CC 3 Meet. 206

TRANSCRIPT OF PROCEEDINGS

UNITED STATES COMMISSION ON CIVIL RIGHTS
CONNECTICUT ADVISORY COMMITTEE

In the Matter of:)
)
FORUM ON ACCESS TO HEALTH\MENTAL)
HEALTH SERVICES FOR SOUTHEAST ASIAN)
REFUGEES AND IMMIGRANTS)

Pages: 1 through 123

Place: West Hartford, Connecticut

Date: March 30, 1989

HERITAGE REPORTING CORPORATION
Official Reporters
1220 L Street, N.W., Suite 600
Washington, D.C. 20005
(202) 628-4888

UNITED STATES COMMISSION ON CIVIL RIGHTS
CONNECTICUT ADVISORY COMMITTEE

In the Matter of:)
)
FORUM ON ACCESS TO HEALTH\MENTAL)
HEALTH SERVICES FOR SOUTHEAST ASIAN)
REFUGEES AND IMMIGRANTS)

University of Connecticut
Social Work Building, Room 207
1800 Asylum Avenue
West Hartford, Connecticut 06117

Thursday,
March 30, 1989

The above-entitled matter came on for hearing, pursuant to notice, at 1:00 p.m.

BEFORE: JAMES H. STEWART, Chairman
Connecticut Advisory Committee
U.S. Commission on Civil Rights

APPEARANCES:

Members of the Committee Present:

MR. LUIS R. DIAZ
DR. IVOR J. ECHOLS
MR. SIDNEY LAIBSON
MR. WILLIAM E. MCCLANE
MS. LE LIEN SMITH
DR. LOU BERTHA MCKENZIE WHARTON

U.S. Commission on Civil Rights:

COMMISSIONER SHERWIN T.S. CHAN

Panel A:

HOUMPHENG PHENGSOMPHONE, President,
Connecticut Federation of Refugees

APPEARANCES: (Continued)

Panel A: (continued)

THEANVY KUOCH, Therapist
CAROL BERTO
Khmer Health Advocates

SAMUEL E. DEIBLER, JR.,
Executive Director
Association of Religious Communities

PATRICK JOHNSON, Executive Director
Catholic Charities Migration and Refugee Services

Panel B:

ELLIOT A. GINSBERG, Commissioner
Connecticut Office of Refugee Resettlement
Connecticut Department of Human Resources

GEORGE RAISELIS, Director
Refugee Health Program
Connecticut Department of Health Services

JOHN CAVANAUGH, Administrator
Connecticut Department of Mental Health

WALTER PAWELKIEWICZ,
Executive Assistant to the Commissioner
Connecticut Department of Children and Youth Services

CAROLINE J. CHANG, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services

C O N T E N T S

P R O C E E D I N G S

MR. STEWART: Good afternoon, ladies and gentlemen. My name is James H. Stewart. And I'm the Chairman of the Connecticut Advisory Committee to the United States Commission on Civil Rights. All such State Advisory Committees around the country consist of eleven members.

The Connecticut Advisory Committee members who are present include:

MR. MCCLANE: William McClane.

MR. DIAZ: Luis Diaz.

MS. SMITH: Le Smith.

DR. ECHOLS: Ivor Echols.

MR. LAIBSON: Sid Laibson.

DR. WHARTON: Lou Bertha McKenzie Wharton.

MR. STEWART: We obviously have a few members who are not present.

In addition, we are honored to have with us today Commissioner Sherwin T. S. Chan, one of the eight Commissioners on the U.S. Commission on Civil Rights. Commissioner Chan is also the first Commissioner in the 32-year life of the Agency to be an Asian-American.

During our morning session, Commissioner Chan told us of his plans to develop a series of round table discussions on civil rights issues affecting Asian-American communities around the United States. It was this interest

that prompted Commissioner Chan to fly from California to be with us today.

Perhaps Commissioner Chan would want to add a few more details about the status of the plans for the round table discussions.

COMMISSIONER CHAN: Thank you, Mr. Chairman. Distinguished panelists, fellow members of the staff, ladies and gentlemen: Apparently, I'm the new kid on the block. But however that's not the reason I'm coming here. I have a regional interest on the Southeast Asian Refugees health and mental health problems because dating back to 1975, I was one of the ones conducting one of the voluntary agencies to resettle Vietnamese refugees at Camp Pendleton and Indian Town Gap in Pennsylvania. So 13 years ago, I was dealing with the refugees.

Now, of course, after they get out of the camp, I never called them refugees. I called them fellow countrymen. You know, for refugees, after they suffer from the war, when they come over here, immediately they're facing the culture shock. They don't speak the same language and everybody, you know, they saw, they cannot communicate. And they also received environmental shock. They don't even know how to get to the bus. And when they get to the bus, they found they can get free transfer tickets which they never had in Vietnam, , you know.

And then they said, well, some people want to go to -- that was in Los Angeles -- they want to go to San Francisco to visit somebody. He said, do I need any paper work, you know. Those are the culture shock.

But, anyway, I know the most important thing is the health and the mental health especially. That's the reason I came over here. And also if you've probably seen the Asian's economic status report which is the first report from the Civil Rights Commission concerning the Asian problems. However, I found the Asian economical is not the only problem for Asians, because there are many discriminations.

To mention a few, you know, the education discrimination, housing, jobs and promotions, and the religious and social. And all these are one of the few problems. And that's why last month I had the Civil Rights Commission's approval to conduct three Asian Civil Rights round table conferences to be held in Houston, New York, and San Francisco, mostly in the third week of May in Houston, third week of June in New York City, and the third week of July in San Francisco.

Now, the purpose of these three Asian civil rights conferences is to hear the civil rights leaders' concern about Asian civil rights discrimination problems and issues. And then we'll summarize all these problem areas possibly in

October of this year in Washington D.C., and we'll have a forum on the Asian civil rights. Now, hopefully, we can select some of the most critical problems so we can have a forum similar to what you're going to have today, inviting government officials, civil rights leaders and the ones who suffer, to testify for us.

So that's the purpose. And I may say, ladies and gentlemen, if you are interested in that area, please contact Dr. Cunningham at the U.S. Civil Rights Commission in Washington, D.C., 1121 Vermont Avenue. Dr. Cunningham, 1121 Vermont Avenue -- and let me get the zip code -- 1121 Vermont Avenue, Northwest, Washington, D.C. 20425. And he will send you an application.

Now, I don't know how influential of our people but you have an equal chance to say something, express yourself, unless we're over crowded, and then we'll have to select the most important people to make the speeches.

Thank you.

MR. STEWART: Thank you, Commissioner Chan.

This afternoon's session consists of a forum focusing on the health and mental health needs of Southeast Asian refugees and immigrants, and more specifically on their access to health and mental health services in Connecticut. The topic was selected by the Committee last year after our colleague, Lien Smith of North Haven,

encouraged us to review the question of access.

To assist us, we have invited eleven panelists. As indicated on the agenda, and other guests to apprise us of the health and or mental health needs of Southeast Asians and to what extent such needs are generally being met. Where needs appear not to be met, we are hoping that our panelists and guests can identify what barriers may stand in the way of needed services and what might be done to overcome any such barriers.

In our brief survey of the literature, we have become familiar with some writings on the subject which have been published in the Global Refugee Problem, U.S. and World Response. The May 1983 issue of the Annals of the American Academy of Political and Social Science and in the special issue on Migration and Health, the Fall, 1987 edition of the Quarterly International Migration Review, published by the Center for Migration Studies in New York City.

However, the papers contained in these documents are national in scope or do not focus on the situation in the State of Connecticut. Consequently, we are grateful for the cooperation of today's panelists and guests. Our panelists were informed in the invitation sent to them that the information which they provide is given voluntarily. The proceedings are being transcribed and the transcript will be maintained in the offices of our staff in

Washington, D.C., in accordance with the Privacy Act.

For access to the information you share with us, you may contact the Office of the Solicitor at the Commission at the address shown on the Agenda.

Federal law also requires us to request that all persons avoid or refrain from degrading or defaming any other individuals when providing information. At the same time, persons presenting information to us have the right by law not to be reported or photographed by the media. If you wish to exercise this right, please let a Committee member or our staff know so that your request can be accommodated.

Having stated those requirements, let me welcome our guests, and call for the first panel to begin.

We have two panels, one representing the members of the community and one representing various governmental agencies. Each of the panelists have been told and should be reminded here that the remarks should be kept to ten minutes. And the Committee has decided it will be best to hear all the panelists from both groups prior to opening up the questioning on the part of the Committee.

The first panel members: Mr. Phengsomphone? Is he here?

Ms. Kuoch? Would you please come up here and sit at this table.

Carol Berto?

Samuel Deibler?

And taking the place of Sister Dorothy Strelchun is Patrick Johnson.

Have you determined an order of presenting?

STATEMENT OF MR. HOUMPHENG PHENGSOMPHONE, PRESIDENT, CONNECTICUT FEDERATION OF REFUGEES

MR. PHENGSOMPHONE: Good afternoon, ladies and gentlemen.

On behalf of the Connecticut Federation of Refugees Assistance Association, I would like to take this opportunity to introduce myself. My name is Houmpheng Phengsomphone. And I am the President of the Connecticut Federation of Refugees in Connecticut.

I would like to share with you a brief history of the Federation. The Connecticut Federation of Refugees is a new Refugees organization in Connecticut founded in June, 1987, funded by the Federal Office of Refugees through the State of Connecticut, Department of Human Resources. It provides social and employment services to the refugees in Connecticut.

CFRAA currently combines with four cultures: Cambodian, Laotian, Muong and Vietnamese. Prior to the founding of the Connecticut Federation, each ethnic group had their own mutual assistance association to provide for the needs of the refugees in Connecticut. There are approximately 8,000 Southeast Asian refugees in Connecticut. Most of them are resettled by voluntary agencies, relatives, and some of them are second migrations, moved from different states to Connecticut for family reunion or job ties.

The majority of the concentration of Cambodians are resettled in Danbury, the Laotian are in Bridgeport, and the Muong in the Eastern and Northern Connecticut, and the Vietnamese are in Hartford. The welfare dependency and unemployment rates of refugees in Connecticut are low. They are very productive new citizens. And it's good to have them resettle in Connecticut.

The unique experience of the Southeast Asian refugees prior to coming to the United States, the trauma of communist terror, after the Vietnam war ended in 1975, the Americans completely withdrew from Southeast Asia. The communists took over. When the communists took over, many of the Southeast Asian family members were taken away to re-education camps or execution without trial.

The Southeast Asians became refugee deferred from their war torn country, many of them experienced communist brutality and mass family executions. They are survivors, these people. When they escaped from the communists, they did not know where to go, just hoped to survive. After they survived from the communists, they waited years and years in refugee camps with a half life, waiting for a third country to accept them for resettlement.

The primary reason they are here is to raise their children in safety and to live in freedom. Prior to coming to the United States, they had little preparation in the

refugee camps about American culture. They speak little English and have some knowledge of America when they arrived here. Many of them have encountered problems such as social culture adaptation, past experience of war and frustration, barriers to access.

There is no professional who understands the social and cultural backgrounds of Southeast Asians who can provide effective services to these people. Southeast Asian refugees have encountered the same type of discrimination and insensitivity and ignorance of the culture that other ethnic groups of refugees have faced, especially in health and mental health services.

I wonder how a doctor can cure a patient with mental illness without knowing his or her social cultural background. The majority of Southeast Asians are Buddhists. It's difficult to assimilate to a new culture. Some Southeast Asians have committed suicide. Some of them are in a mental institution.

These kind of people are looking for help.

For the conclusion of my speech, I would like to ask you as a friend, as a person who loves justice to think that these people are here to stay and they are going to be American citizens like you are, very productive American citizens. I ask you to help them to get the help they need to the effective services that they need.

Ladies and gentlemen, thank you very much.

MR. STEWART: Thank you, sir.

STATEMENT OF MS. THEANVY KUOCH, THERAPIST, KHMER HEALTH ADVOCATES

MS. KUOCH: Good afternoon, ladies and gentlemen. My name is Theanvy Kuoch, and I am a Cambodian survivor of the Pol Pot regime and a family therapist. I am here today to tell you about the great need my people have for mental health services.

The story of Cambodian refugees is a very tragic one. In 1970, Cambodia was a stable nation of at least seven million people. From 1970 to the present time, at least one-third and possibly as many as one-half of the Cambodian people have perished as a result of war, disease, starvation, and political terror. Ninety percent of the Cambodian refugee population meets the United Nations definition of torture and victims. Cambodians entered the United States with only a few possessions and almost none of their traditional resources for comfort and healing.

The elders of the community have been almost thoroughly destroyed. Few Buddhist temples exist and traditional healers have no access to traditional herbs and medicines. In addition to psychological trauma, Cambodian refugees came with an extraordinary number of physical problems such as t.b., cholera, malaria, parasites and hepatitis. Cambodians are already showing a high incidence of liver cancer and eye disorders which are a result of

chronic malnutrition.

In 1982, Khmer Health Advocates was formed to address some of the complicated health and mental health problems of the Cambodian refugees. In the early days, it was our goal to help Cambodians into mainstream health and mental health services. However, it soon became clear that it was an impossible task because of the relatively small refugee population in the State, health care providers had little background and understanding of the Southeast Asians and almost no idea of the differences in their culture and experiences. They also felt that it was not their responsibility to train or employ translators.

Today, Khmer Health Advocates provides direct mental health services for at least over 40 Cambodian families. We are in contact with other mental health providers who specialize in working with Cambodian survivors and are extensively reviewing the research about Cambodian mental health problems.

We find that the Cambodian community in Connecticut is experiencing a kind of mental health problems consistent with other areas of the country. Studies show that about 20 percent of adult Cambodians have serious symptoms of depression and another 16 percent have symptoms of post-traumatic stress disorders.

How do Cambodians cope with these problems?

