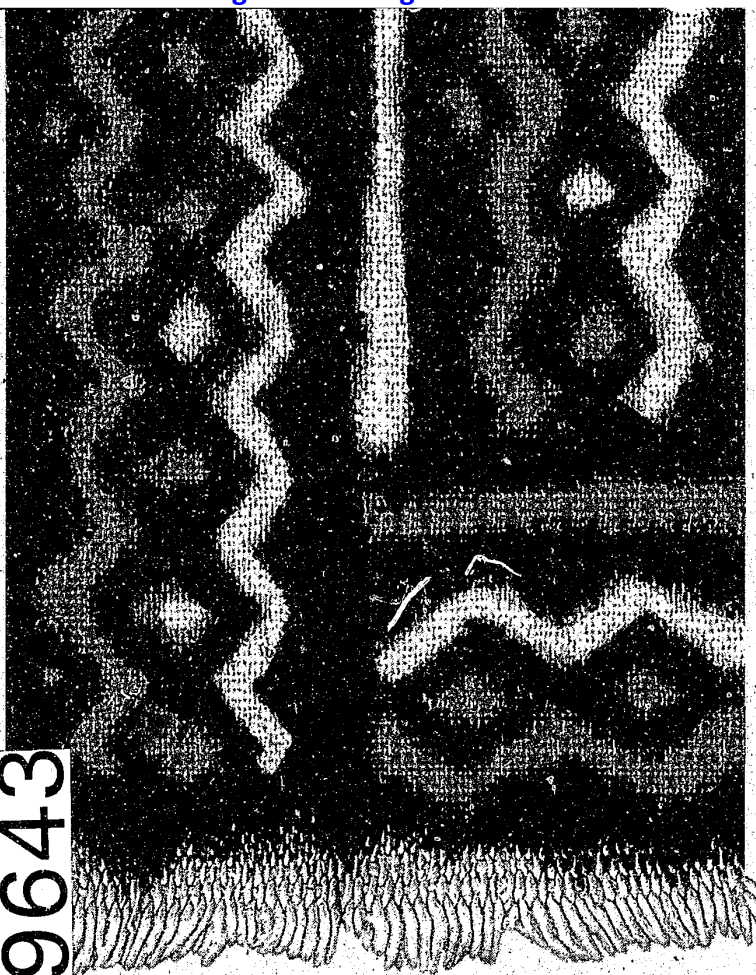
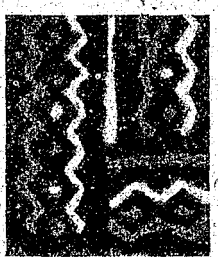




# Health Care of Black Male Children and Adolescents

## Report from the Annapolis Summit



*An actual swatch of mud cloth from Mali, West Africa, was used in the design of the front cover. Mud cloth is made by painting with liquid from the bark of the wolo tree and the leaves of the n'goloma tree, after which a gray-black mud is added. Designed by Robin Landis.*

# Health Care of Black Male Children and Adolescents

## Report from the Annapolis Summit

*Edited by*
Linda S. Thompson, M.S.N., Dr.P.H.

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# Contents

# Preface

The Maternal and Child Health Bureau (MCHB) for the last several years has taken a leading role in focusing on the social and health issues facing black male children and adolescents. This summit has been a natural outgrowth of regional and national activities focused on this at-risk population.

There is ample evidence from public health data and other research to support that young black males are overrepresented among persons affected by many of the health problems facing America's youth today. The most prominent causes of morbidity and mortality are violence and injury; sexuality problems, including sexually-transmitted diseases, HIV infection, and adolescent pregnancy; learning difficulties, illiteracy, and school failure; and drug abuse.

In previous gatherings, the Maternal and Child Health Bureau has sought to shed a brighter light on the plight of the black male child and adolescent, focusing on the children incarcerated in the juvenile justice system and those with minimal or no family ties who are members of the urban homeless. These MCHB-sponsored forums have focused on the experience of being a young black male in American society, with developmental problems stemming from a lack of opportunity and inadequate social and job skills. It has become clearer with the bureau's recent look at this population that these health problems contribute inordinately to morbidity and mortality and are inseparable from the social and economic difficulties that many of these youngsters face.

In an attempt to collaborate with other federal agencies concerned with the problems of young black males and to develop project priorities which may lead to solutions, the Summit on the Health Care of Black Male Children and Adolescents was held July 26–27, 1991, in Annapolis, Maryland. Participants in previous MCHB scientific and educational sessions on the subject and representatives from other key organizations were brought together to guide the bureau in developing new initiatives to improve the health of this population.

The summit approached the process by highlighting the health issues of black male children and adolescents and by developing a consensus expression of these problems as a public health issue. The summit addressed specific populations, such as those children and adolescents involved in the juvenile justice system, to suggest specific ways of improving their health status and health care. The bureau's historical role supporting interdisciplinary training has been extended to promote the involvement of historical black colleges. Lastly, the important roles of advocacy and family involvement, and the role of neighborhoods, schools, community, and the private sector were reviewed.

The bureau views this summit as a central step in developing programmatic priorities for future projects to improve the health and social condition's of young black men and children in America.

This summit represents the coming together of experienced individuals who have dedicated themselves to the task of developing workable solutions.

VINCE HUTCHINS, M.D., M.P.H.
*Director, Maternal and Child Health Bureau*

# Summit Overview

*Linda S. Thompson, M.S.N., Dr.P.H.*

The Maternal and Child Health Bureau (MCHB) has been supporting initiatives which promote interagency collaboration in addressing the needs of high-risk children and youth for many years. Black male children and adolescents are a particular subset of this population and the issues they present to the health care delivery system are significant. It is widely understood that black male youth are at risk for many health and social problems. Although black male youth suffer from numerous health problems, access to health care services and culturally sensitive programs is limited.

Therefore, in July 1991, the Maternal and Child Health Bureau convened the Summit on the Health Care of Black Male Children and Adolescents in Annapolis, Maryland. The summit made a deliberate attempt to bring together experts from a wide array of disciplines and cultural backgrounds including: child health, social welfare, community-based organizations, and education. The aim of the summit was twofold. The first goal was to systematize primary health care for black male children and adolescents. The second goal was to increase awareness of the health and social problems of the population. This report reflects the initial discussion and examination of selected issues associated with the health status of black male children and youth. Unfortunately, it is impossible to comprehensively cover all of the issues relevant to black male youth in a single summit or report. This report should be viewed as an important first step in the design of future effective prevention, education and treatment programs for black male children and adolescents.

I would like to commend the summit planning committee for their ideas, enthusiasm, and efforts to secure the best possible participants. The participants, too, should be thanked, for their concern and dedication made this document possible. It is my hope that state and regional leaders in maternal and child health, minority, and ethnic programs and child advocates will use this document as a resource in the design of effective strategies for vulnerable youth.

# The Health Status of Being Young, Black, and Male in America

*James Farrow, M.D.*

The so-called "new morbidities" of youth have been given increasing attention over the last several years. The most prominent causes of morbidity and mortality are violence and injury; sexuality problems, including sexually transmitted diseases, AIDS and teen pregnancy; learning difficulties, illiteracy and school failure; and drug abuse.

A number of studies support the conclusion that young black males are overrepresented among persons with these public health problems. Young black men are disproportionately represented on the unemployment roles, among school dropouts, and as victims of violent crimes, and they succumb earlier to fatal injury and illness. They experience developmental problems due to the lack of opportunity and inadequate social skills. These health problems, which contribute to their inordinate morbidity and mortality, are inseparable from the social and economic difficulties that many of these young men face.

They begin to face these difficulties at a very young age if they are born into poverty or into inadequately constituted families. Many of these young men grow up in multigenerational matriarchal families without adult male role models. The recently released film *Boyz N the Hood*, which unfortunately has been surrounded by violence, is a poignant depiction of the importance of having positive adult male mentors.

Further, young black men are severely overrepresented in the juvenile and adult criminal justice systems. According to Maurer, "The number of black men 20 to 30 years of age under criminal justice supervision is higher than the number of black men of all ages involved in higher education."[1] This higher incarceration rate for young black men, a rate that is evident even in my own community where 55 percent of the juvenile detention population is black in a community that is only 10 percent black, results from a number of factors. Unequal sentencing procedures, even in juvenile courts, and the so-called "get-tough" sentencing policies disproportionately affect urban, poor males. The criminal justice system is focused more on crimes of the poor; on "crimes in the

streets" more than on "crimes in the suites." Racial bias in the system, while often not overt, may be operating covertly in arrests and prosecutions, and stereotypes regarding the activities of young black men may attribute deviance where it does not necessarily exist.

With a decrease in social and economic support for these adolescents and a manifest lack of opportunity, there is often a sense of hopelessness, which may contribute to crime rates and subsequent incarceration. The so-called "war on drugs" is clearly weighted against drug use by inner-city, low-income persons. As a result, young blacks and Hispanics in our inner cities are arrested, convicted, and incarcerated at higher rates.

Black adolescent males in the juvenile justice system have an array of physical and mental health problems, which are often inadequately addressed within that setting. Upgrading health services for all detained youth presents us with an opportunity to remediate, or at least to begin addressing, these problems, and represents a legitimate public health strategy.

There has not been a great deal of good research on the physical and mental health problems of the black adolescent male. One significant step toward improving our base of knowledge in this area is represented by the research reported at the Maternal and Child Health Bureau-supported East Coast Scientific Symposium on the Health of the Black Adolescent Male, in Baltimore, Maryland, September 1990.[2] The conference brought together researchers, adolescent health clinicians, and public health officials to review some of the important health problems contributing to the excessive morbidity and mortality observed in this population.

Papers were presented on public health concerns related to sexuality, pregnancy and childbearing, parenting, sexually transmitted diseases (STD), and HIV infection. The earlier sexual activity of young black men, which in part serves to help them form their male identities, does not tarnish our sense that these young men, for the most part, want to be adequate fathers. Little is known about the differences between these young fathers and their peers who have not fathered children. One proposed difference is that young fathers have less hope for the future, perceive fewer options, and lack role models to otherwise define their identities. We do not have a clear idea why these young men are often poor condom users, except that some might consciously or unconsciously wish to father early, and perhaps some, faced with near-daily violence and peer death, can hope only to procreate in the face of a fatalistic personal view of the future, a proposition eloquently stated in our South

Carolina meeting by Beverly Coleman-Miller of the D.C. Commission of Public Health.[3]

The young black man will be at inordinate risk for HIV infection if he becomes involved in a lifestyle that involves polysubstance abuse and prostitution. These young black men are often attracted to this lifestyle early in their youth because of perceived increased power and status and financial benefit. Studies presented at the East Coast Scientific Symposium on the Health Care of Black Male Adolescents documented increased STD rates, which in all research are considered proxy measures for unsafe sexual practices, inadequate condom use, and higher risk for HIV infection. In the black community the HIV epidemic represents a shift toward high-risk heterosexual behavior often correlated with drug use.

A few studies have pointed out how little we know about some populations of black young men, such as the black gay male adolescent. Much more research needs to be done—looking at this population with respect not just to HIV risk, but also to mental health problems such as depression and suicide. The few studies that have been carried out looking at the mental health of gay youth have small numbers of black adolescents.

Substance abuse, specifically chemical dependency, is an enormous problem for these young men, although it appears to be more of a problem for urban-dwelling poor adolescents. Some research has confirmed that middle-class black families produce no more substance-dependent adolescents than their white suburban counterparts. In fact, suburban white adolescents often have a more significant problem with alcohol than middle-class black adolescents. And while black males are overrepresented among drug dealers, race does not appear to be predictive of drug dealing.

