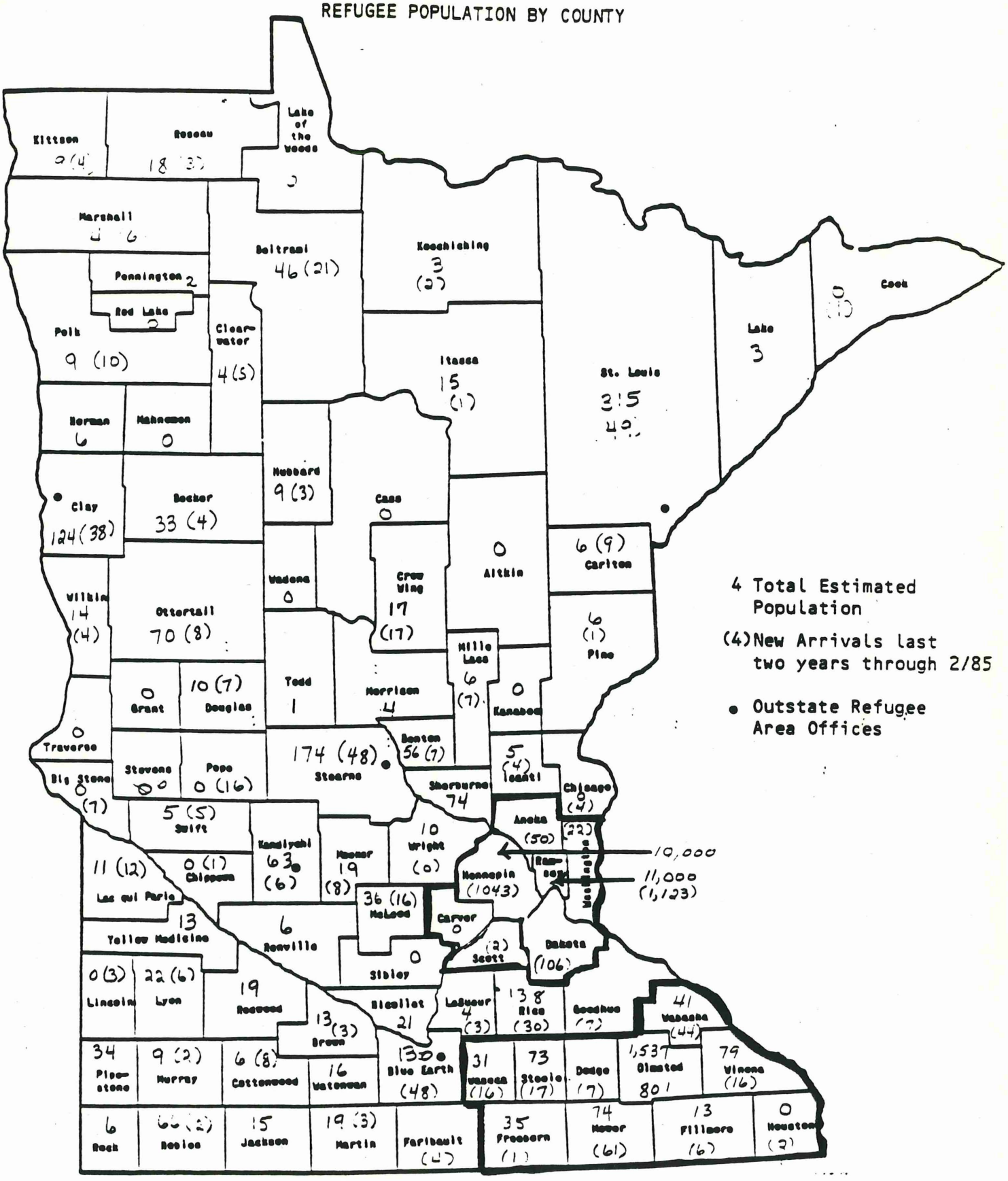
Appendix I

DPW-.18
(9-7.)

# STATE OF MINNESOTA

## REFUGEE POPULATION BY COUNTY




4 Total Estimated Population

(4) New Arrivals last two years through 2/85

• Outstate Refugee Area Offices

# POPULATION ESTIMATES

| Counties | Refugee New Arrivals thru 2/85 | | | | | | Total Est. Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | CY 85 | CY 84 | CY 83 | TOTAL | MO AVG | % | BEA | OTHER | TOTAL |
| AITKIN | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| BECKER | 0 | 0 | 4 | 4 | 0 | 0 | 33 | 0 | 33 |
| BELTRAM | 0 | 14 | 7 | 21 | 1 | 1 | 29 | 17 | 46 |
| BENTON | 0 | 0 | 7 | 7 | 0 | 0 | 56 | 0 | 56 |
| BIG STN | 0 | 0 | 7 | 7 | 0 | 0 | | | 0 |
| BLUE EA | 6 | 16 | 26 | 48 | 2 | 1 | | | 0 |
| BROWN | 0 | 0 | 3 | 3 | 0 | 0 | 13 | 0 | 13 |
| CARLTON | 0 | 0 | 9 | 9 | 0 | 0 | 5 | 1 | 6 |
| CARVER | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| CASS | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| CHIPPEW | 0 | 0 | 1 | 1 | 0 | 0 | | | 0 |
| CHISAGO | 0 | 3 | 1 | 4 | 0 | 0 | | | 0 |
| CLAY | 0 | 25 | 13 | 38 | 1 | 1 | 101 | 23 | 124 |
| CLRWTR | 0 | 1 | 4 | 5 | 0 | 0 | 0 | 4 | 4 |
| COOK | 0 | 0 | 1 | 1 | 0 | 0 | | | 0 |
| CTNWD | 3 | 3 | 2 | 8 | 0 | 0 | 4 | 2 | 6 |
| CROW WI | 0 | 0 | 17 | 17 | 1 | 0 | 17 | 0 | 17 |
| DODGE | 0 | 0 | 7 | 7 | 0 | 0 | | | 7 |
| DOUGLAS | 0 | 0 | 7 | 7 | 0 | 0 | 10 | 0 | 10 |
| FARIBAU | 0 | 3 | 1 | 4 | 0 | 0 | | | 0 |
| FILLMOR | 0 | 3 | 3 | 6 | 0 | 0 | | | 13 |
| FREEBOR | 0 | 0 | 1 | 1 | 0 | 0 | | | 35 |
| GOODHUE | 0 | 6 | 1 | 7 | 0 | 0 | | | 0 |
| GRANT | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| HOUSTON | 0 | 0 | 2 | 2 | 0 | 0 | | | 2 |
| HUBBARD | 0 | 1 | 2 | 3 | 0 | 0 | 9 | 0 | 9 |
| ISANTI | 0 | 0 | 4 | 4 | 0 | 0 | 5 | 0 | 5 |
| ITASCA | 0 | 0 | 1 | 1 | 0 | 0 | 9 | 6 | 15 |
| JACKSON | 0 | 0 | 0 | 0 | 0 | 0 | 15 | 0 | 15 |
| KANABEC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| KANDIYO | 0 | 6 | 0 | 6 | 0 | 0 | 49 | 14 | 63 |
| KITTSON | 0 | 0 | 4 | 4 | 0 | 0 | 0 | 9 | 9 |
| KOOCHIC | 0 | 2 | 0 | 2 | 0 | 0 | 3 | 0 | 3 |
| LACQUIP | 0 | 0 | 12 | 12 | 0 | 0 | 11 | 0 | 11 |
| LAKE | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 3 |
| LAKE OF | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| LESUEUR | 0 | 8 | 0 | 8 | 0 | 0 | 4 | 0 | 4 |
| LINCOLN | 0 | 0 | 3 | 3 | 0 | 0 | | | 0 |
| LYON | 0 | 0 | 6 | 6 | 0 | 0 | 22 | 0 | 22 |
| MCLEOD | 0 | 7 | 9 | 16 | 1 | 0 | 36 | 0 | 36 |
| MAHNOME | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| MARSHAL | 0 | 5 | 1 | 6 | 0 | 0 | 0 | 4 | 4 |
| MARTIN | 0 | 3 | 0 | 3 | 0 | 0 | 19 | 0 | 19 |
| MEEKER | 0 | 6 | 2 | 8 | 0 | 0 | 19 | 0 | 19 |
| MILLE L | 0 | 4 | 3 | 7 | 0 | 0 | 6 | 0 | 6 |
| MORRISO | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 4 |
| MOWER | 7 | 22 | 32 | 61 | 2 | 2 | | | 74 |
| MURRAY | 0 | 0 | 2 | 2 | 0 | 0 | 9 | 0 | 9 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| NICOLLE | 0 | 0 | 0 | 0 | 0 | 0 | 21 | 0 | 21 |
| NOBLES | 0 | 1 | 1 | 2 | 0 | 0 | 66 | 0 | 66 |
| NORMAN | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 6 |
| OTTER T | 0 | 3 | 5 | 8 | 0 | 0 | 59 | 11 | 70 |
| PENNING | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 |
| PINE | 0 | 1 | 0 | 1 | 0 | 0 | 6 | 0 | 6 |
| PIPESTO | 0 | 0 | 0 | 0 | 0 | 0 | 34 | 0 | 34 |
| POLK | 0 | 5 | 5 | 10 | 0 | 0 | 5 | 4 | 9 |
| POPE | 0 | 0 | 16 | 16 | 1 | 0 | 0 | 0 | 0 |
| RED LAK | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| REDWOOD | 0 | 0 | 0 | 0 | 0 | 0 | 19 | 0 | 19 |
| RENVILL | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 0 | 6 |
| RICE | 0 | 11 | 19 | 30 | 1 | 1 | | | 0 |
| ROCK | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 0 | 6 |
| ROSEAU | 0 | 0 | 3 | 3 | 0 | 0 | 14 | 4 | 18 |
| ST LOUI | 4 | 20 | 25 | 49 | 2 | 1 | 312 | 3 | 315 |
| SHERBUR | 0 | 0 | 0 | 0 | 0 | 0 | 74 | 0 | 74 |
| SIBLEY | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| STEARNS | 7 | 16 | 25 | 48 | 2 | 1 | 173 | 1 | 174 |
| STEELE | 0 | 5 | 12 | 17 | 1 | 0 | | | 73 |
| STEVENS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SWIFT | 0 | 0 | 5 | 5 | 0 | 0 | 5 | 0 | 5 |
| TODD | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| TRAVERS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| WABASHA | 8 | 17 | 19 | 44 | 2 | 1 | | | 41 |
| WADENA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| WASECA | 0 | 0 | 16 | 16 | 1 | 0 | | | 31 |
| WATONWA | 0 | 0 | 0 | 0 | 0 | 0 | 16 | 0 | 16 |
| WILKIN | 0 | 1 | 3 | 4 | 0 | 0 | 13 | 1 | 14 |
| WINONA | 0 | 16 | 0 | 16 | 1 | 0 | | | 79 |
| YELLOW | 0 | 0 | 0 | 0 | 0 | 0 | 13 | 0 | 13 |
| UNKN | 4 | 39 | 26 | 69 | 3 | 2 | | | 0 |
| SUBTOT | 39 | 273 | 385 | 697 | 27 | 18 | | | 0 |
| | | | | | | | | | 0 |
| ANOKA | 0 | 21 | 29 | 50 | 2 | 1 | | | 0 |
| DAKOTA | 1 | 50 | 55 | 106 | 4 | 3 | | | 0 |
| HENNEPI | 74 | 559 | 410 | 1043 | 40 | 27 | | | 0 |
| RAMSEY | 107 | 526 | 490 | 1123 | 43 | 29 | | | 0 |
| SCOTT | 0 | 0 | 2 | 2 | 0 | 0 | | | 0 |
| WASHING | 1 | 16 | 5 | 22 | 1 | 1 | | | 0 |
| WRIGHT | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 0 | 10 |
| SUBTOT | 183 | 1172 | 991 | 2346 | 90 | 61 | | | 0 |
| | | | | | | | | | 0 |
| OLMSTED | 56 | 388 | 357 | 801 | 31 | 21 | | | 1,537 |
| TOTAL | 278 | 1833 | 1733 | 3844 | 148 | 100 | | | |

Estimated Total Numbers of Refugees in Minnesota - By Year

| Year | Hmong | Vietnamese | Cambodian | Ethnic Laotian | SE Asian Total | Cuban | Haitian | Afghan | Ethiopian | Soviet Jews | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10/1975 | | 4,300 | 300 | | 4,600 | | | | | | |
| 10/1976 | 130 | 3,870 | | | 4,000 | | | | | | |
| 10/1977 | 330 | 3,000 | | | 3,300 | | | | | | |
| 10/1978 | 1,000 | 2,380 | | | 3,380 | | | | | | |
| 10/1979 | 2,000 | 3,600 | 400 | 300 | 6,300 | | | | | | |
| 11/1980 | 8,500 | 6,000 | 1,800 | 2,000 | 18,200 | 700 | | | | | |
| 11/1981 | 10,500 | 7,000 | 4,000 | 3,900 | 25,400 | | | | | | |
| 9/1982 | 9,600 | 6,500 | 4,800 | 4,000 | 25,500 | | | 40 | 20 | | |
| 10/1983 | 8,500 | 6,200 | 5,000 | 3,500 | 23,200 | | 25 | 60 | 400 | | |
| 6/1984 | 8,500 | 6,400 | 5,600 | 3,500 | 24,000 | 500-800 | 25 | 60 | 400 | 1,200 | 26,000+ |

DGD-s10

April, 1985

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REFUGEE PROGRAM OFFICE

DHS Interbureau Agreements
Leng Wong
Cindy Westbrook
Pete Wilcox (Accounting Officer)

REFUGEE PROGRAM COORDINATOR

- MN Dept. of Education
- MN Dept. of Health
- MN Dept. of Economic Security

Clerical ½ Tag/½ RPO

RPO Clerical

- Senior Program Evaluation (IAG & Social Services) Specialist
- Program Monitoring & Evaluation Specialist
- Program Monitoring & Evaluation Specialist
- Case Management Monitoring Specialist
- Senior Planner for Program Development
- Analyst for Policy and Systems Management
- Analyst for Finance & Budget Development
- Contracts Officer

Prepared by the Management Operations Division

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March 1985

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VICE-CHAIR: Marc-Paul Smith (612-292-6690)
SECRETARY: The Rev. Lyn Lawyer (612-363-2499)

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## Mental Health Committee

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Leng Wong
Program Administration DHS
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State of Minnesota
# POSITION DESCRIPTION A

EMPLOYEE'S NAME

| AGENCY/DIVISION | ACTIVITY |
|---|---|
| | |

| CLASSIFICATION TITLE | WORKING TITLE (if different) | POSITION CONTROL NUMBER |
|---|---|---|
| Mental Health Program Consultant | Director, Refugee Mental Health Program | |

| PREPARED BY | PREVIOUS INCUMBENT | APPRAISAL PERIOD to |
|---|---|---|
| | | |

| EMPLOYEE'S SIGNATURE (this position description accurately reflects my current job) | DATE | SUPERVISOR'S SIGNATURE (this position description reflects the employee's current job) | DATE |
|---|---|---|---|
| | | | |

**POSITION PURPOSE** The purpose of this position is to direct the Refugee Mental Health Project. This project will attempt to contact and coordinate all persons, programs and agencies involved with services to the refugees. It will also establish outreach to all persons, programs and agencies that are responsible for but do not have the technical capacity to provide services to the target population. This position will administer and direct this initiative including supervision of project staff, statewide planning and development and enhancement of service systems through consultation, funding, training and technical assistance.

This position will develop and implement standards and guidelines regarding levels and types of services to the target population, act as liaison to other State Departments, facilities, agencies and divisions, assist in community social services planning, initiating and monitoring program development plus coordination and administration of funds appropriated to the Office.

**REPORTABILITY**

Reports to: Assistant Commissioner
Director, Mental Health Program Director

Supervises:

**DIMENSIONS**

Budget: Direct administration Refugee Mental Health Office
Planning and Management of State and Federal Block Grant funds.

Clientele: Human service officials of local, state, federal and private agencies, service providers and managers both public and private sectors, county social service staff and DHS staff, various groups composed of, representing and serving the refugee population.

| POSITION DESCRIPTION B | EMPLOYEE'S NAME | I-2 | POSITION CONTROL NUMBER |
|---|---|---|---|

| Resp. No. | PRINCIPAL RESPONSIBILITIES, TASKS AND PERFORMANCE INDICATORS | Priority | % of Time | Discretion |
|---|---|---|---|---|
| 1. | Direct the promotion and improvement of interagency cooperation with local service providers to serve mental health needs of the population.<br>a. Serve as Technical Assistance to facilitate and direct use of resource people as consultants.<br>b. Create an informational clearing house for local service providers and refugee groups and individuals.<br>c. Identify helping systems and disseminate information. | | | |
| 2. | Assist in system definition and referring.<br>a. Serve as the Task Force and work group convenor to direct collection and analysis of needs assessments, service and cultural resources. | | | |
| 3. | Assist in the creation of interagency mechanism to achieve a coordinated system of mental health services to the target population. | | | |
| 4. | Assist in knowledge transfer and direct Technical Assistance efforts of the Refugee Mental Health Program.<br>a. Plan and direct activities to assist in training mental health, health, education and legal system professionals and para-professionals in mental health needs and services to the target population. | | | |

State of Minnesota
**POSITION DESCRIPTION A**

EMPLOYEE'S NAME: I-3

| AGENCY/DIVISION | ACTIVITY |
|---|---|
| | |

| CLASSIFICATION TITLE | WORKING TITLE (if different) | POSITION CONTROL NUMBER |
|---|---|---|
| Mental Health Program Advisor | Technical Assistance Coordinator, Refugee Mental Health Office | |

| PREPARED BY | PREVIOUS INCUMBENT | APPRAISAL PERIOD to |
|---|---|---|
| | | |

| EMPLOYEE'S SIGNATURE (this position description accurately reflects my current job) | DATE | SUPERVISOR'S SIGNATURE (this position description reflects the employee's current job) | DATE |
|---|---|---|---|
| | | | |

**POSITION PURPOSE**

Serve as Technical Assistance Consultant to service systems providers and consumers.

Serve as focal point for coordination of information and technical assistance needs and resources.

Assist Director of Refugee Office in development of a Department of Human Services Technical Assistance strategy, technology and program for information and resource sharing.

**REPORTABILITY**

Reports to: Director, Refugee Mental Health Program Office.

Supervises:

**DIMENSIONS**

Budget:

Clientele:

| POSITION DESCRIPTION B | EMPLOYEE'S NAME | I-4 | POSITION CONTROL NUMBER |
|---|---|---|---|

| Resp. No. | PRINCIPAL RESPONSIBILITIES, TASKS AND PERFORMANCE INDICATORS | Priority | % of Time | Discretion |
|---|---|---|---|---|
| 1. | Develop list of resources, services and strategies for meeting needs of the refugee population.<br>a. Contact all resources.<br>b. Serve as staff to Refugee Mental Health Program Office.<br>c. Act as principal liaison to all service and technical assistance agencies and resources.<br>d. Assist Task Force in assessment and evaluation of technical assistance resources. | | | |
| 2. | Assist in the development and presentation of workshops, literature and resource directories.<br>a. Coordinate information, investigate newsletter feasibility.<br>b. Serve as public information contact. | | | |
| 3. | Assist in development of a Technical Assistance, Knowledge Transfer and Skill Acquisition Plan.<br>a. Serve as principal liaison to all training offices.<br>b. Plan and arrange workshops.<br>c. Identify training needs.<br>d. Identify training resources. | | | |

| State of Minnesota **POSITION DESCRIPTION A** | EMPLOYEE'S NAME Vacant | I-5 |
|---|---|---|
| AGENCY/DIVISION Department of Human Services Refugee Program Office - Mental Health | ACTIVITY | |
| CLASSIFICATION TITLE Clerk Typist II | WORKING TITLE (if different) | POSITION CONTROL NUMBER |
| PREPARED BY Al Oertwig | PREVIOUS INCUMBENT None | APPRAISAL PERIOD to |
| EMPLOYEE'S SIGNATURE (this position description accurately reflects my current job) | DATE | SUPERVISOR'S SIGNATURE (this position description reflects the employee's current job) / DATE |

**POSITION PURPOSE**

To provide Planning and Resource Management Section with secretarial support including typing, filing and related clerical activities, to implement the Refugee Mental Health Program

**REPORTABILITY**

Reports to: Mental Health Consultant
Refugee Program Office - Mental Health

Supervises: None

**DIMENSIONS**

Budget: Products will affect Division's budget of approximately $300,000/year.

Clientele: The refugee persons effected by this work number approximately 7,000.

| POSITION DESCRIPTION B | EMPLOYEE'S NAME | POSITION CONTROL NUMBER |
|---|---|---|
| | I-6 | |

| Resp. No. | PRINCIPAL RESPONSIBILITIES, TASKS AND PERFORMANCE INDICATORS | Priority | % of Time | Discretion |
|---|---|---|---|---|
| 1. | Typing. To type draft and final correspondence, reports, contracts, memoranda and charts as needed by section staff. | A | 50 | B |
| | 1.1. Develop system to assure timely turnaround of typing. | | | |
| | 1.2. Proofread typing and correct errors on all final copies prior tto returning to staff or sending out. | | | |
| | 1.3. Decide which material should be sent to word processing and route accordingly. | | | |
| | 1.4. Secure appropriate signatures for correspondence and contracts. | | | |
| | 1.5. Prepare reports. | | | |
| 2. | Filing. To develop and maintain a working file system for section staff and integrate, as necessary, into Division's files. | A | 10 | A |
| | 2.1. Develop file system which is easily accessible and understandable by staff. | | | |
| | 2.2. Fill all materials in a timely manner. | | | |
| | 2.3. Purge and store out-dated files on a regular basis. | | | |
| 3. | Calculation. To assist section staff in calculations/tabulations of data and cost figures. | B | 5 | B |
| | 4.1. Assist staff in the compilation and layout of data for use in reports, correspondence, etc. | | | |
| | 4.2. Checks figures for accuracy. | | | |
| 4. | Communication. To assure that telephone calls and mail (incoming) and outgoing) are properly distributed. | A | 10 | A |
| | 5.1. Receive calls and make proper disposition of problems. | | | |
| | 5.2. Take accurate phonemessages. | | | |
| | 5.3. Screen calls and visitors. | | | |
| | 5.4. Distribute mail to staff. | | | |
| | 5.5. Assure that outgoing mail is sent to appropriate peopld and in a timely manner. | | | |
| | 5.6. Provide relief for maindesk receptionist. | | | |

| POSITION DESCRIPTION B | EMPLOYEE'S NAME | I - 7 | POSITION CONTROL NUMBER |
|---|---|---|---|

| Resp. No. | PRINCIPAL RESPONSIBILITIES, TASKS AND PERFORMANCE INDICATORS | Priority | % of Time | Discretion |
|---|---|---|---|---|
| 5. | To compose original correspondence without dictation. | A | 10 | A |
| | 511. Compose assigned correspondence, obtaining information as needed. | | | |
| 6. | Schedule meetings and prepare travel arrangements. | A | 5 | A |
| | 6.1. Contact participants for meetings. | | | |
| | 6.2. Finalize date, time and place | | | |
| | 6.3. Prepare materials needed. | | | |
| | 6.4. Secure state cars. | | | |
| | 6.5. Secure plane tickets and room reservations, as needed. | | | |
| 7. | To perform related work as required. | | | |
| | 7111 Assist supervisor and section staff in related tasks on an as-needed basis. | B | 10 | A |
| | 7.2. Assist other clerical staff as time allows. | | | |