Depression and PTSD are a major cause of domestic problems. Family violence and child abuse are increasing in Cambodian families. Likewise, there is an alarming increase in alcohol and drug abuse. Very often the drug abuse comes from Chinatown black market and include intravenal, amphetamines and antibutide which are not only dangerous but extremely costly for a family that is just making enough to get by.

Social problems such as gambling and compulsive shopping are often the avoidance mechanism of post-traumatic stress disorder. It is a well known fact that PTSD causes problems with intimacy and family, and this is evidenced in increased child sexual abuse and family abandonment.

These are all serious problems that threaten the existence of the Cambodian families. Here in Connecticut, Cambodians are now receiving appropriate treatment because of language and cultural barriers. Complex medical and psychological problems are often treated on the basis of a translation by a translator who has no training in medical or psychological terms.

Cultural beliefs are also often translated on a purely personal basis.

I would like to tell you about some of the individual problems we have seen.

A Cambodian woman was admitted to the hospital

after threatening to kill herself. Her first husband and seven children were killed during the Pol Pot regime. And she was also the victim of torture and multiple rapes. She was kept only a short time because she could not communicate and was told that she could not have long term therapy at a local Federally-funded clinic, because therapists refused to work through a translator. She was admitted again several months later after she stabbed her husband.

A father was excluded from the treatment plan of a psychotic daughter because he believed that she had spirit problems. The translator who was ashamed of this belief refused to translate the father's concern that the spirit must consult before his daughter received medication. She was given a large dose of a tranquilizer which made her drool and unable to sit still. He signed her out of the hospital and was reported to the Department of Welfare for child neglect. He later moved out of the State.

In recent years, research has been done on the long term effects of the holocaust. Torture centers have opened in the U.S. and in Europe which now offer insight into the needs of torture victims. It has been clearly stated that these victims do not spontaneously recover from their injury. The long term effects can be measured in terms of illness and family dysfunction. These are factors that cannot be morally or economically ignored.

At Khmer Health Advocates, we have identified specific actions that can help prevent long term problems. These are the education and employment of bilingual health interpreters in regional hospitals and clinics where refugees can be referred.

The education and employment of paraprofessionals who can identify symptoms of depression and PTSD and can offer health education and referral.

The development of a regional center where health care professionals are dedicated to deal with refugees and torture experiences.

The education and development of community leaders who can work with high risk groups in the community in a self-help capacity. These high risk groups include adolescents, widows, and elderly.

In closing, I would like to remind you that refugees are not immigrants. They are different. They did not come to the United States seeking a better life. They came to escape war, torture and famine. They have lost all their personal property and much if not most of their families. We ask that in the name of fairness and compassion, the refugee be given access to culturally appropriate service and a system to which they can be comfortable.

Thank you very much.

MR. STEWART: Thank you, Ms. Kuoch.

Ms. Berto?

STATEMENT OF MS. CAROL BERTO, VOLUNTEER, KHMER HEALTH ADVOCATES

MS. BERTO: My name is Carol Berto, and I have resettled refugees since 1985 and I've also been a volunteer with Khmer Health Advocates because that's the first thing any refugee needs is some mental health care.

Refugees have endured war and systematic destruction of their society and for many of themselves as individuals through torture. Ms. Kuoch and Mr. Phengsomphone spoke about this pain that I also see. And if untreated, this pain goes down the generations as the Jewish holocaust research has shown.

But who can provide services in this State? As you have heard, not mainstream clinics and institutions. Not only are there language and cultural barriers, especially to self-referral, but mainstream professionals just don't know about torture. They might know about a mid-life crisis or maybe a little child abuse, but they don't know major torture. They misdiagnose. They give people the wrong drugs, or they shut them away. There have been two Vietnamese women in this State who have been shut away in an institution for eight years with no therapy, just drugs, just to keep them quiet.

Refugees need clinics of trained para-professionals working as a team with trained bicultural

paraprofessionals. This model has proven effective and is employed widely in other states. Massachusetts and Rhode Island have wonderful programs.

This month Khmer Health Advocates did a state-wide telephone survey of 36 mental health clinics. Of 14 who cared to respond, eight clinics served some Southeast Asians. None provided translators but depended upon the client to bring a relative or a friend. If the patient didn't have a relative or a friend, only one clinic used the service of a local university. Two others called a local refugee association which I assume probably was the Federation. And the Federation doesn't have people trained in mental health interpretation.

Only Khmer Health Advocates offers the kind of bicultural long term therapy that can help these people. Although we are a mutual assistance association, we receive no Federal or State funding because we don't fit the ORR guidelines for designated services.

I'd like to tell you a little bit about the structure in which refugees are allowed into this country in the refugee program. The Office of Refugee Resettlement directs the nationwide program of refugee services. They partially fund voluntary agencies known affectionately as "Vol-Ags" who provide case management and find sponsors.

Contracted services are focused on physical

resettlement: housing and jobs and schooling. The Federal Government also sponsors mutual assistance associations which are community organizations of refugees. Our four Southeast Asian Associations were merged into the Federation in 1987. And their responsibilities are, in addition to community building, the provision of social services for refugees after Vol Ag involvement ends, which is currently at 12 months. (In 12 months, very damaged people are expected to be on their own and totally self-sufficient.)

They also are expected to provide interpreter services. Now, their interpreters are very dedicated people but they don't have the training in mental health or medical or legal areas. Yet, they're called constantly and a lot of times, they're called at night, any time. And if they cannot go, they're screamed at. And there is only one ethnic worker that covers the whole state. There is one Cambodian worker, one Vietnamese worker, one Lao and one Muong. And they have to cover the whole State all of the time. In addition to that, their funding is often erratic and lately they were not paid for three months. This is very demoralizing for an already overstretched staff.

A minor problem is that nobody really knows how many refugees there are in this State. We know about primary entrants that come straight over, but we don't keep track of the babies they have; we don't keep track of

secondary migrants who come to Connecticut because there's jobs here. And plenty come from Texas and from California. And they need services, too, but their heads aren't counted, so nobody's paid to provide them services. And it's not that people like to turn them away.

In this, you'll see that the Federal Government basically funds a lot of social services except mental health in this State. In fact, they only have 12 areas around the country where they do seem to provide this. Years of research show that mental health is a major problem in any Southeast Asian community. And yet, the Office of Refugee Resettlement provides mental health funding only to a few States while job training is made available nationwide.

In Connecticut, we have jobs for unskilled people. They get paid well. Higher level jobs do require training but training requires that you know English. So a refugee with mental health problems is parked in an English class where it's nice and quiet. And do you know what happens? he starts thinking back. He starts getting flashbacks. He starts remembering all the bad things and he doesn't really concentrate on English. He needs mental health services as much as he needs English; maybe more.

If the Federal Government has to rob Peter to pay Paul, I'd rather them put money into mental health than into

job training.

Now, at the State level, the Department of Human Resources is the one who is the ORR designate in the area that funnels the money. And that's what they do; they funnel the money. They have never appointed a head of the Refugee Program in Connecticut who is anyone who's professionally concerned, has enough authority to advocate for the refugees in this State. It's been a very passive program and it's unfortunate because there were mental health funds from the Feds that we didn't get. And there are other opportunities that are continually passed up because there's no advocacy.

DHR funds ORR funds. They chair a monthly meeting of Vol-Ags and other agencies that work with refugees. And that's good because at least we all get to talk about our problems.

There have been previous attempts to get mental health in this State, a couple of them. And they were presented to ORR and not funded. In the Spring of '87, many attendees of the monthly DHR meeting decided to act now because the problem is really terrible. So we formed the Refugee Mental Health Task Force, a separate group, unfunded by anybody. We wrote to the Governor asking that a representative from the Department of Mental Health attend our meetings. We wrote a proposal to the Department of

Mental Health for a refugee mental health clinic in July of '88, but unfortunately, DMH said we'd presented it too late.

So we spent a year educating about refugees and their needs amongst all kinds of citizen action councils and the five regions of the Department of Mental Health. We traveled all around the State and spent a great deal of time and got nowhere because the refugees are basically an invisible population to many. They don't walk into mental health clinics so people kept saying, what are you talking about? I don't see the need.

So we finally decided to ask for a clinic option for the budget this year written from DMH central in Hartford because, like the hearing impaired, the refugee population is just not concentrated in one area where a lot of people would care; it's spread all over the State. DMH first responded with a one-day seminar in March of last year on refugee mental health. And they brought in outside speakers from Massachusetts clinics. And it was attended by a variety of policy makers and workers and it was very good.

DMH also agreed to hire interpreters, and they did. But the frequency and quality of interpretation are totally uncontrolled. The basic refugee out-patient clinic budget option for fiscal year '90 budget and it almost got there. This option doesn't include outreach workers who would refer, follow-up, and build trust in the communities.

It's very basic. It only includes one therapy team for each ethnic group and costs about $450,000 including all those little fringe benefit things.

And DCYS wrote a related option for children because child abuse is a big part of PTSD. These options were among the new programs cut from the State's budget but they might reappear in the final budget. Task force representatives advocated at a public hearing before the legislature.

We wrote and distributed the brochure called "Making the Transition: Southeast Asians in Connecticut," which the panel has a copy of. And we've invited people here because we feel that this is a terribly timely forum. The finished budget for the State is going to come out at the end of April and we were hoping legislators would care enough to be here and learn more about it.

It's unfortunate that the Federal priority with job training rather than mental health is in effect, and it's unfortunate that there is not more active advocacy in the State at the right level for refugees. Because the State and Federal Governments must act because the problem is going to get worse.

Refugees deserve access to the services they pay taxes to help support. What more can we do to gain recognition of this need?

Thank you.

MR. STEWART: Thank you, Ms. Berto.

Mr. Deibler?

STATEMENT OF SAMUEL E. DEIBLER, JR., EXECUTIVE DIRECTOR, ASSOCIATION OF RELIGIOUS COMMUNITIES

MR. DEIBLER: Good afternoon ladies and gentlemen. My name is Sam Deibler. I'm the Executive Director of the Association of Religious Communities in Danbury, and I'm responsible for the Danbury Resettlement Center which is a social service center responsible for what is called client-oriented coordination of services for Southeast Asian refugees living in our community.

Since I'm a direct service provider, I felt that it was my part of the responsibility this afternoon to give you a firsthand view of some of the community-based issues that infringe on the ability of the Southeast Asian refugees to find a comfortable place in our society. And I'm going to comment about a number of areas. And these are areas that in your capacities I'm sure you have encountered with all minority groups in our country, but this is something which I think needs special underlining in terms of the Southeast Asians.

In terms of health services, the Danbury Hospital, the Health Department of the City of Danbury, the various clinics and the private non-profit agencies in our community are all concerned about the needs of Southeast Asians. We have a very active WIC program that's part of the health department in the City. We have very active health clinics

that do a great deal in the Danbury Hospital in terms of extending care to Southeast Asians, and they've been very successful.

I think the bellwether of their success has been that Southeast Asians, themselves, refer new arrivals, new secondary migrants who don't have their own sponsors, to the health care clinics when they first arrive in the community. Perhaps the best measure of success as far as that is concerned is that I think it's fair to say that Southeast Asians suffer from the same things anyone else suffers from. They have to wait 20 minutes or 30 minutes to see a doctor in the clinic. They undergo the same privations and the same problems: no more and no less.

In the area of education and training, we have a little bit more of a spotted record. Early on, refugees came to our part of the country because they recognized the success that our regional technical school was having under the old CEDR program and now under the JTPA program in providing job training services.

The public school system also did a very good job, especially at the elementary level, in providing good English-as-a-second-language programs for young children. However, when you get to the secondary school level, things begin to change.

The Danbury high school has not had a good record

in being able to provide good services. In fact, in 1981, the Danbury high school decided to stop admitting for enrollment Southeast Asians who were 18, 19 and 20 years old, saying that since they would not probably be graduating anyway, it was not of any use to them to enter the school in the first place. So they were sent instead to a ten-hour a week adult education English-as-a-second-language program. I don't have to tell you that there's a great difference between a ten-hour English ESL program and a full school week.

And at that time, our agency was involved in contacting the school system and raising the question as to whether or not it was legal to exclude from enrollment these students. And we found that indeed it was illegal and the school system's equal opportunities officer did so inform the administrators and that practice was stopped. I have in the file I will give to you a copy of a letter that indicates that indeed those students should have been enrolled, and secondly, that the students were not enrolled in violation of the law.

I wish I could tell you that that was the end of the matter. This fall in the autumn of 1988, that same policy was put back into effect by the same administrators who were there in 1981 who were told at that time, in 1981, that it was illegal. Now, I don't know the reason that

those administrators tried to promulgate that same policy. I've been told by some teachers that it was to save money so that new classes in ESL and bilingual education would not have to be opened. I was told by others that perhaps they forgot. I haven't forgotten and I'm sure many of you would not have forgotten if there were such an incident in your own lives.

In any event, we find ourselves with a situation where students in the school have a sense that perhaps they're not as welcome as other students may be. And that is of great concern to me because I believe equal access to education has a great deal to do with a sense of welcome and a sense of belonging to a school system.

The employment picture is also spotty. People came to our area in great numbers. In fact, two-thirds of our refugee population of about 1300 are unsponsored secondary migrants. A great percentage of them came because there was a good job market in Danbury, even during the worst of the recession back in the early 80s. People came because there were good entry level job opportunities, and especially with the job training that was available through Henry Ebbett Tech. People knew that they could get jobs.

Well, the local economy has begun to slow down. We've lost 2,000 jobs in the manufacturing area in the last seven years. We've more than replaced them with service

level jobs but you all know that service level jobs carry fewer benefits, have no overtime opportunities, rely on many part time positions, and are more likely to be dead end jobs. And that's what our refugee entry level employees are now facing.