Mental health problems of young blacks are often ignored or misinterpreted. The young black male who is depressed may not appear sullen or sad, but may manifest that mood disorder in angry, aggressive outbursts or with behavior that appears to be hostile. As a result, these young people often go without appropriate mental health care or are labeled with the wastebasket diagnosis of "conduct disorder," which has little diagnostic or therapeutic utility. Attention deficit and hyperactivity disorder may be overlooked or mislabeled as lack of ability or poor motivation. In a review by Janice Hutchinson, 20 percent of young black men in the D.C. Youth Detention Center were found to have histories of psychiatric hospitalizations and/or to have been prescribed psychotropic medications.[4]

Lastly, injury and death due to living in violent environments are a major problem for these young men. Intentional injuries, drownings, and loss of life in house and apartment fires are extremely common. In one Baltimore study on adolescents' exposure to violence, 23 percent of young black men had been robbed, 11 percent had been shot, 70 percent knew someone personally who had been robbed or shot, 12 percent knew someone personally who had been raped, and 50 percent of the study population had witnessed at least one shooting.[5] These young men have been psychologically traumatized if not physically victimized—by the violence that they see around them, almost on a daily basis. The psychological toll on these young people has not been well described, but it is obvious that they are exposed to a startling amount of violence.

In spite of this real and unexaggerated litany of difficulties faced by young black men, many of them are quite resilient, many are goal-directed. But even these adolescents need periodic support and as high a standard of health care as we can provide them. The approaches we develop in this working summit will have to stretch our definitions of public health strategies. Strategies—and specifically priorities for funding—must be comprehensive, must in some fashion address social and economic problems as well as health issues, and must be innovative in mobilizing the private and public sectors and community-based organizations.

The strategies must attempt to "deconcentrate" areas where low-income families and low-income young men congregate, and perhaps disperse these young men through the creation of broader opportunities. These strategies must address academic achievement, improve child and adolescent supervision, incorporate mentoring programs, and promote peer involvement in life skills training. Incentives must be provided to these young men to take greater responsibility for their health, partly by improving access to male-focused health care and by enhancing health education programs aimed at young men.

It is too easy to be pessimistic about the future of the young black man in America. Pessimism produces no solutions, nor will dollars alone help without fresh and creative approaches. It is my hope that we black and white men and women can use our creative minds to develop workable ideas that will address some of the important public health needs of this population.

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# Developing a Strategic Plan for Primary Prevention: The Case Made

*Linda S. Thompson, M.S.N., Dr.P.H.*

The principal goal of this summit is to develop a strategic plan for the primary prevention of health and social problems of black male children. This goal will be met, in part, by increasing awareness of the health needs and problems facing black male children and adolescents.

The following statistics are indicative of the numerous problems facing black males.

1. Three out of 10 black residents live in households with an annual income under $10,000. Poverty is most prevalent in the 0- to 4-year-old age group, particularly if only a single parent is present.

2. Seventy-two percent of black males drop out before completing high school.

3. Fifty-six percent of teachers in the New Orleans public schools reported that they do not expect black males to go to college and do not encourage them in school.

4. Nationally, 45 percent of black males are unemployed, and in some cities, 70 percent of black males between the ages of 16 and 24 years are unemployed.

5. A working man is twice as likely to marry the mother of his children as a man who is unemployed.

6. Approximately 610,000 black males between the ages of 20 and 29 years are in prison, on probation, or on parole, whereas only 437,000 black males are enrolled in college.

7. A black male is twice as likely to die before the age of 45 years as a white male. Many black males die as a result of homicide.

These statistics tell only a small part of the story. They fail to describe the underpinnings of people who live in poverty and their relationship to the health care delivery system. They fail to describe the isolation that most black low-income people feel. Finally, they fail to describe the fact that many problems of low-income blacks are "invisible" to policymakers and power brokers. If we, as health care providers, plan to make an impact in any way on the problems of black male children, then new solutions must be designed for the problems. The solutions must be implemented by institutions and individuals with knowledge of and credibility within the black community. More significantly, professionals must be adequately trained to be culturally sensitive, with heightened awareness of individual differences.

**Objectives**

During this summit, we hope to achieve five specific objectives:

1. Identify strategies for designing programs for black male children and adolescents.

2. Develop a dissemination plan for materials focusing on the health and social needs of this vulnerable population.

3. Design a long-range strategic plan for improving the health status of black male children and adolescents.

4. Identify ways to involve black professionals and historically black colleges in the design of demonstration programs.

5. Design the priority for MCHB's FY 1992 funding for demonstration programs targeted to black male children and adolescents.

The objective will be met in several ways: in the brainstorming session; in presentations of information and data describing the health and social status of the population, training needs, programmatic needs, and advocacy needs; and finally, in the workshops. Each activity was specifically designed to meet the summit's goals and objectives.

## Recommendations

In closing, the following recommendations are offered:

1. Identify ways to provide incentives to universities to devise effective strategies for urban revitalization. These startegies should include plans to link with established community-based institutions.

2. Discuss ways to create economic opportunities for black males that are meaningful and encourage self-esteem and self-efficacy.

3. Identify ways to increase the competency of black parents and families.

4. Conceptualize the issues of the black male as community issues with community-based solutions.

5. Identify ways to design community programs with a variety of activities for black males such as: rites-of-passage ceremonies to transition boys to manhood; cultural programs to encourage positive self-esteem and cultural pride; mentoring programs to provide positive adult male role models; and supplemental educational programs to encourage high academic achievement. These programs should start at an early age when young people are formulating their ideas about people and the world.

If public health professionals hope to have any impact on the lives of black male youth, then the above recommendations must be considered. More significantly, intervention startegies for prevention, education and treatment should be community-focused with solutions emanating from community stakeholders.

# Reducing Barriers and Promoting Programs for Black Male Children and Adolescents

*Paula M. Sheahan*

The Maternal and Child Health Bureau (MCHB) convened the Summit on the Health Care of Black Male Children and Adolescents in Annapolis, Maryland, to achieve two primary goals: First, to design a systematic approach to the primary health care of black male children and adolescents; and second, to increase awareness of the health and social needs of this population.

To achieve these goals, summit participants were asked to address two specific questions: (1) What are some of the barriers to improving the quality of services to black male children and adolescents? and (2) What types of policies and incentives should be developed, and how should programs be structured, to reduce the problems facing black males? Participants explored these questions in-depth within the context of the health and social problems of this population. The major intent of the brainstorming session was to define a future role for MCHB in its ongoing efforts to design programs and projects to improve the health status and provide primary health care to this underserved population.

## Summary

The remarks for both reducing barriers and promoting programs for black male children and adolescents can be divided into four areas:

- *System*, broad nationwide generalities;
- *Program*, general comments about service-delivery programs;
- *Providers*, the health-care professionals within programs; and
- *Patients*, those receiving services.

Cultural misunderstanding was a recurring barrier both as a problem in the general structure of programs as well as individually in health professionals. Finances were also listed as a common barrier to providing services: It is often prohibitively expensive for individuals to access health care, and programs

themselves are either insufficiently funded or funded for too short a period of time to be effective. The specific problems and needs of the black male children and adolescent community are not a high enough (national) priority, and therefore do not receive the attention they deserve.

A national health service system was strongly and frequently recommended. The need for a family-centered, community-based, universally accessible system was recognized, as well as the need to involve the community in planning, implementing, and funding health service programs. Health care should be accessible using a multiservice approach, such that health care is comprehensive and longitudinal, and even linked with nonhealth-specific services, such as career development. Programs should be systematically evaluated and held responsible for the outcomes of their programs, and role modeling should be a necessary facet of all approaches to service delivery.

### I. System

*Philosophy*

**Barrier.** The first barrier is a philosophical one. This country has not made the needs of young black males an important priority. There is not even a clear definition of "black male." Violence prevention is not seen as a health issue. There has been no effort focused on early intervention. Until this country accepts that black males are in crisis and that the situation affects the population as a whole, there will be no solutions to this problem.

**Recommendation.** Programs should be structured around the ideas of family-centered, community-based, coordinated care. There should be technical assistance to programs involved in the application process and help for developing programs. Under Title V of the Maternal and Child Health Bureau, there should be a review requirement to ensure attention by state maternal and child health agencies to issues of special importance to this group (i.e., violence prevention).

*Policy*

**Barrier.** The lack of a strong national policy is the second barrier. Regulations systematically disenfranchise this population. Social programs encourage family disintegration. Policymakers see benefit to keeping the status quo. Children, the group most affected, do not vote and have no one to speak for them.

**Recommendation.** Restructure current social policies so that there is a national health service policy, a national family policy, and people-driven educational reform. Universal health insurance and universal health care access should be a priority.

*Community/Cultural Issues*

**Barrier.** There is little geographical sensitivity and a poor appreciation or ignorance of black culture. The black community is a heterogeneous one, more mixed—culturally and economically—than many see it. There are too few black men in leadership positions, especially in policymaking positions. Alcoholism is a pervasive problem, on both individual and family levels. There is a general failure to appreciate each youth's unique background.

**Recommendation.** Role modeling should be a necessary component of every approach. There should be a public education program based on Afrocentric concepts. We must develop in black children and adolescents a sense of self-pride and appreciation of cultural history. Programs should be specifically targeted to the community; "color-blind" programs are ineffective. Children should learn about economics from the very first grade.

## II. Program

*Management*

**Barrier.** The opportunity to educate during incarceration is not used. There are not enough people working in this area and too many staffing problems. There is insufficient integration of services and services are often given at the wrong time. Perhaps we will see an improvement when programs have population-specific plans and are held accountable for outcomes.

**Recommendation.** Programs should be multiservice centers wherever possible. Health care should be longitudinal rather than fragmented. Health education should be provided with and linked to the delivery of health care. Programs should be required to be collaborative. They should include peer education, conflict resolution, and parental health education. All programs should be routinely evaluated for effectiveness and outcomes. To do so, standards for health-care service delivery should be developed and mandated.

*Program Funding*

**Barrier.** Financial resources for program implementation are insufficient. Interventions are cost-prohibitive, and community-based groups have difficulty accessing funds.

**Recommendation.** Funding must be increased and/or extended. Too many programs disappear for lack of funds.

*Consumer/Outside Input*

**Barrier.** The community is ignored. Relationships with community groups should be encouraged and community needs should be acknowledged. Minority-based groups are not recognized as resources. Black males have little or no control over resources and services.

**Recommendation.** Programs should be required to be collaborative. Private-sector involvement, especially groups not usually involved (i.e., churches and black colleges) should be encouraged. Consumers should serve on program planning boards.

*Marketing*

**Recommendation.** There should be a concerted effort to counteract the messages of the media advocating alcohol, cigarettes, sex, violence, and so on. There should be a massive public-education program using Afrocentric concepts. Innovative marketing of services can be designed with the help of consumer/community input. Youth should receive "vouchers" as incentives that can translate into purchases of "positive" activities or services.

### III. Provider

*Attitudes*

**Barrier.** The first barrier is one of attitude. Providers are often overwhelmed by the special problems of young black females. Males are not the priority. Care workers have a low expectation for black male children and adolescents and often fear them. Racism is a pervasive problem.

**Recommendation.** Role modeling should be a necessary component of every approach. Encourage groups to use mentors; they can introduce black youth to services and keep them interested.

*Professional Training*

**Barrier.** Health care workers lack experience. Providers are not prepared to do proper assessments and lack resources to intervene if a problem is discovered.

**Recommendation.** Improve training programs.

### IV. Patient

*Access*

**Barrier.** Access is a major problem. There is poor transportational and/or financial access to services.

**Recommendation.** Centers should be accessible, multiservice oriented, and user-friendly. Centers should be tied to self-help programs (job skills) at work sites. Bring services to where the kids are.

*Attitude/Family*

**Barrier.** Youth do not receive enough health education. They do not recognize a need for health services and/or have a fear of health-care programs. There is very low or a total lack of expectations for male children. Male children are not held accountable for their actions.

**Recommendation.** There should be more self-esteem building approaches to help youth assume more responsibility for themselves and others

# Correctional Health Care: Issues and Strategies

*Edward A. Harrison, M.B.A.*

The National Commission on Correctional Health Care was formed at the American Medical Association, with funding from the old Law Enforcement Assistance Administration. Since the late 1970s, its goal has been to improve the health care provided in our nation's jails, prisons, and juvenile confinement facilities. The board of directors, the "commissioners," is composed of representatives of some 32 national associations concerned with health care or justice, such as the American Academy of Pediatrics, the Society for Adolescent Medicine, the American Medical Association, and the American Bar Association. The commission evaluates correctional health care programs, measuring them against a set of standards that are widely recognized by professionals working in this field, and by the courts, as the appropriate health care practices to be followed. In addition, we conduct education and training programs, produce publications, and do research. Dr. James Owens is a former chair of the commission, and Dr. Carl Bell, whom many of you know for his work on preventing black-on-black violence, will be chair beginning in fall 1991.