VI. Planning Process

| Year | Activity | Participating Agencies |
|---|---|---|
| 1975 | | |
| | o Vietnamese bilingual/bicultural social worker (MSW) hired to work with unaccompanied minors and refugee families | Lutheran Social Services |
| 1976 | | |
| | o Dr. Joe Westermeyer identified as mental health resource | Voluntary Agencies: Catholic Charities/St. Paul Catholic Social Service/ St. Cloud and Rochester Lutheran Social Service International Institute |
| | o State receives HEW Community Services Grant for Voluntary Agency bilingual staff | |
| 1977 | | |
| | o State provides training to volag bilingual workers on casework and crisis strategies | Department of Public Welfare (now Human Services) Catholic Charities/St. Paul Catholic Social Service of Winona Diocese Catholic Charities of St. Cloud Lutheran Social Service International Institute |
| | o Volag bilingual personnel conduct statewide survey of refugee population | |
| 1978 | | |
| | o MN Consortium for Refugee Resettlement receives mental health grant from HEW for inservice training of bilingual and American workers | |
| | o State, voluntary agency and county personnel participate in national inservice training program (Columbus, Ohio) | |
| | o Community University Health Care Center (CUHCC) begins medical service provision to refugees | RPO funded health interpreters |
| 1979 | | |
| | o MN Consortium for Refugee Resettlement receives grant for "Indochinese Mental Health Through Education, Training and Consolidation of Services" | Hennepin County Ramsey County University of MN/School of Social Work Voluntary Agencies: see above |

| Year | Activity | Participating Agencies |
|---|---|---|
| 1980 | | |
| | o Hennepin County Community Support Project/Minority Task Force recommends funding refugee position | |
| | o Mental Health Advisory Board discusses project focus:<br>1) Prevention<br>Support System Development<br>Bilingual Worker Training<br>2) Culutral Barriers<br>Stigma of term "mental health"<br>Stigma of seeking services<br>Lack of understanding<br>3) Training American service providers<br>4) Referral resource director<br>5) Inclusion of Mutual Assistance Associations in process of training: leaders are helping solve domestic and mental health problems (natural healers and helpers)<br>6) Differences between 1975 and 1979 (boat arrivals)<br>7) Increase of problems over time | Advisory Board:<br>University of Minnesota:<br>Departments of Psychiatry, Psychology, Anthropology, American Indian Studies, College of Home Economics, School of Social Work<br>Ramsey County Human Services<br>Hennepin County Bureau of Social Services - Community Services Department (Minority Issues)<br>Lutheran Social Service,<br>International Institute, and<br>State Refugee Resettlement Office |
| | o Minneapolis Foundation funds CUHCC position for bilingual/bicultural worker | |
| 1981 | | |
| | o Mental Health Project continues; Revisions based on key informant needs assessments; visits to service and training projects in several cities | |
| | o Survey (by mental health project director Rogers and Stasick) of 50 mental health service providers:<br>-problems in standard methodology of diagnosis, therefore making it difficult to draw conclusions;<br>-refugees not using mainstream services, reinforcing need to make use of natural support systems | |
| | o Creation of Planning and Outreach Committee of the Indochinese Mental Health Project (i.e., to mainstream providers) | Lutheran Social Service<br>Metro Area Refugee Service Coordination Committee<br>Hennepin County Minority Mental Health Task Force<br>Minority Mental Health Human Resources Advisory Committee/<br>Mental Health Bureau/State Human Services |

| Year | Activity | Participating Agencies |
|---|---|---|
| 1981 (cont'd) | | Member of Planning Committee and Conference Faculty of University of Minnesota, Department of Conferences<br>Member of Board of Directors of Mental Health Association of Hennepin County<br>Member of Branch, Mental Health Advocacy Coalition of Minnesota<br>Member of Advisory Board of Transitional Volunteer Program/ Voluntary Action Center, Minneapolis |
| | o Hennepin County uses McKnight Funds to support Minneapolis Foundation | CUHCC |
| | o Under auspices of Mental Health Project, University of Minnesota conducted 12 week course on American Social Welfare Programs and Services (history, development and structure of American Human Service System and how to use it) to 45 students | |
| | o Project sponsored professional career assessment for bilingual staff. | |
| | o Project sponsored numerous workshops on wide variety of adjustment issues (e.g., divorce, marital problems, elderly) | |
| 1982 | o January - State RPO submits foundation request for mental health services:<br>-prevention<br>-case consultation to Americans<br>-crisis intervention<br>-short term and long term counseling<br>-referrals for therapeutic treatment<br>-development of a coordinated delivery system provided in a culturally appropriate manner<br>Proposal not funded | Included all health agenies serving refugees or interested in serving refugees |
| | o July - State Health Planning Task Force identifies Social Adjustment/ mental health as the number one major health issue for refugees | |

| Year | Activity | Participating Agencies |
|---|---|---|
| 1983 | | |
| | o Planned training of American Refugee Committee Volunteers with previous mental health experience following return home from Thailand doing mental health services | CUHCC and American Refugee |
| | o The Refugee State Advisory Council Subcommittee for Socail Adjustment/ Mental Health assumed planning responsibility<br>Program elements were:<br>1) Prevention<br>2) Psychiatric component linked to social adjustment using culturally appropriate design and methodology<br>3) Deliver service in community settings<br>4) Ethnic professional or para-professional services<br>5) Joint in-service planning and training<br>6) Referral system<br>7) Local level coordination | Lutheran Social Service<br>CUHCC<br>St. Paul Ramsey Medical Center<br>Hennepin County<br>Ramsey County |
| | o State negotiates contracts with CUHCC and Wilder Foundation for refugee Social Adjustment/Mental Health Services | |
| | o Wilder receives demonstration grant from ORR to train bicultural (native) helpers and evaluate their effectiveness | |
| 1984 | | |
| | o American Refugee Committee receives grant to train mainstream and bicultural workers in mental health approaches | |
| | o CUHCC and Wilder write to Minnesota Department of Human Services, Mental Health Bureau for funding | |
| | o Refugee Program Office and Mental Health Bureau hold series of meetings to establish plan for refugee mental health services | |
| | o Minnesota Department of Corrections issues Request for Proposals to address problem of battering within the Southeast Asian Community | |

| Year | Activity | Participating Agencies |
|---|---|---|
| 1984 (cont'd) | | |
| | o Project Program Coordinator and Assistant Commissioner for Mental Health participate in NIMH/ORR work group on Refugee Mental Health | |
| | o State convenes meetings to discuss mental health funding strategies | Olmsted County<br>Zumbro Valley Mental Health<br>Hennepin County<br>Ramsey Coutn<br>CUHCC<br>Wilder |
| 1985 | | |
| | o Refugee Program Office conducts comprehensive program review and planning process | |
| | o State holds mental health grant planning meetings both pre and post publication of ORR/NIMH announcement | Hennepin County<br>Olmsted County<br>Ramsey County<br>Zumbro Valley<br>CUHCC<br>Wilder<br>Dr. Westermeyer Clinic<br>MAAs<br>Voluntary Agencies<br>State Departments<br>Health and Social Adjustment Committees |

JUL 0 5 1985

K-1

MEDICAL EDUCATION AND RESEARCH FOUNDATION
Application for
GRANT IN AID OF RESEARCH

(For Office Use Only)
DATE RECEIVED_____
ACCOUNT #_____
IRB #_____
AMOUNT AWARDED:_____

Submit 20 copies (including originals) of Application (p.1-4)
5 copies of Research Plan and C.V.'s
5 copies of Progress Reports.

I. Study Period: July, 1985 (MO. YR.) TO July, 1986 (MO. YR.)

II. $ 19,930 Requested.

III. Name, position and department of Principal Investigator(s); also faculty appointment, University of Minnesota: James Jaranson, M.D., M.A., M.P.H., Director, ADAP Programs, Department of Psychiatry; Assistant Professor, University of Minnesota School of Medicine
Co-Investigators (if applicable): Neal Holtan, M.D., M.P.H., Director, International Health Clinic, Department of Medicine; Assistant Professor, University of Minnesota School of Medicine

IV. Title of Research: Assessment of Psychiatric Symptoms and Testing Instruments in Laotian and Cambodian Refugees

V. Research Abstract (300 words - outline objectives and methods):

Recent advances in the field of psychiatric epidemiology have now made it possible to more accurately assess the psychiatric symptoms and adjustment problems of refugees from Southeast Asia in the United States. Minnesota, in particular, has large numbers of Southeast Asian refugees from Laos, Cambodia and Viet Nam. Two of the groups that are least studied, however, are the Laotian and Cambodian refugees. In order to adequately plan for treatment for the refugees, we need to know prevalence rates for psychiatric symptoms, the extent of untreated psychopathology, factors that favor or prevent help-seeking behavior, and the relationship of stressful life events on the occurrence of psychopathology.

We propose a pilot study to determine the prevalence of psychiatric symptoms in the Laotian and Cambodian communities in the Twin Cities, to document the prevalence and nature of the psychiatric symptoms, to compare community and clinical profiles of the Lao and Cambodian subjects with Hmong data, and to test the utility of psychiatric assessment instruments in identifying untreated members of the refugee population. We propose to use the Symptom Checklist-90 which will be translated into Lao and Cambodian, Life Events Checklists to assess recent and distant psychosocial stressors, and a questionnaire for basic bio-demographical data. The SCL-90 and Life Events Scale have been well standardized cross-culturally, and the SCL-90 has also been used by Westermeyer in his studies of the Hmong population in Minnesota.

We plan to compare the results of the measures obtained from these Cambodian samples and compare them with the Laotian samples, compare combined community samples with combined clinical samples, correlate clinical assessments with community ratings, and correlate risk factors with psychiatric symptomatology. Patients identified in the community as having severe psychiatric symptoms will be referred to our International Health Clinic and other clinical treatment settings.

# Psychiatric Diagnosis Across Cultural Boundaries

Joseph Westermeyer, M.D., Ph.D.

*Diagnosis across cultural boundaries has become a practical rather than an esoteric matter as migration, the number of effective psychiatric therapies, and access to psychiatric care have increased. Cross-cultural diagnosis involves such theoretical considerations as diagnostic categories, pathoplasticity of psychiatric disorder, so-called culture-bound syndromes, "emic" (intracultural) versus "etic" (cross-cultural) conceptual frameworks, and different reporting of symptoms and expression of signs from one cultural group to another. Important clinical issues include distinguishing cultural belief systems from delusions and understanding the special problems of minority, migrant, and refugee patients.*

(Am J Psychiatry 142:798–805, 1985)

The term "cross-cultural diagnosis" has different meanings. It can refer to diagnostic schemata across cultures: this is the "classification" meaning. To what extent are these schemata identical, merely overlapping, or essentially different? Cross-cultural diagnosis also implies the ability of a clinician from one culture to make a diagnosis for a patient from another culture: this is the "diagnostic method" meaning. Can the clinician take the signs and symptoms of the culturally foreign patient and arrive at a diagnosis? Other meanings can be discerned, such as cross-cultural comparability of folk diagnoses or interrater reliability of diagnosticians from two different cultures.

Cross-cultural diagnosis concerns the ability of the classification consistently to reflect clinical phenomena so well that even cultural differences in mode of complaint and in lay or folk meaning attached to symptoms do not mislead the average competent clinician away from the diagnosis. To be effective, cross-cultural techniques, skills, and conceptual frameworks must be available for evaluating a patient who may not share even the language, much less the culture or world view, of the clinician.

Diagnosis involves more than a mere Linnaean classification of homogeneous entities. In the medical context it serves at least one purpose: predicting the course or the probabilities of outcome from alternate courses. It satisfies a human need in bringing discomforting, sometimes terrifying, uncertainty into the realm of the known. Only sometimes does diagnosis meet a second goal: to recommend a course of treatment. This involves, then, a second prognosis regarding the expected course or courses following treatment.

## THEORETICAL CONSIDERATIONS

### *Diagnostic Classification in Various Countries*

Diagnostic schemata vary among countries in small and large ways. Some examples of national diagnostic categories include the following:

1. *Bouffées délirantes*, a type of acute psychosis described by the French, consists of a transient psychosis with elements of trance or dream state (1, 2).
2. The definition of schizophrenia varies from the tight, narrow syndrome preferred in Western Europe, Asia, Latin America, Africa, and Australia (3) to the wide spectrum, more inclusive syndrome described in the Soviet Union (4) and the United States (5–7). *DSM-III* criteria have shifted toward the more specific criteria used elsewhere.
3. Scandinavian psychiatrists have long favored a category of reactive psychosis distinct from schizophrenia and affective psychosis. It consists of acute onset associated with severe precipitating stress, a better premorbid adjustment, and favorable outcome (8). This category is also approximated by the *DSM-III* diagnosis of schizophreniform psychosis.
4. Japanese psychiatrists recognize a syndrome marked by obsessions, perfectionism, ambivalence, social withdrawal, neurasthenia, and hypochondriasis. They refer to it as *shinkeishitsu* (9).
5. During the 1950s to 1970s, Chinese psychiatrists preferred the generic term "neurasthenia" for all types of neurotic disorders rather than more specific categories (10).
6. In Spain and Germany, "involutional paraphrenia" is a midlife condition with paranoid features. In these countries, "paraphrenia" is distinct from

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schizophrenia and depression while containing elements of both (11).

Are these cross-national differences due to true national differences in psychopathology or merely to national preferences that have developed over time? Often, national preferences and historical factors appear to account for these differences, but national variations in psychopathological expression may also exist.

In contrast to these idiosyncratic national variations, highly similar diagnostic categories are also used by psychiatrists around the world. These categories include manic-depressive disorder and various forms of neurosis, alcoholism, drug dependence, mental retardation, organic brain syndromes, personality disorder, and various adjustment disorders (12–15).

Diagnostic criteria can and do change over time. Perhaps most notable over the last decade has been the movement in the United States from emphasis on psychodynamic and psychoanalytic concepts and fairly loose diagnostic criteria before the 1970s to more specific diagnostic criteria since the 1970s (16, 17). This change has led to a decrease in the diagnosis of schizophrenia (17), although as late as 1980, older American clinicians were still using broad criteria for this diagnosis (18). Attitudinal, political, historical, and perhaps even economic factors can also influence diagnostic criteria and diagnostic practices (4, 19–21).

### *Pathoplasticity of Psychiatric Disorder*

As has been repeatedly demonstrated, the concomitants of schizophrenia vary widely from one culture to another and even among ethnic groups in a single country. Core elements of the disordered perceptions, thought processes, and behavior are highly consistent, however. Differences mainly involve the content, severity, or relative frequency of such symptoms as withdrawal, volubility, agitation, compliance, and paranoia (22).

Another type of pathoplasticity involves the nonpsychotic disorders. For example, the relative distribution of depression, conversion reaction, anxiety, somatoform disorder, and obsession-compulsion differs from one culture to another (23).

A manifestation of cross-cultural pathoplasticity is the better outcome of schizophrenia in developing countries than in developed countries (24). One interpretation of these data is that patients in developing countries have better outcomes due to social factors (e.g., more stable social networks, better work opportunities). It may also be that acute, self-limited psychosis (so-called hysterical psychosis, *bouffées délirantes*, acute reactive psychosis, or schizophreniform psychosis)—which may be mislabeled as schizophrenia—is more common in these countries.

It seems likely that certain psychopathological states may change diagnostic category entirely in different cultures. Lesse (25) has made the point that syndromes classified as behavioral problems or psychosomatic syndromes in one culture may mask what is termed "depression" in other cultures.

Pathoplasticity may also be manifest in alcohol and drug abuse. In societies with high rates of substance abuse, the rate of neurotic-type disorders is correspondingly low (26). This finding suggests that alcoholism and drug abuse may be an alternative to neurotic disorders. Other data supporting this interpretation include the genetic and family links between depression and substance abuse, the correlation of parental loss during childhood with both types of disorder, the inverse sex distribution of these disorders, with more depressed females and more substance-abusing men, and similar age at onset of both disorders (27).

### *Culture-Bound Syndromes*

Certain trance-like or behavioral disturbances occur with unusual frequency in certain societies. A few examples of these many syndromes include the following:

1. *Latah* in Southeast Asian females: minimal stimuli elicit an exaggerated startle response, often with swearing; also reported among the Ainu of Japan, the Bantu of Africa, and French-Canadians (28).
2. Anthropophobia among Japanese, especially males: involves easy blushing, anxiety with face-to-face contact, and fear of rejection (29).
3. *Koro*, especially in Asian males: consists of the fear that the penis will withdraw into the abdomen, causing death; also reported infrequently in Europe and America (30, 31).
4. *Grisi siknis* among the Miskito of Nicaragua: involves headache, anxiety, irrational anger toward people nearby, aimless running, and falling down (32).
5. *Amok* among Southeast Asian males: involves sudden mass assault, usually including homicide and sometimes the death of the perpetrator (33).
6. Bulimia in North American Euroamericans, mostly females: food binging is followed by self-induced vomiting; sometimes associated with other conditions such as depression, anorexia, or substance abuse.
7. "Falling out" among black Americans and black Caribbeans: consists of sudden collapse and paralysis and inability to see or speak; hearing and understanding are intact (34).

Most students of these syndromes agree that they are not uniquely "culture bound"; that is, they occur in a variety of cultures including quite dissimilar ones separated by considerable distances. In addition, the subsegments of these syndromes are not unique but include such common manifestations as fear, anxiety, amnesia, aimless escape, psychophysiological symptoms, social withdrawal, behavioral deviance, and nondirected violence. Nonetheless, it is remarkable that these syndromes do occur with much greater frequency in some societies than in others. They often wax and wane over time and can occur in sudden

widespread "epidemics," such as outbreaks of *koro*, bulimia, and *amok* (35).

These syndromes do not accompany a single psychiatric diagnosis. Instead, associated psychiatric disorders include personality disorder, "neurasthenia," crisis or adjustment disorders, organic brain syndromes, drug-induced delirium, major depression, mania, schizophreniform psychosis, and schizophrenia.

Some students of these phenomena (mostly social scientists) stress the cultural uniqueness of these syndromes and insist that they can or should be considered only within their own sociocultural context (36). Others (usually clinicians) argue that we can learn by studying and comparing the biopsychosociocultural concomitants of these disorders wherever they occur (28). This controversy appears to be related to the research methods at the command of the various investigators. Some social scientists object to psychological or biophysiological approaches that point up similarities among these and other disorders, whereas physiologists, psychiatrists, and psychologists do use these research approaches.

### *Emic and Etic Perspectives*

The terms "emic" and "etic" have been borrowed from the linguistic concepts "phonemic" and "phonetic." Emic refers to socially unique, intracultural perspectives, such as *susto* or "the fallen fontanel syndrome" among Mexicans. Etic refers to universal, cross-cultural concepts such as febrile dehydration or hypertrophic pyloric stenosis that can occur in any cultural group (and which, for example, could account for *susto* in an infant). Cross-cultural diagnosis (an etic activity) and so-called culture bound syndromes (supposedly emic phenomena) are closely tied to the emic-etic concept.

Psychiatric diagnosis has involved methods and classification systems that basically are etic, even though certain emic considerations (such as the content of delusions) must be considered. Even psychometrics (such as the MMPI) and self-rating scales (such as the Zung Self-Rating Depression Scale) have been translated into numerous languages and restandardized using the original concepts and symptoms. Concepts reflected in such tests and scales may be culture bound so that, even with a grammatically accurate translation, the translated instrument may not be strictly comparable to the original. Symptoms may also be differently attended to or reported among various cultures. A large and growing literature does indicate the utility of these instruments across cultures, but with enough minor variability so that small differences observed between two cultural groups may be due to the instrument and not to true cultural differences (37–39). Use of the Hamilton Rating Scale for Depression in Italy has demonstrated that scales rated by psychiatrists may have very high intercultural validity (40). Thus the diagnostic issue may not be "emic *or* etic?" but rather "to what extent emic *and* to what extent etic?" Stated differently, to what extent do depressed patients from various cultures express symptoms differently, and to what extent do psychiatrists from different cultures recognize the same depressive syndrome?

Recently, attempts have been made to develop emic rating scales for depression among Vietnamese refugees in the United States (41) and for somatic complaints among Nigerians (42). Creation of such scales may contribute to our better understanding of the way such disorders are reported and/or perceived across cultures. Some investigators believe that an etic version of depression across cultures has not been demonstrated (43). So far, it has not yet been demonstrated that emic depression scales have an inherent advantage over well-translated etic depression scales for either clinical or research purposes, although such research is currently underway. It will also be of interest to assess versions of such emic scales translated into other languages, since they hinge mostly on experiences, symptoms, feeling states, and attitudes that are more universally human than specific to only one culture.

### *Differential Reporting of Symptoms and Expression of Signs*

There is considerable overlap among ethnic groups with regard to presenting symptoms. For example, in a Connecticut patient registry, sleeping problems and eating problems were the first and second most common symptoms among white, black, and Puerto Rican patients (44). In addition, the next three most frequent symptoms (other physical problems, suicidal thoughts, and relationship disturbance with a child) were reported in the three ethnic groups, but with different relative frequencies. Thus, the similarities were impressive, but there were evident differences as well.

Leff (45) demonstrated a highly significant difference with regard to terms differentiating affect between six Indo-European languages and two non-Indo-European languages. He reports that the Indo-European patients showed greater affective differentiation than did the others. His findings probably relate to the fact that he chose symptoms such as "anxiety" and "irritability" that are more elaborated in the Indo-European languages, while he ignored affective concepts such as those involving degrees of sadness, loss, and frustration that are better developed in other languages. Despite my quibble (because of my familiarity with the Lao and Hmong languages), Leff has shown that languages do differentially favor this or that affective expression—a valuable contribution.

Cultural differentiation extends to the expression of affect in facial display (physiognomy) (46, 47). Within cultures, affect can be discerned with a high degree of interrater reliability, and this reliability persists to a considerable extent across cultures. However, at least one study indicates that strong emotion is modulated or expressed differently among Japanese than among Americans (48).

The endocrine, physiognomic, and central nervous systems make up the biological infrastructure for affective, behavioral, and cognitive functions. Little research attention has been devoted to this axis across cultures. However, the biological infrastructure may be a factor influencing cultural differences. Sociocultural factors can indeed lead to malnutrition and growth failure (49), and even neonates can demonstrate differences in behavior across ethnic and cultural boundaries (50, 51). Adult disorders with uneven geographic distribution (e.g., cerebral malaria, filariasis) can produce organic brain disorder (52). Thus, there may be culturally or geographically determined biological differences that influence the expression of signs or symptoms.

Despite these cultural differences in signs and symptoms, similarities exist as well. Orley and Wing (53) found a level of symptoms in African villages that was twice as high as the level in London, but the actual morbidity rates did not vary so greatly. Marks (54) observed that African and English university students had similar prevalence rates for psychiatric morbidity.

Thus far, few cross-cultural data exist regarding child psychiatric patients. Available clinical data suggest that cultural factors may account for greater differences among child than among adult psychiatric patients (55).

## EVALUATION OF CROSS-CULTURAL DIAGNOSIS

Interrater reliability is an important means for evaluating cross-cultural diagnosis. However, its utility is limited to a single event in time: the ability of two diagnosticians to agree with each other. A more important characteristic of cross-cultural diagnosis is validity. The latter depends on observing the course and the effects of treatment over time. Reliability often accompanies validity, but the reverse is not always true. Thus, we cannot rest content on establishing the reliability of cross-cultural diagnosis; validity must also be demonstrated.

### *Diagnostic Reliability*

Concerns about diagnostic reliability in psychiatry (i.e., the probability that two clinicians will agree with each other's diagnosis) go back more than half a century (56). Much work on reliability of psychiatric diagnosis was done during the 1940s and 1950s (57–60), but it was not until the late 1960s and early 1970s that quantitative measurement of diagnostic reliability became available with the kappa statistic (61–64). Perfect kappa agreement is 1.0 and random agreement is 0.0. The kappa scoring method usually measures only one category at a time, such as "schizophrenia" and "not schizophrenia," although more categories can be compared. For more robust and consistent results in using the kappa statistic, about half the cases should belong to the diagnostic group under consideration (59).

Application of the kappa statistic to psychiatric diagnosis has demonstrated that psychiatrists agree with each other about as often as electrocardiographers agree regarding abnormal ECGs or radiologists agree on abnormal intravenous pyelograms. Diagnostic reliability among psychiatrists is high for organic psychiatric syndromes ($\kappa$=.7–.8), intermediate for schizophrenia ($\kappa$=.5–.6), and low for depression and affective disorder ($\kappa$=.3–.4) (65). These interrater reliability scores can be improved considerably by using specific diagnostic criteria (66), but this results in a number of undiagnosed cases (67, 68). Discordant rating is greatest for cases in which the symptoms and signs cut across diagnostic categories, such as an admixture of schizophrenic findings with depression (69, 70).

Soon after the development of the kappa statistic, comparisons of cross-cultural diagnosis began to appear. Numerous methods have been used, including actual interviews of the patients (71), films and videotapes of patient interviews (37, 72), and written case reports (70). Interestingly, regardless of method, these cross-cultural studies have given kappa scores comparable to intracultural reliability scores.

The first studies of cross-cultural psychiatric diagnosis involved comparisons between English and American psychiatrists (71, 73–75). Greater international representation appeared in later studies, with Japan, Sweden, and other countries represented (76, 77). Later, similar studies were conducted under the aegis of the World Health Organization (24, 78). These studies showed certain diagnostic biases, such as the tendency for American psychiatrists to diagnose schizophrenia in cases that psychiatrists elsewhere recognized as affective or brief reactive psychosis (6). Psychiatrists from industrialized countries did well in their interrater scores with patients from nine industrialized societies, but they had poorer reliability scores with patients from four developing countries. Psychiatrists from the developing countries did well with patients from both developing and industrialized countries, probably because they had experience with patients from both types of societies as a result of their having trained in industrialized countries (72).

