

SOUTHEAST ASIAN REFUGEES AND THEIR ACCESS TO HEALTH AND MENTAL HEALTH SERVICES

CONNECTICUT ADVISORY COMMITTEE
TO THE UNITED STATES
COMMISSION ON CIVIL RIGHTS

This summary report of the Connecticut Advisory Committee to the United States Commission on Civil Rights was prepared for the information and consideration of the Commission. Statements and viewpoints in the report should not be attributed to the Commission or to the Advisory Committee, but only to individual participants in the community forum where the information was gathered.

A SUMMARY REPORT

MARCH 1990

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Letter of Transmittal

Connecticut Advisory Committee
to the
U.S. Commission on Civil Rights

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The Connecticut Advisory Committee submits this summary report to advise the Commission on the level of access to health and mental health services experienced by Southeast Asian refugees of our State. The report summarizes the proceedings of a forum conducted by the Committee in West Hartford on March 30, 1989. It has been recently updated and was unanimously approved by those members on the Committee at the time of the forum.

Appropriate background work was carried out to prepare for the forum, with every effort made to assure a balanced perspective on issues by inviting Federal and State agencies, resettlement units of nonprofit agencies, and community organizations. Indeed, as one community participant wrote after the forum, "Never before have we had the simultaneous attention of all the relevant State agencies!" We were also gratified to have been joined by former Commissioner Sherwin T.S. Chan, who was then completing plans for the series of roundtable conferences on the civil rights of Asian Americans around the U.S.

Unfortunately, turmoil in parts of the globe persists. With last year's collapse of peace talks in Cambodia, continuing flights of boat people from Vietnam, the expulsion of some boat people from Hong Kong, and an expected increase in the emigration of Soviet Jews and others in search of refuge from oppression, we trust that this report may prove informative regarding certain problems faced by refugees in our region of the U.S. today.

Respectfully,

IVOR J. ECHOLS, *Chairperson*
Connecticut Advisory Committee

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Nicholas Wolfson**
West Hartford

* Appointed after the forum.

** Member at the time of the forum.

Acknowledgments

The Connecticut Advisory Committee wishes to thank the staff of the Commission's Eastern Regional Division for its help in the preparation of this report. The forum and report were the principal assignment of Tino Calabria with support from Edna Y. Nicholson and Linda Raufu. The project was carried out under the overall supervision of John I. Binkley, Director, Eastern Regional Division.

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PART I: BACKGROUND, VOLUNTARY SECTOR PANELISTS

Background

From the fall of South Vietnam in 1975 to the end of 1989, between 8,200 and almost 10,000 Southeast Asian refugees from Vietnam, Cambodia, and Laos arrived in Connecticut; more than half are documented in records maintained since late 1980 by the Connecticut Department of Health Services Refugee Health Program.¹ The health and mental health needs of these refugees and the barriers to services which they encounter became the focus of the March 30, 1989, forum held by the Connecticut Advisory Committee to the U.S. Commission on Civil Rights.

Representatives of the private, nonprofit sector and of Federal and State agencies addressed the Committee. The Committee was accompanied by former Commissioner Sherwin T.S. Chan, who was organizing three roundtable conferences on the civil rights status of Asian Americans to be held in subsequent months. This summary report is based on the transcript of the forum and the prepared remarks submitted by the panelists. Where appropriate, other documents are cited to cover subsequent developments or amplify upon the matter under discussion.

Perspective from Federation of Refugee Associations

Houmpheng Phengsomphone, president of the Connecticut Federation of Refugees Assistance Association (CFRAA), opened the forum. He explained that CFRAA was organized through the merger of what had once been four separate mutual assistance associations serving Cambodians, Laotians, Lao Hmong, and Vietnamese, respectively. Through the Connecticut Department of Human Resources, Federal funds have supported the CFRAA since 1987.

"The majority of Cambodians are resettled in [the] Danbury area, Laotians are in Bridgeport, Lao Hmong are resettled in eastern and northern Connecticut, and the Vietnamese are in Hartford," said Mr. Phengsomphone.² Most were resettled by voluntary agencies, and some came to Connecticut after first having been resettled in another State. Refugees in Connecticut have become productive new citizens, and their welfare dependency and unemployment rates are low, according to Mr. Phengsomphone.

¹Using Federal statistics, the nonprofit U.S. Committee for Refugees counts 8,200; see "Southeast Asian Refugees: Estimated Cumulative State Population Including Entries From 1975 Through September 1989," *Refugee Report*, Dec. 29, 1989, p. 11. (See appendix A.) For higher estimates, see also p. 1 of untitled materials circulated by the State office of refugee resettlement during the March 30, 1989, forum of the Connecticut Advisory Committee. The State materials are on file in the Commission's Eastern Regional Division office.

²The official forum transcript and the panelists' prepared remarks submitted to the Committee for the record are on file in the office of the Eastern Regional Division.

Their unique experience before arriving in the United States was the trauma of communist terror, he explained. Many Southeast Asian family members were taken away to reeducation camps or even executed by the communists after the communist takeover of their country. Those who survived did not know where to go but simply hoped to survive. If they were able to escape from communism, they waited years and years in refugee camps for a third country to accept them for resettlement.

Prior to arriving in the United States, few had any preparation in the refugee camps about American culture, claimed Mr. Phengsomphone. Upon arrival, they generally spoke little English and encountered problems related to cultural adaptation. He asserted that:

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 cultural social background.

Some of the Southeast Asian refugees have committed suicide, and some are in mental institutions. Mr. Phengsomphone asked the Committee to help these refugees receive the help they need while making the transition to the mainstream.

Cambodian Victims of Torture

Khmer Health Advocates, a West Hartford-based organization, was represented by two officers. Theanvy Kuoch, an American-trained family therapist who is the organization's program director, described herself as a survivor of the Cambodian regime of Pol Pot. She said that Cambodia was a stable nation of about 7 million people in 1970, but since then, at least one-third and possibly as many as one-half of the Cambodians have perished from war, disease, starvation, and political terrorism. She added that 90 percent of the Cambodian population meets the United Nations' definition of torture victims.

Upon entering the United States, Cambodian refugees had few possessions and almost none of their traditional resources for comfort and healing. She cited studies indicating that about 20 percent of adult Cambodians show serious symptoms of depression, and another 16 percent exhibit symptoms of post-traumatic stress disorder.³ But the community elders had almost all been eliminated, and few Buddhist temples existed. What traditional healers there were had no access to native herbs and medicines. In addition to psychological trauma that went untreated, the refugees arrived with diseases such as tuberculosis, malaria, hepatitis, and cholera. Some had parasites, while a high incidence of liver cancer and eye disorders among them was caused by chronic malnutrition.

In 1982, Khmer Health Advocates was formed to help Cambodians avail themselves of mainstream health and mental health services, Ms. Kuoch said.

However, it soon became clear that this was an impossible task. Because of the relatively small refugee population in the State, health care providers had little

³For related data, see "Cambodian Mental Health Screening Project," Khmer Health Advocates, Inc., West Hartford, March 1988.

background and understanding of Southeast Asians and almost no idea of the differences in their cultures and experiences. They also felt that it was not their responsibility to train or employ translators.

Meanwhile, depression and post-traumatic stress disorders have become a major cause of domestic problems. Family violence and child abuse, both physical and sexual, has increased as well as alcohol and drug abuse, family abandonment, and gambling. Ms. Kouch observed that in the face of all this,

in Connecticut, Cambodians are not 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 child or a translator who had no training in medical or psychological terms.

Example Cases and Suggested Remedies

Ms. Kouch then described four specific cases to illustrate her charges. One woman, who had lost her first husband and seven children during the Pol Pot regime and who was tortured and raped, was hospitalized after threatening to kill herself; she was kept only a short time because she could not communicate and was told that long-term therapy was unavailable because the therapist refused to work through a translator.