## Juvenile Confinement Facilities and Their Residents

There are more than 1,200 public juvenile confinement facilities in the United States. According to a report from the Office of Juvenile Justice and Delinquency Prevention, the average daily population of youth in custody is more than 56,000.[1] Annually, the total number of youth admitted to facilities is much more than 600,000—a rate of 221 per 100,000. Eight of ten youth in public confinement facilities are male. Blacks constitute approximately 42 percent of the juveniles incarcerated, whites 40 percent, and Hispanics 15 percent. This is the first time since record keeping began on juveniles in confinement that the number of blacks has exceeded the number of whites. Therefore, what goes on in juvenile facilities is a matter of particular importance to those concerned with the health care of black male children and adolescents.

According to an Indiana University study, abused and neglected children have a higher likelihood of arrest for delinquency, adult criminality, and violent criminal behavior. They are 1.5 times more likely to be arrested as juveniles, and 1.4 times more likely to be arrested for a violent crime.[2] The children seen in facilities throughout the country are usually from dysfunctional families where one or both parents are gone. These children are often not part of a regular school system and therefore are "invisible" to the common avenues of health education and care.

The majority of youth in public facilities are held for delinquent crimes, acts that would be crimes if committed by adults. Of youth confined in public facilities, 41 percent were held for property offenses and 26 percent were held for violent offenses. Public order offenses, probation violation, and other delinquent offenses account for 17 percent of juveniles in custody. Seventeen percent of youth in confinement were held for an alcohol- or drug-related offense—an increase of 50 percent between 1987 and 1989.

Juvenile facilities are generally classified as either "short-term" or "long-term." Short-term facilities typically have youth in custody for less than two months: About 45 percent of all juvenile facilities are of this type, and they hold approximately 36 percent of youth in custody.

Long-term facilities constitute 55 percent of all public facilities and house 64 percent of youth in custody. Generally, these youth are the most serious offenders with the longest criminal records.[3] The majority of youth (a little more than 60 percent) in long-term state-operated facilities are between the ages of 15 and 17. Seventy percent of these juveniles grew up in a single-parent household. More than half (54 percent) have a family member who has been incarcerated. Juveniles in these institutions have lower levels of education than the general population. Of all residents between the ages of 15 and 17 years, only 42 percent have completed more than eight years of education. This compares quite unfavorably to the fact that 76 percent of teenagers this age in the general population have more than eight years of education.

Youth in correctional institutions have a greater than expected rate of selected physical and emotional problems, such as depression, substance abuse, sexually transmitted diseases, and unplanned pregnancies.[4] A study conducted of a group of formerly incarcerated juveniles in Connecticut, published last year in the *American Journal of Psychiatry*, found that the mortality rate among this group was 58 times the national mortality rate for 15- to 24-year-olds.[5]

Young women in confinement facilities become involved in sexual behavior at earlier ages and have greater rates of sexually transmitted diseases (STD) than do nondelinquent young girls.[4] Sexually transmitted diseases such as gonorrhea and syphilis increase the likelihood of HIV transmission through anal, oral, or vaginal intercourse.[6] According to a report from the Centers for Disease Control from April 1991, 20- to 29-year-olds account for one out of five AIDS cases.[7] Because of the long incubation period of HIV (the virus that causes AIDS), many individuals who develop symptoms of illness in their twenties probably became infected as adolescents. Health education is a cornerstone of preventing further spread of the disease. A study of juvenile confinement facilities undertaken by our office in 1989 showed that a great majority of the administrators (more than 80 percent) believed they were providing AIDS education, although we question the effectiveness of their efforts.

According to a Bureau of Justice Statistics' survey, more than 75 percent of juveniles in a state training school drank alcohol in the year prior to their current offense, and nearly half (47.6 percent) of incarcerated youth were under the influence of alcohol at the time of their current offense.[3] Nearly 83 percent of confined youth in long-term state-operated facilities reported use of an illegal drug in the past (compared with the 51 percent of public high school seniors that have tried an illegal drug); 13 percent of incarcerated youth in long-term state-run facilities have used heroin at some time in the past (compare with the approximately 1 percent of public high school seniors that have used the drug).

Unfortunately, there is really little information on a national level about the health of incarcerated youth. Our office is currently completing one of the few such national surveys, a youth risk behavior study comparing the health risk behaviors of incarcerated youth with those in the public school system.[8]

### Issues and Strategies

A few matters in particular need our attention and advocacy. First, we must make sure that juvenile confinement facility personnel are able to separate their need for security from the child's health care needs: A juvenile's access to health care should not be interfered with by staff who are not medically qualified or by policies that do not place adequate emphasis on health care.

Second, there must be a recognition and strong commitment from juvenile confinement facility administrators for adequate health department staffing and services. Skilled nursing, psychiatric, and medical care must be available for

routine as well as emergency treatment. Opportunities for continuing medical education should be made available to health staff, as well as basic and emergency medical training for line staff (who are often in more regular contact with residents). This should include recognizing signs and symptoms for potential suicide, alcoholism, and drug addiction.

Third, juvenile confinement facilities should adopt and adhere to recognized medical standards in their development and implementation of health care polices, procedures, and practices. Following recognized health care standards allows both administrative and health staff to operate with confidence in knowing that their health care delivery system is operating under a comprehensive, medically approved program. Using such standards improves quality, reduces legal challenges, and improves cooperation and coordination between administrative and medical staff.

Fourth, we should include the juvenile court judges and administrators in our educational efforts. The judges are often the only ones with the direct access and power to affect meaningful change. They need to know the strategies available to help improve the health care of incarcerated black male children and adolescents, as well as our concerns for improving the system.

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# Opportunities for Advancing an Agenda Within State Title V Programs

*Holly Grason, M.A.*

There are many ways in which the Association of Maternal and Child Health Programs (AMCHP) can be a partner with the Maternal and Child Health Bureau (MCHB) and the summit participants in encouraging and supporting state MCH programs to extend and intensify their focus on addressing the health needs of black youngsters. There are ample opportunities within the Title V legislation for accomplishing this mission.

One opportunity is the Title V linkage with the year 2000 objectives as a fundamental basis for engaging Title V programs in activities you seek to promote, concerning intentional and unintentional injuries (violence), sexually transmited diseases, adolescent pregnancy, school completion, substance abuse, and so forth. The specific objectives committed to memory can be found in *Healthy People 2000* and are linked to Title V activities along with infant mortality reduction, immunizations, and systems of care for children with special health needs (CSHN).

A second avenue would be the more recently specified requirements for comprehensive statewide assessments of health needs and plan development to be submitted annually to MCHB.

Requirements further specify public involvement in development of Title V applications (not a new provision), thus providing a third opportunity or sanction for approaching your Title V colleagues with an agenda on behalf of vulnerable black youth.

I mention these statutory requirements to suggest that perhaps a new partnership can evolve, whereby your interest, concerns, expertise, information, and energy can be offered to enrich the Title V application and, most importantly, program development processes.

I propose that before you leave this summit you list the specific contributions related to the health concerns of these youth. I suggest that you carry this meeting's agenda to your home state to further extend what is accomplished here in Annapolis. Consider: Can you provide needs assessment information? Can you offer time to participate in planning meetings? Can you

offer training or technical assistance to program staff to extend their professional understanding of these issues? Can you be a public voice and political vehicle for leveraging the resources needed to support expanded program efforts?

What is it you will "bring to the table?" I suggest that these too are means by which you can extend the impact of your work at the summit in your home state.

Changes during the last decade in the economic, political, and health care delivery and financing environment, coupled with legislative changes in Title V and in a number of other health-related federal programs, have significant implications for the future role and impact of Title V at the state level. Changes in major causes of mortality and morbidity among children have also been notable. These changes need to be better understood, assessed, and taken into consideration as the Maternal and Child Health Bureau and the states look toward implementation of the OBRA 1989 Title V amendments and the role of the program in the year 2000 and beyond. The 1989 Title V amendments present both challenges and opportunities to build on innovations developed by many states, while working to establish solid, consistent, and effective Title V programs in all states. Implementation of provisions for a strong role for Title V in achieving national health goals and other congressional intent embodied in OBRA '89 necessitate considerable collaboration among all levels of government as well as private sector organizations. Such collaboration needs to be built on mechanisms that enhance state access to information regarding national MCH priorities and initiatives as well as information about approaches undertaken in other states to respond to current changes and challenges.

The Association of Maternal and Child Health Programs (AMCHP) is a national nonprofit organization which brings together public health programs addressing the needs of women in their reproductive years, children, and their families. The mission of these programs and of AMCHP is to provide state and national leadership to assure the health of all mothers, children, and families.

First formed in 1944 as the Association of Directors of State and Territorial Maternal and Child Health and Crippled Children's Programs, AMCHP's membership continues to be comprised of these program directors and other salaried staff. Five officers and ten regional councilors elected from among this membership form the Executive Council, which governs AMCHP. Associate memberships are available for individuals and organizations interested in maternal and child health. Incorporated under its new name in April 1987, AMCHP established its Washington office in January 1988 to expand its

capacity to influence MCH policy and to support state efforts to maintain current MCH programs. AMCHP committees constitute the major focus within the organization for generating policy. Policy position statements contribute to development of policy and legislation commentary provided to Congressional members and committee staff, contribute to the work of MCHB in developing priorities and initiatives, and to the work of other organizations through AMCHP participation in national coalitions and consortia. Committees develop written policy statements or papers that are disseminated to the states in order to communicate AMCHP's priorities and to support state efforts to promote activities in targeted areas. The association's process for developing such statements provides for initiation by any concerned member and for review and deliberation by the entire membership in conjunction with our annual meeting. Committees also contribute to developing the content of AMCHP's annual meeting program, an evolving forum that has come to represent a "hub" for national Title V policy information exchange and networking.

Additional AMCHP activities, conducted under the federal Maternal and Child Health Bureau-funded Partnership for Information and Communication Cooperative Agreement, facilitate and assist MCHB in collaborating with state Title V MCH and CSHN programs. Goals are to (1) achieve improved information collection and dissemination supporting national, state, and local policy and program development; and (2) promote improved consistency, accountability, and effectiveness of state Title V programs. To achieve these broad goals, AMCHP's cooperative agreement project objectives focus on providing information on state Title V programs to state and national policy-makers; developing policy and program frameworks for implementation of state Title V programs; providing up-to-date information to states on national issues, activities, and resources to assist in strategic planning; assisting states in meeting federal legislative and executive agency expectations as established in Title V; and establishing effective vehicles for communication among federal and state MCH/CSHN policymakers regarding the role and activities of state Title V programs. These objectives are built on the longstanding traditions of the association.

AMCHP provides multiple mechanisms for communication and information transfer—among state, federal, and national professional and private sector entities involved in development of policies and programs for women and children—through five major categories of activity. State Title V information services involve timely responses to requests for information on

state Title V program issues, activities, capacities, and concerns; and expansion of the information base on state Title V programs by conducting and reporting on special surveys. A white paper series related to state Title V implementation is being developed to address issues of national MCH/CSHN policy significance. Forums for discussion and consensus building contributing to the white papers are convened, building on the organization's committee structure. The Title V newsletter, *AMCHP Updates*, is published six times each year and includes federal and legislative updates and analyses; news from MCHB offices, updates on national work groups and policy developments (such as this summit), and information on relevant initiatives, conferences, reports and publications of other federal agencies. State capacity building and accountability assistance services entail consultation on preparation of required Title V applications and reports and publication of a Title V program practices series. Collaborative planning and information forums between MCHB and AMCHP leadership convene to confer on federal and national MCH/CSHN program and policy priorities and state activities to address them.

These provisions in Title V and activities of AMCHP are available to introduce and move forward your agenda to improve health care for black male children and adolescents. The association welcomes your interest, expertise, and commitment.