In line with these data, clinicians in one cross-cultural study (70) had the highest confidence in their organic diagnoses, intermediate confidence in diagnoses of schizophrenia, and low confidence in diagnoses of affective psychosis.

### *Diagnostic Validity*

Cross-cultural diagnosis can be assessed by observing treatment variables. A pilot study of 15 Hmong refugee patients in the United States was undertaken for this purpose (79). All 15 outpatients had major depression according to *DSM-III* criteria, including six with simple depression, four with melancholic depres-

sion, and five with psychotic depression. Those patients with simple depression were treated over an average of 2.8 visits and none received pharmacotherapy. Melancholic patients had a mean of 6.0 visits, and all received tricyclic antidepressants. Psychotic depressed patients made 9.8 visits on the average, and combined tricyclic-neuroleptic therapy was prescribed in all cases.

Validity of diagnosis can also be assessed by studying outcome. It has been suggested that episodic heavy alcohol consumption, or binge drinking, among American Indians does not constitute actual alcoholism. However, a 10-year follow-up study of 45 American Indian subjects demonstrated outcomes similar to those of alcoholic populations rather than those of normal populations (80). There was a high mortality from alcohol-related causes, especially among younger subjects (N=9, 20%), and those with continued heavy drinking had deteriorated in health and/or social status (N=19, 42%). Those who were improved in health and/or social status (N=7, 16%) had been abstinent from alcohol for periods of 3 to 10 years (their mean abstinence in the past decade was 72 months). These data indicate that the cross-cultural diagnosis of alcoholism in this sample was a valid one.

Another potential means for assessing diagnostic validity would be to measure treatment response vis-à-vis drug dose and blood level of medication. However, limited work to date reveals that the ratio of oral dose to blood level is quite inconsistent from one cultural group to another (81). Therapeutic dose levels and even EEG responses to dose levels also show much variability across cultures (82). The meaning of these data is not clear. Are there racial or nutritional factors that modify drug responsiveness? Or are there psychosocial factors that facilitate therapeutic response at lower tissue levels? Are both types of factors operative? Are there yet other explanations?

## CURRENT AND FUTURE RESEARCH ISSUES

### *Cultural Bias of the Researcher*

Cultural bias can quietly invade the thinking of even the most objective empiricist. A renowned example is the nineteenth-century physician, Morton, who measured aboriginal skulls in North America (83). His own published quantitative data show no significant differences in the cranial capacity among races, but on the basis of his apparently unconscious finagling of the data analysis, he erroneously concluded that Euroamericans have greater cranial capacity than do Native Americans.

If this type of bias can infiltrate even measurement of the cranium, we must be ever vigilant against its incursion into psychiatric research. Of course, it is not always a simple matter to discern bias. Recently, a reviewer for research grants indicated that I had introduced a cultural bias into translation of the Zung Self-Rating Depression Scale. After lengthy discussion with Hmong co-investigators and a pilot study, we had decided that the translation of an item on sexual function was insulting and hence unacceptable to Hmong currently without a sex partner. In order to devise a culturally sensitive item that still tapped into this important topical area, we created two questions for this one item: one for those with and one for those without sexual partners. We believed our translation was culture fair and reduced test bias, and our reviewer believed the opposite.

### *Folk Diagnosis Versus Psychiatric Diagnosis*

Several investigators have observed the overlap between folk categories and psychiatric categories. Such diagnostic categories include mental retardation, epilepsy, neurosis, and psychosis (84–89).

At least one reliability study of two major categories (psychosis and neurosis) showed good agreement between some psychiatrists and folk diagnosticians. Two "culturally naive" clinicians (i.e., not familiar with the culture studied) had low kappa scores of .21 and .52 when their clinical diagnoses were compared with local folk diagnoses. Three "culturally experienced" clinicians (i.e., familiar with the culture area of the subjects) had high kappa scores of .63, .63, and .68 when their diagnoses were compared with the local folk diagnoses (90).

### *Intelligence Testing for Mental Retardation*

Diagnosis of moderate or severe mental retardation across cultural and/or linguistic boundaries poses little challenge to the experienced clinician with a modicum of cultural sensitivity. This is not true with mild and borderline cases of retardation, however. I have encountered foreign-born and American Indian individuals of average to low-average intelligence who have been labeled as mentally retarded by psychologists and educators using tests standardized to middle-class, English-speaking Euroamericans. And, conversely, I have encountered several Indochinese patients with borderline, mild, and moderate retardation who had been placed in educational settings well beyond their abilities when intelligence testing was not undertaken. These misplaced students were then subsequently referred to me for conduct disorders in the classroom, depression, and/or academic underachievement. Consequently, cross-cultural intelligence testing is increasingly important for prevention as well as assessment of mental disorders.

Unfortunately, intelligence has been reified, perhaps even deified, as a concrete entity, rather than viewed as a conceptual entity with strong cultural aspects. New thought on this subject may help to dissipate old notions (91, 92). At this point it seems clear that intelligence testing across cultural boundaries is a highly specialized task that should be conducted by a trained, experienced cultural psychologist.

*Cross-Cultural Personality Assessment*

Anyone who has plunged into another language, culture, and social network has recognized the full gamut of personality types manifest in the new culture. To be sure, at first blush the entire culture may appear more laden with one or another overdetermined personality type. But as the cultural scales drop from the voyager's eyes, the similarities in personality types across cultures are remarkable. These differences and similarities are well known to students of cross-cultural testing (93, 94).

Cross-cultural personality assessment in the clinical context is another matter, however. Even intracultural personality assessment in clinical settings is difficult. In the midst of crisis or acute psychiatric symptoms, manifestations of personality disorder often emerge only to disappear again as the distress recedes. Add to this such factors as the foreign patient in a strange cultural milieu, unfamiliar with psychiatric procedures, or the clinician unfamiliar with a minority group, and it is easy to perceive the difficulties involved.

My own practice is to remain desultory in appending a personality label across cultural boundaries in clinical settings. This is not an adequate solution to this difficult problem, however. One hopes that the increasing cross-cultural research into personality assessment will contribute to our knowledge in this area.

*Changes Over Time*

Unlike the chemistry of neurotransmitters, the pharmacology of psychoactive drugs, and the anatomy of the limbic system, cultures can and sometimes do change rapidly. The notion of an entirely uniform, traditional, and unchanging culture can exist only in the mind of the observer; it does not exist in the real world. This constant feature of cultures creates mischief for students of psychopathology across cultures.

Further problems relate to the fact that, on the basis of reports over the last century, psychopathology also changes. As Prince (95) has pointed out, the cause of this change is not obvious. Is it due to modifications in our diagnostic fashions? Or to several factors, such as increased education or decreased religiosity? Or to cultural factors? Or is it due to the changing functions of psychiatry in society (i.e., less involvement with social control and more involvement with treatment)? Or do we now diagnose more of certain disorders, such as depression, because there are more beneficial things that we can do for these conditions? Perhaps many or all of these elements may contribute to the observed changes.

## DISCUSSION

Clinical diagnosis has long had two fundamental purposes for the art of medicine, both of them practical rather than theoretical or abstract. The first of these is the setting of a prognosis. Even in classical Greek and Roman times, before powerful treatment methods were available, skilled clinicians were consulted for their prognostic skills. The second purpose involves selecting a treatment. Especially as more specific therapies have become available, at times expensive or risky or difficult to apply, the need for accurate diagnosis-making has increased.

Diagnosis-making has come to have greater scientific importance, especially for psychiatry. When little is known about the prognosis or treatment of a symptom or syndrome, diagnostic categorization becomes a serious investigative method. To be sure, it is at the most primitive level of science, a first-phase endeavor to be followed later by comparative studies, treatment outcome studies, epidemiology, research into etiology, and so forth. Primitive though it is, however, diagnostic classification is a key step in pursuing epidemiological distribution, possible etiological factors, and description of pathological process, with the goal of being able ultimately to set accurate prognosis and select effective treatment. Cross-cultural diagnosis has not presented great difficulties for biopathological processes (e.g., rheumatic fever, cervical cancer, diphtheria). However, cross-cultural diagnosis of psychopathological processes has created dilemmas for psychiatry.

Only recently has cross-cultural psychiatric diagnosis begun to be practical for clinical service and research. In the early days of this century, students of psychiatric diagnosis despaired even about intracultural diagnosis. Writing in 1904, Kraepelin observed that "our clinical concepts vary so widely that for the forseeable future such comparison is possible only if the observations are made by one and the same observer" (96). It was another half century before Galdston, in 1957, was able to write about the existence of "a national psychiatry," yet he still emphasized that there was not yet an international psychiatry in the same sense that there was an international surgery (97). As outlined in this paper, national diagnostic preferences still continue. Greater consensus in international diagnostic practice is underway. The World Health Organization has greatly facilitated this process.

Why should we be concerned about the reliability of psychiatric diagnosis across national and cultural boundaries? One reason is that clinicians are called on more often to diagnose and treat people from other cultures. Tourism, education abroad, economic migration, and refugee movements have greatly increased in the last few decades. Return to the home country for psychiatric care may not be desirable or even feasible. Psychiatrists today must be prepared for this eventuality.

A second reason concerns more the science than the art of psychiatry. Surawicz and Sandifer (37) described this problem as follows: "A report on the effectiveness of drug A on psychosis B in country C will be more

meaningful to a psychiatrist if psychosis B is identical with B in his country." Of course the argument is applicable not only to psychopharmacology but also to etiology, epidemiology, prevention, and other forms of treatment. Much psychiatric research is difficult, time consuming, and expensive. No country can afford to ignore psychiatric knowledge gleaned elsewhere.

Currently our training programs and much of our clinical practice lag far behind the cross-cultural research findings and demonstrated diagnostic techniques. Over the remaining years of this century, the cross-cultural tasks facing psychiatrists will be challenging ones. Their solution will contribute not only to care of patients across cultural boundaries but to theoretical issues in the field of psychiatry at large.

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# REFUGEE SOCIAL ADJUSTMENT PROGRAM

## QUARTERLY PROGRESS REPORT

## JANUARY 1, 1985 - MARCH 30, 1985

(1) Casework Services

| | Carried Over From 1984 | New Cases for January 1 - March 30, 1985 | Unduplicated Total Clients Served |
|---|---|---|---|
| Hmong/Lao | 108 | 23 | 131 |
| Cambodian | 88 | 32 | 119 |
| Vietnamese | 28 | 6 | 34 |
| Total | 224 | 61 | 284 |

A total of 284 unduplicated clients were served in this quarter. In the past quarter a number of requests have been received to provide service to refugees from countries other than South East Asian. Some consultation and/or referral was provided in every case. An attempt is being made for non-southeast Asian refugees who speak some English to be served by the social worker on the program staff.

(2) Identification of Natural Helpers Linked With Cases

Out of 60 new clients for the first quarter 49 natural helpers linked with cases were identified. Documentation of their natural helping activity is attached in Appendix B.

(3) Training Sessions For Natural Helpers

One two-hour discussion/consultation group was conducted for 6 Hmong natural helpers. A brief summary of their background and notes from

discussion are attached in Appendix D.

(4) No training sessions were provided for bilingual workers in this quarter.

(5) One training session in cross-cultural issues/counseling was conducted for ten western social service providers.

(6) One East Metro Social Adjustment/Mental Health Coordination meeting was conducted in this quarter. The focus of the meeting was coordinating existing refugee resources with the services being provided by St. Paul Public Schools. Notes of this meeting are attached in Appendix C. Four coordination meetings were held with staff of Community University Health Care Center along with several telephone contacts. Four coordination meetings were conducted with staff of American Refugee Committee. The program director attended monthly Metro Health Task Force meetings.

(7) Community Based Support Groups -

Two Hmong groups and one Cambodian group are being led by program staff. The Cambodian Women's Group meets at Roosevelt Housing Project with nine women who have attended five sessions so far. The Hmong Women's Group with an average of six women, has met seven times so far. The Hmong Men's Group, with five members, has met once this quarter.

(8) Evaluation

Post tests were given in the months of January, February and March, 1985, after six months of service to clients who were referred in July, August

and September of 1984. Though evaluation activity has created additional workload including extensive paper work for staff, post tests are being completed with minimal difficulty.

Some Highlights

- An additional half-time Cambodian staff person was hired to meet the growing need in the Cambodian Community.

- An M.S.W. social worker continues to work part-time with the program providing case supervision and jointly working with bilingual workers on some difficult cases.

- The consulting psychologist and psychiatrist continue to provide biweekly consultation to staff on cases and offer inservices along with some direct service.

- In this quarter bilingual workers attended workshops on family counseling, crisis intervention and staff burnout.

- Asian Business News reported on Social Adjustment Program in their March 1985 issue. This also generated a number of referrals.

- A brief description of the program was reported in the annual report of the Wilder Foundation.

WILDER SOCIAL ADJUSTMENT PROJECT FOR REFUGEES
SUMMARY OF CLIENT INFORMATION
PERIOD JANUARY 1, 1985 - MARCH 31, 1985

CAMBODIANS

| AGE | SEX | MARITAL STATUS | NO. OF CHILDREN | NO. IN HOUSEHOLD | INCOME INFO. | PRESENTING PROBLEM |
|---|---|---|---|---|---|---|
| 47 | F | Married | 3 | 6 | 9000 | New arrival in U.S.; job and financial stresses; medical problem and no medical insurance; depressed; lack of cultural orientation |
| 42 | M | Separated | 0 | 1 | 7000 | Marital and parenting problems; wife depressed; in auto accident with resulting injuries and death of nephew; needed legal assistance |
| 63 | M | Married | 2 | 4 | 9000 | Marital problems; feels inferior, apathetic, ashamed; some role reversal as wife many years younger; sponsor's controlling his family's life closely; housing problem |
| 60 | M | Separated | 0 | 1 | 3000 | Wife deserted him; depressed, lonely |
| 37 | M | Married | 3 | 6 | 9000 | Lack of orientation to U.S.; depressed; loss of status as so far unable to support his family after trying; financial stresses |
| 17 | F | Single | 0 | 7 | 10000 | Verbal, physical and emotional abuse by foster parents |
| 45 | F | Widowed | 4 | 5 | 8000 | Widow; suffered many losses in Cambodia; son just killed in automobile accident in U.S. |
| 23 | F | Married | 4 | 6 | 8000 | Lack of orientation to U.S.; isolated; depressed; lonely as missing family and community |
| 29 | M | Married | 4 | 6 | 8000 | Lack of orientation to U.S.; isolated, depressed; lonely and missing family and community |

CAMBODIANS (CONTINUED)

| AGE | SEX | MARITAL STATUS | NO. OF CHILDREN | NO. IN HOUSEHOLD | INCOME INFO. | PRESENTING PROBLEM |
|---|---|---|---|---|---|---|
| 29 | F | Married | 2 | 4 | 7000 | Marital problem; physical, emotional and verbal abuse by spouse thirty-four years older |
| 31 | F | Separated | 5 | 6 | 8000 | Worried, depressed. Has high blood pressure. Marital problems as spouse behaving independently, privately |
| 27 | F | Married | 3 | 5 | 12000 | Physically, emotionally and verbally abused by spouse for long time; wants to change life. Depressed, hopeless |
| 58 | F | Married | 3 | 5 | 8000 | Has serious asthmatic condition; feels hopeless about help from Western culture; waiting to die; physically weak and confined to bed |
| 32 | M | Married | 4 | 6 | 8000 | Lack of orientation to U.S. culture; depressed; housing proble |
| 30 | M | Single | 0 | 3 | 1000 | Lack of orientation to U.S. culture, lonely, isolated, worried and depressed. Needs help plannin for the future |
| 31 | M | Married | 3 | 5 | 12000 | Marital problems, worried, depressed. Needs help with legal aid and needs social support |
| 17 | F | Separated | 2 | 3 | 5000 | Physically abused by spouse; spouse deserted when she called police. Needs culture, orientatio to U.S. and help planning for future life |
| 57 | F | Widowed | 2 | 3 | 6000 | Conflict with children and neighbors. Depressed and suicidal |
| 20 | F | Single | 0 | 1 | 4000 | Conflicts at work with supervisor and colleagues. Problem with boyfriend. Relationship problems with family members |

CAMBODIANS (CONTINUED)

| AGE | SEX | MARITAL STATUS | NO. OF CHILDREN | NO. IN. HOUSEHOLD | INCOME INFO. | PRESENTING PROBLEM |
|---|---|---|---|---|---|---|
| 67 | F | Married | 1 | 3 | 8000 | Depressed. Lost six children in Cambodia and separated from three who are in refugee camp |
| 8 | F | Single | 0 | 7 | 8000 | Stealing and lying behaviors. Feels insecure in her family. Needs eyeglasses |
| 47 | F | Married | 0 | 2 | 2000 | Pressure from and conflicts between her and her sponsor. Long separation from sister and brother. Ten children missing in Cambodia |
| 37 | F | Widowed | 2 | 3 | 4000 | Widow with two children; family conflicts; isolated; depressed |
| 18 | M | Single | 0 | 1 | 2000 | Conflict with his mother |
| 43 | F | Married | 4 | 7 | 8000 | Marital problems; conflicts with children |
| 55 | M | Married | 0 | 2 | 2000 | Financial aid problems; misunderstandings and arguments with agency personnel. Sadness and frustration about sister in refugee camp. Ten children missing in Cambodia |
| 36 | M | Married | 4 | 6 | 9000 | Prohibiting wife from having an abortion. Depressed. He has throat cancer. Cannot work |
| 24 | F | Single | 0 | 1 | 3000 | Suicide attempt. Hospitalized. Husband abandoned her to live with other woman. Feels ashamed with other Cambodians |
| 46 | M | Married | 5 | 7 | 9000 | Newly arrived; needs cultural orientation. Problems with AFDC and Child Protection (neglect |
| 56 | M | Married | 3 | 4 | 5000 | Alcohol abuse; marital problem (abuses wife). Depressed. Loss of status. Illiterate, unemployed hopeless. |

CAMBODIANS (CONTINUED)

| AGE | SEX | MARITAL STATUS | NO. OF CHILDREN | NO. IN HOUSEHOLD | INCOME INFO. | PRESENTING PROBLEM |
|---|---|---|---|---|---|---|
| 27 | F | Separated | 4 | 5 | 9000 | Depressed, worried. Fainting, dizzy. Marital conflicts |
| 50 | F | Widowed | 4 | 5 | 8000 | Needs orientation to new city child paralyzed from polio - worry. Crowded housing |
| | | | | VIETNAMESE | | |
| 24 | F | Married | 2 | 5 | 0000 | Physically and sexually abused by her husband (not legally married); wanted to separate from him with their two daughters; needs ESL instruction |
| 39 | F | Married | 3 | 5 | 0000 | Physically abused by her spouse who is alcoholic; needs ESL instruction and help with child care |
| 35 | M | Married | 2 | 5 | .0000 | Physically and sexually abusing his wife (not legally married); wanting to evict his wife's two brothers who live with them |
| 39 | M | Married | 3 | 5 | 8000 | Alcoholism; physically abusing his wife; living at his place of employment as his wife will not allow him back home |
| 13 | M | Single | 0 | 2 | 0000 | Using drugs and is truant from school |
| 55 | M | Married | 1 | 2 | 9000 | Single parent; son is using drugs and is truant from school; wife and six children are still in Vietnam |

HMONG

| AGE | SEX | MARITAL STATUS | NO. OF CHILDREN | NO. IN HOUSEHOLD | INCOME INFO. | PRESENTING PROBLEM |
|---|---|---|---|---|---|---|
| 16 | F | Single | 3 | 6 | 3000 | No close family with her - lonely isolated. Depressed - with suicidal thoughts. Other Hmong family making accusations about her family still in Laos |
| 39 | M | Married | 3 | 5 | 11000 | Employment related injury - broken bone in his back. Cannot work. Sued employer as not paying medica bills. Depressed |
| 31 | M | Married | 5 | 7 | 9000 | Father-in-law recently died; feels guilty. Depressed. Infant son is ill - he is worried. Difficulty adjusting to the new culture. Parents and siblings still in Thai camp |
| 53 | M | Married | 4 | 6 | 4000 | Alcohol abuse. Memory problems. Visual problems. Unable to work. Family problems |
| 51 | F | Married | 3 | 7 | 4000 | Recently moved to MN (fourth move since arriving in U.S.). Husband abuses alcohol. Has memory and visual problems - cannot work. She is main provider for the family. Depressed |
| 43 | M | Married | 4 | 6 | 5600 | Hearing impairment - occasional loud ear ringing and pain in ears. No medical findings. Has been unable to learn English. Depressec frustrated |
| 52 | M | Married | 0 | 2 | 3000 | Rash on legs; fears venereal diseas Marital problems. Depressed, hope-less |
| 65 | F | Widowed | 0 | 1 | 3648 | Very sad. Son passed away. She and her daughter-in-law did not get along. She moved out and stayed with her daughter and son-in-law. They already had 13 people in the household. Missed the grandchildren a lot but daughter-in-law forbids her to see them. |

HMONG (CONTINUED)

| AGE | SEX | MARITAL STATUS | NO. OF CHILDREN | NO. IN HOUSEHOLD | INCOME INFO. | PRESENTING PROBLEM |
|---|---|---|---|---|---|---|
| 76 | F | Widowed | 0 | 13 | 3900 | Had been in an auto accident recently and was afraid to ride again |
| 12 | F | Single | 0 | 9 | 11124 | Long term hospitalization for encephalitis; problems with aggressive behaviors since dischar |
| 31 | F | Widowed | 2 | 2 | 5124 | Believed she had V.D. but no medic proof. Also very depressed, hopeless, and uninterested to do anything because medical profession couldn't help cure the V.D. |
| 21 | F | Separated | 4 | 5 | 7332 | Husband deserted; now living alone with her 4 children. Some support from husband's relatives, but no relatives of her own. Baby is unhealthy but no transportation to get to hospital |
| 23 | F | Married | 4 | 6 | 7200 | Suspected physical abuse by her husband, but denied. Depressed, sad, and hopeless. Children are very ill but husband doesn't help take them to see a doctor. She takes care of everything. |
| 24 | F | Married | 4 | 6 | 9096 | Recently came from Thailand, isolated, because husband attends VoTech School full time. Would like to attned E.S.L. class but has problem with baby sitter and also is pregnant. Youngest child is obese; also has T.B. and is on medication |
| 25 | F | Married | 2 | 4 | 6000 | Isolated; husband works all day and goes to school at night. Home alone with 2 small children. Would like to attend school, but problem with baby sitter |

HMONG (CONTINUED)

| AGE | SEX | MARITAL STATUS | NO. OF CHILDREN | NO. IN HOUSEHOLD | INCOME INFO. | PRESENTING PROBLEM |
|---|---|---|---|---|---|---|
| 44 | F | Married | 0 | 2 | 8536 | Visually handicapped; needs support from other blind persons |
| 8 | F | Single | 0 | 7 | 12000 | Mute at school except with peers; talks to parents but not relation |
| 40 | F | Married | 5 | 8 | 12888 | Very depressed, cries all the tim when thinking of 18 year old son who went to live with an American lady who already has grown up children |
| 12 | M | Single | 0 | 9 | 4800 | No control over him. Plays video games a lot. Doesn't listen to anyone, doesn't go to school. Ha hearing impairment and needs glas |
| 41 | M | Married | 4 | 6 | 9000 | Family problems - father left former clan to start new one; arguments with younger brother. Depressed |
| 33 | M | Separated | 0 | 1 | 2000 | Legal problem - shot a police officer. Medical problem - shot by policeman. Stole his father's car; ongoing disagreements with his father. Wife and children left him. Depressed |
| 7 | F | Single | 0 | 9 | 4800 | Oldest brother parenting her; she does not do her homework |
| 30 | F | Married | 4 | 6 | 7500 | Recently came to this country, no resourses. Needs help to adjust to this country. Blind and also needs help to apply for Social Security |