A father was excluded from the treatment plan of his psychotic daughter because he believed that the spirits must be consulted before his daughter received medicine; the translator was ashamed of this belief and refused to communicate the father's concern. Upon being medicated, the daughter drooled and was unable to sit still. After the father signed her out of the hospital, he was reported to the authorities for child neglect.

A woman suffering from convulsions was termed uncooperative for not permitting medical personnel to perform brain tests. It turned out that she had been tortured by the Khmer Rouge, who tied plastic bags on her head until she would pass out. As a result, she could not bear having her head touched or covered.

A man who had suffered a serious stroke in a refugee camp and who still had markedly high blood pressure was denied supplemental security income because he had no physical handicaps from the first stroke. None of the four physicians who had examined him noticed that he was confused and did not know where he lived or what day it was. He could not work, and his family could not leave him alone because he would wander off and become lost.

To remedy such problems, Ms. Kuoch then proposed four measures: educating bilingual health interpreters and employing them in regional health facilities, such as hospitals, to which refugees can be referred; educating and employing outreach workers able to identify symptoms of depression and post-traumatic stress disorders and knowledgeable about health education and referral; establishing regional centers where health care professionals can be trained to treat refugees and torture victims; and educating local leaders who can work with high risk groups such as adolescents, widows, and the elderly in a self-help capacity.

Ms. Kuoch closed by stressing that refugees are not immigrants. 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. In the name of fairness and compas-

sion, said Ms. Kuoch, refugees should be given access to culturally appropriate services in a system to which they, too, contribute.

Untreated Mental Health Needs Affect Generations

Carol Berto, the community relations director of Khmer Health Advocates, has helped to resettle refugees since 1985 and stated that the first thing any refugee needs is some measure of mental health care. She observed that, if the psychological effects of systematic destruction and torture remain untreated, the aftereffects can be passed on to a later generation, as Jewish holocaust research has shown.

However, mainstream clinics and institutions are incapable of providing appropriate services, asserted Ms. Berto. Not only are there language and cultural barriers—especially to self-referral—but mainstream professionals just do not know about torture. They might know about a midlife crisis or a little about child abuse, but they do not know about severe torture. She reported that they misdiagnose, prescribe the wrong drugs, or shut refugees away, as happened to two Vietnamese women in Connecticut who were institutionalized for 8 years without therapy but with drugs “to keep them quiet.”

How Many Refugees, and How Many Require Services?

Ms. Berto added that a minor problem is that no one really knows how many refugees reside in the State. Upon initially arriving, a refugee may be identified, but if a refugee gives birth, the newborn may not be added to the known population of refugees. Moreover, a refugee who first arrived in California but later moved to Connecticut is similarly not necessarily added to the population of refugees thought to be in Connecticut.⁴ Although many may require services, because these refugees go uncounted, no agency is paid to provide services to them.

She pointed out that the Federal Government does fund some social services, including mental health care, in a few States but not mental health care in Connecticut. She reported that, just prior to the Committee's forum, 36 mental health clinics throughout Connecticut were surveyed. Of 14 respondents, 8 clinics served some Southeast Asians. None had translators but depended on the patient's friends or relatives, whether or not those friends or relatives were trained. If the patient was not accompanied by a translator, one clinic utilized the services of a local university, while two others requested help from a local refugee organization. No clinic had outreach services, and only one reported staff training for handling refugee patients.

The four bicultural social workers from the federation have been expected to translate in medical and mental health situations for which they have no training, according to Ms. Berto. They must cover the entire State on their customary resettlement business, and sometimes the

⁴See also R. L. Bach and R. Carroll-Seguin, “Labor Force Participation, Household Composition and Sponsorship Among Southeast Asian Refugees,” *International Migration Review*, vol. XX, no. 2, Summer 1986, pp. 381 ff. The authors note that January 1980 U.S. Immigration and Naturalization Service “records cover all refugees who lived in the United States in January 1980” and that a U.S. Office of Refugee Resettlement Master Data File of Refugees “covers all refugees who entered the United States after 1979.” The authors also observe that “The INS file provides an address that was accurate in January 1980. By 1982 or 1983, many of these addresses had changed. Similarly, the [Office of Refugee Resettlement] files included only the refugees' initial place of residence,” p. 391.

federation has been unable to pay the workers for months, yet hospitals have expected these workers to respond to calls at any hour. Ms. Berto added that, if workers protest that they are exhausted or untrained for the specific situation, they may be verbally abused.

Mental Health Over Job Training

Ms. Berto noted that job training is made available nationwide, and since job training requires a knowledge of English, usually language instruction is also available. But she said to the Committee that, if the Federal Government has to "rob Peter to pay Paul," she would rather have it put money into mental health than into job training. She imagined a situation in which a refugee in training is "parked" in an English class where it is nice and quiet. However, he starts thinking back. He starts getting flashbacks remembering all the bad things, and he does not really concentrate on English. He needs mental health services as much as he needs English, perhaps more.

She also explained that the Connecticut Department of Human Resources has been designated by the Federal Office of Refugee Resettlement (ORR) to channel funds in the State. However, she asserted that the department has never appointed a State program head with sufficient authority or concern to advocate adequately for Connecticut refugees. It has been a very passive program, and it is unfortunate because there were mental health funds from the Federal Government that Connecticut did not get. And there are other opportunities that are continually passed up because there is no advocacy.

State-Convened Meetings and Unofficial Task Force

Ms. Berto acknowledged that at the direction of the Federal ORR, the State department of human resources created the federation. She said that the department chairs the monthly meetings of the voluntary agencies and other organizations, which are positive because at least all the participants get to talk about their problems. She further noted that there had been two attempts to acquire needed mental health services, but without active advocacy by the State coordinator, the Federal ORR did not respond with funds.

Consequently, in early 1987, many attendees of the department's monthly meetings formed the Refugee Mental Health Task Force, a separate group funded by no one.⁵ Members spent a year traveling the State attempting to explain the needs of refugees in all five regions under the Connecticut Department of Mental Health. Then, in July 1988, the task force submitted a proposal to the mental health department, seeking resources for a mental health clinic. However, the department later replied that the proposal had come too late. In retrospect, Ms. Berto said,

. . . We spent a year educating about refugees and their needs. . . . 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 do not walk into

⁵"Making the Transition: Southeast Asians in Connecticut," an undated brochure, was recently published by the Refugee Mental Health Task Force. It describes what it is to be a refugee beginning life in the U.S. faced with inaccessible mental health services. The brochure also describes refugee mental health services proposed for Connecticut. (See appendix B.)

mental health clinics so people kept saying, "What are you talking about? I don't see the need."

Health Care in Danbury Applauded

Samuel E. Deibler, Jr., executive director of the Association of Religious Communities in Danbury, is responsible for the Danbury Resettlement Center that manages client-oriented services for Southeast Asian refugees. He stated that the Danbury Hospital, the Health Department of the City of Danbury, and various clinics and private, nonprofit agencies are concerned about the health services needs of these refugees. The bellwether of their success has been that Southeast Asians themselves refer new arrivals, secondary migrants without sponsors, to the health care clinics when they first arrive in the community.

On the other hand, Mr. Deibler claimed that the record is more uneven in education and training. Refugees came to Connecticut because of the success that the training programs run by the regional technical school experienced. He added that elementary schools performed well in providing English-as-a-second language instruction for young children. However, at the secondary school level, the situation is different. The Danbury high school has not had an equally good record, and in 1981 it decided to stop admitting Southeast Asians who were 18-20 years old, reasoning that since they would probably not be graduating anyway, it was not of any use to them to enter the school in the first place. Instead, these older students were enrolled in a 10-hour a week English-as-a-second language program for adults which, Mr. Deibler claimed, was not the same as such a program given during a full school week.

Exclusion by Secondary Schools Found Illegal

In 1981 Mr. Deibler's agency questioned the school system about the legality of excluding the older students and found that it was illegal. The school system's equal opportunities officer then informed the school administrators, and that practice was halted. However, in the fall of 1988 the exclusion policy was reinstated by the same administrators who were there in 1981 and had been told that exclusion was illegal. Various reasons have been speculated as to why this has occurred again, but "In any event, we find ourselves with a situation where students in the school have a sense that perhaps they are not as welcome as other students may be," said Mr. Deibler.