# Recruiting, Linking, and Continuing Education: Innovations to Improve Social Work Training

*Kenneth J. Jaros, M.S.W., Ph.D.*

The magnitude and scope of the health and mental health issues facing black male children and adolescents has been clearly and forcefully stated at workshops, conferences, and in numerous scholarly and popular publications. We know a major problem exists, but what do we propose to do about it? Our challenge is how to make our training function—whether our students are black, white, Hispanic, or another race—to produce professionals willing and well-prepared to take action to improve the health status of black male children and adolescents.

I plan to suggest ways that we and other training programs can more aggressively and effectively train social workers and other health and human service professionals to support improved health care strategies for black male children and adolescents.

## Background

Since the late 1960s, schools of social work and other institutions involved in the formal training of social workers have been grappling with the issue of how best to prepare social workers to work effectively with minorities. In the early years, these efforts consisted primarily of providing historical and sociological information about minorities, and sensitizing students and practicing professionals to cultural differences. By the early 1980s, however, it became apparent that this reliance strictly on the teaching of "minority content" was not particularly successful in leading to improved interventions by social workers.[1]As a result, during the last half of the decade, there was something of a shift toward a posture of "minority practice."[2] The concept of teaching minority practice employs a prescriptive teaching model (as opposed to an interpersonal training model), relying primarily on giving the professional specific interventions and effective approaches to intervening with minority "clients."[1] A number of interesting strategies have emerged from this more practical, action-oriented philosophy of teaching, such as direct linking of "minority content" classes to volunteer field experiences, the linking of formal

field placements with course content, and the development of more concrete intervention models.

Unfortunately, however, social work education (both in formal degree programs and in continuing education) vis-a-vis minorities is based too exclusively on cross-cultural education and cultural sensitivity; and on how to effectively integrate this material into the curriculum. This type of training is clearly an important function in social work education/training, but it is essential that as trainers and educators we adopt a more proactive role. If we seriously want social workers to affect health care services for black male children and adolescents, we cannot rely simply on a business-as-usual approach. Essentially we have to try new things and begin breaking out of our traditional mold. Teaching social workers about black males is not enough—we should give them tools to intervene, and examples of strategies to implement.

This becomes a particular challenge because social workers are typically not clamoring to work with black male children and adolescents. They are much more interested in doing individual and family therapy in the secure confines of a traditional mental health or family service agency, or perhaps eventually moving into private practice. We need to take steps to turn this situation around. I would like to suggest some areas where training programs may make a difference.

Before talking about specific ideas based on my experiences with the Public Health Social Work Training Program in Pittsburgh, I would like to mention a program which could serve as an example in terms of training and educating social workers to intervene with our target population. This aggressive strategy (which is representative of the practical, prescriptive approach to social work education) is the Community Mental Health Practice with Minorities Project implemented by the School of Social Work at the University of Georgia. This program was specifically designed to train black students to work with urban black populations. Aggressive recruiting of minority students was part of this program, and a specialized curriculum and set of field placements was developed and coordinated. This program relies heavily on a cultural relativity approach which takes into account the black experience and the extended family when defining mental health and when formulating interventions. The program appears to have been a success, and the sponsors attributed the success of the program to three factors: (1) administrative and financial support from the school, (2) an adequate base of black faculty, and (3) the fact that the minority content was incorporated into the overall curriculum objectives.[3] It

seems that in approaching the issue of health care for black male children and adolescents, in designing our interventions we could use many of the principles of professional recruitment and theoretical perspectives which drove this project.

**Recruitment and Training**

An important factor in improving services to black male children and adolescents is the emergence of black male professionals both in direct service, and in decision-making roles in the health and social service field. I contend that we will see little significant long-term change in the health status of black male children and adolescents until this change begins to occur.

The Public Health Social Work Training Program in Maternal and Child Health in the Graduate School of Public Health at the University of Pittsburgh recruits social workers (master of social work with at least two years post-graduate work) experience to enter the program leading to the master's degree in public health. Most students also choose to pursue the doctorate in social work as part of this joint program. Program graduates typically assume administrative and planning positions in health departments or health services agencies, and those who complete the doctorate often go into teaching positions in schools of social work. In addition, the Public Health Social Work Training Program sponsors an annual continuing education institute (primarily for Regions III and V) for public health social workers in the maternal and child health field. A third major function of the program is the provision of technical assistance and on-site continuing education, particularly in evaluation, research, and program planning, to local and regional MCH programs.

My presence today is probably a direct result of (1) the fact that our program has been successful in recruiting minority students, and that the graduates have been successful in finding jobs, and (2) the fact that earlier this year our Public Health Social Work Institute examined health issues facing black male children and adolescents.

Our Public Health Social Work Training Program has had some success in training minority men for leadership roles in academic and administrative settings, but I sense that our experience is not the norm. We have been lucky. We have benefited greatly from the efforts of our graduates, the Maternal and Child Health Bureau (MCHB), and the Pittsburgh School of Social Work in identifying and recruiting excellent students. It is frightening to see that nationwide less than 2 percent of M.S.W. students are black males, and in the public health field the situation is only slightly better. Clearly, we are facing

some considerable challenges, including recruiting black males into the profession. It is evident that most traditional recruiting efforts are not working.

The School of Public Health at the University of Pittsburgh has at least partially attempted to address the lack of minorities through the Public Health Career Opportunities Program. This program has been in operation for eight years, three of them funded by the Office of Disadvantaged Assistance, U.S. Deptartment of Health and Human Services. The Pittsburgh program has managed to operate with partial support from the commonwealth of Pennsylvania, local foundations, and from the graduate school itself when federal funding was not forthcoming. Although this program has adopted several forms over the past several years, its basic objective is to interest more minority students in the field of public health. Each summer several minority college students with an interest in health are invited to the Graduate School of Public Health for a six-week in-depth introduction to public health principles. Students receive formal class sessions in epidemiology, biostatistics, computer operation, and technical writing. In addition, students are teamed with a faculty mentor to work on a practical research or community-based project during this period. Ultimately it is hoped that these students will enter a health or public health program, either at the University of Pittsburgh or at another college or university.

In recent years, the program has also involved several outstanding high school students who are supported through the National Institutes of Health program designed to interest minority students in biomedical careers. This year an additional strategy is being initiated: training selected high school science teachers (from schools with primarily minority students) in public health principles. They will in turn integrate this material into their classes and interest more students in the field.

Although this program is schoolwide, the Public Health Social Work Training Program has worked closely with Public Health Career Opportunities Program and has in recent years been the mentor for two students each summer. Last year students worked with a neighborhood health center in the adolescent outreach and education component. This year our students are developing and pilot-testing a survey instrument to measure violence among adolescents. We are now discussing with the Pittsburgh Urban League the possibility of having next year's students work on the local violence prevention initiative targeting minority youth.

Public Health Career Opportunities Program offers an excellent vehicle for involving minority young men (at both the university and the high school

levels) in health and human service activities. It seems to be a particularly relevant experience for those with a public health social work interest. The program can facilitate a direct link between training programs and community-based agencies. In addition, the direct involvement of the program with these young men will enable us to learn more about the issues facing them, and, hopefully, help us be more responsive as a community resource. It would seem feasible for other training programs (and even schools of social work) to explore this type of strategy as part of their efforts in recruiting and community development. As indicated above, local foundations have shown an interest in this type of programming, and there certainly might be support from schools, community agencies, and the business community as well.

**Links with Community-Based Service Providers**

A second major challenge for training programs involves ways of creatively linking with community-based programs. If we want to encourage social workers and social work students to attack the problems of health care for minority male children and adolescents, we must provide an interesting and useful learning experience for them beyond the classroom. If we are to be successful in recruiting minority males and others interested in this issue, the training experience must be appropriate to the task.

It is clear that university-based faculty are not in the best position to know about creative community strategies for reaching this target population. It is therefore essential to engage the key program people in the education and training process. In most cases they become major trainers. We must learn how to work with community-based programs to create interesting and meaningful field placements and research experiences for students, and to demonstrate that this aspect of minority health can be a gratifying and rewarding area to pursue. Making this link can be difficult in educational institutions where faculty are pushed toward publishing and obtaining research grants, which leaves little time and no incentive to pursue community-based program development.

In many cases this may mean working with programs that are unfamiliar and often intimidating to us. We may find it easy to link with neighborhood health centers and with groups such as the Urban League, but getting involved with juvenile court or alternative street outreach programs may be much more challenging for the academic. These programs are often perceived by the student, or by the professional, as undesirable (or lacking in glamour) as a place to work. One potential mechanism for breaking down these barriers and

facilitating these linkages is through collaborative program development. Although training programs have a primary mission to teach, the process of program planning can prove to be an excellent training vehicle, not only for the students involved, but also for the agency personnel.

For example, we are developing—in conjunction with the Allegheny County Juvenile Detention Center—an approach to violence prevention for their youth. This is essentially a spin-off idea from the Tri-Regional Workshops on the Health Care of Incarcerated Youth on linkages with the juvenile justice system, and our Use of Public Health Social Work Leadership Tools and Strategies: Addressing Health Issues of Black Male Adolescents and Children conference, April 28–May 1, 1991, held in Pittsburgh. The detention home health educator has been communicating with the Violence Prevention Program in Boston and will attempt to adapt their educational materials for use in the detention center. Our public health social work students would be involved in the design, evaluation, and research phases of the project. Our role expands beyond training to include brokering information, collaborating in program design, and acting as evaluation consultant. This process provides, however, a meaningful and practical training opportunity in an area in which Public Health Social Work Training Program has previously not been particularly active. This type of training experience also provides excellent opportunities for students and professionals to publish the results of their work.

**Continuing Education**

It is also essential for programs of continuing education in social work to become more responsive. Since certification and licensure of social workers have been adopted in more states, the demand for continuing education is certain to grow. Unfortunately, the available continuing education is in many cases not appropriate to the needs of organizations and is not related to major issues needing attention in the community. Within Public Health Social Work Training Program, our primary continuing education effort has been the annual institute, which in 1991 addressed the issue of health care for black male children and adolescents. But this is not enough. We need to engage in more ad hoc training that involves active partnerships between academia and community programs. These continuing education efforts should, whenever possible, present successful program models and encourage the adaptation and implementation of these models in appropriate sites. On-site continuing

education and technical assistance in the area of program development and program implementation should also be explored.

## Suggestions

Although the above suggestions are by no means revolutionary, they represent a step in the right direction. I would ask, however, whether we as training programs are likely to try many new approaches. Will we translate the rhetoric from meetings like these into action? In reality, we probably will not change the way we do things unless there is an incentive (or a directive) to do so. This is where the Maternal and Child Health Bureau (and other funding agencies) can play an important role.

For example, many MCHB-funded training programs could be required to generate a strategy for addressing this issue of the health of young black males, either through a creative recruitment effort, a community-linked program initiative, or a targeted continuing education strategy (or some combination of the above). This could become a requirement for funding, and would force the training institutions to move more aggressively into this arena. Program ideas, and examples of "how to do it" could be provided by MCHB to prime the pump. Another approach might involve allocation of funds for ad hoc continuing education and information dissemination projects. Applicants for these funds would be required to establish partnerships with community programs, and would promote the implementation of intervention models which have been shown to be effective. Alternatively, these projects might be required to generate their own program models based on successful local programming.

Based on my experience in public health social work education and training, I believe that this type of priority-setting and direction from the MCHB would be well received and would result in a variety of creative approaches, with considerable potential for dissemination to other sites.

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# The Role of Interdisciplinary University Training

*Marianne E. Felice, M.D.*

The Maternal and Child Health Bureau currently funds six university-based interdisciplinary training programs in adolescent health care across the country, in Baltimore (where I am the director), Birmingham, Cincinnati, Minneapolis, San Francisco, and Seattle. The disciplines represented in these programs are medicine, nursing, social work, psychology and nutrition. The goals of these programs are: (1) to provide knowledge, training, and skill development to health care providers to enable them to give comprehensive service; (2) to groom young leaders as teachers, administrators, and researchers in adolescent health; and (3) to be resources in the community concerning adolescent issues. All of the programs serve minority youth. To reach young black males effectively, there are five programmatic issues that I would like to address: (1) faculty and staff sensitivity training; (2) faculty and trainee recruitment; (3) community outreach; (4) hospital clinic milieu; and (5) community and discipline leadership.

