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Service System Models for Ethnic Minorities

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For well over two decades great concern has been expressed over the delivery of mental health services to ethnic minority individuals and communities (see Torrey, 1970; Karno & Edgerton, 1969; Sue, 1977; Mollica, Blum, & Redlich, 1980). This concern has stimulated two major developments. First, there has been a greater understanding of the types of problems that exist in attempting to deliver effective services to ethnic minority groups. These problems include the lack of bilingual/bicultural mental health personnel, the failure to take into consideration the cultural backgrounds and community dynamics of clients, and the infrequent application of innovative intervention approaches for nonmainstream Americans. Second, knowledge about these problems has resulted in efforts to develop certain conceptual strategies for more appropriate service delivery systems, a task advocated by the President's Commission on Mental Health (1978).

While obtaining knowledge of problems and generating developmental strategies for service delivery are important processes in the eventual implementation of ethnically responsive programs, it seems wise to exam-

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ine core principles that can be derived from such conceptualizations. Thus the purpose of this chapter is twofold: (1) to formulate core or guiding principles that underlie many mental health service delivery systems for ethnic minority groups and (2) to identify certain service system models that exemplify the successful operationalization of such principles into practice.

In the ethnic mental health literature, many investigators have proposed various conceptual schemes for the design and reorganization of service delivery systems embedded within minority communities. For example, Cuellar (1980) underscores the necessity of making changes at all four levels of the social structure—namely, the individual, the family, the organization, and the community or social system—when examining approaches to the intervention and resolution of Hispanic problems and needs. Undoubtedly, this comprehensive approach to intervention applies to any community mental health system regardless of the type of community it purports to serve. Yee and Lee (1977) have suggested that effective service delivery approaches for ethnic minorities should enhance cultural identity. Weidman (1973) has introduced the role of the culture broker as a key element in effective service delivery to various cultural groups. The culture broker is a clinically oriented social scientist from the particular culture being served. This person would mediate between the clinical and community systems using his or her expertise based on the integration of social science and cultural perspectives.

Apart from recommendations for ethnic minorities in general, others have proposed alternatives specifically designed for a particular ethnic minority group. King (1981) delineates five criteria for consideration when delivering services to Black communities: (1) the setting must be accessible; (2) service agents must be catalysts for facilitating change; (3) recipients must be addressed in the context of the kinship network; (4) the mode of delivery must address the conception of time; and (5) evaluation should involve the interaction of the family and the agency.

Kahn et al. (1975) urge the sole use of indigenous personnel, both professional and paraprofessional, as the ultimate goal for systems of service delivery to Native Americans. Others have emphasized the need for more collaboration between traditional healers and non-Indian mental health personnel (Attneave, 1974), greater community control of service programs (Ostendorf & Hammerslag, 1977), and more involvement of social networks in treatment interventions (Murdock & Schwartz, 1978). The latter consists of having family or clan members help the individual client or family make certain transitions, encourage family cohesion, and serve as adaptive coping role models.

In their review, Padilla, Ruiz, and Alvarez (1975) have recommended that innovative programs for the Spanish-speaking/surnamed (SSS) population incorporate many of the following features: (1) treatment services that address the nature of specific social problems that plague the SSS; (2) use of some combination of (a) community consultation as a preventive measure, (b) crisis intervention as the primary mode of treatment, and (c) "back-up" treatment with individual, group, family, and drop-in therapies; (3) validation research to guide effective program development; (4) community representation in the program's administration; and (5) adoption of a business model approach (such as use of the advertising media to disseminate information concerning available services) to attract clientele.

With regard to services for Asian Americans, Murase (1977) indicates that a culturally relevant social service has many of the following structural and organizational characteristics: (1) location of delivery site within the community itself; (2) involvement of a broad cross section of the community in decisions concerning the service programs; (3) employment of fully bilingual and bicultural staff; (4) cultivation and utilization of existing indigenous formal and informal community care/support systems; and (5) development of intervention methods that (a) recognize the family as an integral part of treatment, (b) establish a more active, supportive, directive, and highly personalized therapeutic relationship, (c) focus on survival-related, task-oriented services to facilitate the engagement process, (d) consider the possible conflict between the concept of "face" and the "confessional" character of the therapeutic situation, (e) differentiate between cultural behavioral tendencies and pathology, (f) reevaluate the self-determination construct, (g) allow for flexibility in session duration and schedule, and (h) acknowledge the therapeutic function of a familiar and predictable cultural milieu.

From this modest survey of the literature it becomes apparent that certain guiding principles and rationales for the development of effective and responsive service delivery systems to ethnic minority communities have received thoughtful attention and elaboration. However, the question remains whether such concepts have been developed into a coherent model of service delivery that, in turn, has directed the design of a viable service delivery system for a particular ethnic minority community.

Guiding Principles for Effective Service Delivery

Although the specific policies considered to be crucial for the development of an effective service delivery system vary depending on the particular ethnic minority community involved, the literature tends to converge

on a set of core principles that can be implemented to guide such development efforts. Four of the six principles presented are similar to those proposed by Baker (1974) as characteristic of the "human service ideology" but are particularly oriented toward ethnic minority concerns. The following principles can be considered as an interrelated set of essential conceptual components of any responsive service delivery model for ethnic minorities:

(1) *Match or fit of services* to the particular needs and help-seeking patterns of the client population with a particular emphasis on addressing the impact of social problems (such as alcohol abuse, truancy, unemployment) on adaptive psychological functioning.
(2) *Integration and linkage of relevant services,* namely, mental health services with other health related and social services.
(3) *Efficient utilization of services,* primarily by focusing on primary prevention efforts that incorporate natural support systems.
(4) *Comprehensive services* at the four levels of intervention—individual, family, organizational, and social system levels.
(5) *Community control* by means of advisory board and administration representation and service accountability.
(6) *Knowledge development and utilization* with an emphasis on promoting the adoption and implementation of innovative service system models.

This review will examine each of the principles in terms of their implications for service delivery, the specific service system problems involved in implementation, and the actual service system models that have succeeded in operationalizing such principles. Despite the independent treatment of these principles, the close interrelationships between each of them cannot be underemphasized. For instance, one cannot discuss match or fit of services without considering service linkage issues. However, for heuristic clarity each principle will be discussed separately to highlight the various programmatic features each service system model exemplifies.