The employment situation also appeared mixed, according to Mr. Deibler. He estimated that two-thirds of his area's refugee population of 1,300 are unsponsored secondary migrants and that 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 eighties. Now, however, the local economy has slowed, and 2,000 manufacturing jobs have been lost in the last 7 years; they have been replaced with service jobs which offer fewer benefits and no overtime, and tend to be part-time and dead-end jobs. Adequate housing has been similarly limited.

Under these circumstances, the mental health needs of Southeast Asian refugees have become exacerbated. Mental health service providers report, however, that these refugees have not appeared in their clinics. Mr. Deibler attributed some of this absence to culture and tradition, saying one may go to a western service for financial support or for job training or to get heat. But you do not bare your soul to people whom you do not recognize.

Meanwhile, traditional religious support is only beginning to appear. Just one Cambodian temple exists in the whole State, in Danbury because of the large population there. But that is a long way from Hartford, Bridgeport, and New London where other Cambodians reside.

Quick Public and Private Action After Massacre

Patrick Johnson is executive director of Catholic Charities and Catholic Family Services for the Archdiocese of Hartford, one of three voluntary agencies which resettles refugees in Connecticut. He observed that 2 months after five Southeast Asian children were gunned down and killed while playing in a schoolyard in Stockton, California, in January 1989,⁶ the President suspended the importation of semiautomatic assault weapons, and the Colt firearms company in Connecticut halted the sale of its assault weapons to the general public.⁷

Mr. Johnson marvelled at the swift action that followed upon the tragedy and wondered what it would take to obtain similarly quick action on the resources needed to deal with the critical mental health needs of Southeast Asian refugees in the State. Since 1975 his agency has resettled over 4,700 such refugees in the State; Episcopal Social Service, over 850; and the International Institute, from 2,500 to 3,000. He estimated that 15 to 20 percent of the refugees are in need of mental health care, and he presented a synopsis of over 40 example cases. He also mentioned that, less than a month before the Committee's forum, an 18-year-old Vietnamese girl committed suicide and that five other suicides had occurred in the past 2 years. At another point, he said, "The dramatic success of so many Southeast Asians in our academic settings often mask the equally dramatic failures," as numerous accounts suggest.⁸

Voluntary Agencies and Mental Health Referrals

According to Mr. Johnson, in the first 30 days after the arrival of a refugee, his agency and the other two provide reception and placement services and a case management system which, together with employment services, results in a low welfare dependency rate in Connecticut. Their bilingual-bicultural staffs have been trained in all aspects of resettlement, but they have not been trained as mental health counselors or therapists. After they have referred Southeast Asians for treatment services, the refugees encountered treatment staff who were unable to speak their language or understand their culture. He added that:

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.

⁶"Racism Is Cited in School Deaths," *Washington Post*, Oct. 8, 1989, p. A-36.

⁷See also Jay Mathews, "Legacy of Schoolyard Turned Killing Ground; Stockton Massacre Fueled U.S. Local Restrictions on Firearms," *Washington Post*, Jan. 14, 1990, p. A-3.

⁸See, e.g., Fox Butterfield, "Why They Excel," *Parade* cover story, Jan. 21, 1990; Nathan Caplan, "The Boat People Belong Here," *New York Times*, July 23, 1989, p. E-25 (Caplan's 5-year study of boat people outlines their educational and economic success in the U.S. despite their previous hardships); Ron Givens, et al., "The Drive to Excel: Strong Families and Hard Work Propel Asian-Americans to the Top of the Class," *Newsweek on Campus* cover story, April 1984, pp. 4-13.

Expressing concern about how to serve the Amerasian children who were then expected to arrive in the summer of 1989, Mr. Johnson speculated that many in this high risk population will require mental health care.⁹ However, the care that they and refugees, who experienced reeducation camps, need is not available in the State. 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.

Mr. Johnson concluded by referring to the 1984 film *The Killing Fields* and the biography of its leading actor, Dr. Haing Ngor, entitled *Haing Ngor: Cambodian Odyssey*.¹⁰ People may leave the killing fields, stated Mr. Johnson, but the killing fields will never leave the people who survived. He concluded by soliciting the Committee's support for culturally sensitive mental health services for refugees.

⁹See also Gail Sheehy and Mohm Sheehy, "Who Will Help the Children of Nowhere?" *Parade*, Aug. 27, 1989, pp. 4-7.

¹⁰See also Dith Pran, "Return to the Killing Fields," *New York Times Magazine*, Sept. 24, 1989, pp. 30 ff. Pran is the Cambodian photographer whose story is told in *The Killing Fields*, produced by Goldcrest Films and Television. Haing Nor portrayed Pran in the movie.

PART II: STATE AND FEDERAL PANELISTS

Remarks by State Human Resources Commissioner

Elliot Ginsberg, commissioner of the Connecticut Department of Human Resources (DHR), acknowledged that there are services that are in fact not being given and individuals who are not being served, but stressed that the question now is: How can limited resources begin to supply the services needed? He said that the presence of his department and the others represented at the Committee's forum evidences their attempts to bring to bear their resources on the needs under discussion, adding:

The past 6 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 6 months and made a very, very big effort to reallocate the limited funds from ORR [Federal Office of Refugee Resettlement]. And I think it is important again not to put blame or to point a finger, but to recognize the reality . . . that the funds from ORR have been diminished over the years and that the number of dollars given have been reduced. And the service needs have increased, and those two twains shall never meet.

Federal Restrictions on Funded Activities

Mr. Ginsberg also pointed out that until recently the Federal Government limited itself on how it spent funds, calling for an emphasis on employment and moving refugees off the welfare rolls. He suggested that States met the goal to the general satisfaction of the Federal Government. He also explained that the policy has now changed, and States are able to allocate more funds to social services. In recent months, his department added 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 without using Federal funds to duplicate State services.

He cited examples of what his department has done, adding case management services in the voluntary agencies and more funds to the federation. Nonetheless, he reiterated his belief that the resources allotted are not sufficient to go around. As compact as Connecticut is, it is a big State and impossible for one or two persons to travel around the entire State to provide services. Regarding State funds, Mr. Ginsberg stressed that the State in almost every case rejected all budget options or proposals from all departments. That the State did not approve a budget option proposed by the department of mental health did not reflect a lack of understanding or that department's lack of persuasion with the office of policy and budget.

Mr. Ginsberg closed by reiterating that "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." Furthermore, he emphasized that what also must be done is to raise the whole base of funding on a national level.

Health and Mental Health Screening Abroad

George Raiselis, the refugee health program director in the Connecticut Department of Health Services, explained that his department's program began in 1980 under the direction, urging, and support of the U.S. Center for Disease Control. The State health services department provides the public health component of Connecticut's Office of Refugee Resettlement. His refugee health program cooperates with and complements the State refugee resettlement plan by ensuring that the refugees' health problems are addressed expeditiously.

Before refugees arrive in the United States, said Mr. Raiselis, they are screened for health conditions, classes A or B. Class A includes contagious physical diseases, ranging from AIDS to tuberculosis; mental problems, ranging from mental defects through psychopathic personality, drug addiction, and sexual deviation. Any class A condition would preclude the refugee's entering the United States, unless the refugee were to be given special consideration.

Class B includes 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 U.S. Then, Mr. Raiselis pointed out, his department's goals are to ensure a health assessment for all refugees arriving in the State. Refugees found with sexually transmitted diseases, intestinal parasitic diseases, tuberculosis, incomplete immunization status, or the like will commence treatment. Refugees with dental problems, heart and vascular diseases, psychiatric disorders, and the like also begin treatment, and finally, refugees in need of counseling in family planning, prenatal care, nutrition, and health education will be appropriately referred for these services.

