MENTAL HEALTH NEWS™

The Impact of Race and Racism on Mental Health Clients, Practitioners, Organizations, and Delivery Systems

Crossing the Racial Rubicon

By Rev. David Billings, BA, MDiv, DDiv
Anti-Racist Organizer and Trainer
People's Institute for Survival and Beyond

Race is the Rubicon we have never crossed in this country. Some claim that race is no longer a factor in the United States. We are "beyond racism." The opposite is actually the case. Everything in this country is touched by race, from where we live or choose to live, go to school or send our children to school, where we worship and with whom, go to the movies or even walk at night. Nothing escapes race. Our mental and physical health in the United States are both impacted by our relationship to the concept of race.

If you are statused as white in this country you tend to live longer and reside in neighborhoods where property values are appraised higher. Police in your community are more likely to actually

"protect and serve." The concept of racial profiling is not a part of your everyday consciousness.

If you are of color in this country you experience stress levels that affect your personal

longevity. Your environments often make you more susceptible to certain diseases. In your community, police often operate as a social control mechanism and racial profiling is employed as a primary operational tactic.

For most of us, living and working within the confines of our particular racial group constitutes normality. Even as we are evermore a multi-racial nation, the vast majority of us are like ships passing in the night. We come close to each other, interact in commerce together, but we are navigating separate channels. We rarely board the other's vessel.

Race is deeply imbedded in the psyche of this nation. The stereotypical regional splits of North and South, urban versus rural have no saliency within the larger history of systemic and structural racism which is embedded in every facet of American civic consciousness regardless of where we live in the United States. The fear associated with race rears its ugly head in all kinds of places: at town meetings on health care reform, on the front porch of an elite Harvard professor's home, hourly on the some cable news channels, and in Night Court in any city or town across the country. Our southern border seethes with racial hostility. As a popular white talk show host loses control on air

Noted Panelists Discuss The Impact of Race and Racism on the Mental Health Professions and on the Therapeutic Alliance

Moderated By Peter Beitchman, DSW, LMSW, Executive Director, The Bridge and Board Chair, Mental Health News Education, Inc.

Moderator's Note: I had the pleasure of assembling a panel to address the impact of race and racism on the mental health professions. All of the panelists had participated in the Undoing Racism Workshop training offered by the People's Institute for Survival and Beyond and were familiar with its framework for analyzing the realities of racism in contemporary America. The panel members, all of whom work in New York City, included: Robert Abramovitz, MD, psychiatrist, Distinguished Lecturer, Hunter College School of Social Work; Kalima De Suze, MSW, social worker, feminist, and anti-oppression community organizer; Billy Jones, MD, psychiatrist,

Clinical Professor of Psychiatry, New York Medical College and former Commissioner of the New York City Department of Mental Health; Julie List, LCSW, social worker, Director of The Harry Blumenfeld Pelham Counseling Center, Jewish Board of Family and Children's Services; Alan Siskind, PhD, social worker, adjunct faculty, Hunter College School of Social Work, private practitioner, former CEO of the Jewish Board of Family and Children's Services and Co-Convener of the First Monday Anti-Racism Collaborative; and Peter Yee, LMSW social worker, Assistant Executive Director, Hamilton Madison House, a settlement house that provides a range of services, including mental health.

Peter Beitchman: Of course we can't separate the mental health professions from the clients we serve so let's begin with what we know about the impact of racism on our clients.

Robert Abramovitz: The impact of racism on clients of color is pervasive, affecting all aspects of their experience and development. So often the experience of racism has been internalized so that clients don't give voice to the experience that they've had. In fact if a client came to treatment angry, and declared that his or her problems were attributed to racism, we know that years ago they would have gotten some sort of diagnosis of paranoia.

Alan Siskind: It's the imprinting that occurs from pervasive and repetitive experience and then how all subsequent cognitive and emotional experience gets filtered through that imprinted response. The result is that people of color often develop a belief system that their repetitive negative experience with the environment are their fault and that "there's something wrong with me." White people also have their perceptions of people of

color and their participation in racist systems reinforce in the same way.

Julie List: We've learned that one of the examples of how the constant experience of racism gets internalized is that in communities of color there's a lot of concern about the shade of one's skin. In families where some members are darker they feel that they're treated less fairly in their own family.

Robert Abramovitz: In fact I just heard a talk by an African American woman who plays in the WNBA. She talked about how her father sent her such strong messages because he felt she was too dark and too tall. Her entire self-image revolved around her father's attitude towards her, including his internalized racism.

Peter Beitchman: What happens when clients bring this internalization, mostly

Table of Contents

**Mental Health News
2011 Theme and Deadline Calendar**

Spring 2011 Issue:
"The Mental Health Needs of Older Adults"
Deadline: February 1, 2011

Summer 2011 Issue:
"Women's Issues in Mental Health"
Deadline: May 1, 2011

Fall 2011 Issue:
"Health Reform and Mental Health Parity
and their Impact on People and Service Providers"
Deadline: August 1, 2011

Winter 2012 Issue:
"Housing for People with Mental Illness"
Deadline: November 1, 2011

Advancing Anti-Racism Work: The First Monday Collaborative

By Peter D. Beitchman, DSW, LMSW
and Onaje Muid, MSW, LMHC,
CASAC, FDCL

For the past three years, as a direct outgrowth of the *Undoing Racism* training workshops provided by *The People's Institute for Survival and Beyond*, a learning and action collaborative consisting of human service executives and senior managers, as well as leaders from academia and the human service advocacy sector, has been meeting to advance anti-racism work. Brought together by the powerful training of *The People's Institute*, the cost of which was initially subsidized by United Way of New York City, a diverse group of human service leaders formed the "First Monday Collaborative" to further anti-racism efforts within our organizations and beyond.

The First Monday Collaborative is co-chaired by Mary Pender Greene, LCSW-R, Assistant Executive Director of JBFCS, and Dr. Alan Siskind former Executive Vice President of the Jewish Board of Family and Children's Services (JBFCS). The Collaborative is based on the principle that *organizational leaders* have a crucial role to play in recognizing and addressing the impact of racism on the human service system and their organizations, as well as clients and staff of color. The Collaborative offers an opportunity for participants to deepen our understanding of the impact of racism in general and specifically its impact on the

First Monday Collaborative Members (from left): Andrea Harnett-Robinson, President, Harnett-Robinson Consulting; Lawrence Mandell; Onaje Muid, Clinical Associate Director, Reality House, Inc.; Dr. Alan B. Siskind; Mary Pender Greene, Assistant Executive Director, Jewish Board of Family and Children's Services; Maurice Lacey, Executive Director, Faith Mission Crisis Center; Michael Stoller, Executive Director, Human Services Council of New York City; David Billings, Core Trainer, People's Institute for Survival and Beyond; Dr. Alma Carten, Associate Professor, NYU Silver School of Social Work; Dr. Peter Beitchman, Executive Director, The Bridge; Dr. Robert Schachter, Executive Director, National Association of Social Workers NYC Chapter.

delivery of human services. It also provides a place to share and creatively develop strategies to transform organizational structure and practice to embody anti-racist principles.

The Collaborative has been an important forum for learning about racism in the current American experience and in our own organizations. Many of us initially viewed racism as being individual and intentional acts of meanness, not recognizing the structural and systemic issues to be addressed. Using the framework and language offered by the *People's Institute* as a crucial common ground, including the lessons of history, tools to identify and analyze structural racism and the crucial roles of organizing, leadership and networking in addressing it, participants have learned to identify contemporary forms of racism at large, in our agencies and delivery systems. We have recognized the impact of racism on the lives of our clients and staff of color and, in recognizing institutional bias, we have focused on how to make structural changes to achieve both equity and accountability.

Since the conversation on race is difficult and acknowledgement of racial bias in our organizations takes both courage and encouragement, the Collaborative has created a safe, open environment for mutual learning and support to explore these issues and share solutions. The fact that such a safe space could be created was a major accomplishment, allowing for honest, self-reflective dialogue among the participants. During Collaborative meetings, organizational efforts to address racism are discussed, including the formulation of organizational goals, how to initiate the discussion using a common language, and models of intervention to address racism in the provision of services and in organizational operations.

Mental health agencies are particularly important in these efforts. Given our understanding of the impact of racism on personal and social development, the mental health community has a special role to play in confronting the realities of racism and the urgent need to address them in our services and organizations.

We offer a round of applause in thanks to Mental Health News. By devoting its winter issue to topics of race and racism in the field of mental health, this publication has offered an opportunity to practitioners in the field who, in various ways for many years, have been working to address race and racism through their work. The planning committee for this issue was the First Monday Undoing Racism Collaborative, a monthly discussion, one of many offered by the Anti-Racist Alliance. To maximize participation and ensure inclusion of diverse points of view – all grounded in the principles of antiracist organizing developed by the People's Institute for Survival and Beyond – topic areas were identified and a convener selected for each. Conveners were asked to work with a cross-racial group of contributing authors and resource people. In order to achieve an integrated final product, we relied on Dr. Alma J. Carten, Associate Professor of the NYU Silver School of Social Work, as editor, assisted by Susan Baydur, Program Planning Coordinator and co-facilitator of the White Antiracist Caucus at JBFCS. Our hope is to spark dialogue and offer practical ideas. By sharing their experience, challenges, and the learning they arrived at through their work in planning, research, practice and administration, we hope these articles might help professionals in the field and consumers of services to recognize where racism has diminished us, and to move toward antiracist practice in all of the spheres that encompass mental health services. While the voices and perspectives of consumers are too few among these articles, we invite consumers and others to respond, enriching the dialogue we hope will continue in these pages.

First Monday Undoing Racism Collaborative

Mary Pender Greene, Assistant Executive Director, JBFCS   Alan B. Siskind, Former CEO, JBFCS
Co-Chairs

Members

Sandra Bernabei, Founding Member Anti-Racist Alliance, community organizer, private practitioner; Peter Beitchman, Executive Director, The Bridge; David Billings, Core Trainer, People's Institute for Survival and Beyond; Alma J. Carten, Associate Professor, NYU Silver School of Social Work; Andrea Harnett-Robinson, President, Harnett-Robinson Consulting; Maurice Lacey, Executive Director, Faith Mission Crisis Center; Lawrence Mandell, former CEO, United Way of New York City; Onaje Muid, Clinical Associate Director, Reality House; Robert Schachter, Executive Director, National Association of Social Workers NYC Chapter; Michael Stoller, Executive Director, Human Services Council of New York City

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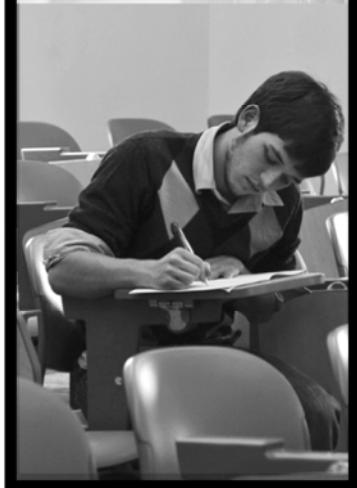
We are committed to preparing

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bringing about a more humane

and just society for everyone.

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our graduates to work toward

the elimination of Racism

in all its many forms.

Dean Frances L. Brisbane, Ph.D.

Faculty & Staff

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Preparing Students, the Workforce and Ourselves for a Critical Competency: Anti-Racist Practice and Service

By Robert Schachter, DSW, LMSW
Executive Director
NASW-NYC Chapter

An increasing number of educators, trainers, administrators, and supervisors are providing leadership in preparing the workforce to be competent in anti-racist practice and service delivery. Seven of these leaders are doing pioneering work and share their thinking and insights.

Frances L. Brisbane, PhD
Dean, School of Social Welfare
Stony Brook University

Racism is not a hot topic anymore as it was in the '60s, 70's and 80's. There was a time when Whites went out of their way to be relevant about racism. How many times do we dodge the topic, thinking there are bigger issues to talk about? If we do not teach about the terror of racism, future generations will think it is all right.

Racism is a mental health issue, but it is basically a social ill. We hurt people when we don't see them as human. Social workers need to find ways for people to understand their own biases and prejudices, and we need to talk about this in settings where we work. We especially need to be aware of how racism is perceived by the people on the other side of the desk.

Most people will go for training on cultural competency, but not for racism. But cultural competency is not a cure for racism. Racism needs to be handled before addressing cultural competency.

Margery Freeman
Core Trainer/Organizer
The People's Institute for Survival and Beyond

Professionalization has unintended consequences for us all because it often separates us from the people we serve. We profes-

sionals are rarely encouraged to spend time in our constituents' communities so we do not build authentic relationships with the families we are working with. Since we do not know much about their lives, we rarely trust them to take the lead in their own healing.

In The People's Institute's 2 ½ day Undoing Racism™ workshop, we model what it would be like to approach our professional life in a different way. We sit in a circle—no agenda, no paper, no table—so we can see and hear one another. We use the experiences and wisdom of the collective to push past intellectual understandings so we can be genuinely human with one another. We experience dramatic changes as we take time to engage with one another without our own preconceptions and biases getting in the way.

In similar ways, changes can occur in professional organizations. As we build genuine, trusting relationships with individuals and their families, we can organize together with them to bring about effective changes in our institutions so they are accountable to the people they serve.

Candida Brooks-Harrison, LCSW, Director
The Village Enrichment, LCSW, PLLC
Supervisor, Undoing Racism Internship Project
Lecturer, Brooklyn College – CUNY
Person-in-the-Environment

In working with graduate students, over the years and currently on the Undoing Racism Internship Project (URIP), I am keenly aware of the need for reflective supervision that specifically addresses issues of race. Everyone enters the conversation on race at different points and fall along a continuum of being equipped to work with diverse communities.

Many students of color have been dealing with issues of race for 20+ years and want solutions; while others are just beginning and want to know where they fit in the discussion. In reflective supervision groups, this can be processed so as not to create a mismatch that is parallel to what can occur with clients.

In clinical practice, a lack of understanding of systemic racism can contribute to overrepresentation of people of color in some areas of mental health. Without an analysis of racism and its effects, we may never consider the question and could be missing a large component of the person-in-environment.

As a field, we need a multi-level approach to help students co-construct their own individual growth, advocate for education that addresses racism and to encourage faculty to integrate an analysis throughout the curriculum.

Natania Kremer, LMSW, MSEd
Director of Early Childhood Support Services
JBFCS Child Development Center

As a white social worker and educator, I am committed to bringing an anti-racist lens to my supervisory relationships with the early childhood special educators in my department. In supervision, we practice resisting the tendency to silence or avoid conversations about race. We have created a space where we can grow dynamically and integrate an analysis of racism as well as an understanding of our racial identities into our work. In case presentations, we share how each family identifies in terms of race, class, ethnicity, religion, gender, and culture, in addition to how we perceive them. We also explore how we are perceived. All of this informs our relationships with parents and children. Our supervision space is both supportive and challenging, and offers opportunities to bring our whole selves to the work, developing both personally and professionally. We push each other to continue to struggle with our own racism and to transform our ways of being in the world. I am grateful to engage in this anti-racist process with my staff and appreciate the ongoing support I receive from colleagues.

Sheilah D. Mabry, LCSW-R, Director
Bronx Domestic Violence Services
JBFCS

My work involves the supervision of supervisors responsible for administrative and clinical work and staff who work directly with clients. It also involves teaching and developing domestic violence curriculum for the agency that incorporates a clinical anti-racist practice lens.

Through constant conversations, we look at who we and our clients are racially, ethnically, and culturally; ways that we are impacted by systems of subjugation and oppression; and how white superiority and internalized racial oppression play out in our work. We also discuss correlations

between who comes into our shelter, their being African-American or Latino, and the experience of poverty and violence.

As a woman of color in a position of power in the organization, my greatest tools are self reflection, trusting my teams, and in creating spaces where everyone is able to contribute to decision making. Staff need to feel comfortable in asking for help and to be sensitive to why they might not.

We use a team approach because clients have different relationships with different staff and will often trust people who look like them or to whom they feel most connected. When a client breaks a shelter rule, we are interested in their understanding that safety is our goal, not being punitive. We see women, men and children blossom, and we see staff optimally supporting their clients.

Marion Riedel, PhD, LCSW-R
Associate Professor of Professional Practice
Columbia University School of Social Work

Many white students come to social work school to "help those poor people" in communities of color. Most are unaware of how their privilege and internalized racial superiority affects their work.

Most students of color are aware of the oppressive force of structural racism in their communities. They are more likely to see the responsive strengths developed, such as capacity to survive and thrive, than their white counterparts. Yet they might be less clear about their racial identity development and internalized inferiority.

I begin class with the power analysis moving from intellect to affect. Early good process supports us using the analysis throughout the semester providing a framework for the other skills-based content.

Feelings such as guilt, shame, and anger may arise. Sometimes they linger preventing honest dialogue. Together we can recover, revisit the conversation and re-engage. If we cover up and ignore the discomfort, the class won't move forward.

This is critical process for developing professionals that will protect human rights and further social justice. Without this lens they risk causing further harm rather than help. This is hard work requiring self-exposure and persistence. I use my peers and trusted colleagues to keep me honest, motivated, and consistent.

Assessing Racial Equity Impact in Mental Health Policymaking: Reflections and Recommendations

By Mimi Abramovitz,
Sandra Bernabei, LCSW,
Carmen Collado, LCSW,
Robert Hawkins,
Wayne Ho, MPP,
Eri J. Kim,
Larry Mandell, MSW,
Jonathan Morgenstern,
Gabriel Sayegh,
Michael Stoller,

Racism has a long and unique history in the practice and policy of mental health in the United States. In colonial times, for example, it was a common belief that Blacks did not have the intellectual capacity to experience mental illness. In later periods runaway slaves were diagnosed with "drapetomania," or flight from home madness, when they attempted to flee the "loving arms" of their master. In our more enlightened times, we still see the results of structural racism and personal stereotyping-- more children of color enrolled in public schools are receiving medication for mental disorders, and mental health itself, operating on a social gradient where income and race predicts mental health outcomes. Striking disparities in mental health outcomes for people of color as compared to whites are documented in the 2001 Supplement to the Surgeon General's Report on Mental Health.

Given the history of structural racism in the United States in general and in the mental health field in particular, racism is perpetrated at the micro and macro societal levels. It is important to recognize the consequent control inherent in the gate-keeping roles that social service agencies exercise in terms of access to resources and supports. The goal of achieving real equity requires no less than building anti-racism accountability into the very fabric of service provision

It is with this goal in mind that agency executives, managers, and providers who completed the Undoing Racism™ Workshop conducted by the People's Institute for Survival and Beyond convened as a group to advocate for the integration of anti-racism principles into mental health policy and service delivery. It is our goal to develop a framework to promote meaningful and equitable outcomes and advance organizational effectiveness.

Communities of color have been traditionally victimized by institutional bias and discrimination. Local budget and resource allocation practices are traditionally biased toward more affluent and white residents of local jurisdictions. By measuring the overall equity in a few representative areas, policymakers can advance anti-racist policy, spread the burden of regulation fairly, and help address historic patterns of institutional bias and discrimination. Likewise, agencies also have a responsibility to advance anti-racist policies and programs to better serve their clients.

Most social services including mental health services are funded by contracts issued by government agencies. Like most agencies, funding requirements and guidelines drive process and outcomes. Cur-

Mimi Abramovitz

Robert Hawkins

rently the Mayor's Office for Contract Services is in the process of developing a universal New York City contract that governs the way all human services are provided within the City.

As the City moves forward in developing a universal approach to vetting human services contracts, we recommend that all contracts be evaluated through the lens of a racial impact assessment process. Since funding requirements and guidelines drive process and outcomes, the expectation of eliminating structural racism should be reflected in the language of all contracts and require that they include steps for engaging undoing racism activities and clear accountability statements relating to the goal of racial equity in outcomes. Compliance with government contracts will enable policymakers to advance anti-racist policy and help address historic patterns of institutional bias and discrimination. Likewise, agencies will have a responsibility to advance anti-racist policies and programs to better serve their

Carmen Collado, LCSW

Eri J. Kim

clients and promote racial equity.

Policymakers, executives, managers, and service providers who serve as gate-keepers should consider several factors in developing policy and programs. One approach for developing and maintaining an anti-racist focus is to consider integrating racial impact statements into the policymaking and program development process. The Applied Research Center has proposed a series of questions to guide this process:

- Which communities carry the greatest burden if the policy is implemented? Which gain the most benefit?

- Will this proposed policy or program affect compliance with state, federal, and international anti-bias and anti-discrimination policies? In what ways?

- How will the policy or program affect access to livelihood (i.e., affordable

housing, jobs, transportation, food access, medical care, school access and quality)?

- Will the policy or program compromise/improve quality of life? How and for whom?

- How does this policy or program change or maintain the status quo? If it maintains the racial or cultural status quo in some manner, is it still worth considering? Why? Why not?