## Faculty and Staff Sensitivity Training

In all systems, programs, or clinical settings, attitudes towards minorities are set by those in power. Faculty and staff in all the training programs must be sensitive to issues specific to various minority groups, including those issues specific to black children and adolescents. Some relevant key issues include sensitivity training for faculty and staff to acknowledge their own biases. Everyone, both blacks and whites, have biases. Faculty and staff must confront themselves before they try to help others understand their biases. There are many ways to do this; sometimes sensitivity workshops are helpful, or outside consultants can be used. On a daily basis, faculty and staff can set an appropriate tone concerning the care of others not of their own race or ethnic background by not tolerating derogatory remarks, sarcasm, or racial slurs in the clinical or office setting. Patients and parents may not be tolerant of racial groups outside their own neighborhoods and may make statements to faculty or staff members that are inappropriate or derogatory. All disciplines should be taught how to

respond to such statements in order to help break down bigotry and prejudice and to build understanding among and between racial groups.

The training programs should incorporate cultural, racial, or ethnic issues into treatment plans for all young people. This may be more easily recognized when providing services for groups such as Hispanics or Asians. But it is also true when providing health care for black males, and health care providers should acknowledge those issues that are relevant to the black community. For example, not all blacks are African-Americans; some may be of Caribbean descent. Some treatment plans can take advantage of the large support network of extended families that exists in many black communities, or can incorporate issues relating to the church, or use services of certain black organizations, such as Big Brother groups.

**Faculty and Trainee Recruitment**

Academic medicine is primarily composed of non-Hispanic white male professionals. In order to incorporate minority faculty members into the academic setting, a major effort has to be made to recruit qualified trainees and faculty from minority groups. One way is to recruit trainees and groom them for faculty positions. It is hoped that in the future black males and females will be more highly represented in academic faculty positions. But it is also important to make certain that the individuals recruited be likely candidates for promotion in the academic system. To simply fill quotas with minority group members who do not have the training, background, or interest to be promoted in the tenure track would do everyone a disservice. Academic medicine has a grave need for well-trained academicians from minority groups.

In those settings where minority groups are not well represented, it is important that white faculty members be good role models to young physicians concerning minority recruitment. This may be through mentoring of young black trainees or expressing an interest in the health care problems of young black males (or females), or in providing important research that will affect the black male (or female) community.

It is also important to note that not all blacks who are recruited into academic medicine must have a research interest in black issues. Rather, they should be encouraged to pursue those interests that most challenge and interest them, just as are white academicians.

### Community Outreach

All the interdisciplinary training programs have some community outreach programs and either provide community-based clinical care or perform community-based clinical research on issues related to young black males. Some of the community sites that are being used are incarceration centers for youth, sports, schools, community health clinics, church groups, the Job Corps, and trauma programs. In all of these settings, there are large numbers of black males. Not every program can encompass each of these community settings, but all of them are involved in some of these settings. It is important that the relationship of the university training program with the community-based program be one of partnership, and not exploitation. Sometimes in academic medicine, community-based programs are unintentionally (one hopes) exploited for purposes of clinical research and academic advancement by the university employee. This is wrong! All relations in the community should be developed and carried out to the mutual benefit of both the community and the university.

### Hospital Clinic Milieu

Most adolescent medicine clinics across the country are predominantly female. There are mostly female staff and female patients. In fact, 70 percent of the patient population in most clinics are young women. In order to attract young black males to the clinic to seek and receive care we must make the clinical setting comfortable and appropriate. The milieu of the clinic must reflect both young male and female interests, and ideally there should be male as well as female staff. The milieu could be influenced by the posters and pamphlets that are available and the types of programs that are advertised for young men. For example, adolescent pregnancy programs should make a concerted effort to attract male partners into the clinic. Special programs could be developed with adolescent fathers, with special times for meetings with special staff. The needs of young black males could be addressed in those settings.

### Community and Discipline Leadership

One purpose of the university programs is to be a resource in the community on adolescent issues. This leadership can revolve around certain disciplines or around certain topics. Not all physicians are interested only in medical topics; some physicians may play a leadership role in psychosocial issues. Not all medical issues must be dealt with only by physicians. For example,

an experienced, knowledgeable social worker or psychologist can provide much insight into the adaptation skills of a young black male with the human immunodeficiency virus. The important issue here is that the university program recognizes its role as a leader in the community and helps provide direction, knowledge, and advocacy for young black males.

Clearly, academicians who are interested in young black males should be participating in community advisory boards, community-based committees or task forces, or city and government advisory boards concerning the health issues of young black men. Academicians in the university do not necessarily have to be the leaders in these roles. They can collaborate with community-based leaders and provide university resources to further the interests of young black men.

**Summary**

The academic training program can also serve as a way to dispel myths, biases, or fears concerning young black men. This latter issue is often the seat of prejudice and bigotry in the academic setting as well as in the community. Sometimes people are simply afraid, and dispelling those fears is a valuable service to those who are feared as well as those who are fearful. University-based interdisciplinary programs must make a major effort to invest in young black males in this nation. By not investing in them, we are not only harming their future, but the future of the nation as a whole.

# The Role of Historically Black Colleges and Universities

*Robert Hill, Ph.D.*

There is increasing concern across the nation about the special plight of black males at all stages of their life cycle. In fact, black males are overrepresented among persons experiencing numerous health-related problems, such as behavior problems in school, truancy, suspensions, expulsions, special education placements, long-term foster care placements, delinquency, gang violence, physical assaults, alcoholism, suicides, incarceration, drug addiction, and homicides. And while the life expectancy for whites continues to increase, the life expectancy for blacks—especially black males—continues to decline. Clearly, black males run a gauntlet from the cradle to the grave.

Yet, black males do not start out at such a disadvantage. We always refer to the low sex ratio that reveals only about 85 black males for every 100 black females. But, from birth to 14 years old, there are 60,000 more black males (3,861,000) than black females (3,804,000). It is only from the age of 15 years and older that the number of black women exceeds the number of black men. Concerted efforts are needed to significantly enhance the social and economic well-being of black males.

What role can the historically black colleges and universities (HBCUs) play in enhancing the health status of black male children and adolescents? Unfortunately, the unique contributions and roles of major self-help institutions in the black community, such as extended families, the black church and black colleges, are usually omitted or deemphasized in discussions about developing strategies for resolving the crisis among black children and families.

Ironically, black colleges and universities continue to demonstrate that they are important lifelines to thousands of black youth and their families. Although the number of blacks enrolling in predominantly white colleges and universities continues to decline steadily, the number of blacks attending predominantly black institutions of higher education steadily increases. Moreover, seven out of ten blacks attending predominantly white colleges drop out, but seven out of ten blacks attending predominantly black colleges graduate.

Consequently, although less than one out of every five black students attends a black college, more than half of all blacks who attain baccalaureate degrees in the nation receive them from black colleges. And while predominantly black colleges disproportionately recruit students from low-income families and with low SAT scores, predominantly white colleges disproportionately deny such students a college education. Despite these phenomenal accomplishments, there are unrelenting efforts to undermine the effectiveness of HBCUs by underfunding them or by merging them out of existence.

### Role of Historically Black Colleges

What role can historically black colleges and universities play in enhancing the health status of black male children and adolescents? There are six areas in which HBCUs can perform important functions: primary prevention, secondary prevention, tertiary prevention, training, program evaluation, and research and policy analysis.

### Primary Prevention

Health care providers generally distinguish three levels of prevention activities—primary, secondary and tertiary—in order to insure a continuum of services for individuals and families according to the severity of their impairments or disabilities. Primary prevention usually refers to services and other efforts designed to prevent the onset of high risk behavior. Thus, HBCUs could provide a broad range of primary or "early" prevention activities targeted to prevent the onset of alcohol or other drug use, premarital sexual activity, out-of-wedlock pregnancies and births, drug selling, delinquent behavior, and the use of violence to resolve disputes.

HBCUs' early prevention activities might include: (a) male sexual responsibility education campaigns designed to make black males more aware of actions that they should take to prevent out-of-wedlock births, such as sexual abstinence, use of condoms, etc.; (b) sex education workshops for both males and females; (c) parenting programs to enhance their skills in rearing black boys; (d) mentoring programs for black male children to provide positive male role models for encouraging healthy attitudes, high educational aspirations, high academic performance, and positive lifestyles; (e) conflict resolution classes targeted to students in elementary and junior high school to teach them how to resolve arguments nonviolently; (f) African-American cultural workshops designed to increase positive self-esteem and stronger racial and cultural

identity; and (g) rites-of-passage programs to provide positive transitions of black boys to responsible manhood and fatherhood.

Increasing numbers of black colleges are incorporating primary prevention programs targeted to enhance the well-being of black males. Morgan State University has established the Center for Educating Black Males directed by Dr. Spencer Holland, who is implementing his project 2000 to obtain male volunteers as teaching assistants to provide positive male role models for students in grades 1–3 in three inner-city schools in Baltimore. Morehouse College has established a research institute to conduct research and hold workshops, conferences, and other forums to examine strategies for improving the social and economic status of black males. Howard University has been holding national conferences on the plight of black males over the past two decades.

### Secondary Prevention

Secondary prevention usually refers to services to ameliorate impairments or dysfunctional behavior that have had only mild or moderate impact on individuals or families. HBCUs, alone or in collaboration with direct health providers, such as hospitals, outpatient clinics, community health centers, and community mental health centers, might be involved in the following secondary prevention efforts: (1) comprehensive prenatal health care services for pregnant adolescents; (2) comprehensive postnatal health and child care services for adolescent mothers; (3) parenting programs for adolescent mothers and fathers; (4) substance abuse programs for adolescents who are moderate users of alcohol or other drugs; (5) tutoring, mentoring, and mental health programs for students in special education classes or children placed in foster care; and (6) diversion and other delinquency-prevention programs for first-time offenders and status offenders.

### Tertiary Prevention

Tertiary prevention usually refers to services to "rehabilitate" individuals and families with serious and severe social, physical, or psychological impairments or antisocial behavior. HBCUs that have hospitals or medical schools, such as Howard University, Meharry Hospital, and Morehouse School of Medicine, can play major roles in providing direct health services to children and youth with severe disabilities. Thus, HBCUs, alone or in collaboration with direct health providers, may be involved in the following tertiary prevention

efforts: (1) comprehensive prenatal health services for alcohol-abusing or drug-addicted mothers; (2) comprehensive postnatal health services for alcohol-abusing or drug-addicted mothers; (3) parenting programs for mothers and fathers with repeat out-of-wedlock births; (4) educational and vocational training for single mothers on welfare; (5) educational and vocational training for young fathers; (6) drug treatment programs for alcohol-addicted or drug-addicted young mothers and fathers; (7) educational and vocational training and mental health programs for "hard-core" delinquents and incarcerated felons; and (8) educational and vocational training and mental health programs for long-term foster care children, to permit positive transitions to independent living.

### Training

HBCUs can also play a major role in training a broad array of personnel to provide primary, secondary, and tertiary prevention services to high-risk children and youth. Of course, those institutions with schools of medicine continue to make important contributions to increasing the supply of black physicians and other health-related professionals. HBCUs still account for the majority of black medical professionals, especially physicians and pharmacists, produced each year in this nation. HBCUs with schools of nursing are also contributing disproportionately to the number of blacks in the field of nursing.

Yet many other HBCUs, through their schools of social work, schools of gerontology, schools of human ecology, Head Start and other preschool programs, day care programs and schools of continuing education, can also make important contributions to increasing the supply of blacks in health-related professions. Thus, HBCUs can train numerous black males and females as paraprofessionals and professionals to provide a continuum of health care services from primary through tertiary prevention, targeted to black male children and adolescents. HBCUs could be especially effective in reaching persons working in community-based groups and churches in inner-city areas who would have a high interest in being trained in health-related fields.

### Program Evaluation

An underutilized role that HBCUs can play in enhancing the quality of health care for black male children and adolescents is providing program evaluation. Funding sources are increasingly asking grantees to evaluate in a systematic fashion the effectiveness of their particular social programs. Such

evaluations are very important in determining which components of innovative programs might be used by other groups interested in replicating or adapting those programs.