Chief Health Problems Among Southeast Asian Refugees

Mr. Raiselis reported that among Southeast Asian refugees in Connecticut, the chief disease has been tuberculosis, followed by intestinal parasites, hepatitis Type B, and syphilis. The chief personal health disorders are abnormalities in dental conditions, vision, and hearing. The chief operational problem has been the lack of interpreters knowledgeable in bicultural translation of medical/health terminology. At the same time, he observed that:

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 the various cultures. Many Southeast Asian medical terms or health conditions when translated literally to English tend to mislead or confuse western health care providers.

Mr. Raiselis noted further that many people, in and outside of the health profession, view Southeast Asians as one homogeneous group instead of according full recognition to the differences among the Cambodians, Hmong, Lao, Vietnamese, and others.

Mental Health Services Through Public and Private Sectors

John Cavanaugh, administrator of the Connecticut Department of Mental Health and director of treatment services there, stated that meeting the mental health needs of Southeast Asian refugees poses a complex challenge for the mental health service system in Connecticut, particularly during the current fiscal crisis. He also pointed out that services in the State are available from the private sector as well as from the public sector and that the linkages between the two sectors are grants and contracts.

The private sector includes private practitioners, psychiatric hospitals, general hospitals, nonprofit agencies, and other organizations. Public agencies include his department (for those 18-and-over whose primary problem is not substance abuse), the Connecticut Department of Children and Youth Services (for those under 18), and the Connecticut Alcohol and Drug Abuse Commission.

Mr. Cavanaugh said that, as in most States, the need for services far outstrips what is available in both the public and private sectors. Consequently, his department focuses its resources on the most needy, particularly on poor persons with severe and prolonged mental illness and persons at risk of hospitalization. In each of the five mental health regions into which the State is divided, there is a regional board in addition to area councils composed of consumers, providers, and other interested residents. A region's board and councils identify service needs, review the quality and adequacy of services, and make decisions on how funds are allocated among current and new programs. It is at this level that support for new programming or program expansion must be generated if these programs are to be developed.

With regard to the forum topic, Mr. Cavanaugh said,

Connecticut's mental health service system . . . and the department of mental health in particular has had very little, limited experience in trying to meet the special mental health service needs of the Southeast Asian refugees. . . . [We] have relied on experts from other States. These include persons from the Indo-Chinese Psychiatric Clinic in Brighton, Massachusetts, 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 estimates he has received, the incidence of mental health problems among refugees ranges from 45 to 72 percent. High levels of anxiety, depression, psychosis, and substance abuse were among the most common types of mental health problems identified. Unusually high suicide rates have also been found among certain subgroups, such as Cambodian women.¹¹ Nonetheless, the utilization of mainstream mental health services by these groups has been very low, according to Mr. Cavanaugh.

As pointed out earlier, barriers to utilization include the fact that only a small percentage of the refugees speak English well enough to utilize mainstream clinic services. In Connecticut, there are only a few mental health professionals proficient in the languages of the refugees, and they are not necessarily in a position to serve Southeast Asian refugees. In addition, Mr. Cavanaugh confirmed that most mainstream health clinicians

¹¹Alexandra Smith, "Cambodian Witnesses to Horror Cannot See," *New York Times*, Sept. 8, 1989, p. A-10. Smith reports on a study of "functionally blind" Cambodian women in southern California who witnessed atrocities in Cambodia and who now cannot see, although there is no evidence of physical ocular damage.

have little experience with, or understanding of the cultural differences and their implications for assessment and treatment.

In addition, many problems are an expression of post-traumatic stress disorders, survival guilt syndrome, or other syndromes rarely seen in mainstream practices, and they require some variations in the treatment approaches most commonly used to manage and treat the presenting symptoms.

Massachusetts Model at 100 Percent Capacity

Mr. Cavanaugh went on to say that in States where programs have been designed to overcome these service barriers, the utilization picture is dramatically different. In Massachusetts, for example the Indochinese Psychiatric Clinic, serving greater Boston, and its spinoff agencies have been operating at 100 percent capacity with waiting lists almost since their inception 6 years ago. He believed that the contrast with the situation in Connecticut is due to the special approach designed to overcome barriers.

First and most importantly, all phases of outpatient assessment and treatment are handled through bicultural treatment teams of trained mental health professionals joined by indigenous paraprofessionals working on each case. Secondly, the program is linked closely with general hospitals, local Southeast Asian refugee organizations, and the Southeast Asian communities' own support networks. Lastly, combined with these features, the clinic adopts an aggressive case-finding and outreach posture.

\$400,000 Request to Be Resubmitted

As part of the department of mental health effort to collaborate with Southeast Asian refugee advocates, in March 1988, a team from the Indochinese Psychiatric Clinic in Brighton was invited to Connecticut to hold a workshop for over 80 of the mental health and social service staff of the department. In early 1989, the department submitted a \$400,000 request for such a program. The plan was to set up a bicultural team for each of the four Asian refugee groups. The four teams would provide outpatient services from outpatient clinic sites located in areas heavily populated by Southeast Asian refugees. However, the request was not included in the Governor's budget proposal, which included no funding for newly proposed mental health services.

According to Mr. Cavanaugh, the State's financial problems can be gauged from the fact that his department had to cut last year's budget of \$230,138,547 by \$5.4 million. Although the cut precluded any new initiatives for fiscal year 1989, he said that a similar budget request would be filed for fiscal year 1990

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.

Mr. Cavanaugh stated that his department is attempting to offer mental health services for refugees without additional funds during a time when resources were being reduced. For example, Federal policies have not allowed for ongoing direct funding for this type of specialized mental health service, and over the last 8 years, Federal funding for community mental health services in general has declined. With the inception of the block

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

Catch-22 for Southeast Asians

He noted again that the department is organized as a regionalized system, relying on regional boards and area councils to identify service needs and also to provide the primary impetus for program expansion and new funding. Consequently, the State's regional apparatus must be engaged in the process for any proposed program expansion. The low utilization of mainstream services by the Southeast Asian refugees has thus had a Catch-22 effect on them, he observed. These refugees do not seek services, even though services are needed. As a result, the mental health service providers—the regional boards and area councils—have not felt the pressure to develop these specialized services.

Mr. Cavanaugh stated that his department has collaborated with Southeast Asian refugee groups to increase the visibility of their needs. This included involvement in a one-day statewide conference, assistance to groups preparing presentations to be made to regional boards and area councils and to legislators, and giving encouragement to Southeast Asian health care consumers to become members of the boards and councils. His office recently worked with a refugee group on the development of a brochure to be widely distributed throughout his department's service system. (See appendix B.)

He also reported that his department has begun furnishing mental health care providers with video cassettes and training materials obtained through the Indochinese Psychiatric Clinic in Boston and the University of Minnesota Refugee Program Technical Assistance Center. Efforts have also been made to recruit Asian refugees for clinical positions. Mr. Cavanaugh added that the need to meet personnel standards does limit choices, but that there are applicants who qualify for mental health worker and for entry level psychiatric social worker positions.

Services for Refugees Under Age 18

Walter Pawelkiewicz, executive assistant to the commissioner of the Connecticut Department of Children and Youth Services (DCYS), stated that his is the single State agency for child abuse and neglect, juvenile delinquency, and mental health and substance abuse services for youth under the age of 18. DCYS is also the State agency responsible for the unaccompanied refugee minors program which is administered by Lutheran Child and Family Services of Connecticut. DCYS has requested a budget that would also support mental health services for Southeast Asian refugee children and will continue to press for the budget even though it was not adopted this fiscal year.

A different kind of endeavor for the agency was its cooperation with Southeast Asian advocates on a grant proposal to the Robert Wood Johnson Foundation for developing models for underserved populations. That particular effort did not bear fruit, but he expected that his agency would continue to attempt to make its services more accessible to refugees under 18.