Match or Fit of Services

Frequently, it has been found that services delivered from a traditional clinic setting have focused on issues and problems that held little relevance for the needs of the minority clientele (Brown, Stein, Huang, & Harris, 1973). These services often were delivered in a manner that conflicted

with or failed to capitalize on the typical help-seeking patterns found in the community. The match or fit principle posits that both the content and process of services should be culturally relevant and culturally functional. For ethnic minorities culturally relevant service content involves particular attention to the ways in which social problems in the current living situation affect the client's mental health. This focus implies the employment of interventions that affect not only the immediate, more tangible social problems, such as unemployment, language barriers, and immigration regulations, but the broader social and political realities in which these problems are embedded. In other words, interventions must facilitate the development of coping skills (on the individual level), supportive relations (on the family and neighborhood levels), program policies (on the organization level), and social action (on the social/community system level) to ameliorate the adverse consequences of racism.

Process matches entail the delivery of services in a manner that is (1) congruent with the client's world view, (2) supportive of culturally acceptable help-seeking behaviors, and (3) compatible with the natural support systems within the community. Besides the logical attraction of the match principle, client-system matches may facilitate positive outcomes because they enhance perceptions of control (Sue, 1978). An impressive array of studies have found that perceived control or noncontrol has effects on behavior and emotion (Seligman, 1975). The perception of noncontrol or learned helplessness may result in (1) poor motivation, apathy, and passivity; (2) cognitive disruption and the subsequent failure to learn that events can be controlled; and (3) emotional disturbance such as anxiety, depression, and withdrawal. Thus the enhancement of the perception that what happens to oneself (outcomes) is affected by what one does (actions) mitigates against the development of motivational, cognitive, and emotional disturbances that may disrupt effective coping and problem-solving behavior.

To increase the fit between clients and the service delivery system, Sue (1978) has identified three strategies for change. The first alternative involves finding the right service for the person. This strategy is based on the assumption that appropriate services are available somewhere. The primary task is to make a wide range of services accessible basically involving effective referral and public knowledge of services. In general, the former has been plagued by impermeable catchment area boundaries and poor linkage among mental health and other health-related services. Despite the President's Commission on Mental Health's (PCMH, 1978) recommendations to have greater flexibility in delineating catchment area

boundaries by using waivers of boundaries where it would best serve the needs of natural communities and those requiring services and to encourage cross-catchment-area program sharing to facilitate the delivery of high cost and/or specialized services, the catchment area will remain the basic unit for the development of community mental health service systems. The utility of the catchment area concept deserves critical review particularly when applied to ethnic minority communities. Frequently, catchment area boundaries fail to accommodate the structure of natural communities and create unnecessary barriers for both those who need and those who provide care (PCMH, 1978). The use of the waiver to make barriers more permeable appears to be a "band-aid" measure. In its implementation report on the PCMH recommendations, the Health, Education and Welfare (HEW) Task Force (1978) did not propose any specific guidelines for waiver use. If waivers are to be at all effective, specific criteria for waiver acceptance must be established along with recognized procedures for maximum community input in these decisions. It is not surprising that the service system models with successful service linkage operations tend to exist within one catchment area (see Lefley & Bestman, 1982; Delgado & Scott, 1979).

This problem becomes more acute when a service system attempts to reach ethnic communities widely dispersed across a certain geographical region. For example, in San Francisco the Asian/Pacific population is concentrated in three different catchment areas. In this case catchment area boundaries have impeded the efficient delivery of certain highly specialized services such as bilingual/bicultural inpatient services to monolingual clients.

The public's lack of knowledge about available services compounds the establishment of accessible services within and across catchment areas. Miller (1981) found that of the programs and services offered within one catchment area the clinical staff correctly identified 84 percent and the clerical staff correctly identified 73 percent. However, the general public sample only correctly identified 45 percent of the available services. Considering that the findings pertain to services within a catchment area, they suggest that public awareness of services across catchment areas is poor. Interestingly, when asked to indicate services that needed development in the future, both the client and general public samples listed public information groups as important. However, such groups were not so designated by any of the advisory board, administrator, or clinical staff samples. Not only does the public have little knowledge of services, but this problem is exacerbated by the apparent lack of interest in educating

the community about programs and services that exist. Because of these problems in knowledge dissemination and catchment area crossover, the task to make a wide range of appropriate services available to clients with particular needs remains very difficult and infrequently used.

The second approach is to change the person to fit the service. Preparing clients for services (explaining the services, giving information on the process of treatment, correcting stereotypes of treatment, or other forms of pretherapy intervention) may facilitate a better person-mental health service match. Orne and Wender (1968) have developed the "anticipatory socialization interview" to educate clients who have had little experience or understanding of psychotherapy. The interview includes an explanation of the process and rationale behind traditional (psychodynamic) expressive psychotherapy, a discussion of client and therapist roles throughout the process, and the consideration of possible resistances that may develop. Extensive history taking is recommended to facilitate rapport building.

Although proposed to increase the potential efficacy of traditional psychotherapy with lower socioeconomic status and ethnic minority clients, the method can also be hazardous if it is carried to the extreme of denying cultural differences and of implying that there exists but one standard helping process for psychological change and progress. In an example of an effort to minimize these problems, Aoki (1981) has offered several alterations to the typical socialization interview to account for the cultural nuances of the Asian American experience. The therapist must minimize the egalitarian nature of the therapeutic learning process with many Asian American clients who seek an "authoritative guide" in solving their problems. A discussion of immediate survival-related as well as the typical planning of long-term personality-related goals will facilitate engagement. As the therapist moves from an active to a more nondirective, reflective role, the transition is presented to the client as a planned, intentional change. In this way the therapist has not relinquished the roles of authority and expert. An open discussion of the client's disillusionment that could occur regarding the helpfulness of therapy and of the client's possible feelings of shame over seeking help outside the family adds credibility to the psychotherapist and helps the client sustain the relationship, increasing the likelihood that he or she will return for subsequent sessions. Because the expression of negative feelings toward significant others is often considered unacceptable, indirect methods (nonverbal symbolic gestures, fantasies, dreams, letters) are utilized to process affects without discussing them openly in the beginning of therapy.