Housing is a terribly critical issue. We have in our community an anomalous situation in that we have one landlord who is the major landlord for the low income private market tenants in the community. He owns about 900 units, second only to the Danbury Housing Authority in the total number of apartments available for low income residents. This landlord has not operated his business in the most agreeable manner. He has had a number of complaints of violations well in excess of what would ordinarily be expected of any landlord operating.

I also have in this file that I will give to you copies of a newspaper article from 1982 involving an assault on a Southeast Asian tenant. This was one assault where the tenant was willing to complain to the police department. We had a number of other incidents where tenants were simply not willing to allow us to call the police and to create a complaint because they were afraid that they would be discriminated against in housing or denied access to housing in the future. The tenant whose case was mentioned in this newspaper article was facing, was willing to go to the trial

and to testify, but the landlord's lawyer was able to get three continuances. And by the time the fourth continuance was due, the tenant had left town. This was a tenant who had no money of his own but suddenly was able to show up in Louisiana and buy interest in a fishing boat. He left town, according to the testimony we had from friends of his, because he was concerned about the future of his family.

In 1983, our agency entered a class action lawsuit against this landlord because he stopped providing heat to hundreds of the apartments. In 1985, we received a stipulated judgment from the Courts requiring that the heat and essential services be turned on, and the courts continued to monitor the provision of those services, because this landlord has shown, and his heirs now that he has died, have shown less than full regard for the health, housing and occupancy codes that require that essential services be provided.

We also have in here a letter from the Health Department in regard to a complaint we issued about spraying for roaches. Unlicensed exterminators were hired and I was personally in an apartment one day when a sprayer showed up, a man who gave no evidence of having any training, did not allow people an opportunity to put their food away, and simply sprayed the kitchen from top to bottom while there was food out on the tables. He sprayed the living room from

top to bottom, not allowing the children's toys, plush toys to be put away, and they all received a dosage of the spray.

These are the circumstances in which the Southeast Asians are living on a daily basis. The mental health needs of these people are exacerbated, as we've heard before. They've had terrible conditions in their home countries, and in the camps. Now that they're here, the conditions that they find here are marginally better but not by much. The mental health needs are not being addressed because mental health service providers tell me that people are not showing up in the clinics.

And it doesn't mean that they're not needed; it means that they're not making use of those services. Culture and tradition may play some role in this. Western style services are not recognized as being the kinds of places that you go to get your needs taken care of. You may go to a western service to get your financial support or to get your job training or to get your heat, but you sure don't bare your soul to people that you don't recognize.

Traditional religious supports are only now beginning to be developed. There's one Cambodian temple in the State; that's in Danbury because of the large population there. But that's a long way from Hartford and Bridgeport and New London where other Cambodians have to travel.

Service providers, as Mrs. Berto mentioned, are

largely ignorant of the experiences of refugees. And a common response by a staff person on hearing pieces of the stories of Cambodian survivors is usually something on the order of, oh, my God, this is overwhelming; I didn't know. And they are not prepared to proceed.

Although refugees are rapidly developing English proficiency, they don't have enough proficiency and will not in the near future, if at all, to be able to take advantage of regular talking therapy involved in what most mental health services provide. Translators are not a viable means by which to conduct this therapy and contact with helping professionals in their own language should be a requirement.

We have a large invisible population in regard to mental health services. The fact that they are not showing up at agencies does not mean that they do not need those services. It means that those services are not provided in a way that allows those people who need them to show up and take advantage of them. And I would encourage this advisory committee to do what it can to underscore the needs of this particular population in regard to these kinds of services.

Thank you.

MR. STEWART: Thank you, Mr. Deibler.

Mr. Johnson?

STATEMENT OF PATRICK JOHNSON, EXECUTIVE DIRECTOR, CATHOLIC CHARITIES AND CATHOLIC FAMILY SERVICES IN THE ARCHDIOCESE OF HARTFORD

MR. JOHNSON: My name is Patrick Johnson. I'm Director of Catholic Charities and Catholic Family Services in the Archdiocese of Hartford. I'm here this afternoon as a poor substitute for Sister Dorothy Strelchun who administers our migration and refugee service program. She regrets her inability to attend due to her mother's recent illness.

Mr. Stewart, Commissioner Chan, and other members of the Committee, on January 17, 1989, five Southeast Asian children were gunned down and killed while playing in their school yard in Stockton, California. That tragic incident has brought the killing fields here.

Two months later, our President suspended the importation of semi-automatic assault weapons, and here in Connecticut, Colt Firearms has halted the sale of such firearms to the general public. This was indeed fast action. We just wonder what it will take to provide fast action on the necessary resources to deal with the critical issue of mental health care for our Southeast Asian residents here in Connecticut.

Catholic Charities Migration And Refugee Services is one of three voluntary agencies who resettle Southeast

Asian refugees throughout the State. Since 1975, Catholic Charities Migration and Refugee Services has resettled over 4,700 Southeast Asians; Episcopal Social Services over 850; and the International Institute from 2500 to 3000 Southeast Asian refugees. An estimated 15 to 20 percent of these are indeed in need of some form of mental health care. I have attached a list of over 40 case examples which I have made available to the Committee.

Our agencies are funded through the Office of Refugee Resettlement to provide reception and placement services during the first 30 days after their arrival. And we also provide support for a strong case management system which, together with our employment service, is funded through a grant from the Department of Human Resources here in Connecticut. And we're grateful to Commissioner Ginsberg and his fine staff for that support.

The efforts of these programs have resulted in a very low welfare dependency rate here in Connecticut, one of the lowest in the nation. Our bilingual and bicultural staffs are trained in all aspects in resettlement; they are not mental health counselors or therapists. Yet, frequently, they encounter refugees of all ages who are in need of mental health care. Yes, referrals are made, but to date, workers and patients have experienced mental health staff who were unable to speak their language or understand

their culture.

Yes, refugees are hospitalized and maintained with medication; refugees are institutionalized, sometimes for years without adequate treatment programs. As recently as three weeks ago, one of our clients, a young 18-year-old Vietnamese woman committed suicide. We have had five such suicides in the past two years in the Catholic Charities Program alone.

The crisis situations are numerous and it is usually the resettlement agency or mutual assistance association who receives a telephone call for help from the hospitals across Connecticut. Our workers are not trained psychiatric interpreters and most mainstream mental health clinicians have little experience or understanding of the multifaceted cultural differences and their implications for assessment and treatment.

References to natural phenomenon as described by some Southeast Asian people are often misinterpreted and do not translate well, thus common dreams can become hallucinations and descriptions in spiritual terms of animistic beliefs are too easily interpreted as psychotic ideation. Today, the focus is on mental health care for Southeast Asians.

As a director of a refugee resettlement program, I also must speak on behalf of Polish, Hungarian, Romanian,

Afghan, Ethiopian and others who also require trained interpreters and culturally sensitive clinicians.

We are particularly concerned now about the Amerasians who will begin arriving during this coming summer. A great percentage of this high risk population will be in need of mental health care. Our agencies are also finding that the more recent arrivals who have spent years in the refugee camps and re-education camps have need of mental health care soon after arrival.

The care that they need is not available here in the State of Connecticut at this time. Over the years, efforts were made and proposals were submitted requesting adequate funding for the needed services. Connecticut has not provided for the bilingual bicultural training of paraprofessionals who could work side by side with clinicians or therapists.

We all know the impact of the Vietnam war on our own GIs; the depression, flashbacks, post-traumatic stress and other more serious symptoms afflicting so many of them. The natives of Vietnam, Cambodia, Laos and Thailand who've arrived here often display similar symptoms for similar reasons. The dramatic success of so many Southeast Asians in our academic settings often mask the equally dramatic failures.

For an excellent portrayal of the experiences of

many of our refugees, I refer you to the film "The Killing Fields" or the recent biography of its primary actor, Haing Ngor, entitled "Journey to Freedom, A Cambodian Odyssey." The trauma, the genocide, the unspeakable terror and barbarism, the holocaust experienced by so many of our refugees seems well beyond the limits of human tolerance and endurance. In fact, it is. And the psychic and physical scars are omnipresent.

People may leave the killing fields but the killing fields will never leave the people who survived. I reflect often on the boat people with the wind adrift, so fragile, so vulnerable and so courageous. We have all read of the traumas they endured to come here and we laud their success. But some are in desperate need of help now.

The Australian poet, David Martin, captured it best, perhaps, when he said that:

> "Emigres are proud people. The further they travel, the harder they dream, till their dreaming bitters the sun, and the world grows embarrassed. Quixote at least dared a windmill, but who will pity the strangers who dare the wind."

We ask you today to have pity on these strangers, these new Americans and support their need for culturally sensitive mental health services.

Thank you very much.

MR. STEWART: Thank you, sir.

I hope you'll stay in attendance because we'll have some questions, later.

Panel B. The Honorable Elliot Ginsberg, Commissioner of the Department of Human Resources.

Mr. John Cavanaugh, Connecticut Department of Mental Health.

Mr. Walter Pawelkiewicz, Connecticut Department of Children and Youth Services.

Caroline Chang, Regional Manager of the Department of Health and Human Services, Office of Civil Rights.

STATEMENT OF HON. ELLIOT A. GINSBERG, COMMISSIONER, CONNECTICUT OFFICE OF REFUGEE RESETTLEMENT, CONNECTICUT DEPARTMENT OF HUMAN RESOURCES

MR. GINSBERG: Members of the panel, my name is Elliot Ginsberg. I'm the Commissioner of the State Department of Human Resources of the State of Connecticut. It's a pleasure to be here and it's a pleasure to have the distinguished guests before us today for really the need to discuss a very very important issue.

As members of the first panel have described, I think everyone in State Government recognizes, I don't think the issue today should be or needs to be the fact that there are services that are in fact not being given and individuals who are not being served. The question for all of us is: how do we take and use limited resources to try to survive for a lot of services that we need.

I think one of the things that's really important to put in perspective is the fact that we have, at the Department of Human Resources through the Staff that are here today, and through all the other departments that are represented, attempted to bring to bare our resources on the needs of the community as really distinguished by the community. The past six months have been an interesting experience for all of us in DHR because for the first time, we have tried to really go at Federal Government and its

rules by saying to the community, what are your needs? Develop for us what you think you need. And to the extent that you can, put that together. We will bring it to Washington in our case and try to make sure that they hear what we have to say.

We have met over the past six months and made a very very big effort to reallocate the limited funds from ORR. And I think it's important, again, not to put blame or to point a finger, but to recognize the reality; that is to say that the funds from ORR have been diminished over the years and that the numbers of dollars given have been reduced. And the services needs have increased and those two twains shall never meet.

We have met at the Department with the Federation as well as the Vol-Ags to try and reestablish as we best thought the priorities for the community. We made a very big venture this year for the first time in taking a significant amount of money and moving it from one category to another, for the perspective of using the money in a better way. It was the first opportunity I think that we have had as a policy making body to try to do that with ORR funds and in fact had very much received the spirit and cooperation from Boston and the regional office to do that.

The Federal Government, until just recently, though, was limiting itself on how it spent money. It said,

under an 85.15 rule, you need to really focus on employment and getting people off of assistance, making sure that they who remain on assistance to the extent that they treated refugees different than others, they really said we don't expect them to be on the welfare rolls, and therefore push everything you've got into making sure that the efforts are put into finding them jobs.

I think Patrick Johnson mentioned, and others from the Vol-Ags, and I think --, the fact of the matter is States have done a wonderful job in doing that. I mean, Boston's real pleased, everybody's real happy. I'm not sure that the focus, though, has been the one that everybody needed or should have had for as long as it did have.

Fortunately, the number of the 85.15 rule has been removed and we are now able to put a little bit more money into social services at the discretion of the Department. And as I said, it is really made in conjunction with the community based organizations. We have added significant dollars these past months, almost $200,000 to social services, by reallocating Federal monies and making sure that state programs in the employment and training fields were made available to refugees in order that we not use limited Federal funds to duplicate state services.

It's important to note that in many cases what goes unnoticed is the fact that we are trying to create the

same set of services for this population as we are for any other population that's in the Connecticut. And we recognize that we need to make available the State resources that are given for employment training to this population. And as I said, not use valuable resources that come in from ORR to duplicate.

We have done that. We have added case management services in the Vol-Ags. We have added a significant amount of money to the Federation to do the same thing. It is not enough to go around. I don't want to make you believe that it is. As small as this State is, it is a big state for a single person or two persons to try to travel and do services around the entire State. It is impossible to do that.

The State has, I think, responded in terms of the Department of Mental Health and the Department itself will speak to that in trying to recognize the limitations of ORR dollars and Federal dollars on the whole, and to put State dollars into the mental health and health services. We, like everyone else, though, are faced with major crises in terms of our own fiscal status. And I think to the extent that there was not a budget option adopted, I think it's important to put it in perspective.

This State in almost every case rejected all budget options from all Departments. So I don't want you to

believe, or leave believing that because a DMH budget option was not adopted, it was reflective of a lack of understanding or need or the Department's lack of persuasion with our Office of Policy and Budget.

The other thing that I think is important to understand is that where we have had to take an aggressive role, I think we have done that. I think if you were to speak to the individuals in the regional office, you would find that in trying to get the waiver early on that we did and now the elimination of the 85.15 rule, we said to them: we have a new way of doing business down here. We want to talk to the community, listen to what they have from the bottom up feed up to the regional office and do that. And I think they did respond, and as I said, we have reallocated the money.

It's also important to note that in a State that has a problem, even though it is a small State, is competing with a larger problem nationwide in terms of the way ORR divides its limited dollars. It does it on a percentage of need of the numbers here are put against the numbers in other States by a formula basis, we receive the dollars, and those limited dollars get divided.

I think it's also important to note how the Federal Government has reacted to the nuance of service that the Vol-Ags for instance can maintain with their clientele.

A number of years ago, we were talking about 18 to 21 months. It was reduced. It was reduced again. And now we're talking about services for no longer than 12 months. That is a statement by somebody making a policy decision as to how and where it wants to put its money.