1964 Civil Rights Act/Title VI and the Hill-Burton Act

Caroline J. Chang, regional manager of the Office of Civil Rights (OCR) in the U.S. Department of Health and Human Services/Boston, which covers the six New England States, distributed materials on the Federal statutes underlying OCR's compliance work. Two laws of immediate relevance to the forum topic are: (1) Title VI of the Civil Rights Act of 1964, prohibiting discrimination on the basis of race, color, and national origin in services receiving Federal financial assistance, and (2) the Public Health Service Act of 1965, known as the Hill-Burton Act, which requires health institutions built with Federal funds to provide services "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."

She went on to say that OCR 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, and cited the 1974 U.S. Supreme Court *Lau v. Nichols* decision. In New England, said Ms. Chang, the earliest case involving bilingual services occurred in Connecticut with the then-department of welfare, when OCR worked with that department on the provision of services to limited-English-speaking Hispanic clients.

Filing Complaints With OCR

Ms. Chang explained that OCR investigates complaints filed with it and said that:

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 does not have to be in any formal form. A letter will suffice . . . We will accept complaints in [all languages.]

OCR may also initiate compliance reviews on issues of a national or a regional priority without having received a complaint.

In addition, said Ms. Chang, OCR gives technical assistance and guidance on the responsibilities of agencies receiving Federal funds and on the rights of persons attempting to utilize the funded services. For example, OCR recently cosponsored a conference with the Massachusetts Health Council on the need for interpreters and bilingual staff in hospitals. OCR also supplies training and technical assistance on how bilingual-bicultural services can be offered.

At the time of the Committee's forum, OCR was also working with an interhospital group in Rhode Island on this subject. From her experience there and elsewhere, she has come to believe that:

many times the organizations and 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.

Efforts in New England to Serve Limited-English Speakers

As to bilingual services involving health care institutions, Ms. Chang reported that over the last few years OCR has engaged in four cases involving what hospitals had available to serve limited-English-proficiency patients. OCR has also dealt with about five or six State agencies throughout the region in terms of how they delivered services to limited-English-proficiency clients. One message to the State agencies dealt with

situations in which a private clinic might imply to a Southeast Asian refugee that the clinic cannot serve the refugee because of language barriers. She pointed out that:

The State can say, hey, you [the private clinic] can't do that by law, not as long as you are getting funds through our medicaid office or as long as you are a medicare provider, you cannot do that.

Ms. Chang then discussed examples of how to serve Southeast Asian refugees. Massachusetts has long benefited from its Governor's Advisory Council for Refugees which has looked at refugee needs across the board. Another difference is that the Bay State has had an established community of Asian Americans, which over time developed its own service network; thus, there have been places for new groups to join in, a situation that may not be true of other States.

She described another important element, the Massachusetts Health Council, a coalition of public and private service providers that:

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 cochairs, 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. . . . That task force cosponsored [the fall 1988] conference.

Rhode Island Conference and Interhospital Cooperation

In Rhode Island, OCR cosponsored a conference 2 years ago to review issues affecting Southeast Asians. Funded by the Rhode Island Foundation, the conference involved representatives of the State legislature and State agencies and included a health care panel. That subsequently led to the formation of interhospital groups which began to work together very closely. Because of the small size of Rhode Island, Ms. Chang speculated that it may have been easier to bring about cooperation there than elsewhere.

OCR also worked with the Rhode Island Department of Health. The department organized a conference on data collection in which the need for collecting data by race and ethnicity was discussed. Ms. Chang encouraged the Rhode Island conferees to consider adding a category of data based on language. She then stressed to the forum participants the need for having accurate data of all types when lodging a complaint with OCR.

Interpreter Services at No Cost to the Patient

OCR's involvement in the complaints filed against four hospitals resulted in compliance agreements regarding how they will serve limited-English-proficiency patients. Ms. Chang reported that interpreter services must be provided at no cost to the patient and that the patient cannot be forced to use a relative unless that is the patient's preference.

Ms. Chang closed by saying that 20 years ago, when she was on a board setting up a health center in Boston's Chinatown, the board experienced severe difficulties.

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 is the message I would 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 kind of things you need to make it happen.

PART III: QUESTION AND ANSWER PERIOD

Invisiblity and Lack of Political Clout

During the question and answer period, Ms. Berto of Khmer Health Advocates was asked whether the problem of obtaining bilingual services was primarily a budgetary problem. She replied that it was a matter of invisiblity and political clout. Other ethnic groups may not suffer the problem as much due to:

their numbers and because of their cultural training to be assertive. This group is not only culturally nonassertive, but they are broken because they come from war. . . . In America, it's the squeaky wheel rule. And I think that in a State that has benefited greatly from armaments dollars, you don't really want to see these refugees.¹²

At the same time, Ms. Berto added that it has also been a matter of priorities.

State Human Resources Commissioner Ginsberg remarked that this is not an issue of a silent group that has been ignored while the State of Connecticut has been trying to make adjustments within the resources available to the State. The question is, "Have we tried to move forward in as many creative ways as we possibly can?" Given the limitation on available resources, he thought it necessary to find a way to help Southeast Asians avail themselves of mainstream services, and then to apply the scarce Federal resources and the limited State resources to create the unique measures required, such as interpreter services and culturally appropriate methods tailored to specific populations—whether those populations are Asians, Hispanics, or eastern European. He added that the State was beginning to do this.

Mr. Ginsberg also pointed out that his department has reallocated \$200,000 of existing funds and that the Governor created a human services cabinet a year and a half earlier that brings together the commissioners of 10 or more agencies to review issues that cut across agency lines. The State has also created task forces in specific areas such as mental health, and they meet on a monthly basis.

On the lack of fresh funds from the Federal level, Mr. Ginsberg noted that ORR "is one of the single agencies that sequestered money. That unit made an effort to not spend money under the Gramm-Rudman cuts." Indicating that both the Federal and State governments may be unable to help in terms of new discretionary funds, he suggested that corporate givers and grant foundations might be appealed to regarding the needs under discussion.

¹²See also Tran Tuong Nhu, "The Trauma of Exile: Viet-Nam Refugees," *Civil Rights Digest*, U.S. Commission on Civil Rights, Fall 1976, pp. 59-62. On aggressiveness as an ethnic trait, Nhu writes that "If the Vietnamese are not considered aggressive by American standards, the Khmer [Cambodians] and Lao are even less so."

Priorities: Interpreters and Filing Complaints

When asked what ought to be addressed as the first priority, Mr. Phengsomphone of the federation named the shortage of bilingual interpreters. He suggested that a Lao person suffering from what would be diagnosed as a health problem here would typically go to a Lao elder or a Buddhist monk, and a mainstream health provider should be apprised of this. Ms. Kouch said that a translator may not have the ability to understand a patient, though the two may be compatriots. She mentioned one example in which the English language medical record indicated a heart case, but the Cambodian language text spoke of arm pain. She hoped that training could be given to translators to overcome this and also to help them to become more compassionate.

Ms. Chang of OCR stated that in terms of the "squeaky wheel" OCR does not receive many complaints from Southeast Asians; she again stressed that one of the ways to get OCR involved and looking at what a hospital or a State is doing is to submit a complaint to OCR. This is because with the limited resources at the disposal of OCR, investigating a complaint is given the highest priority by law.

Mr. Ginsberg restated his assumption that there were no prospects for significant new resources, and then said that his colleagues and he need to "mobilize an attempt to figure out how we can share the resources that we do have." He said in this regard that he would consult with the hospitals commissioner and his other colleagues on the issue. As to translation problems, he observed that they exist in the legal and health professions, and that taking steps to remedy the problem may not require new staff dollars but the use of training dollars.

Training Translators, Paying Community Translators

Catholic Charities executive director Johnson stated that some voluntary agencies have staffs that are bilingual-bicultural and recognize mental health needs. He said that a judge phoned him threatening to cite him for contempt of court if he would not order one of his staff to appear as a translator in the judge's courtroom. He also mentioned that a doctor demanded that an interpreter come to his hospital for a Vietnamese who could not communicate in English. When told that the man spoke French, the doctor was reported as inquiring "What he's doing learning French before he learns English?"