Implicit in the application of socialization interviews and other pre-therapy methods is the assumption that traditional modes of psychotherapy require little modification to be optimally effective with ethnic minority clients. The validity of this notion varies depending on such factors as the acculturation level, presenting problem, previous therapy experience, language capability, and mental ability of the client. In many cases with ethnic minorities subtle modifications prove insufficient and drastic changes are required, which leads us to the third and final approach to achieving a client-system match.

To change services to accommodate persons from diverse cultures is the most innovative and responsive but also the most complicated and difficult alternative. It implies system flexibility, multiethnic and multilingual mental health personnel, an organizational structure dictated by community needs rather than by bureaucratic precedent or roles, extensive knowledge, and, more important, experiences relevant to ethnic groups, and the integration of new forms of intervention. The first step in modifying services to maximize fit requires a way of accounting for the social and political realities of the minority experience in the clinical conceptualization of a case.

McFadden (1976) has offered a conceptual method for examining the Black experience in clinical assessment. In his framework each therapeutic issue has three primary dimensions, the cultural-historical, the psychosocial, and the scientific-ideological. The first dimension refers to cultural heritage and knowledge passed from one generation to another and to personal experiences linked to the individual's status as a member of a minority culture. The second dimension refers to intrapsychic issues. The third dimension refers to actual observed behaviors or attitudes regarding one's relationship with the external environment. McFadden conceptualizes Black experiences as gradually progressing from the cultural-historical dimension into the psychosocial dimension into the scientific-ideological dimension. For example, the dynamics of slavery (cultural-historical) may influence a Black client's psychological security (psychosocial), which influences logic-behavioral chains (scientific-ideological). These chains correspond to the person's perception of a behavior and its logical or adaptive value in a situation.

Regardless of the validity of certain aspects of the model (such as the unidirectional flow of the psychological dynamics), it represents an effort to develop a heuristic device that allows clinicians to integrate the influence of culture into their case conceptualizations. Despite the awareness of ethnic-specific issues, normative behaviors, and coping styles, few explicit

conceptual strategies (that is, models of assessment) have emerged to guide the incorporation of such knowledge into an integrated understanding of the minority client. Just as the advent of family systems theory resulted in the effective implementation of family therapy approaches, viable system changes to match minority client needs are largely contingent on the development of conceptual models that can be used as cognitive thinking tools to do a sensitive, comprehensive assessment of the minority client and his or her specific cultural milieu. Equally important is the explicit delineation of traditional models of assessment to examine value biases and erroneous assumptions that could lead to misinterpretations of minority client behavior. Some promising developments include critiques of traditional models for the assessment of family systems (Kim, 1982) and irrational belief patterns (Zane, 1981) with respect to Asian Americans.

The most frequently adopted model for organizational changes to increase match is the professional adaptation model as described by Padilla et al. (1975). Basically, the model incorporates only slight variations from the traditional community mental health model, with the major change involving professionals and paraprofessionals who "adapt" their clinical skills, service orientation, and language skills to the specific requirements for serving the ethnic minority population. Usually these adaptations translate into placement of the center within the community and the hiring of bilingual/bicultural personnel, the majority of whom are paraprofessionals who originate from the target population. There tends to be a greater emphasis placed on prevention efforts, on short-term, crisis-oriented, problem-focused treatment, and on more community input into program policy. However, the basic service structure, program priorities, and staff-client roles essentially resemble those of the traditional community mental health center. Unchanged features may include adherance to the 50-minute session, placement of clients on a waiting list, reliance on office-based outpatient therapy as the primary treatment mode, and focus on diagnosed problems with little attention to the direct problems of food, housing, employment, and so on. As an alternative service system the professional adaptation model represents a conservative and, typically, a center's first rudimentary step toward the development of responsive services.

More innovative service delivery models involve major changes in service system structure and program priorities. Programs based on these models frequently capitalize on a major cultural feature or a culturally acceptable attitude or practice to engage and treat clients. The barrio service center

model organizes its services around a critical feature of many Hispanic communities, the concurrent need for mental health and basic economic services (Padilla et al., 1975). The model emphasizes the "social broker" role, in which staff help clients obtain jobs, bank loans, and other economic services in addition to providing counseling in the community. Abad, Ramos, and Boyce (1974) describe a clinic primarily serving Puerto Rican residents. Besides providing typical outpatient services (such as walk-in coverage, psychiatric evaluations, individual, group, and family therapy, and referral services) the clinic offers home visit and transportation services. A major role of the bicultural/bilingual staff centers on that of "intermediary between Spanish speaking clients and other agencies" (Abad et al., 1974, p. 592). Treatment may focus on numerous problem situations that are not "clinical" in nature.

The Chinatown Child Development Center (CCDC) has reorganized services around an educational model to make the delivery of mental health services more acceptable to immigrant Chinese families (Chan-sew, 1980). Traditionally, the Chinese culture places a high value on education and considers it to have great utility for survival and upward mobility. CCDC programs capitalize on these attitudes by offering mental health services in the context of educational experiences. The continuum from preventive to clinical mental health services is presented as a progression from general to more intensive education. The chronic shortage of appropriate child-care facilities in Chinatown provides the motivation for parents to enroll their children in either the Drop-In or After School program, both of which charge no fees. Participation in these educational programs enables the clinic to screen each child for existing or potential mental health problems and to provide feedback about the child's progress to parents. The on-site mental health education program enhances continuity of service by offering parents classes and activities that address not only mental health concerns but also basic economic, language, and legal problems faced by immigrant families. The group experiences embedded within this program frequently facilitate the development of supportive networks among parents. Because of the educational child-care programs, the frequency of interaction between staff and parents is much higher than at most clinics, resulting in the enhancement of cooperative, trusting relationships. Such relationships reduce the resistance to subsequent referrals for diagnostic evaluations and outpatient treatment.

Thus far, the models discussed with respect to the match or fit principle have focused on the individual client or family as the basic unit of service. The design of service systems to accommodate community needs at the

other two levels of intervention, the organizational and social system levels, implicates the fourth principle (comprehensive services), which basically is an elaboration of Sue's third alternative to achieve match at all four levels of intervention.