Thus HBCUs should be considered important resources for assisting hospitals, community-based health centers, or other health care providers in developing appropriate program monitoring, management information, and program evaluation. Such information systems would permit comprehensive data collection and periodic feedback to program operators to facilitate effective process and outcome evaluations of their programs. Numerous community-based groups in inner-city areas, operating many innovative programs, urgently need technical assistance in developing competitive proposals as well as in developing credible evaluations of their programs. Many HBCUs are ready to meet that need—if they are provided appropriate funding.

### Research and Policy Analysis

Another underutilized role that HBCUs can perform is conducting research studies and policy analyses of issues related to enhancing the health care status of black male children and adolescents. Increasing numbers of HBCUs, such as Howard University, Morgan State University, Clark College (Atlanta), Morehouse College, and Norfolk State College, have developed research institutes to address the range of social and economic issues affecting the black community and low-income groups. Moreover, numerous HBCUs have strong research capabilities in health-related departments, such as social work, psychology, sociology, human ecology, biology, and nursing, which would permit them to conduct studies to address many neglected issues related to the health status of black males.

### Recommendations

Historically black colleges and universities should be used increasingly as major resources for providing important health-related functions in the following areas: primary prevention, secondary prevention, tertiary prevention, training, program evaluation, and research and policy analyses. The following recommendations should be considered by the Maternal and Child Health Bureau in developing its program guidelines for enhancing the health of black male children and adolescents:

1. Serious consideration should be given to establishing set-asides for HBCUs to provide primary, secondary, or tertiary prevention health-related services. Other government agencies, notably Housing and Urban Development (HUD) and the U.S. Agency for International Development (AID), have special procurements for which only HBCUs can apply in order to utilize their unique capabilities in these areas.

2. Set-asides for HBCUs should be established to permit them to provide training, program evaluation, and research and policy analysis.

3. Predominantly white institutions, especially those with hospitals, medical schools, or other major health facilities, should be strongly encouraged to subcontract with HBCUs as part of collaborations or partnerships to provide health-related services targeted to black male children and adolescents.

# Involving Families in Health Services Delivery: Lessons from Child Maltreatment

*Lois Abramczek, M.S.S.W., Ed.D.*

My concern about family involvement comes from my research and experience with child maltreatment, my primary area of study, but I think the transition to health issues will be smooth. Certainly some of the primary health issues for black male children and adolescents—injury, suicide, homicide, substance abuse, early pregnancy, and sexually transmitted disease—are the same problems we see in the child-maltreating families. In addition, the reluctance of this population to use health care services frequently mirrors the family attitudes toward "our services" in general—whether health, child welfare, or mental health—based upon cultural and family history and experience with our services.

I will borrow from the child maltreatment literature to present some ideas and issues related to family involvement in services—health and related social services—directed toward improving the health care of black male children and adolescents.

## Assumptions about Health and Family

Let me review some assumptions I am making about health and about families. First, about health: It is increasingly clear that health issues in general, and certainly for the population of concern here, are inseparable from social/psychological/emotional issues. Both the major health problems themselves and the problems of access to and use of health care and prevention are social in nature. Thus these problems are very complex and defy simplistic solutions.

Second, about families: Family involvement is essential for adequate health care of children and adolescents. The Maternal and Child Health Bureau recognizes that the family is the major influence on a child's health and development.[1] Early attainment of basic physical and emotional needs, communicating values and sense of worth, and teaching mechanisms for coping all contribute to a positive outcome—children and adolescents with a fair chance of withstanding the ordinary and extraordinary stresses of life. On the other

hand, the absence of these gifts from the family leaves the child vulnerable to life's stresses.

Next, we accept an ecological view of the family. We cannot talk about involving families without an appreciation of the ecological context of those families—the neighborhoods and cultures in which they struggle, survive, and sometimes flourish. The etiology of health-related problems is, as we have said, complex, involving the interaction of a constellation of contributing (risk) factors and compensatory (protecting) factors. Thus the explanatory models we use to guide our thinking must be integrative, including characteristics of individuals (parenting skills, education) and the microsystem (family patterns of interaction, extended family) but also the exosystem (community supports, structure of employment) and macrosystem (cultural acceptance of violence).[2,3]

Last are definitional issues. It seems clear that any definition that prescribes an exclusive or restricted way to be a family, based upon structure, imposes a heavy burden upon those whose life circumstances do not allow for that particular structure, or whose history and/or values present other options and definitions. Moreover, research does not support a particular family form as much as it supports necessary functions. In other words, families provide such things as nurturance, self-definition, self-esteem, guidance, and protection, and our concern is that a child receive adequate doses of these things rather than that a particular family form provide them. This is not to say that a more traditionally defined family is not "best" but rather that (1) research does not yet support that other forms, if supported by society, are not viable; and (2) we need to deal positively with reality rather than wallowing in the arena of "shoulds," which is always unproductive.

### Philosophic Approach to Family Involvement

Regardless of which specific strategies are used for involving families, one basic philosophic approach is essential. Social work has said it from the early days of the profession: Start where the client is. Yet as our services have become more institutionalized, our attention diverted by mandates, accountability, liability, and treatment technology, we do not even know where the client is, much less have the time to start there. We want to be empathetic, but are frequently out of touch with the inner and immediate world of our clients.

We assume that each of us lives in a world of our own beliefs and perceptions and that those are more powerful in guiding our behavior than some presumed external "reality." We readily recognize this in the case of an abused

child who, when approached by a nurturing adult, reacts as though he or she was being attacked. That is, we can understand that the child is reacting to his or her own beliefs about adult intentions rather than to actual intentions. Yet we are generally not attuned to others' perceptions, blithely assuming that our clients, colleagues, and kin see the world as we do. We have intimate conversation with those nearest to us about love without ever knowing, for example, that to one love is unconditional acceptance while to the other it is preventing harm.

"Do you love me?"

"Yes, I love you."

"Well, why don't you show it?"

"I do. You're just impossible to please."

And so it goes, with no meaningful exchange of information or emotional satisfaction. How much less do we understand the private reality of the impoverished caretaker of a black youth who has just been found dead in the street, several blocks from his own home.

Family health behaviors, including use of services, are based on beliefs, a set of assumptions about reality. Particularly relevant are what families see as costs and benefits of their behaviors, which may be based on cultural history, personal history, previous experience with "helpers," and other experiences. Regardless of perceived benefits, perceived costs are often more than the family will pay—erosion of already marginal self-esteem, feelings of helplessness and incompetence, and self blame.

How, though, can we enter the private world of our families? Not easily. Even the client cannot easily explain how he or she views the world, because it is too close to be open for examination, and so is taken for granted. But we can begin to know by "bracketing" our own perceptions and beliefs, listening without judgment but rather with a sense of awe at the rare privilege of being allowed to enter another's world.

This presents an enormous challenge for us. We need to identify and respect family perceptions and belief systems; challenge those that do not lead to outcomes that are good for people, and—at the same time—allow our own perceptions and belief systems to be challenged. This approach has implications for research and for treatment, some of which will be discussed later.

## Concepts Related to Family Involvement

The literature on family involvement in health and social services contains a number of concepts that are thought to be important to our understanding of families, their needs, and how to involve them in services. These concepts are cultural context, isolation/social support, social control, empowerment, family strengths, resistance, and engagement.

### *Cultural Context*

Garbarino (1977) concluded from a review of research on child maltreatment that, while numerous sufficient conditions to explain that phenomenon had been identified (e.g., poverty, lack of education, family form), these would be viable only if certain necessary conditions were met, the first of these being cultural acceptance of physical force.[4] This gives empirical support to the overriding importance of cultural factors in explaining private—individual or family—behavior. While cultural context is difficult to modify, understanding its power in relation to health behaviors may give us a better appreciation of family endangerment and leave us less quick to blame families for their own troubles.

### *Isolation/Social Support*

The second necessary condition Garbarino identified was social isolation—the absence of potent support systems.[4] In other words, regardless of other associated factors, child maltreatment occurs only when sufficient social support is absent. Again, family problems are seen not as individual or family defects of character but as linked to community context.

Social support can provide for families psychological support, intimacy, advice, material assistance, instrumental assistance, models for social skills, opportunity for reciprocity, and a prosocial orientation. It is in privacy (social isolation) that marginal families sink into depression, fall below minimal standards of family and social behavior, and feel no investment in their neighbors or communities. With a constricted base of resources to model and support healthy behaviors, families repeat their own dysfunctional patterns. Whereas modifying cultural attitudes, such as acceptance of violence, is fairly difficult, modifying social support is quite manageable within our current treatment technology, though our actual practice in this area needs to be greatly strengthened and expanded through working with groups of families, self-help groups, and networks.

*Social Control*

Garbarino states, "For intervention to succeed . . . it must link the nurturance of individuals who have been subjected to circumstantial stress and to their own psychological inadequacy, on the one hand, with explicit sanctions and stringent vigilance against further dysfunction (social control) on the other hand."[5]

Social control, vigilance, and surveillance have a negative ring, though most accept the importance of informal enforcement of community standards in helping families behave in ways that are good for themselves and for their communities. Essentially, it is important that others see, make judgments, and provide corrective feedback to families.

Garbarino asks, "Is the community parent to the family?"[5] The parenting literature tells us that unconditional love is vital, but leads to competence and independence only when coupled with a disciplinary style that sets limits and makes demands—in other words, that emphasizes reciprocity. It appears that the same may be true for the family's relationship with the community, which needs to support the family but also asks for something in return. Yet we are very ambivalent about disturbing the privacy of families for either support or control, frequently waiting until after harm has occurred to justify our intervention, at which point our services are coercive. How preferable for us to be involved with families earlier, so that our surveillance can indeed be coupled with nurturance rather than with coercion.

*Empowerment*

Empowerment may be an overworked term. A colleague recently asked me (derisively, or so I thought), "What is all this empowerment stuff? I see it everywhere." Yet the concept does have meaning and perhaps one needs to be familiar with how our services have traditionally been offered to appreciate that. Any services that intrinsically or through delivery modality reduce a family's feelings of efficacy, deny reciprocity, or cause the family's esteem to shrink are disempowering. Such services promote the very qualities of dependence, resentment, passivity, or hostility that we then use as negative labels for our families. Punitive services are most obviously disempowering, but services offered with an attitude of noblesse oblige can be equally so. The institutionalization of our services may also be disempowering to families and communities by damaging natural systems of support. Our professional services may provide temporary relief but at the same time disempower families and communities by

lowering their capacity to develop and maintain their own structures and processes for problem solving.[6]

*Family Strengths*

Our knowledge and skill lag behind our intent when it comes to recognizing and building upon family strengths. First, we lack the vocabulary to deal with strengths. While extensive classification systems exist for describing pathology, we have very limited terms for describing health. Attempts have been made to describe the healthy family (using constructs such as communication, leadership, emotional expression, and independence). Yet the constructs and the instruments used to measure them—geared, as they are, toward middle-class families—sometimes seem difficult to apply to the families with whom we work.

A second difficulty in understanding strengths has to do with cultural difference. In keeping with our definition of family and with our phenomenological approach, it is important not to let a middle-class frame of reference blind us to real family strengths. Boyd-Franklin, in discussing the strengths of black families, cites as examples kinship bonds, work orientation, adaptability of family roles, and high achievement motivation and shows how these strengths arise from the history of the black family.[7] For instance, kinship orientation may be viewed as reflecting African tribal heritage as well as the importance of "maintaining cohesion in the face of adversities connected with slavery," role flexibility as a response to economic necessity, and achievement orientation that views education as a way out of poverty.

Religion and spirituality must not be overlooked as potential family strengths. For the black family, the church has traditionally provided social support, and spirituality has provided hope and meaning. It is curious, in spite of separation of church and state, that we should be reluctant to deal with what, by definition, is of ultimate concern to our families.

While most recognize the importance of family strengths, our understanding of strengths is frequently sentimental rather than based upon facts. For instance, a good assessment must distinguish between the extended family that truly provides a supportive function and the family that intrudes, denies members' individuality, and perpetuates nonadaptive patterns. Or at least we need to see both the supports and risks associated with the extended family, if both are present. A more sophisticated understanding of strengths can discern that the same behaviors and relationships may be both strengthening and

endangering, that what is strengthening in one context may be endangering in another, and that strengths, to be potentiated, need social sanction. We have a long way to go in our understanding of family strengths.