Thus, the training needed for staff, according to Mr. Johnson, is not so much for voluntary agency staffs as for current health or mental health staffs. He pointed out that there are:

Southeast Asian people who have come to this country who are very qualified to work in the health field. . . . 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. [Some are graduates of the finest] medical schools in Europe. 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.

Adding Anatomical, Medical Terms in English Training

Referring to a different profession, Mr. Johnson said that Aetna Life and Casualty in Hartford has a unit of 15 people who are training supervisors

to work with an ethnically diverse work force. He believed that such training would prove beneficial for health care and human services professionals as well and also thought it important for Southeast Asian communities to encourage their youths to pursue careers in human services and health. In terms of English instruction, he suggested that the curriculum might include medical and anatomical terms so that the students receiving instruction can describe their ailments to health care personnel.

Ms. Berto of Khmer Health Advocates agreed that voluntary agency staffs or other persons from the Southeast Asian communities can prove more sensitive and knowledgeable in areas of health and mental health. However, were it to become more widely known that they make better translators, "they are going to be working 16 hours a day instead of 8. A lot of times interpreters are asked to come, and they are not paid for interpreting. And these poor workers are already stretched beyond endurance." She emphasized her hope that a much larger pool of people would be trained and also that "they would be paid to be trained because they all have families." Mr. Ginsberg agreed.

Proposal Writer to Seek Private Funding

Returning to the question of private funding, Ms. Berto recalled that when Mr. Cavanaugh of the department of mental health and she spoke earlier about private funding, his department did not have the personnel to write a major proposal. Since health and mental health issues are intertwined and since Mr. Ginsberg's department of human resources is responsible for refugees in Connecticut, Ms. Berto inquired whether their two State agencies and other State agencies could provide a staff person who could write a grant proposal.

Mr. Ginsberg replied that each month his staff meets with the refugee advisory committee and suggested that it might be the mechanism to accomplish what Ms. Berto asked about. Ms. Berto, however, suggested that this could mean expecting volunteers or staff of the voluntary agencies or State agencies, individuals "who are already vastly overworked," to write proposals.

Mr. Ginsberg then explained that what he meant was that proposals for community-based services should reflect "the input of those that are going to be involved in those services." Regarding an individual who would write a proposal, Mr. Ginsberg said, "I cannot . . . tell you all the logistics because I do not 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." He noted that it remained to be determined from which agency the proposal writer would come, but he stated that there would be a proposal writer.¹³

To the list of priorities Mr. Johnson outlined previously—the training for mainstream physicians and clinicians, the training and payments for interpreters, an English-as-a-second-language component adding anatomical and mental health terms, and the recognition and certification of physicians

¹³See, however, Carol Berto, letter to Tino Calabia, Oct. 20, 1989, in which she states that no "visible effort to find outside funding" for refugee mental health has been made nor has any proposal writing resource been provided. Ms. Berto's letter was sent to Mr. Ginsberg on November 17, 1989, but as of January 25, 1989, no response has been received. (See appendices C and D.)

and nurses trained abroad—Mr. Johnson added and emphasized that “above all else, I think dollars is still a driving force, and the need for additional resources is, I think, clear and evident.”

Restructuring Job Tests

Mr. Phengsomphone noted that a test must be passed for one to become employed by the State department of children and youth services. However, that job test, in its present form, is difficult for refugees. Mr. Pawelkiewicz, who represented that department's commissioner, stated that about 3 years ago his department and other human services agencies encountered a similar situation with Puerto Ricans who took the social work test. The agencies met with the State director of personnel and restructured the test.

Thus, suggested Mr. Pawelkiewicz, if there is a need for a certain classification of workers, there are avenues of change that can affect the personnel system, which has increased its capacity to hire candidates who are bilingual. Asked if there has been any difference in the performance of those who were hired after taking the restructured tests compared with those who had taken the original tests, Mr. Pawelkiewicz replied that, “My understanding . . . is that there has been no negative fallout from those changes.”

Caroline D'Amato of the department of nursing of the University of Connecticut announced that she is working on grant funding to “bring in Southeast Asian students into the nursing program.” Without going into details, she asked for assistance from those attending the Committee's forum.

Massachusetts Model and Budget Constraints

Regarding whether Southeast Asian refugees would seek help at a model health care facility if one existed in Connecticut, Mr. Cavanaugh replied that a model currently under consideration is the Massachusetts model in Brighton. He said that “[Brighton's] experience suggests that if you get the right kind of casefinding or . . . the right kind of services in place, [they] will be utilized.” Mr. Ginsberg added that his experience with public legal services was that, if the public perceives that there are services, the public will come to use the services. But if the public perceives that the services are not quality services, the public will not return.

A member of the audience noted, however, that the State of Connecticut rejected the Brighton model and asked whether it was for philosophical or financial reasons. Ms. Berto thought that the reason was financial; “it just was not allowed to stay in the budget.” Mr. Pawelkiewicz stated that it should not be inferred that someone made an evaluation of the Brighton model “even on fiscal grounds and said we do not want to go this way. . . . The funds just were not there for a number of programs. . . . I just do not want you to think that it was a negative affirmation of that program in any way or shape or form.” Mr. Ginsberg added that it was a case of “not being able to put on new programs at the time when old programs were being reduced.”

SUMMARY

The Connecticut Advisory Committee invited members of different Southeast Asian refugee communities to discuss the health and mental health needs of their communities and the level of access to the services intended to meet such needs. Accompanying the refugees were officers of typical nonprofit agencies which help to resettle refugees in Connecticut.

Public health and mental health service providers from three State agencies also appeared as well as the regional manager of the Office of Civil Rights of the U.S. Department of Health and Human Services. One State participant was both the commissioner of the department of human resources and the head of the State's office of refugee resettlement. As a followup letter by one panelist indicated after the forum, "Never before have we had the simultaneous attention of all the relevant State agencies!"¹⁴

The Southeast Asian refugees and the heads of the nonprofit agencies were in agreement that the refugee communities are afflicted by mental health and health problems. However, for various reasons, some refugees might not avail themselves of existing services, while others may appear for services only to discover that they cannot be understood, are misunderstood or misdiagnosed, or dismissed and untreated. Sample cases were described. It was also asserted that there is a shortage of bilingual-bicultural personnel and that those available are in constant demand and often expected to translate without pay. A few translators appear to be in need of training related to mental health and health care as well.

The representatives of the State agencies concurred with the general assessment of the community representatives and heads of the nonprofit agencies serving the communities. But they also stressed the State's budget constraints leading to a reduction in services and an inability to institute new programs. With regard to the need for bilingual-bicultural services, the State office of refugee resettlement director said that some aspects might be addressed by utilizing already existing resources to train some personnel already on staff. The representative of the State department of children and youth services noted that employment tests may be restructured to afford some refugees an opportunity to be hired to work for the relevant State agencies.