Integration and Linkage of Services

The intimate relationship between mental health and other health or social service problems is an ecological reality for most ethnic minority groups and directly influences their conceptualization of mental health difficulties (Harwood, 1981). Mental health is considered to be an element in the total welfare of the individual. Frequently, psychological problems gain expression in terms of other health or social difficulties such as physical or work/study complaints. For example, Kleinman (1980) and Tung (1980) have noted that somatization is the common mechanism for coping with psychological difficulties such as depression in the Chinese and Southeast Asian cultures, respectively. Consequently, effective service linkage can enhance treatment effectiveness by concurrently affecting interrelated problems in living. It also embodies an approach that reflects the manner in which ethnic minority individuals conceptualize mental health problems.

Lawrence (1975) identified three types of interorganizational linkage patterns: consultative, confederated, and federated. The consultation model is commonly found where there exists a shortage of mental health specialists (Schulberg, 1977). Due to the professional human resource problems within ethnic communities, most ethnic service systems have this type of linkage pattern. Consultation agreements tend to be inconsistently implemented and are constrained by fiscal limitations (that is, third-party insurers do not include consultation as a reimbursable service). In essence, the burden of establishing service linkages falls on individual staff members, with little emphasis on a systems approach to network development. The resultant pattern of system coordination is one of nonuniform agency relationships, with some being of a close collaborative nature while others involve only infrequent individual case referrals.

In response to the National Institute of Mental Health's requirement that mental health centers establish affiliation agreements with local resources to ensure continuity of care, confederated linkages have emerged. Within such system arrangements there are formal, specified patterns of personnel, client, or information exchange, but the participating agencies retain their functional autonomy. Although the establishment of con-

federated linkages requires extensive interagency negotiations, such costs in time and effort are often offset by savings in startup costs and operating demands needed to establish separate clinics in several geographical locations. The Worcester Youth Guidance Center's Hispanic Program has succeeded in circumventing many problems in service delivery through collaborative agreements with two health and social service centers serving high concentrations of Hispanics in Worcester, Massachusetts (Delgado & Scott, 1979). Placement of mental health personnel in these host agencies helped destigmatize the use of mental health services and enabled the provision of many services in the home. In another formalized collaborative arrangement with the local court and a youth service agency, the Hispanic program helped develop a foster parent program for children referred from juvenile court (Delgado, 1978). In addition, the program provided support and consultative services to the foster parents once children were placed in their homes. In this manner intervention efforts were applied prior to the full development of problems in these potentially high-risk situations.

In terms of comprehensiveness of service connections, the federated linkage model provides the structure for maximizing agency collaboration. Under this model, agencies are components of a larger system whose central authority can prescribe operating policies and practices for all member programs. Using this approach, the South Cove Community Health Center has provided mental health services as part of a low-cost, comprehensive general health care program for Boston's Chinatown and South Cove area residents. According to Lee (1979), the programmatic and geographic integration of mental health services with other health services yields the following advantages: (1) easier and quicker referrals with less patient "loss" between referring agencies and caregivers; (2) better coordinated care of patients with multiple problems as facilitated by the ready access to allied caregivers, a common record system, and a common administrative hierarchy; (3) reduction in health care delivery problems through the improvement of patient-provider relationships by means of mental health staff input into the management of behaviorally difficult patients and of health staff use of their ongoing relationships with patients to facilitate the acceptance of mental health services; and (4) increased appreciation of emotional problems by general health staff as a result of frequent informal contacts between health and mental health personnel located in the same setting. In addition, the health center maintains confederated linkages with the three agencies (the public elementary school, a day care center, and an elderly residential project) that share the same complex.

Although the federated model appears to be most effective and efficient in the development of coordinated service linkages, certain structural and dynamic conditions of an ethnic community may limit its application. First, the wide geographic dispersal of ethnic communities mitigates against the development of multiservice centers. In contrast, the South Cove Community Health Center basically serves Boston Chinatown, which is the fourth largest Chinese community in the United States. Second, the degree to which there exists consensus among members as to the community's aspirations may affect efforts to establish a federated system. The implementation of a major project such as a comprehensive multiservice center requires a sustained, concerted, collective effort on the part of the community. The South Cove Community Health Center was an outgrowth of seven years of community planning and development. The pursuit of common goals by the community reflects its high degree of integration (Mann, 1978). Parsons (1951) has identified two fundamental dimensions of integration: the coordination among the community's working parts or processes and the distinctiveness or integrity of the social system in relation to other systems in its environment. Thus ethnic communities that have poor internal coordination and problems of a boundary-maintenance nature may find it difficult to summon the resources and commitment necessary for the federated approach. In these cases confederated linkages may actually serve the community more effectively.

Efficient Utilization of Services

In an overview of the projected federal program and policy changes under the proposed block grant program, the director of the National Institute of Mental Health indicated, "It behooves us to identify cost-effective programs because the current legislative climate is to reduce Federal spending on many social and health programs" (ADAMHA News, 1981). The combination of funding cutbacks and the resultant cost-effective focus places an even greater demand than before on ethnic community agencies to deliver services in the most efficient manner. The emphasis on maximizing impact with minimal cost involves two processes that are frequently in opposition. Powerful, effective interventions often incur high costs as a result of the extensive organizational development and human resource effort needed to implement such projects.

To circumvent these problems certain agencies have adopted primary prevention strategies that encourage the use of natural helping resources within the ethnic community. Conceptually, primary prevention efforts

based on natural support systems appear cost-effective for the following reasons. First, they enhance the coping potential of individuals and groups, which decreases their susceptibility to the development of mental health problems. Second, the resultant reduction in incidence and prevalence as well as in the severity of mental disorders decreases the need for the more costly clinical interventions. Third, the utilization of natural support systems makes use of that which the community already possesses, reducing the need for further resource development. Finally, the incorporation of systems that people would naturally use when seeking help facilitates case-finding and outreach efforts, thereby conserving some time and energy normally applied to increasing accessibility and availability of services. Despite the conceptual appeal of this approach, its cost-effectiveness requires empirical validation. This is not a simple matter. Heller, Price, and Sher (1980, p. 286) have noted that the evaluation of primary prevention interventions is "a complex undertaking with conceptual ambiguities and methodological difficulties which impede the systematic collection of evidence." Moreover, cost-effectiveness requires not only that interventions be effective but that they only be applied when less costly and simpler interventions have proven ineffective. Thus cost-effectiveness implies two principles, intervention efficacy and effort conservation.