While these five questions can generate much debate and disagreement in the policy decision-making and program development processes, we believe that a clear and meaningful consideration of these areas will in the long term benefit those receiving mental health services and result in a more efficient and effective use of mental health resources. These questions alone, however, are only a beginning. A deeper and more meaningful commitment to equitable outcomes would require organizations to evaluate all dimensions of their infrastructures. To ensure racial equity at every level of decision making should include a re-examination of the organization's vision and mission statements, board composition, operational policies and procedures, hiring practices and how they present themselves to their clients. For some agencies, for example, creating positive changes will mean a reconsideration of orientation programs for new employees to reflect an anti-racist agenda. Anti-racist training may be approached in a similar manner as mandated child-abuse training which is a requirement for state licensure for all professional groups that have contact with children.

Whether it is through compliance with government contracts or agency policy changes that leads to anti-racism in mental health, we believe that the overall result will be better mental health outcomes for clients of color. Therefore, following are suggested as key areas for governmental officials and agency administrators to consider in integrating anti-racist policies in the contracting process and implementing these in agency operational procedures and practices:

- All funding should require a racial impact analysis that considers the historical and structural nature of racism in mental health services.

- Public contracts should identify the elimination of the impact of historical and current racism as important.

- Leaders in agencies should recognize the importance of identifying and understanding the role of historical and current racism in mental health practice.

- Policymakers should establish accountability measures, such as community expert panels of community

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The Jewish Board of Family and Children's Services (JBFCS) provides a comprehensive network of mental health and social services to people of all faiths, races, and cultures in greater New York City. Founded more than a century ago, JBFCS is a nonprofit and promotes well being, resilience, and self-sufficiency for individuals and families alike. For more information, visit JBFCS online at www.jbfcs.org.

The Mental Health Needs of Special Populations

By Onaje Muid, MSW,
Laura Smith, PhD,
Michael Arsham, MSW,
and Theresa Lacey, CASAC

The history of mental illness in the United States and in New York State in particular amongst special populations is a very complex one, having within it all the politics, economics of a hierarchal, power centric, race constructed society. What are the key issues for practitioners who wish to incorporate an antiracist/social justice analysis within their work with specific client populations? In the space of this article, we cannot fully address such broad topics as these, but we hope to propose some key issues for mental health practitioners working with particular populations: clients living in poverty, children in the welfare system, and the mentally-ill incarcerated.

Clients Who Live in Poverty

People living in poverty are generally underserved by the mental health fields, both in terms of their access to services and also the ability of conventionally-trained mental health professionals to serve them usefully. As the result of Whites' historical domination of American wealth-creation, people of color are disproportionately represented among people living in poverty, underscoring the fact that class-aware mental health practice must simultaneously be informed by an antiracist framework.

Appropriate services for poor communities begins with the acquisition of knowledge about structural oppression, social class, the race-class intersection, and poverty – training that many practitioners do not receive as part of their graduate curricula. Professionals can begin to attend to their own continuing education in this area through the work of scholars, listed in the resource bibliography, who have addressed the intersections of racism and classism. Moreover, when poverty and oppression are addressed, it often is presented from a "helping the needy" point of view. Certainly, there is nothing wrong with intentions to be helpful, but when practitioners are working with clients who occupy oppressed social locations, the idea of help is more complicated than may immediately be apparent. The opening quote directs us to a position that as humans we must assist each other's liberation. This notion was also expressed by Dr. Martin Luther King, Jr. shortly before his assassination, and weeks before the intended launch of his Poor People's Campaign:

"On the one hand, we are called to play the Good Samaritan on life's roadside, but that will be only an initial act. One day we must come to see that the whole Jericho Road must be transformed so that men and women will not be constantly beaten and robbed as they make their journey on life's highway. True compassion is more than flinging a coin to a beggar. It comes to see that an edifice which produces beggars needs restructuring."

Onaje Muid, MSW

Laura Smith, PhD

Michael Arsham, MSW

Theresa Lacey, CASAC
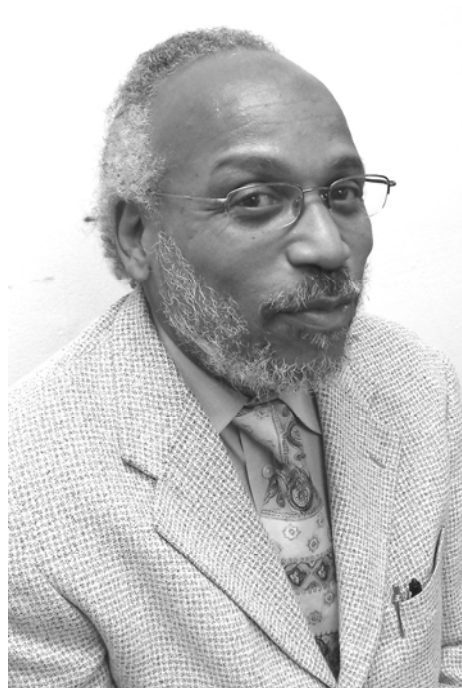
In other words, when clients live in the context of oppression, true help must extend beyond charity to effect change in the edifice – in society – itself.

How can practitioners incorporate anti-classist, antiracist movement within their practice? To accomplish this clinicians must broaden that discourse and find meaning and practice that is aligned with an anti-racist agenda. It is suggested that after supplementing their own knowledge base with regard to the race-class intersection, they can work to analyze and modify their practices accordingly. Such re-imagined anti-oppressive therapeutic models and techniques fall under the headings of multicultural, social justice, liberatory, and/or emancipatory approaches, and include the Stone Center's Relational-Cultural Therapy, multicultural counseling and psychotherapy and anti-oppressive social work practice. Such approaches incorporate therapeutic roles and techniques that directly challenge the power-over dynamics inherent in conven-

tional therapeutic dyads as they subvert the voicelessness and internalized oppression that can accompany life in social location that are marginalized by both racism and classism. Practitioners can furthermore initiate community-based interventions that feature actual activist components as they promote psychological well-being, such as participatory action research. Finally, as individuals and as members of a professional field, practitioners can organize and advocate with regard to public policy issues that affect all poor and working-class clients, such as the replacement of the minimum wage with a living wage, and the rights of all people to organize in the workplace.

Children in the Welfare System

The vast majority of parents facing child maltreatment charges in Family Court are charged not with abuse, but with neglect, most often related to poverty. A very small number of parents place their own children in foster care

voluntarily. For the most part, foster care is a "service" that devolves to those families most powerless to resist it. Addiction, mental illness, domestic violence, and parent / adolescent conflict cut across all racial, economic, ethnic, and geographic lines. In addition to reporting bias, privileged families have the resources to retain attorneys, hire nannies, enter private rehabilitation facilities, or send children to boarding schools. The fewer options available to families, the greater the likelihood that family crises, magnified by poverty, will trigger a downward spiral ending in permanent dissolution. People of color living in poverty are exposed to greater public scrutiny than the wealthy. They are more likely to live in public housing, and to use public schools, healthcare, and daycare facilities. They are more likely to be accused of child abuse, more likely to be found culpable once accused, more likely to have their children removed to foster care thereafter. Once their children are in care, conditions that never would have constituted valid legal reasons for removal become insurmountable barriers to reunification-- their incomes are too low, their apartments are too small, their neighborhoods are too dangerous. Their children remain in care longer, the parents' rights are more likely to be terminated. No explicit animosity towards people of color is necessary; this is simply the system's default setting.

The key to antiracist child welfare practice is not simply about more services for poor families; it is about correcting power imbalances and restoring autonomy and self-determination to families and communities. Federal child welfare policy and spending must be reordered to emphasize safe, proven programs that keep families together. Services of first resort must be more comparable to those which most families would purchase voluntarily, if they had the means. Just as an overemphasis on child removal and adoption disproportionately harms low income families of color, a system more oriented toward keeping children safely in their own homes will help reduce such discrimination.

On a neighborhood level, public child welfare authorities must meaningfully partner with communities to prevent child maltreatment, with legal mandates to involve community residents in all levels of child welfare service planning, delivery, and evaluation. It is more productive, humane, and cost effective to help people rebuild their communities than to remove thousands of children from those communities. In most instances, children at risk are more effectively protected by respecting, enfranchising, and strengthening their families than by separating them from their families. "Child welfare" must become less about pretending to protect children from their parents, more about recognizing, listening to, and supporting parents as, potentially, the best and most dedicated protectors of their own children. How can we as professionals continually fail to acknowledge and join with the enormous strengths of families who have survived and achieved despite a history of slavery,

NewYork-Presbyterian Psychiatry

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Clinical Reflections on the Impact of Race and Racism on the Counselor/Client Relationship

By Joan Adams, LCSW,
Bonnie Cushing, LCSW,
Sandra Bernabei, LCSW,
Gail Golden, EdD, LCSW,
Jeff Hitchcock, MS,
Natania Kremer, LCSW,
Jonathan McLean, LMSW,
and Jordan Margolis, LCSW

This article was prepared in collaboration with an interracial group of mental health providers practicing in a variety of public and private mental health settings. Each clinician has completed the PISAB Undoing Racism Workshop™ and does anti-racist organizing in their various settings.

In July 2006 the American Psychiatric Association Board of Trustees approved a *Resolution against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health.* This resolution was prepared by the Committee of Black Psychiatrists of the Council of Minority Mental Health and Health Disparities and states in part that:

"Racism and racial discrimination adversely affect mental health by diminishing the victim's self-image, confidence and optimal mental functioning." "Racism also renders the perpetrator unprepared for the 21st century society that is becoming increasingly multicultural and global."

"The APA and its members should be mindful of the existence and impact of racism and racial discrimination in the lives of patients and their families, in clinical encounters, and in the development of mental health services."

We understand that mental health theories, practice models and service delivery systems are constructed in the context of white Western norms and values. Therefore, racist power structures that exist in societal institutions, including health and mental health care, contribute to the structural racism affecting people of color, and especially poor people of color who are often seen in public mental health settings. In order to provide culturally competent, anti-racist mental health services clinicians and supervisors need the following:

Knowledge about the history of race and racism, and their manifestations, understanding of white skin privilege and how it advantages and empowers white clinicians and contributes to a power differential between white clinicians and clients of color, and familiarity with racial identity development theories developed by various and clinical and counseling psychology theorists. Many of these are anchored in the pioneering work of Cross and Helms. Two other important areas of knowledge are Sue's work on racial micro aggressions and Leary's work on Post Traumatic Slave Syndrome. It is also important to understand the relationship among race/culture and class, gender, sexual orientation, class, age, religion/spirituality and various forms of structural oppression.

Self awareness about our racial/cultural identity and our experience of racism is necessary. Clinicians of color and white clinicians must know their assumptions, values, vulnerabilities, privilege and power around race, and understand the dynamics and implications of internalized racial superiority and internalized racial inferiority for the therapeutic relationship.

Understanding the client in terms of their specific specific experience of race, culture, class, racism and other forms of social oppression; including an understanding of how white skin privilege affects white clients and their families. A holistic understanding of clients includes the interaction of their psychological and interpersonal issues, their social identities and their experience of racism and other oppressions. In order to understand the client the clinician should include questions about race and culture, its import and impact in assessments with all clients -white and clients of color; and routinely explore the impact of race and racism in all treatment planning, development of therapeutic alliances, and in supervision and case conferences.

Recognizing manifestations of racism in mental health is also essential. Gail Golden in her article "Retooling Mental Health Models for Racial Relevance" examines ways in which "most mental health theories have failed to incorporate an analysis of societal oppression into their understanding of human behavior." Accordingly, this failure disadvantaged members of marginalized groups by measuring their behavior against what has been established as "Eurocentric and privileged notions of normal." This perpetuates a "diagnosis industry that inaccurately characterizes people of color from a perspective of deficits and pathologies. Resultantly, people of color are as misunderstood and "damaged by the Mental Health System as they are by every other system in this country."

The following examples from the work of the contributing authors illustrate the positive outcomes of incorporating Anti-racist approaches in clinical practice.

Sandra Bernabei shared the following feedback illustrating some of the dynamics that emerge in the therapeutic relationship between white therapists and client of color:

"I have been in therapy in the past, but working with you was the first time I felt really understood in a social context larger than my immediate personal life. Balancing my personal stuff alongside the larger social justice issues I care about will be an ongoing challenge, but I thank you for helping me to build a framework for this."

Jonathan McLean described an African American male therapist's work with a Latina who initially resisted been seen by a Hispanic male therapist. The careful exploration of her underlying feelings facilitated the uncovering of internalized stereotypes about Hispanic males and subsequent establishment of a productive therapeutic alliance with this client.

Jordan Margolis described the difficulty a young white male therapist had engaging an older African-American man in family therapy:

The client, the father in the family, commented as he walked with the therapist from the waiting room, "where are you taking me – the gas chamber? Recalling that the client had recently been released from prison, the therapist stated "I may be white but I'm not a prison guard."

The client seemed to sit down comfortably, and asked "Really? Are you so sure about that? One thing you have to understand is that I naturally put up a wall." "Well," said the therapist, "I won't try to change your mind."

The therapist did not acknowledge to himself his defensive position. Since he did not know how to move the conversation forward, he asked a general question about the client's experience as a Black man without directly addressing the feelings and interaction in the room. The client obliged the therapist with an intellectual response that also maintained the barrier between them. He did not continue the therapy beyond the first few sessions.

It was not until several years later, after the therapist attended an Undoing Racism Workshop™ and began to read and have dialogues about race, power and ethnic identity, that he understood more clearly the elephant in the treatment room that was not addressed in the work with this African American family. For example, the therapist had an increased understanding of the cumulative impact of structural racism on the client, the client's understandable mistrust of an unknown white male therapist, whose presence embodied white privilege and white power in society, the therapist's discomfort with his white skin privilege and the therapist's lack of experience having authentic cross-racial conversation about race and racism. In the engagement process, the therapist might have opened a dialogue by validating the client's concern about how he would be treated by a white man, and stating that the therapist was aware of the unequal resources and opportunities available to white and Black people in the society. This opening could have made space for the client to bring himself more fully into the therapeutic encounter.

As we strive to provide anti-racist mental health treatment, there are a number of questions we might ask ourselves:

What norms and values do we use as markers of good mental health? Do we place a high value on individuated separation from family, competiveness and the importance of acquiring material goods? Do we undervalue strong connections to family and community, cooperativeness and the importance of relational and spiritual resources?

Additional questions we can ask ourselves were posed by Gail Golden in the previously cited article:

How might African Americans deal with their anger towards a white person in a mental health setting? What is socially sanctioned and what is not? Do our diagnostic categories help or hurt people? Are they flexible enough or elastic enough to incorporate experiences of oppression? When making assessments, are we able to identify the resilience and assets of people who are not like ourselves?

Our discussion suggests clinicians can improve their clinical practice and mental health outcomes with all clients by increasing their knowledge about race and racism, self-awareness, understanding of clients and recognition of manifestations of racism in mental health. Here are three avenues for continued learning and development:

Joan Adams, LCSW

Bonnie Cushing, LCSW

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Panelists from page 1

unconscious, into the treatment relationship?

Julie List: When clients who have internalized racism come into treatment—especially poor clients of color with no job, often no decent housing or health care—they're feeling powerless. In addition, there's a hierarchy in the therapeutic relationship. The white therapist has the power by virtue of color, education or class. Clients will react to the same experience inside the therapy room that they experience outside the therapy room, unless the clinician has the proper training and awareness. I think if you don't acknowledge this difference between the clinician and the client in treatment, and the client continues to act on the basis of the internalization of superiority and inferiority, then the treatment is a lie. If not a lie, then it is certainly inauthentic.

Alan Siskind: What makes this so complicated, of course, is that the client is coming in with a presenting issue and it's so easy for the clinician to not consider the impact of something like internalized racism or the experience of being oppressed and acknowledge it in the assessment and in helping the client address the problem. We as professionals have to think about the impact of racism on all aspects of our clients' lives as challenging as that may be. And we must to be aware of our own agendas. For white therapists the agenda is often the therapist's guilt and other distortions of perception that come from their own internalized feelings

Julie List, LCSW; Peter Beitchman, DSW, LMSW; Billy Jones, MD; Robert Abramovitz, MD; Kalima De Suze, MSW; Peter Yee, LMSW; Alan Siskind, PhD

of racial superiority. The guilt can get in the way of really hearing and understanding the client.

Kalima De Suze: Yes, I've seen that guilt, where therapists over-identify with structural racism and the therapeutic relationship becomes patronizing. That kind of false solidarity with people is just as damaging.

Alan Siskind: Assessment is complicated, even more complicated when you acknowledge the role of racism in both the client's and therapist's (white or of color) lives.

Billy Jones: My first analyst was white and as an African-American medical resident in psychiatry I recognized a lot of difference between me and him: his color, certainly his power, education and class. Yes, the client rarely brings those differences out in treatment but it's important for the therapist to help bring them out. Through a number of life experiences I returned to analysis years later and this time with a black analyst. And while there weren't a lot of differences I did feel freer with the back analyst if only because he understood my language, like when I referred to my grandmother as Big Mama, which I'd have to explain to the white

analyst but which instantly communicated an image to the black analyst.

Peter Beitchman: Peter, how do you see this playing out in the mental health services provided in the Asian community?

Peter Yee: My experience is quite different. We've been exploring the issues of racism and difference to empower clients. In the Asian Community the culture is so different. New immigrants come to treatment only as a last resort. In fact, the Chinese culture believes "the more pain you endure the more virtuous you are." The idea of empowerment is a new concept. So when someone comes for help it is to address something very concrete. We tell our clinicians and doctors to prominently display their credentials, which are respected; an equal therapeutic alliance based on acknowledging difference is a foreign idea. The racism that is felt is the racism against our community as a whole—the lack of resources, long waiting lists, and gaps in services. For example, there is no supervised mental health housing for people who speak Chinese or Korean.

Billy Jones: So what we're saying is there are different manifestations of racism in mental health services: in the relationship between those who treat the client and within the system of funding and the structure of services. Basically, when I was at the City Department of Mental Health, for a host of reasons, we could not start with assessing need in various

"The denial of racism is a form of racism itself."

-Tim Wise

The Impact of Race and Racism on Mental Health Outcomes

By Andrea Harnett-Robinson, ACSW, LCSW
Kimberley Richards, EdD,
Milta Vega-Cardona, MS,
Ben Kohl, PhD, LCSW-C

Achieving positive mental health outcomes in the context of race and racism begins with awareness and action. Clinicians are motivated to relieve negative symptoms and support well being ; however their work rarely promotes anti-racist values such as Learning from History; Sharing Culture; Developing Leadership; Analyzing Power; Networking, Maintaining Accountability; Gatekeeping; Organizing, and Undoing Internalized Racial Oppression. The contributing authors to this article focus our attention on the multiple realities for people who seek help. We become aware of the myriad of ways to create an anti-racist environment and the actions necessary to reach that goal.

Armed with research findings that illustrate "the over-diagnosis, misdiagnosis and under-diagnosis of mental disorders in people of color," Ben Kohl provides the broader context and helps us define a model of anti-racist clinical practice. He argues that if the intent is to improve mental health outcomes, anti-racist principles must be integrated with clinical treatment. His insights remind us, that our clinical work does not have to contribute to racial oppression, and sets the stage for learning how to better serve people of color. He asserts "we must not only meet clients where they are, but listen and create opportunities for them to tell us where we are."

In "They Spoke about the Things that bothered them," Milta Vega-Cordova invites us to listen to the dialogues of several women who participated in a long-term research group that focused on the disparities in women's physical and mental health in several communities in the Bronx, New York. We learn from the women's narratives about the blatant aggressions and micro-aggressions they experienced from systems that claimed to help them. They tell of the careless assumptions made by mental hygiene professionals that caused them further hardships. When the dialogue ends, many of us wonder how we may have unknowingly contributed to the racial oppression of our clients.

Kimberley Richards' contribution, "Community Sage," helps us to see how a wise woman guided her family, her community and local institutions to health by using anti-racist principles. Looking through a different lens, we see community leaders like Ma Richards, as true organizers, a traditional/non professionalized clinician, and a natural leader.

What Does Anti-racist Clinical Practice Look Like?

Clinical social workers treat the mental, behavioral and emotional disorders of individuals, families and groups using numerous modalities and theoretical orientations. Most of us are trained to assess the biopsychosocial needs of individuals and provide interventions that embrace a

Andrea Harnett-Robinson, ACSW

Kimberley Richards, EdD

Milta Vega-Cardona, MS

Ben Kohl, PhD, LCSW-C

person-in-environment perspective. While clinical treatment can ameliorate symptoms and empower clients to manage mental illness, it often has little to do with an essential anti-racist principle: organizing. Mental health and sociological outcomes, such as the misdiagnosis of people of color and disproportional representation of children of color in foster care, reflect the need to integrate anti-racist organizing principles with clinical practice.