Assistance in designing appropriate services had been obtained from out-of-State sources including Massachusetts and Minnesota institutions. On the other hand, the Brighton, Massachusetts, model program could not be established in Connecticut because of the budget constraints. Since the prospects for new funding may be limited to the private sector, the State office of refugee resettlement head said that a proposal writer would be found from among the State agencies to work with community represen-

¹⁴Carol Berto, letter to Tino Calabria, Mar. 31, 1989.

tatives and nonprofit agencies to obtain insights on what constitutes the kind of privately funded services best suited for Southeast Asian refugees.¹⁵

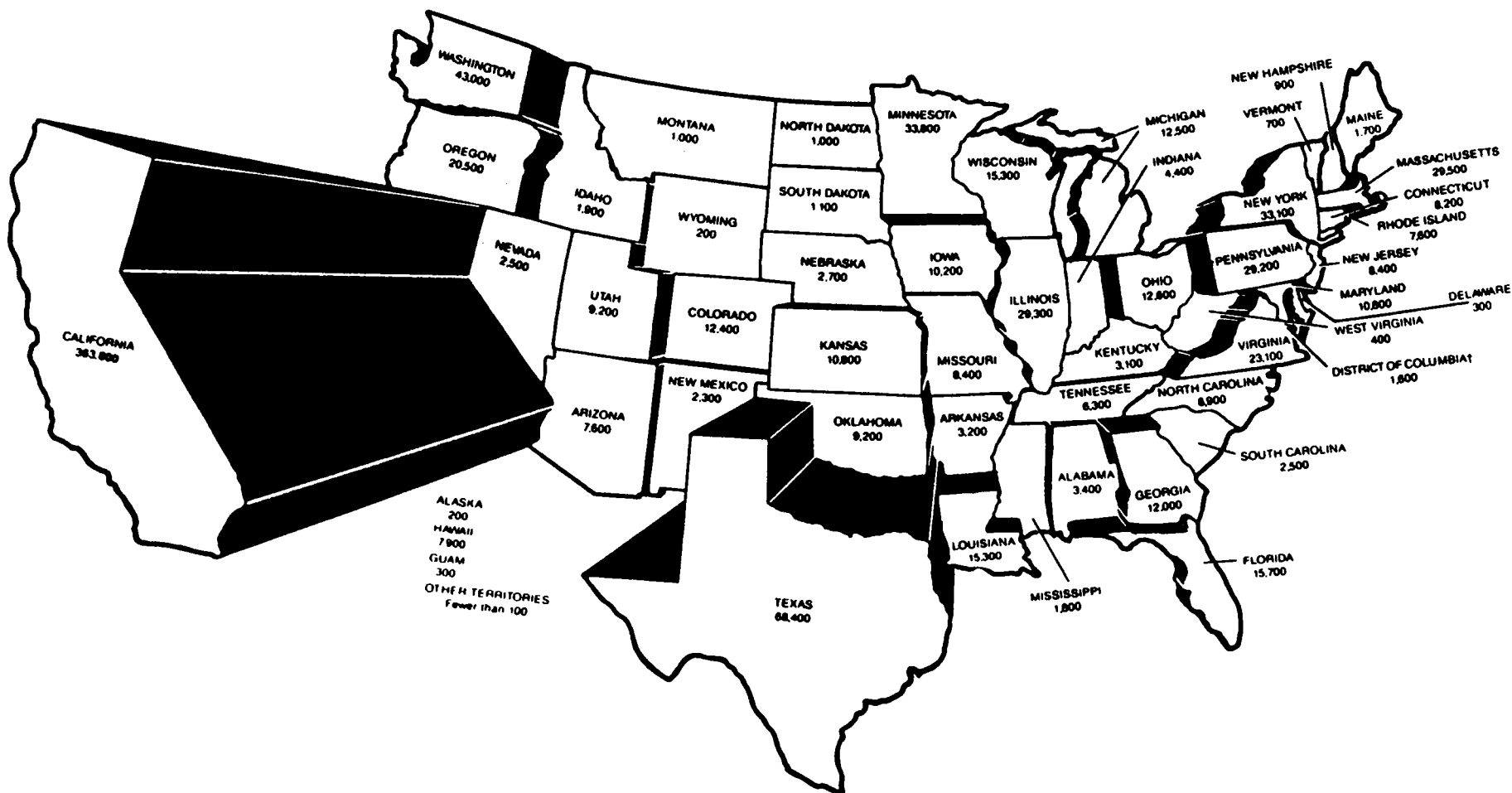
The regional manager from the Boston unit of the Office of Civil Rights in the U.S. Department of Health and Human Services reported that she received few complaints from Southeast Asian refugees¹⁶ and that complaints receive priority in terms of investigations undertaken by her office. She also stated that health care institutions cannot require patients to rely on relatives to provide translation services and that private health institutions receiving medicaid or medicare funds cannot turn away refugees on the basis of a language barrier. In addition, she said that OCR can provide technical assistance on how service providers can better meet the needs of those not proficient in English.

By unanimous vote, the Connecticut Advisory Committee approved the submission of this report to the U.S. Commission on Civil Rights.

¹⁵As of Oct. 20, 1989, however, no proposal writer had yet been provided. See appendices C and D.)

¹⁶At least one such complaint has since been filed with the Office of Civil Rights. Carol Berto, letter to Tino Calabria, Oct. 20, 1989.

SOUTHEAST ASIAN REFUGEES: ESTIMATED CUMULATIVE STATE POPULATION* INCLUDING ENTRIES FROM 1975 THROUGH SEPTEMBER 1989



[P. 23]

APPENDIX A

* Adjustments for secondary migration through FY 1988. All totals rounded to the nearest hundred.


† Arrival figures for the District of Columbia are overstated because they are based on the address of the sponsoring organization. Most of those persons are thought to settle directly in nearby Maryland or Virginia.

Source: Office of Refugee Resettlement / U.S. Department of Health and Human Services



Making the Transition...

Southeast Asians in Connecticut



Connecticut is home to nearly 10,000 Southeast Asian refugees. Bridgeport, Danbury, Hartford, and other industrial towns have large communities of Vietnamese, Laotians, and Cambodians. The H'Mong live in north central Connecticut. Refugees have made valuable additions to Connecticut's workforce in factories, nursing homes, and many other businesses. Their restaurants and food markets allow us to sample marvelous cuisines.

But refugees lead a double life. While many are "making it in America," they are also victims of years of war and systematic genocide. Many are struggling with unbearable pain ... pain they cannot resolve without your help.

In the FY 1990 state budget, the Departments of Mental Health and of Children and Youth Services requested funding to provide refugees access to mental health care. These requests were not in the budget presented to the Governor. The cost in human lives for any delay in adequate care is large.

The Refugee Mental Health Task Force urges your support for this worthwhile program. The task force has been building awareness of the need and support for refugee mental health clinics. Why? Because social services agencies daily see refugees desperately in need of help, but there is no place to send them. This booklet explains the situation. And, it shows you how your support can be the beginning of the solution.

Being a Refugee

For most of us, the images of *The Killing Fields* or *Apocalypse Now* seem unreal. Yet the events portrayed are stark, ever-fresh memories for refugees. Southeast Asians endured many years of landmines and gunfire, of communist terrorism and systematic torture.

The experiences of Southeast Asians refugees are beyond our ability to imagine. Many were forced to witness the death of family members, either by mutilation or starvation. One widow saw the evisceration of her entire family. Then she was put in a plastic bag and beaten until she nearly drowned in her own blood. People who endured these things need healing.

Many are able to transcend the serious problems faced as refugees and create a new life in the United States. The children are good students. Their parents, hard-working and conscientious employees, are becoming citizens. Extended families give each member support, and in turn, each member helps the economy and well-being of the family.

Like our grandparents, many young people forgo further education to support their families. Seeing their supportive, extended families, we remember the strong families of our immigrant parents and grandparents. We remember our past and see our future in looking at refugee families.

For many Southeast Asians, however, it is not easy to live with their terrible memories. And we know,

from the experience of the Jewish Holocaust, the outcome if terrible memories are left festering: the trauma of genocide is passed down to younger generations, especially when family members are still in danger overseas. Sorrow, anger, and guilt - these feelings prevent a normal life. Survivor Guilt Syndrome and Post-Traumatic Stress Syndrome are serious refugee illnesses. Many of our Vietnam veterans suffer the same depression and anxiety, which can lead to the extremes of suicide and family violence.

All suffer - the young men who grew up as orphans in a refugee camp, boatwomen gang-raped at sea, mothers whose children were forced to work until starvation killed them, men who endured the tortures of the re-education camps, the bewildered older widow raising orphans in a two-room tenement apartment.

Being a Newcomer

Add to this trauma, the challenges of being an immigrant.