I think, again, this is not a reflection on their needs or their individual desires in terms of one program over another, but I think it's reflective of the fact that they have made decisions that we in the State Government have to implement. We have tried where we can to use all the resources we have to maximize the dollars that we do get from the Fed. We have tried as we can to provide State dollars, if not directly but indirectly by providing services to all individuals including refugees where we have individual programs paid through by State monies.

I think what we have done in a cooperative way and it is a cooperative venture. We are all here today, and we were all there when the budget options went in. We all know what's going on. The Department of Human Resources as sort of a lead agency is reflecting I think the desires both of mental health and Children and Youth Services and this is not sort of government going its own way in individual agencies. We do speak and we do know what's going on.

The funds are limited. I think to the extent that the communities have asked us to address needs, we have done

that. To the extent they would ask us to readdress needs, and spread the same monies in different ways, we would certainly be willing to do that. I don't want to sit here and tell you that I know best how to spend their money, anymore than I think we all know how best to spend each other's monies. But clearly if there is a need and we can reallocate monies that are now given for other services, we would be more than willing to do so. We are not in a position, I think, of saying we want to direct monies to anything because clearly with limited funds, it's going to come out of some other service and some other need.

What we do need is certainly to raise the whole base of funding and I would certainly suggest to you that we all need to speak to the importance of this issue on a national level because clearly it is an issue that I think, in looking at both the way the Government has reorganized itself in terms of ORR status within the regional offices, as well as the kind of reductions in funding, is a statement both to the State and I think to the public about the lack of importance that some people feel may have been there against other programs.

I thank you for being here today, and I would certainly be happy to answer any questions you may have.

MR. STEWART: Thank you, Mr. Ginsberg.

Mr. Raiselis?

STATEMENT OF GEORGE RAISELIS, REFUGEE HEALTH PROGRAM DIRECTOR, CONNECTICUT DEPARTMENT OF HEALTH SERVICES

MR. RAISELIS: My name is George Raiselis, and I'm representing the Connecticut Department of Health Services. And I'll just give a brief overview of refugee health problems in Connecticut.

The Refugee Health Program of the Department was started in 1980 under the direction, urging and support of the Center for Disease Control in Atlanta, Georgia. The Department of Health Services is the public health component of Connecticut's Office of Refugee Resettlement. The Refugee Health Program cooperates with and complements the State Refugee Resettlement Plan by ensuring that refugee health problems are addressed expeditiously.

Before refugees arrive in the United States, they're examined in the camps. And so-called Class A and Class B conditions are identified. Class A conditions are dangerous contagious diseases and they include chancroid gonorrhea, granuloma agranulocytosis, leprosy in the infectious stage, lymphoma granuloma venereum, syphilis in the infectious stage and active tuberculosis, and since July 1, 1988, Aids. Also mental conditions can be classified as Class A conditions and they include previous occurrence of one or more attacks of insanity, mental defects, narcotic drug addiction, psychopathic personality, chronic alcoholism

and sexual deviation. Any of these so-called Class A conditions would preclude the entrance of one of these refugees into the United States unless they were given special consideration.

They are also examined for Class B conditions which include physical defects, diseases or disabilities serious in degree or permanent in nature to mark a substantial departure in normal physical well being. These conditions will allow the refugees to enter the United States but they're trapped once they get here.

We've established and maintain several goals in our department.

Number 1, to ensure health assessment for all refugees who arrive in Connecticut.

Number 2, to ensure that all refugees assessed as having conditions of potential public health significance such as sexually transmitted diseases, intestinal parasitic diseases, tuberculosis, incomplete immunization status, will effectively commence diagnosis and treatment for these conditions.

Three, to ensure that refugees assessed as having personal health problems such as dental problems, correctable vision problems, healing disorders, psychiatric disorders, skin infections, malnutrition, heart and vascular diseases, hypertension, thyroid conditions and hematological

disorders commence treatment after the identification of such problems.

And, finally, to ensure that refugees assessed as needing health related counseling such as family planning, nutrition, prenatal care and health education be referred to appropriate programs or facilities for these services.

The Southeast Asian refugees that have entered the State so far, their chief problem of public health significance is tuberculosis. Over 42 percent of them tested have tested positive tuberculosis. And in descending order, also, intestinal parasites, hepatitis and hepatitis Type B.

Personal health disorders, the chief problem for them is over 29 percent have abnormal dental conditions, and also two percent abnormal hearing, and four percent abnormal vision.

The chief operational problem that has been identified by the program is the lack of interpreters knowledgeable in bicultural translation of medical health terminology for Southeast Asian refugees. Cultural, religious and social considerations must be addressed when translating for refugees. Not all medical health terminologies are translatable into the various Southeast Asian languages and dialects, nor can the Southeast Asian expressions of their physical and mental states be directly

translated for western health care providers.

The interview of a Southeast Asian refugee must be interpreted by one who is aware of the nuances of these various cultures. Many Southeast Asian medical terms or health conditions when translated literally to English tend to mislead or confuse western health care providers. Also, we believe that it's many people, not just in the health care profession, look at Southeast Asians as one whole group where they're actually very distinct cultures. And a lot of people don't recognize that the Vietnamese have a different culture than a Lao or a Muong or a Cambodian or a Chinese. That's definitely a problem.

Another major problem for newly arriving refugees is mental health. Though the Department of Health Services is not the agency responsible for attending to this matter, we do upon request make referrals to the appropriate agencies or services.

I've got a more detailed response I'll leave with the Court stenographer -- pardon me, not Court stenographer -- wrong term.

MR. STEWART: Yes. A very detailed summary generated questions for all of you, being if you have copies of your remarks, it would be appreciated to help the stenographer, okay.

MR. RAISELIS: Yes. Thank you.

MR. STEWART: John Cavanaugh?

STATEMENT OF JOHN CAVANAUGH, DIRECTOR OF TREATMENT SERVICES, DEPARTMENT OF MENTAL HEALTH

MR. CAVANAUGH: My name is John Cavanaugh. I'm a Director of Treatment Services with the Department of Mental Health. I'm pleased to be here today to make this presentation.

The task of meeting the mental health service needs of Southeast Asian refugees in Connecticut poses a complex challenge for the mental health service system in Connecticut, particularly in the time of fiscal crisis in this State.

Before describing the Department's response to this challenge, I want to briefly describe Connecticut's mental health service system, and then summarize our assessment of the nature and scope of the mental health problems experienced by Southeast Asian refugees.

Mental health services in Connecticut are delivered by a large private sector, as well as a public sector. Linkages exist between the two sectors in the form of grants and contracts. Private sector providers include private practitioners, private psychiatric hospitals, general hospitals, and other organizations which may provide a range of services including acute in-patient care, partial hospital services, out-patient services, and emergency crisis services.

Some general hospital programs are funded by the Department; most are not. The private sector also includes non-profit agencies, most of whom are supported directly by the Department. These agencies provide a range of services including such things as counseling, case management, residential services for mentally ill persons, and social and vocational rehabilitation services.

Among the public sector providers of service, the Department of Mental Health, the Department of Children and Youth Services and the Connecticut Alcohol and Drug Abuse Commission are the agencies which provide the bulk of public sector services in the area of mental health. The Department of Mental Health service mandate is limited to adults ages 18 and over who are suffering from a primary mental health problem, as opposed to a primary problem of substance abuse. Mental health services for people under the age of 18 are provided through the Department of Children and Youth Services.

In Connecticut, as in most States, the need for mental health services far outstrips what is available in both public and private sectors. National data indicates that approximately 15 percent of the adult population experiences a diagnosable mental disorder during any six-month period. Of these individuals, only 20 percent have access to mental health treatment. These problems in access

to care are compounded by the stigma of seeking care, discriminatory insurance coverage for mental as opposed to physical illness, general problems in access to health care for the poor, and cutbacks in Federal funding for community health care in general.

Given these broad service needs and the limited resources that the Department has at its disposal, the Department focuses its resources on the most needy individuals, particularly poor persons with severe and prolonged mental illness and persons at risk of hospitalization. The priority population also responds to Federal mandates expressed in Public Law 99-660, which directs our planning priorities.

The Department of Mental Health directly provides or funds the provision of three general categories of mental health services. These include in-patient services, community psychiatric services which would include emergency crisis services, partial hospital programs, and out-patient services, and then community support program services, which would include such things as case management, residential services and social rehab services.

The Department of Mental Health also provides services in the area of consultation and training and some specialized programs including a forensic program, a program for compulsive gamblers, and an extended care program.

The bulk of the community psychiatric services and community support program services are provided by the private non-profit organizations I've already mentioned. These organizations provide the services through grants from the Department of Mental Health. In many instances, these organizations are also serving a broader spectrum of the mental health service population than that which is defined in the Department of Mental Health statutory service mandate. However, the grant funds provided by the Department of Mental Health are focused only on its mandated service population.

The Department of Mental Health Service System is organized along regional lines. There are five Department of Mental Health Regions. Services in each region are provided through a combination of direct Department of Mental Health operations, and again, private non-profit agencies. Services are coordinated and monitored by a Department of Mental Health Regional Director working collaboratively with a regional board and area councils.

The Regional Board and the Area Councils consist of consumers, providers and other interested citizens. The Board and the Councils are charged with the responsibility of reviewing the quality and adequacy of services within their region or area, identifying service needs and making decisions with regard to the allocation of funds among

programs and the funding of new programs.

It is here that support for new programming or program expansion must be generated if these programs are to be developed. Now, in estimating the nature and scope of the needs of the Southeast Asian refugee population, we could not draw on many resources within our own service system. Connecticut's mental health service system, as has already been mentioned, and the Department of Mental Health Service System, in particular, has had very little limited experience in trying to meet the special mental health service needs of the Southeast Asian refugee population.

In making our assessment of these needs, we have relied on experts from other States. These include persons from the Indo-Chinese Psychiatric Clinic in Brighton, Massachusetts, and the University of Minnesota's Center for Technical Assistance in Refugee Mental Health, and also on national studies of mental health problems among refugees.

According to the estimates we've received, mental health problems among refugee groups range anywhere from 45 to 72 percent in the samples that were studied. Chronically high levels of anxiety, depression, psychosis and substance abuse were among the most common types of mental health problems identified in these studies. Unusually high rates of suicide have also been found among certain subgroups, such as Cambodian women. The high incidence of mental

health problems is not surprising in light of the refugees' experience.

These problems I think have been adequately detailed by the earlier speakers. But in spite of the problems and in spite of the fact that they are a fertile ground for the development of mental health type illnesses, Southeast Asian utilization of mainstream mental health services in Connecticut has been very low. There are a number of barriers to service utilization. Many of these have already been pointed out. The most obvious barrier is the problem of language. Only a small percentage of the refugees can speak English well enough to use mainstream clinic services.

In Connecticut, there are only a few mental health professionals who can speak in the refugees' native tongue and these persons are not necessarily employed in programs which are in a position to serve the Southeast Asian refugee population.

Less obvious but equally important are the cultural barriers. Most mainstream mental health clinicians currently have little experience or understanding of these cultural differences and their implications for assessment and treatment. Moreover, many of the presenting problems of anxiety, depression, psychosis, are often an expression of syndromes such as post-traumatic stress syndrome or a

phenomenon described in the literature as survival guilt syndrome. Problems of this type are rarely seen in the mainstream systems, and they require some variations in the treatment approaches most commonly used to manage and treat the presenting symptoms.

In States which have developed specialized programs designed to overcome these service barriers, the utilization picture is dramatically different. Massachusetts provides a relevant example. The Indochinese Psychiatry Clinic which serves the greater Boston area, and some of its spinoff agencies have been operating at 100 percent of program capacity with waiting lists almost since their inception six years ago. This is true even though the programs carefully triage new referrals to determine if they can be referred on to mainstream programs.

The reason for this dramatic contrast in program utilization rates, we believe, is that the special programs have been able to design a service approach that effectively overcomes the most significant barriers. Perhaps the most important design feature is that all phases of the out-patient assessment and treatment services are handled through bicultural treatment teams consisting of trained mental health professionals and indigenous paraprofessionals working in tandem on each case.

The second important feature is that the program

is closely linked with general hospitals, the local Southeast Asian refugee service organizations, and key elements of the Southeast Asian community support network. Finally, the clinic in combination with these elements adopts an aggressive case finding and outreach posture.

As part of our effort to collaborate with the Southeast Asian mental health refugee advocates, we have brought a team from the Indo-Chinese Psychiatry Clinic in Brighton to Connecticut to help develop our approach to this service problem. On March 3, 1988, the team presented a workshop on Southeast Asian refugee mental health needs to over 80 mental health and social service professionals from throughout the DMH system. Our staff benefitted from this training which helped us in developing the budget request to initiate a similar type of mental health program for Southeast Asian refugees in Connecticut.

This year, the Department submitted a request for funds for this type of program. The amount of funding requested was close to $400,000. The plan was to establish a bicultural team for each of the four Southeast Asian refugee groups and to have these teams provide out-patient services out of two out-patient clinic co-sites located in areas heavily populated by Southeast Asian refugees.

This budget proposal was not included in the Governor's budget proposal which, due to the State's

unprecedented revenue crisis, includes no new funding for proposed mental health services. The extent of current financial problems can be seen by the fact that the Department of Mental Health has cut its current year's budget by $5.4 million. This precludes any new initiatives for this fiscal year.

We intend to file a similar budget request next year because we believe that refugee mental health services are a critical component of our mental health service system. Unlike prior years, we now have a basis and understanding of how to develop these services and we have a basis for a collaborative relationship with the local refugee mental health subcommittee and the local refugee community.

Before reviewing the other initiatives we've taken there are two points which I think need to be recognized if these issues are to be understood in their proper context. First, the Department of Mental Health is attempting to provide these services without additional budgetary support during a time when resources are being reduced. Federal policies, as they relate to the funding of mental health services, have not provided on-going direct funding support for this type of specialized mental health service.