As the Antiracist Alliance gained momentum in New York City and increasing numbers of social work practitioners and educators attended the Undoing Racism workshop many of us struggled with how to integrate what we were learning into clinical practice. The workshops resonated with our values, renewed and deepened our awareness of the impact of the race construct on our lives, and began to change the language we used to understand our profession. We also began to understand the limitations of the treatment models we subscribed to and how the service delivery systems we worked for

often perpetuated systemic racism. As we recognized our role as gatekeepers, and endeavored to increase our accountability in dismantling the race construct we were challenged to integrate the skills and tools we used in our profession with the call to organize.

One place to begin is in organizing our educational and training structures to teach racial self-awareness before cultural knowledge. Our field has done a remarkable job in indentifying norms and values that need to be understood in order to engage assess and treat people from specific ethnic and marginalized groups. However, without an awareness of how practitioners' social identity group memberships impact the dynamics of helping relationships, culturally specific knowledge is less likely to have traction in clinical practice. Research I conducted at the Jewish Board of Family and Children's Services associated significantly higher multicultural knowledge scores with clinicians who had attained a threshold of racial self-awareness. This suggests that clinicians who understand this county's race-based

power arrangement are more likely to seek out and integrate culturally specific knowledge needed for effective practice.

An important caveat is that racial self-awareness (and this was especially true for white practitioners in the sample) leveled off and even decreased over time, unless clinicians had been involved in further training or projects with outcomes related to dismantling racism. This finding emphasizes the importance of understanding antiracism as an ongoing process with the need for regular "tune-ups."

Even when clinicians have a healthy level of racial self-awareness, and are knowledgeable of the backgrounds and lived-experiences of the people they are helping, consumers of mental health services still need to be engaged in a therapeutic relationship before they can be accurately diagnosed and successfully treated. When clinicians are able to integrate an understanding of the race construct into their practice many clients will more freely relate their problems of living and current attempts to solve them. How do we organize clinical practice to more effectively engage consumers?

One way to begin is by analyzing how power is reified in our clinical settings. The magazines and art in our waiting rooms, questions on our client satisfaction surveys, and level of consumer involvement on our advisory committees are necessary, but not sufficient ways to value community participation and flatten hierarchy in service delivery. Antiracist clinical practice must also embrace who and how we hire and the resources we assign to supervision. We need to invest in ongoing training not just to serve the community, but whenever possible to be trained by the community. In the clinical hour as in the management of our programs we must not only meet the clients where they are, but listen and create opportunities for them to tell us where they think we are. The following narratives give us important insights into how to do this.
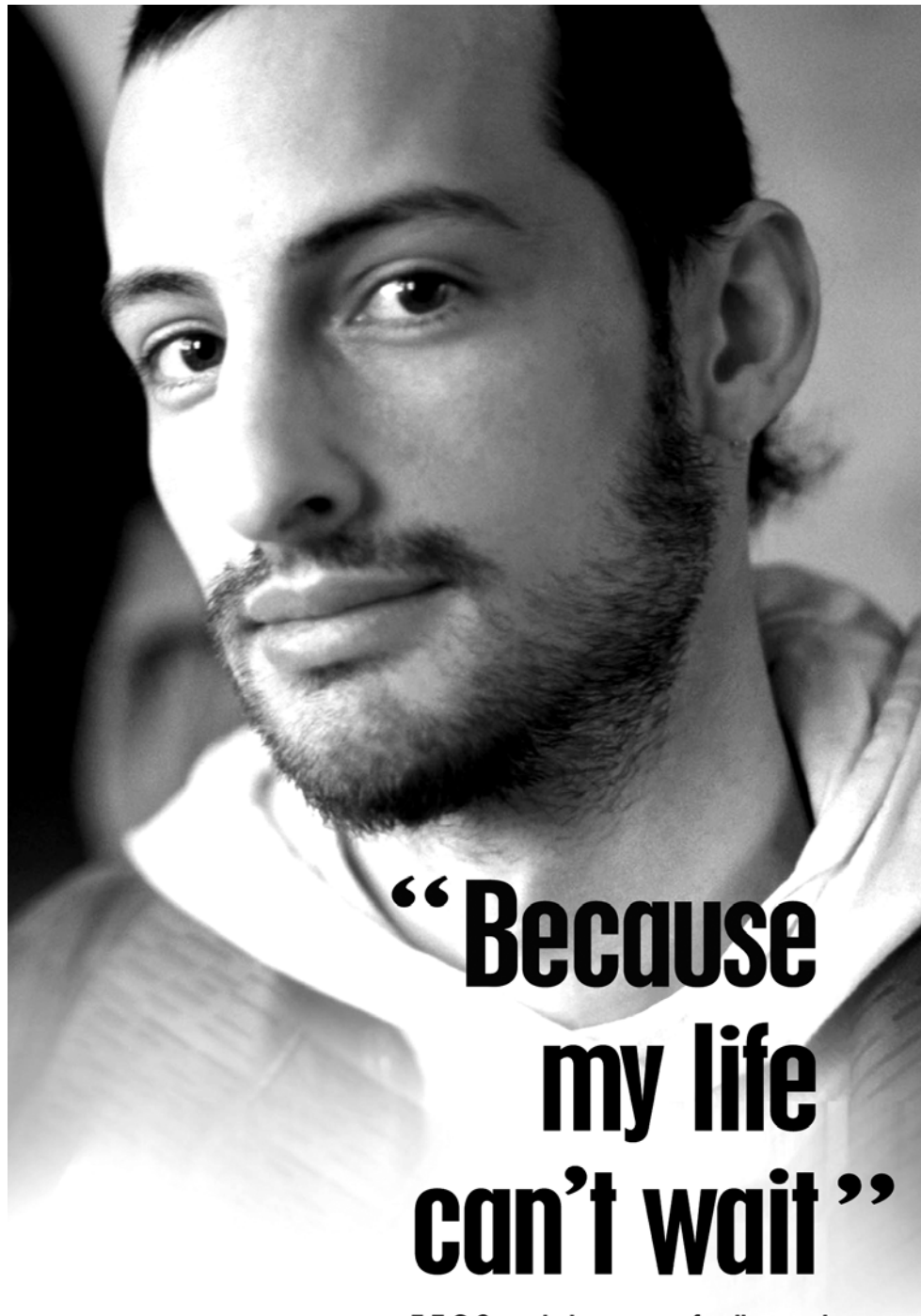
They Spoke About
Things that Bothered Them

These narratives from women using mental health services shared incidents that made them feel shame, less than and abused... At times, there were deafening silences in our meetings and at other times overwhelming, unstoppable laughter shook the room. The women that joined us were the leaders, the strong advocates, the victims and the survivors of what we saw as the disparities in women's health and mental health services. Because of what they experienced, they came together to help us create something "different." For six years we heard their stories, and worked together to build a strong net that would work for them. In the end we developed a national model, "Community Centers of Excellence in Women's Health", that was funded by the Department of Health and Human Services' Office of Women's Health.

The following are a sampling of the narratives that helped shape health and mental health services that were accountable

Rubicon from page 1

with a fusillade of N-----, N-----. over and over again. Scratch us even a little bit and the prejudices of race well up.

Noted mental health practitioner, Dr. Alan Siskind says: "It is critically important to recognize race-based traumatic stress and not ignore its psychological and emotional impact even though there are numerous pressures to deny or underestimate the impact of it. As David Billings notes, race is so definitive in our lives that it pervasively defines the context in which we live. Mary Pender-Greene has, poignantly, noted that "being a person of color is a full-time job." The trauma of racial discrimination creates poorer self-image, poorer living conditions, and poorer access to health and mental health services. This is true even as the socio-political and economic context in which people of color live creates greater need for these services. In addition, then, to the well-researched and accepted myriad of health issues created by the traumatic stress of racism, there is strong consensus that there are greater levels of anxiety, depression, suicidality and somatization among those impacted by racism. There is, as well, a wide range of psychological issues that exist as a result of the need to continually adapt to greater deprivations, e.g., poorer services, poorer housing, poorer education, and generally poorer access to those opportunities that get positively defined in our society." Alan Siskind is the former CEO of the Jewish Board of Family and Children's Services in New York City. He is now in private practice and a consultant in the field of Mental Health.

The 2008 election of the nation's first African American president painted a striking and contradictory picture of America's core fears and attitudes on race. On the one hand, people of all races cheered in an emotional frenzy—a sort of political and national catharsis. For some Obama's election demonstrated finally that the race demon that had haunted the nation since its beginnings had been exorcised. A shroud had been lifted from the body politic. Obama was the living embodiment of the American dream, proving that we are a nation where hard work and determination pay off and racial limits are no longer real. Racism was a relic of history. After all, the President is a Black man.

For others, the election of a Black president stirred long-submerged fears and rage over whose country *is* this United States. Gun sales spiked to unparalleled levels. Individual white people appeared with side arms and rifles at presidential events, claiming such actions are protected by the Constitution. Furious Whites stormed discussions of health care policies with blue veins popping and faces contorted in racialized frenzy. Similar behavior took over the national debate on immigration reform: laws were passed militarizing the southern U.S. border and mandating police officers to racially profile those who looked "suspicious." Political commentator Glen Beck claimed on national television that Barack Obama is a Communist who hates White people (even his own mother, one must surmise). Parents in Texas prohibited their school district from participating in a webinar where the President of the United States urged students to stay in school and make good grades. This is the ruse of race. On
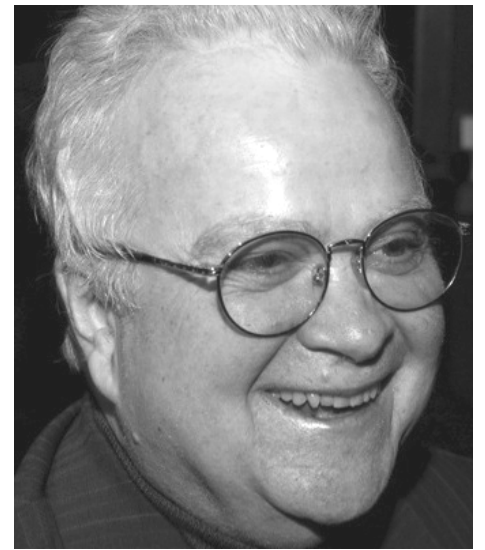
Rev. David Billings, DDiv

the one hand we prize freedom and liberty and the notion that we are all one people. On the other, we are a people scarred by race for so many generations that the thought of equity across race lines brings out the worst in the American character.

Race is a mental health issue. It has been since the nation's founding. European immigrants seeking greater personal freedoms and promises of possible land ownership, wealth accumulation and participation in the body politic, would find the continent already inhabited. Race would be used as one of the primary reasons that the "Indians" could be removed from their ancestral homes and shunted off to reservations and excluded from the nation's social contract. These striking dichotomies created a nation fragmented by race categories that tore asunder ideals of equity and democracy. Some of the greatest visionaries of their age or any other age founded the United States of America. Names like Jefferson, Washington, and Franklin symbolize the democratic ideal and the potential of a people to self-govern. Yet, Jefferson and Washington were slave owners. Africans formed the base of their incredible wealth. When Washington married Martha Ball, their combined wealth from the enslavement of Africans made them one of the richest families in the United States. Even Benjamin Franklin, himself not an owner of enslaved Africans, hoped for a country that would exclude Africans and "tawnys" and become a nation of "lovely white." This contradictory state of mind about race created a mental and moral disconnect that robbed both the persecuted and the persecutor of their humanity. What Gunnar Myrdal called in 1932 the "American Dilemma." The psychologist Frances Cress Welsing will claim America *is* race. She will quote her mentor, Neely Fuller, that "in America, if you do not understand racism, what it is and how it is manifested, then all that you *think* you understand will only tend to confuse you."

Community activist and anti-racist trainer with The People's Institute for Survival and Beyond, Margery Freeman reflects on the role of Mental Health services in communities of color: "Mental health care is driving my people crazy!" When I first heard my colleague Barbara Major say that at a health clinic she directed in an African American community in New Orleans 20 years ago, I laughed

Building a Race Conscious Research Agenda

By Robert Hawkins, MPA, MA, PhD
Assistant Professor, New York University
Silver School of Social Work,
McSilver Assistant Professor in
Poverty Studies

People of color have held a long and often damaging relationship with mental health researchers, practitioners, and policymakers. Throughout the colonized history of the United States, the mental health of Native Americans, Africans, Asians, Latinos, Pacific Islanders, and other groups of color have been seen as mentally ill or not by a one-way comparison of whites. In addition to those bias comparisons, people of color, especially African Americans have historically been wrongly diagnosed for mental disorders, undertreated, overmedicated, experimented upon, and have had their culture, race, and ethnicity used against them in the name of mental health research.

Through his 1976 book *Even the Rat was White: A Historical View of Psychology*, Dr. Robert Guthrie brought to the world's attention what psychologists of color already knew: that many psychological theories and ideas regarding human behavior and personality were deeply rooted in racism. Harriet A. Washington, an expert in medical ethics, also documents the haunting history of the mistreatment at the hands of mental health researchers and experts by African Americans and people of mix race in her book *Medical Apartheid*.

Mental Health disparities have existed for centuries, although some of the earliest research to pay attention to meaningful differences in services was published in 1974 by Stanley Sue, Herman McKinney, David Allen, and Juanita Hall in the *Journal of Counseling and Clinical Psychology*. This study highlighted the reality that African Americans and whites have different experiences in the mental health system. The study found that the mental health system was not equipped to serve African Americans. Similar research has found other cultural and ethnic groups also have similar experiences with the mental health system living them out and using the white, European model as the standard for positive mental health. While Native Americans and other groups have suffered from mistreatment in mental health research, Asian Americans, too, have been victims. With the stereotype of the model minority, Asian Americans have been overlooked in mental health. Further, according to researchers examining data from the National Latino and Asian American Study (NLAAS), Asian Americans show a low level of mental health services use. Low use, however, does not mean that the need does not exist, instead there may be structural, cultural, social, and personal barriers that limit mental health services use.

According to the Surgeon General's Report on Mental Health: Culture, Race and Ethnicity (2001), living in poverty have measurable effects on the rates of mental illness. These effects are disproportionately seen among low-income people of color. Research from the National Council of Science (2000) concluded that economic disadvantages have a long-term effect on the mental health and overall development of children. This and other research suggests that poverty constrains development in a way that forces low-income children in a limited box while non-poor children develop in a spacious playground. If left unchecked or ignored into adulthood, what this translates to is that low-income people of color are at least 2-3 times more likely than white, non-poor individuals to experience a mental disorder.

Low-income people of color are often placed in a spatial cycle where ecological factors increases the probability of mental health stress, yet this same environment limits their access to prevention and intervention services. Lack of jobs, limited access to education and transportation, low-resourced and sometimes dangerous neighborhoods are just some of the factors that directly contribute to poverty and at least indirectly contribute to the higher reported rates of mental illness in low-income people of color. While this higher rate of mental disorder can be linked to poverty, these factors do not work alone and are confounded by racism, microaggressions, lack of access to care, prevention, and early intervention, and over diagnosis based on race, ethnicity, and culture. Lack of access to care is especially important as prevention and early intervention measures can save the need for more chronic mental health conditions.

It is important for researchers to remember, too, that these ecological factors may have risk elements, but potential resilient or more positive elements as well. Cultural factors that contribute to resilience and coping in stressful situations should not be ignored. Several studies document the resilience of often low-income children of color who have been placed at risk, who overcome their adversity and strive.

While the comprehensive nature of racism and mental health is rarely studied, neither do we as researchers examine closely enough the mental health and complicating issues of those society has placed at risk. In research greater attention should be paid to the role of race and social position in mental health. Below we make six recommendations that we believe that mental health researchers should pay greater attention:

- The role of race and racism in current mental health treatment facilities;

- The role that racism, discrimination, and microaggressions play in people of color's desire to receive and accept mental health treatment;

- The short and long-term effects of discrimination and microaggressions o the mental health of people of color;

- The role that neighborhood and other environmental factors contribute to the overrepresentation of people of color in receiving mental health treatment;

- How racism experienced by parents affects the mental health of their children;

- The role of resilience in low-income people of color and how that resilience can be fostered.

While race and racism has been a part of mental health for decades if not centuries, researchers have not fully embraced studying these phenomena. Funding mechanisms for research on race/racism and mental health are rare and specific interventions are rarer still. As with the general population, it has been easier to ignore the effects of race and racism on mental health. Researchers need to take a comprehensive look at how these issues affect mental health and move toward a more in-depth analysis.

Transforming Service Delivery Systems, Organizational and Administrative Structures

By Mary Pender Greene, LCSW-R,
Paul Levine, LCSW,
Phyllis Frank,
Elwanda Young, LMSW,
Christiana Best-Cummings, PhD,
Lisa Blitz, PhD, LCSW-R,
Willie Tolliver, PhD,
and Steve Burghardt, PhD,

In looking at organizational infrastructures and the challenges involved in bringing about antiracist change, we invited leaders of not-for profit health and human service organizations to describe their experiences, and share what they have learned about what is required for transforming organizational and administrative structures as they pursued an anti-racism agenda in their respective agencies. They speak from several different perspectives and in different voices. These differences are preserved so that each writer can reach the many audiences that make up the Mental Health News readership.

Paul Levine, LCSW
Executive Vice President and CEO
JBFCS

Where does the not-for-profit sector start in transforming organizational and administrative structures to address race and racism? My experience, as a senior administrator and executive of a large not-for-profit, is you start with the organization's mission. This means starting as close to practice as possible.

For mental health organizations that means the therapeutic relationship, which is built on honesty, trust and mutual respect between helper and client. Of course, the relationship itself is always affected by the power equation and the feelings the patient evokes in the therapist. So it is not surprising that the feelings between the "partners" in treatment would eventually require facing race and racism. When the patient and therapist are of different races, how can they forge a successful treatment relationship if race is not on the table for discussion? If mental health organizations are to be true to their missions, race must be addressed as part of the therapeutic relationship. This is the beginning of understanding and addressing accountability.

Fundamental to accountability is developing ways of working that involve service consumers and the community in their own care, and responding to their definitions of need and relationship. Addressing racism and developing ways to be responsive and accountable to communities of color is the clinical case that must be made to staff and board members of an organization in order to gain broad support at all levels of the agency, which is the major – and exhausting -- effort it takes to deal with race.

Following this, is enhancing the organization's capacity for cultural awareness related to group identification. People want to be understood and met with empathy, especially when taking the risk to expose fears, symptoms, and personal feelings. To walk into an organization where some of the staff look like you and speak your language encourages hope and confidence that you will be understood in the treatment process. This is why staffing patterns that reflect the communities of identification of clients is so important. This is another aspect of the case that has to be made. Here, the case is not only about race. It may also be about "foreignness" in immigrant communities, about religion in orthodox or fundamentalist communities, about language, and about being sensitive to cultural differences. Staff that is representative of consumers is essential – but not sufficient. The organization must also develop feedback mechanisms for understanding community needs and service preferences that may not be obvious when viewed through a dominant culture lens. These systems of accountability will help reduce the barriers between community, consumers, helpers, and agency and encourage genuine partnerships that support culturally responsive clinical practice.

Accountability also requires an honest appraisal of systems of power within the organization: Who is making program design decisions? Who has access to decision-makers? Whose culture and race is represented within the executive management team and board of directors? How are the diverse staff members at the service delivery level of the hierarchy being prepared to move into leadership roles over time? Does the organization's strategic plan reflect methods to ensure that the communities served will be reflected at different levels throughout the organization within a 5-10 year span?

Finally, we come to the "business case" for an organization's transformation toward antiracist practice. Developing sensitivity and accountability regarding race and diversity promotes trust among individuals and communities that are not part of the dominant culture. In turn, increased trust among communities served will enhance an organization's standing as a preferred provider and strengthen its competitive edge.

In sum, we must start by making the case in all three of these areas -- enhanced clinical capacity, increased cultural awareness, and good business practices -- if we are to successfully transform our organizations toward antiracist practice.

Phyllis Frank
Assistant Executive Director, VCS

When predominantly white organizations wish to earn the description, "antiracist," a commitment of time, focus and energy towards this goal must become daily fare. That is the long . . . and the short of it. It is why so few agencies, despite great intentions, ever get there. It is not easy and there is no single path to follow. Training alone, although a good start, is not adequate. To begin, whoever it is that has the real power to create everyday policy and practice, must not only want it but must insist on it. This is a step that must occur at the administrative level after learning from an analysis of structural and institutional racism in the United States.

One must question why so many of us with decades of experience and multiple degrees don't know this already. Respect for this question – and its answer, is crucial. Understanding the depth and complexity of how racism self perpetuates amongst white people – while producing intense denial of that very truth – is prerequisite to moving forward. Once understood, anti-racism becomes an ethical and moral mandate. Power dynamics shape racism, which is better understood when called "white supremacy." Power dynamics must be voluntarily shifted in order to proceed. For example, no program or other initiative should be conceived without collective input from the group to be served. "Not in our name – without us!" Every policy and process must be looked at with questions. "Does this favor white people, center on norms culturally specific to European white populations; respond to the needs of funders, program managers . . . or to communities? And, of course, who gets to answer these questions?