Muñoz (1980) has adopted a prevention model proposed by Christensen, Miller, and Muñoz (1978) to promote the utilization of natural Hispanic support systems. He addresses the two principles of cost-effectiveness by incorporating into the model an evaluation methodology that regulates the extensiveness of the prevention services. Muñoz indicates that educational programs focused on preventive mental health issues hold particular relevance for many Latinos whose families have reinforced the values of learning more, becoming more educated, and increasing control over their own lives. This emphasis on learning to be more self-efficacious facilitates the acceptance of mental health services delivered in the form of education rather than of therapy. While the strategy increases effective outreach efforts to people who want information and advice, it does not forestall treatment to Latinos whose problems require more extensive clinical intervention.

The approach specifies three levels of intervention: prevention, treatment, and maintenance. Within each level, six types of mental health agents perform various functions in the delivery of mental health services. Besides professionals, the strategy uses five adjuncts: (1) paraprofessionals, (2) partners (nontrained voluntary helpers), (3) peer clients, (4) communicative paraphernalia (such as mass media, tapes), and (5) printed material.

These agents are listed in decreasing order of training sophistication and implementation cost. Through adjuncts the model utilizes natural support systems at every level to make optimum use of available personnel found in Latino communities. Because adjunctive agents are less expensive but more available to the community, their use prior to professional intervention for certain problems and certain people embodies a cost-effective approach to service delivery. In other words, service delivery proceeds in a systematic hierarchical fashion guided by evaluation outcomes. If evaluation finds a certain adjunct to be more effective or as effective as professionals or other more expensive adjuncts, there exists no need to invoke the more extensive and sophisticated procedures. Finally, the clear delineation of each agent's functions and procedures at the three intervention levels establishes an empirical base for the determination of provider status. For example, whether or not a person can qualify as a paraprofessional or a partner-companion will depend on the outcomes that the person obtains at the preventive, treatment, and maintenance levels. This competency-based approach to personnel development also enhances cost-effectiveness.

In summary, this model incorporates the following features that would facilitate the efficient utilization of resources in many ethnic minority communities: (1) a teaching orientation in the presentation of preventive mental health issues and interventions; (2) the basic evaluation-controlled strategy of delivering less costly and more available interventions, followed, if needed, by increasingly more costly and more extensive clinical efforts; (3) the employment of adjuncts in prevention, treatment, and maintenance to make optimal use of natural support systems; and (4) an outcome-oriented approach to determine personnel qualification.

One adjunctive agent in the Muñoz model involves the use of peer clients. Peer clients represent a rich but as yet undeveloped community resource for service delivery. Besides increasing mental health human resource potential, the peer client role may have a therapeutic effect on the peer client's own psychological functioning. According to Goldberg (1972), the client must experience three roles in the ameliorative process. Clients commonly see themselves in the role of a patient, one who is sick, disabled, and unable to help others. Alternatively, they assume the role of student, a person who perceives him- or herself as having few or no psychological problems. Rather, the person seeks therapy to learn about the therapeutic process and to promote his or her own psychosocial development. The third and least recognized role is that of a healer. As a healer the client makes an attempt to cope with his or her own problems

and tries to help and assist others. The recognition and appreciation of such helping efforts enhances the client's sense of self-worth and interpersonal relatedness.

The experience of discovering that one can be effective in helping others and that such efforts are appreciated may be the most basic therapeutic feature in treatment. According to Bandura (1977), self-efficacy expectations--the belief that one can successfully execute the behavior required to produce certain desired outcomes--affect both the initiation and persistence of coping behavior. In addition, he contends that personal mastery experiences are especially powerful in the enhancement of perceived self-efficacy. By performing the role of healer, clients can engage in many activities that result in these crucial personal mastery experiences. Unfortunately, most mental health agencies have failed to incorporate the client healer role into their treatment programs.

The Laurel Center in Maryland has designed a program to provide clients with the opportunity to demonstrate their particular skills and abilities in the process of helping others (Goldberg & Kane, 1974). The services in-kind program allows clients to compensate the center for services rendered them by delivering services in-kind to others. For example, one client paid for marital and individual counseling services by serving as a cotherapist in a play therapy group. Other clients who received marital counseling tutored students having problems in school. Some clients who were housewives provided child-care and transportation services for other mothers. The most in-kind services delivered were of a secretarial nature. These contributions have furnished many auxiliary services to the agency, which, like many other community-based organizations, operates with a limited budget for support personnel. Notwithstanding its economic value, the primary function of giving services in-kind is seen as therapeutic. During sessions, therapist and client discuss the specific compensatory service and incorporate it into the client's treatment plan. Despite certain problems in implementation (state and county health systems resistance, staff resistance, systematizing the assignment of services, and supervision of services), the services in-kind program appears to be a feasible approach for service delivery expansion and resource conservation worthy of inclusion in many ethnic minority mental health programs.

Comprehensive Services

There has been an increasing awareness of two primary social conditions that are associated with mental health difficulties. First, it has become apparent that many psychological disorders have their etiological

and developmental bases in deep-rooted and interrelated social problems (such as racism, poverty, and overcrowding). Second, the sources of these problems emanate from the respective social structures of groups, organizations, communities, or larger social systems. Recognition of the larger social environment as an important part of the treatment context has stimulated service programs to expand the scope of intervention to include not only the individual but the family or group, the organization, and the social system as appropriate foci for change. The degree to which services are delivered in a comprehensive fashion determines to a great extent the efficacy of such interventions. This is especially true for many ethnic minority communities burdened by the social consequences of economic and political inequities.

The emphasis on affecting the broader ecological context reflects a relatively new ideology that is just beginning to gain extensive consideration in terms of program design and theory development (see Snow & Newton, 1976). Consequently, few working models exist to guide the formulation and operation of a systematic approach to comprehensive service delivery. For most agencies, including those serving ethnic minority populations, the individual client, the client group, and the family remain as the basic units of service. Occasional attempts to intervene at the organizational and social system levels usually occur at the personal initiative of one or several staff members. The absence of a programmatic approach to change organizational and social system conditions such that they enhance mental health constitutes one of the major gaps in the delivery of services to ethnic minority communities. As La Follette and Pilisuk (1981, p. 221) have noted, "The community movement in mental health presents the mental health advocate with a major decision. Will we retreat behind more manageable forms of treatment for mental illness and the now legitimate ancillary community services, or will we push the frontiers of service into areas which our community approaches have exposed as vital to the emotional well-being of our clients?"