Furthermore, over the last eight years, there have been declining Federal dollars available for community

mental health services in general.

Simultaneously and since the inception of the block grant, Federal categorical requirements have become more stringent and large segments of the needy mental health population, as well as the population in general, continue to have to try to meet their health and mental health needs without benefit of medical insurance.

Secondly, as we already mentioned, the Department of Mental Health Services system is organized as a regionalized system. It relies on its area councils and regional boards to identify service needs and provide the primary impetus for program expansion and new funding.

It is essential that these levels of the Department of Mental Health's Service System be actively engaged in any proposed program expansion. That is why one of the crucial issues for the refugee community in trying to obtain mental health services has been that of visibility. And that issue has already been mentioned.

The community's relatively low utilization of conventional or mainstream services has had something of a catch 22 effect. Services are not sought even though they are needed. Consequently, the providers of mental health services, the area councils and the regional boards have not felt the pressure to develop these specialized services. Clearly, then, for this community, it is important that

initiatives be taken that will help all levels of the Department of Mental Health system to recognize the special health needs and problems that exist.

It is also important that the task of outreach and education be aggressively pursued in the refugee community itself. Over the last two years, the Department of Mental Health has collaborated with the Southeast Asian refugee mental health group to increase the visibility of this population's mental health needs. Besides the statewide one day conference, which I already mentioned, and assisting the refugee mental health group members in making presentations to our regional directors regional mental health boards, area councils and to legislators, we have encouraged representatives and consumers from the communities to become members of these boards and councils.

This office has recently worked with a refugee mental health subgroup on the development of a brochure primarily designed for a legislative audience. This will be widely distributed throughout our service system.

We're also trying to address training manpower recruitment and direct service issues within the framework of our limited budgetary resources. We have been concerned about the adaptations needed in clinical assessment and treatment procedures in order for a successful treatment regimen to be instituted. The issues here include the

proper use of interpreters, the modification of the psychiatric assessment and mental status exam, and then appropriate treatment approaches to such disorders as post-traumatic stress syndrome and survivor guilt syndrome.

These disorders are very different from the problems experienced by most of our clients, even if cultural differences were not involved. We are taking steps to improve the ability of our providers to recognize and meet these needs. We have begun a systematic effort to furnish providers with training materials on these subjects. We are using video cassettes and training materials provided through the Indo-Chinese Psychiatry Clinic in Boston, and the University of Minnesota Refugee Program Technical Assistance Center.

We are also trying to recruit members of the Southeast Asian refugee community for clinical positions in our system. We've met with job developers from the voluntary action groups and briefed them on our service system, the types of positions and the qualifications needed for these positions. Our central office personnel section has been doing preliminary screenings on several applications and we have referred persons on to our local facilities.

The need to meet accepted personnel standards do limit choices but there are applicants who qualify for mental health worker positions and in some cases for our

entry level psychiatric social worker positions. We will continue our efforts in this area.

We are at a juncture in the development of a response to the real service need where we are still trying to understand all of the dimensions of these special problems and their implications for service delivery. We appreciate efforts which have been expended by the refugee Mental Health Subcommittee and their role as advocates and educators. We want to continue a collaborative working relationship with this group. We are also open to any consultation or suggestions by members of the panel or by the Commission about different ways we might consider approaching this real mental health service need.

Again, I want to thank the Commission on behalf of the Department of Mental Health for the opportunity to make this presentation.

MR. STEWART: Thank you, sir.

STATEMENT OF DR. WALTER PAWELKIEWICZ, EXECUTIVE ASSISTANT, COMMISSIONER, CONNECTICUT DEPARTMENT OF CHILDREN AND YOUTH SERVICES

MR. PAWELKIEWICZ: My name is Dr. Walter Pawelkiewicz. I'm Executive Assistant to the Commissioner, Amy D. Wheaton, who sends her regrets. She had another engagement. The Department of Children and Youth Services is the single State agency for child abuse and neglect, for juvenile delinquency, for mental health services and substance abuse services for youth under the age of 18.

The Department, through a small social service block grant also is the agency of cognizance for the unaccompanied refugee minor program that is administered by Lutheran Child and Family Services of Connecticut. We, as has been said before by Commissioner Ginsberg and eloquently by Mr. Cavanaugh, have attempted to advocate for a budget option to develop mental health services for Southeast Asian refugee children. And that budget request was not part of the Governor's budget.

As has been previously stated, with the current State fiscal situation, we will continue to advocate for the development of these services. However, we may need to look to some other areas for service development. One area that we have been looking at, and I was in communication with Carol Berto briefly as we were preparing a mental health

services grant for the Robert Wood Johnson Foundation, and they were particularly interested in developing models for under served populations. We did submit such a grant. However, we did not receive that funding.

We will continue to make efforts to increase accessibility within our current system for children under the age of 18 who are Southeast Asian refugees. We also have, I have been in contact with our interstate compact office that receives requests because of a coordination process that they're responsible for. The person who's in charge of that office, Polly Champ, is aware that we have requests from our own staff, from our own direct service workers, those social workers in the child welfare offices who have gotten involved with individual family cases, that are frustrated by the lack of either the current public system in terms of State administered services, and also the community-based system, to find adequate both linguistically and culturally accessible services for clients who are in need of mental health services.

Thank you very much.

MR. STEWART: Thank you, sir.

Ms. Chang?

STATEMENT OF CAROLINE J. CHANG, REGIONAL MANAGER, OFFICE FOR CIVIL RIGHTS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, REGION I

MS. CHANG: Mr. Chan, Mr. Stewart, members of the Advisory Committee, thank you for this opportunity to speak to this forum. My name is Caroline Chang. I'm the Regional Manager for the Office of Civil Rights in the U.S. Department of Health and Human Services, Region I.

I wanted to tell you a little bit about what the Office is responsible for, and then tell you a little bit about some of the experiences we've had in dealing with access problems for non-English speaking populations and then with refugee populations, because we have had some experience.

The Office of Civil Rights is the civil rights enforcement component of the Department of Health and Human Services. We have ten regional offices. Region I covers the area of New England, so I have jurisdiction over all six New England States. We're responsible for ensuring that institutions, facilities and agencies that receive funding form the U.S. Department of Health and Human Services comply with a variety of civil rights laws.

I brought with me a package of some of the materials that we provide to the public about what we do and the Committee members have it. But there is one fact sheet

that I have for audience members if they'd like to pick it up on their way out.

The two laws that I think have the most application for the population that we're most concerned about today are Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color and national origin, as well as the community services assurance of the Hill-Burton Act which is the Public Health Service Act of 1975, which requires that health institutions which are constructed with Federal funds provide services to residents of their service area and in some cases people who are employed in their service area without regard to race, color, national origin, or ability to pay, or any other regard other than the fact that the service being required is not offered at that facility.

The Office of Civil Rights has long recognized that failure to provide effective communication to a limited English proficiency national origin minority person would constitute a violation of Title VI. In 1970, the then Department of Health, Education and Welfare issued a memorandum to school districts indicating that policy, which was reaffirmed in the Supreme Court's landmark decision Lao v. Nickels. That just providing English textbooks, even though they're the same as that provided to English speaking children is not providing effective education, if no other

service is being provided.

That's the basis of current policy in terms of access to services for the listed minority clients. In Region I our earliest case involving bilingual services in fact occurred in Connecticut with the then Department of Welfare in which we worked with the Department of Welfare in terms of their provision of services to limited English speaking Hispanic clients. So we have sort of a long history, if intermittent, in terms of dealing with access issues, particularly for limited English proficiency clients and beneficiaries.

In the last few years in our regional office, -- let me just tell you what we do. Our activities are carried out in several ways. We investigate complaints that are filed with the office. Any individual or organization can file a complaint. It's a very simple matter; you just have to tell us what happened, dates and times, if possible, and names of individuals. And it doesn't have to be in any formal form; a letter will suffice. It does have to be written, though, if you're able to write. And it can be in a language other than English. We will accept complaints in other languages and we try to find someone to translate them.

We also have the authority to self-initiate compliance reviews where we might take an issue and it may

be an issue which has a national priority or an issue which has a regional priority and conduct compliance reviews among the several facilities over which we have jurisdiction to see whether a particular service is being carried on in a non-discriminatory fashion or whether their admissions policies might be barriers to specific groups.

We also spend quite a bit of time, to the extent that time allows, providing technical assistance and guidance by speaking at workshops during educational forums, both to those that receive funds in terms of what their responsibilities are and to community organizations in terms of what their rights are. Our most recent one dealing with this specific issue was a conference that we co-sponsored with the Massachusetts Health Council around the issue of interpreters and bilingual staff in the hospital setting, which was very successful and very well attended.

We are currently working with an inter-hospital group in Rhode Island trying to do the same thing. Because, I think, one of the things we found and I have found in the years of my civil rights enforcement experience is that many times, the organizations and the responsible parties want to do the right thing, and it's a question of knowing what the right thing is and what the law requires and what the obligations are. So that I place a very high value on outreach and education.

We have had very few cases around bilingual services, but we have had some. In the last few years, we've had four cases involving hospitals in terms of what they had on location for dealing with limited English proficiency clients, and we've dealt with about five or six state agencies throughout the region in terms of how they, themselves, delivered their own services with regard to limited English proficiency clients.

We also have dealt with an after school program where the complaint that came in did not have to do with bilingual services. It was one where it was one brought under one of our other jurisdictions which prohibits handicapped discrimination but it turned out to be a child whose father was Cambodian and could not speak English. And the after school program was not providing the father adequate information to make judgment decisions about the child's treatment. So that became a bilingual services case, too. And I'm just mentioning it because there are other ways that this comes into play.

I was asked very recently to be on this panel and I was asked to talk a little bit about some examples of some approaches that seemed to be working. And I would like throw those out for your consideration. I'm sure many of the people here already know about them or have participated in them, or have even led them. But nevertheless, I'm going

to mention them and then I'd be glad to entertain questions.

What has been helpful, I think, and let me talk a little bit about Massachusetts, and then I'll talk a little bit about Rhode Island.

In Massachusetts, I think what has been helpful is that there has always been an active Governor's Advisory Council for refugees. And they've looked at refugees issues across the board. So that's been one level of activism. The other difference in Massachusetts may be that there has been an established Asian community which has developed its own service network, so that there have been some parallels or some places for new groups to sort of join in which may not occur in other states.

I think the Mass Health Council, which is a coalition of health providers, public and private across the State, has been also in the forefront of looking at health issues that affect various populations. And about a year ago, they established a linguistic minority task force which one of my staff people co-chairs, and that helps to bring issues involving linguistic minorities to the forefront to a large audience of providers who might not think of it on a day to day basis. I think that helps to highlight the issues that highlight the problems. And with that task force, they co-sponsored the conference that I mentioned earlier last fall.

In Rhode Island, the Rhode Island Foundation took on the issue of Southeast Asians as an important community issue. And they funded a conference which we helped co-sponsor about two years ago, which sort of brought all the state legislatures, state agency heads in to talk about issues affecting Southeast Asia. They had a health care panel, education panel. And I think that served as a very good impetus to identify key issues affecting Southeast Asians, and started people talking about what are some ways to resolve these problems.

That also led to some inter-hospital groups in the Rhode Island area. Rhode Island is a very small state so it's easier for hospital groups to sort of maybe and maybe not work with each other because, you know, the State is what, seven -- I don't know, I'm not good a geography, but they're very close together, and they could work very close together very easily. And they can in fact do things like doing interpreter pools that they can share because the traveling distance is not as great. But you might be able to replicate that on a regional level somehow.

We've also worked with the State Department of Health in Rhode Island. Last fall they had a conference on data collection. Because one of the things that Rhode Island Department of Health found, in conjunction with the Urban League, is that there's very poor minority health

data. And so they wanted to start collecting health data by race and ethnicity. And I encouraged them to also do it by language. And they had a workshop in which they included my office where we talked about the civil rights aspect of collecting data, because there's a lot of misconception about what you're allowed to ask and not allowed to ask of a client in terms of their race or their national origin, or their language.

And I think that process is underway. And given what I heard earlier about the lack of data, I would encourage, especially at the state agency level, some serious consideration of more accurate data collection.

As a matter of fact, when we get a complaint, that's the first thing we ask you for, too. So it's sort of meeting two needs.

We also have helped and commented as various groups worked on training programs both for interpreters and for bilingual staff. We've worked in the four complaints that dealt with hospitals. We've gotten compliance agreements for the manner in which that hospital will serve limited proficiency clients which include things like how do you identify the client that needs the assistance, what choice does a client have. We emphasized that the interpreter service has to be provided at no cost to the client and the client cannot be forced to use a relative or

a family member unless it's the client's own preference.

So we do a lot of that kind of technical assistance as well.

Let me stop with the examples, now, and just close by saying that I realize that there is a resource problem; not only a financial one but a human power one. It reminds me of what we face in Chinatown Boston when we started a health center 20 years ago, and I was one of the Board members of the health center. We had a very hard time finding bilingual staff, but the only reason it happened was because we decided it had to happen, and I think that's the message I'd like to leave. That it will only happen if you decide it has to happen, and you are willing to look for and begin doing now the kinds of things you need to make it happen, whether it's reshuffling priorities or whether it's looking for new innovative ways to do it.

From our vantage point, Title VI requires that all of your programs and activities be accessible, not just those funded by ORR and not just those funded by whatever program. It's looking at the programs in their entirety. So I think, you know, my message is, let's begin trying to do something now.

Thank you.

MR. STEWART: Thank you, Ms. Chang.

I'll ask the members of Panel A to pull their

chairs up closer to the Panel B group so that we can have a dialogue of some kind. While they're moving up, I think I neglected to introduce our field representative for the Eastern Region, professional and the one who will get communications to you and will collect your remarks, Tino Calabia. So all of you who have your texts typed, you can hand them to Tino before you leave, or if you intend to send them, to see Tino and get the correct mailing address.