Elwanda Young, LMSW
Chief Operating Officer
United Way of New York City

I am a woman of color who joined with colleagues – all senior executives at my organization – to participate in the Undoing Racism Workshop offered by the People's Institute for Survival & Beyond in 2006. At the end of the workshop, staff rated our organization against the continuum of becoming an anti-racist and multi-cultural institution. We were in for a rude awakening when there was general consensus that at best we were at stage 3, or symbolic change in the range of tolerance of racial and cultural differences. We had thought of our organization as made up of well- intentioned, social minded, progressive people. After all, being of service to the community and those in need was the focus of our work. We believed ours was not an organization where racism was a serious issue.

After the initial shock and denial, the training began to sink in, we were able to expose those structural areas where racism could indeed exist and begin to constructively look for ways to move the continuum needle. We begin to examine aspects of our organization to ensure full participation and engagement of People of Color – through an anti-racist lens we looked at our vendors, our policies, Board and staff composition, our interaction and accountability to the community, our assumptions and decisions around grant making and even our role as gatekeepers. We began to develop awareness, consciousness and understanding about ways to be more effective in the work we do within our organization and the community around race.

Transforming organizations is hard work; it's much easier to slip into the comfortable and less challenging ways of operating. When other pressing issues come to the fore, antiracist transformation can easily slip down the list of organization priorities. However real change requires a commitment on the part of the leadership to examine and expose struc-

tural and systemic racism even in organizations with the best of intentions.

Christiana Best-Cummings, PhD
Executive Deputy Director, ACS James
Satterwhite Training Academy

My understanding of antiracist transformation of organizational and administrative structures begins with self knowledge. What did I see in myself and what did I see around me as a middle manager in a public child welfare organization? In my nine years with New York City Children's Services James Satterwhite Academy, I have experienced many moments in which some form of structural or institutional bias vividly came to my attention. One of these is what I refer to as my "elevator experiences." At the Academy, we often share elevator rides with the people who attend varied trainings at our NYC location. When the door opens I can always tell which class is on the elevator. If the elevator is filled with young black women, I know they are newly hired caseworkers. When largely young white women I know they are newly hired attorneys, and when middle aged white men, I know they are investigative consultants, recruited from the ranks of retired police officers.

My responsibilities at the Academy include training and curriculum development. The Undoing Racism Workshop helped me recognize my responsibility for educating others about the impact of race on child welfare policies and services, as well as on staff relationships within the agency. Self reflection and a commitment to constantly deepening my own racial awareness is a must. This means having difficult conversations that move me and my colleagues out of our racial comfort zones. For me, this also includes helping well-intended trainers examine labeling behaviors that pathologize people of color, particularly Black people.

Armed with a better understanding of history, an analysis of power and the manifestations of structural racism as a result of my participation in the Undoing Racism Workshop, I feel I have an added responsibility to help others engage in a similar form of evolution. As one of the leaders for the Professional Development Program Department, I develop educational programs for new MSW students who are frontline staff about structural and institutional racism. This has included a series of seminars led by experts in the field of Disproportionality and Disparity. These seminars have increased staff awareness about the impact of systemic racism on how we think about the work, the clients we serve, and influences our behavior. Many forums were used to broaden the discussion beyond the Academy, which included lunchtime seminars, discussions and conferences convened by the ACS Task Force for Racial Equity, faculty of the metropolitan schools of social work, and trainings offered by People Institute for Survival and Beyond. Staff was also encouraged to participate in

Challenges of Black Males with Mental Illness

By Maurice Lacey, LMSW, MS Ed,
CASAC, Executive Director
Faith Mission Crisis Center, Inc.

This entry is focused on the mental health issues among Black males and the challenge of dealing with race and racism in mental health agencies. Because of the extensiveness of need, combined with stereotyping that is perhaps unique to this population, and notable gaps in culturally appropriate services, special consideration is given to Black males as an added special population of concern. Further, the mental health needs of Black males are a mirror reflection of those of the special populations discussed earlier.

The Scope of the Problem

Approximately 25% of American adults experience a mental health or substance use disorder in any given year. However, only a fraction of those affected will be properly diagnosed and receive care. For Black males and their families, the consequences of neglected mental health needs are devastating. Our prisons are bursting at the seams with mentally ill Black men. Failure to address mental health issues among Black men often leads to substance use or relapse, job loss, various social and family crises. Finding care that is affordable, respectful, and accessible is a major challenge for African Americans in general and for black males in particular.

Suicide rates are creeping up each year. For example, over the last twenty years, suicide rates among black males between ages 15 and 19 increased 114%. Suicide is currently the third leading cause of death among black males between fifteen and twenty four years of age.

Despite the extensiveness of need, there are a dearth of agencies that are sensitive, familiar and capable of dealing with the needs of Black males suffering from mental illness and its accompanying problems. Nor do these agencies have sufficient therapist of color to effectively engage or retain Black males in therapy over extended periods. Further, mental health is still a taboo subject for Black men. They suffer in relative silence. Overall, there is very strong stigma and shame in the Black community associated with mental health problems generally. This stigma and shame is generated from culture, and for males exacerbated by cultural norms and expectations of masculinity, and the socio-political environment.

Black men are not exempt from perceived threats to their masculinity. Like other men in American society Black men have learned to place an emphasis on independence, competitiveness, emotional stoicism and self-control. In fact, there is hyper masculinity present in younger Black males to deal with societal emasculation. This hyper masculinity often mask's problems in daily living. It's called "fronting" among urban youth. These are but some of the factors contributing to low service utilization rates, racial, and gender disparities in mental health outcomes.

What's race got to do with it?

There is a fragile relationship between the Black community and the mental health services sector. On one hand there is mistrust, doubt, confusion, and on the other fear, misinterpretation, and racism. Research clearly shows that in medical and mental health, Black Americans have poorer access to care, quality of treatment, and outcomes than whites. For Black males, these inadequacies are even more pronounced.

The staffs in some mental health agencies are often wary of the black males, have limited insight into their lives, and lack the skill sets to deal with the volume and complexity of problems Black males face. The situation is fuelled by prejudice, misunderstanding, misconceptions and sometimes overt racism. A major problem is that mental health agencies have limited Black clinicians and program managers.

Nationally the numbers of black male psychiatrists, psychologists, and social workers are dismal. New York State is no exception to this reality. Increasing the presence of Black males in clinical and managerial positions is a pressing need. Professional schools can contribute to this effort by developing outreach and marketing strategies that are appealing to the career interests of Black males, and also ensure that curriculum offerings are designed to support their retention and success in these programs once enrolled.

White led agencies have an important role to play in ensuring an appropriate representation of Black males in staffing patterns and to increasing the availability of culturally appropriate services. Unfortunately, however, too many of these agencies have not used their considerable platform and resources to raise awareness about how racism creates obstacles to both proper diagnosis and treatment for Black males with mental illness or to increase the number of males of color in key staff positions. Therefore, there must be a commitment amongst these agencies to on-going training that goes beyond cultural competence and include addressing the structural racism present in mental health agencies as in all other American institutions.

Dr. Alvin Poussaint, Harvard psychiatrist, says "one reason African-Americans may not seek out professional help is because only about 2.3% of all psychiatrists in the United States are African American." Therefore the perception is that the "therapist". "Doctor" or "counselor" will

Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

- **Adjunct service to community mental health programs**
- Structure in the home environment.
- Assistance with home management focusing on inadequate levels of functioning, hygiene issues and compliance with medication regimen.
- Administration of I.M. long-acting psychotropics.
- Liaison with the community treatment team informing them of changes and important symptoms that may indicate decompensation or need for changes in the treatment plan.
- On-going assessment of all health needs relevant to the individual's diagnoses.
- Consultative services for the individual whose primary diagnosis is medical/surgical in nature, however, due to difficulty coping with illness, requires mental health intervention.
- Coordinated home care services for non-compliant individuals and those with complex combined mental health/physical needs that present ongoing problems.

Program Features

- Facilitate psychiatric care from in-patient to home & community
- Prevent in-patient psychiatric hospitalization
- Decrease symptoms & improving functional ability
- Improve knowledge base about medications, illness, coping & staying well
- Improve medication compliance
- Access community services

The Big Picture

Visiting Nurse Services in Westchester (VNSW) believes in a holistic, broad approach to the treatment of mental illness, addressing the "whole person's" life circumstances and environment. VNSW fields nurses with advanced psychiatric training, and in some cases, advanced degrees in related fields. The staff provides home visits for assessment, evaluation and development of a treatment plan with interventions related to mental health issues in conjunction with medical/surgical needs. This program meets the total health care requirements of individuals utilizing a case management approach led by a psychiatric nurse specialist. Adjunct services complementing the mental health component include psychiatric social workers, home health aides, medical/surgical nurses and relevant rehabilitation therapies.

The program serves the elderly, adults, adolescents and children.

To receive further information or make a patient referral, contact:

Lisa Sioufas, LCSW-R, ACSW • Mental Health Program Manager
(914) 682-1480, Extension 648 • e-mail: MentalHealth@vns.org

Visiting Nurse
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VNSW services are covered by Medicare, Medicaid and other health insurance plans.

— Point of View —
Looking Back with Pride: Mental Health Policy in the 2nd Half of the 20th Century

By Michael B. Friedman, LMSW

I have had the good fortune over most of the past two decades to participate in the vast effort made by the Mental Health Association movement to make life better for people with mental illness, especially those who are disabled and rejected by society.

There are two tremendously important symbols of the Mental Health Association. One is a bell modeled on the Liberty Bell. Historically, it was used as the logo of Mental Health Associations everywhere. But it is more than a logo. Years ago the national MHA forged a real bell from "shackles and chains" that had been used to restrain people with mental illnesses in institutions.

This is what we have come from—a time when people with serious mental illnesses were housed in "asylums" and "hospitals" not worthy of their names, places where terrifying restraints, where harsh treatments that we now know to be little more than tortures, and where physical, verbal, and sexual abuse were day-to-day facts of life.

The bell symbolizes the rights of people with psychiatric disabilities—their right to be recognized as human beings, their right to be treated with dignity and respect, and their right to liberty. It also symbolizes hope—hope for a decent quality of life, hope for satisfying and meaningful lives, and hope to overcome the horrors of acute madness, which have plagued the human species from its very beginnings.

The second symbol of the Mental Health Association movement is its founder, Clifford Beers, a man who spent three terrible years in mental hospitals in the first decade of the 20th century, a man who suffered frequent abuse by the people who were supposed to care for him, a man who developed a grandiose dream while in the hospital to create a national and international movement to humanize the treatment of people with mental illness, and a man who realized his dream when he finally was able to leave the hospital and return to life in the community.

Beers is the best possible symbol of the potential of people with mental illness and of the hope for recovery. He is a symbol as well of the power of advocacy and of the obligation we have as human beings to reject abuse and neglect of those who are mentally ill, to reject warehousing them in institutions and denying them a life in the community, and to insist on their acceptance in the communities where they choose to live.

Symbols, of course, are not actualities. High moral feelings are not achievements. And so we have to ask, what has become of the vision that Beers spun out in the first four decades of the 20th Century?

The answer is that there has been remarkable achievement. Yes, there is much left to be done, but we can still take pride in what the field of mental health accomplished in the second half of the 20th century—after Beers had died.

Sadly, he died in a psychiatric hospital (fortunately a good one) in the early
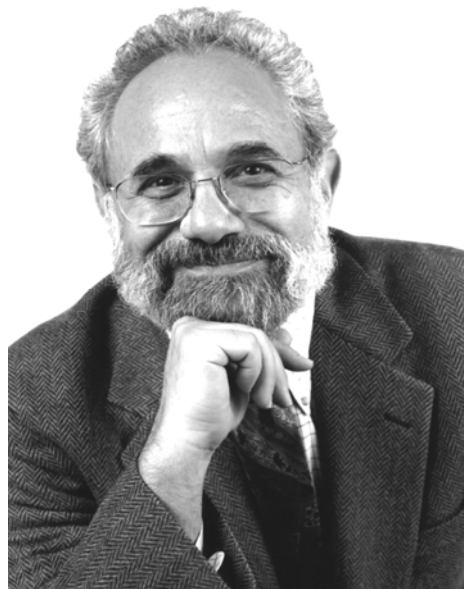
Michael B. Friedman, LMSW

1940s during a period when people with mental illness in state hospitals suffered some of the worst abuses in the history of the United States because of the Depression and World War II.

It brings to mind a poem by Robert Frost called "Death of The Hired Man" about a man who, having nowhere else to go at the end of his life, returns to a farm where he had once worked. He is described as a man who "has nothing to look backward to with pride and nothing to look forward to with hope." And he was not welcomed.

Beers returned at the end of his life to a hospital that took him in with great respect for his remarkable achievements. Unlike the hired hand, Beers had much to look backward to with pride and much to look forward to with hope, not for himself but for the field he had helped to shape.

We too can look back with pride and forward with hope. Since the middle of the 20th century, the mental health system has been transformed, much in the image Beers envisioned, from an institution-based system to a community-based system. We should be proud of that fundamental transformation, and we should be careful not to diminish the magnitude of this achievement even as we confront a myriad of major challenges to improve life for children whose growing up is interrupted and distorted by serious emotional disturbances, for adults trying to build lives for themselves despite psychiatric disabilities, and for older adults who frequently face emotional and cognitive barriers to aging well. We should not lose our sense of pride in what we have achieved even as we pursue major structural change so as to become what is strangely called "patient-centered" and "recovery oriented." (Imagine how mysterious those terms are to people outside our field.) We should not lose our pride even as we reshape our conception of what a mental HEALTH system should be, from a system that is just about mental illness to a system that also helps people to be mentally and physically healthy and to live well.

Think of what we have accomplished. We have made it possible for hundreds of thousands of people with mental illnesses who at one time would have been institutionalized to live where they prefer to live—in the community.

But wait. The critics ask: how many are homeless, how many are in prison, how many are in nursing homes or adult homes?

We need to answer. And mental health policy will have to be transformed again to end warehousing in shelters and the use of jails and prisons and nursing and adult homes as substitutes for asylums. More and more people must be enabled to live decent lives in communities of their choice.

But it is still true and important that many people with serious mental illnesses are living outside of institutions, have access to decent care, and are pursuing lives that they find satisfying and meaningful.

That, as you know, did not happen at the beginning of the transformation from institution-based to community-based care. Deinstitutionalization—the first phase of communitizing mental health—was done poorly. Excessive optimism about the healing powers of medication and of simply being out of institutions led to a failure to put services in place that people with psychiatric disabilities need.

During the most aggressive period of deinstitutionalization, from 1968 to 1973 when the population of New York's state hospitals dropped from 80,000 to 40,000, people leaving did not become homeless. That happened later. But those who could not manage on their own and who did not return to their families lived in squalid and often dangerous single room occupancy hotels and in adult homes—many (but not all) as scandalous then as they were recurrently revealed to be over subsequent decades. Little treatment was available in the community for people discharged from state hospitals, and what was available was generally of very poor quality.

In 1978 the concept of community support was introduced. It was a simple idea. People with serious and persistent mental illness need support to lead safe, tolerable lives in the community. They need housing, and they need rehabilitation and case management as well as good outpatient treatment and access to brief inpatient care in their local communities.

This is still the fundamental vision of mental health policy in America, and it has driven tremendous positive changes over the past 32 years. In New York State alone there are about 30,000 units of housing where none existed before. There are hundreds of rehabilitation programs. There has also been vast expansion of outpatient services, not only clinics but also day programs of various kinds. Assertive community treatment and case management have become key elements of the system. Local inpatient capacity has also grown as the capacity of state hospitals has been reduced. The state hospitals that are left are far better places than they used to be because of major capital investments and a commitment to quality that began in the 1980s.

And, very importantly, people who use mental health services and their families now play important roles in the planning, design, and delivery of services.

During the early 1980s, children and adolescents with serious emotional disturbance began to get the attention they deserve. Child mental health leaders were appointed in governmental agencies. Plans were developed. A new vision emerged of comprehensive service networks providing access to needed clinical services, bringing together the diverse child-serving systems, and involving families as respected resources rather that as blamed causes of their children's disorders.

Over the past 25 years there has been significant service expansion for kids, including not only outpatient clinics but also school-based services, home and community-based waivers, case management, therapeutic foster care, much improved residential treatment, and more.

While the public mental health system was growing, so was the private sector. Thanks to ongoing advocacy as well as changes in professional standards and expectations, health insurance expanded to cover inpatient and then outpatient mental health services. Employee assistance and similar programs also sprouted up in the workplace. The result was a vast increase in the number of people who get treatment.

About 20 years ago advocacy for health insurance coverage of mental health moved from mere coverage to *equal* coverage of mental and physical health services—parity. This culminated in the last few years with the passage of Timothy's Law in NYS and federal parity legislation, which—to our great relief—was retained and improved in federal health care reform.

Over the past half-century, there has also been tremendous investment in mental health research. Even though it has not produced the breakthrough we keep seeming on the verge of, it has resulted in significant improvements in treatment and rehabilitation technology and determination to translate research into practice in both the private and the public sectors. As a result services are better and more effective than ever in history.

So the system is unquestionably better, but as Richard Franks and Sherry Glied put it in the title of their very important book evaluating the first 50 years of community mental health, *Better But Not Well*. There are many needs still to be met, many changes still to be made, many fundamental concepts of mental health policy still to be challenged and reformulated. In the next issue of *Mental Health News* I will write about the hard work still to be done, but for now I will say again that we should look back with pride on the progress the field of mental health has made over the past half century even as we look forward with hope to improvements yet to come.

Michael Friedman recently retired as Director of the Center for Policy, Advocacy, and Education of The Mental Health Association of NYC. The statement above was adapted from his policy address at the first annual MHA Mental Health Policy Lecture. Mr. Friedman can be reached at mbfriedman@aol.com.

The Economics of Recovery: Who's Driving the Bus?

By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

There appears to be an incredible variety of people guiding our journey of recovery; elected and career government officials, all manner of professionals, academics, health insurers, providers, family, labor unions, big pharma, etc. If recovery takes a village – then it seems they all made it on the bus!

But who's driving? Is it the person with the most education? The most votes? The most money? The most legal authority? The most raw power? Who determines which route to take? How fast we should go? When we'll get there? If we are lost, who do we throw off the bus? Do we have the authority to elect a new driver? Most importantly, who has the map? (Tell me there is one)

SAMHSA's "map" lists six strategic initiatives or goals. NYS's Commissioners of Mental Health have over a dozen priorities for 2010-14. But the problem is, there's only about one-third overlap between the two agendas!

Let's hope Governor Cuomo and the next round of Commissioners and Committees can agree to a single set of priorities.

Recently, the CDC's Dr. Friedan published his short list of six priorities for keeping the nation healthy; long standing, major challenges which he characterizes as "winnable battles." Dr. Friedan (NYC's former DOH Commissioner and a Mayor Bloomberg appointee) believes, "If we are all on the same page and working in the same direction, we can create a lot more momentum."

Similarly, the Bill & Melinda Gates Foundation, the most generous foundation in the world having given out over twenty-three billion dollars in grants since its inception sixteen years ago, pioneered the linear, quantitative, results oriented for-
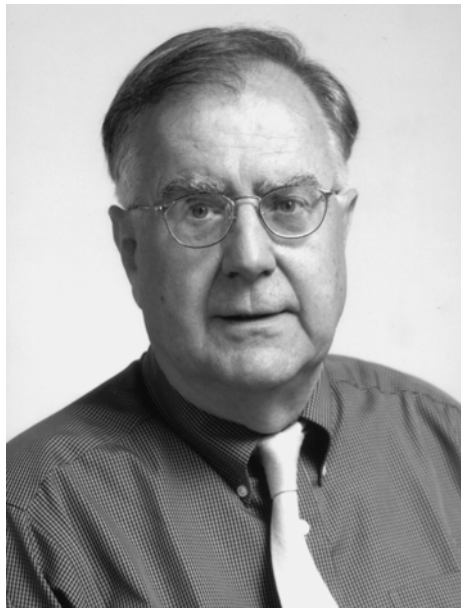
Donald M. Fitch, MS

profit approach to delivering social services. Their website, www.gatesfoundation.org, succinctly describes the "who, what, when, where, and how" of each grant.

Assuming our newly elected officials can agree on their agendas, then we'll need to find a way to determine the priorities of our recipient population. Historically, convenience samples have been used to poll Recipients at community meetings, conventions, rallies, etc. Focus group verbatims and anecdotes are often pasted together as a kind of inclusive "kitchen sink" of Recipient opinion. Democracy in action, yes, valid quantitative evidence yielding actionable priorities, no.