## IDENTIFIED NATURAL HELPERS LINKED WITH CASES

| | Ethnicity | Age | Relationship | Type of Help Given |
|---|---|---|---|---|
| 1. | Vietnamese | 23 | Friend | Gives advice, encouragement, and emotional support |
| 2. | Vietnamese | 35 | Friend | Gives emotional and moral support. Makes visits to her home |
| 3. | Vietnamese | 22 | Friend | Socialize together; provides encouragement and advice; visits at home |
| 4. | Vietnamese | 38 | Friend | Advises about how to get along with friends at school, to attend school regularly, and about acceptab behavior |
| 5. | Vietnamese | 38 | Friend | Socialize together; provides encouragement and moral support. Provides transportation and financia support |
| 6. | Cambodian | 47 | Cousin | Provides emotional support. Orients to resources |
| 7. | Cambodian | 34 | Friend | Helps locate resources; orients to new culture; provides transportation |
| 8. | Cambodian | 32 | Friend | Provides emotional support; helps locate needed resources |
| 9. | Cambodian | 47 | Cousin | Provides emotional support. Orients to resources |
| 10. | Cambodian | 34 | Friend | Helps locate resources; orients to new culture; provides transportation |
| 11. | Cambodian | 30 | Friend | Orients to new culture and ways of life in U.S.; helps locate resources |
| 12. | Cambodian | 30 | Sister-in-law | Provides transportation, helps locate resources needed |
| 13 | Cambodian | 35 | Friend | Helps as a sponsor - finds food, shelter, clothing and resources as needed |
| 14. | Cambodian | 36 | Friend | Helps as a sponsor - finds food, clothing, shelter and resources as needed |

| | Ethnicity | Age | Relationship | Type of Help Given |
|---|---|---|---|---|
| 15. | Cambodian | 31 | Monk | Orients to American culture. Provides emotional support and shares similar past experiences |
| 16. | Cambodian | 35 | Friend | Helps as a sponsor - finds food. shelter, clothing and resources as needed |
| 17. | Cambodian | 32 | Sister-in-law | Provides emotional support; orients to American culture |
| 18. | Cambodian | 34 | Friend | Helps as a sponsor - finds food, shelter, clothing and resources as needed |
| 19. | Cambodian | 25 | Friend | Provides transportation; helps with social service problems |
| 20. | Cambodian | 38 | Brother-in-law | Provides some financial help, transportation, translation, help with school problems, and family advising |
| 21. | Cambodian | 26 | Cousin | Provides transportation, school advice, and job-seeking orientation |
| 22. | Cambodian | 25 | Friend | Provides transportation; helps with social service problems |
| 23. | Cmabodian | 37 | Foster son | Advises about family problems; provides financial help, bicultural orientation, and help with resettlement problems |
| 24. | Cambodian | 38 | Son-in-law | Provides some financial help, transportation, and help with family problems |
| 25. | Cambodian | 38 | Brother-in-law | Provides some financial help, transportation, and help with family problems |
| 26. | Cambodian | 40 | Daughter | Provides housing, financial help, food, clothing, orientation to U.S. culture, and transportation |
| 27. | Cambodian | 26 | Second cousin | Helps with school problems; advises about parent-child problems; provides transportation; helps locate communit resources as needed |

| | Ethnicity | Age | Relationship | Type of Help Given |
|---|---|---|---|---|
| 28. | Cambodian | 37 | Foster Son | Advises about family problems; provides financial help. bicultural orientation, and help with resettlement problems |
| 29. | Cambodian | 25 | Friend | Provides transporation; helps with social service problems, provides some advice about family problems |
| 30. | Cambodian | 32 | Friend | Provides housing, job-seeking orientation, bicultural orientation and help locating needed community resources |
| 31. | Hmong | 28 | Son-in-law | Provides shelter. Takes care of daily needs. |
| 32. | Hmong | 40 | Son | Provides transportation |
| 33. | Hmong | 28 | Grandson | Provides shelter. Takes care of daily needs |
| 34. | Hmong | 43 | Uncle | Advocates with community service providers |
| 35. | Hmong | 50 | Mother-in-law | Helps with child care |
| 36. | Hmong | 52 | Mother-in-law | Helps with child care |
| 37. | Hmong | 30 | Mother-in-law | Helps with child care |
| 38. | Hmong | 30 | Son | Provides shelter and daily needs |
| 39. | Hmong | 30 | Friend | Provides emotional support and friendship |
| 40. | Hmong | 25 | Brother-in-law | Provides transportation, interpreter, and gets help from resources |
| 41. | Hmong | 36 | Brother | Helped find housing; helps with public assistance problems; social adjustment and orientation to new culture |
| 42. | Hmong | 35 | Cousin | Provides transportation; helped enroll him in school; helps buy food sometimes; takes him to church |
| 43. | Hmong | 30 | Aunt | Helps with everything parent would do (meets physical, social and emotional needs) |

| | Ethnicity | Age | Relationship | Type of Help Given |
|---|---|---|---|---|
| 44. | Hmong | 35 | Cousin | Translates; counsels the family; helped with school enrollment; sponsored him and his family |
| 45. | Hmong | 30 | Son | Sponsored his family - helps family get settled in new culture |
| 46. | Hmong | 34 | Brother | Translates; helped enroll in school orient to new culture and help locating resources as needed. Located housing |
| 47. | Hmong | 32 | Brother-in-law | Helps locate housing, clothing, enroll in school, with translation and finds resources |
| 48. | Hmong | 33 | Nephew | Provides transporation, shelter, food, clothing |
| 49. | Hmong | 30 | Niece | Helps translate, find housing; provides food, transportation, and counseling |

March 22, 1985

Natural Helper Meeing

Led by Geu Vu

Present:

1. Cheng Thao
2. Pao C. Yang
3. Kao Yang
4. Moua Lee
5. Yang Yang
6. Lo Yang

After presenting what was on the agenda, Geu Vu added that the Hmong workers who work at different refugee agencies should cooperate with one another in terms of spending their time outside of work to help the Hmong refugees to deal with their stress. This is because he saw that many people in the Hmong community were so lonely and so depressed. They need some encouragement from those who are better-off and who have already been able to adjust to the new life in this country. He used a few examples of people who he has worked with that have mental health and emotional problems. He said these people need to be cared for by someone. As a refugee worker, he said that these special services are not needed only by the elders, but by the younger person as well. It is sometimes so difficult for some of these kids to cope with the situation of coming to this country alone. Many of them are here without parents and close relatives. They need someone to talk with.

Discussion suggested that there are three types of people in the refugee community. The first type is the older generation. This group of people are

the ones that have the most difficulty adjusting to the new life and new culture. The second group is the younger generation (children). Some of these youngsters are becoming "Americanized" so quickly. They forget their Hmong culture while trying to assimilate to the new culture, which sometimes creates a struggle between them and their parents. And finally the "middle generation. These are the young-old people, like those who can see and communicate with both sides, either between the younger and older generations or between Hmong and Americans. They are people who are bridging the gaps. Therefore, Geu Vu and others suggested that these people need to be a "model or example for the new generation to follow and to keep.

Geu Vu then added that some refugees complained about agencies which don't provide adequate services for them. The discussion centered around heavy workloads and not being able to meet community's demands and resulting in some criticism. He also said that, because confidentiality is important, a person who works with another person needs to learn to keep the other's information confidential.

There was a long discussion based on everyone's experience and opinions. The group brought up a case who was arrested by the police illegally and later on found not guilty. This was just an example on how a natural helper can get involved with a case.

Moua Lee suggested that the problems he sees most are depression and loneliness. People who are better-off need to pay attention to the persons who have these problems. Many of these people are unemployed and unable to go anywhere. They feel so withdrawn and tired. Some of them just act like

crazy people. However, in order to serve the Hmong People effectively. Lee suggested that volunteers need some kind of training which provides information about how to identify and deal with the problems. Geu Vu shared with the group some of his experience working with such problems. He said he has met people who continuously cry. An elder, for example, was concerned about not being able to get out of the house. He felt so lonely. For awhile after Geu intervened with the case, he went to see this person quite often. He helped taking him to register for an English class. This person met friends in school. He now feels better and realized that someone in the world still cares about him.

Kao Yang commented that it was good to have this meeting. He said that people in the Hmong community do need our help. They are suffering from emotional problems. We need to encourage them that they are not the only persons who have such problems. As a church leader, Yang knew there is a program through the Hmong Christian Church which provides counselling. Everyone agreed that it is a good place to let people know about the program.

Cheng Thao commented that the workers at different agencies also have difficulty coping with their workload and stress. On one hand they are pressured by their supervisors and on another hand they are blamed by the refugees for not helping them adequately. So there is a dilemma between the two sides. These workers have no place to seek help and have their stress and tension released. He said it might be a good idea to have a consulting group, or a group of professional people that these paraprofessionals can go and talk to about their stress. Also it might be good if the Hmong bilingual workers can get together once in awhile to discuss about their places of work, which will help other

workers to serve the Hmong people in the community better.

The meeting was over at 7:10 P.M.

Notes compiled by Sao Yang and Geu Vu.

# Short History of Natural Helpers

March 22, 1985

Cheng Thao
- is an Indochinese refugee social worker at Ramsey County Community Human Services, Child Protection Unit
- earned a B.S. Degree in social work, University of Wisconsin
- is an important person in the Thao Group
- was one of the highly educated Hmong in Laos
- volunteers very much time to help and organize the Hmong people

Yang Yang
- is a bilingual worker at the Neighborhood Justice Center
- is a respected person in the Hmong Community
- has some familiarity with the court and legal system
- helps explain the legal system to the Hmong people
- completed high school in Laos; once was Geu Vu's classmate

Mona Lee
- is a bilingual worker at Ramsey County Community Human Services, WIN Program
- is a board member (secretary) of LFC
- helps explain the welfare rules to the people in the community a lot
- worked with the Immigration Service in Thailand and has been known by many people
- completed high school in Laos and joined the service thereafter (a radio operator for American pilots)

Pao Choua Yang
- is an employment specialist at LSS in Minneapolis. He has found a lot of jobs for the Indochinese refugees within the Twin Cities
- he is young but an intelligent person and volunteers so much time to help both the young and old
- is a church member, youth association member and an boy scount master at the Indianhead, Boy Scouts of America

Youa Kao Yang
- is a bilingual worker at the City of St. Paul Public Housing Agency
- is a church leader, and volunteers so much of his time to help the people in the community both naturally and spiritually
- was a soldier in Laos

Lo Yang
- works at Lutheran Social Service as an employment representative and is very active in the community in terms of helping his people
- has just moved from Utah not too long ago. While in Utah, he worked at LFC and helped the people there
- was another highly educated Hmong who received his education in the capitol of Laos

Mayo Clinic Data--Rochester, Minnesota

| DATE | AGE | SEX | NATIONALITY | DIAGNOSIS | REFERRAL |
|---|---|---|---|---|---|
| 7/84 | 60 | M | Hmong | Conversion reaction | St. Francis, La Crosse |
| 10/84 | 5 | M | Cambodian | Behavioral disorder | School district |
| 12/84 | 17 | M | Vietnamese | Behavioral/suicidal depression | School district |
| 12/84 | 19 | F | Vietnamese | Depression | School |
| 1/85 | 50 | F | Cambodian | Mental retardation; depression | Priority immigration |
| 1/85 | 20 | M | Cambodian | Leprosy | Priority immigration |
| 1/85 | 33 | F | Cambodian | Mental retardation; depression | Priority immigration |
| 1/85 | 40 | F | Cambodian | Mental retardation; depression | Priority immigration |
| 1/85 | 57 | M | Cambodian | Renal failure; gout | Priority immigration |
| 2/85 | 57 | M | Cambodian | Hypertension | Priority immigration |
| 2/85 | 48 | F | Cambodian | PTSS | IMAA |
| 2/85 | 1½ | M | Cambodian | VSD | Priority immigration |
| 2/85 | 50 | F | Cambodian | Breast carcinoma | Priority immigration |
| 2/85 | 20 | F | Cambodian | Suicidal/PTSS | School |
| 2/85 | 3 | M | Cambodian | Developmental delay | Sponsor |
| 2/85 | 12 | F | Cambodian | Congenital heart disease | Priority immigration |
| 2/85 | 17 | F | Cambodian | Abdominal pain | School |
| 2/85 | 51 | M | Vietnamese | Back pain/depression | Sponsor |
| 3/85 | 15 | M | Cambodian | Downs Syndrome | Priority immigration |
| 4/85 | 40 | F | Lao | ACA; cultural transition | School |
| 4/85 | 27 | F | Vietnamese | Child abuse; ? psychoses | Social Services |

| DATE | AGE | SEX | NATIONALITY | DIAGNOSIS | REFERRAL |
|---|---|---|---|---|---|
| 4/85 | 32 | F | Hmong | Tuberculosis | Priority immigration |
| 4/85 | 48 | M | Cambodian | Depression; neck pain | Sponsor |
| 4/85 | 50 | F | Cambodian | Hypertension | Sponsor |
| 5/85 | 27 | M | Cambodian | Child abuse; rule out psychosis | Social Services |
| 5/85 | 25 | F | Cambodian | Problem pregnancy | Sponsor |
| 5/85 | 15 | M | Cambodian | Learning disability | School |
| 6/85 | 32 | F | Cambodian | Child abuse | Social Services |

# NETWORK-CLAN THERAPY

Network-Clan Therapy, an adaptation of urban network therapy, provides intervention with the natural clan on behalf of a member of that clan who is in crises. Urban network therapy is based on the concept of mobilizing the family, relatives and friends into a social force that counteracts the depersonalizing trends in contemporary life patterns. When these principles are applied to natural networks such as tribal groups, you have network-clan therapy. Application of intervention with the natural multigenerational clan on behalf of dysfunctional members potentially counters one of the major difficulties with urban network therapy, the tendency for constructed therapeutic networks to dissolve a short time after intervention cases. In working with a clan the continued benefits will be more assured due to the longevity of the clan. In this regard, both the dysfunctional members and the clan are clients with the treatment goal of mobilizing the clan as a force which facilitates functional behavior among its members.

With the Southeast Asian population the primary emphasis is on mobilizing the clan network into a functional social force to counteract the depersonalizing and crippling effects of grief, loss and cultural void. Cultural void is the state of internal confusion sometimes experienced by individuals making the transition from one culture to another. Cultural void is characterized by disorientation, values conflicts, confusion, and disintegration of coping skills resulting in ineffective problem solving in any culture. In other words, one's original frame of reference is lost and has not been replaced by a new cultural frame of reference. The high incidence of depression and dysfunctional behavior among refugees appears to be closely linked to grief, loss, and cultural void issues.

The methods of implementation of treatment services will vary, depending on the client or the population receiving treatment services. Network-Clan Therapy will be the primary meeting in all cases. In general, however, Vietnamese and Cambodian clients will receive most services in the family group. Hmong clients will be served primarily through tribal groups in homes and at local MAA sites; the ethnic Lao through a combination of natural groups, and extended family work. Treatment teams will be used and work with the focus of strengthening the network-clan, and helping both the client and clan develop an effective frame of reference for problem solving with a concomitant sense of safety within the American cultural environment.

Since the therapy will focus not only on the person in crises, but also on the clan. Close consultation will be maintained with leaders in the local refugee community. Outreach and education to the refugee community will be a natural part of the therapeutic process. Working relationships already exist with local leadership (see letters of support included in attachments) and a close working relationship will be continued throughout the project.

To develop culture-specific mental health diagnostic criteria.

During the first year of the three-year project, the staff who will be responsible for this objective (Deinard, Mackenzie, Dunnigan, Westermeyer, Butcher, List, Brysky, Habenicht) will work together and in conjunction with the ORR/NIMH Technical Assistance Center (TAC) which is to be funded to provide technical assistance to the Refugee Assistance Mental Health Program. Efforts will be focused on those refugee groups who live in Minnesota: Hmong, Lao, Cambodian, Vietnamese, and Ethiopians. In addition, to the extent that it is feasible, an attempt will be made to consider directing the effort on other refugee groups identified by the TAC. Activities of the first year will consist of: 1) a detailed search of the literature to learn a) which standard U.S. psychological measures have been translated into the native languages and utilized in a cross-cultural fashion and b) whether any test materials have been developed specifically for these refugee populations and translated into the native languages. Certain measures are known (e.g., The Center for Epidemiologic Studies Depression Scale (Kuo, W.H.: Prevalence of Depression among Asian-Americans. J Nerv & Mental Diseases; 172:449-457, 1984); Social Readjustment Rating Scale (SRRQ) (Holmes, T.H. and Rahe, R.H.: The Social Readjustment Rating Scale. J Psychosomatic Research; 11:213-218, 1967); The Cornell Medical Index (CMI), a widely-used health status questionnaire consisting of eighteen sections, the first twelve of which deal mainly with symptoms of discrete physiological systems, while the last six are mainly concerned with psychological symptoms (Lin, K-M., Tazuma, L., and Masuda, M.: Adaptational Problems of Vietnamese Refugees. Arch Gen Psychiatry; 36: 955-961, 1979).

Once the extant measures have been collected, the research group will analyze each in detail to determine:

a) whether the measure has been constructed in English in a manner which assesses the desired trait (cognitive function, depression, psychosis, etc.);

b) whether the measure has been accurately translated into the native language or, if not, whether it lends itself to being accurately translated. Each of these considerations will involve back-translation;

c) whether certain facets of a measure are items which are considered to be culturally insensitive, confusing, humiliating, etc. If such qualities are discovered, they will be eliminated and the measure refined;

d) whether it can be administered by bilingual mental health workers;

e) what its inter-rater reliability is;

f) what the test-retest reliability is; and

g) what the validity is within each refugee group.

In this regard, every patient tested will be evaluated by a psychiatrist, along the lines described by Williams and Westermeyer (Williams, C.L. and Westermeyer, J.: Psychiatric Problems among Adolescent Southeast Asian Refugees - A Descriptive Study. J Nerv & Mental Diseases; 171: 79-85, 1983) which will include a collection of demographic information, mental status, presenting complaint, physical findings, psychosocial development, medical history, and current treatment. This aspect of the project will require that a random sample of patients be tested, some with and some without mental illness.

During the course of this first year endeavor, attention will be paid to the caveats enunciated by Butcher (Cross-Cultural Research Methods in Clinical Psychology. Butcher, J.N. in Handbook of Research Methods in Clinical Psychology, pp. 273-308, 1982, John Wiley & Sons, Inc., edited by Kendall, P.C. and Butcher, J.N.). He has emphasized: 1) that, although it is important to use standard diagnostic criteria to provide a framework of classification which can serve a valuable function in psychopathology research, and although a number of systems are in use (e.g., the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM III)), there still remains the question of how well these systems apply when they are employed with individuals from mixed ethnic or national backgrounds; 2) that related questions include: Are some diagnostic entities or "disorders" universal? Are there culture-specific disorders? Do the presently available diagnostic criteria, which by no means are widely accepted in a single culture, apply in cross-ethnic or cross-national situations? 3) that, for a diagnostic test to be valuable, it must have demonstrable clinical utility and validity, i.e., that one important requirement for test equivalence is that tests used in cultural contexts that are different from their original environment show a similar or equivalent factor structure in the target culture; 4) that attention must be paid to the importance that accurate communication plays, i.e., assuring translation adequacy and equivalence of verbal materials is an important aspect of many cross-cultural projects. (Butcher has found this to be true even where linguistically close national languages, such as those spoken in the United States and in Australia, are involved. He

observed that some of the MMPI item contents developed for the United States in the early 1940's appear quite quaint or inappropriate in other countries (e.g., "feeling blue" or liking to play "Drop the Handkerchief").

Butcher provides a series of considerations as a guide to translation of psychological material (see attach #1). These can be summarized as: 1) using more than one translator; 2) working independently or in committees during initial translation of material; 3) using a back-translation procedure to detect any difficulties or failed communication; 4) field testing translated material to assure readability, style and accuracy of content communication; 5) conducting bilingual studies in the case of translated tests; and 6) determining the psychometric adequacy or translanguage equivalence of the test in all the target languages.

Lastly, attention will be paid to Butcher's outline of cross-cultural research methods, which addresses the goal of the method, selected references, and some potential problems with each approach (see attachment #2).

By the end of the first year, summaries will be made of the shortcomings of extant tests, the extent to which those tests have been modified, and the extent to which the group believes new tests must be developed de novo for this project. That activity will occur in years two and three of the project.

During the second and third years, new measures will be developed which will address and hopefully correct the deficiencies detected in the extant measures reviewed in year one. Because depression and complaints of cognitive dysfunction of the Hmong are the most common problems which psychiatrists in Minneapolis-St. Paul must address, an effort will be made in years two and three to develop a screening tool which will

assess cognitive function. To have available such a tool will enhance: 1) recognition of cognitive impairment; 2) treatment of its etiology; and 3) management of its consequences. It will also allow quantitative communication with governmental and social agencies seeking information about cognitive function of Hmong who are applying for various social welfare programs.

An example of such a measure is attach. #3. For this particular tool, necessary characteristics will include:

(1) Brevity

To validate and establish norms, the exam will require administration to hundreds of Hmong. Also to be useful in clinical settings, it should take less than 30 minutes.

(2) Minimization of cultural biases

Cannot rely on recognition or manipulation of material indigenous to U.S.A. culture or education.

(3) Suitability for administration by bilingual workers with rudimentary testing skills.

To serve as a clinical screening instrument, it will have to be given by bilingual workers. All instructions must be explicit and allow little discretion.

(4) Absence of dependence on literateness of subject.

Many Hmong cannot read or write their own language and cannot recognize the alphabet. Thus, the test cannot utilize these functions.

(5) Binary scoring which involves minimal interpretations.

Bilinguals cannot be expected to interpret responses in which there is more than one correct answer.

(6) Results which yield a numerical score.

Establishment of norms will require a numerical score which will allow for plotting a distribution of scores and seeking characteristics which correlate with the scores.

(7) Useful as a screening tool only and not as a diagnostic tool.

The following considerations will be observed as the tool is developed:

(1) The instrument will be written in English to assess cognitive function (attention, memory, abstraction, foresight and planning, visual perception). Its content will be decided in consultation with Hmong bilinguals, neuropsychologist, and cross-cultural mental health workers.

(2) The instrument will be translated into White Hmong and will be back-translated by Hmong bilingual workers not responsible for original translation.

(3) The instrument will be piloted on five Hmong attending a mental health clinic and five Hmong who have not sought mental health care (perhaps medical clinic attendees).

(4) The instrument will be revised to a) eliminate items which are confusing, humiliating, etc. and b) clarify instructions by refining of language and adding further clarifying information.

(5) Bilinguals will be trained in its administration.

(6) Interrater reliability will be determined - Bilinguals will observe the same administration of the test but will score it independently. Since all instructions are included in text of exam and outcomes are restricted to explicit responses, variance should be low.

(7) Test-retest reliability will be ascertained - Ten subjects will each be tested 2-3 times over a one-week interval.

(8) Validity will be measured - The items used in construction have face validity. Similar items and tasks are well validated as measures of cognitive function in the United States and Europe. The first validity check will be to correlate numerical scores with the subject's assessment of his/her own memory and ability to learn. A strong correlation is expected. This will be done by administering the exam to fifty refugees attending a mental health clinic and to fifty refugees attending a medical clinic who are not considered to have mental health problems.

# EVALUATING MENTAL HEALTH SERVICES FOR SOUTHEAST ASIAN REFUGEES


## Abstract

Southeast Asian refugees have experienced a high level of trauma, stress, hardship, and family disruption while settling in the U.S. These factors, in addition to significant dissonance between Asian and American cultures, frequently result in a high rate of depression, disorientation and grief reactions.

This proposal presents the evaluation design, instruments and results of three programs providing mental health services and/or training to 170 Southeast Asian refugees in the Minneapolis-St. Paul metropolitan area. The process of developing a cross-cultural program evaluation and the problems inherent in such a task is also discussed.

## SUMMARY

Title: Evaluating Mental Health Services for Southeast Asian Refugees

Subject Index Term: 23.1 Measurement/Statistics/Methodology/Computer: Program Evaluation

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## Evaluating Mental Health Services for Southeast Asian Refugees

Southeast Asian refugees have recently settled in the Minneapolis-St. Paul area of Minnesota in significant numbers; this area has the second highest per capita rate of Southeast Asians in the nation. Refugees from Southeast Asia have, in general, experienced a high level of emotional trauma, chronic stress, personal hardship, and family disruption prior to resettling in this country. These factors, in addition to significant dissonance between Asian and American cultures, frequently result in a high rate of post-settlement depression, situational disorientation, and grief reactions. Frequently occurring symptoms are physical complaints, confusion, anger, violent behavior, dependency, and isolation. A recent study conducted at the Ramsey County Medical Center International Clinic (Minneapolis Star & Tribune, 1983) indicated that 65 percent of a sample of 45 Hmong refugees were suffering from "some degree of depression".

It is clear that the resettlement of refugees is a complex and extensive process.

> "On the road toward integration, stress is constant, prolonged and severe. Casualties are to be expected. They are frequent and diverse in nature and in severity, but not necessarily inevitable. Damage can be manifest in terms of psychiatric symptoms, physical illness, interpersonal difficulties, acting-out, social maladaptation. . .singly or simultaneously. All could, and do, undermine the individual's capacity for functioning in an effective fashion." (Tung, 1980.)

Over time, mental health needs may emerge as even more severe than during the initial post-settlement period.

> "Despite the enormous strains of the adjustment process, a considerable number of refugees are most vulnerable to depression after the more immediate tasks of resettlement are completed--when the needs for food, clothing, housing, work, etc. are satisfied--and the newly settled refugees have time to reflect more deeply on their ordeal. In this period, the need for counseling and support is great." (Robinson, 1980.)