Imagine that you can never go home again; that you find yourself in a society that does not value your skills. Add the search for affordable housing and a job that pays enough to feed your family, despite your language difficulties. Imagine that you are employed in a sweatshop profiting from your ignorance of the law. How can you cope with income tax, credit agreements, or verify that you were a doctor when your papers were destroyed in the chaos of war? Consider the reversal of family authority when your children learn the new language faster than you do.

Having lost all else, each of the four national groups strives to continue its language and protect its cultural inheritance, while learning our language and culture. Yet imagine your children shunning your ways and adopting new values.

Beginning a New Life in the U.S.A.

Refugees enter the U.S. with the approval of the U.S. Immigration and Naturalization Service. They have been screened against communicable diseases and they are given a few months of education in the English language and American culture.

Once approved for entry, refugees are assigned to non-profit agencies that oversee resettlement and further health checks. Sponsors - those helping find housing, jobs, etc. - may be a relative already in the U.S., another individual or a church group that volunteered to work with the resettlement agency.

Currently, the U.S. Refugee Program allows refugees twelve months of training, health care, and cash assistance, if needed. Some refugees come into the U.S. on other programs (such as Immigrant Visa) that do not offer any support or language training.

Connecticut offers some resources for new arrivals:

- ◆ Resettlement agencies with strong case-management and employment programs
- ◆ Refugee mutual assistance associations offer social services
- ◆ English-as-a-Second-Language programs
- ◆ Job training at the state's technical schools
- ◆ Jobs

In addition, each of the four communities support religious associations, including Buddhist and Roman Catholic. Refugees are raising money among themselves to build temples and churches. Yet, while these associations strive to make the lives of refugees whole, they cannot, alone, heal serious psychological problems caused by war, communist social engineering, and refugee camp life.

Inaccessible Mental Health Services

The most important resource needed by refugees is access to mental health care. Without this help, the amazing strength of their families is pushed beyond its limit.

Southeast Asians are accustomed to seeking mental health support from family and religious life. These two resources are overwhelmed now. Yet refugees cannot walk into a mainstream clinic, try to speak the unspeakable in broken English to a stranger who doesn't understand. Neither can they afford to wait until they learn English to use mainstream services. The pain is too sharp, and may lead to family violence or suicide, to lost wages and inability to concentrate on schoolwork.

Equally important, mainstream mental health professionals are not trained to deal with refugee trauma - the effects of the years of torture, terror, starvation, and beatings.

The major factor in accessibility is trust. For refugees to be healed, they must trust the healer. For years, they have not been able to trust anyone. Refugee mental health services must be offered by a permanent staff. Merely calling in a bilingual person to aid a professional unversed in refugee trauma does not work.

Many refugees now go to emergency rooms when psychological pain results in physical symptoms. Physicians generally don't have the time to develop trust or the expertise to conduct culturally appropriate interviews to distinguish between organic and psychiatric damage. It is painful for a refugee to tell a stranger about the specific ways he or she was abused.

At present, there is one non-profit agency which can help only a limited number of Cambodians. It cannot meet the demand.

Vietnamese, H'Mong, and Lao people have no resource at all.

Proposed Refugee Mental Health Services

Investment in refugee mental health services *now* will strengthen these communities so that in the future they can take care of their own. It is a very wise investment.

Proposed service would use bicultural therapy teams: mainstream mental health professionals working with Southeast Asian paraprofessionals at several sites around the state to deliver a range of outpatient services. The teams would receive training in refugee trauma. This model has been very successful elsewhere, for example, the Indochinese Psychiatry Clinic in Boston.

Clinics would be placed within medical facilities, because of the interrelation of refugee medical and psychological problems.

Your support of refugee clinics is needed now to make these services possible. Please don't let the refugees down.

Join the Advocates

This brochure was produced by the **Refugee Mental Health Task Force** and friends:

Association of Religious Communities

Connecticut Federation of Refugee Assistance Associations

Khmer Health Advocates

Catholic Charities Migration and Refugee Services

Episcopal Social Service, Refugee Service Division

International Institutes of Connecticut

Lutheran Child & Family Services, LIRS-LSA

Connecticut Department of Children and Youth Services

Connecticut Department of Mental Health

Connecticut Department of Human Resources

Task Force contact:

Carol Berto
Khmer Health Advocates
8 Lowell Road,
West Hartford, CT
203/233-0313

APPENDIX C

[p. 28]

Khmer Health Advocates
8 Lowell Road
West Hartford, CT 06119

October 20, 1989

Mr. Tino Calabria
Connecticut Advisory Committee
US Commission on Civil Rights
1121 Vermont Avenue, N.W. Rm 710
Washington, D.C. 20425

Dear Mr. Calabria,


Here is a summary of the present situation for refugee mental health in Connecticut, as I see it.

1. One civil rights complaint, filed by a CFRAA social worker, is being investigated by the Boston office of the Federal Civil Rights Commission.
2. The refugee MH clinic option in the CT Department of Mental Health (DMH) budget for FY 1990 was not funded, because of a state fiscal crisis. The option is in the DMH FY 1991 budget, recently submitted to the state's Office of Policy and Management.
3. The lobbyist for the United Church of Christ in Connecticut is working with the Refugee MH Task Force to interest legislators in funding a refugee MH clinic.
4. DMH will hold a Spring '90 seminar on refugee mental health for administrators, especially those from possible sites for a refugee MH clinic.
5. DMH and the Dep't. of Children and Youth Services have both attempted to hire Southeast Asians at various levels. However, strict state requirements have been a barrier to hiring. Many positions require a college degree; experience is not an acceptable substitute. Meanwhile the tremendous need for bicultural workers is unmet.
6. Elliott Ginsberg, Commissioner of DHR and nominal refugee coordinator, has not made any visible effort to find outside funding for refugee MH. Not even resources for proposal writing, as he promised.
7. There is still no dedicated refugee coordinator in the state. Some unfortunate situations might be mitigated or avoided if this position were filled by a full-time advocate. For example, ORR funding, as funneled through the CT Department of

Human Resources, has been both reduced and many months late. Existing programs are cut to the quick; survival of at least one agency is in question. Loss of any bicultural workers would hurt already our state's already overstrained resources, espeically since we have so many uncouneted refugees needing services.

Attached are edits for the draft report. Thanks for the article on hysterical blindness in Cambodian women. In return, enclosed are alerts on the civil war in Cambodia, from a new project of Khmer Health Advocates: Cambodian Mothers for Peace.

Sincerely,


Carol Berto



UNITED STATES
COMMISSION ON
CIVIL RIGHTS

Eastern Regional Division
1121 Vermont Avenue, N.W. Rm. 710
Washington, D.C. 20425

APPENDIX D

November 17, 1989

[p. 30]

Hon. Elliot A. Ginsberg, Commissioner
Connecticut Department of Human Resources &
Connecticut Office of Refugee Resettlement
1049 Asylum Avenue
Hartford, Connecticut 06105


Dear Commissioner Ginsberg:

My office has completed work on the last draft of the summary report on Southeast Asian Refugees and Their Access to Health and Mental Health Services, a report primarily based on the March 30, 1989 forum in which you were a participant. The last draft reflected our consideration of the comments received about the first draft from the participants and the members of the Connecticut Advisory Committee which held the forum.

As Tino Calabia of my staff noted in his letter to you of October 11, we would be assuming that having no response by October 30, regarding the first draft (which had earlier been sent to you), would be interpreted as meaning that the draft passages reflecting your participation were adequate.

In a related development, as part of her response to the October 11 letter from Mr. Calabia, Ms. Carol Berto of the Khmer Health Advocates wrote us the attached letter. As you may see, Ms. Berto has briefed us on the current situation from the perspective of the Khmer Health Advocates. In points No. 6-7, she asserts that you have not made any effort to find outside funding for mental health services for refugees and that the absence of a fulltime State refugee coordinator has resulted in additional problems for refugees in need of services. We are sharing this letter with the Committee and hope that we might also share your views on this matter.

Sincerely,


JOHN I. BINKLEY, Director
Eastern Regional Division

Attachment

[As of 1/30/90,
no response has
been received.]