To achieve a scientific evidentiary level of data validity, we'll need to first define: our universe - e.g. "the three-hundred thousand plus persons in New York State currently receiving SSI/SSDI disability for mental disorders,"; a sampling frame - e.g. "persons currently attending OMH programs"; and a method - e.g. a fifteen minute self-administered questionnaire to every "Nth" person dis-

tributed and processed via OMH's Patient Characteristic Survey Staff, next October, 2011. This approach, I believe, will fulfill the prerequisite probalistic sample selection, yield a robust sample size (1K plus), and be cost effective.

To efficiently meet the challenge of measuring the complex, multi-dimensional and subtle nature our Recipients' needs, we offer for consideration and refinement the "Center's Peer Problem and Solution Survey Questionnaire" consisting of over one-hundred fifty variables. (Email me for a copy at donfitch@freecenter.org)

In compiling the list of eighty-six "problems," we drew primarily on our one-on-one intake interview notes. This method yielded a greater depth and breadth of issues than either focus groups or community meetings. Just as in psychotherapy, privacy and rapport can uncover valuable research content. (I can't imagine a community meeting where folks shout out; "I'm fat and I need love")

As any therapist knows, most of our folks are adept at articulating their problems. Effective solutions however, are much harder to come by. Our list of sixty-nine solutions is a compilation of three types: opposites to the problem - e.g. "Never be depressed," components of the American Dream - e.g. "Find my true love," and pure Hollywood fantasy - e.g. "Be a rock star."

Twenty-one respondents rated all eighty-six problems on both importance *very/somewhat/not at all* and frequency (often/sometimes/not at all). Then, they rated sixty-nine solutions on effectiveness (very/somewhat/not at all).

The output is a list of the most important problems, to most of the consumers, most of the time.

We believe these are excellent criteria for developing any agenda because we'll never have all the resources to solve everybody's problems. While setting priorities requires courage, it is essential to our success. Like the Rolling Stones said: "You

may not get what you want – but if you try real hard – you'll get what you need."

While the solution's data confirms the importance of offering programs on health (nutrition, dieting, exercise, smoking cessation, etc.), the data also highlights the desire for more social activities and outings. Other implications include groups about woman's social and spiritual issues, coping with suicidal thoughts, money management, beauty tips and pet therapy.

There were two problems we didn't ask about because the answers seemed so obvious yet incredibly, they both belong at the top of anyone's Mental Health agenda:

- Early death due to the side effects of psychiatric drugs

- Defiance of the U.S. Supreme Courts' Olmsted decision to release inpatients into the community

If Big Pharma can make billions selling drugs whose side effects can take twenty to twenty-five years off our lives, as studies in the US, Canada, and UK have reported, then "BP" must be the most powerful person on the bus. "Early death" has become just another side effect. It is even mentioned in TV ads.

But if some Labor Unions have the strength to defy the highest court in the land and keep thousands of our folks locked up in state-run institutions (and Nursing Homes) for the sake of "preserving jobs," then couldn't they also be the most powerful person on the bus? Hopefully the recent court decisions in Chicago, Georgia and New York will force the institutions to release folks out of the psychiatric hospitals and nursing homes and into the community.

Governor Cuomo's strategy is to "isolate, destabilize, and ultimately defeat the tangle of entrenched interests that has left state government bankrupt, infamously dysfunctional and mired in scandal" (NY Times 10/24/10). He has my vote.

Recipient Ratings of Problems

"Very Important" (59% - 79%)

- I'm overweight; poor physical health; no stamina or motivation; low energy
- Anxiety, stress, depression, low self-esteem, confidence
- Can't work, find a job; not enough education, job skills, computer skills
- No family; need more friends; alone
- Government Benefits not enough; no money for food, meds, utilities, clothes, etc
- Need more privacy

"Somewhat Important" (42% - 58%)

- Head, body aches; stomach/cholesterol problems
- Meds not effective; can't seem to recover
- Poor concentration; confused
- Can't have fun; no fun in my life
- No romance
- Can't sleep
- Owe a lot of money
- Legal problems
- Poor housing

Recipient Ratings of Solutions

"Very Effective" (59% - 100%)

- To be loved; have one really good friend
- No more famine, wars, hunger, disease, violence, crime
- No more nightmares, feeling depressed, being angry, afraid, sad, anxious
- A happy home; to be spiritually fulfilled; get respect

"Somewhat Effective" (16% - 58%)

- No more headaches, dizzy spells, hallucinations; never be sick again; never take another pill
- Get married; find my true love; have a child; own my own home
- Eat all I want and never gain weight; have a great body, be skinny
- To be one with the universe; to be in heaven; be one with the Lord; to see God's face
- Regular massages; a personal trainer; sauna in my home
- Have a pet
- Have beautiful skin, hair, nails; be beautiful/handsome
- Sleep as long as I want

— The NYSPA Report —
Medication for Children and Adolescents

By Lenore Engel, MD
and Priyadarshan Bajpayi, MD, MPH

A doctor's recommendation to use psychotropic medication for a child can lead to many concerns and questions in both the child and their parent. This article is meant to help clarify these concerns and help families understand that they can get safe, effective treatment for their child.

The prevalence of Child and Adolescent Psychiatric disorders is substantial. Currently approximately 1 in every 4 to 5 youth in the U.S. meets criteria for a mental disorder with severe impairment across their lifetime. The prevalence of ADHD in school age children is approximately 8 %. Many mental disorders in adults first emerge in childhood and adolescence; this highlights the need for services early to avoid or minimize the impact of an illness on a developing child, including on home life, friendships, academic success and future productivity. If possible, focus should be on prevention and early detection.

Increasingly medications are used to help a child with emotional problems achieve remission or reduction in symptoms. The right kind of medication, along with other interventions can be an effective and important part of treatment. The NIMH, sponsored Multi Modal Treatment Study (MTA), has shown that stimulant medication works and should be a first line treatment for ADHD. Medication for ADHD not only aids in improving focusing, learning, academic performance but also helps a child achieve better relationships with parents and peers, decreased aggression and impulsivity.

In the past most medication studies were done on adults, not children. Due to this, many times child psychiatrists used adult studies to give them a direction on how to use these medications in children and adolescents. This was necessary then, as there were limited child studies, but unsatisfying as children are not mini adults, and medications do not necessarily work the same way as in adults. Their brains are still developing and some of the neurotransmitter systems targeted by medications are not fully developed. In addition metabolism of the drugs differ because of differences in functioning of the liver, kidney and differences in weight.

Most child psychiatrists often prescribed off- label because the medications used are only FDA approved for adults or if approved for children, are being used for a non-approved indication. This problem has begun to be rectified with more research, better empirical evidence and treatment algorithms.

In order to get adequate care, whether with medication or a non-medication treatment, it is important for a child to get a thorough assessment. As part of any assessment, the parent and child are usually seen together and individually, school records and information is requested and information about the child's health is collected. Contact with the Pediatrician and lab work may be required. In addition there are a variety of useful rating scales, questionnaires and structured or semi-

structured interviews that may help assess your child's issues. Children also often have more than one issue that they are coping with and will need to be addressed.

During the assessment and treatment process a parent needs to know they should have a dialogue with the person (s) who is doing the assessment and with the treating psychiatrist. In this discussion, the review should include: a parent's understanding of their child's problem, the factors affecting it, the treatment approaches recommended, other options and the impact of not accepting the proposed treatment.

If medication is recommended, a parent should know the name of the medication, what it will help with, what target symptoms will be monitored, how the doctor and they will know whether it is working, what is a reasonable time frame to see a benefit and what else besides medication should be part of the treatment approaches. They need to know typical side effects and any special precautions. Parents sometimes feel they cannot ask questions, or the physician is too rushed to answer them, but doing it is an essential part of their child's care and getting the best treatment possible.

This past summer, New York State Assembly Bill 5602 was vetoed by Governor David Patterson. The bill would have mandated the Department of Health and other agencies, to do research and study the effects of psychostimulants, selective serotonin reuptake inhibitors, antidepressants and other drugs prescribed for ADHD in school age children. The focus of the study was to look at the efficacy and the harmful side effects of drugs.

In his veto, Governor Patterson said others are responsible for this research and that much of this research already exists. Passing it would have diverted funds away from other important functions done by the Department of Health (DOH), Office of Mental Health (OMH) and Office for People with Developmental Disabilities (OPDD), including the funding for programs to help children and families who are dealing with emotional problems. The bill ignored that there is

already a large body of evidence supporting the efficacy and safety of psychostimulants to treat ADHD. The bill was prejudicial against the use of psychotropic medication in children and erroneously implied that they were being medicated in a reckless manner.

Since the mid nineties, there has been increased research on medications used with children. In 1997, US Congress passed the Food and Drug Modernization Act which provided financial incentive for pharmaceutical companies to conduct research on pediatric use of their drugs. The Patent Exclusivity extension program provided for a 6 month extension of their patent if they conducted research on how their drug would work on children; this led to pharmacokinetic and clinical trials on children and adolescents. There are also limited funds to study the use of off patent medications. Other legislation allows the FDA to insist a pharmaceutical company do pediatric studies for a drug when it is likely to be prescribed to children, even if it is only being introduced for adult use. Such legislation has all helped with advancing the field of Pediatric psychopharmacology research.

Since then the NIMH has funded several important multisite studies, including the MTA, that looked at treatments for ADHD in a school age population, the PATS study, which looked at stimulant use in preschoolers, TADS, treatment of adolescent depression study, TORDIA , the treatment of resistant depression in adolescents, POTS, Pediatric OCD treatment study, and CAMS, Child and adoles-

cent anxiety multimodal study. These studies looked at both medication and non-medication treatments for several key conditions seen in children including ADHD, Depression, OCD and anxiety disorders. These studies followed children for longer periods of time than most drug studies that only follow children or adults for weeks or months. Hopefully studies like these will continue to help us better understand and treat psychiatric disorders in children and adolescents.

A child is referred to a Child Psychiatrist usually when he/she has been disruptive or the illness has affected many aspects of his/her life. In the future, we hope that children, adolescents can be identified and treated early, before an illness severely disrupts their life. Identifying and treating emotional problems in children have both short and long terms benefits. Reducing symptoms helps a child stay on track, functioning better at home, with peers, at school and helps keep a child on the right developmental path. It can reduce their emotional pain, avoid legal and drug problems, improve their self esteem and confidence. It can reduce violence against themselves and others and reduce the impact on their adult development.

Dr Engel is Chairman of the NYPSA Child and Adolescent Psychiatry Committee, Director of Child Psychiatry Training at SUNY-Downstate Medical Center/ Kings County Hospital Center and former Director of Child and Adolescent Psychiatry at SUNY – Downstate/KCHC, Dr Bajpayi is a first year child fellow at SUNY – Downstate Medical Center/ KCHC.

Achieving Services Children Deserve

By Mary Lou Jones, LCSW, DSW
Executive Director
South Shore Child Guidance Center

Every young person is fully prepared for adulthood, with a supportive family and community, an effective school environment as well as high quality healthcare. According to the New York State Office of Mental Health 2008 Children's Mental Health Plan is introduced with the above strategy supporting the American dream.

However, as we know for the American reality: 1) Studies indicate that at least 1 in 5 children and adolescents have a mental health disorder; 2) At least 1 in 10 has a serious emotional problem; 3) When untreated mental health disorders lead to school failure, family conflicts, substance abuse, violence and even suicide; 4) Suicide is the third leading cause of death for 15-24 year olds in our society.

As we also know, mental health disorders in children and adolescents results mostly from biological and environmental causes. Biological causes include genetics, chemical imbalances in the body, damage to the central nervous system such as a head injury, etc. Environmental factors also put children at risk for mental health disorders: - exposure to violence, i.e., being a witness or victim of physical or sex abuse; stress related to long term poverty; loss of significant people due to

Mary Lou Jones, LCSW, DSW

death, divorce, and broken relationships.

Some of the major themes and recommendations that are offered in the Office of Mental Health's Children's Mental Health Plan which has emerged are that: 1) Each action should strengthen our capacity to engage and support families in raising children with emotional health as well as resilience; 2) Social and emotional development and learning form a foundation for success in school and in life; 3) Major emphasis is needed in identifying

children and families needing supports and services, early and in natural settings; 4) State agencies and service providers must be accountable to individual families for more integrated and effective care; and 5) An adequate workforce that is culturally competent and steeped in a new paradigm of integrated and family driven care should be developed and sustained.

Stigma continues to be a problem even though many educational campaigns have been offered throughout the state including Nassau and Suffolk counties. In 2007 -08 the Mental Health Association together with Nassau County Department of Mental Health, Chemical Dependency & Developmental Disabilities undertook a comprehensive anti-stigma campaign, i.e., radio spots, media ads, as well as hundreds of picture posters of real life people with mental health issues being distributed throughout the county; in addition, the following year, Nassau and Suffolk counties also promoted (NAFAS) a far reaching anti-stigma campaign on Substance Abuse Disorders. However, there still continues to be profound societal misconceptions about the terms of disorders, and mental illness and mental health which tend to limit our ability to break down such barriers (NYS Office of Mental Health's Engaging in the next step 2008).

In New York state a unified commitment was made in 2006 (The Achieving the Promise Initiative) which represented the largest investment in child mental

health in the state's history. Action occurred thru these initiatives introduced by a public health approach to early identification and intervention, widespread access to treatment, etc.

Also in 2006, the Children's Mental Health Act was passed which was a call to action to families, providers, advocates, communities and policy leaders that social emotional development for children is a priority! Legislation then provided collaboration between the Office of Mental Health and the State Education Department to foster social and emotional development and learning to improve the emotional well-being of New York's children. Thus the plan was centered on enhancing social emotional development and on mental health, NOT mental illness.

Major medical, psychological or sociological theory recognizes that we develop emotionally – as well as physically, yet historically we have not integrated mental and physical health in our communities and in our public policy.

Sadly, in spite of great efforts, our specialized child serving systems are fragmented and difficult to navigate for families with multiple needs. It remains quite difficult for these systems to achieve the simple goal of effectively dealing with the most complex needs of the children they are designed to serve (New York State Children's Plan).

Designing Integrated Services for Adolescents: One Agency's Experience

By Jean Holland, LCSW-R
Clinic Director
Northside Center for Child Development

Addressing the mental health needs of teens in a clinic setting offers a unique set of challenges. Adolescent clients can strain the assumptions and framework of traditional mental health services in a number of ways: they have a developmental imperative to separate from parents and adult authorities, yet are often told to go to treatment by families and schools. They are neither autonomous adults, nor children fully dependent on their families, and above all they value and respond to peers. Minority teens in low income urban environments struggle with additional burdens such as community violence, enticement of gang belonging, limited access to resources, and the impact of racism on identity formation and self-esteem. This article describes our experiences designing a service model geared specifically toward the complex needs of minority teens living in a low income area. A key factor in establishing this model was the request from members of the agency's Consumer Advisory Council. They saw the need for a program integrating mental health and positive activities for their teens who, due to their emotional issues, often did not fit into the few available teen programs. By integrating comprehensive mental health services with a range of other teen-friendly activities, the program was built to support teens' emotional growth in many areas including the crucial areas of emotional self-regulation and building healthy self-esteem.

Northside Center for Child Development, a 64 year old agency in Harlem, was begun by psychologists Drs. Kenneth and Mamie Clark to provide quality mental health and educational services to children and families at a time when there were few such services for minority youth. Their program expanded greatly over the years with 522 teens receiving mental health services during this past fiscal year. The families of these Harlem and South Bronx teens self identify as African American (58%), Latino (31%) and bi-racial (6%). Seventy-five percent of these 522 teens come from homes at or below the poverty line and 21% of our clients (ages 5 to 18) do not live with a biological parent. The teens are referred for therapy by psychiatric inpatient/ER, schools, foster care agencies and families distressed by some aspect of their teen's behavior. Trauma is a fact of life for these teens, some of whom have witnessed, been victims of or have friends or family who have been victims of family or community violence.

Diagnostically 48% of Northside clients fell in the externalizing category (ADHD, Oppositional Defiant/Conduct Disorder, and Impulse/Disruptive Behavior Disorder) with 37% having two or more diagnoses and 93% a GAF score in the serious (44%) to moderate range (49%). Problems with self-regulation are apparent in this preponderance of externalizing diagnoses and in the analysis of initial assessment tools (ASEBA Child Behavior Checklist for ages 6 – 18 and Youth Self-Report fro ages 11-18)) while issues with both self-regulation and self-esteem were clear to their clinicians.

The outcome was the creation in 2008 of an integrated mental health program for teens. A clinician with a particular interest in teens was selected as the teen mental health social worker focusing on all aspects of teen programming including meeting regularly with teens for their input. Clinicians were provided with additional clinical training around working with teens. Existing services used by teens (tutoring; art therapy) were integrated into this program perspective. Mental health group offerings for teens were greatly expanded by adding both short-term and longer-term therapy groups: Power Source; Knowledge Empowers You (KEY); art therapy groups for sexually abused teens; Teens and Medication; Becoming a Man/Woman; Family Problem Solving; Music and Feelings. In addition there was a clinician-led Daily Check-In group in the after-school component to help teens express problems and achievements of the day and to receive support.

The program also included activities requested by teens (cooking, Tae Bo, yoga, basketball, photography, dance) which the teens saw as fun or exciting. Group leaders saw these as venues for learning and practicing self control, healthy self-expression, frustration tolerance, positive peer interaction and building healthy self-esteem. These activities also provided additional opportunities for the teens to develop trusting and meaningful relationships with adult leaders who also function as role models. To further self-care, positive self-identity and enlarge their vision of their potential, there were health and wellness workshops led by an RN; career roundtables and visits to worksites of interest to specific teens; and opportunities for community service (assisting in community food distribution, creating care packages for Haiti, helping to host the Northside gala). Since some teens persistently "forgot" their homework, a group was created to read and discuss a book with emotional resonance for teens living in problematic situations.

For a program working almost entirely with African American and Latino youth, positive self-identity is enhanced by programming that helps teens visualize a

Is Mental Health Keeping Pace with Applications of Technology?

By Giselle Stolper
President and CEO
Mental Health Association of NYC

H enry Ford was once quoted as saying, "If I had asked them what they wanted, they would have said faster horses."

The world has seen advances in communications that few could have imagined only fifty years ago. Since the invention of the worldwide web in 1973, there has been a virtual explosion of new technologies that allow us to communicate better, faster and in more ways than ever. In less than 10 years we have seen fledging social networking venues expand to claim over 50% of Americans as users of social networking tools and 61% of the population who primarily seek their health information online.

While the business world has eagerly embraced the Internet and social networking to extend their reach and create new markets, mental health and social service providers have been slower to realize the potential that new technologies offer us. The potential to: reach new audiences with messages of hope; provide information about mental health and wellness; link consumers to services and each other; empower consumers to take charge of their mental health care; organize for

Giselle Stolper

needed policy change; and to improve our own business practices to name but a few of the opportunities that await us.

The early successes of the MHA-NYC in applying technology to help realize our mission of advocacy, education and service innovation should provide encouragement for others to harness the power of technology to help them meet their goals. In our role as administrator of the National Suicide Prevention Lifeline

(NSPL), MHA-NYC manages NSPL's online social networking communities. Both NSPL and Lifenet, MHA-NYC's local family of hotlines lines and online resources, use social networking tools such as Twitter and Facebook to provide our consumers and supporters with relevant information — ranging from depression and PTSD to coping skills and resources for bullying.

Other innovative technological ventures include the creation our Lifeline Gallery. Lifeline Gallery creates a safe space where, through the creation of avatars, or online representations of themselves, survivors of suicide, suicide attempt survivors, those who struggle with suicidal thoughts and suicide prevention specialists can share their stories of hope and recovery. In the two years since the inception of the Lifeline Gallery, over 600 individuals have shared their stories which are heard by over 3,000 visitors a month.

MHA-NYC is also piloting chat and texting functionality through Veterans Chat and 1-800-LifeNet. By knowing our communities and the demographics of our consumers, we can match available technologies with the communications preferences of the audiences we want to reach. For example, we know that youth, on average, send over 3,000 texts a month and that communities of color are more likely to use mobile applications and mobile

web services than traditional internet service. This type of information helps guide our choice of online communications strategies.

Other applications of behavioral health technologies such as the use of personal health records, online availability of wellness trainings, online support groups, online libraries and resources can all reduce the stigma of reaching out for help and increase consumer participation and knowledge. Curated interactive technologies also hold promise for increasing consumers' participation in activities that promote mental health and well being.

Making help and information accessible and easy to use through technology can help to remove significant barriers to needed care and information. Furthermore, these tools increase our efficiency and can help us better track and evaluate our results. Gone is the day of guessing impact of messaging- we now have the capacity to measure impressions, clicks and community dialogue.