**Prior Research**

Studies of refugee mental health have not been reported in any systematic fashion. Very few studies have reported patterns of service utilization and outcome for Southeast Asian refugees in the United States (Van Deusen, 1982). It seems, however, that refugees tend to "under-utilize" formal health care services--at least relative to their report of problems (Van Deusen and Lappin, cited in Van Deusen, 1982). Van Deusen reports on a study of Vietnamese refugees in Los Angeles (Le, cited in Van Deusen, 1982) which shows that most informants would prefer to use family or friends as a primary source of help for mental health problems, sustaining a tradition from the homeland. This fact, in combination with difficulties in communicating with American providers, contributes to their "under-utilization" of services (Van Deusen, 1982).

Another factor contributing to the "under-utilization" services is the fact that major mental illnesses are highly stigmatized in Southeast Asian cultures (Nguyen, 1982a). A mentally ill person is often considered an individual born under an unlucky star or a person who is meant to suffer the consequences of misdeeds in previous lives or those committed by parents and ancestors (Nguyen, 1982a).

As for "minor" mental illnesses, most Southeast Asians feel obliged by their culture to be strong in the face of adversity and present a strong front, so as not to betray their weaknesses. Their culture stresses harmony in interpersonal relationships and encourages the use of repression, denial, and suppression as ways of handling negative feelings. In addition, according to Buddha's teaching, life is a "sea of suffering" and people should learn to cope with their suffering without burdening others with one's own problems. Thus, little external help is expected for minor emotional problems, and family conflicts are usually handled within a small circle of relatives and friends (Nguyen, 1982a). Therefore, it is not surprising that researchers have concluded that the most effective mental health treatment models appear to be those which take account of the basic cultural preferences of Southeast Asians to work within a family system and/or through a central member (Scott and Lappin, cited in Van Deusen, 1982).

Cohon (cited in Van Deusen, 1982), in a preliminary report of mental health services provided by a special project in the San Francisco area during 1976-1977, reports on 54 Southeast Asian patients being seen by Southeast Asian paraprofessional trainees working under supervision. Characteristics of Cohen's client and paraprofessional group will be compared to the characteristics of clients and paraprofessionals in the programs evaluated in this proposal. By their second year in the United States, depression appears to have emerged as a primary problem in approximately half of the San Francisco patients. After 2 1/2 years, virtually all of the San Francisco clients exhibited depression as a primary problem. Counseling by the paraprofessionals averaged three visits over five months. After this time, ratings by the paraprofessional trainees showed 67% of the clients improved. The ratings are congruent with the views of the patients, 65% of whom felt that the services helped them.

According to Van Deusen, between 1976 and 1981, state and federal grants and contracts have supported over 50 model mental health and training programs to serve the Southeast Asian refugee population in the United States. Descriptive and evaluative reports have been published for only a handful of those ventures. This project will add to that meager literature.

## Description of Programs

This paper will present the evaluation design and data of three programs providing mental health services and/or training to Southeast Asian refugees in the Minneapolis-St. Paul metropolitan area. All three mental health programs are affiliated with the University of Minnesota and/or the Amherst H. Wilder Foundation, a large operating foundation providing human services in the St. Paul metropolitan area. Funding for the evaluation projects was provided by general sources:

(1) The U.S. Office of Refugee Resettlement, Department of Health and Human Services, Social Security Administration, Washington, D.C.,

(2) Refugee Program Office, State of Minnesota,

(3) Amherst H. Wilder Foundation.

Two of the programs provide direct mental health services to Southeast Asian refugees via bilingual workers, representing the Hmong, Cambodian, Lao and Vietnamese communities. These bilingual workers have been trained and equipped to listen and provide acceptance and emotional support, assist the person to problem-solve, and find appropriate help from other professionals and natural helpers in the community. In addition, these bilingual workers attempt to serve as a bridge or link between professional mental health services and indigenous sources of caregiving. The third program provides mental health training to Hmong natural helpers (e.g., community leaders, religious leaders, traditional healers, clan leaders, etc.).

The purpose of the evaluation study is to assess the effectiveness of these three non-traditional programs providing services to Southeast Asian refugees. More specifically, the evaluation attempts to determine:

(1) the amount and type of services delivered (e.g., individual therapy, couple/family therapy, psychiatric assessments).

(2) the socio-demographic characteristics of refugee clients (e.g., age, sex, marital status, income, number of children, education, fluency with English, etc.).

(3) the incidence and severity of depressive symptoms among the Southeast Asian client population as measured by the Depression Scale For Cross-cultural Use and the Problem Checklist.

(4) the effectiveness of mental health services in reducing the level of depression in the refugee persons served.

(5) the incidence and severity of problems among the Southeast Asian client population as measured by bilingual worker ratings on the Problem Checklist.

(6) the effectiveness of mental health services in reducing the severity of the targeted problems among refugee clients.

(7) the satisfaction of clients with mental health services.

(8) the relationship of socio-demographic characteristics, type and amount of service, type and severity of problem to treatment outcome (i.e., level of depression, severity of problem, client satisfaction).

(9) the use of indigenous "natural helpers" within the Southeast Asian community in the mental health treatment of clients.

(10) the attitudes of Southeast Asian refugees toward mental health issues and systems and the degree to which those attitudes change after training as measured by the Attitudes Toward Mental Health Issues and Help-Seeking Advice Questionnaire.

(11) the extent of the Southeast Asian refugees' knowledge about mental health concepts and the degree to which their knowledge about mental health concepts increases after participating in the training.

## Research Methods

### Sample

The sample consists of 170 clients of the three programs. This sample represents all the Southeast Asian clients entering the three programs during a seven month period of time from June 1983 through December 1984.

### Instruments

Several evaluation instruments were created for use specifically with this client population. All instruments were developed in conjunction with bilingual program staff and needed to be translated and back-translated into the four relevant Southeast Asian languages. Developing culturally relevant instruments and designs was extremely difficult. This difficulty was exacerbated by the fact that even though this cross-cultural research called for a more unstructured and qualitative approach to evaluation, the language problems of the bilingual workers demanded a structured, quantitative approach requiring little English use.

The evaluation instruments used were: Southeast Asian Problem Checklist, Walton and Brantner's Depression Scale for Cross-cultural Use, Southeast Asian Background Information Form, Attitudes Toward Mental Health Issues Questionnaire, and Help-Seeking Advice Questionnaire.

### Methods

The Southeast Asian Problem Checklist is a 70-item instrument which asks bilingual workers to rate their clients on a series of mental health problems (e.g., marital problems, crying, headaches, etc.). It is based on a similar measure developed by the Indochinese Mental Health Project of the International Institute of San Francisco.

Walton and Brantner's Depression Scale for Cross-cultural Use was developed in response to expressed clinical dissatisfaction with Western psychopathology scales, even when they were well-translated. Items were gathered from the Walton and Brantner's extensive clinical experience with depressed Southeast Asian clients, standard mental health scales and a nursing study on well-being. Items were clarified, translated and back-translated by 11 bilingual counselors to form a final 20-item scale.

The Southeast Asian Background Information form gathers background information about the client's previous experience, including traumas and stresses (e.g., death of family members, torture and imprisonment, separations, living in refugee camps, etc.), previous mental health history, and proficiency with English.

The "Attitudes Toward Mental Health Issues Questionnaire" asks refugees questions about their attitudes toward mental health issues, the American mental health system, and the best ways to deal with emotional problems. The last instrument, the "Help-Seeking Advice Questionnaire", presents actual vignettes of problem situations gathered from case records and an anthropological study of natural helpers within the Southeast Asian community (Midelfort, 1983). Refugees are asked to decide what referral source (e.g., Mai Kong [family representative], clan leader, American counselor) they would recommend.

All data was collected on clients before (pretest) and 4-6 months after (post-test) their participation in the various mental health programs. Data was provided by the bilingual workers providing service, by the clients themselves, and by bilingual interviews. Thus, perspectives on clients' problems and outcomes are gathered from three perspectives: the client her or himself, the bilingual counselor, and interviewers.

## Conclusions and Discussion

Results from the evaluation tend to confirm the effectiveness of the programs in meeting many of their program goals. However, this presentation will focus on the process of developing a cross-cultural evaluation and the problems inherent in such a task. Even though great care was taken in the design of the evaluation to consult with program staff, including 10-15 Southeast Asian bilingual workers, evaluation is an American invention that is foreign to Southeast Asian culture. Their understanding of, and idiosyncratic responses to, such evaluation procedures is not well known. In addition, it is extremely difficult to insure that the translation of items from English into Cambodian, Lao, Hmong, and Vietnamese maintains the original intent and integrity of the items. These are some of the inevitable hazards encountered in doing cross-culural research with such a dissonant (e.g., Asian, non-industrialized) cultural group; these hazards will be discussed in some detail.

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# GOVERNOR'S STATE ADVISORY COUNCIL FOR REFUGEES

444 LAFAYETTE, ST. PAUL, MINNESOTA 55101



July 25, 1985

Mr. Leonard W. Levine
Commissioner
Department of Human Services
Centennial Office Building
St. Paul, MN 55155

Dear Commissioner Levine:

As the Chair of the Governor's State Advisory Council for Refugees, I am writing to express our support for the Department of Human Services' application for federal funds for the refugee mental health project.

As an organization dedicated to improving services available to refugees, we are aware of many unmet needs. We are excited about the possibilities that this grant offers for improving mental health services for refugees. We believe that with increased cooperation and coordination mental health services for refugees can be improved.

As an advisory committee for the Governor, we are also aware of the Governor's strong support for this project and we appreciate his commitment to work toward such service system improvements.

We are pleased with your efforts on this project and will assist you in whatever ways seem appropriate.

Sincerely,

Stan Breen

Stanley B. Breen A.C.S.W.
Chair

SB/bc

Minnesota Department of Corrections

Office of the Commissioner

July 18, 1985

Commissioner Leonard W. Levine
Department of Human Services
Centennial Office Building - 4th floor
St. Paul, Minnesota 55155

Dear Commissioner Levine:

This letter is intended to express our Department's support of the Minnesota Department of Human Services' application to the National Institute of Mental Health - the Refugee Assistance Programs - Mental Health (MH-85-10). We have reviewed the Human Services Department proposal and pledge our full cooperation in encouraging its funding.

As you know, the Minnesota Department of Corrections has focused on the Southeast Asian refugee community as a group requiring specialized services. Our state program for battered women has provided funding for advocacy and informational services for Southeast Asians.

One of the primary goals of the Human Service Department's proposal is to promote strong linkages among existing agencies and services. I again would like to assure you and the reviewers of the application that our Department will continue its cooperative efforts with your Department and with other affected agencies in targeting this essential area of need in the refugee community.

We are in full support of the application. Please let me know if our Department can lend any further assistance in securing funding of the application.

Sincerely,

Orville B. Pung
Commissioner

OBP/fc

300 Bigelow Building•450 North Syndicate Street•St. Paul, Minnesota 55104•612-642-0282

RAMSEY COUNTY

# COMMUNITY HUMAN SERVICES DEPARTMENT

160 East Kellogg Blvd. — St. Paul, MN 55101
(612) 298-5351



July 25, 1985

Mr. Leonard W. Levine, Commissioner
Minnesota Department of Human Services
Centennial Office Building - 4th floor
St. Paul, Minnesota 55155

Attention: Mr. Al Oertwig

Re: Minnesota's Application for the Refugee Assistance Program - Mental Health

Dear Commissioner Levine:

This letter is to provide Ramsey County Community Human Services Department's support for Minnesota's application for the Refugee Assistance Program-Mental Health. There is a need in Minnesota for greater funding and system coordination for refugees.

Through Ramsey County's experience in providing and managing services to refugees, it has become evident that there are increasing needs for coordinated mental health services. Refugees are experiencing mental health problems because of cultural and language differences and loss issues. Adequate services are not readily available within the service delivery system as it is currently structured.

We support Minnesota's application as an excellent means to improve the mental health system for refugees.

Yours very truly,

Tom Fashingbauer

Thomas J. Fashingbauer
Director

TJF/LM/mk

HENNEPIN

COMMUNITY SERVICES DEPARTMENT
MENTAL HEALTH DIVISION
A-1605 Government Center
Minneapolis, Minnesota 55487-0165

July 25, 1985

Leonard W. Levine, Commissioner
State of Minnesota
Department of Human Services
Centennial Office Building
St. Paul, Minnesota 55155

Dear Commissioner Levine:

I am writing this letter in support of the Department of Human Service's application to the National Institute of Mental Health for a Refugee Assistance Program in Mental Health. Hennepin County is one of the major resettlement areas in the State of Minnesota and has been aware of the need of additional mental health services for Indochinese refugees for some time.

The Hennepin County Mental Health Division sponsored a Minority Task Force to address the "varied options for minority chronic mentally ill clients" under the auspices of the Hennepin County Community Support Program. This Task Force met beginning in 1979 and broadened membership in 1980 to include representation from the Indochinese community. Recommendations from this group were presented to the Hennepin County Mental Health Management Team and to the Director of the Community Services Department in 1982. As a result of these meetings and subsequent formal recommendations, an agency was funded to provide mental health services for Indochinese clients utilizing our McKnight Foundation initiative. Although the Community University Health Care Clinic (CUHCC) developed mental health services for Indochinese Refugees beginning in 1979, their funds were in jeopardy of being drawn down. Hennepin County Mental Health Division used a combination of County and McKnight funds to continue this service by expanding our already existing contract with CUHCC.

Having been involved in assessing the Mental Health service needs at a systems level, Hennepin County supports the request from National Institute of Mental Health (NIMH) for additional resources to assist in coordinating efforts at the systems level to improve mental health services to Indochinese Refugees in the State of Minnesota. We remain willing to continue to work with the Department of Human Services in the development of this initiative and stand ready to assist by cooperating in efforts to advance this capability.

Sincerely,

Tish Halloran

Tish Halloran
Director

TH:bt

cc:Mary Huggins

**HEALTH DEPARTMENT**
PUBLIC HEALTH CENTER
250 SOUTH FOURTH STREET
MINNEAPOLIS, MINNESOTA 55415

DAVID M. LURIE
COMMISSIONER OF HEALTH

minneapolis
city of lakes

July 15, 1985


Commissioner Len Levine
Department of Human Services
658 Cedar Street
4th Floor Centennial Building
St. Paul, MN 55415

Dear Commissioner Levine:

As chair of the Minnesota Refugee Health Task Force, I would like to express our strong support for the Office of Refugee Resettlement - National Institutes of Mental Health proposal to be submitted by the Minnesota Refugee Program office.

The purpose of the Task Force is to promote access for refugees in Minnesota to quality care in the most efficient and effective manner, to act as a source of information about programs and services for refugees and to encourage cooperation among health care agencies.

The ORR-NIMH proposal outlines a plan that would ensure available and appropriate mental health services for refugees by increasing cooperation and coordination of existing mental health agencies and services.

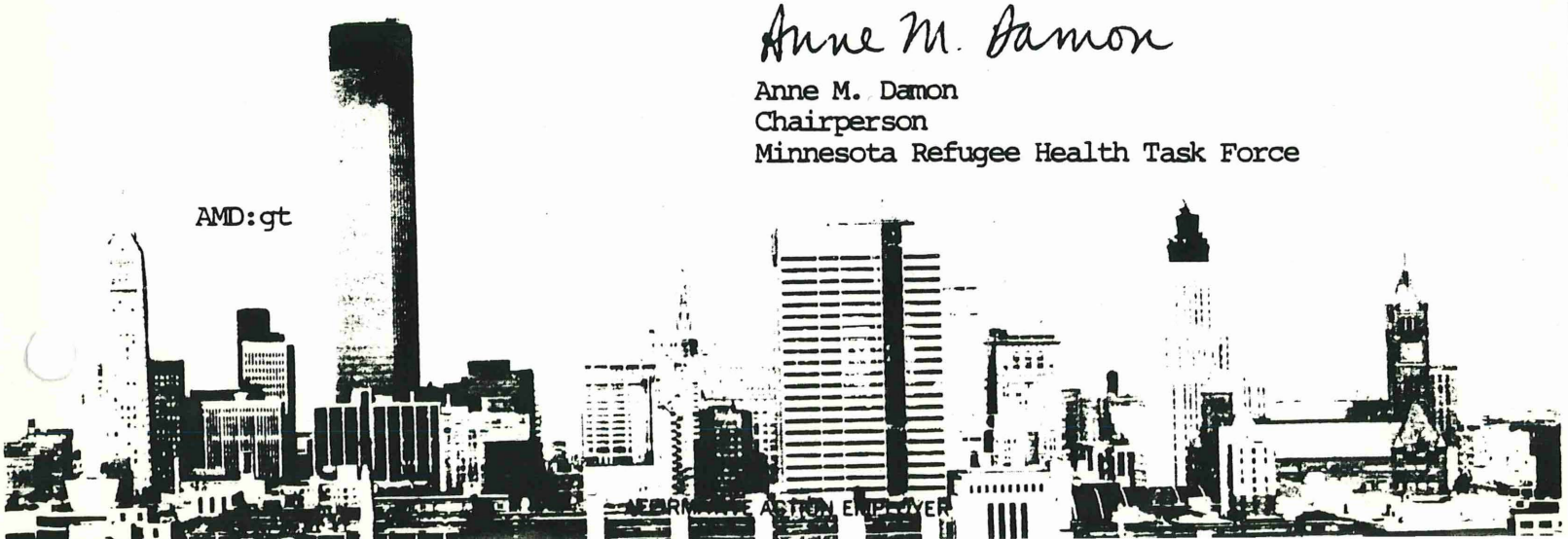
The Task Force would be honored to act as part of the Advisory Board for this comprehensive, needed program intended to assist refugees in overcoming the trauma associated with adjustment to a new life. We applaud your efforts to raise mental health issues of refugees to a higher level of public awareness and look forward to working with you and the Refugee Program Office in the implementation of this plan.

Sincerely,

Anne M. Damon

Anne M. Damon
Chairperson
Minnesota Refugee Health Task Force

AMD:gt



JUL 25 1985

**HEALTH DEPARTMENT**
PUBLIC HEALTH CENTER
250 SOUTH FOURTH STREET
MINNEAPOLIS, MINNESOTA 55415

DAVID M. LURIE
COMMISSIONER OF HEALTH

minneapolis
city of lakes

July 18, 1985

Commissioner Leonard Levine
Department of Human Services
658 Cedar Street
St. Paul, Minnesota 55415

Dear Commissioner Levine:

The Maternal and Child Health Program of the Minneapolis Health Department would like to express its support of the Mental Health Planning grant proposal to be submitted by the Minnesota Refugee Program Office to the Office of Refugee Resettlement - National Institutes of Mental Health.

Our Maternal and Child Health program provides free primary health care to a low income population through prenatal, family planning, and child health clinics. We have a large proportion of refugee patients and have followed many of them since their arrival. Because of our emphasis on comprehensive, multi-disciplinary care we have become involved with many psychosocial issues and problems of refugees and are aware of service needs and gaps. The increased planning and coordination sought by this proposal should improve mental health services to refugees by making the services both more accessible and more appropriate.

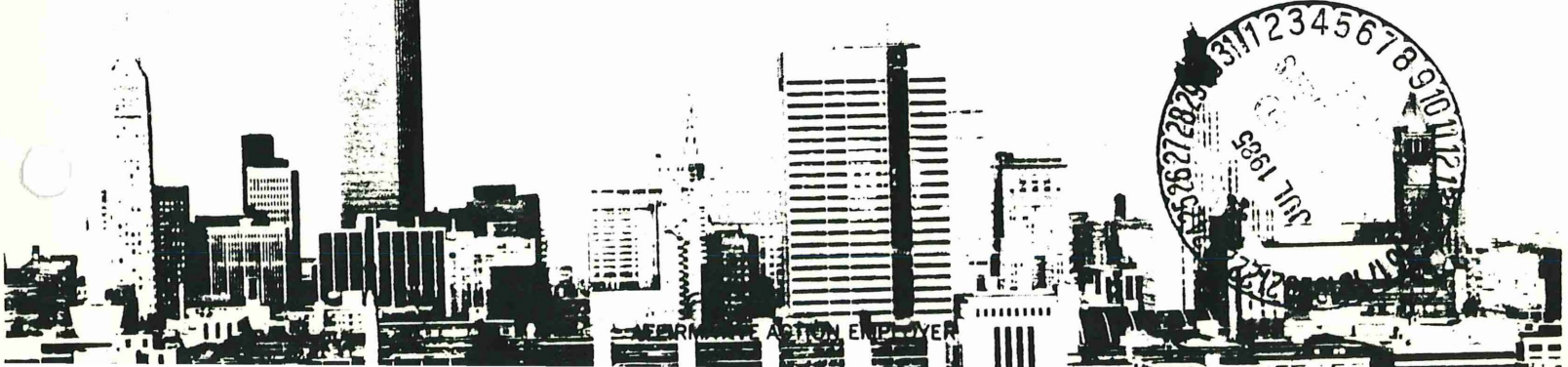
We hope this proposal will be funded and offer any further information or support that may be helpful to you in making the proposal or implementing the plan.

Sincerely,

Edward P. Ehlinger, M.D.
Director of Personal Health Services

Anne Damon
Assistant Coordinator
Community Health Services

Pauline Bamford
Supervisor
Social Work Services



RAMSEY CLINIC

Executive Offices
Suite 9, North Building • 640 Jackson Street • St. Paul, Minnesota 55101 • 612/221-2025

July 3, 1985

Leonard W. Levine
Commissioner of Human Services
State of Minnesota
4th Floor
Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Commissioner:

I am writing in support of Minnesota's application to the Refugee Assistance Program - Mental Health (MH-85-10) in which the National Institute of Mental Health will accept applications for cooperative agreements from the states to improve systems of care for refugees with severely disabling mental health problems. I have reviewed the formal request for proposals and feel that Minnesota meets the program specifications to a very high degree. In regard to the planning process specified for the program, our state has already defined its target population through the work of Dr. Westermeyer at the University of Minnesota. Dr. James Jaranson of the Department of Psychiatry at Ramsey Clinic and I have recently received funding to do a similar prevalence study with Lao and Cambodian refugees in their communities. We hope to determine the prevalence of emotionally disabled individuals by employing a random selection process of refugees settled in the metropolitan area and interviews in their homes using standard psychiatric assessment tools. I am aware that Jane Kretzmann from the Refugee Resettlement Office in your department and personnel from the Mental Health Division are working together to assess present needs and service use, define the nature and components of systems of care, and establish goals and priorities for the state.

The activities which I have mentioned demonstrate quite well the degree of collaboration among our agencies and systems in this state. There is a broad range of interests and we are quite used to working with each other to provide mental health services to refugee populations. Unfortunately, the coordination, planning and evaluation aspects of such work are beyond the resources of any particular agency or health provider. I am in full support of an application to the Refugee Assistance Program - Mental Health to obtain the resources for these vital components of a coordinated system of mental health care for refugees.

Finally, I would like to say that as a physician who sees over 1,000 refugees per year in clinics at St. Paul-Ramsey Medical Center and the St. Paul Division of Public Health, I know firsthand how deep the need is for mental health

services for them. At present we make do from month to month with the resources we have. It would be excellent if we could obtain additional funding for the state to maximize our resources through coordination and planning.

Sincerely yours,

Neal Holtan

Neal R. Holtan, M.D., M.P.H.
Department of Internal Medicine

NRH/cl
cc: James Jaranson, M.D.

UNIVERSITY OF MINNESOTA
TWIN CITIES

Community-University Health Care Center
Health Sciences
2016 16th Avenue South
Minneapolis, Minnesota 55404

July 24, 1985

Commissioner Leonard W. Levine
Department of Human Services
4th Floor
Centennial Office Building
St. Paul, Minnesota 55155

Dear Commissioner Levine:

In my role as Acting Director of the Community-University Health Care Center, which provides mental health care to large numbers of refugees, and as a primary care physician who has been involved since 1979 in providing health care to Asian refugees, I realized early on that ultimately mental health issues and not physical health issues would prevent refugees from becoming fully assimilated and acculturated. Thus, I write to endorse in the strongest possible terms Minnesota's response to the RFP issued by the Office of Refugee Resettlement and the National Institutes of Mental Health. That RFP calls for a cooperative agreement program designed to fund 8-10 state mental health agencies in order to stimulate and assist state mental health agencies to assume leadership in promoting service system improvements for refugees.