*Resistance*

A definition of resistance that is pertinent to our understanding of engaging families in treatment is the following: Resistance is what we call it when someone does not do what we want him or her to do. Families are not apt to want to be involved with us in ways and for goals that they do not value, that are not consonant with their culture, and that they do not believe will benefit them (except, perhaps, at unacceptable cost).

An important pair of concepts we might examine to help us understand resistance is treatment integrity/treatment acceptability. If our services have integrity, that means there is good reason to believe they will produce the desired results. If a youth attends a tutoring class, there is good reason to believe he or she will do well in school (i.e., get a good job, become rich). If a mother keeps her appointments with the well baby clinic, there is reason to believe any problems her child may have will be detected early and treated. Treatment acceptability means that the client views the treatment as good for him or her. It fits his or her values, culture, and life style. These two concepts have implications for honesty regarding what we have to offer and how it might help the client; communication about our services; and flexibility in offering services so they are more acceptable—and, therefore, accessible—to the client. If our services lack integrity and acceptability, we should expect healthy resistance to involvement with us.

*Engagement*

As I mentioned earlier, a colleague and I are currently conducting research on child neglect; this research has involved extensive interviews with three groups of Aid to Families with Dependent Children-eligible families: neglecting, formerly neglecting, and never neglecting. In the course of this study we have learned much about how to engage families. We would be going into some very impoverished homes, homes that had already suffered intrusion from our public services, homes in which suspicion was already realistically high, to ask caretakers and their children to do something for us! This does not sound like a very strong position to start from—entering their world, without an invitation, to meet our needs. In general, engaging families is seen as the most challenging

aspect of research with this population. Thus, up front, we gave maximal attention to engagement. Interviewers were steeped in a certain approach (based on phenomenology and construct theory), every step of their approach to families was examined for sensitivity, and we took our time. We realized that we needed to work on their time frame, not try to force them to meet ours.

Our planning paid off. First, after initial telephone calls and visits, the refusal rate was minimal and most families kept their appointments, which were in their own homes. Second, rather than dropping out, families continued with us throughout rather long and laborious interviews with repeat visits. The interviewers' willingness to enter and accept the participants' world was best demonstrated by one instance in which, during the interview, the caretaker talked a while, then disappeared to a back room and returned later with renewed "energy." The interviewer was patient as the caretaker, as she determined she could, worked her way through the interview. Third, our interviewers had meaning for participants. After interviews were over, many caretakers wanted the interviewers to return and said they had never had anyone listen to them like that before; this in spite of their having had many service providers in the past and present.

What does this demonstrate? Many of our services are offered to families during a period of crisis in their lives. We as service providers are also in crisis, since we are mandated to solve some problem and to do it quickly. If it is a case of child maltreatment, emergency measures may need to be taken to protect children; investigations and hearings must be accomplished within a prescribed time frame. In juvenile justice, the adolescent or society must be quickly protected. Even in schools, a child who cannot be managed in the classroom must be quickly handled so the rest of the class can continue to learn, undisrupted by the offender. This crisis nature of our services militates against the kind of deliberately sensitive approach our interviewers were able to use. There is always some system demanding that the "problem" be "solved." While we know something about the difficulty of change, very few service systems allow for the kind of incremental goal-setting that begins with establishing trust, proceeds to helping clients get what they want, helps them expand their views of what they want or believe is possible for themselves, and then finally expands their idea of reality and of what is possible for them. Preventive services—actually more available through health than social services—have more potential for allowing the time for the "deliberately sensitive approach" described here.

**Recommendations**

This brief discussion of several concepts related to family involvement suggests recommendations for the kinds of research and demonstration programs that may prove helpful.

1. We might rethink what it means to know. We have often deluded ourselves that, by using standardized methods and instruments, we obtain standardized results, yet we know very little about what our stimulus materials mean to our subjects or, for that matter, if they mean anything. Brofenbrenner has warned, ". . . It becomes not only desirable but essential to take into account in every scientific inquiry about human behavior and development how the research situation was perceived and interpreted by the subjects of the study."[8] Thus we need to give more emphasis to qualitative research that adequately accounts for subject perceptions, which may involve fewer numbers of subjects followed much more intensively.

2. Any research on families must also involve study of the context. Microanalysis of family characteristics is of limited value, given that societal attitudes and relationships between family and community are such an important component of the etiology of family distress as well as of viable treatment planning.

3. More research regarding family strengths should be encouraged to deepen our understanding of the strengths of black families, how these strengths operate in various social contexts, and how we can support them.

4. As in research, in service planning and delivery we need to pay much more attention to client perceptions and beliefs. Demonstration programs that include plans for eliciting and responding to these should be favored.

5. Demonstration projects that stress neighborhood capacity-building should be encouraged. Any projects should be required to show (a) that they do not disempower families and communities and (b) that they include specific mechanisms for empowering and ways to prove it.

6. Demonstration projects that focus on family engagement and allow time for that to occur should be encouraged.

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# Private Sector, Public Role: The Community Organization as Advocate

*Eddie Harrison*

Justice Resources, Inc. (JRI) is a private nonprofit 501-C (3) organization incorporated in the state of Maryland in 1977. JRI was established to promote a greater responsiveness from the public and private sector to the needs of at-risk children and youth.

JRI defines itself as an advocacy agency. Its role is to advocate for expanded services for youth and families and to address issues of public policy and practice which adversely affect youth. Justice Resources is committed to the development of community-based alternatives to institutionalization for children and adolescents.

The role of JRI, as a part of the private sector, in ensuring an awareness of the needs of black males has taken several approaches. First, JRI supports direct service delivery to black youth. Second, JRI educates the public on issues related to black youth. Next, JRI participates in public policy debates. Finally, JRI develops networks with professional affiliates and broadens opportunities to involve indigenous community organizations in juvenile justice issues.

JRI has provided an array of services to approximately 10,000 youth during the past 20 years. Eighty-seven percent of them have been black males between the ages of 15 and 18 years. All were classified as "juvenile offenders" and many were "repeat offenders."

This paper reflects the past and current experiences of Justice Resources as a way of defining its role as a community-based organization in ensuring awareness of the health and social needs of black male children and adolescents. The issues presented in this paper address the mental health and social needs of black male children that are in the juvenile justice system, some of whom have been served by JRI.

The opinions expressed concerning the mental health status of these children and the variables which influence their mental health does not represent the clinical perspective. The intent is to provide a practical overview of the factors which influence the mental health status of black male children and adolescents.

After 20 years of working with black children, I have come to realize that the majority of the children who enter the juvenile justice system labeled as "juvenile offenders" are more "offendees" than offenders. This opinion is supported by the following factors: (1) the social and economic variables which influence the minds of children; and (2) the extent to which economic circumstance and social environment have on determining values, morality, mentality, and mortality. These two factors have convinced me that black urban youth have little or no chance of experiencing a disability-free life in America.

Advocacy efforts on behalf of black males (adults and adolescents) must become the highest priority of the public and private sector. This advocacy must be encouraged because of the following: (1) the disproportionate number of black males incarcerated in adult and juvenile facilities; (2) the high rate of unemployment among black males; (3) the high number of female-headed households with dysfunctional families; (4) the amount and type of adolescent problem behaviors including pregnancy, substance abuse, and drug trafficking; (5) low college enrollment; (6) high infant mortality; (7) the high rate of homelessness; (8) the low rate of homeownership; and (9) the high number of black males who live at or below the poverty level.

Advocacy efforts must be directed to every federal and state government agency that funds human service initiatives, as well as private institutions and foundations, communication networks, advertising agencies, elected officials, parents, teachers, police officers, child-care workers, and private citizens who have any influence on youth.

I recently presented a paper, "Correcting Juvenile Offenders in Their Social Environment," at the American Correctional Association's annual congress. As I reflected on the topic, it occurred to me that correcting the social environment would offer the greatest potential for affecting significant, positive, and permanent change in the characteristics and behavior of persons who live in a negative social environment. It reminded me also of a statement by one of my mentors, Dr. Carl Menninger, who wrote in his book, *The Crime of Punishment*, "All of the crimes committed by all of the jailed criminals do not equal, in social damage, the crimes committed against them." This was written some 20 years ago and is as relevant today as when it was written.

Youth who enter the juvenile justice system represent the failures of other primary support systems responsible for their development; specifically, the immediate family, public education, social service, health care, religion, law enforcement, judicial and correctional systems. Simply put, black children in

the juvenile justice system are there because of the failure of our society to meet their most basic, fundamental human needs. Failures of these primary support systems are shown by the vast majority of the black male youth in the juvenile justice system who have low self-esteem, distorted values, no moral foundation, no sense of "future," and are prone to violent behavior. These same youth have educational deficiencies and function one to two grades below their grade level. As a result, many of these youth drop out or are pushed out of the education system.

As related to employment, these same youth are either unemployed, underemployed, or unemployable. Many are from families that must receive some form of public subsidy in order to have the basic necessities of life.

These children have not received adequate preventive health care, early diagnosis of treatable illness, or adequate treatment of detected illness. The overall physical health status of black children and adolescents is poor characterized by high rates of sexually transmitted disease, low birthweight, and infant mortality.

Religious institutions appear to have failed in their ability to provide a spiritual and moral foundation for these youth. The basic tenants of religious beliefs related to peace, harmony and social order are not evident in these youth or their families.

The above characteristics are seen in children 10 years of age and younger. Many of these same children have suffered years of physical, emotional, and spiritual abuse. Many have been sexually abused and have suffered years of moral deprivation by being exposed to violence, drugs and drug abusers, prostitution, pornography, adolescent homicide, and many forms of social and racial injustice: Such is the life experience of black urban youth prior to their involvement in any form of delinquent activity.

These youth are victims of a social and economic environment over which they have no control. They are victims in every sense of the word and their plight gets even worse when they reach adulthood and enter the adult criminal justice environment.

These same black children grow into adulthood with little or no positive change in their mentality or their mental health status. They then become the victims of, as well as the perpetrators of, violent crime and drug and alcohol abuse. Subsequently, they are arrested, incarcerated, sentenced to longer terms and serve more time than any other groups. Unless we focus a concentrated and massive attack on the social and economic issues which are responsible for

shaping the mentality of black males, we will have minimal success in changing the status of black children and adolescents in this country.

Let me illustrate this point by applying it in the context of criminal justice. If, by some miracle, all of the prisoners and clients of all institutional and community programs were to be removed from our records and files, it would take just a short time to fill every institutional bed and replenish the caseload of every child care worker and probation and parole office in this country. This clearly shows that the correctional approach to the problems of crime and delinquency have little, if any, potential for positively impacting the causes of crime and delinquency. What this also suggests is that unless we address the causes of crime and delinquency from a societal and community perspective, we will continue to experience an escalation in the rates of crime and delinquency.

The role of the private sector and community-based organizations in ensuring public awareness of the health and social needs of black male children is through expanded information dissemination and public education. Private sectors organizations must be aware (or made aware) of the extent to which health-care resources are lacking in our respective jurisdictions and must remain concerned and committed to focusing awareness of the health and social needs of black youth on a personal as well as professional basis.

The private sector should involve all segments of the community in focusing awareness of the health-care needs of black youth. The social and health needs of black youth must be brought to the attention of the United States Congress and to all federal and local departments of education, labor, health, human resources, housing, community development and public safety. Similarly, public sector agencies should encourage and expand opportunities for private sector involvement in addressing the social and health needs of black children and adolescents.

# Rethinking the Role of Health and Education in Today's World

*Meldon S. Hollis, Jr., M.P.A., M.S., J.D.*

More and more, society looks to the school system to solve problems that, in other contexts, would not be considered the province of education officials. School systems are expected to address the social, medical, and educational problems of our children. Those problems include substance abuse, adolescent pregnancy, violent crime, child abuse, AIDS, nutrition, "values," and readiness for the workplace. Supposedly, the financial and human resources left over, after addressing these problems, are to be applied to the education of our children. Ironically, these increased expectations are imposed on school systems at a time when financial resources for urban school districts with large numbers of low-income students are strained—to the point where it is difficult to provide even the most basic education programs. School systems rely heavily on state and local contributions for resources.