Looking ahead, MHA-NYC hopes to join with others to create a dialogue within the mental health community about how we can more effectively use technology to promote mental health and wellness across diverse communities. We can't afford to let the traditions of the mental health community blind us to this potential.

Shattering the Silence of Selective Mutism

By Sheree Incorvaia, MSEd
Director of Recruitment and Admissions
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If you've ever worked with a student identified as being diagnosed with Selective Mutism, you might see how easy it is to understand why many assume that the student is willfully avoiding eye contact, conversation, or compliance. How can it be that the same child, who speaks so clearly and animatedly in one setting, does not speak in another? Why is it that an individual who is described by family and acquaintances as sweet, compliant and sensitive, can seem so obstinate and manipulative in school? We assume that if a child is able to speak, then when he refuses, the decision must be conscious. Having encountered Selective Mutes in my professional life, and having witnessed the parents speaking for the child before he even had a chance to respond, I, too, fell into the erroneous belief that such behaviors were intentional and controlled.

Selective Mutism (SM) is described as a psychiatric disorder characterized by a persistent failure to speak in specific social situations, which continues for more than a month. It is most commonly found in children and appears to be related to severe anxiety, shyness and social anxiety. The exact cause of SM is still unknown and was first reported by the German physician Kussmaul in 1877, who called the condition "Aphasia Voluntaria" meaning voluntary autism. The term "Elective Mutism" was later coined by English physician Tramer in 1934 who used this term to describe children who spoke only to certain people. In 1994, the Selective Mutism Foundation (www.selectivemutismfoundation.org) was instrumental in changing the name in the DSM IV to *Selective Mutism* as the feeling was that the word "elective" suggested a preference, implying a deliberate decision not to speak, and "selective" implies a less willful component. Another important change brought about by the foundation was replacing the term "refusal to speak" with "failure to speak."

The first symptoms of SM usually appear between the ages of one and three and apart from a reluctance to speak (with the exclusion of populations including immigrants who speak another language, experience SM for a short period of time, and those who temporarily stop speaking due to a traumatic event) can include shyness, little eye contact, social isolation, fear of social embarrassment, withdrawal, clinging behavior, compulsive traits, negativism, oppositional behavior when trying to avoid social situations, temper tantrums and a fear of people. Seventy-one percent of children in a study conducted by Fundutis et. al. (1979), dis-played difficulty in performing motor activities and had bowel and bladder problems. Some people with social anxiety symptoms may experience pauresis, a fear of using public restrooms, perhaps to avoid the sounds of urinating that others may hear (Stein & Walker, 2001).

Current research has discarded the theory that SM is caused by abuse, which in the past has caused devastation to families suspected or accused of parental child abuse and has deterred many families from seeking help for their children. It should also be noted that there is no relationship between SM and Autism, with the difference being that Autistic individuals have limited language ability while people with SM can speak, and normally will do so in comfortable situations. True language delays, speech pathologies or learning problems are only present in about 10 percent of cases, but because their language and academic abilities are hard to evaluate due to the mutism, children are often placed in speech and special educational services, aimed at improving language or speech skills, without needing or benefiting from them. Selective Mutism has mistakenly been classified as a speech or communication disorder, but it has been shown that this is inaccurate.

There are varying degrees of the disorder and not all those with SM require treatment, and it is difficult to know if intervention is necessary. For those who experience severe forms of SM, treatment is recommended as symptoms can increase, and generally the younger the child is when treatment begins, the better the chance of recovery. Treatments consisting of behavioral management programs that deal with phobias and medications used for anxiety and/or social anxiety, have been beneficial for many, usually in conjunction with behavioral treatment. Prozac (fluoxetine), a selective serotonin reuptake inhibitor, is useful for socially anxious adults. Based on this new understanding of mutism as a consequence of social anxiety, Prozac has been used in three studies with selectively mute children: an uncontrolled trial (Dummit et al, May 1996, Journal American Academy Child Adolescent Psychiatry), a small placebo-controlled trial (Black & Uhde, 1994, Journal American Academy Child Adolescent Psychiatry), and a crossover-discontinuation placebo-controlled study (Dummit et al, reported as New Research, AACAP Annual Meeting, 10/96). All three studies support efficacy and safety in this use. Treatment needs to be consistent with positive reinforcement and rewards used to motivate the child to speak. Punishment, negative consequences and bribery have been shown to be harmful.

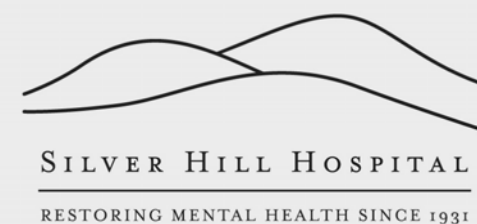While certainly not the norm, there have been cases of un-treated or ill-treated
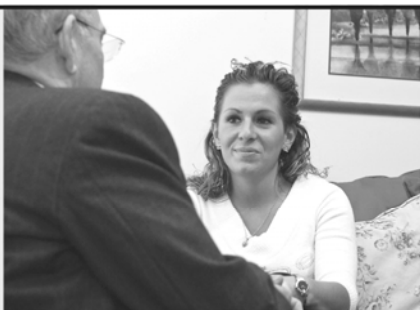
a racial affinity group for Men of Color and Women of Color. To promote an antiracist perspective among middle managers and supervisors, monthly meetings were facilitated to encourage open discussions about race and structural racism . These meetings use a variety of media such as articles, videos and power-point presentations.

As would be expected, there is pushback from people of different races. Some experience this as both a personal and professional loss, others are fearful about upsetting the applecart. The question I often hear is "How can we expect young, inexperienced staff to take the information they are learning about racism and apply it to practice in a way that doesn't compromise child safety?" This is, of course, the major priority of a public child welfare organization.

In all these endeavors undertaken in the interest of promoting greater understanding about the impact of race and racism in the child welfare system, the goal is to create an atmosphere of learning and self examination in which change could begin to occur. Education and self awareness of the problem has to be the first step in getting buy-in. Each person is encouraged to take responsibility both internally and on an organizational level for examining policies, practice and procedures that unconsciously or consciously have a detrimental effect on the families we serve, the ability of staff to effectively carry out the work, and impact on the community at large.

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Effective implementation of multicultural antiracist practice must include active support from all levels of the organization, particularly the agency's top executive leadership. The attitude of the chief executive officer and his or her willingness to move the initiative forward sets the tone for the rest of the organization. The role of the CEO and other top executives is to establish two fundamental aspects of multicultural antiracist practice: vision and accountability.

An antiracist vision includes:

- The ability to imagine and communicate the essential nature of multicultural practice. It is not enough to state that diversity is beneficial or preferred; it must be valued as necessary for the agency to move forward.

- An analysis of power, privilege, and marginalization within the organization that highlights subtle inequities that discourage employees who are not part of the dominant cultural or racial group of the organization.

- Modeling antiracism for senior leadership, including demonstrations of the learning and professional growth process on the path toward antiracist practice.

Accountability includes:

- The willingness to take action to oppose enactments of oppression, discrimination, or favoritism.

- Readiness to allocate funds for professional development, specialized training, or access to needed resources to support multicultural antiracist practice.

- Setting clear, well articulated standards for multicultural antiracist practice that have been developed in collaboration with members of racial and cultural groups outside the dominant group of the organization.

Managers and program directors play a vital role in the realization of the antiracist vision. Mid-level managers are typically the people responsible for hiring, developing, promoting, disciplining, and firing staff. They are often more closely connected to the community or populations served by their program than upper management and have a tremendous amount of power in the program or agency culture. Managers and directors, therefore, are responsible for:

- Defining cultural competency as including the ability to respond effectively to the dynamics of oppression and privilege and including this as criteria for hiring, promotion, and professional development.

- Developing and maintaining a critical consciousness of all aspects of program functioning, including décor, policies and procedures, and relational practices, to ensure genuine multicultural inclusiveness.

- Creating flexible and responsive systems of accountability to the community or population served by the agency.

Supervisors often have the most direct contact with line staff and thus have a central role in the creation of a program culture that is experienced as welcoming and responsive to the range of strengths and needs brought by the community or population served. Supervisors have the responsibility to:

- Remain conscious of the differences and similarities between themselves and their supervisees-- awareness of social distance, boundaries, and how people interpret or experience authority and relationships with people in authority.

- Promote and teach multiculturalism, cultural competency, and responsiveness to dynamics of difference, privilege, and oppression that is incorporated into evaluations and considerations for promotion.

- Actively recruit staff members who represent the range of clients or consumers served by the program and consistently respond to any issue within the organizational culture that inhibits the growth and development of all staff.

This is difficult work. It takes time – always more than anticipated or planned on, and requires consistency and perseverance. Collective effort and commitment are essential. That said, we encourage agency leaders to engage in the antiracist

Therapeutic Groups for Girls

By Maria DePena-Nowak, MD
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Girls with learning disabilities, attention deficits and pervasive developmental disorders commonly experience different degrees of social impairment. They can be referred to the Social Skills Program in our Child and Adolescent Outpatient Clinic at NewYork-Presbyterian Hospital-Westchester Division, coordinated by Jo Hariton, PhD. When compared to young boys, the number of young girls referred for social skills training is fewer, likely due to the lower prevalence of disruptive behaviors in group settings that are seen in younger girls compared to younger boys. However, as children grow and develop into adolescents and young adults, the prevalence of mood disorders like depression and anxiety, as well as eating disorders, is significantly higher among females.

This past summer, I developed through our outpatient department a group program for girls who were at high risk for being bullied, excluded by their peer group, lured into experimenting with illegal substances and developing a mood or other clinical disorder. The program was

Maria DePena-Nowak, MD

designed to empower each girl with necessary coping skills and tools to successfully manage challenges which could otherwise impede their optimal development. All girls completed an evaluation prior to joining the group to determine their eligibility. For this evaluation, the girls came accompanied by at least one parent. It

offered an opportunity for them to ask questions about the program and for the group leader to assess their cognitive level, interests and goals as well as cohesion among prospective peers.

Eight 75-minute long sessions were offered and focused on social skills training around everyday issues. They included navigating relationships; dealing with bullies; strategies for diplomacy and problem solving; identifying one's strengths and managing one's weaknesses; understanding our changing bodies; achieving a healthy body image; educating oneself about nutrition, substances and medications; and achieving emotional and financial stability. The groups were led by a team of experts in Child and Adolescent Psychiatry and included games and discussions around a pre-selected topic, as well as some time outdoors if weather allowed.

The girls were separated in three different groups based upon their developmental needs and school grade level: elementary (3rd to 5th grade), middle (6th, 7th and 8th grade) and high school (9th through 12th grade) with a maximum of six girls in each group. They had the option to join as many or as few groups as they were able to participate in or interested in.

The format of the core curriculum for each unit was sensitive to and designed to accommodate the developmental differ-

ences among the three different age groups. As such, an introduction to the Cognitive Behavioral Therapy (CBT) model was incorporated in the unit to address strengths and weaknesses. The girls were invited to discuss how thoughts affect feelings and, much like the well known domino effect, the direct impact of these feelings on the behaviors displayed in public and noted by others around us. Some exercises included vignettes from interactions at home with relatives or in school with peers which illustrated the connection between thoughts, feelings and behaviors; other times, a list of evidence against and evidence in favor of a previously identified belief or thoughts (i.e. "she doesn't like me") was completed. Girls were invited to use this skill in other situations back at home or in the community when meeting friends and peers. Similarly, clinical scales like the Children Depressive Inventory (CDI) and the Body Distortion Image in Children and Adolescents (BDI-CD) were used in all age groups to elicit measures of mood symptoms or body image distortion.

Although each unit was introduced with a unique set of projects, role plays, oral demonstrations and group activities, the girls often brought up for discussion real life scenarios that linked one or two of the topics together. For example, during

Transforming from page 28

transformation of their organization. Why? Because the rewards are priceless and the milestones of success – however these are described – are necessary for delivering culturally competent and effective services.

Willie Tolliver, PhD, Associate Professor
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In 1982, a group of Hunter College School of Social Work students petitioned the faculty to have a required course for all students on "cultural diversity." They failed. Over the years, four other student groups made the same request, with the same results. Twenty-six years later, in 2008, yet another group met with the faculty and this time succeeded. The outcome of their efforts was the School's adoption of an anti-oppression and restorative social work lens for the year-long required foundational "Practice Lab" for all incoming students. Today, the course has moved from an exploratory pilot, to a requirement for all students. What did we learn, and what can other schools of social work take from the Hunter experience?

For us, the most important lessons fall into three areas: (1) the effectiveness of student organizing, and use of lessons from the past to strengthen tactical choices for promoting change; (2) the implications of demographic shifts in both the composition of the school's student body and service consumers for curriculum development and renewal and; (3) the cultivation of faculty allies who have re-

mained committed to anti-oppression work within their own classrooms and expanding the anti-racism and anti-oppression material among younger, junior faculty who are new to the School community.

First, strategic effectiveness of student activists. Most important to the change effort was students leaders within the school student governing body and others in various student alliances who began a coordinated campaign organized around the following three tactics: (1) The development of a petition campaign among all students to show the widespread support for the course and not just among community organizing students. Students consciously partnered with and gained wide support of clinical students and effective counter claims that this material would only be on interest to community organizing students; (2) Individual meetings with every faculty member to explain the course content and to ascertain their degree of support for the course. This process helped overcome untenured faculty members' fears that such a course would be met with disapproval by their more senior colleagues and jeopardized their obtaining tenure; (3) The use of the internet to locate equivalent courses at other schools and programs to effectively argue that the course served powerful practice purposes and not simply "politically correct" positions on topics of race, sexuality, gender, and class. Such an emphasis gave their cause substantive weight related to the classroom.

Second, was the demographic shifts in student enrollment and consumers -- New York City has continued to be a remark-

able cultural and social amalgam of races, colors and creeds. Whites are no longer a majority in the city of 8.5 million people, and the School's student body is increasingly reflective of the city's diversity. The working students' program, the One Year Residency Program, has over three-quarters students of color, many of them first generation immigrants. While the other programs are less diverse racially, significant numbers of openly LGBT students are found throughout the program, as are immigrants. Perhaps one of the most significant statistics on the conscious diversity among the students is that 57% of the entire entering class (about 450 students) is fluent in at least one other language besides English. Such remarkable diversity made the need for a required course that prepared students for effective practice with increasingly diverse consumer groups more obvious.

Third, was the cultivation and mobilization of faculty allies to institutionalize anti-racist changes. Faculty were identified who had maintained an active engagement in developing an anti-oppression framework in social work who shared past lessons and provided moral support for student efforts. From the start, students sought out faculty who were known for their anti-oppressive work in order to avoid repeating past errors of organizing or misinterpreting faculty points of view. Most of these faculty were involved in a monthly "anti-racism" faculty sub-committee attended by numerous junior faculty. Here they learned of their concerns and how to overcome them. They were also able to share that this work was not about a political stance but

related to improved practice. The result was a far more collaborative and supportive environment for the work as the academic year progressed.

Thus, by the time the students attended the faculty meeting in May of 2009, there was widespread support for the anti-oppression course moving ahead first as a pilot and then, with its positive impact, into the entire School in the fall of 2010. Other factors are also important to note. During accreditation, the School administration readily embraced the inclusion of diversity content into the Practice Lab. Students further lobbied throughout the accreditation process, leading the CSWE site team leader to acknowledge their positive efforts. Now alumni, many of the leaders continue to meet with new students in a "community of practice" so that anti-oppression material is not watered down. One of the faculty involved in the earlier effort agreed to co-chair the Practice Lab and work with new faculty on how to develop this material for all students. Another continues the Anti-Racist faculty group as an arena in which new material and issues on oppression can be raised for all faculty and not just those teaching the Lab.

Strikingly, the students in last year's pilot and new faculty to this year's Lab have found that this material has strengthened their practice, redefined their own roles in a less hierarchical and more engaged manner, and enriched their lives as well as their work. While this content has been long in coming, anti-oppression and restorative social work practice is making a vital contribution to the Hunter College Social Work community and, hopefully, beyond.

Panelists from page 14

communities, we had to start with the given and then try to add a little bit new. Redirecting resources and meeting needs is very difficult and it shows itself racially and ethnically.

Alan Siskind: There's no question about the systemic racism in terms of how resources get assigned. There is always more need than resources. And limits on funding become a place where policy makers can hide so they don't have to deal with how racism plays out in the allocation of resources. Ideally, our mental health system should be organized to ensure that all communities are getting what they need; and if that's not being done, which I think is the case or if it can't be done, let's be honest and acknowledge it. The worst thing is to pretend that our system is meeting the needs for mental health services universally.

Peter Beitchman: How does that kind of systemic or institutional racism play out at the provider agency level?

Julie List: This is where white privilege comes in. When you think about it, the people at the table making diagnoses and treatment plans for people of color are usually white. And the therapist, regardless of color is usually reporting to a supervisor who may be white, and there are often white people in charge above them on the management team and on the board level. Our institutions, which are founded on racism, leave our clients at the very bottom before they even open their mouths. That is why the anti-racism movement has to take place from the top down as well as from the bottom up. It has to be integrated into our work on an ongoing basis. We need to diversify people in supervisory positions who are making the diagnoses and the treatment plans. The upper echelons of our agencies need to have members who represent the clients we see in the city. I think that this is one way to begin to change the way things have always been.

Kalima De Suze: I think there are also some basic problems with the constructs of our therapeutic models. As an African-American, anti-racist feminist, when I'm working with a therapist, black or white, and I say something like marriage is not for me, if the psychodynamic construct

the therapist is using points to "oh-oh, she's got daddy issues," that construct just doesn't acknowledge who I am. That therapist simply won't hear or understand me. That kind of therapy would just drive me further away from myself. So it's not just having people of color in leadership positions or more therapists of color, it has to be people who have an analysis and clear understanding of racism to begin to make change. One of these important changes is for clinicians to recognize the need to explore client material that move beyond traditional psychodynamic constructs.

Robert Abramovitz: In the anti-racist training we learned about gate-keeping, which I understood to mean the control of access to concrete services. But what I now understand is that having the Western psychodynamic model and the clinician hearing you and translating what you're saying through that model is a profound example of gate-keeping on a deeper level. The model directs us to internal dynamics, rather than the life you've lived, a totally different mindset.

Alan Siskind: And it's our clients' life experience, including the impact of race, class, ethnicity and gender that impact on both me as the therapist and my client. I agree we just can't understand this if our lens is clouded by a purely psychodynamic lens. Our assessment tools need to be psychosocially broad enough to include the impact of race, oppression, gender, as well as biology. As we think about race, ethnicity and culture we need to consider that there is often as much diversity within groups as there is between groups, as is true, for example, in the myriad of Latino communities.

Billy Jones: When we talk about our therapeutic model it's so ironic to me because there's been a huge swing from the more analytic dynamic approach to the biological. And in that swing we're missing exactly what we've been talking about: the understanding of race, culture and class that had begun to get into the mainstream now, in psychiatry, we're skipping over these things.

Peter Beitchman: Is there a therapeutic model that incorporates an understanding of racism and the related "isms?"

Robert Abramovitz: I think, although

it's imperfect, looking at the client from a trauma perspective holds some real promise. It holds that life experience affects biology. It starts from the perspective that adverse life experiences are the source of problems, although it recognizes that there are protective factors that promote coping and adaptation. The trauma model, at least as it's being conceptualized in government-funded studies, stops short in labeling "racism" as a crucial life experience, preferring "culture" as a euphemism and it doesn't readily make a connection between the adversity caused by racism and mental health problems, but it is a promising perspective to do so.

Alan Siskind: I agree about the utility of a trauma approach**.** Virtually 100% of our poor clients of color have trauma from racism sometimes with a small "t" sometimes with a large "T." And the trauma approach gives you understanding of the imprinting and impact of the accumulated experience. What's missing and what's needed is an integrated therapeutic model that explicitly includes racism. For now we have lots of individual thinkers – Robert Carter for example – who write important articles about racism and mental health. I think there will be an integrated paradigm, hopefully in the nor too distant future.

Kalima De Suze: And I hope that in addition to creating constructs around the effects of racism, the emerging therapeutic model will incorporate an element of political consciousness as part of the clinical work. We know that when your consciousness is raised you begin to understand the racism in so many systems, you feel empowered and feel that you can advocate for change. You feel less powerless.

Peter Beitchman: In the absence of a fully formed therapeutic model how do we incorporate race-sensitive practice into our agencies?

Julie List: I agree that the first step is to have the analysis. We're so fortunate to have the People's Institute Undoing Racism training. Implementing the understanding is challenging and, I admit, uneven. You have to have agency leadership behind the effort, as I do. You have to make it part of everyday discussion at the agency – in the record room, in the lunchroom, and talking about it in supervision, both individual and group. We meet every

other week to talk about race and racism in our clinic, how these issues come up in our work and in our lives. As a supervisor, I listen for it all the time and if no one brings it up, I do. Some people are resistant: they say, "I didn't become a social worker to talk about social justice." That's when you say "but it's a deep clinical issue; we have to look at racism to understand what your clients' lives are like."