We have some time to ask questions of both panels from the Committee and members of both panels can ask questions of each other. We don't have an unending amount of time but we do have time enough to have a dialogue if that is the wish of the group.

So let me begin by asking two questions. One to Ms. Berto. Why don't you move up. Do you see it only as a function of budgeting or is that a primary characteristic for getting more than the one translator for each of the particular groups? Is there anything else involved in that other than money? Is there something that the group itself, the various ethnic groups themselves can do to enhance that?

MS. BERTO: Well, I think that again it's a question of invisibility and political clout. And other ethnic groups may have it because of their numbers and because of their cultural training to be assertive. This group is not only culturally non-assertive, but they're

broken because they come from war. They don't have the voice that other ethnic groups do. And that's unfortunate because when they're invisible, no one cares. In America, it's the squeaky wheel rule here.

And I think that in a State that has benefitted greatly from armaments dollars, you don't really want to see these refugees. And it's a pity.

MR. STEWART: So it's more than just the budgetary matter?

MS. BERTO: I think so. I think it's a matter of priorities. If it were more than budget, some money would have been found. We've been asking for mental health resources for a long time now.

MR. STEWART: Okay. Commissioner Ginsberg, following up this squeaky wheel rule just mentioned by Ms. Berto, given the present status as relates to political action of this community and not having either door or desk being counted on counseling as perhaps other groups do, is there anything you could suggest different from that kind of noise that might be helpful and persuasive to you, the government or whomever?

MR. GINSBERG: Let me say that there's no question that the life in the political arena has a lot to do with who's making noise and I don't want to minimize that. But I do want to say that to the extent that the Vol-Ags and the

Federation and the issues have been brought even to the point of being either options, are going forward, this is not an issue of a silent group that has been ignored in the sense of trying to make adjustments within the resources that we have.

We recognize, I think at this point, and I think Commissioner Hogan, Commissioner Wheaton and myself, and Commissioner Etz, that this is an issue that we all would like and want to address. I mean, it is not a question of the desire to do that. As I said, I think we've gone beyond the question of whether there's a need. The question for us is have we tried to move forward in as many creative ways as we possibly can. It is not so just looking at money from new state dollars. It's looking at attempting to make resources.

As I said, we would be willing to reallocate an amount of the given resources, even, for this priority of the mental health and health services. Something may have to be given on the other end, but I think, as we've all said, that's a question of priorities. I think the Federal Government has recognized thankfully that its priority in terms of employment and training for almost all of its dollars and has now been released, and gives us a lot more flexibility.

What you have to do, I think, when you have

limited resources, is go back and figure out how you essentially can use mainstream services for this population, instead of segregating it for everything and use the Federal resources and limited state resources for those things that are unique to this population.

We've learned some lessons in the past with the Hispanic population. We've got to learn the same lessons with this population. Where we can integrate the population, we should. There should not be specific, for instance, dollars for just housing for this. Housing ought to be an issue across the board.

But interpreter services and language services and culturally appropriate services are unique to any population, be it Hispanic or refugees or as Pat Johnson said, Eastern European cultures. We need to use the limited dollars for those things that are unique to the population. And I think we're beginning to do that. As I said, we've moved money around internally. We'll continue to do that if possible.

I think as the population becomes more integrated, we're going to find ourselves finding them having access on a regular basis. Not just that the law says that we should but it's right to do it. The will is there, I guess I'm saying, distinctly, that it's a question of how do we make the limited resources go further. And I think we're trying

to do that.

MR. STEWART: Just a quick follow up. It's encouraging to hear that you express willingness to move funds around.

MR. GINSBERG: $200,000 and some people who were benefitting are not very happy at the other end of it.

MR. STEWART: It's a challenging task for some members of your staff and we appreciate hearing that. But what forum, what forum aside from the traditional squeaky wheel principle, should this Committee take, in your opinion, if you're willing to offer advice here, to get not so much yourself but perhaps some of your colleagues who are involved with this community, to take the initiative that you've just expressed?

MR. GINSBERG: One of the things the Governor did do about a year and a half ago is he created a human services cabinet which allows the Commissioners of the ten or 12 agencies to come together on a regular basis in the human services arena on human services issues to talk about those issues that are sort of across agency lines.

And as I said, this is an issue where Commissioner Hogan, Commissioner Wheaton, and Mr. Ades and myself have talked. And while the option goes in under one department, it is a collaborative effort in trying to make sure that we all where we can we share resources. I think to the extent

that in the health arena efforts have been made because that's the primary focus of where the mental health dollars need to get going, there is an attempt to find a community based arena for them to have a forum. The Federation was added last year, actually two years ago, to our Statewide Advisory Council as one of the 12 or 15 pure grantee sort of agencies. We had someone from the homeless on it. We now have someone representing refugee associations sitting on our Statewide Advisory Council. So that it's forum, and in fact one of the issues that Katrina did bring to a public forum among our advisory committee was her particular problems against others who were also looking for other new resources.

That since we have I think created as I said the task forces on specific issues like the mental health issues. Our staff meets with on a monthly basis to bring issues to the front. Where we have I think have attempted to be as flexible as possible. When the Feds have been late in getting money down, we have tried to use State resources to cover that shortfall.

It's a very difficult situation but I think we're making efforts. We recognize the problem. I think Commissioner Hogan, as I think has been mentioned, recognizes the problem. It's a question of now looking at how we can do it creatively. And it is not solely one of

just resources and we have to look beyond.

MR. STEWART: Commissioner Chan?

MR. CHAN: First, I'd like to ask the Panel A ladies and gentlemen to express what their desire is. The Government only has a limited budget. Now, what is the most needed assistance you need in your work area? I will start with Mr. Phengsomphone.

What do you need? If God granted you a wish and if the budget is limited, granted, I mean, we cannot ask for the moon, now what do you need immediately, the most needed the most important in your work area?

MR. PHENGSOMPHONE: I think the mental health series is one priority that we need in the community because we don't have enough interpreters when he's needed for a patient who can understand and know the background of the refugees to collaborate with the professional.

MR. CHAN: Now, our framework today is a forum on the mental and mental health problems. So what you're saying is to provide interpreters is the most important thing. Am I correct?

MR. PHENGSOMPHONE: Yes. And also if possible to train the ethnic people if it is possible --

MR. CHAN: To speak their own native dialect.

MR. PHENGSOMPHONE: That's correct, sir.

MR. CHAN: Now, for Panel B people, gentlemen and

lady, within your, granted that you're not speaking for your own personally, I mean, we all work for the Government and we have a limited budget and we have a certain legal decision to make and so on, what can you help in that area. Feel free to speak. I'm not going to ask each one of you individually. And we need volunteer answers.

MS. CHANG: I have a two-part answer. One is I said that we had worked on a few complaints. And one of the realities is that it's the squeaky wheel syndrome again, but we don't get too many complaints from typical Southeast Asian groups. And one of the ways to get us involved and looking at what a hospital or a state is doing is to get a complaint. Because with the limited resources we have, those get the highest priority by law.

So don't say, you know, I think there are ways, or you can bring up issues with us and we can discuss them and give you some ideas about approaches.

I think the other thing that I think is a very I think constructive way to approach it is that the State agencies and all of us need to remember that it's not just the State agencies who have a part of the health care system, or the mental health care system. There are many people out there and many people who get funds, particularly from the Department of Health and Human Services.

(Continued on following page.)

So, this is providing more education and information to those providers to say that they have obligations as well, so that the clinic down the street that says: We don't take Cambodians because we don't have anybody to speak or you can only come. The state can say: Hey, you can't do that by law, not as long as you're getting funds through our Medicaid office or as long as you are a Medicare provider, you cannot do that. So, I think there is lots of programs in fact that the state and the community groups can do just to educate people of what the law requires.

COMMISSIONER CHAN: So this is within your technical assistance service.

MS. CHANG: That's right.

COMMISSIONER CHAN: And you can provide bilingual service to --

MS. CHANG: We can help set up some of the programs and give -- we can educate some educators because if you are asking me what my wish would be in my office, I would say 20 more staff people. So, that gives you an idea. And that's like everybody else's wish is. So, I can't say that we can be at every corner, I mean in every part of the state to do this, but we can supply some training and some technical assistance on how to do this.

COMMISSIONER CHAN: Well, I am glad there is a

helping hand there. Since I intend to ask Panel A one question, each person, what about you, Ms. Kuoch? What do you wish? What is the most needed assistance you need besides money, I mean?

MS. KUOCH: I think money has to be included, too.

COMMISSIONER CHAN: Within the framework of the limited budget from the government. Let's say it this way.

MS. KUOCH: My concern, I think that we already have a translator who provide translation to the health care provider. But the office, I do not have well trained and I don't think they have a confidence. And what the doctor or the health care provider told them, they ignore the patient and they will say to the doctor or the health care provider told them to tell the patient.

I think that for that matter, to ignore the people, they feel very unvaluable and they feel like they're not important. They go to the doctor and they cannot express what they are concerned about their sickness and also it may depend on the translator. The translator do not have the competence to understand for their own people. So, very often, I see the doctor using the translator just what the doctor to tell the patient. So, I wish now that the doctor should be more free to the translator and the translator should be trained as compassionate so they will be equal in terms of sharing information and in term of

treat the refugee.

COMMISSIONER CHAN: So, what you are saying is a special trained type of people to assist the patient.

MS. KUOCH: Yes.

COMMISSIONER CHAN: I wonder if you can hear that for the record?

MS. KUOCH: Receive the document for the written record. We ask for a nurse who will volunteer to go to see the recall. And she came to tell me that between the English writing and the Cambodian writing are different, English writing say that the patient has a heart case and the Cambodian writing, they say that the patient has arm pain. So, it is very different.

COMMISSIONER CHAN: Well, now, the question becomes more refined on the interpreter, I think. I wonder who can answer question from Panel B.

How do we get these more refined and trained interpreters?

MR. RAISELIS: One thing I wish you would do is the Committee would enter into a dialogue with the hospital commission who is not directly represented today.

COMMISSIONER CHAN: Off hand, may I ask a question from Ms. Chang. Does your technical assistance program provide something in that special level?

MS. CHANG: No. We are basically a Civil Rights

enforcement agency. But we have found -- I am aware in Rhode Island, for example, that some of the local hospitals worked with the community college in setting up an interpreter-training program. So, that could be one way of doing it. I know in Boston there are some local community colleges that have special programs for health care providers. There are also some schools that provide -- I am aware of Spanish at this point, not any of the Southeast Asia languages, but some Spanish language courses for health professionals so that they can learn some language and culture, too, so that they can deal with patients.

COMMISSIONER CHAN: Well, in this case, may I ask the Commission a question. Within the Connecticut DMH, do you think that you can help in this problem area?

MR. GINSBERG: What I am sitting here thinking is and I'll ask my colleagues: If we do not have, and I want to presume that for the moment it is not on the table, significant new resources, what we do have to do is mobilize an attempt to figure out how we can share the resources that we do have.

And let me just say two things: One, because the hospital commission is in my building, I will take it upon myself to certainly speak to Commissioner Wright about that. But generally if we look at associations like the hospital, like the medical association, one of the two things that

what I have heard today is the need to figure out how do we make the professionals, the case managers be able to at least have some understanding possibly from their perspective of the mental health and health needs of the clientele. There is no question that Mr. Johnson and his staff and the others will not become truly professionals. But to the extent that there was some ability to give them some understanding, that will help them in doing their job and hopefully help clients.

To the extent that the interpreters that we do have need to understand medical issues better so that in fact it is not people going in without any understanding of nuances and maybe even just being able to sit down with all the interpreters and say how do we -- we know there are going to be translation problems. There have been translation problems whether it's in court in legal issues or whether it is in issues of health, take the professionals who have to receive the information through the translation and work backwards and say, let's figure out what are some of the common problems we may all have through the translation process. That will take money, but it will take money in the sense of training dollars and TA dollars, not in terms of new staff dollars.

I think we need to sit down and look at just generally, I think as the MH is doing, its whole network and

our whole network, and at least share the information we need among all those who are involved. Again, the idea would be to have more people. That not being the case, how do we at least bridge the gap?

We can enforce and we certainly have enforced because at this point affirmative action in a lot of areas and I don't just mean in terms of affirmative action traditionally, but 504 and otherwise, require contract compliance as much as it does hiring.

So, we can make some real efforts if in fact services are not being given. The question is if they are being given, what is the quality of them? And what I heard today is a two-part problem. One, people having access, but even when they get it, what quality do they have. And I think to the extent we can deal with the quality through some kind of sharing, we can do that. I think we all know the networks we need to quote "network" with and the individuals who are most powerful in those. And I think that to the extent that there are people here who can make it happen, we should. That will not take necessarily dollars that we don't have. We will have to redirect training dollars, but we can do that. It is inexpensive. But I think from my understanding, and I can turn to Pat because I know him well enough to just turn and put him on the spot, I think that everyone would be willing to have

their staffs go through some kind of introductory, if nothing else on what psychiatric issues are.

MR. JOHNSON: Yes. I think many of our staffs have some familiarity in that area already. They are aware that particular clients have mental health need. The problem arises then when the staff of the VOL-AGS identifies a client who has a mental health need, or staff of the MAAs and then try to find the resource for that person, because the staff in the resettlement organizations are, in our groups, culturally sensitive and many of them are bilingual and bicultural, they recognize the need.

It is finding the trained professional who can deliver the basic service that they then need. And the demands on those staff -- I've had a judge call me up one morning and threaten to cite me for contempt of court because I would not order one of our staff members to appear as a translator in his court. I have had a doctor call me up one morning demanding that we send an interpreter to the hospital because he had a Vietnamese man there who did not speak English. This doctor was very surprised to find out that this same man spoke French. The doctor said, "What he's doing learning French before he learns English?"