Already some pioneering efforts have emerged. Most of these models rely on a core individual or team of individuals to deliver services at each level of intervention. This generalist approach to comprehensive service delivery probably reflects the natural evolutionary expansion of service responsibilities for agency staff. Whether this approach is more or less cost-effective than a specialist orientation in which certain staff only work at certain levels remains a matter for empirical inquiry.

Using an approach that emphasizes social systems reform and ethnic accountability, the University of Miami-Jackson Memorial Medical Center Community Mental Health Program (CMHP) has provided proactive and

reactive mental health services to a low-income, multiethnic catchment area within inner-city Miami (Lefley & Bestman, 1982). The area contains five ethnic groups, Bahamian, Black American, Cuban, Haitian, and Puerto Rican, as well as an elderly Anglo American population. At the core of the CMHP are seven teams, one team for each ethnic population and two geriatric teams to serve elderly Anglo Americans and elderly Blacks. Each ethnic team employs professional and paraprofessional personnel whose cultural background matches that of the ethnic community served. The director of each team is a culture broker. As previously indicated, the culture broker is a social scientist with expertise in the culture being served and, in most cases, of the same ethnicity. The combination of professional qualifications with culturally relevant personal experiences allows the culture broker to exert influence in both the community and the mental health network as well as on the relationship between these two systems.

In practice, directors and team members share the culture broker role. Besides providing highly accessible and culturally responsive preventive, treatment, and aftercare services to individuals and families, the teams act as social change agents to alter environmental conditions that may contribute to mental health problems. Some teams may initiate or coordinate projects that bolster existing resources or supply new resources for the community. Others will design and implement action research to obtain empirical support for needed services or programs. They may organize the community and/or advocate on its behalf for changes in agencies found lacking in culturally appropriate services. Teams also have advised residents on how to induce these agencies to rectify certain neighborhood problems. They have developed support systems for both preventive and aftercare purposes. They have established linkages between consumer groups and appropriate agencies.

Prior to these social action efforts, each team conducted an extensive community entry program involving advisory board selection and utilization (in terms of assisting in personnel selection and suggesting needs of the area), key informant and indigenous leadership contact, and comprehensive multimodal needs assessment (empirically derived survey questionnaires, block mapping and observation to assess availability of community resources, reanalysis of census data to determine ethnic clustering and need patterns, and so on). Using this data base, each team established an accessible, multiservice "mini-clinic" with confederated linkages to other community agencies and to the area's two psychiatric hospitals.

Several examples of social action projects demonstrate the CMHP's effectiveness in producing change at various levels of the community social

structure. The Cuban team, in collaboration with other ethnic interest groups, successfully procured $450,000 of Community Development Project funds for the area. It also has developed a crime prevention program for predelinquents in public housing projects. The Puerto Rican team initiated a project to start a community school. The project represented the first collective action effort taken by all the Latino groups in the largely Puerto Rican area. The Bahamian team, in conjunction with another community agency, organized an innovative summer employment program for low-income Black teenagers. Rather than employ teenagers in typical summer jobs such as janitorial and recreational assistants, the program consisted of training in office procedures, viewing films on mental health and social services, recreation, and field experience involving participation in a community needs assessment survey. Upon discovering that 70 percent of its clients were illegal aliens with multiple needs but with questionable eligibility for public benefits, the Haitian team helped conduct two advocacy projects for the Haitain community. One resulted in the changing of school admission requirements to enroll Haitain children of illegal alien parents. The other helped Haitian illegal aliens obtain social security cards in order to qualify for the concomitant welfare benefits.

Several features of the Miami model merit mention as potentially key factors in any attempt to achieve service comprehensiveness by addressing social system concerns as well as individual ones. First, the team approach to social system intervention can foster the necessary emotional and intellectual support to sustain concerted advocacy and organizing efforts in the face of social system inertia or resistance. Often the complicated and arduous task of initiating social system reform appears less intimidating and more feasible when seen from a collective perspective as opposed to an individualistic one.

Second, a detailed needs assessment of the community can enhance the efficiency of system change projects. Frequently, advocacy projects fail because they are too broadly focused or inappropriately targeted. Besides helping to minimize these problems, a community needs assessment may exert a beneficial iatrogenic effect on staff. A training issue often overlooked is whether or not indigenous mental health personnel actually have embraced the human service ideology (Zane, 1982). The reorientation of professionals trained under the traditional, individual-focused clinical model is a related matter that has received more attention in the field. However, the assumption that, once trained, indigenous personnel can totally suspend traditional culturally ingrained beliefs about mental illness (for example, the stigma of being mentally ill, illness caused by an

individual's transgressions) in favor of mental health concepts has proven to be a naive one. Both of these factors can operate to increase staff resistance to the adoption of innovative interventions, particularly those of a social action nature. A comprehensive needs assessment scrutinizes the role of environmental factors in the development and maintenance of psychological difficulties. Social stressors, social systems, and social resources become more of the foreground in the conceptualization of mental health problems. Consequently, in the process of obtaining information for a needs assessment both indigenous and nonindigenous staff may develop a perspective that is more in accordance with the human service approach.

Third, the indirect positive effects of collective action often have received little attention. Social action projects increase the availability of direct services (Lefley & Bestman, 1982). In addition, community development helps assure the longevity of a mental health program. Community organization efforts demonstrate the program's utility to the community as an important resource. More significantly, the organization of the community into a potent advocate force can generate the necessary local support for continued public funding of the agency. Considering the current scarcity of public funds for mental health, effective lobbying on the part of local constituents is a political necessity. The potential economic benefits indirectly accruing from social action interventions cannot be underemphasized. Many agency administrators still see their primary responsibilities as involving the management of direct and ancillary services. Redefinition of the administrator role to incorporate collective advocacy concerns will not only increase service comprehensiveness, but will expand the supportive base needed for the economic survival of the program.

Finally, it must be recognized that lowering environmental stress actually does improve psychological functioning. Frequently this premise is not taken seriously and receives less consideration than the traditional psychodynamic assumption that improved intrapsychic functioning is required before a client can significantly change environmental conditions. This intrapsychic focus persists in the face of literature indicating that mental health problems are lower in well-organized communities (Leighton, Harding, Macklin, Macmillan, & Leighton, 1963). Lefley (1979) has provided evidence supporting the social problem orientation to psychological adjustment. She found a significant relationship between the level of success in attaining environmental goals (finding jobs, locating appropriate social and medical services, obtaining financial benefits) and therapeutic

outcome as defined by symptom reduction, level of functioning at home or work, quality of interpersonal relationships, and the client's success in utilizing therapeutic resources. Until the social problem approach to psychological amelioration gains the widespread acceptance that it merits, the development of comprehensive services will remain a socially desirable but inconsistently attained objective for many mental health programs serving ethnic minority populations.

