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ORIGINAL PAPER

The Evolution of Community Mental Health Services in Asian American Communities

Duy Nguyen · Tazuko Shibusawa · Mouchuan Teddy Chen

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Abstract This paper explores the history of Asian immigration to the United States, and its intersections with the mental health system. As mental health care have evolved since the 1960s from institutions to the community, public mental health services for Asian Americans have become increasingly culturally relevant. Major policy shifts, trends in immigration, and mental health practice will be presented with a focus on the Bridge Program at the Charles B. Wang Community Health Center. Integrative practice and research models that extend evidence-based knowledge to Asian American communities and practice implications are discussed.

Keywords Asian Americans · Community mental health services · Cultural competence · Evidence based

Introduction

Three health and social policies enacted during the 1960s continue to shape twenty-first century mental health practices. First, deinstitutionalization initiatives that began in the early 1960s sought to shift the treatment of people with mental illness from traditional inpatient psychiatric care to community care. Disparities in care were observed during the tumultuous decade as more affluent states were able to fund care at a higher level (Grob 1991). New York, Massachusetts, and three other states accounted for more than half of the monies spent by all states on mental health services as hospital expenditures varied greatly among the states (Grob 1991). Second, the enactment of the Civil Rights Act of 1964 and accompanying social changes resulted in the recognition of the need to protect the rights of racial and ethnic minority groups and other disempowered segments of society. Health disparities became a Federal issue, no longer isolated among the states. With passing of the Community Mental Health Center Act of 1963 and Civil Rights Act, the landscape of mental health care for persons of color changed dramatically. A third policy initiative—the Immigration Act of 1965—played a pivotal role in changing American demographics (Kitano and Nakaoka 2001). Lifting the preexisting quota system based on national origin and promoting immigration from all parts of the world based on skills and family reunification, the Immigration Act of 1965 lead to the influx of racial and ethnic minorities and the subsequent diversification of American racial discourse beyond discussions of black and white.

Using the three policy initiatives of the 1960s as a turning point, this paper explores how mental health policies and practice have been translated into services for Asian Americans. We first discuss the demographic characteristics and mental health issues of this population and present a clinical case to illustrate an evidence-based and culturally competent approach for Asian Americans. We conclude our paper by discussing future issues for Asian American mental health care.

D. Nguyen (✉) · T. Shibusawa
Silver School of Social Work, New York University,
1 Washington Square North, New York, NY 10003, USA
e-mail: duy.nguyen@nyu.edu

T. Shibusawa
e-mail: tazuko.shibusawa@nyu.edu

M. T. Chen
Mental Health Bridge Program, Charles B. Wang Community Health Center, 268 Canal Street, New York, NY 10013, USA
e-mail: tchen@cbwchc.org

Confluence of Three Social Policies

The community mental health movement accelerated in the 1960s with the Community Mental Health Center (CMHC) Act of 1963 (Grob 1991). Combining mental health and mental retardation issues, the Act sought to provide support for the construction and initial operating costs of community-based clinics. In doing so, the Act diminished the role of state government by de-emphasizing the importance of inpatient mental institutions. States were mandated to develop a plan, designate an agency to administer the plan, appoint an advisory council, and establish a construction program. Having a decentralized system that empowered the community to define goals further reduced the states' role. The 1963 Act was limited to the construction of the centers, and mental health leaders helped pass legislation in 1965 to amend the law to provide grants to hire mental health service providers.

The Civil Rights Act of 1964 ensured that all Americans regardless of race, color, religion, sex, or national origin could vote, go to school, and access public places and government services. Enacted in the response to domestic segregationist practices, the Civil Rights Act influenced immigration policies that were enacted the following year. The Immigration Act of 1965, which was enacted the following year, lifted the quota-based immigration system that promoted immigration from European countries and set a worldwide quota for immigration (Kitano and Nakaoka 2001; Takaki 1993). The quota-based immigration system was part of the historical legacy of discriminatory policies towards Asians. While more than 27 million Europeans immigrated to the United States during the 1880s and 1920s, the Asian population remained small because of exclusionary policies (Zhou and Gatewood 2000). Anti-Asian policies included the 1790 Naturalization Law that prevented non-Whites from gaining US citizenship and the 1882 Chinese Exclusion Act, which banned Chinese from immigrating to the United States. Anti-Asian sentiments culminated in the incarceration of 120,000 Japanese Americans, many who were citizens, in concentration camps during World War II (Takaki 1993). An overview of the major Asian groups, social policies, and mental health practices are presented in Table 1.