(Laughter.)

So, the lack of cultural sensitivity, I think, is omni-present there. I think the training is not so much

needed for the staff of the VOL-AGS as it may be for mental health or health personnel.

COMMISSIONER CHAN: I am in sympathy with Ms. Kuoch, because you know, for an interpreters, because if they are interpreters and laymen, if the doctors say: Yes, this person has a cardiac spasm. The layman doesn't know what that means. "Oh, yes, his arm hurts." He will interpret it that way.

But I would like to leave some chance for my colleagues to ask questions here. So, I return the podium to them.

MR. DIAZ: The question of translators, I remember when I arrived in Connecticut, I did offer my services as a translator and I was called one night at 2:00 a.m. to identify these two teenagers that were completely destroyed in an accident. And it was a real heart-wrenching thing for me that, for months, I had this image of these two kids in that car. So, here I was, so, it could be a painful situation trying to go in and translate for these people without really getting into the problems and feeling part of it and while trying to be objective and describing, you know: That's his name. He's Hispanic. Yes, that's his head next to him and all that stuff. I have been through that experience and it is not something that I would like to go through again.

My question is so that I can understand better maybe from the client's point of view, maybe Panel A, could somebody, let's assume for a moment that I am coming from Laos, from a little town in the country. And let's say I am still there and I experience any of these problems, what do I do? What is the traditional way for me as a resident of that country to go look for help if I have mental or physical problems? What? Is it so different from us? Those are the things that I would like to see how different it is seeking this help.

MR. PHENGSOMPHONE: The mental health, this area is not well know, especially -- I can say, when you say Laos, I can Laos, especially when you say mental health. The world is crazy. In translating mental health -- well, we have to get around to interpret with a conception, what is the concept of the interpretation. The question, if I have the problem, I will go to see the elderly people, I go to the Buddhist monk. I would do meditation and sometime use medicine as the help that I would go for.

MR. DIAZ: The point that I am trying to make is that on the accessibility of the service, would the acceptance of these people of those services and that treatment. That in reality even we can have the best translators and the best services available and still those people are, because of their operating and their culture

will not accept that as good treatment and they reject it.

MR. PHENGSOMPHONE: See, if the professional, it's the mainstream professional American person here, of course, he was going to college here and great medical school and whatever it is. He would use the interpreter at his facility and then the interpreter could translate only to what he has been asked to translate. But the culture, background and belief, it could be different, of course. That's what I'm concerned.

My concern is how can we cure the patient psychologically effective to the patient without knowing the background and history of the patient of mental illness patient?

MR. DIAZ: What I am saying is it goes both ways. The knowledge of the patient of the medical profession and the profession of other clients. And I know in some cultures, you go to the doctor and the doctor tells you what's your problem and here the first thing the doctor tells you is: What's wrong with you?

So, maybe we're -- in this society, we are more asking the doctor than the doctor telling us. Those are the kind of differences that I'm trying to make.

MR. PHENGSOMPHONE: What I can see if the professional can collaborate or work together through the ethnic people to figure out, to combine, to learn from each

other and to collaborate, this technique I believe that it would work well.

CHAIRMAN STEWART: Along with that question, if Commissioner Ginsberg and his colleagues are able to work their magic and upgrade the training of professional translators who are competent in the subject. Are there such people in numbers necessary available to be recipients of this training and this position?

MR. PHENGSOMPHONE: Yes.

CHAIRMAN STEWART: Yes.

MR. PHENGSOMPHONE: Yes.

CHAIRMAN STEWART: Ms. Gordon?

MS. GORDON: I have two questions. One is for Commissioner Ginsberg. I know you shared that it would be possible maybe in the future to work within the same framework that the federal or state has, but I want to know what would be your primary recommendations for the State of Connecticut in trying to seek more vital federal and state dollars for the Asian refugees to provide more credible mental and health services for them? In other words, I also heard, which is a part of the second question, that state officials and also people from private entities have filed for various grants and the second part would be: was there some type of common reason why they were not funded? Not a significant part of the population of people within the

State of Connecticut or just what? But in other words, what would be some of your recommendations in seeking more federal and state dollars?

MR. GINSBERG: Well, I think in terms of just -- it is very awkward and I don't mean to single out ORR, but, for instance, it is one of the single agencies that sequestered money. That unit made an effort to not spend money under the Gramm-Rudman cuts.

I think that to the extent that I had the ability to ask to put more money, not even across the board, that I think to the extent that it could put out grants for mental health services or for that matter for just services, but I think what I really do believe is that those who have spoken today and those have spoken to any of us are best able to define the needs of that population. And to the extent that mental health and health services are a primary focus it will come to be a primary focus in the discretionary dollars.

So, it may be that rather than focusing solely on that issue, it would be more dollars to allow in the broadest discretionary way. And I think, as I said ORR has begun to do that.

We need across the board, as we have done now in other issues, is to look for the fact that the federal government may not and the state government may not be able

to and to use private resources where possible. That means grant foundations, corporate giving, anything to attempt to make this a very important issue to them. We have raised other issues in very short times so that the public acceptance is very high of the need for dollars. I think we need to do that here.

Its history in ORR is unfortunate in many ways. And I will just take a minute if I can to briefly say what I mean. Because it was a federally funded program, financed almost fully by whatever Congress believed needed to be funded. And because it has been funded over years against the need that came out of the war, as people have literally forgotten the need, the dollars have been reduced. And whatever the reason, they were not picked up because it continued to look like a federal-funded program, one of the few solely federal funded programs.

As the bottom fell out, I think we have tried to fill that but the timing has been off. We need to go out and find other resources beyond governmental dollars to make it happen. It can be a long hard effort, but I think one that we all need to do.

I would say that flexibility would be the priority. And I would be willing to say flexibility is one of the contingencies that the state government or whoever it is work with the community to make sure that their needs are

being addressed so it is not what we believe it is, it is what they believe it is.

If they tomorrow turned around and said, for whatever the reason, that mental health and health services were not primary, that something else is primary, I think we have got to be able to say that's a population that needs to decide for itself what is most needed for them.

(Continued on next page.)

MR. GINSBERG: I think also, just generally in terms of our report and I would say that to the extent that it's possible to say that this is an important issue for yet years to come that if you recognize it within HHS it's an important part of HHS. I don't know where the new secretary is going to fall on it, I don't know where under the secretary it's going to fall, but I think that to the extent that people perceived it as being reduced in terms of importance and it's being absorbed in other structures, it needs to get a resurgence if Congress and the administration believes it ought to.

CHAIRMAN STEWART: Comment here, if any of you want to comment you may make a comment as well.

MR. JOHNSON: I'm sitting here reflecting on some of the things that have been said, it occurred to me that from our own experience there have been a number of southeast Asian people who have come to this country who are very qualified to work in the health field, for example. And there are other barriers out there particularly for positions. At one point we had three medical doctors on our staff who were working with resettlement workers because they could not get certified as physicians in this country.

One of them at one time was the personal physician to the King of Saudi Arabia and could not get qualified to be a physician in this country. Graduates of some of the

finest universities in Europe, medical schools in Europe who could not get qualified and they are southeast Asian people.

So there are barriers inherent in our own health system that exclude persons educated abroad or trained abroad who are in fact health and mental health professionals, both nurses and physicians. And perhaps this arena too in the health field needs to be examined. I know another -- changing the subject a little bit, Aetna Life & Casualty here in Hartford has a unit of 15 people who are doing nothing but training supervisors on how to work with an ethnically diverse work force. That is becoming clearly for business and industry an arena for the future. I think it would be a beneficial arena for health care professionals and human service professionals as well, to bring some focus along that line so that the kinds of things that the Commissioner spoke of earlier relative to training of mainstream professionals so that they're sensitized to ethnic and cultural diversity is essential.

I think too, within the southeast Asian ethnic populations and national populations I think those populations themselves have some responsibility to encourage young people to pursue careers in human services and health. And I know they do. And the education arena, the English as a second language area, perhaps the curriculum there needs some review to insure that a key part of it deals with

medical terms and anatomical terms so that those who are learning the language can adequately communicate what their ills and ailments are to mainstream positions. So that's just a couple of quick reflections on some of the comments.

CHAIRMAN STEWART: Any other of the panel members?

MS. BERTO: I would like to go back to talking about getting private money which I am very happy to hear. But second the idea of training people, for example, the federation workers can be more sensitive and knowledgeable in areas of health and mental health.

They already have with their primary resettlement roles a whole plate. And then when it gets known that they're even better translators they're going to be working 16 hours a day instead of eight. A lot of times interpreters are asked to come and they're not paid for interpreting. And these poor workers are already stretched beyond endurance as it is. I would like to make sure that we don't get shafted with a very quick and seemingly cheap way of educating people. I would hope that a much larger pool of people would be trained and they would be paid to be trained because they all have families.

CHAIRMAN STEWART: Yes?

MR. CAVANAUGH: Just like the use of interpreters is extremely helpful, but ultimately for us I think the service system we would like to see the approach adoption

requested be put in and funded and we would like to see that kind of a service model evolve. I think that ultimately would be the best solution for the problems that we're talking about here.

MS. CHANG: I would like to ditto that because I would say if the bottom line from a civil rights point of view is the equally affected services, you have to look at the service and you have to look at the individual to make that determination. And for some, an interpreter -- for some types of services, for some individuals an interpreter is fine. Other types of services and for other individuals it may be finding the staff.

So training in the profession for which the service is being assigned. So it's a case by case development.

MR. GINSBERG: I think there's also a need to make sure we don't single track the issue. That is to say do one or the other. This is a need greater than supply all the resources we have if we just go one track. To the extent that I think Carol's right, I am not advocating that we sort of have this free supply of people. What I guess I was saying was that to the extent that they argue -- again go back to the question of whether there's access and what's the quality of it? If people are being used now they ought to be able to be used in the most and best way, not to be

overused because they do not have a greater skill, put much more of a burden on them. We need to increase the numbers. And to the extent we can I think we will.

CHAIRMAN STEWART: Ms. Berto?

MS. BERTO: I was wondering when we heard that the budget option was sliced out of the budget. John Cavanaugh from DMH and I were talking about trying to find private monies. And DMH did not have the personnel resources to do a major proposal. But since mental health and health issues are very intertwined and since DHR is responsible for refugees in Connecticut, I was wondering whether all four of these agencies could pull resources that could come up with one person that could write grants, could find this outside money.

Maybe one agency doesn't have one person that can do that. But maybe four agencies could find that kind of thing. Because there's more than the Johnson Foundation out there.

MR. GINSBERG: I think there is a clear role the DHR has to play, no question. I think to the extent that it's been a question to try to allow those who are best able in some cases, where the services directly are going to be to go forward as it should. I think there's a need to look at everything that's available, whether it's discretionary federal dollars. Out of any place, not in terms of -- or

any other grant that's available. We've gone after every dollar that was available for homeless, we need to go after every dollar that's available for this population as well. That's a simple succinct answer.

CHAIRMAN STEWART: The question was quite specific to a pooling of resources for one individual. Is that something that's immediately possible?

MR. GINSBERG: Yes. I mean I think it is to the extent that -- no, I mean to the extent that I don't want to mislead anyone up here. That there is state employees who are just doing nothing. We are all going through tremendous look sees in terms of staffing. To the extent that this is a priority, and I guess that's what this is all about, we need to be able to figure out how best to utilize resources through departments to go forward on an issue. And to the extent that there is a group that needs -- to the extent there is a group that has not yet met we all get the Federal Register, we all know by word of mouth what's available. We have to make sure that we don't miss any opportunity.

Part of the question that was asked before about history, I think we did -- we had in the late 70's, early 80's grant, it ended the issues that I think John spoke about in terms of numbers is an effort that we all have to make to make sure that we can substantiate. Because whether it's this issue or any other issue somebody's looking at

need. And need is determined by numbers not just in the abstract.

CHAIRMAN STEWART: What are the mechanics to address Ms. Berto's question. You answered in the affirmative that that is possible. What would the mechanism be from this moment on?

MR. GINSBERG: There is a group that meets on a monthly basis that discusses and describes all issues surrounding refugees that my staff meets with, both --

CHAIRMAN STEWART: What is it called?

MR. GINSBERG: Refugee Committee.

CHAIRMAN STEWART: Volunteer organization?

MR. GINSBERG: No, it's --

CHAIRMAN STEWART: Does Governor Spielman serve as cabinet?

MR. GINSBERG: No not that one. That's a different issue. There's a group of staff people that meet --

CHAIRMAN STEWART: Human Services Cabinet, is that the one?

MR. GINSBERG: No, that's --

MS. BERTO: I think it's Refugee Advisory Committee?

MR. GINSBERG: Yes.

CHAIRMAN STEWART: Committee Member Smith is

familiar with the group so we can rely on her input and experience to follow up Ms. Berto's suggestion and the affirmative for response of Commissioner.

Before we stop we have a comment from Committee member Eckles.

MS. ECKLES: My question in a way has been answered, part of it. But I wanted to pursue a little bit this mention made of developing training models, or some special ways of reducing some of the needs that I heard.

Mr. Cavanaugh spoke of their past of being aggressive case finding, but is that really going to take care of it because obviously adding more staff or putting in some more resources right now doesn't seem to be the answer. I have heard a number of you speak of people who don't come to clinics that even if they were bound, you know, would you be able to intervene. Is there any hope for that kind of thing?

I'm worried about the attitude now, I guess, of the country and where we have gone. And not having time to develop the agency, but how will that be addressed in a proposal, or is there really a need to come up with something and maybe it's already there. But how do you feel about really designing something that addresses a different relation. We've had to do that, that's the history of the country. And it has been to address different groups in

ways that were in there?

CHAIRMAN STEWART: Anybody?

MS. ECKLES: Anybody.