Community Control

A widely accepted notion in community mental health is the value of community participation in the planning of service delivery programs. This proposition holds particular relevance for ethnic minority communities, because often there has existed a clear disparity in values and goals between program administration and citizens. A community advisory group can help align agency goals and operations with community needs by establishing program policy, advocating for client interests and safety, evaluating services, and consulting on community dynamics and problems (Morrison, 1976; Silverman & Mossman, 1978).

In practice, the response to community control has been less enthusiastic. Chu and Trotter (1974, p. 83) indicate: "By and large community advisory boards have been added after the fact, few of them with any real fiscal control, policy making power, or program responsibility." Their study examined only publicly supported community mental health centers developed in response to federal and state legislation. In contrast, alternative mental health agencies that originated more from organized community efforts than from governmental directives have had more local involvement in the decision and policymaking process of programs (La Follette & Pilisuk, 1981). Many of the agencies serving ethnic minority populations began as alternative mental health clinics.

Besides the obvious strategy of placing more indigenous ethnic group members on agency boards, greater community control has been achieved by including former or current clients as board members and by selecting indigenous personnel for administrative positions. With respect to the former, one alternative clinic, El Centro de Salud Mental, considers all clients eligible for board nomination after their third visit. The inclusion of clients in board membership reflects a consumer orientation to which many community-based agencies purportedly subscribe. Thus it is surprising that only a few of these programs have adopted a concerted effort to enlist client participation in board activities. Such efforts require not

only recruitment, but the preparation of the client for this decision-making role. Preparation may involve orientation to the larger mental health or health system to which the agency belongs, education in patient's rights and ethical principles, clarification of advisory board responsibilities, and training in problem-solving skills.

The employment of indigenous personnel to conduct a service program undoubtedly represents one of the most direct extensions of community control. Considering that conflicts over agency direction initially arose as a result of administrative resistance to meaningful participation by disadvantaged groups (Mann, 1978), the administration of a program by community individuals obviates many of these control issues. The problem has been to find indigenous personnel who have the requisite managerial skills and bureaucratic expertise to perform effectively as administrators. Recently, a program was developed to train ethnic minority mental health professionals for managerial positions (Wong, 1981). It is the first project of its kind designed to ameliorate the current shortage of qualified ethnic minority administrators in the mental health field.

Thus far this discussion has focused on ways to increase community involvement, with the assumption being that community participation will improve services. However, is this premise always valid? At times, it appears that community involvement hampers the design and implementation of innovative intervention approaches. Mann (1978) has observed that communities frequently oppose intervention programs with the same fervor that characterizes their opposition to research studies. While there is a tendency to consider this resistance as due to self-serving actions on the part of certain vested interests in the community, it should be made clear that this type of reaction is more the result of the inherent cyclical nature of the social change process operant in any community system.

Using Hegelian dialectics, Boulding (1970) has examined the social change phenomena. In his analysis a social innovation, or "thesis" (as it is referred to in dialectic terms), contains within itself a contradiction. This contradiction tends to produce an opposing reaction or antithesis as the thesis develops and peaks. Following this ascent of the thesis, the antithesis develops and gains dominance. Because the antithesis also contains a contradiction, it declines and is followed by a synthesis. Although the synthesis is essentially the restoration of the original thesis, it includes elements that integrate both thesis and antithesis. Probably due to this integrative process, the cycle does not return to its original baseline in social functioning. Rather, there is a gradual increase in the baseline of social functioning that reflects a cumulative process of development as a

result of learning. In other words, social change involves two processes. The cyclical dialectic process is commonly referred to as "revolutionary" changes, while the cumulative process can be considered to consist of "evolutionary" changes. The total social change process can be seen graphically as a series of alternating peaks and valleys representing the more transitory revolutionary changes, with the cumulative effect of evolutionary changes gradually raising the baseline of the curve such that the resultant graph is tilted upward.

The history of the civil rights movement reflects the revolutionary and evolutionary aspects of social change. An atmosphere of political and social reform to establish equity between advantaged and disadvantaged groups in terms of political, social, and economic opportunities in the 1960s gave way to the reactionary conservatism of the 1970s. Despite the deemphasis on civil rights in that period, there was an increased sensitivity to ethnic minority concerns. Due to this and other related evolutionary changes, the political and social climate of the 1970s was only somewhat similar to that of its cyclical sister, the socially conservative 1950s.

The descriptive model of social change suggests that significant, consistent social progress develops more from evolutionary processes than from revolutionary changes. If this assumption is valid, it has important implications for the relationship between community control and social interventions. Responsive service delivery to ethnic communities is not simply a matter of designing culturally appropriate program content. Any intervention, regardless of the culturally relevant features that it possesses, may be opposed by the community if it is considered revolutionary in nature. The problem with innovative interventions is that they often are implemented in a revolutionary manner, which generates a reaction. The crucial question then becomes: How can innovative programs be introduced and operationalized such that they do not trigger a dialectical process? Boulding (1970, p. 61) underscores the utility of information in facilitating evolutionary processes: "It is ignorance, rather than knowledge which makes for dialectical processes. Once knowledge is achieved (disseminated and absorbed) the dialectical pattern disappears."

Viewed from this perspective, community involvement can be either an effective catalyst or a retarding influence on the development and implementation of innovative mental health approaches. The pivotal factor is the degree to which participants are knowledgeable about mental health in general and about the intervention program in particular. The value of having informed community input is not a new assertion. Its importance has been argued on the basis of common sense and the right of individuals

and communities to determine their own destiny (the self-determination principle). Boulding's analysis reveals that, apart from social responsibility concerns, there are valid technical reasons for developing informed cooperative relationships with community members.