Clearly, the mental health issues of the refugees are becoming more apparent as the medical problems are being attended to and corrected. Without appropriate intervention, these mental health problems will continue to escalate, precluding ever-increasing numbers of refugees from ever being able to assume an active role in the mainstream of American life. Planning, advocacy, and coordination of a refugee mental health program are clearly essential elements. An increased number of refugee mental health professionals must be trained and available to provide mental health services to refugees. More effective placement, utilization and career development of trained refugee paraprofessionals in state mental health agencies is critical. Ongoing needs assessments and epidemiologic studies regarding refugee mental health issues must be developed and pursued. All of these issues can be dealt with effectively should Minnesota's application be funded.

In view of the large number of refugees who live in Minnesota and the escalating number of instances of mental illness that are being detected,

it is essential that Minnesota be funded. I endorse your application and offer my assistance and that of the staff of the Community-University Health Care Center in whatever way either can be utilized effectively in the pursuit of the objectives.

Sincerely yours,

Amos S. Deinard, M.D.
Associate Professor
Department of Pediatrics
Acting Director, Community-University
Health Care Center
Box 85 Mayo
University of Minnesota Hospitals
420 Delaware Street Southeast
Minneapolis, Minnesota 55455

ASD/mo

JUL - 4 1985

minneapolis
city of lakes

**MAYOR DONALD M. FRASER**

July 23, 1985

Leonard W. Levine, Commissioner
Department of Human Services
Centennial Building
St. Paul, MN 55155

Dear Commissioner Levine:

I am pleased to endorse your application to the National Institute of Mental Health for funds to improve mental health services for refugees.

Our state, and particularly Minneapolis and St. Paul, has received large numbers of refugees who are going through the difficult process of acculturation. Obviously, such an experience will cause a certain amount of psychological trauma and our experience indicates traditional methods of treatment are inadequate for a variety of reasons. Although existing clinics are doing an admirable job in their attempts to serve this population, there are many needs not being met, some of which your proposal would begin to address.

I support your proposal and hope you are successful in your efforts to obtain funding for it.

Sincerely,

Donald M. Fraser
M A Y O R

DMF:BRh

AFFIRMATIVE ACTION EMPLOYER

AMERICAN REFUGEE COMMITTEE
2344 Nicollet Avenue, Suite 350
Minneapolis, MN 55404
Phone 612-872-7060

July 24, 1985

Mr. Terry Sarazin
Minnesota Department of Human Services
Centennial Building
St. Paul, Minnesota 55155

Dear Mr. Sarazin:

The purpose of this letter is to add the support of the American Refugee Committee to your application for federal grant for the Refugee Assistance Program - Mental Health.

For the past two years the Domestic Program of ARC has been cooperating with two projects in the metropolitan area - Community University Health Care Center and the Wilder Refugee Project. Both of these projects are concerned with the mental health of refugees. Further ARC has been involved in a variety of educational programs focused on refugee mental health. Our knowledge of the refugee experience both in the camps and during resettlement convinces us that more programs are demanded in the area of mental health. Some of the deeper problems of the refugee surface only after the refugee is resettled in the United States for several years.

Minnesota has been in the forefront of planning and programing for the mental health of refugees. However, we believe, that the needs we have seen thus far are only the tip of the iceberg and that there is a demand for even more programing in this area. Also there is a need to coordinate with agencies who are just beginning to service refugees. This programing must be done in the near future if Minnesota is to respond to the very critical issue of mental health in the refugee community.

Again I reiterate the support of the American Refugee Committee for the grant request made by your office.

Sincerely,
Michael Roan
Michael Roan
Director, Domestic Program

# minnesota council of churches

122 W. FRANKLIN, ROOM 230, MINNEAPOLIS, MN 55404
TELEPHONE: (612) 870-3600


JUL 24 1985

July 23, 1985

Commissioner Leonard W. LeVine
Department of Human Services
Centennial Office Bldg.
658 Cedar Street
St. Paul, MN 55155

Dear Commissioner,

I have conferred with the Chairperson for the Minnesota Council of Churches Ecumenical Advisory Committee on Refugee Concerns and we jointly agree to the need for increased mental health services for refugees within Minnesota.

We applaud and encourage the State of Minnesota, through its Department of Human Services, to apply for federal funds to assist and promote the mental health of refugees and their access to such services as they may need to function effectively within this culture.

Sincerely,

Sylvia D. Farmer
Director of Refugee Services

cc: Margaret J. Thomas
Jane Kretzmann

Amherst H.
Wilder Foundation
Since 1906



July 25, 1985

Leonard W. Levine, Commissioner
Department of Human Services
Centennial Building
St. Paul, MN 55155

Dear Mr. Levine:

Department of Human Services is making a much needed effort in seeking federal funds to assist it in its efforts to foster and promote the mental health of refugees in the state of Minnesota.

Wilder Foundation's bi-lingual workers provide culturally appropriate social adjustment/mental health services to their respective refugee communities with back-up from western-trained mental health professionals.

As part of the contract with Refugee Program Office, State of Minnesota, Wilder Foundation has served a coordinating role in refugee mental health services for the past two years in the East Metro area with involvement of key agencies from the West Metro area.

Three members from the Mental Health Coordination Committee will serve on the Advisory Committee for the proposed effort being made by the Department of Human Services. Strengthening the coordination efforts is necessary for effective delivery of social adjustment mental health services to the refugee community.

Sincerely,

Neelam Bhataja

Neelam Bhataja, A.C.S.W.
Program Director
Southeast Asian Social Adjustment Program

NB/asd

Division of Services to
Children and Families
**Community Care Unit**
919 Lafond Avenue
St. Paul, MN 55104
(612) 642-4060

LAO FAMILY COMMUNITY
OF MINNESOTA, INC.
A Non-Profit Organization
ອົງການສັມຄົມລາວ

July 17, 1985

JUL 22 1985

Leonard W. Levine
Commissioner
State of Minnesota
Department of Human Services
Centennial Office Building
St. Paul, Minnesota 55155

Dear Commissioner Levine:

This letter is written in support of the Department of Human Services' application for federal funds to assist it in its efforts to improve the access which refugees have to mental health services in the state so that the mental health of refugees may be more adequately served.

As an organization which serves the 10,000 some Hmong refugees in Minnesota, we are involved daily with refugees whose social adjustment/mental health problems prevent them from attaining economic or social self-sufficiency. The special programs which have been funded for their benefit are used extensively and have certainly helped many people. But as our people are integrated more and more into the larger community, it becomes imperative for state agencies to make changes or find new ways of providing services to an underserved population. Recent legislation and Governor Perpich's growing concern for non-English speaking citizens such as our Southeast Asian refugees make this an opportune time for your proposal. We actively support state agency initiatives which will result in more and better, culturally appropriate, bilingual services, particularly in mental health.

Please be assured that Lao Family Community will be happy to assist you in any way possible as you develop your proposed plan.

Sincerely yours,

Teng Ly
President

TL:dr

976 W. Minnehaha Avenue, St. Paul, MN 55104 487-3466

Supported by United Way

LSS STATE CENTER
2414 Park Avenue
Minneapolis, MN 55404
(612) 871-0221
MN WATS (800) 582-5260

# LUTHERAN SOCIAL SERVICE OF MINNESOTA

LSS STATE CENTER
2414 Park Avenue
Minneapolis, MN 55404



July 23, 1985

Mr. Leonard W. Levine
Commissioner of Human Services
Department of Human Services
Centennial Building
St. Paul, MN 55155

Dear Commissioner Levine:

This letter comes in support of the proposed application of the Minnesota Department of Human Services for federal funds to provide better mental health services to refugees resident in this state.

Our agency is involved in the placement of refugees in Minnesota and recognizes the trauma that goes with the uprooting of people from their culture and transplanting to a new environment. Frequently the effect is not felt till several years have passed. I am pleased that this state with its fine services in the area of mental health seeks to expand its capability specifically to such persons with special need. The goals of linking providers and pursuit of mainstreaming of mental health services is very important.

This proposal has our support and endorsement. If you have questions, I would be happy to respond.

Sincerely,

Ellen Erickson

Ellen Erickson, Director
Refugee Resettlement Program

EE:sm

JUL 25 1985

CATHOLIC SOCIAL SERVICES DIOCESE OF WINONA, INC.
Administrative Office
55 West Sanborn
PO Box 588
WINONA, MINNESOTA 55987
Tel. (507) 454-4643

Address Correspondence to:
Rochester Branch Office
903 West Center Street
Rochester, Minnesota 55902
Tel. (507) 287-2047

Rochester, 23 July 1985

Mr. Leonard W. Levine
Commissioner, Dept. of Human Services
St. Paul, Minnesota 55155

Dear Mr. Levine,

As Chair of our MINNESOTA CONSORTIUM of Refugee Resettlement Agencies, I write today to extend our endorsement to the Mental Health/Social Adjustment proposal currently being prepared by your staff for submission to the Office of Refugee Resettlement (ORR). For the past seven years our Consortium has served a coordinating role for member agencies via monthly meetings and sponsorship of workshops and other projects. During this period of time, members have frequently raised their concerns regarding the worrisome vacuum created by lack of specific planning and programming in the area of refugee mental health. Feelings were often expressed that the absence of such planning and prevention was potentially compromising and undermining notable successes already achieved by our programs in such areas as education, health and employment. There has also been anger and dismay that our refugees would face denial of access to fundamental services already available to others here in America. Our long-standing national tradition of removing cross-cultural barriers to services should not be set aside in so important an area of need, especially for refugees who have suffered unprecedented hardships in their personal lives and yet, because of that struggle, hold so much promise for contributions to our society in the future.

We are therefore delighted that this opportunity has now come via the ORR RFP to address this important need here in Minnesota, and that your staff is responding with a proposal. Please accept here our appreciation and warmest best wishes as well as our offer to assist in whatever manner you might feel appropriate. For your reference, I attach a listing of our current membership. Thankyou for your attention to this important matter.

Sincerely and respectfully,

Robert R. Jones III
Chair, The Minnesota Consortium

Southeast Asian Refugee Studies Project

UNIVERSITY OF MINNESOTA
TWIN CITIES

Department of Linguistics
142 Klaeber Court
320 16th Avenue S.E.
Minneapolis, Minnesota 55455
(612) 373-5769

July 24, 1985

Mr. Leonard W. Levine
Commissioner
Department of Human Services
Centennial Office Bldg., 4th Floor
St. Paul, Minnesota 55155

Dear Commissioner Levine:

On behalf of the Southeast Asian Refugee Studies Project of the University of Minnesota I want to express our strong support for the State of Minnesota's application for a grant for a project within the NIMH Refugee Assistance Program - Mental Health. Minnesota's proposal is deserving of funding not only because of the State's large refugee population, but because the Minnesota Department of Human Services has consistently succeeded in mounting innovative and appropriate programs to address the varied needs of this population.

The mental health problems among the State's refugees are clearly very great, they seem to be growing more serious, and not enough has been done either in direct provision of services or in the way of training of refugee and other professionals and paraprofessionals. At a recent local conference on refugee health care, Dr. Joseph Westermeyer, Director of the University Hospital's International Mental Health Clinic, which serves mostly refugees from Southeast Asia, stated that the major illness, both in terms of incidence and prevalence among the Hmong people at the present time is major depression. He pointed out also that mental health has largely been overlooked in the training and re-training of refugee professionals. The State's proposed program should help substantially in addressing those needs.

We have been very pleased with the close cooperation that has existed in the past between the faculty and students from various disciplines conducting research related to refugees under the auspices of the Southeast Asian Refugee Studies Project, on the one hand, and the various State agencies and State-funded programs serving the refugee population, on the other. We stand ready to cooperate and provide support in any way we can in connection with a State Refugee Assistance Program for Mental Health. In particular, our reference collection and bibliographic resources, particularly strong with respect to Hmong and Cambodian refugees, are of course available for your use, in addition to whatever assistance the members of our staff and associated faculty may be able to provide in their respective areas of expertise.

With best regards,

Bruce T. Downing

Bruce T. Downing
Associate Professor (for the Coordinator)

CURRICULUM VITAE

MARGARET SANDBERG, ACSW, MPH
116 South Ottawa Avenue
Golden Valley, Minnesota 55416
Telephone: 612/297-4284 (Office)

## EMPLOYMENT HISTORY

- MINNESOTA DEPARTMENT OF HUMAN SERVICES
  - Assistant Commissioner, Program Development and Regulatory Services — 1/85 to present
  - Assistant Commissioner, Mental Health Bureau — 1/83 to 1/85
- MINNESOTA DEPARTMENT OF HEALTH
  - Director, Office of Community Development — 5/82 to 1/83
  - Acting Director, Office of Community Development — 6/81 to 5/82
  - Director, Community Support Services, Office of Community Development — 9/76 to 6/81
  - Planner, Executive Office — 6/72 to 9/76
- METROPOLITAN HEALTH BOARD - METROPOLITAN COUNCIL
  - Health Planner Mental Health, Chemical Dependency, Mental Retardation — 2/71 to 6/72
- MINNESOTA DEPARTMENT OF PUBLIC WELFARE
  - Medical Care Consultant, Medical Assistance Program — 9/69 to 2/71
- UNIVERSITY OF MICHIGAN - MARY HARKLEY HALL
  - Resident Director (Part Time) — 1/67 to 8/69
- ROCHESTER STATE HOSPITAL
  - Psychiatric Social Worker — 10/63 to 12/67

## EDUCATION

### Graduate Schools

University of Michigan:
School of Social Work 1967-68
Master of Social Work Degree - April, 1968
Major: Administration
Minor: Group Work

School of Public Health
Master of Public Health Degree - August, 1969
Major: Medical Care Administration

Post-Graduate Courses

Mini-MBA Course
St. Thomas College
St. Paul, Minnesota
September-December 1982

"Child Abuse," Short Course
University of Minnesota
School of Public Health
July, 1975

"Concepts Basic to Area Wide Comprehensive Health Planning"
Short Course, University of Oklahoma
School of Public Health
March, 1971

"Epidemiology of Mental Health," Short Course
Extension Division
University of Minnesota
July, 1970

Undergraduate School

University of Minnesota
Duluth, Minnesota
Bachelor of Arts Degree - June, 1963
Major: Political Science
Minors: Sociology, Psychology

FACULTY RELATIONSHIPS

University of Minnesota, Minneapolis
School of Social Work - Clinical Instructor
1972 to present

University of Minnesota
School of Public Health - Adjunct Assistant Professor
Public Health Administration
1973 to present

University of Minnesota, Duluth
School of Social Development, Clinical Instructor
1973 to 1977

Macalester College, St. Paul
Field Instructor - 1978

Kenney Rehabilitation Institute, Lecturer
1973 to 1978

## PROFESSIONAL MEMBERSHIPS

Academy of Certified Social Workers of the National Association of Social Workers
American Association for the Advancement of Science
American Public Health Association
American Society of Planning Officials
Association of Mental Health Administrators - Associate Member
Mental Health Association of Minnesota, Inc.
Minnesota Chapter, National Association of Social Workers - President, 1977-1979
Representative to Midwest Coalition 1976 to 1979
Minnesota Future Society
Minnesota Gerontological Society
Minnesota Planning Association
Minnesota Public Health Association, President 1979-1980
Minnesota Social Service Association
National Association of Social Workers
National Conference on Social Welfare
Rural Health Association, Minnesota Chapter
World Future Society
American Society on Aging
National Council on the Aging
American Society for Performance Improvement

## CIVIC ACTIVITIES

Battered Women's Consortium - Metro Area
Citizen's League of the Twin Cities Metropolitan Area
Health Care Advisory Committee to the Minnesota Department of Corrections
Member, Board of Governors, University of Minnesota Hospital, 1979-1983
Joint Religious Legislative Coalition - member
Minnesota Association for Retarded Citizens - member
University of Michigan - Alumni Association
University of Michigan School of Public Health - Alumni Association
University of Minnesota - Alumni Association

## PUBLICATIONS, PAPERS, PRESENTATIONS

Guidelines for Levels of Care in Chemical Dependency Services

Adult Day Health Services Guidelines

Family Involvement in Long-Term Care

Guidelines for Social Services in Long-Term Care

Directory of Health Regulatory and Advocacy Groups

Report on the Third Party Reimbursement for Mental Health, Chemical Dependency and Retardation Services

Guidelines for Early and Periodic Screening

Advocacy Definitions - Issues

PUBLICATIONS, PAPERS, PRESENTATIONS (continued)

Supervised Development of Program Guidelines
Health Education
Community Planning
Indian Health Care in Minnesota
Responsibilities of Local Boards of Health and Medical Consultants
Home Care, Long-Term Care

1978 American Public Health Association - Social Work and Public Health Nursing: A Team Approach to Health Policy Development and Implementation.

A Developmental Approach to State Regulation of Minnesota Community Health Services.

REFERENCES

Furnished upon request.

# RESUME

James Terrence Sarazin

| | |
|---|---|
| Date of Birth: | April 30, 1932. |
| Marital Status: | Married, father of three daughters. |
| Address and Telephone Number: | 5201 - 14th Avenue South<br>Minneapolis, Minnesota 55417<br>612/824-9440. |
| Education: | |
| St. Mary's College<br>Winona Minnesota | 1954. B.S.S.<br>Social Sciences, Education. |
| Loyola University<br>Chicago, Illinois | 1955-57. Part-time study in<br>Sociology and Psychology. |
| University of Minnesota | 1959. M.S.W.<br>Social Work. |
| | 1966. M.A.P.A.<br>Public Administraiton. |
| | 1975-76. Part-time study in<br>Organizational Development and<br>Educational Administration. |
| Professional Employment: | |
| Teacher, History and English | 1954-57. St. Mel High School,<br>Chicago. |
| Probation Officer,<br>Adult Division | 1957-60. Hennepin County<br>Department of Court Services,<br>Minneapolis. |
| Counselor/Probation Officer | 1960-61. Hennepin County Home School<br>for Boys, Glen Lake, Minnesota. |
| Division Director,<br>Domestic Relations Division | 1962-67. Hennepin County Department<br>of Court Services. |
| Assistant Director,<br>Community Programs Division | 1967-69. Minnesota Department of<br>Public Welfare (state mental health<br>authority). |
| Director, Community Programs Division | 1969-71. Grants management re<br>community mental health centers. |

Professional Employment (cont'd)

| | |
|---|---|
| Acting Director, Medical Services Division | 1971-73. Administration of state hospitals and Community Programs Division. |
| Bureau Coordinator, Comprehensive Programs Bureau | 1973-76. Bureau included state mental health, alcohol and drug authorities, grants management program for mental health centers, and program licensure functions. |
| Director, Mental Health Program Division | 1976-present. Responsible for assuming high quality cost-efficient and effective services for people with mental illness problems in Minnesota. The Mental Health Division administers over $12 million each year, mainly in grants to counties for Community Support Programs, for residential treatment services for adults, and for federal ADM Block Grant Services. Initiated and implementing program of training professionals and peers to treat compulsive gamblers and to gather base line data on extent of the problem. Responsible for reports to the Legislature on the availability of mental health services in each county. |
| Additional Professional Experience: | 1964-67. Part-time private practice of marriage and family counseling, Minneapolis. |
| | 1964-67, 1971-73. Part-time marriage and family counseling, Catholic Social Service, St. Paul, Minnesota. |
| | 1979-83. Part-time surveyor of community mental health centers for the Joint Commission on the Accreditation of Hospitals. |
| Academic Activities: | |
| University of Minnesota | 1958-59. President, Student Association of Social Workers. |
| | 1976-77. Instructor, Independent Study Program in Mental Health Administration. |

Professional Memberships:

1959-present. National Association of Social Workers, Minnesota Chapter.

1978-1981. Conference of Social Workers in State and Territorial Mental Health Programs, Executive Committee.

1971-present. Member, National Association of State Mental Health Program Directors;
1981-present, chair of the Association's Finance Committee.

PROJECT DIRECTOR

CURRICULUM VITAE

NAME: Bonnie W-H Brysky, A.C.S.W., M.H.A.

EDUCATION: University of Wisconsin, June, 1966, B.S., Major: Philosophy

University of Wisconsin, February, 1969, M.S.S.W.

University of Minnesota, June, 1979, Certificate of Advanced Studies Major in Mental Health Administration

University of Minnesota, August, 1979, M.H.A., Major in Hospital and Health Care Administration

PRESENT POSITION: Director, Mental Health/Community Services Division

Community-University Health Care Center, since April, 1975

RELATED WORK EXPERIENCE:

11-77 to Present Program and Therapy Consultant
The Group Home of the City/Southdale

3-77 o 3-78 St. Josephs Home for Children - Night Child Care Worker

12-71 to 4-75 Community-University Health Care Center,
Minneapolis Coordinator of Mental Health Student Field Placements

4-72 to 1-74 South Minneapolis Coalition, Minneapolis, Minnesota
Community Organizer, Volunteer

2-69 to 11-71 Dane County Mental Health Center, Madison, Wisconsin
Psychiatric Social Worker

9-68 to 2-69 Childrens Treatment Center, Madison, Wisconsin
Child Care Worker

9-68 to 2-69 Childrens Treatment Center, Madison, Wisconsin
Field Placement, University of Wisconsin

Graduate School of Social Work, Psychiatric Social Work

6-68 to 9-68 Headstart, The Bronx, New York City
Social Work Consultant

11-66 to 6-68 Childrens Treatment Center, Madison, Wisconsin
Child Care Worker

9-67 to 6-68 Madison Redevelopment Authority, Madison, Wisconsin

Field Placement, University of Wisconsin Graduate School of Social Work
Community Organizer

6-67 to 7-67 Atwood Community Center, Madison, Wisconsin - Group Worker

1-67 to 6-67 Dane County Department of Social Services, Protective Services Unit, Madison, Wisconsin

Field Placement, University of Wisconsin Graduate School of Social Work
Child Abuse Investigator

6-64 to 8-64 Redevelopment Authority, Columbia, Missouri
Community Organizer

CURRICULUM VITAE

Amos S. Deinard, M.D.

Birthdate: November 12, 1935 Birthplace: Minneapolis, Minnesota

Education:

| Degree: | Year: | Institution: | Major: |
|---|---|---|---|
| B.A. | 1957 | Harvard University<br>Cambridge, Massachusetts | Chemistry |
| | 1957-58 | University of Minnesota<br>Law School | Law |
| M.D. | 1962 | University of Minnesota<br>Medical School | Medicine |
| * M.P.H. | 1985 | University of Minnesota<br>School of Public Health | Maternal & Child Health |

| Positions Held: | Period of Time: |
|---|---|
| Intern, University of Minnesota Hospitals (Pediatrics) | 07/01/62 - 06/30/63 |
| Medical Fellow, Dept. of Pediatrics, Univ. of Minnesota | 07/01/63 - 06/15/65 |
| Research Fellow, Dept. of Pediatrics, Univ. of Minnesota | 06/16/65 - 06/30/69 |
| Instructor, Dept. of Pediatrics, Univ. of Minnesota | 07/01/69 - 06/30/70 |
| Assistant Professor, Department of Pediatrics, University of Minnesota | 07/01/70 - 06/30/75 |
| Assistant Professor, Program in Maternal and Child Health, School of Public Health, Univ. of Minnesota | 10/01/74 - 06/30/75 |
| Associate Professor, Department of Pediatrics, and Program in Maternal and Child Health, School of Public Health, University of Minnesota | 07/01/75 - present |
| Director, Outpatient Clinic Program, Department of Pediatrics, University of Minnesota | 04/01/77 - 12/31/84 |
| Pediatric Consultant, Children and Youth Project, Bureau of Maternal and Child Health, Minneapolis Health Department | 07/01/69 - 8/31/84 |
| Acting Director, Community-University Health Care Center, University of Minnesota | 9/1/84 - present |

Memberships:

American Society of Hematology
Society for Pediatric Research
Sigma Xi
Central Society for Clinical Research
Ambulatory Pediatric Association
American Federation for Clinical Research
Society for Research in Child Development
American Public Health Association
Delta Omega

* Should be completed by fall, 1985

# Committee Activities

## 1) Hospital

| | | | |
|---|---|---|---|
| a. | Chairman | -Concurrent Review Committee | 1975 - 1980* |
| b. | Chairman | -Outpatient Committee | 1979 - present |
| c. | Member | -Quality Assurance Committee | 1975 - 1980* |
| d. | Member | -Utilization-Medical Record Committee | 1980 - present |
| e. | Member | -Emergency Room Committee | 1977 - present |
| f. | Member | -External Disaster Committee | 1977 - present |
| g. | Member | -Quality Assurance Steering Committee | 1980 - present |
| h. | Member | -Hospital Planning Steering Committee | 1980 - 1982 |
| i. | Member | -Ambulatory Care Management Council | 1976 - present |

* These committees were merged on 7/1/80 to form the Utilization-Medical Record Committee.