Changes in immigration policy after 1965 allowed for increased migration from Asian countries, and the foreign-born Asian American population began to increase after the 1970 census (Kitano and Nakaoka 2001). A large number of professionals immigrated from Korea, India, and the Philippines to fill the labor shortage in the fields of medicine and engineering. During the years following the end of the Vietnam War, US policymakers granted refugee status to members of three Southeast Asian groups, the Vietnamese, Hmong, and Khmer. The mass exodus of over 100,000 Vietnamese at the conclusion of the Vietnam War resulted in a humanitarian crisis, and the vast majority was relocated to refugee camps across the US, as were smaller numbers of Hmong refugees from Laos. In the late 1970s, Cambodians fleeing the Killing Fields of the Khmer Rouge were granted refugee status to enter America. During the late 1970s, volunteer agencies lead the resettlement of Southeast Asian refugees. The formal involvement of the Federal government did not occur until the Refugee Act of 1980 as a response to the second wave of Vietnamese refugees, the Boat People. Refugees were then allowed to receive public assistance and government social services as they sought to adapt to life in the United States (Freeman 1995).

Vietnamese, Laotians, and Cambodians endured extensive traumas as a result of war and genocide. Vietnamese fled the persecution of the communists, particular groups that were at risk included those who had been allied with the US government, and Christians who had experienced persecution in previous decades at the hands of the communist regimes of the North. Hmong refugees had participated in the war helping both sides during the Vietnam War as the fighting passed through their Laotian homeland. Cambodians were also affected directly by the war, but also by the ensuing internal conflict as they fought off Vietnamese invaders, and their own communist regime, the Khmer Rouge. The highly traumatized groups, with pronounced mental health needs, contrasted greatly with the voluntary Asian immigrants that preceded them.

Table 1 Summary of Asian American immigration, social policies, and mental health services

	1960–1979	1980–1996	1997–2010
Major Asian American groups	Chinese[a], Filipino[a], Japanese[a], South Asian[a], Korean[a]	Southeast Asians, South Asians, Korean, Chinese	Hmong, Nepalese, Bangldeshi
Social policies	Deinstitutionalization 1962; Immigration Act 1965	Community Mental Health Act 1979; Refugee Act 1980	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)
Asian Americans in mental health care	Ethnic matching	Ethnic matching and culturally competent services	Evidence based practices and integrated care

[a] Some were in the US prior to Immigration Act of 1924, which prohibited immigrants from Asia

During the 1970s, mental health providers recognized the need for greater cultural considerations in mental health practice, especially the needs of the growing refugee community (Kushida et al. 1976). The recognition for the need for ethnic specific services was the result of the emergence of the Asian American movement which had been influenced by the civil rights movement in the 1960s. Inspired by a call for social equity, previously disparate Asian groups came together under as one group under the umbrella term *Asian Americans* to give voice to their past struggles, and to fight social discrimination (Takaki 1993).

Building the organizational capacity to reach out to linguistically and culturally diverse communities lead to the development of ethnic specific services, particularly for the Asian American community. Sue, who conducted research on mental health service utilization, found that compared to non-Hispanic Whites, Asian Americans and members of other minority groups were more likely to drop out of treatment and end treatment early (Sue 1977). As a result, Sue and his colleagues advanced the cultural responsiveness hypothesis suggesting that mental health services that were culturally and linguistically appropriate would be more acceptable to racial and ethnic minority groups, and increase responsiveness to treatment. Sue suggested three forms of services: one where existing mainstream services are informed by cultural information, another where mainstream agencies would create specific programs and hire staff specifically to work with racial and ethnic consumers, and finally separate, parallel mental health service organizations that would provide culturally and linguistically competent services.