MR. CAVANAUGH: I think that's a good question. I think that was one of the questions that when I got initially involved in this I had myself. Even if we did everything that was supposed to be done would there really be a response? Basically the model that we've been talking about is a model that is in place in Brighton. And if their figures are reliable they have gotten people.

So while we don't have direct evidence that there's a service demand out there in the usual sense certainly their experience suggests that if you get the right kind of case finding or you get the right kind of services in place you will be utilized.

MR. GINSBERG: My experience in legal services is that it's very clear that if a public perception is that there are services to begin and people will come because they see those services. And public perception is there are not services to get either quality or acceptance, you will find them going right back out in terms of they will not come forward.

The public and the "street" is very very cognizant of the world. And I think as John said, if the services are there that people feel good about it you're going to find

people coming out to get those services. Until it believes that the numbers are going to not be there just because they know they don't want another rejection. There's no need to have more frustration to come forward and then find yourself unable to get services that you feel satisfy your needs. So you just don't request them.

CHAIRMAN STEWART: Ms. Berto, before we get another question do you want to respond?

MS. BERTO: Yes. I want to ask Commissioner Ginsberg, you talked about the Refugee Assistance Program being the proper place for proposal writing, and that's composed of volunteers like myself and VOL-AGS and Department of Health and Welfare and things like that. Why do you think any of those people who are already vastly over-worked are going to write proposals that should be properly --

MR. GINSBERG: I think you misunderstood me. Let me clarify. I'm saying that I think grants and proposals, community based services have to have the input of those that are going to be involved in those services. I raise it at that form only because not that they would end up writing it, but because I think they have a strong input of what goes in. Not being created in a vacuum in state government that says this is what we think we're going to go after. And then people say to us but this isn't what we think we need.

The VOL-AGS and the Federation are closest to what nuances and what needs there are when someone else decides to sit down and put pen to paper. That's all I was reflecting on.

CHAIRMAN STEWART: The Refugee Committee was responding to, in reference to the one individual that would help agencies.

MS. BERTO: Yes, is this one individual going to end up coming to the Refugee Assistance Program meetings when there are proposals that should be responded to?

MR. GINSBERG: I can't sit here and tell you all the logistics because I don't have them yet. But I think to the extent that the state government needs to go after resources that it finds available for funding it will do so.

CHAIRMAN STEWART: And structurally that's a first step.

MS. PHENGSOMPHONE: Are you saying that you're going to have to find that person?

MR. GINSBERG: Yes, and my sense is it may be somebody from one of the agencies, depending on -- or it may be somebody from my agency or maybe some other way to find it.

CHAIRMAN STEWART: That's very generous of you and we thank you for it. Any questions on that?

COMMISSIONER CHAN: It seems Ms. Berto has asked

several questions so I guess she's pretty satisfied.

(laughter)

COMMISSIONER CHAN: Now I have a question I would like to ask Mr. Diaz.

CHAIRMAN STEWART: He left.

COMMISSIONER CHAN: Oh, he left, okay. Well, sorry. How about Mr. Johnson? Mr. Johnson you are representing the public area and first let me say I really admire the public people on the Refugee Resettle area because came back to 1975 I was one of the -- and the Catholic Conferences and now the -- we all work hand in hand in the Camp Pendleton and Indian Tomcat, Pennsylvania.

Now since you are on panel A, and like I said besides money and understanding the panel B people have the limited ability of funding and so on, what is your most important thing that you wish?

MR. JOHNSON: First of all thank you for your nice compliments and the Catholic Agencies have many friends working in the same field and some of them are represented here today from a fiscal consumption service and social services and various other centurion and non-centurion groups as well. I would be remiss if I did not recognize their mutual contribution as colleagues in Connecticut.

In terms of what my wishes would be, to some degree, as I reflected earlier, I kind of captured those.

Some ways perhaps that would have minimal cost factors would include training programs for mainstream professionals. In other words, providing training programs for physicians or clinicians or various professions to assist them in being more sensitive to the medical and cultural needs of southeast Asia people. That might be one cost efficient way of at least getting at the problem by addressing what services are already out there that need some cultural assistance.

Beyond that the training of interpreters and para-professionals and perhaps the creation of a pool of people who would be available as interpreters and trained to do the interpreting and a fund set aside to pay them for the hours that they devote to performing that task. The problem with that is it doesn't necessarily assure ongoing employment to people, their availability if they're working people becomes very limited but there might be some potential there.

The curriculum issues with the English as a second language as a curriculum perhaps needs to be addressed to insure that medical and mental health terms are part of that curriculum. And the certification and recognition of credentials from physicians and nurses in other areas. I would ask the panel B folks representing state agencies to be sensitive and I know they mention this in their remarks in hiring new staff that they seek people with the culture,

background, training that will enrich their existing status by making them more diverse and more responsive to the needs in the broader community.

So those might be a few things. But above all of that I think dollars still is a driving force and the need for additional resources is, I think, clear and evident. And I think the volunteer community certainly would welcome the opportunity as we've had it in the past to continue to work with our responsible state agencies to address this.

CHAIRMAN STEWART: Thank you. Anybody provide any questions?

MS. KUOCH: I would just like to add one thing. I would like to wish that this refugee came to the state of Connecticut. We need people to give them the possibility. Perhaps Mr. John Cavanaugh will contact the Health Department and the other alien who already had program, go elsewhere, and will put together, work together to assist. Because either we ignore this time, I know that in the future this refugee became American and they're all going to come over again I guess. So we have to take care of individuals. Thank you.

CHAIRMAN STEWART: Yes sir?

MR. PHENGSOMPHONE: I would like to emphasize today regarding Mr. Johnson concerning the certification and qualification in order to become, to work with a state

agency, that it's really, to me, they have to pass some tests. That's what I know in DCYS they have to -- the refugees have to pass. Not the refugees, everybody has to pass the test. And that test is an American made test. And the refugees here for only eight or nine years is like a grade 7 or grade 8. And being the second language they do have the experience of dealing with the community. I see that it is very difficult to pass the test in order to become -- the state system will observe the ethnic people it will become a possibility for their own people in order to work in a state agency.

CHAIRMAN STEWART: Well, if I understand the thrust of that question, it's the quality of tests. Is there a response to that?

MR. PAWELKIEWICZ: Yes, I would like to respond to that. We at DCYS about three years ago ran into a problem with people who were of Puerto Rican descent who would take our social work exam, and this was not just a DCYS problem, all but Human Services agencies were having the same kind of problem, and we got together and met with the Director of Personnel and restructured the test. So there is a capacity within the system, and depending upon the job classification, I don't want to get into the bureaucratic wording but there is, if there is a need -- if the state identifies from a policy perspective a need for a certain

classification of workers, there are avenues of change that can affect the personnel system.

I'm not saying it's just carte blanch, it does take work. But I am saying that there are vehicles and mechanisms within the state of Connecticut's personnel division to accommodate that.

CHAIRMAN STEWART: Is that a structural change or a qualitative test?

MS. PHENGSOMPHONE: It was really a structural change in terms of working with members of the Puerto Rican community, of the U Conn School of Social Work. There was a committee that looked at the test and it was found that irrespective of the credentials of the candidates taking the test that people of Puerto Rican descent were doing less well when we just translated the English test into Spanish. So there was an accommodation made so that you could get at the same content areas but in a different manner. And I must say that part of my training has been in test construction and so that what they changed was not the quality of the candidates, but they changed the process in which the selection took place so that there was no bias in the test.

CHAIRMAN STEWART: Follow up to that?

MR. PAWELKIEWICZ: We've increased our capacity to hire candidates with the capacity to be bilingual. And we

have the numbers to show for that. And I'm sure our personnel department would be willing to share those kinds of statistics.

CHAIRMAN STEWART: Have you seen any practical functional difference between those that took the structurally changed test in their performance as opposed to those who were main stream, main lined?

MR. PAWELKIEWICZ: My understanding which at this level is one that is not as direct as when we were instituting these changes is that there has been no negative fall out from those changes. And we've also -- what we've also done and I think this is something that can be said in terms of recruiting professionals to work with the southeast Asian population, we have and continue to go to the University of Puerto Rico to recruit Puerto Rican social workers. And I think that what it is is that if you're willing to -- and cost effectively, it is a cost effective practice.

And I think we can make the same kinds of avenues in terms of the state of Connecticut. I think that the issue is to put this issue on the table and then to decide how it is that we're going to get to where we need to go.

CHAIRMAN STEWART: Is the Refugee Committee the vehicle for that as well to begin that effort?

MS. BERTO: There they can find people that might

help them make the test not culturally biased. I know DCYS is just very desperately seeking southeast Asians for the Denver area but none of the people who were brought forward have been very good.

CHAIRMAN STEWART: How often does the Refugee Committee meet?

MR. CAVANAUGH: Monthly.

CHAIRMAN STEWART: So we have two agreed upon tasks that has resulted from this forum to begin with next year. Is that correct?

MR. CAVANAUGH: There is an issue though that also has to be addressed at the same time and that issue is the credentials. Because in order to get into the examination at certain levels you need to have certified credentials. The problem that we're encountering most frequently is the credentials are not at the level that qualifies desertion for the examination. So that has to be addressed at the same time.

MR. GINSBERG: Yes. I think what Walter was speaking to was how to you take people who are credentialed in terms of social recourse who could deal with DHL in terms of the direct service and make sure that somehow once having been entered into the exam process they're ranked in some way that makes them excessive and available for choice. Because in the civil service there is a promotion system,

there's a list and you have to be at a certain level with a number of openings. Which John, I think, is speaking to as a problem of how do you get into the fold to be able to take the exam to begin with, regardless of how well you would do if you were to take it.

I don't want to mislead anyone to think that this is something that is very simple. It's clearly one that we will have to walk an edge between what's right and not looking like as you said, Mr. Chairman, on the other side looking like we're going to have these people come down in violation. The whole issue of testing and credentials and acceptance is I'm not sure the courts have decided exactly where we're going to fall.

CHAIRMAN STEWART: Let's keep it out of the courts, please.

MS. BERTO: We don't have to reinvent the wheel. We could go to a state like California who has already been through this and see what they did.

CHAIRMAN STEWART: Well, you might want to check with the Commissioner after we break and before he runs to his plane.

COMMISSIONER CHAN: No more questions.

CHAIRMAN STEWART: No more questions? Well, the public generally in these forms has no specific voice but since I have the boss here --

(laughter)

CHAIRMAN STEWART: Anybody from the public who would like to ask a question or make a comment? Yes?

QUESTION FROM AUDIENCE: I would like to ask a question that is probably very naive but I am coming in at the tail end of this. Has Connecticut rejected the model in Brighton for philosophical reasons or financial reasons?

MS. BERTO: Financial, as I understand. It just was not allowed to stay in the budget.

MR. PAWELKIEWICZ: And I wouldn't term it as rejection, I would term it because that would imply that someone made the evaluation of the model even on fiscal grounds and said we don't want to go this way. That's not the way that I understand this decision to have been made. The funds just were not there for a number of programs. And that was one of a number of programs. And I'm sure my colleagues will correct me if I'm wrong.

But I just don't want you to think that it was a negative affirmation of that program in any way or shape or form.

MR. GINSBERG: I think I said it earlier, but I guess I just want to reaffirm it. This budget cycle, the one that we just passed, there were, I don't want to say none because there were a small number of new initiatives. But you're talking about new initiatives. As every agency was

going through itself reductions from between 5 and 10 percent of its ongoing services budget. So it is not a reflection of this program versus something else. It's a reflection of not being able to put on new programs at the time when old programs were being reduced.

MS. BERTO: Were new initiatives funded when they had losses?

MR. GINSBERG: I don't know how to respond to that, Carol, in terms of the general -- clearly if there's a court decision on something that the state needs to do, it does. It doesn't respond solely because of a law suit.

CHAIRMAN STEWART: Before we have another comment, may we get your full name ma'am, for the record?

QUESTION FROM AUDIENCE: Mary Sanady.

CHAIRMAN STEWART: Could you spell that for the reporter?

QUESTION FROM AUDIENCE: S-a-n-a-d-y.

CHAIRMAN STEWART: Okay. We have a couple of people who have to catch planes out of the great city of Hartford. If there is any final question, comment, criticism or agreement that you'd like to make we'd be happy to hear it. Yes?

QUESTION FROM AUDIENCE: I'm Caroline D'Amato from the University of Connecticut Department of Nursing. One of the things that I'm doing now is working on grant funding so

that we can bring in southeast Asian students into the nursing program. So if there's any way that any of you can help me to do that or if there's any way we can share information on that that would be something that we would like to get involved with.

CHAIRMAN STEWART: Thank you. Okay I'd like to thank all of you and particulary the public represented here, and my colleagues on the Committee. And I think if we follow up the two concrete suggestions and affirmations by the Commissioner and others through the Refugee Committee we will have taken one giant step to helping this community out. Thank you all.

(Whereupon, at 4:00 p.m., the hearing was adjourned.)

Certificate of Reporter, Transcriber and Proofreader

Forum on Access to Health/Mental Health Services et al
Name of Hearing

Docket No. (If applicable)

West Hartford, Connecticut
Place of Hearing

March 30, 1989
Date of Hearing

We, the undersigned, do hereby certify that the foregoing pages, numbers 1 through 123, inclusive, are the true, accurate and complete transcript prepared from the reporting by Jay Lavelle in attendance at the above identified hearings, in accordance with applicable provisions of the current GSA professional verbatim reporting and transcription contract, and have verified the accuracy of the transcript by (1) comparing the typewritten transcript against the reporting or recording accomplished at the hearings and (2) comparing the final proofed typewritten transcript against the reporting or recording accomplished at the hearings.

Date — Name and Signature of Transcriber
Heritage Reporting Corporation

3/31
Date — Name and Signature of Proofreader
Heritage Reporting Corporation

3/30
Date — Name and Signature of Reporter
Heritage Reporting Corporation