## 2) Department

| | | | |
|---|---|---|---|
| a. | Director | -Pediatric Clinic | 1977 - 1984 |
| b. | Chairman | -Pediatric Ambulatory Committee | 1976 - 1984 |
| c. | Board Member | -Pediatric Specialists | 1979 - 1981 |
| d. | Member | -Resident Selection Committee | 1979 - present |

## 3) Community

| | | | |
|---|---|---|---|
| a. | Member | -Acute Care Committee, Foundation for Health Care Evaluation (representative from the University Hospitals) | 1975 - 1980 |
| b. | Chairman | -Acute Level of Care Task Force, Foundation for Health Care Evaluation | 1977 - 1980 |
| c. | Member | -Medical Care Evaluation Task Force, Foundation for Health Care Evaluation | 1979 - 1980 |
| d. | Chairman | -Quality Assurance Review Task Force, Foundation for Health Care Evaluation | 1979 - 1981 |
| e. | Member | -Reuben Lindh Learning Center | 1984 - present |

## 4. University

| | | | |
|---|---|---|---|
| a. | Member | -Committee on the Use of Human Subjects in Research | 1982 - present |
| b. | Member | -Senate Judicial Committee | 1983 - present |
| c. | Member | -Center for Early Education & Development Continuing Education Task Force | 1984 - present |

## 5) Medical School

| | | | |
|---|---|---|---|
| a. | Member | -Ambulatory Care Rotation Planning Committee | 1982 - 1984 |

PUBLICATIONS


1. Deinard, A.S. and Page, A.R.: An Improved Method for Performing Neutrophil Survival Studies. Blood 36:98, 1970.

2. Deinard, A.S. and Bilka, P.J.: Joint Involvement Following Vaccination for Rubella--An Unusual Presentation in an Adult. Minnesota Medicine 54:377, 1971.

3. Deinard, A.S. and Libit, S.A.: Coagulase Negative Staphylococcus Bacteriuria in a Child. Pediatrics 49:300, 1972.

4. Gatti, R.A., Robinson, W.A., Deinard, A.S., Nesbit, M., McCullough, J.J., Ballow, M. and Good, R.A.: Cyclic Leukocytosis in Chronic Myelogenous Leukemia: New Perspectives on Pathogenesis and Therapy. Blood 41:771, 1973.

5. Deinard, A.S., Hoban, T.W. and Venters, H.D.: Clinical Reactions in Children after Rubella Vaccination. Health Service Reports 88:457, 1973.

6. Deinard, A.S., Fortuny, I.E., Theologides, A., Anderson, G.L, Boen, J. and Kennedy, B.J.: Studies on the Neutropenia of Cancer Chemotherapy. Cancer 33:1210, 1974.

7. Deinard, A.S., Bilka, P.J., Venters, H.D., Herrmann, K.L. and Page, A.R.: Rubella Antibody Titers in Patients with Rhematoid Arthritis. Lancet I: 526, 1974.

8. Anderson, G.L. and Deinard, A.S.: The Nitroblue Tetrazolium (NBT) Test: A Review. Am. J. Med. Tech. 40:345, 1974.

9. Biggar, W.D., Holmes, B., Page, A.R., Deinard, A.S., L'Esperance, P. and Good, R.A.: Metabolic and Functional Studies of Monocytes in Congenital Neutropenia. Brit. J. Haemat. 28:233, 1974.

10. Deinard, A.S. and Page, A.R.: A Study of Steroid-Induced Granulocytosis in a Patient with Chronic Benign Neutropenia of Childhood. Brit. J. Haemat. 28:337, 1974.

11. Fisch, R., Deinard, A., Disch, L. and Krivit, W.: Potential Toxicity of Iron Overload in Successive Generations of Rats. Am. J. Clinic. Nutr. 28:136, 1975.

12. L'Esperance,P., Brunning, R., Deinard, A.S., Park, B.H., Biggar, W.D. and Good, R.A.: Congenital Neutropenia: Impaired Maturation with Diminished Stem-Cell Input. Immunodeficiency in Man and Animals. Ed. - Bergsma, D., Vol. XI, pp. 59-65, 1975.

13. Gonyea, L.M., Lamb, C.M., Sundberg, R.D. and Deinard, A.S.: Isolation of Human Ferritin for Use as a Standard in an Immunoradiometric Assay. Clin. Chem. 22:513-518, 1976.

Publications (cont'd)


14. Deinard, A.S., Murray, M.J. and Egeland, B.: Childhood Iron Deficiency and Impaired Attentional Development or Scholastic Performance: Is the Evidence Sufficient to Establish Causality? J. Pediatr. 88:162-163, 1976.

15. Fisch, R.O., Bilek, M.K., Deinard, A.S. and Chang, P.: Growth, Behavioral and Psychological Measurements of Adopted Children: The Influence of Genetic and Socioeconomic Factors in a Prospective Study. J. Pediatr. 89:494-500, 1976.

16. McCullough, J., Weiblen, B.J., Deinard, A.S., Boen, J., Fortuny, I.E. and Quie, P.G.: In vitro Function and Post-Transfusion Survival of Granulocytes Collected by Continuous-Flow Centrifugation and by Filtration Leukapheresis. Blood 48:315-326, 1976.

17. Deinard, A.S. and Libit, S.: Screening of a High-Risk Ambulatory Female Population for Urinary Tract Infection: A Cost-Effectiveness Study. Minn. Med. 60:123-126, 1976.

18. Fortuny, I.E., Theologides, A., Hadlock, D.C., Kennedy, B.J. and Deinard, A.: Neutrophil Leukocyte Reserves in Lymphoreticular Malignancies. Med. Pediatr. Oncol. 2:167-172, 1976.

19. Fortuny, I.E., Deinard, A. and Theologides, A.: The Rebuck Skin Window as a Guide in Cancer Chemotherapy. Cancer Treat. Rep. 60: 903-906, 1976.

20. Egeland, B., Phipps-Yonas, S., Brunnquell, D. and Deinard, A.: A Prospective Study of the Antecedents of Child Abuse. Caring, Vol. 5(4):1-4, 1979.

21. Vaughn, B., Deinard, A. and Egeland, B.: Measuring Temperament in Pediatric Practice. J. Pediatr. 96:510-514, 1980.

22. Deinard, A.S., Dassenko, D., Kloster, B., Welle, P. and Zavoral, J.: Otogenous Tetanus. JAMA 243:2156, 1980 (letter).

23. Deinard, A.S., Geehan, G., Page, A.R. and Holmes, B.: Function Studies of Monocytes from Patients with Cyclic Neutropenia. Am. J. Ped. Hemat/Onc. 2:201-206, 1980.

24. Deinard, A.S., Gilbert, A., Dodds, M. and Egeland, B.: A Study of Iron Deficiency and Behavioral Deficits. Pediatrics 68:828-833, 1981.

25. Deinard, A.S. and Ogburn, P.: A/NJ/8/76 Influenza Vaccination Program - Effects on Maternal Health and Pregnancy Outcome. Am. J. Obstet. Gynecol. 140:240-245, 1981.

Publications (cont'd)


26. Chang, P.N. and Deinard, A.S.: Assessment of Behavioral Aspects of Iron Deficiency and Iron Deficiency Anemia. Proceedings of the First International Lead Conference, September: 106-115, 1981.

27. Chang, P. and Deinard, A.S.: The Single Father Caretaker: Demographic Characteristics and Adjustment Processes. Amer. J. Orthopsychiatry 52:236-243, 1982.

28. Deinard, A.S., Schwartz, S. and Yip, R.: Developmental Changes in Serum Ferritin and Erythrocyte Protoporphyrin in Normal (Non-Anemic) Children. Am. J. Clin. Nutr. 38:71-76, 1983.

29. Yip, R., Schwartz, S. and Deinard, A.S.: Screening for Iron Deficiency with the Erythrocyte Protoporphyrin Test. Pediatrics 72:214-219, 1983.

30. Oberg, C.N. and Deinard, A.S.: Marasmus in a 17-Month Laotian: Impact of Folk Beliefs on Health. Pediatrics 73:254-257, 1984.

31. Miller, V., Onotera, R.T., and Deinard, A.S.: The Denver Developmental Screening Test - Cultural Variations in Southeast Asian Children. J. Pediatr. 104:481-482, 1984.

32. Yip, R., Deinard, A. and Schwartz, S.: Hematocrit Values in White, Black and American Indian Children with Comparable Iron Status: Evidence to Support Uniform Diagnostic Criteria of Anemia for All Races. Am. J. Dis. Child. 138:824-827, 1984.

33. Fifield, G.C., Magnuson, C., Carr, W.P. and Deinard, A.S.: Pediatric Emergency Care in a Metropolitan Area. J. Emerg. Med. 1:495-507,1984.

34. Miller, V., Swaney, S. and Deinard, A.S.: The Impact of the WIC Program on the Iron Status of Young Children. Pediatrics 75:100-105, 1984.

35. Rosen, G.M., Deinard, A.S., Schwartz, S. and Smith, C.: Iron Deficiency Among Incarcerated Juvenile Delinquents. J. Adolesc. Health Care (accepted for publication).

MANUSCRIPTS IN PREPARATION

1. Luikens, B., Chun, K. and Deinard, A.: Intestinal Parasites and Iron Status in Southeast Asian Refugees.

2. Chun, K. and Deinard, A.S.: Iron and Lead Status in Southeast Asian Refugee Children.

3. Deinard, A.S. and Dunnigan, T.: Southeast Asian Health Care - Reflections on a Five-Year Experience.

4. Blankson, M. and Deinard, A.: Breast Feeding Practices Among Low Socioeconomic Status Blacks.

5. Deinard, A., List, A., Lindgren, B., Hunt, J. and Chang, P.: Cognitive Deficits in Iron Deficient and Iron Deficient and Anemic Children.

6. Deinard, A. and Eaton, J.: Hair Zinc Concentration Depends on Hair Color.

7. Deinard, A., Dodds, M., Pianta, R., and Egeland, B.: Environmental Factors Influence Scores on the Bayley Scales of Infant Development.

8. Deinard, A., Pianta, R., and Egeland, B.: Nurses Ratings of Newborns Predicts Later Maternal Attachment and Infant Outcomes.

9. Cifuentes, R. and Deinard, A.: Plasma Ferritin Levels and Estimated Iron Balance in Very Low Birth Weight (VLBW) Infants.

GRANTS AND AWARDS

1. The Arthritis Foundation - Minnesota Chapter. White Cell Kinetics in Mesenchymal Disease States. 7/1/68 - 6/30/71 (total = $4,560). Principal Investigator.

2. American Cancer Society, Minnesota Division, Inc. White Cell Kinetics in Malignant Disease. 6/1/68 - 6/30/70 (total = $9,600). Principal Investigator.

3. Minnesota Heart Association. An Investigation of Anergy to SK-SD Associated with Acute Nephritis. 9/1/68 - 8/31/69 (total = $2,970). Principal Investigator.

4. Damon Runyon Memorial Fund for Cancer Research, Inc. A Study of Therapy - Induced Neutropenia in Patients Who are Being Treated for Solid Tumors. 7/1/70 - 6/30/74 (total $89,200). Principal Investigator.

5. University of Minnesota Graduate School. Prevention of Iron Deficiency in Children from the Poverty Area. 7/1/71 - 6/30/72 (total = $2,000). Principal Investigator.

6. Kidney Foundation of the Upper Midwest, Inc. Pathogenic Mechanisms of Bacteriuria. 7/1/71 - 6/30/72 (total = $1,000). Principal Investigator.

7. Minnesota Medical Foundation. Urinary Immunoglobulins and Their Relationship to Bacteriuria. 12/1/71 - 11/30/72 (total = $2,500). Principal Investigator.

8. Maternal and Child Health and Crippled Childrens Services. Early Detection of Children at Risk for Iron Deficiency. 6/15/72 - 6/14/75 (total = $146,050). Principal Investigator.

9. University of Minnesota Graduate School. Does Hypoferremia Affect Cognition or Attention? 7/1/75 - 6/30/76 (total = $2,000). Principal Investigator.

10. Center for Disease Control. A/New Jersey/8/76 Influenza Vaccine--Effects on Maternal Health and Pregnancy Outcome. 9/1/76 - 12/31/77 (total = $55,630). Principal Investigator.

11. Office of Human Development/Office of Child Development. Child Abuse and Neglect Research and Demonstration Project -- A Prospective Study of the Antecedents of Child Abuse. 5/1/75 - 6/30/78 (total $442,756). Co-Principal Investigator.

12. Office of Child Development. Child Welfare Research and Demonstration Project. The Effects of Parental Knowledge and Expectations on the Development of Child Competence. 12/1/77 - 5/31/79 (total $106,141). Co-Principal Investigator.

GRANTS AND AWARDS (continued)

13. Maternal and Child Health and Crippled Children's Services. Early Maladaptation - A Prospective-Transactional Study. 5/1/78 - 4/30/83 (total = $486,309). Co-Principal Investigator.

14. Maternal and Child Health and Crippled Children's Services
The Ford Foundation
Ross Laboratories
General Mills
Pillsbury Company
Gerber Products
Behavior and Iron Status - A Preliminary Study. 4/1/77 - 3/31/79 (total = $114,530). Principal Investigator.

15. Minnesota Medical Foundation. The Single Father Caretaker - A New Societal Entity. 7/1/78 - 6/30/79 (total = $5,000). Co-Principal Investigator.

16. Food and Drug Administration. Relationship Between Iron Status and Mental Development. 10/1/79 - 9/30/83 (total $514,534). Principal Investigator.

17. Department of Agriculture. A Model WIC Clinic Serving Indochinese Refugees. 1/21/80 - 7/20/81 (total = $66,664). Co-Principal Investigator. Awarded to Minneapolis Health Department.

18. Northwest Area Foundation. Health Care for Indochinese Refugees. 3/15/80 - 3/14/81 (total = $75,000). Principal Investigator. Awarded to Minneapolis Health Department.

19. Northwest Area Foundation. Health Care for Indochinese Refugees. 3/15/81 - 3/14/82 (total $125,000). Principal Investigator. Awarded to Minneapolis Health Department.

20. University of Minnesota Graduate School. Relationship Between Family and Individual Characteristics and Various Custody Arrangements. 1/1/83 - 6/30/83 (total $7,000). Co-Principal Investigator.

21. W.T. Grant Foundation. The Development of Adaptation/Maladaptation in Early School Years. 3/1/83 - 2/28/86 (total $85,699). Co-Principal Investigator.

22. Office of Special Education. Developmental Antecedents of Educational Handicaps in a High-Risk Sample. 1/1/83 - 12/31/87 ($91,869 - first year). Co-Principal Investigator.

23. Department of Health and Human Services - Office of Refugee Resettlement. Refugee Health Professional/Paraprofessional Retraining Project. 10/1/83 - 3/31/85. (total = $91,264). Principal Investigator.

GRANTS AND AWARDS (continued)

24. Burroughs-Wellcome Co. A Controlled Clinical Trial to Determine the Effectiveness and Tolerance of Permethrin 1% Creme Rinse as a Pediculicide and Ovicide for Pediculus humanus capitis (head lice). 1/1/84 - 7/31/84. ($19,200)

25. Burroughs-Wellcome Co. A Controlled Clinical Trial to Determine the Effectiveness and Tolerance of Permethrin 1% Creme Rinse in the Prevention of Infestation with Pediculus humanus capitis (head lice). 1/1/85 - 4/30/85. ($40,000)

ABSTRACTS AND PRESENTATIONS

1. Lillehei, C.W. and Deinard, A.S.: Surgical Treatment of Atrial Secundum Defects Utilizing the Pump-Oxygenator. (Abstract - American College of Cardiology, 1963).

2. Deinard, A.S., Nesbit, M.E., Gatti, R.A. and Page, A.R.: Neutrophil Kinetics in Chronic Myelogenous Leukemia. (Abstract - Society for Pediatric Research, 1970).

3. Gatti, R.A., Deinard, A.S., Nesbit, M.E., Robinson, W.A. and Good, R.A.: Chronic Myelogenous Leukemia. Studies of Cyclic Leukocytosis and Identical Twin Discordance. (Abstract - Society for Pediatric Research, 1970).

4. Gatti, R.A., Robinson, W.A., Deinard, A.S., Nesbit, M., Ballow, M. and Good, R.A.: Studies on the Pathogenesis and Treatment of Chronic Myelogenous Leukemia. (Abstract - ESPHI Meeting, Hamburg, Germany, September 9, 1972).

5. Deinard, A.S., Fortuny, I.E., Theologides, A. and Kennedy, B.J.: Granulocyte Stores, Release and Function in the Neutropenia of Cancer Therapy. (Abstract - XIV International Congress of Hematology, San Paulo, Brazil, July, 1972).

6. McCullough, J., Fortuny, I.E., Deinard, A.S. and Hadlock, D.C.: In Vitro Function and In Vivo Survival of Fresh and Stored Granulocytes Collected Using the Continuous-Flow Centrifuge. (Abstract - Amer. Assoc. Blood Banks, Miami, November, 1973).

7. Hadlock, D.C., Deinard, A.S., McCullough, J. and Fortuny, I.E.: Intravascular Kinetics of Transfused Granulocytes in Febrile Neutropenic Patients. (Abstract - Amer. Assoc. for Cancer Research - Houston, Texas, March, 1974).

8. Hadlock, D.C., McCullough, J., Deinard, A.S., Kennedy, B.J. and Fortuny, I.E.: Role of Continuous-Flow Centrifuge (CFC) Leukapheresis in the Management of Chronic Myelogenous Leukemia (CML). (Abstract - Amer. Soc. of Clinical Oncology - Houston, Texas, March, 1974).

9. Deinard, A.S., Nelson, W., Kuhl, J.F.W., Halberg, E., Carandente, A. and Halberg, F.: Physiologic "erogodicity"of Circadian Leukocyte Dynamics and Circadian Stage Dependence of Methylprednisolone Effects on Serum Corticosterone and White Blood Cells. (Abstract - XII International Conference, International Society for Chronobiology, NIH, Bethesda, Maryland, August, 1975).

10. McCullough, J., Weiblen, B.J., Hadlock, D., Deinard, A.S., Fortuny, I.: Effects of Collection and Storage on Granulocyte Post-Transfusion Survival. (Abstract - Amer. Assoc. Blood Banks, Chicago, Illinois, November, 1975).

ABSTRACTS - Continued

11) Fortuny, I., Theologides, A. and Deinard, A.: Skin Window Inflammatory Response in the Neutropenia of Cancer Chemotherapy. (Abstract - 57th Annual Session of American College of Physicians. Philadelphia, Pa., April, 1976).

12) Taraldson, B., Brunnquell, D., Deinard, A.S. and Egeland, B.: Psychometric and Theoretical Credibility of Three Measures of Infant Temperament. (Abstract-the Society for Research in Child Development. New Orleans, La., March, 1977).

13) Deinard, A.S., Brunnquell, D., Taraldson, B. and Egeland, B.: An Evaluation of Three Measures of Infant Temperament. (Abstract - Society for Pediatric Research, San Francisco, CA., April, 1977).

14) Egeland, B. and Deinard, A.S.: Preliminary Results of a Prospective Study of Antecedents of Child Abuse. (Abstract-the Second International Congress on Child Abuse. London, England, September, 1978).

15) Vaughn, B., Joffe, L., Egeland, B., Deinard, A.S. and Waters, E.: Relationships between Neonatal Behavior and Infant-Mother Attachment (Abstract - Society for Research in Child Development. San Francisco, Ca., March, 1979).

16) Yip, R. and Deinard, A.S.: The Value of Free Erythrocyte Protoporphyrin (F.E.P.) for Screening of Iron Deficiency. (Abstract - 52nd Annual Meeting of the Central Society for Clinical Research. Chicago, Ill., November, 1979).

17) Yip, R. and Deinard, A.S.: The Value and Optimal Screening Level of Free Erythrocyte Protoporphyrin (F.E.P.) for Iron Deficiency. (Abstract - 22nd Annual Meeting of the American Society of Hematology, Phoenix, Az., December, 1979).

18) Yip, R., Deinard, A.S., Schwartz, S. and Stephenson, B.: Erythrocyte Protoporphyrin (EP): The Ratio of Free EP to Zinc-Complexed EP in Normal Children. (Abstract - 51st Annual Meeting of the Society for Pediatric Research, San Francisco, Calif., April, 1981).

19) Yip, R., Deinard, A.S., and Schwartz, S.: Hematocrit Status in White, Black and American Indian Children with Comparable Iron Nutrition. (Abstract - 22nd Annual Meeting of the Ambulatory Pediatric Association, Washington, D.C., May, 1982).

20) Chun, K. and Deinard, A.S.: Iron Status and Lead Overburden in Southeast Asian Children. Northwestern Pediatric Society, September, 1983.

ABSTRACTS - Continued

21) Rosen, G.M., Deinard, A.S., and Schwartz, S.: Iron Deficiency Among Incarcerated Juvenile Delinquents. (Abstract - 53rd Annual Meeting of the Society for Pediatric Research, San Francisco, California, May, 1984.)

22) Cifuentes, R.F., Miller, P.A. and Deinard, A.S.: Estimated Iron Balance and Plasma Ferritin Levels in VLBW Infants. (Abstract - 53rd Annual Meeting of the Society for Pediatric Research, San Francisco, California, May, 1984.)

23) Johnson, K., Deinard, A., Miller, V., and Roan, M.: Refugee Health Professional/Paraprofessional Retraining Program. American Public Health Association, November, 1984.

24) Miller, V., Deinard, A. and Swaney, S.: The Impact of WIC on the Iron Status of Young Children. American Public Health Association, November, 1984.

# TEACHING

1) Medical Students

a. Peds 5-520 - Outpatient Pediatrics - clinic tutorial
UMI and Minneapolis Health Department.
One-three students per six-week rotation.
b. Station 59 - one month each year - 1982-present.

2) Housestaff

a. PL-2 - Mentor to 1-4 residents yearly during their one-half day a week ambulatory rotation.

| | | | |
|---|---|---|---|
| 1. | 1979-1980 | Marjorie Hogan | 18 weeks |
| 2. | 1980-1981 | Michael Silberbach | 12 weeks |
| | | Charles Oberg | 12 weeks |
| | | Karl Chun | 18 weeks |
| 3. | 1981-1982 | James Lindsay | 26 weeks |
| | | Kathy Hackett | 26 weeks |
| 4. | 1982-1983 | Jean Gose | 12 weeks |
| | | Barbara Schaubach | 36 weeks |
| | | James Nelson | 36 weeks |
| | | Michael Nation | 26 weeks |

b. PL-1-2-3
Station 59 - one month each year - 1982-present.

3) Fellows

Yearly involvement, together with other faculty of Ambulatory Program, with those who have taken Ambulatory Fellowship.

| | Year | Fellow | Present Location |
|---|---|---|---|
| a. | 1978-1979 | Craig Humphries | St. Paul Children's Hospital |
| | | Pam Geller | Private Practice-South Carolina |
| | | Sally Colwell | St. Louis Park Clinic |
| | | Jeff Smith | Nicollet Clinic |
| | | Brooks Donald, M.P.H. (MCH) | HMO & Public Health-St. Cloud |
| b. | 1979-1980 | Eva Bleeker | Share Clinic |
| | | Carol Magnuson | Private Practice-Wisconsin |
| | | Kristi Klett | St. Louis Park Clinic |
| | | Ray Yip, M.P.H. (MCH) | USPHS - Centers for Disease Control |
| c. | 1980-1981 | Mary Blankson, M.P.H. (MCH) | CUHCC, Asst. Director, 1983-84 |
| | | James Clark | Nicollet Clinic |
| | | Marjorie Hogan (MPH candidate) | Minneapolis Children's Hospital |
| | | Howard Stang | Group Health Clinic |
| | | Jeffrey Goldhagen (MPH candidate) | Minneapolis Children's Hospital |
| d. | 1981-1982 | Mary Blankson, M.P.H. (MCH) | |
| | | Virginia Baldwin | Share Clinic |
| | | Jean Temeck | Endocrinology Fellowship-NYU |
| | | Mary Roth | Private Practice-St. Paul |

TEACHING (continued)

| | | | |
|---|---|---|---|
| e. | 1982-83 | Mary Blankson, M.P.H. (MCH)<br>Karl Chun, MPH (Epidemiology)<br>Charles Oberg, M.P.H. (MCH) | CUHCC - staff physician<br>Congressional Science Fellow i<br>Child Development (spons -<br>American Association for the<br>Advancement of Science) |
| f. | 1983-1984 | Sandra Mayrand<br>Karl Chun, M.P.H. (Epidemiology)<br>Charles Oberg, M.P.H. (MCH) | Private Practice |
| g. | 1984-1985 | Kent Wegmann<br>David Lipsitz (M.P.H. candidate)<br>Wendy Kahn (M.P.H. candidate) | |

4) Nurse Practitioner Students

Mentor to three students yearly - clinics - UMH and Minneapolis Health Department. 1978-1983.