Contemporary Mental Health Practice with Asian Americans

Since the immigration reforms of the 1960s, the Asian population has grown exponentially. According to census counts, Asians doubled in population from the 1970 to 1980 and 1990 censuses (Kitano and Nakaoka 2001). Currently, roughly 5 percent of the US population identifies with at least one Asian group (US Census Bureau 2002). It is projected that the population will reach 8 percent of the US population by 2050. Asian Americans live in all 50 states, but half of all Asians live in the Western region, while Los Angeles and New York City are the two cities with the largest Asian populations. The majority of Asian Americans are represented by one of six ethnic groups: Chinese, Filipino, Asian Indian, Japanese, Korean, and Vietnamese. Other major subgroups include Bangladeshis, Cambodians, Hmong, Indonesians, Laotians, Pakistanis, and Thai (Tseng 2009).

Mental Health Needs

According to the National Latino and Asian American Study (NLAAS), a nationally representative survey of 2,095 respondents, over 17 percent of Asian Americans reported lifetime prevalence of depressive, anxiety or substance abuse disorder according to the clinical criteria of the DSM-IV (Takeuchi et al. 2007). This figure is less than the 46 percent lifetime prevalence reported in the National Comorbidity Study—Replication (Kessler et al. 2005), and 30 percent lifetime prevalence reported for Latinos (Alegría et al. 2007). and African Americans (Williams et al. 2007).

Despite a lower overall prevalence of mental health disorders, particular Asian American subgroups have high levels of mental health need across the lifespan. Among Asian American youth, adolescent females ages 14–24 have the highest rates of suicide among their age group (Office of Minority Health 2007). According to data from the Centers for Disease Control and Prevention (CDC), Asian American and Pacific Islander women have higher rates of suicide among all older women in their age group. For women aged seventy-five and older, the suicide rate for Asian Americans and Pacific Islanders was 7.95 per 100,000, compared to the rates of 4.18 for Caucasian women and 1.18 for African American women (Centers of Disease Control and Prevention National Center for Injury Prevention and Control 2004).

Asian American elders also have higher rates of depression than non-Hispanic white elders (Mui and Shibusawa 2008). Depression among Asian American elders is associated with health status, poverty, intergenerational conflicts, lack of social support, and life stressors (Mui 1996; Ngo et al. 2001; Pang 1995; Shibusawa and Mui 2001). Southeast Asian elders are also at high risk for psychological distress, especially Post Traumatic Stress Disorder (PTSD), because of their prior exposure to war and experiences as refugees (Yee 1997). Studies of Southeast Asian refugees have focused on depression and PTSD. Beiser (1988) found the highest levels of depression 1 year after arrival, and immediately after arrival in Canada. This finding may be unique to displaced persons who did not voluntarily emigrate to their host country. Non-ethnic Chinese from Vietnam reported higher levels of depression than ethnic Chinese, and persons without social support structures experienced more depressive symptoms. Within the clinical setting, Kroll and his colleagues found that 73 percent of Southeast Asian refugees had experienced a major depressive episode, while nearly 14 percent had symptoms of PTSD (Kroll et al. 1989). Reflective of past traumas, persons who had experienced traumas were more symptomatic than those who had not. Anxiety disorders were observed in 5.7 percent of clients,

while schizophrenia consisted of 3.0% of the studied client population.

Asian Cultural Perspectives of Mental Health

Traditional Asian beliefs about health and illness are influenced by Confucianism, Taoism, Buddhism, and Hinduism. The common principle among these philosophies and religions is the holistic view of health, which emphasizes balance and harmony between the mind, body, and environment (Jenkins et al. 1996; Ranguram et al. 1996). Many Asians believe that physical and psychological functions are interconnected and sustained by an energy called *qi* (also known as *gi* in Korean, *ki* in Japanese, and *khi* in Vietnamese). Health symptoms are regarded as an indication of a weak flow of this energy. For example, East Asians often describe symptoms of depression as "having low *qi,*" "*a heavy chi*," *or* "*a sinking sense of ki*." The notion of qi is similar to *prana* in South Asian cultures (Hankey 2006). Symptoms of mental distress are often experienced by Asian clients as somatic symptoms such as headaches, dizziness, and diarrhea (Chung 2002). Because clients do not talk about depressed mood or feelings of panic, it is important for primary health care workers to be knowledgeable about psychological conditions that may be expressed through somatic complaints (Chen et al. 2002; Shibusawa and Chung 2009a).