In order to contribute to evolutionary processes, programs must attend more to the actual process of keeping the community knowledgeable about its current operations and future plans. In practice, this translates to the design of specific procedures to disseminate information about the program to community members, particularly to those serving in advisory board capacities. Frequently, it has been assumed that the personal motivation of certain community individuals to stay apprised of a program's current activities through their regular attendance at board meetings was sufficient to maintain consistent information exchange between program and community. Chu and Trotter (1974) have questioned the adequacy of this practice. Additional procedures for knowledge dissemination are necessary.

Most ethnic community advisory boards still confine their primary functions to defining program policy and to making various fiscal decisions (such as budget approval). However, community control implies service accountability. It appears that the monitoring of the design and the results of program evaluation projects should become one of the primary responsibilities for community boards.

The inclusion of evaluation findings as a major focus of business in advisory board meetings would greatly increase the availability and accessibility of relevant and current information about program interventions. Such "on-call" evaluation indices as the number of clients seen, types of problems treated, mean length of waiting period (in days), mean Global Assessment Scale score, mean number of clients on waiting list per day, mean client satisfaction rating, mean number of program complaints, mean number of delinquent client accounts, number of sick and vacation days taken by staff, number of referrals made and received, and so on could be required information for presentation at each board meeting. The assumption of evaluation responsibilities by community boards can only serve to enhance community control over service programs. More important, the resultant gain in knowledge acquisition among both community members and program personnel should foster the cooperation and sense of community that Boulding (1970) associates more with evolutionary processes.

Knowledge Development and Utilization

At this point it has become exceedingly clear that there exist viable system models for the responsive delivery of mental health services to

ethnic minority populations. Most of these programs have been described in professional journals or books. They have been recognized by both mental health personnel and community consumers as effective delivery systems. Yet, despite consensus concerning the value of such programs, they have had little impact on the mental health field. At this time it appears that the widespread adoption of innovative service delivery models has lagged far behind their original development. This situation constituted a major reason for the recommendation by the President's Commission on Mental Health (1978) to develop a new mental health system designed to serve ethnic minority populations and other disadvantaged groups appropriately.

The serious gap between knowledge development and its subsequent utilization involves two issues in the marketing of innovative programs. According to Shore (1974), problems in dissemination and problems related to the nature of the program itself can reduce its marketability. The optimal dissemination of research information has been prevented by the lack of data retrieval systems that can both keep pace with the rapid increase in mental health knowledge and provide relevant, current information for an agency's daily and long-range needs. The publication lag has exacerbated this difficulty in knowledge distribution. By the time information is printed, much of it is obsolete or is received too late to have any impact on important program decisions. The National Institute of Mental Health found that only 9 percent of the new developments in mental health services were stimulated by printed research findings. The HEW Task Force (1978) has proposed that the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) establish an explicit policy and program initiatives to encourage research information dissemination. As yet, there are no plans in the near future for the development of a central data retrieval system for mental health practioners and administrators.

Even with adequate publicity, a program may not be adopted because of certain specific features it may possess. Many innovative approaches are not simple interventions. A complex design can be especially detrimental to marketability if the program is not well articulated in terms of a clear conceptual model. Well-conceptualized models allow for flexibility in the adoption of innovative programs. A model identifies operational principles that guide the replication of the program's essential features without preventing the consumer agency from changing certain aspects to accommodate the specific nuances of the ethnic community it serves.

Many innovative ethnic programs require a service delivery role that cuts across professional boundaries. In these systems, the service provider will alternate in the roles of counselor, agency advocate, educator, fiscal agent, employment advisor, and so on. Although this generalist orientation

effectively responds to the multiple needs of minority clients, it clashes with the current service structure based on specialized mental health disciplines. Finally, a program may contest some basic values of the community in which the agency is embedded or of the larger society. This is particularly true of many social problem approaches that challenge traditional sources of authority in an effort to reduce the specific adverse social conditions that plague minority communities.

Given that the resistance to innovative programs may stem from the inflexible nature of service system structures, the adoption of these programs depends on the ability of minority interests to institute major organizational changes. Typically, major changes in service structures can only be achieved by effective political action. Again, the importance of collective action and community organization efforts becomes evident, this time in terms of facilitating the implementation of ethnically responsive service delivery systems. Scientific and social merit are insufficient in the promotion of appropriate intervention approaches. Such information must be integrated successfully into the political process to achieve maximum impact on program design.

Conclusions

A variety of service systems that operate from well-conceptualized, culturally relevant models have been designed and implemented successfully. The lack of coherent service delivery models can no longer be cited as a major reason for the mental health field's slow progress in effectively responding to the multiple needs of ethnic minority communities.

Despite these advances in theoretical and technical knowledge, certain gaps in service delivery still tend to exist. Inflexible catchment area boundaries and poor public awareness of services have limited attempts to make a wide range of services (particularly costly and/or highly specialized services) available and accessible to ethnic minority clientele. Few explicit assessment strategies have emerged to guide the incorporation of cultural knowledge into an integrated understanding of the minority client. Often the cost effectiveness value of an intervention is unclear due to the lack of an evaluation-controlled approach to service delivery. Most agencies have not adopted the potent therapeutic role of the client as healer into their treatment programs. There are no efficient data retrieval systems to keep mental health personnel apprised of recent innovative developments in service delivery. The lack of systematic attempts to keep the community

informed of a program's progress has enhanced the development of dialectical processes that can often result in community rejection of an innovative proposal. A possible solution to this problem involves the reorganization of advisory board functions such that they emphasize program evaluation responsibilities.

However, it is the absence of programmatic approaches to organize the community to change organizational or social system conditions that constitutes the major gap in service delivery to ethnic minority communities. Effective collective action programs are vital because they can have important multiple influences on both the agency and the community. Besides working to ameliorate social problems, community organization efforts can advocate for the continued fiscal support of an agency and campaign for major structural changes in a system to facilitate the adoption of innovative service delivery approaches.

It is time that those in mental health move past elegant discussions of conceptual models and concentrate on the task of encouraging the widespread adoption of these models by agencies serving ethnic minority populations. A beginning step would involve the state agencies administering block grant funds. Such agencies could require applicant organizations to address the six principles discussed in terms of a service delivery model tailored to the specific needs of the ethnic community being served. The use of clear conceptual models to describe a program enables the sponsoring agency to determine how the program explicity relates cultural and community features to service delivery. This approach also facilitates the parsimonious evaluation of interventions in terms of their culturally relevant content and their therapeutic effectiveness.

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