Robert Abramovitz: To maintain this effort there has to be a clear message from the highest levels of the agency that legitimates giving voice to these issues. If it isn't legitimized the effort won't succeed.

Peter Beitchman: What about the education we receive to become mental health professionals? We've heard Billy talk about the lack of opportunity in psychiatry training programs to address issues of race and racism; what about social work education?

Kalima De Suze: In my experience talking to social work colleagues, I hear over and over that there is resistance to incorporate an understanding of race and racism into the curriculum, even to discuss it in class. At the Undoing Racism trainings most, nearly all of the social workers say they haven't had the conversation about race before and certainly, not in their social work education.

Alan Siskind: In a social work class I taught recently, a student was describing the hostility of a group of clients she had been assigned to at her first meeting with them. There were lots of ideas about where the hostility may have come from, but no one suggested that racial difference between the student and group members might have played a role (and it's a racially and ethnically mixed class). It's another example of how hard it is to address the racism and how many places there are to hide when you don't want to deal with it.

Kalima De Suze: I think another contributing piece to the lack of attention to race and racism in social work education is that many of the faculty are not equipped to have those conversations or handle the emotions that inevitably come up. Professors need an analysis of racism; they need to be comfortable with addressing it, so that they are better prepared to have the

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Challenges from page 19

not understand "me". Even worst, some may think they don't even care. In their thought provoking book, Lay My Burden Down: Suicide and the Mental Health Crisis Among African Americans, Dr. Poussaint and co-author Amy Alexander, hypothesize that high rates of the suicide and self destructive behaviors among some African American males is a reflection of longstanding untreated mental health problems and inadequacy of existent mental health services.

There is a strong reluctance to discuss mental illness in the Black community and family systems. Black men are not open to sharing their struggles even with their intimate partners or, at times, even other men of color. Especially around symptoms that deal with emotional vulnerability. This

unwillingness to disclose is magnified when it comes to white mental health professionals. These are but some of the multiplicity of issues that must be addressed for mental health providers and clinician to barriers and increase access to quality mental health services for Black males.

Policy Issues & Solutions

Recognizing that the issues associated with improving mental health outcomes for African American males are not only clinical, but are also political. Black males therefore must move beyond being consumers and engage in political action with other strategic partners. Currently only a few agencies engage their clients in the policy making process in substantial ways. There is also a need to get community power brokers involved in

creating a responsive and effective system of care for these men. We must always remember that policies and programs are developed as a result of advocacy and public pressures in this society. National Alliance on Mental Illness (NAMI) is an excellent case example of the power of organizing, advocacy, and public pressure.

Black men must make local, state and federal officials aware of their distinct mental health needs, and barriers to mental health services by testifying in and organizing public hearings. There must be a demand for services and service models that fit their specific needs. There must also be a strategic process to engage the media into reporting problems related to disparities in care.

The long range goal is to promote policies that lead to social justice and brings

about equity and positive treatment outcomes that address long standing failures in providing effective services for Black males. To do this, it is imperative for agencies and clinicians to understand that Black males are a diverse and complex group and design services accordingly. Agencies and clinicians must see beyond pathology and destruction and anchor services and programs in policies that acknowledge the significant strengths and resilience present in Black males.

Institutional and individual racism must be recognized and addressed. This writer is of the opinion that internalized racial inferiority and superiority must be understood and dealt with at all levels. In the absence of appropriate mental health services disparities and unnecessary suffering of Black males will continue to persist and worsen.

Mutism from page 27

individuals that have turned violent. In April of 2007, Cho Seung-hui, a Korean immigrant, murdered 32 students at Virginia Tech before killing himself. Cho was diagnosed with Selective Mutism in his early academic years, and was placed in special education under the classification of "emotional disturbance." He was excused from oral presentation and answering questions in class. Aided by these efforts to compensate for his disability, he was able to garner A's and B's in regular and Advanced Placement classes and was admitted to Virginia Tech. Mr. Cho's, and others' experiences in special education may suggest that schools might be placing too much emphasis on academic advancement of bright but troubled students and not enough to their emotional or other disorders. As the individual enters adolescence, depression is more common and can lead to more severe anxiety, social isolation, lower performance in school, suicidal thoughts and self-medication with drugs and alcohol.

In order to have any success with individuals with SM, it is important for teacher training addressing the nature of SM and use of classroom strategies with on-going support for all those who work with the student. Understanding that the failure to communicate is due to an anxiety condition and not pressuring the student to speak, with no teasing, threatening or punishment for failure to participate is imperative. Written work, non-verbal communication, audio or videotaping, collaboration with friends, use of a computer or use of another person as a verbal go-between can be used as alternative forms of assessment and participation. Waiting for the student to speak is anxiety-provoking, and making a big deal of any vocalization that does occur might make the student pull away, as that is turning attention toward the student. Clear, specific assignments and expectations can also reduce the student's anxiety, as well as hands-on activities which has the student more engaged and less distracted by worries. Social support outside of the classroom and at unstructured times is another tool that can help the older student with SM develop social relationships and realize academic success.

Sheree Incorvaia is the Director or Recruitment for New York Institute of Technology's Vocational Independence Program and has worked with special needs students for the past 20 years.

Reflections from page 12

- The People's Institute's Undoing Racism Workshop™ contact and schedules can be found on the internet at www.antiracistalliance.org

- Training and case consultation for workers and supervisors on addressing race, culture and racism in mental health treatment contact: JBFCS Anti-racism & Multicultural Consultation and Training Service: joanadams@jbfcs.org

- Introductory continuing education workshop around the nature and impact of white identity, white culture, white privilege. For white practitioners and practitioners of color in multiracial settings or in communities of color Contact: The Center for the Study of White American Culture Bonnie Cushing/Jeff Hitchcock (www.euroamerican.org)

We also suggest next steps for expanding our models of mental health treatment:

- In treatment settings collect data on the meaning and impact of race/culture and racism as ascertained in assessment, treatment, development of therapeutic alliances, supervision and case conferences. Aggregate the data by race/ culture and review for outcomes.

- As Gail Golden suggests, in the article cited previously, "develop asset-based models which incorporate curiosity and respect about the survival skills which whole communities have had to mobilize in order to confront genocidal affronts to their being."

- Review and discuss emerging research on the contribution of gross wealth disparity to mental health problems (WHO report – see the Guardian London, 3/11/09). Wealth disparity is another manifestation of structural racism. People who are white and poor are not poor because they are white (PISAB Undoing Racism Workshop core trainer) whereas many poor people of color are poor because of structural racial inequities in the society.

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JBFCS Child Development Center. Jonathan McLean, LMSW, JBFCS; Steering Committee Member, PISAB Men of Color Group. Jordan Margolis, LCSW, is a Mental Health Consultant, Clinical Consultation Program of JBFCS.

References: Cross, W., (1971) The Negro to Black Conversion Experience; DeGruy Leary, J., (2005) Post Traumatic

Slave Syndrome: America's Legacy of Enduring Injury and Healing, Uptone Press; Golden, G. (2004) Retooling Mental Health Models for Racial Relevance; Helms, J. (1993) Black and White Racial Identity : Theory, Research and Practice, Praeger; Sue, D. et.al. (2007) Racial Micro aggressions in Everyday Life: Implications for Clinical Practice, American Psychologist, Vol. 62, No.4, pp 271- 286

Rubicon from page 16

at the absurdity of the statement. Then I cried over its truth: For it made me realize that we professionals are blinded by a belief in our good intentions. Because we are idealistic, well-meaning, and highly trained, we believe that our efforts are beneficial. Yet the horrific mental health struggles faced by people of color - and white people as well - are only compounded by institutions determined to maintain colorblind policies and practices. As we look squarely at the systemic nature of racism, we can find the courage and conviction to go beyond good intentions to an honest examination of results. With such understanding, we can organize with our clients and colleagues to transform our systems so they no longer "drive

us crazy." Margery Freeman is a trainer/organizer at The People's Institute for Survival and Beyond.

Race is the founding structural reality of the United States. Every system that constitutes the national infrastructure, from education to law to health care, was constructed by and for White people. This national construct of race and its systemic dimensions still hold true today. The disparate racial outcomes produced by these systems in the twenty-first century are based on the built-in assumptions of the eighteenth century racial state. Laws have not changed this basic understanding; legislation has not leveled the playing field. Even personal attitudes that for many have lessened the racial fear and phobia characteristic of prior generations, have not shaken the sturdy pillars of this

race-constructed nation.

Mental health must be understood in the context of this racial construct. Most Whites live in a state of denial about race or, conversely, think we know all about it. Yet the subject of race rarely comes up in our board rooms or staff meetings unless someone of color raises it. We assume a common "colorblind" understanding and approach. We rarely ask, "What's Race got to do with it?" Even in public policy debates or data research, the disproportionality of racial impact is missed. Race comes up only when it is the "issue" under discussion. If the topic is not race, it is rarely seen or heard. In contrast, people of color, especially Blacks and Latinos, see race everywhere. There is no topic or arena where race is not a factor. While Whites accuse Blacks of "playing the race

card," Blacks and other people of color see race as impacting every card in the deck.

Today in the field of social services, more and more of our constituencies are people of color. Yet, the professionals who serve them are overwhelmingly white. Without a thorough knowledge of structural racism those of us in the helping professions can do damage.

This issue of *Mental Health News* is about race and its many dimensions. The authors dissect race from many angles. They analyze the impact of race from both a conceptual and a practical basis. These articles explore how race plays itself out in the therapeutic arena, in policymaking circles, and in direct client interactions. Together they comprise a manual suitable for every one in the profession.

Achieving from page 24

However, even with resources children suffer because of our collective inability to really integrate our services. State agencies need to work towards integrating services and improving outcomes for children and families. The Council of Children and Families in New York State is committed to an aggressive effort to improve access to appropriate care those who require services from multiple agencies. They will develop and oversee a Children's Action Network (CAN) within each county to coordinate local child service systems.

There still is hope. Quite significantly, the OMH, OMR&DD, Office of Children and Family Services, and the Office of Alcoholism and Substance Abuse Services continue the Building Bridges Initiative to develop multiple use, joint licensure and flexible funding across agencies to better support integration of services to benefit all children requiring help. NYS OMRDD in conjunction with OMH have made beginning strides to bridge the gap with addressing the needs of the developmentally disabled child who also has mental health needs. In addition, OASAS and OMH have made greater strides in working with substance abuse and co-occurring disorders to combine a truly integrated treatment model. As a matter of fact our agency, South Shore Child Guidance Center has further incorporated additional psychiatric hours to accommodate our substance abusing

adult population. Since we instituted mental health screening in this population there has been a 27% increase in psychiatric evaluations as well as prescribing appropriate medication for those clients who require it.

Strategic planning by OMH utilizes a basic design of the "Balanced Scorecard Approach" for the Public Health System (2006-2010 Five Year Comprehensive Plan for Mental Health Services). In addition to their mission, their Strategy and Vision is an exceptional one: … a future when everyone with a mental illness will recover, when all mental illnesses can be prevented or cured, when everyone with a mental illness at any stage of life has access to effective treatment and supports – essential for living, working, learning, and participating fully in the community.

The need for services have never been greater! The Children's Plan as well as The Achieving the Promise Initiative are transformational for services but can they become a reality in light of the impending NYSOMH Clinic Restructuring Program which may devastate the availability of services which are paramount to achieving this vision? We hope that the many children we treat, who are most often in significant distress will be able to benefit from all of these values which we embrace, and services which we consider to be of such high value. All our children should be given the opportunity to achieve their potential and live productively in their community. We hope this can be realized for their future.

Competency from page 6

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When I first took the Undoing Racism training seven years ago, I found it to be more penetrating and compelling than addressing issues of diversity and cultural competency. It was eye opening, and I recognized that I needed to play a role in encouraging social workers to take this training. Understanding the impact of racism on the lives of our clients is fundamental in our ability to do accurate assessments, as well as to more effectively engage people in the helping process. We also need to be more open with our colleagues and to understand ourselves. For example, being white allows us to ignore the pervasiveness and magnitude of racism, and our educational and service delivery institutions do not require us to examine it.

At NASW, we succeeded in getting the 2005 Social Work Congress to recognize that addressing racism must be a national imperative, and we collaborated with others to encourage CEOs and executive directors in human service agencies in NYC to take the training, in addition to line workers and middle managers. Ultimately, we need a new set of standards for education, practice, supervision, administration and governance. This is something we need to work on together, in a collaboration.

Groups from page 29

the unit on problem solving the girls used examples that included difficult interpersonal relationships, bullying behaviors and/or issues about their developing bodies. Those girls who participated in more than one session had more opportunities to practice and review previously discussed skills.

A significant number of callers inquiring about the program had a special interest in the body image unit. A particular case is worth discussing because of the high level of distress that it brought to the family for an extended period of time. This young girl, who was 8 years old at that time, was verbalizing statements about her weight and how she was feeling "fat" despite reassurance from the pediatrician and family members to the contrary. Because of her mother's past experiences with the girl's older siblings, she was mortified and worried that not only were her daughter's complaints increasing over time, but that the behaviors she was engaging in could endanger her health. Although initially the mother only wanted her daughter to participate in the body image unit, she considered and agreed to sign the girl up for the entire curriculum. While completing the bullying unit, the young girl provided details about the mean statements that this other girl in school was constantly sharing with anyone who cared to listen. Her mother was already aware of the bullying situation but the full content of the mean remarks and the vicious emphasis on weight and appearance were not fully disclosed until then. During the feedback session, the young girl taught her mother the strate-

gies that from now on she was going to use. Mother agreed to remind her and practice these skills at home as frequently as needed in order to increase her daughter's level of comfort and confidence. Mother later provided further feedback to the group leader a few weeks into the beginning of the academic year. She was pleased to report how much improved her daughter's ability to handle situation in school with old and new peers was today in contrast to the last academic year. She was thankful for the opportunity and the gift of practical tools that the summer program offered to her daughter, and ultimately her family. As she stated, "these are tools that never get too old and could be used on more than one occasion to solve more than one problem."

A parenting workshop was also offered to the legal guardians, where the skills introduced to the girls were taught to them as well. At the end of each session, every parent was asked to schedule an individual session with the group leader. Their daughters were invited to join them to discuss the skills taught and practiced during each unit. It was the goal of the program to enlist parents as their daughter's personal coach beyond the group setting, transferring the role of the group leader to the family where the parents would ideally reinforce and encourage the practice of these skills. Hopefully, this strategy would allow the successful transition of the skills taught in the group setting to the lives of the girls in the community. It is in the community that these skills need to be practiced and reinforced again and again, in order to prevent the onset or an exacerbation of maladaptive behaviors.

Services from page 25

range of career/life opportunities greater than what many had been exposed to. They also needed opportunities to learn more about and take pride in their cultures. As part of this goal, a weekly group for teens, led by staff from the Museum of African Art focused on participatory teaching of African and Caribbean culture and history. The teens in this group created a large mural using aspects of African art with a second group using drumming as an expression of culture and self.

Teens could participate in all or in any single aspect of these additional services in addition to their ongoing therapy. By interweaving therapy groups with other therapeutic activities, the program offered teens the opportunity to develop and practice new patterns of interaction both inside and outside the therapy room.

Assessing the impact of this teen program to date is complicated by the fact that so many avenues impacting mental health, from clinician training to activity groups led by staff from a mental health perspective, occurred at the same time. The ASEBA (pre-and post test Youth Self Report for 11- 18 year olds) completed during this period showed the following results. When asked to respond to "I am better at handling daily life" 71% agreed, 24% felt neutral and 5% disagreed. Seventy-two percent of teens also said that they were "better able to get along with friends and other people" with 24% remaining neutral and 5% disagreeing' (2009-2010 Quality Management Report). What seems clear to clinicians is that teens who chose to participate in the groups and other additional services displayed a greater level of self-control and self-esteem in their lives than they had at the beginning of the program. As one teen wrote recently, "I wish this program could go on forever. It is the one place that I can be myself."

Outcomes from page 15

to a community struggling with racial oppression.

"I have to go to the clinic every couple of weeks. They say I am high risk because of the diabetes and because of the depression. I have my mother to take care of. Sometimes I just can't make it. The clinic is always so crowded and I have to wait all day to see someone. It never is the same person. Sometimes I just leave, cause I have to go to make sure my eats. She forgets sometimes. They called me "non-compliant."

We were determined not to impose institutional "gate keeping" or demonstrate the lack of respect for cultural values that this narrative highlights.

"...They don't know us. They come here to learn on us. I know me and what and who I am. I go to the doctor for the pressure. I eat the low salt and take the pills, but they don't know a pill for the other things that make the pressure. I have two boys, 30 and 32. They were raised right. I know them but others don't know them. They just see two black boys, so I worry because things can happen. We know and we have to deal ..."

We understood the lessons from history. Women of color are anxious about the safety of their sons from their infancy through their sons' adulthood. Mothers worry, "will my obviously Latino or African American son survive the day." Racial stress is a constant in the lives of people of color and has a negative impact their health and mental health outcomes. We accounted for this reality and incorporated stress reduction measures into treatment plans.

"... talking about the doctors. One time, I had a doctor tell me that I had an infection, because I had too many sexual partners. My husband was real mad, me too. He finally said that is not true. It could have gotten crazy. I have the diabetes and get infections when my sugar is high sometimes..."

Misdiagnoses based on racial stereotypes by poorly informed providers add to the community's mistrust of institutions; ultimately compromising positive treatment outcomes. We were committed to undoing internalized racial oppression and were keenly aware when even our own acts of internalized racial superiority surfaced.

"... my mom is in the hospital and was on dialysis and had a heart attack. She was in a lot of pain in her legs when the doctor finally came. He was mad. I guess we woken him up or something. He said, "do you think Medicaid patients get the same treatment here as the patients on the other side?" I told the nurse and the big doctor (Attending), but I knew the other doctor was right. My mother was always scared at the hospital and didn't want me to talk too much. She was scared they wouldn't help her if I did."

In each of these stories the proverbial "elephant in the room," racism, colored the lives of each of the women and their outcomes. The project ended after six years. Many of the women returned to doing what they always did, and others courageously maneuvered the systems that served them and their communities. We never asked them if we could be there, but when we left, they thanked us. They taught us well that undoing racism had to be a fundamental part of treatment for people of color to achieve healthy living.

Community Sage

Every village or community has leaders, sages, wise men and women providing wisdom and guidance to its members. One such community sage is Martha Reen Alfred Richards. She was the wife of the late Henry W. Richards Sr., is mother of five children, grandmother of eight and great-grandmother of four.

Mrs. Richards began counseling and monitoring the human development of her customers in her beauty shop. Many represented three or four generations of a family, which allowed her to observe patterns, behaviors, and correction/treatment efforts for more than forty years. At the same time the Richards family not only parented their own children, but many others who were not related by blood, but circumstance.

Faced with her son's drug addiction and the pregnancy of her teenage daughter, Mrs. Richards was able to reflect on the challenges faced by others while mapping out a treatment plan for her own children and family. She became the lead therapist and service provider for her own children and in doing so formally began her role as Community Sage.

Mrs. Richards saw the new baby as gift to the family versus the sole responsibility of her daughter. This family ownership enabled the teen mother to graduate high school attend college and earn a doctoral degree. When Mrs. Richards saw her son's behaviors change from being a very trustworthy person to someone who broke commitments and lied, she knew something more was going on than alcohol and marijuana. Ultimately her son was placed in an inpatient treatment facility.

Affected by her son's addiction and the drug epidemic consuming the community, Mrs. Richards organized a neighborhood block club. The Club grew into the Southwest Gardens Economic Development Cor-

poration, providing comprehensive services to the community, and she would go on the establish UNITY House in 1989.

Her early work with UNITY House residents established a personal relationship that transformed how the professionalized mental health providers worked with residents at Unity House. She did not define the men in recovery by their addictions or their pathology, but viewed them as whole with aspirations and gifts. Thus, she worked with them from a place of humanity and not pathology. This produced results and provided a difference paradigm for professional mental health providers who were 99% white with pre-conceived notions about African-Americans, and poor whites. In the twenty years that Unity House operated, over 1000 men resided there. More that 50% remained drug free and stayed involved in community work. Although subsequently closed due to funding, the impact of Unity House continues to be felt in the community.

Mrs. Richards exemplifies the principles of a community sage. She is one who uplifts individuals and collectives while being venerable, uplifted by individuals and collectives in return. She is one who serves and leads with an understanding of racism, history, culture, while being a gatekeeper committed to developing leadership and accountability. She believes in people and in the community from a place that speaks life into situations and moves as if it is already so.

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Populations from page 10

colonization, displacement, and genocide?