Mental illness is also viewed as a hereditary disease, which results in stigma as it can bring shame to the family. Moral and character weaknesses are also viewed as causing mental illness. In addition to the lack of ethnic-specific services, the mental health problems of Asian immigrants are amplified because of social isolation, limited job skills, lack of financial resources for health care, ineligibility for health insurance, lack of knowledge of community resources, sense of personal failure in meeting family obligations, and lack of knowledge about mental illness (Chung 2010).

Mental Health Service Utilization

Use of mental health services differs by race and ethnicity and Asians have a lower utilization rate than non-Hispanic Whites (Chen et al. 2003; Chow et al. 2003; Hu et al. 1991; Leong 1994). Among Asian American groups, Southeast Asians are more likely to access care compared to other Asian ethnicities (Hu et al. 1993; Harada and Kim 1995). This is because of efforts to bring ethnic specific mental health services to Southeast Asians as a part of refugee resettlement services.

Broad investigations of service utilization have been conducted to examine general service use patterns. Early analyses of administrative level data found that Asians underutilized outpatient mental health services, while overusing emergency room services (Snowden and Cheung 1990). In a study comparing residents in high versus low poverty areas, Chow et al. (2003) found that Asian respondents were more likely to use emergency services compared to their white counterparts replicating Snowden and Cheung's earlier findings. Furthermore, Asians in high poverty areas were more likely to be diagnosed with a severe mental illness as compared to Asians residing in low poverty areas (Chow et al. 2003). Examining service use in San Diego, Chen et al. (2003) found that Asian Americans continue to underutilize services. Furthermore, researchers found that Asian American consumers had more severe diagnoses at admission than representatives of other ethnic groups (Chen et al. 2003). In his investigation of utilization of public mental health services in Hawaii, Leong (1994) found that Chinese and Japanese Americans underutilized both inpatient and outpatient services, while Filipino Americans underutilized inpatient services to an extent greater than outpatient services, demonstrating interethnic group differences.

Recent research has focused on the cultural dimensions of help-seeking. Abe-Kim and colleagues report generational differences in Asian American's use of mental health services, with third generation Asian Americans at increased likelihood of using services compared to the first generation (Abe-Kim et al. 2007). Higher levels of acculturation, as indicated by a standardized acculturation scale, have been associated with increased use of informal care and specialized mental health services (Kung 2003).

Additionally, social variables have been found to be associated with increased service use. Older age has been associated with different types of mental health service use (Kung 2003; Harada and Kim 1995). Women are more likely to access specialized mental health care (Kung 2003). Perceived discrimination due to English speaking ability has an attenuating effect on service use (Spencer and Chen 2004), and having health insurance is associated with the increased likelihood to use mental health care (Abe-Kim et al. 2002).

The use of specialized mental health care is strongly linked to the presence of assessed or perceived mental health need (Abe-Kim et al. 2002, 2007; Kung 2003; Spencer and Chen 2004). However, only 34.1 percent of Asian Americans with a probable diagnosis sought mental health services (Abe-Kim et al. 2007). Even in the presence of mental health need, consumers were more likely to seek services from emergency services rather than from mental health specialists (Phan 2000).

Mental Health Service Delivery Systems

Early studies focused on the use of psychotropic medication in the treatment of Southeast Asian consumers

presenting with mental disorders. Kinzie et al. (1980) document the challenges and successes of developing a mental health clinic to service Southeast Asian clients (Kinzie et al. 1980). Paraprofessional community mental health workers played a key role by providing interpretation services during the medication appointment, serving as a cultural liaison between Western practitioners and the local community, and providing some limited services for the client population When the clinics initially opened, many clients had psychotic disorders and other severe psychiatric needs. Once clinic were established, people felt safer to seek services and clients presented with a broader range of psychosocial needs.