In this past year, some 35 states reported state budget deficits. The near-term prognosis for the national economy is not good. The urban centers of the country face a financial crisis. Things are likely to get worse before they get better.

Before we consider the issue of health and its interaction with education, we should take a closer look at the environment in which education and health services must be delivered to black males and adolescents. Since 1954 our youth have increasingly become segregated by race and income. Black, Hispanic, and Asian youth are largely segregated into urban school districts, while predominantly white school districts, with a few exceptions, are suburban and rural. In the 25 largest population centers of this country, there no longer exists a predominantly white public school system, with the possible exception of Minneapolis–St. Paul. All of the urban centers—Atlanta, Baltimore, Birmingham, Boston, Chicago, Dallas, Detroit, Houston, Los Angeles, New Orleans, New York City, Newark, Philadelphia, Richmond, San Diego, and Washington, D.C.—are predominantly black, or predominantly Hispanic and black. Recent history has turned our old impressions of segregation upside down. Mississippi, Louisiana, and South Carolina have the most thoroughly integrated

systems of public education in the country; New Jersey, Michigan, and Illinois have the most segregated systems. Since 1954, Maryland moved faster to resegregate its system of public education than any of the other 49 states. There are more black children in segregated systems of public education in 1991 than there were at the time of the Brown *v.* Topeka Board of Education decision in 1954.

Along with more efficient racial segregation has come efficient economic segregation. There is a great deal of evidence that economic opportunity and the quality of life have declined significantly over the past few decades for about two-thirds of the black community. It is only since the 1960s that unemployment levels for blacks have become twice that of white men. Only since the 1960s has the unemployment rate of black adolescents become three times that of white adolescents. In the meantime, white women have joined black women in the work force. The number of white women who have entered the American work force over the past three decades exceeds the entire black population.

The result of national social and economic policies over the past four decades is a highly concentrated urban black population which is no longer "relatively disadvantaged." Increasingly, the black population, and black males and children in particular, are "truly disadvantaged" (with apologies to Julius Wilson). These youngsters live in stressful and unhealthy conditions. Yet in spite of the significant deterioration of the urban environment and the dis-appearance of social structures that traditionally supported urban families, school systems are expected to meet ever higher education goals.

Health issues among our children have risen to a level that makes them significant barriers to a meaningful educational experience. Ideally, the educational foundation for all children is set during early childhood. Increasingly, black children enter the school system without the benefit of extensive or sufficient parenting. A large proportion of them are stored in low-cost "day care centers" while both parents (or the only parent) work. This time is most often not spent in the supportive environment or stimulating atmosphere necessary to encourage intellectual growth or to prepare youngsters for schooling. We often receive youngsters who are not ready for school or who bring significant social deficits with them when they enter school.

It is often difficult to tell whether the unreadiness exhibited by the child has a social or medical basis. The typical range of health issues which may affect educational achievement are: ingestion of lead (paint), nutrition deficits, lack of immunization, prenatal exposure to substance abuse, child abuse, or neglect. Of particular concern is the increased number of youngsters who are neglected

because of the poorly developed parenting skills of adolescent parents. Any of these medical or environmental factors may lead to a child being classified a "slow learner" in need of special education remediation. The walk to school for many of our youngsters has become a race away from violence. For an increasing number of elementary school students in particular, shootings, stabbings, and gang violence at home and on the way to school are leading to increased evidence of stress-induced disorders.

School systems tend to place children into "educationally" relevant categories. We break youngsters into four age groups. Those groups are: preschool, elementary school, middle school, and secondary school. In many discussions, secondary schools are thought to most closely approximate adolescence. School administrators know, however, that the greatest pressure and chaos tends to visit youngsters in their middle school years. In elementary school, youngsters are usually too young to play hooky or become involved in gang violence. A youngster who enters the 10th grade is likely to graduate. We lose most of our youngsters between the sixth and the ninth grades. It is also in that age group that youngsters tend to be at the greatest risk in terms of education and of health. We lose large numbers of female students to pregnancy in the middle school years. Patterns of substance abuse tend to take hold here. Increasing incidence of sexually transmitted diseases in middle school must mean that increasing numbers of youngsters between the ages of 11 and 15 years are contracting the human immunodeficiency virus (HIV). Homicide, of course, is the number one killer of young black male adolescents, and the violence which follows the drug economy has increased stress levels to the point that the behavior of adolescent black males and females can only properly be understood if they are seen as the actions of youngsters living in a war zone.

School systems can do little to attain their educational objectives in this increasingly hostile environment. Medical professionals can do little to better deliver their services in a timely and effective way to help our youngsters persist in the education system. But education professionals and health professionals working together with state and national legislators can do more. We must ensure better nutrition for school-age youngsters. Currently we reach only about 19 percent of the youngsters who qualify for nutrition assistance. Increasingly, the only access to health services for our youth are school-based health programs. School boards and health professionals should design and implement comprehensive school health programs.

We must focus on environmental factors which lead to high stress levels and violence in the schools. These practices include not only reducing violence and improving the physical facilities of the schools, but will also require a re-examination of our policy of segregating youngsters by "ability." This admonition includes both special education programs and "gifted and talented" programs. We must train teachers to better discern the difference between medical and social impairment. We must be more aggressive with mental health support for our youngsters. We must also be more open and frank. We must design health education programs which address the real environmental dangers that our youngsters face—not the problems faced by Dick and Jane.

Both education and health professionals must be determined to reach our youngsters where they are, not where we would like them to be. This means focusing our energies on day care centers and on the juvenile justice system as well as on the public school. With this expanded view and a commitment to the modest proposals set out in this paper, education and health professionals together might make a real difference in the quality of our children's lives.

# Maternal and Child Health Bureau Funding Priority Requirements: Work Group Reports

The Summit on the Health Care of Black Male Children and Adolescents brought together experts from an array of disciplines and cultural backgrounds including child health, social welfare, community-based organizations, and education. A primary aim of the summit was to systematize primary health care for black male children and adolescents. One method of achieving a systematic program to improve the health status of black male children is to create a Maternal and Child Health Bureau (MCHB) funding priority for this vulnerable group. During the summit, participants met in small groups to develop criteria for this priority. The following section summarizes the discussion of the three small groups.

**Purpose of the Priority**

The ultimate goal of the health status of black male children and adolescents program within MCHB is to decrease the morbidity and mortality experience by black male children and adolescents each year. Through its grant program, MCHB assists states and communities in their responsibility to implement or more fully develop a comprehensive system of primary health care for black male children and adolescents in the following ways:

1. Enhances the understanding of factors and interventions which may improve or promote the health status of black male children and adolescents;

2. Develops leadership capacity and fostering interagency coordination and collaboration at the state and local levels in the planning and implementation of comprehensive primary health care programs to special populations of black male children and adolescents (e.g., youth in state custody, homeless/street youth, gang members, adolescent fathers, bisexual and homosexual adolescents);

3. Establishes standards and policy options for the design of primary health care systems for black male children and adolescents;

4. Conducts comprehensive demonstration programs which expand knowledge and understanding of the causative factors, etiology and interventions which may improve or promote health of black male children and adolescents;

5. Develops new or innovative models and builds on existing successful models;

6. Develops self-sufficiency so that project activities continue after federal support ends;

7. Implements incentive grants to replicate proven, successful intervention models or approaches;

8. Maximizes existing resources to pay for direct services and uses federal funds to build community, local, and state coalitions and partnerships;

9. Develops a glossary of terms;

10. Provides technical assistance to potential applicants;

11. Provides strategies for acquiring new resources;

12. Includes minority representation on review panels; and

13. Conducts demonstrations which systematically examine and evaluate components of the strategy being used and assess the impact.

**Specific Program Requirements**

MCHB requires that grants funded under the health care of black male children and adolescents priority pay special attention to the following factors:

1. Projects must include a comprehensive needs assessment which documents existing resources and extent of unmet need;

2. Projects must demonstrate a linkage with state Title V agencies and local or community-based organizations;

3. Priority for funding will be given to projects which make maximal use of public, private, and voluntary resources which exist in their community to encourage continuing funding once federal support ends;

4. Priority should be given to programs which include black males in the planning and implementation of the program; and

5. Projects must provide a detailed comprehensive evaluation component of the program.

**Program Administration**

Eligible applicants would include:

1. Public/private, non-profit and for profit agencies;

2. State MCH agency and other state/local agencies;

3. Special priority should be given to minority community-based organizations which demonstrate capacity to implement successful models; and

4. Historically black colleges and universities.

# Summit on the Health Care of Black Male Children and Adolescents

July 26–27, 1991
Annapolis, Maryland

## Friday, July 26, 1991

8:00–9:00
**Breakfast Buffet**
Duke of Gloucester Room, Maryland Inn

9:00–10:45
**Opening Session**
Duke of Gloucester Room, Maryland Inn

| | |
|---|---|
| Introduction | *Juanita Evans, M.S.W., L.C.S.W.* |
| Greetings and Welcome | *Vince Hutchins, M.D., M.P.H.*<br>*David Heppel, M.D.* |
| Summary of Activities to Date | *Juanita Evans, M.S.W., L.C.S.W* |
| Health and Social Issues | *James Farrow, M.D.* |
| Charge to Group | *Linda Thompson, M.S.N., Dr.PH.* |
| Questions and Discussion | |

10:45–11:00
**Break**

11:00–12:00
**Brainstorming Session**
Duke of Gloucester Room, Maryland Inn
*Linda Thompson, M.S.N., Dr.PH.*
*Moderator*

12:00–1:00
**Luncheon**
Governor Calvert House

1:30–2:40
**Panel Discussion—Programs** — *Ronald Feinstein, M.D., Moderator*
Duke of Gloucester Room, Maryland Inn

Juvenile Justice Advisory Group

National Commission on Correctional Health Care — *Edward Harrison, M.B.A.*

AMCHP — *Holly Grason, M.A.*

2:40–2:55
**Break**
Duke of Gloucester Room, Maryland Inn

2:55–4:20
**Panel Discussion–Training** — *James Farrow, M.D., Moderator*
Duke of Gloucester Room, Maryland Inn

Social Work Programs — *Kenneth Jaros, M.S.W., Ph.D.*

Interdisciplinary/University-Based Training — *Marianne Felice, M.D.*

Historical Black Colleges — *Robert Hill, Ph.D.*

4:30–4:45
**Break**

4:45–5:40
**Panel Discussion—Advocacy** — *Shirley Smith, R.N., M.S., Moderator*
Duke of Gloucester Room, Maryland Inn

Family Involvement — *Lois Abramczek, M.S.S.W., Ed.D.*

Private Sector/Community — *Eddie Harrison*

Saturday, July 27, 1991

8:00–9:00
**Breakfast Buffet**
Duke of Gloucester Room, Maryland Inn

9:00–11:00
**Involvement of Educators** — *Meldon Hollis, Jr., M.P.A., M.S., J.D.*
Duke of Gloucester Room, Maryland Inn

Charge to Work Group — *Linda Thompson, M.S.N., Dr. P.H.*

9:45–11:00
**Work Group Sessions—Development of Statement for Guidance**

Duke of Gloucester Room, Maryland Inn
Group I — *Carolina Endert, M.S.W., L.C.S.W. Facilitator*

Duke of Gloucester Room, Maryland Inn
Group 2 — *Stuart Swayze, M.S.W., A.C.S.W., Facilitator*

Hyde Suite
Group 3 — *Charles Cain, M.S.W., Dr. P.H., Facilitator*

11:00–12:00
**Work Group Presentations** — *Juanita Evans, M.S.W., L.C.S.W., Moderator*
Duke of Gloucester Room, Maryland Inn

12:00–2:00
**Lunch**

2:00–5:30
**Networking Afternoon**

5:50
**Summary of Summit** — *Linda Thompson, M.S.N., Dr.P.H.*
Governor Calvert House

**Crabfeast**

# Summit on the Health Care of Black Male Children and Adolescents

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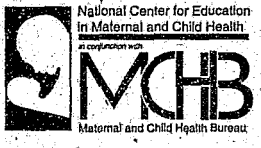
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