5) Individual Residents - Clinic Mentor

Bruce Kloster - 1½ years
Alan Bober - 6 months

6) Graduate Students

| | | | |
|---|---|---|---|
| a. | Mary Blankson | - research advisor - M.P.H. | 1980-1982 |
| b. | Charles Oberg | - research advisor - M.P.H. | 1982-1984 |
| c. | Karl Chun | - research advisor - M.P.H. | 1982-1984 |
| d. | Virginia Miller | - research advisor - M.P.H. | 1981-1983 |
| e. | Julie Johnson | - advisor - undergraduate Summa thesis | 1983-present |
| f. | Renee Lemieux | - advisor and thesis committee member - Ph.D. - Educational Psychology | 1983-present |
| g. | Barbara Luikens | - research advisor - medical student | 1982-1984 |
| h. | Kay Stuart | - research advisor - M.P.H. | 1984-present |
| i. | Wendy Kahn | - research advisor - M.P.H. | 1984-present |
| j. | David Lipsitz | - research advisor - M.P.H. | 1984-present |

## JOURNAL REFEREE

1. American Journal of Clinical Nutrition
2. Developmental Psychology
3. Journal of Pediatrics
4. Pediatrics
5. Science
6. Public Health Reports

# CURRICULUM VITAE

## Personal Data:

Richard E. Immler
1463 Sargent Ave.
St. Paul, MN 55105

Home: (612) 698-3940
Work: (612) 373-8484

Date: September 1, 1984
Date of Birth: November 19, 1951
Place of Birth: Tomahawk, WI

Spouse: Pamela J. Thul-Immler, RN, MPH, ANP
Children: None

## Education:

| | |
|---|---|
| 8/70 - 5/74 | B.S. in Math, Marquette University, Milwaukee, WI |
| 8/74 - 5/78 | M.D., University of Wisconsin Medical School, Madison, WI |
| 7/78 - 6/79 | Flexible Internship, Hennepin County Medical Center, Minneapolis, MN |
| 7/82 - 6/84 | Adult Psychiatry Residency, University of Minnesota |
| 7/84 - Present | Child Psychiatry Fellowship, University of Minnesota |
| 7/84 - Present | Interdisciplinary Program in Public Health (Toward MPH), University of Minnesota |

## Experience:

| | |
|---|---|
| 7/79 - 7/80 | General Practitioner with emphasis in pediatrics. Shiprock Indian Health Service Hospital, Shiprock, NM |
| 7/80 - 7/81 | Clinical (Medical) Director, Shiprock Indian Hospital |
| 9/81 - 4/82 | Volunteer General Practitioner and Health Educator, Phanatnikon and Nong Samet Refugee Camp, Thailand |
| 5/83 - 5/84 | Chairperson, American Refugee Committee, domestic subgroup for Southeast Asian mental health advocacy |
| 7/83 - 6/84 | President, University of Minnesota Psychiatric Residents Association |
| 7/83 - Present | Psychiatric Coverage (moonlighting part-time), Hennepin County, Crisis Intervention Center |

Honors:

| | |
|---|---|
| 1973 | Elected to Phi Beta Kappa as a Junior |
| 1974 | Graduated Summa Cum Laude |
| 1977 | Medical Assistance Program (Reader's Digest) Scholarship for Clerkship at Hospital in Liberia, West Africa (3-5/78) |
| 1978 | Wisconsin State Medical Society Medical Student Award for scholastic achievement and interest in medical organization |
| 1981 | U.S. Public Health Service Commissioned Officer's Award for outstanding service |

Professional Memberships:

U.S. Public Health Serice Commissioned Officers Association (Inactive)
American Psychiatric Association
Minnesota Psychiatric Association
University of Minnesota Psychiatry Residents Association

Medical Licensure:

| | |
|---|---|
| 1979-present | Minnesota |

Publications:

None

References:

1. Richard Miner, MD, Training Director, University of Minnesota Department of Psychiatry, Box 95 Mayo, 420 Delaware SE, Minneapolis, MN 55455

2. Allan Josephson, MD, Clinical Supervisor in Child and Adolescent Psychiatry, University of Minnesota, Box 95 Mayo, 420 Delaware SE, Minneapolis, MN 55455

3. Robert Murtaugh, MD, Clinical Supervisor, Adult Psychiatry, Veterans Administration Medical Center, 54th St. and 48th Ave. S., Minneapolis, MN 55417

RESUME

JANE FRUEHLING KRETZMANN


Address: 3301 46th Avenue South
Minneapolis, MN 55406
(612) 722-5656


Personal Data: Birthdate: January 19, 1949
Birthplace: Waverly, Iowa
Married
Excellent health

Education:

1973 - 1975 University of Iowa, Iowa City, Iowa
M.A. Counselor Education

1967 - 1971 University of Iowa, Iowa City, Iowa
B.A. English
Iowa and Minnesota State Teacher's Certification

Employment Experience:

March, 1978--present Supervisor of Indochinese Resettlement Office, Department of Public Welfare, and State Coordinator of Refugee Program in Minnesota. Responsible for administration of special programs and services to Indochinese refugees in Minnesota. Responsibilities include development of a statewide plan for refugee services, coordination of delivery of services, negotiations with appropriate agencies for development of educational, employment, health and other services for refugees; instruction of local welfare agencies; development of statewide computer system to track services to refugees; administration of federal special grant funds and state contracts for purchased social services for refugees as well as interagency agreements with other state departments; represent the Department of Public Welfare in refugee concerns with federal state, and local agencies, and the media. Provide information to refugees; ensure adequate provider performance; supervise unit staff; plan for future program

services to refugees; administer all funds for refugees including all cash assistance, medical assistance social service and administrative costs incurred in the delivery of services to refugees and secure necessary federal support. Recommend departmental policy related to the state's supervision of the refugee program.

February 1976--1978

Social worker and Coordinator of Refugee Resettlement Program, Lutheran Social Service of Minnesota, Minneapolis. Regional Consultant for Lutheran Immigration and Refugee Service (October 1976-March 1978). Initially performed casework services in the follow-up program to Indochinese refugees and sponsors under auspices of LIRS and LSS. While continuing to work in that capacity, responsibilities evolved to include management of refugee program, supervision of Indochinese staff, maintenance of records, securing funds, reporting and responding to requests from the national voluntary agency, attending meetings with other voluntary agency representatives, obtaining sponsors, cooperating with other LSS staff in program maintenance and responding programmatically to meet and/or identify needs of refugees in the state.

July - December 1975

Director of Matching, Lutheran Immigration and Refugee Service (LIRS), Ft. Indiantown Gap, PA. Placed Indochinese sponsors with verified sponsors. Prepared sponsors and refugees with information regarding one another, the role of a sponsor, expectations. Coordinated with other voluntary agencies, communicated with local voluntary agency personnel around the U.S. Supervised matching staff. Developed sponsorships. Attended meetings with government personnel in charge of camp.

Interviewed refugees in close cooperation with bilingual interpreters.

| | |
|---|---|
| June 1975 | Research Assistant, Iowa Testing Programs, University of Iowa, Iowa City, IA. Assisted in the compilation of data and prepared hypotheses for a booklet dealing with the appropriate usage of data from the Iowa Tests of Educational Development. |
| 1974-1975 | Graduate Assistant, Iowa Testing Programs, University of Iowa. Test Consultant to Iowa elementary and secondary schools. Prepared longitudinal performance data and presented and discussed interpretations with faculties, school boards, and/or administrators. |
| 1974-1975 | Professional patient, University of Iowa Hospitals. Instructed medical students on examination procedures and interpersonal communication techniques appropriate to clinical settings. |
| Summer 1974 | Administrative Assistant, Orientation Office, University of Iowa. Arranged a special orientation program for transfer students. |
| 1973 - 1974 | Graduate Assistant, Office of Student Activities, University of Iowa. Advisor to student groups. |
| 1971 - 1973 | Seventh Grade Language Arts Teacher, Harding Junior High, Cedar Rapids, Iowa. Planned and taught curriculum on an individual and team teaching basis. Worked in open spaces learning areas. Directed the school plays. |
| Summers 1963 - 1970 | Employee, Wartburg College Bookstore, Waverly, Iowa. |

**Completed Practica:**

| | |
|---|---|
| Fall, 1970 | Secondary student teaching: Harding Jr. High |
| Spring, 1974 | School Counseling: Fairmount Elementary School for the Learning Disabled, Davenport, I |
| Summer, 1974 | Group Facilitation: University of Iowa. |

**Related Experience:**

| | |
|---|---|
| 1972 - 1975 | Volunteer for Iowa City Crisis Center, a walk-in and call-in short term counseling center. Served as on-call emergency staff. Trained new volunteers in special 40 hour training. |
| Spring 1975 | Group leader for Communications in Medicine Workshop, University of Iowa College of Medicine. |
| Credentials on File: | Educational Placement Office<br>C103 East Hall, University of Iowa,<br>Iowa City, Iowa 52242<br>(319) 353-4365 |
| References Available: | upon request |

NEELAM BHATEJA, ACSW

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7791 Jeffery Avenue South
Cottage Grove, MN 55016
(612) 459-0475

Wilder Foundation
St. Paul, MN
Project Coordinator..... May 1983 to present

Supervised community care workers for Southeast Asian Refugee Project. Coordinated formal and informal care teams; developed and implemented training program for lay leaders and participants. Developed and refined service protocols, broker services, and coordinated between agencies to provide services. Provided direct care: group facilitation, crisis intervention, and case work.

Midland Public Schools
Midland, MI
School Social Worker.....February 1980 to September 1982

As a member of a multidisciplinary evaluation team, coordinated team efforts; performed diagnostic evaluation of students suspected of being hancicapped. In the area of social intervention, counseled general and special education students in individual and group settings. Consulted with parents, classroom teachers, and school administrators regarding educational planning and intervention. Provided interagency coordination and supportive services for students and parents.

Christian Children's Fund, Inc.
Delhi, India
Child Care Officer..... February 1978 to October 1978

Trained new project directors to develop family helper projects based on sponsorship program. Provided in-service training for project staff. Performed ongoing evaluation of family helper and community projects. Made recommendations for effective programming. Work involved extensive contact with local, national, and international agencies.

Directorate of Social Welfare
Delhi, India
Case-Worker..... December 1977 to January 1978

Performed intake interviews; counseled clients in correctional institution. Provided rehabilitation programs for clients.

Delhi Council for Child Welfare
Delhi, India
Supervisor..... May 1976 to November 1977

Provided planning and administration for training center. Taught courses in social work to child care workers, coordinating instruction with professionals from health, nutrition, and child development fields. Also supervised day care centers for pre-schoolers.

Psychological Research and Services Center
Delhi, India
Research Investigator..... January 1976 to March 1976

Compiled and analyzed data collected through interviews.

## EDUCATION

University of Delhi
Delhi, India

Awarded Master's of Social Work degree in February 1976. Credentials certified by Council on Social Work Education, New York, NY; and Michigan State University, East Lansing, MI.

As part of Master's program: performed investigations and placements for Foster Home; conducted surveys for Family Welfare Planning Clinic; directed service and educational programs for Healthy Family Life; performed investigations and placements for juvenile delinquents, neglected and abused children for Detention Home for Boys.

Awarded Bachelor of Arts degree in February 1973.

## VOLUNTEER

Crisis Intervention Center, Midland, MI

Delhi Women's Welfare Association, Delhi, India

## MEMBERSHIPS

National Association of Social Workers
Licensed School Social Worker II

2. Staff Resumes

a) Project Director

CURRICULUM VITAE

NAME: Thomas A. Duke, Ph.D.

EDUCATION:

Capital University, Columbus, Ohio 1963, BA
Luther Theological Seminary, St. Paul, Minnesota, 1967, B. Divinity
Andover Newton Theological School, Boston Massachussetts, 1968, M. Sacred Theology in Pastoral Counseling
University of Minnesota, 1974, M.A. Education
University of Minnesota, 1979, Ph.D. Higher Education

PRESENT POSITION:

Director of the Community Care Unit, Amherst H. Wilder Foundation, St. Paul, MN, Since July 1979.

RELATED WORK EXPERIENCE:

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|---|---|
| 9-76 to 7-79 | Community Care Unit, Amherst H. Wilder Foundation<br>Program Coordinator. |
| 9-68 to 8-76 | Luther-Northwestern Theological Seminary, St. Paul, Minnesota.<br>Instructor in Department of Pastoral Theology and Ministry. |
| 9-72 to 5-74 | University of Minnesota, College of Education<br>Research Scientist. |
| 9-69 to 8-72 | Bethlehem Lutheran Church, St. Paul, Minnesota<br>Associate Pastor. |
| 9-66 to 8-67 | Plymouth Youth Center, Minneapolis, Minnesota.<br>Coordinator of St. Paul Area Kinship Program. |
| 1-68 to 8-68 | Tewbsbury State Hospital, Tewbsbury, Massachusetts.<br>Assistant Supervisor of Clinical Pastoral Education while on Field Placement<br>from Andover Newton Theological School. |

MEMBERSHIPS:

American Association of Pastoral Counselors, Diplomat
The American Luthern Church, Ordained Minister
American Association of Prevention Professionals

# CURRICULUM VITAE

**Name:** Beatrice Ellen Robinson

**Social Security Number:** 073-40-8573

**Address:**

**Home:**
597 Sterling Street
Maplewood, Minnesota 55119
(612) 738-0031

**Office:**
Amherst H. Wilder Foundation
Office of Research and Statistics
919 Lafond Avenue
St. Paul, Minnesota 55104
(612) 642-4068

Community Counseling Center
4820 Cook Avenue
White Bear Lake, Minnesota 55110
(612) 429-8544

**Education:**

University of Minnesota, Ph.D., 1983 (Family Social Science)
University of Minnesota, M.A., 1979 (Counseling Psychology)
State University of New York (SUNY) at Binghamton, B.A., 1972 (Sociology)

**Honors and Special Awards:**

Magna Cum Laude
Phi Beta Kappa
New York State Regents Scholarship
U. S. Government Rehabilitation Trainee Grant
Freeport High Scholarship
Omicron Nu Honor Society

**Licenses and Certifications:**

Licensed Consulting Psychologist
Clinical Member of American Association of Marriage and Family Therapists (A.A.M.F.T.)

**Professional Affiliations**

Upper Midwest Association of Marriage and Family Therapists (U.M.A.M.F.T.)
National Council on Family Relations (N.C.F.R.)
Minnesota Women Psychologists: Elected to the Steering Committee
American Psychological Association (APA) In process

**Research Experience:**

January 1984 - present: Research Scientist, Amherst H. Wilder Foundation, Office of Research and Statistics, St. Paul, MN.

Principal investigator for the planning and implementation of program evaluation and other research projects. Current research projects include: the evaluation of mental health services for Southeast Asian refugees, children in residential treatment, and families and children, as well as the evaluation of several community-based, mutual-help support group programs.

September 1980 - April 1983: Research Assistant, Family Social Science Department, University of Minnesota, St. Paul, MN.

Involved in the data analysis of a large study of divorcing couples under the direction of Dr. Janice Hogan and Robert Levy, J.D. This study was the basis of my Ph.D. dissertation.

September 1975 - June 1979: Research Assistant, Measurement Services Center, University of Minnesota, Minneapolis, MN.

Measurement Services center provided instructional and program evaluation for the University of Minnesota. Worked on several program evaluation projects listed under publications.

July 1978 - July 1979: Research Assistant, Family Social Science, University of Minnesota, St. Paul, MN.

Worked on a large research project, under Dr. David Olson, investigating the effects of several premarital preparation programs on marriage. The validity and reliability of several relationship assessment inventories were documented.

March 1978 - January 1979: Research Evaluator, Domestic Relations, Hennepin County Court Services, Minneapolis, MN.

Part of an independent evaluation team (funded by the McKnight Foundation) to investigate mediation counseling.

September 1977 - March 1978: Project Assistant, Family Social Science Department, University of Minnesota, St. Paul, MN.

Project investigating the attitudes of working women toward their work and their families.

September 1974 - April 1975: Research Assistant, Center for Youth Development and Research (C.Y.D.R.), University of Minnesota, St. Paul, MN.

Interview study of the needs, concerns, and aspirations of 1,000 adolescent girls.

**Therapy Experience:**

July 1980 - present: Consulting Psychologist, Community Counseling Center, White Bear Lake, MN.

The Community Counseling Center is an outpatient community mental health clinic. I provide individual, family, marital and group therapy to a wide range of clients. Specializations include: single parent families, dependency issues, obesity and eating disorders. Presently providing a new individual and group therapy approach focusing on increasing self-esteem in obese clients.

September 1976 - July 1980: Marriage and family therapist, Family Consultation Center, Burnsville, MN.

The Family Consultation Center is an outpatient mental health clinic. Did a nine month, supervised internship at this agency and then worked as a therapist on the staff. Provided therapy for individuals, couples, families, adolescents and children.

January 1976 - June 1976: Therapist, Walk-In-Counseling Center (WICC), Minneapolis, MN.

Supervised counseling experience focusing on short-term crisis intervention.

September 1973 - June 1974: Practicum counselor, Student Counseling Bureau, University of Minnesota, Minneapolis, MN.

Practicum involved counseling and advising students with personal and vocational problems and included the administration and interpretation of vocational and personality instruments (MMPI, California Personality Inventory, Strong-Campbell Interest Inventory, and the Edwards Personal Preference Scale).

September 1972 - June 1973: Intern counselor, Minneapolis Age and Opportunity (MAO), Minneapolis, MN.

Internship involved counseling, planning and advocating for senior citizens.

June 1971 - September 1971: Social work trainee, Department of Social Services, Mineola, New York.

Traineeship focused on the social services available to foster parents and children.

## Teaching Experience

January 1984 - April 1984: Instructor, Family Social Science Department, University of Minnesota, St. Paul, MN.

Instructor of Family Social Science 5240: Dynamics of Divorce

April 1984 - June 1984; January 1983 - April 1983: Instructor, Family Social Science Department, University of Minnesota, St. Paul, MN.

Instructor of Family Social Science 5260: Dynamics of Family Decision-making

September 1979 - July 1980: Teaching Associate I, Family Social Science Department, University of Minnesota, St. Paul, MN.

Instructor of three sections of Family Social Science 1001: Dynamics of Personal and Family Relationships and one section of Family Social Science 1002: Dynamics of Dating, Courtship, and Marriage.

September 1978 - June 1979: Teaching Intern, Family Social Science Department, University of Minnesota, St. Paul, MN.

This supervised internship included: seminar on teaching techniques with in-class teaching experience, syllabus preparation, experience as a teaching assistant for a family course, and supervised teaching experience as the instructor of Family Social Science 1001.

**Publications:**

Robinson, B. E., Hogan, M. J., Buehler, C., and Levy, R. Former spouse conflict: During marriage, divorce, and postdivorce. Journal of Divorce (under review).

Buehler, C. A., Hogan, M. J., Robinson, B. E., and Levy, R. J. Parental divorce transition: Divorce-related stressors and well-being. Journal of Divorce (forthcoming).

Robinson, B. E. The stigma of obesity: Fat fallacies debunked. The Melpomene Report: A Journal for Women's Health Research, 1985, 4(1), 9-13.

Robinson, B. E. Preliminary Report: Refugee Natural Helper Training Project. Office of Research and Statistics, Amherst H. Wilder Foundation, December 1984.

Robinson, B. E. Family experts on television talk shows: Facts, values, and half-truths. Family Relations, 1983, 32(3), 369-378.

Robinson, B. E. Former spouse conflict: During marriage, divorce, and post-divorce. Doctoral Dissertation, University of Minnesota, 1983.

Hogan, M. J., Buehler, C., and Robinson, B. E. Single parenting: Transitioning alone. In: H. McCubbin and C. Figley (Eds.). Stress and the Family, Volume I: Coping with Normative Translations. New York: Brunner-Mazel, Inc., 1983.

Robinson, B. E., Machalow, S., and Hendel, D. D. Research Example #14: A blending of quantitative and qualitative techniques. In: M. L. Dobbert. Ethnographic Research: Theory and Application for Modern Schools and Societies. New York: Praeger Publishers, Inc., 1982.

Robinson, B. E., and Hendel, D. D. Foreign students as teachers: An untapped educational resource. Alternative Higher Education, 1981, 5(3), 256-259.

Robinson, B. E. Where are you Solomon, now that we need you?: Criteria in determining child custody. In: Child Custody: Literature Review and Alternative Approaches. Monograph. Child Custody Research Project, Hennepin County Domestic Relations Division, September 1979. 6-48.

Robinson, B. E. The personality characteristics of rapists: A critical literature review. Masters' Thesis, University of Minnesota, December 1978.

Robinson, B. E., and Hendel, D. D. Beyond graduation: The educational and employment experiences of the graduates of a nontraditional degree program. Research in Higher Education, 1977, 7(2), 98-115.

Robinson, B. E., and Hendel, D.D. Foreign students as teachers: An evaluation of an experimental course. Measurement Services Center, University of Minnesota, July 1976.

Druckman, J. M., Fournier, D. M., Robinson, B. E., and Olson, D. H. Effectiveness of five types of premarital preparation programs. Final Report for Education for Marriage, Grand Rapids, MN. September 1979.

Holloway, R. L., and Robinson, B. E. Locus of control and sex differences in performance on an instructional task. Improving Human Performance Quarterly, Spring 1979, 42-52.

Hendel, D. D., and Robinson, B. E. The Bachelor of Elected Studies Degree Program: An evaluation of a student designed degree program by its graduates. Measurement Services Center, University of Minnesota, January 1976.

**Papers:**

Evaluating mental health services for Southeast Asian refugees.

Fat phobia: New treatment for its victims. Will be presented at 93rd American Psychological Association. Los Angeles, California, August 1985.

Family feud: Attorney vs. family therapist.

Legal and dyadic conflict between former spouses during marriage, divorce, and postdivorce. Presented at the National Council on Family Relations. St. Paul, MN. October 1983.

Family experts on television talk shows: Facts, values, and half-truths. Presented at the National Council on Family Relations. Washington, D.C., October 6, 1982.

Beyond graduation: The educational and employment experiences of graduates of an elective studies degree program. Presented at the American Educational Research Association. New York, New York, April 1977.

Effectiveness of premarital counseling programs. Presented at the University of Minnesota Program: Exploring Styles in Family Systems. St. Paul, MN. May 1978.

**References:**

All references are on file at the Education Career Development Office, Placement Section, 1425 University Avenue S.E., Minneapolis, MN and are available upon request.

Results of teaching evaluations by students are available upon request.

# CURRICULUM VITAE

## Walter B. Franz, III, M.D.

Born: December 1, 1952, St. Louis, Missouri

Family: Wife - Dinah
Children - Shannon, Ryan

Education:

College: William Jewell, Liberty, Missouri 1970-74
Degree - B.A. Chemistry, Magna Cum Laude, 1974
Honors - Dean's List
Academic Honor Society
American Chemistry Society Award for Outstanding Research Paper
American Chemistry Society Award for Outstanding Graduating Chemistry Major
Activities - Varsity football, soccer, golf

Medical School-University of Missouri Medical School, Columbia 1974-78
Degree - M.D., Cum Laude, 1978
Honors - AOA
Memorial Award for Patient Care
Activities - Honors Council for Medical School

Postgraduate Training: Residency -

Family Medicine, Mayo Graduate School of Medicine, Rochester, MN 1978-81
Honors - Mead Johnson Award
Activities - Secretary, Mayo Clinic Fellows Association, 1980
President, Mayo Clinic Fellows Association, 1981
Committee member, Graduate Medical Education for Internal Medicine
Delegate, MAFP - resident
Delegate, NCPFR
Delegate, AMA - RPS

Faculty Appointments: Consultant, Department Family Medicine, Mayo Clinic, Rochester, MN July 1982
Instructor, Mayo Medical School, Mayo Clinic, Rochester, MN 1982
Assistant Professor, Mayo Medical School, Mayo Clinic, Rochester, MN 1985

Publications: Sutherland, JE, Avant, RF, Franz, WB, Monzon, CM, Stark, NM: Indochinese Refugee Health Assessment and Treatment, The Journal of Family Practice, Vol, 16, No. 1:61-67, 1983
Franz, WB: Fetal Assessment, Primary Care, Vol. 10, No.2, 1983
Franz, WB: Aerobic Exercise and Your Health, Mayo Clinic Health Letter, September, 1984

Professional Organizations: American Medical Association
Minnesota Academy of Family Physicians
Secretary, Treasurer S.E. Chapter 1981-
Delegate 1982-83
Society of Teachers of Family Medicine
Minnesota Medical Association
Delegate 1982-83

Intra-Mayo Committees: Local Affairs Committee, 1984

Other: Medical Director, Southeast Asian Rochester Refugee Committee
Medical Director, IMAA
County Health Advisory Board