Mentally-Ill People in Incarceration

Mental health inside of America's prisons has become a serious problem. Prisons are housing mentally ill patients for crimes that probably would not be committed if they were treated for their mental illness properly within society. A 1999 Bureau of Justice Statistics report estimated that approximately 16 percent of jail inmates, 16 percent of state prison inmates, 7 percent of federal prison inmates and 16 percent of probationers suffer from severe and persistent mental illnesses. Research clearly indicates that people of color are disproportionately represented in the prison population. Blacks are eight times more likely than whites to be incarcerated.

An account of one substance abuse counselor inside of a New York State prison, revealed first hand the tragedies of mental illness with Black and Latino inmates. Many are not diagnosed or receiving care commensurate with best practices

for community mental health care. Staffs are caring but overburden. The need for mental health care is high but funding support for adequate care is limited existed long before current economic fallout.

The incarcerated mentally ill face substantial challenges. Stigma is present in correctional facilities as well as in society. This leads some to refuse mental health services and medication that may be helpful. This population is highly vulnerable. They are likely to be taken advantage of by other incarcerated persons and misunderstood by correctional personnel. These factors lead to victimization and infractions. It is not uncommon for them to be extorted for their personal items and forced to perform sexual favors.

Most of those with mental illnesses have difficulty participating in mandatory programs such as school, vocational training, substance abuse and alternatives to violence. Those that manage to attend groups don't fully understand the content and context of the information being provided. The therapeutic value of these services is compromised and leads to a repeat of the issues and circumstance that

lead back to incarceration. Until those who are mentally ill are given proper care within society, our prisons will continue to be filled with mentally ill patients, who commit crimes when they should be able to live more productive lives. It is time that America to reexamine its role and strategy in dealing with this new epidemic that not only affect the incarcerated person but families and communities as well.

Is it at all a wonder that the mentally ill, particularly mentally ill, people of color find themselves under the direct control a white dominated, punishment system? The unbroken line from slavery, to the convict leasing system to now what is called the prison pipe line or the prison industrial complex started with criminalizing both the Indian and African peoples.

The above glimpses into the depth of the problems connected with special populations, mental health and racism barely scratch the surface. Certainly one article could never account nor even begin to discuss a remedy for centuries of neglect and mistreatment. It has been said that racism, like oppression, is accomplished by omission and commission. The history of racism with respect to special

populations shares that history. We conclude here with the assertion that only a transformed mental health system can undo the racism that created such disparities. Thus the challenge is how do we as New Yorkers embrace the reformulation of a human rights agenda for not only the special populations with mental illness, but for the society itself. This will require the full disclosure of the role, function and impact of racism on all the associated structures and processes dictating policy, education and practice. It almost seems so daunting that such an effort would prove futile. But we also know that doing the same thing over and over and expecting different results is insanity.

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members to not only participate in decision making but to also provide oversight that ensures anti-racist policies are followed. Those advisory groups include the Racial Ethnic Federation groups, Black Agency Executives, Hispanic and Asian Federations.

And finally, the education and training of mental health professionals and educators requires a paradigm shift that would retool mental health models for racial relevance and demand an understanding of the role of structural racism as it is maintained in mental health practice. Traditional mental health theories using Eurocentric and privileged notions of what is considered "normal" have failed to incorporate an analysis of societal oppression into an understanding of human behavior. This has resulted in the creation of a system that has poorly served members of marginalized groups and contributed to the underdevelopment of theories to inform effective practice with people of color, and contributed to glaring racial and ethnic disparities in mental health outcomes.

In the case of social work education, the discipline with the highest visibility in the field of mental health, the work of infusing anti-racist principles must occur at all levels of academic programming in degree bearing and post graduate certificate programs. The profession must also evaluate the implications of credentialing to guard against its being covertly used as a gate keeping device which diminishes access and availability to mental health services for people of color that are pro-

Jonathan Morgenstern

Michael Stoller

Wayne Ho, MPP
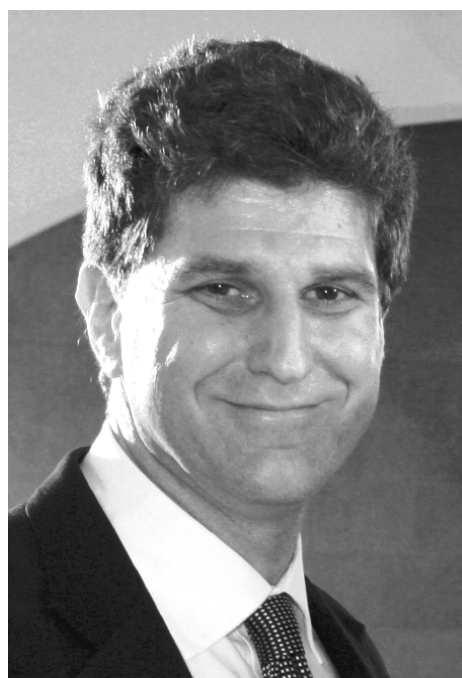
vided by qualified professionals with relevant cultural expertise.

We believe that to change policies and practices that have contributed to disparities in mental health outcomes for people of color will require a meaningful commitment to anti-racist work. This in turn will require an appraisal of how racism is ingrained in all societal institutions including the mental health system. In the words of The People's Institute, "racism destroys humanity and undoing racism brings humanity back." We should settle for nothing less. Our collective mental health depends upon it.

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of Social Work. Wayne Ho, MPP, is Executive Director, Coalition for Asian American Children and Families. Eri J. Kim, is Director of the Safe Horizon Manhattan Community Program. Larry Mandell, is Former President and Chief Executive Officer of the United Way of New York City. Jonathan Morgenstern is Director of Preventive Services at the NYC Mission Society. Gabriel Sayegh is State Director of the New York Drug Policy Alliance. Michael Stoller is Executive Director of the Human Services Council of NYC.

If you are experiencing a difficult time in your life, always remember that you are not alone.
There is a caring and helpful mental health community nearby that can help you get through this difficulty.
Don't feel embarrassed or afraid to ask for help, it is not a sign of weakness.

Best Wishes from Mental Health News.

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conversations and help the students understand the manifestations of racism and how it maintains the status quo. Then they can stress the need for change, not just personal change, but social change.

Peter Beitchman: So are social change and social justice part of our agenda in addition to developing a therapeutic model that incorporates an understanding of racism?

Alan Siskind: Yes, mental health professionals have to understand social justice is an integral part the service we're providing. You have to introduce this to clinicians in a sophisticated way; you can't just say it's important. You have to demonstrate how clinically it has enormous import. Treatment can't take place without caring about the need for our clients to live in a just context. Injustice corrupts the very essence of self. This is true for those behave unjustly as well.

Kalima De Suze: I'm thinking about the social work Code of Ethics, how it demands self-determination, social justice, collective action. The Code insists we not only help the person we're working with,

but also challenge the systems and conditions that contribute to the client's condition in the first place. It's about challenging the root causes; no matter how much you help, if the conditions still exist, the clients and new clients are going to keep coming back!

Robert Abramovitz: When clinicians say social justice is not my issue to me that's a manifestation of how many ways people can hide and it's a way to split off in their own mind what's going on around them. Again, it's the trauma paradigm that helps understand that some of the worst adversities occur when the social contract is broken and nobody cares.

Alan Siskind: And what happens when the clinician doesn't stay with the "ouch" of the violation? How can there be any therapeutic repair if that violation is not addressed?

Kalima De Suze: In Judith Herman's trauma model, the last phase of healing and recovery is activism. Why can't part of our role as mental health professionals in helping our clients heal be referring them to advocacy organizations that are working for change in those areas that the client has been working on in the healing process?

Peter Beitchman: Peter, how would the social justice agenda play out in the Asian community?

Peter Yee: It's interesting; people will march and be active to advocate for children's services or senior services but not for mental health. Remember how in mental health the helping, especially for first generation immigrants, is so concrete. We can't even get a community advisory board formed to support mental health services. If you're a second generation Asian-American maybe you will begin to see the importance of social justice and advocacy. But there's a strong bias even in the new generation against political action and advocacy, given the experience in many of the Asian countries of origin where politics was so constricted. I hope that as new generations emerge—and in New York City we now have three Asian-American elected officials—that more of the community will be involved in advocacy.

Peter Beitchman: We've been talking about bringing systemic change to our own mental health agencies, and granted other systems need to change as well. But, can we possibly be effective in changing other systems as well?

Alan Siskind: It's more than a challenge. Take the social security system for example. I don't know in my lifetime if I'll have a chance to change it, but I can certainly care about and explore with my clients the problems they confront in that system. It's clinically important to care about these issues and understand them to actively engage our clients in addressing their life issues. I think it's also one of the ways to get to race issues more easily because it's right there in their lives.

Robert Abramovitz: It's true that when you see all of those intractable systems out there infused with racism it becomes a case of "the higher the consciousness the lower the morale." You can feel pretty overwhelmed and frustrated. But I agree our clients' experiences with other systems is also a chance to have the conversation with our clients so they understand that the way we work "in here" is not the way other people work in those other systems. The conversation gives you a frame of reference to be able to address the racism. In fact, it's not only an opportunity, it's also our responsibility.

Alan Siskind: Yes, it's an opportunity, responsibility and mission.

Anti-Racism Resources

BOOKS

INCITE! Women of Color Against Violence , "The Revolution Will Not Be Funded: Beyond the Non-Profit Industrial Complex", South End Press, 1-Mar-09

Gloria T. Hull, "But Some Of Us Are Brave: All the Women Are White, All the Blacks Are Men: Black Women's Studies", The Feminist Press at CUNY, 1-Jan-93

Nancy Denton, "American Apartheid: Segregation and the Making of the Underclass", Harvard University Press, 15-Jul-98

Frantz Fanon, "Black Skin, White Masks", Grove Press, 7-Jan-94

bell hooks "Killing Rage: Ending Racism", Holt Paperbacks, 15-Oct-96

Malcolm X, "Malcolm X Speaks: Selected Speeches and Statements", Grove Press, 11-Jan-94

Paulo Freire, "Pedagogy of the Oppressed", Continuum Press, Sep-00

Janet Helms, "A Race Is a Nice Thing to Have: A Guide to Being a White Person or Understanding the White Persons in Your Life", Content Communications, Jun-92

Audre Lorde, "Sister Outsider: Essays and Speeches", (Crossing Press Feminist Series) Crossing Press; 1st edition, Jun-84

Manning Marable, "The Great Wells of Democracy: The Meaning of Race in American Life", Basic Civitas Books, Nov-03

Jonathan Kozol, "2005, The Shame of the Nation: The Restoration of Apartheid Schooling in America", Three Rivers Press, Aug-06

Ira Katznelson, "When Affirmative Action Was White: An Untold History of Racial Inequality in Twentieth-Century America", W. W. Norton & Company, Aug-06

Paul Kivel, "You Call This Democracy?: Who Benefits, Who Pays, Who Really Decides", Apex Press; 2006

Meizhu Lui, Barbara Robles, Betsy Leondar-Wright, Rose Brewer, Rebecca Adamson, "The Color of Wealth: The Story Behind the U.S. Racial Wealth Divide", New Press, June 2006

Joseph Barndt, "Understanding and Dismantling Racism: The Twenty-first Century Challenge to White America", Fortress Press, Oct 2007

Elizabeth K. Gordon, "Triplet Boys, Their Teen Parents and Two White Women Who Tagged Along", Crandall, Dostie and Douglass Books, Inc., Roselle, New Jersey, 2007

Barbara Beckwith, "What Was I Thinking?", New York: St. Martin's Press, 2009

Robin Parker & Pamela Smith, "The Anti-Racist Cookbook", Crandall, Dostie & Douglas Books, Inc, 2005

Jeff Hitchcock, "Lifting the White Veil", Crandall, Dostie & Douglas Books, Inc, 2003

Micheal H. Cottman, "The Wreck of the Henrietta Marie: An African American's Spirtual Journey to Uncover a Sunken Slave Ship's Past", Crown, 1998

Edward Ball, "Slaves in the Family", Ballantine Books, 1998

Peter Mattiessen, "In the Spirit of Crazy Horse" Penguin Books, reprinted 1992

Shane DeRolf and Michael Letzig, "The Crayon Box that Talked", Random House, 1997

Mildred Taylor, "Roll of Thunder Hear My Cry", Puffin, 1991

Joseph Bruchac, "Navajo Long Walk: The Tragic Story of a Proud People's Forced March from their Homland", National Geographic Children's Books, 2001

Carmen Lomas Garza, "En Mi Familia/In my Family" Women & Therapy, Volume 33 issue 3 & 4 Routledge Press, 2010

Tim Wise "White Like Me: Reflections on Race from a Privileged Son" Soft Skull Press, December 2005

bell hooks "Belonging: A Culture of Place", Taylor and Francis, October 2004

Toni Morrison, "Playing in the Dark : Whiteness and the Literary Imagination", Harvard University Press, 1992

Inga Muscio, "Autobiography of a Blue-Eyed Devil: My Life and Times in a Racist, Imperialist Society", Seal Press (CA), April 2005

Robin D.G. Kelley, "Freedom Dreams: The Black Radical Imagination" Beacon Press, 2003

Tim Wise "Speaking Treason Fluently: Anti-Racist Reflections From an Angry White Male" Soft Skull Press, September 2008

Becky W. Thompson, "A Promise and a Way of Life: White Antiracist Activism", University of Minnesota Press, August 2001

bell hooks, "Where We Stand", Routledge, October 2000

Sandra Cisneros, "The House on Mango Street", Vintage, April 1991

Rodolfo Acuna, "Occupied America, A History of Chicanos", Pearson, 1987

Michelle Alexander, "The New Jim Crow: Mass Incarceration the Age of Colorblindness", The New Press, 2010

Theadore Allen, "Invention of the White Race", Verso Books, Vol.1-Vol.2, 1994

Herbert Aptheker, "Anti-Racism in the U.S. History", Praeger, 1993

Joseph Brandt, "Dismantling Racism:The Continuing Challenge to White America", Augsburg Fortress Press, 1991

Leron Bennett, "Before The Mayflower: A History of Black America, 25th Anniversary Edition" Peguin Press, 1961

Douglas Blackman, "Slavery by Another Name: The Re-Enslavement of Black Americans from the Civl War to World War II", Anchor Books, 2008

Eduardo Bonilla-Silva, "Racism without Racists: Color Blind Racism and the Persistence of Racial Inequality in the U.S.", Rowman & Littlefield, 2003

Ann Braden, "The Wall Between", University of Tennessee, 1999

Bonnie Crushing, "Accountability and White Anti-Racist Organzing", Crandall, Dostie & Douglass Books, 2010

Angela Davis, "Women, Race, and Class", Random House, 1981

Louise Derman-Sparks, Carole Branson Phillips, Asa G. Hillard III, "Teaching/Learning Anti-Racism: A Developmental Approach", Teachers College, 1997

W.E.B. DuBois, "The Souls of Black Folk", Pengin Books, 1989

John Hope Franklin, "From Slavery to Freedom: A History of African Americans", Vintage Press, 1961

Mindy Fullilove, "Root Shock: How Tearing Up City Neighborhoods Hurts America and What We Can Do About It", One World/Ballantine, 2005

Thomas Gossett, "Race: The History of an Idea in America", Pendulum Press, 1987

Janice Hale, "Learning While Black: Creating Educational Excellence for African Americans", Vintage Press, 1961

Leon A. Higginbotham Jr., "In The Matter of Color: Race and The American Legal Process: The Colonial Period", Oxford, 1980

bell hooks, "Ain't I a Women: Black Women and Feminisim", South End Press, 1981

Langston Hughes, "The Ways of White Folks", Vintage Books, 1990

Noel Ignatiev, "How the Irish Became White", Routledge, 1995

Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", Nation Press, 2002

Annette M. Jaimes, "The State of Native American Genocide, Colonization & Resistance", South End Press, 1992

Winthrop D. Jordan, "The White Man's Burden: Historical Origins of Racism in America", Oxford Press, 1974

Joe L. Kinchelow, "White Rein: Deploying Whiteness in America", St. Martin Press, 1998

Paul Kivel, "Uprooting Racism: How White People can Work for Racial Justice", New Society Publishers, 2002

Jonathan Kozol, "Savage Inequalities: Children in America Schools", Harper Collins, 1991

AUDIO/VIDEO

Library of Congress, Library of Congress: Original Slave Interviews, http://memory.loc.gov/ammem/collections/voices/

State of the Dream 2010: DRAINED, Jobless and Foreclosed in Communities of Color, http://www.faireconomy.org/files/SoD_2010_Drained_Report.pdf

State of the Dream 2009: The Silent Depression, http://www.faireconomy.org/dream, 2009

White's fare better in every indices of life, The Wealth Gap Gets Wider,http://www.antiracistalliance.com/The-Wealth-Gap-Gets-Wider.html

C-SPAN Racial Wealth Gap - C-Span interview with author Meizhu Lui, http://www.c-spanvideo.org/program/284774-9

Foreclosed: State of the Dream 2008: http://www.faireconomy.org/files/StateOfDream_01_16_08_Web.pdf

Sandy Bernabei, Undoing Racism? Everywhere, http://endthestructureofracism.ning.com/video/undoing-racism-everywhere

Sandy Bernabei, Angela Glover Blackwell on Race & America's Future by PolicyLink, http://endthestructureofracism.ning.com/video/angela-glover-blackwell-on

Sandy Bernabei, A Girl Like Me, White Doll Black Doll Experiment, http://endthestructureofracism.ning.com/video/a-girl-like-me-white-doll

Sandy Bernabei, 6 Rules for Allies, http://endthestructureofracism.ning.com/video/6-rules-for-allies

Sandy Bernabei, Blue Eyes Experiment, http://endthestructureofracism.ning.com/video/blue-eyes-experiment

Sandy Bernabei, Using a Racial Impact Statement, http://endthestructureofracism.ning.com/video/using-a-racial-impact

ARTICLES

Onaje Muid, "Moving from a needs analysis to a power analysis", http://tinyurl.com/29yejf2

Margery Freeman, People's Inst, "To white women who insist that addressing sexism must be part of your institution becoming ""antiracist."", http://tinyurl.com/29gct4m

Phyllis Frank, "Some Ideas We Learned from the Peoples Institute", http://tinyurl.com/2avr9tz

Margery Freeman, "How Do We Respond to the "Money and Time" Challenges in Undoing Racism?, http://tinyurl.com/2f62skl

Social Work, "Racism in Canadian Health Care", http://tinyurl.com/24xjsgp

Sandy Bernabei, "Guidelines for choosing trainers to address racism", http://tinyurl.com/2cs9xet

Sandy Bernabei, "Share your Undoing Racism Anecdotes", http://tinyurl.com/26cvpnr

Sandy Bernabei, "A Call to Schools of Social Work: Prepare the Profession to Undo Racism", http://tinyurl.com/2dgtyr6

Anonymous, "Ron Chisom, The People's Institute for Survival and Beyond, and Me",http://tinyurl.com/234y776

Anonymous, "What participants say about the workshop", http://tinyurl.com/27dd2k5

Sandy Bernabei, "A hero among us!", http://tinyurl.com/285f37m

Sandy Bernabei, "Tribute to the Trainers", http://tinyurl.com/2fm898u

Sandy Bernabei, "What to Expect from the Workshop, http://tinyurl.com/26lnr87

Sandy Bernabei, "Calling all Social Workers" , http://tinyurl.com/27hzp6j

Jeff Hitchcock M.S., M.B.A. and Charley Flint, Ph.D, "DecenteringWhitnes", www.antiracistalliance.com

Cooper Thompson, "White Men and the Denial of Racism", www.antiracistalliance.com

Judith Katz Ed.D., "White Culture and Racism", www.antiracistalliance.com

Jenifer R. Holladay M.S., "White Antiracist Activism", www.antiracistalliance.com

Peter Heinze, Ph.D., "Why White People Love White Supremacists", www.antiracistalliance.com

Diversity Conversation Flash Cards, "What Stands Between Us", www.antiracistalliance.com

Peter Beitchman, "The Impact of Race and Racism on the Profession", www.antiracistalliance.com

Andrea Harnett-Robinson, "Impact of Racism on Mental Health Outcomes—Focus on Disproportionality, Racial and Ethnic Disparities (Human, Fiscal, and Social Costs)", www.naswnyc.org/members/documents/April2007Currents.pdf

Mary Pender Greene, "Transforming Organizational and Administrative Structures", www.antiracistalliance.com/PISABNortheastRegion2007ANNUALREPORT.doc

Joe Adams, "Practioner Level- Impact of Racism on Counselor /Client relationships, Diagnosis, Treatment; the Continuing Eurocentric paradigm; Another Opportunity to Include Consumer Perspective", http://www.antiracistalliance.com/

Robert Hawkins, "Building A Race Conscious Research Agenda- Expanding the Theoretical Base for Race Conscious Program and Practice", http://www.antiracistalliance.com/

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