Sue's culturally responsive hypothesis, which contends that culturally appropriate mental health services increase utilization rates among racial and ethnic minorities, have been tested over the years. Researchers have investigated the effects ethnic and linguistic matching exerts on process, outcome, and client satisfaction. Ethnic matching has been found to reduce the likelihood of treatment drop out among Asian American consumers (Sue et al. 1991; Takeuchi et al. 1995). When examining ethnic specific programs versus mainstream programs, ethnically matched consumers returned for services more often than unmatched consumers, and ethnic specific programs reduced drop out rates irrespective of matching (Takeuchi et al. 1995).

Ethnic matching also predicted an increased number of outpatient treatment sessions for Asian Americans (Gamst et al. 2001; Sue et al. 1991; Takeuchi et al. 1995). For inpatient treatment, ethnically matched Asian inpatients had a longer length of stay than their non-matched counterparts as did Asian patients who only spoke an Asian language compared to bilingual Asian patients (Mathews et al. 2002). Comparing Asian ethnic groups, Ying and Hu (1994) found that ethnic matching predicted more sessions for all Asian ethnic groups studied and that Southeast Asians in treatment were matched for more sessions (Ying and Hu 1994). Zane found that Vietnamese clients ended treatment earlier, defined as attending less than four sessions than other comparison groups, and were in less individual therapy than whites (Zane et al. 1994; Zane and Hatanaka 1994).

Researchers have used the Global Assessment of Functioning (GAF) as a measure of treatment outcomes for ethnically matched Asian American consumers. Sue et al. (1991) found that ethnic-language matching predicted positive treatment outcomes for non-English speaking consumers. When comparing five Asian ethnic groups, Ying and Hu (1994) found that Southeast Asian consumers, while attending more sessions, have lower closing GAF scores. Additionally, ethnic matching predicts higher closing GAF scores for Chinese clients. Finally, treatment duration was associated with higher global assessment scores for Chinese, Filipino, and Korean consumers.

Ethnic matching also influences discharge plans in inpatient treatment. Possible referral destinations included locked facilities, outpatient treatment, residential treatment, and home self-care. Mathews et al. (2002) found that compared to non-ethnically matched inpatients, ethnically matched inpatients were referred more frequently to residential or outpatient treatment than to locked facilities. The authors also found that ethnically matched patients were less likely to refuse follow-up referrals when compared to unmatched patients. A study of Australian community mental health consumers found that Vietnamese clients who were matched with a Vietnamese caseworker had more frequent and longer contact with continuing care teams, less contact with crisis teams, and fewer hospitalizations, which were shorter in duration than non-matched clients (Ziguras et al. 2003). Thus, matched clients were better able to receive treatment in the community rather than in an inpatient setting.

Turning their attention from process and outcome measures to client satisfaction, researchers have found that racially matched Asian American consumers report higher levels of satisfaction with their care compared to unmatched consumers (Gamst et al. 2003). The researchers' finding is consistent with earlier research by Zane et al. (1994), which found that Asian consumers reported less satisfaction with their mental health treatment when compared to White counterparts in unmatched settings. Thus, Asian consumers are more satisfied with the services they receive from ethnically and linguistically matched providers. It is important to note, however, that matching does not necessarily improve treatment outcomes (Zane et al. 1994).

Evolving Practice Models: The Bridge Program

Mental health care delivered in primary care settings are an empirically supported treatment model (Thielke et al. 2007) that hold promise for reaching minority groups (Brown et al. 2003). The Asian American Primary Health Care and Mental Health Bridge Program (Bridge Program) at the Charles B. Wang Community Health Center (CBWCHC) based in New York City's Chinatown is an example of integrated health and mental health care for Asian Americans. The CBWCHC was established in 1971 to provide primary care and support services for medically underserved Asian Americans in the New York metropolitan area. In 2009, its bilingual and bicultural 500 full and part time staff served more than 38,000 patients. The services of CBWCHC include internal medicine, women's health, pediatrics, dental care, mental health, health education, social work, care management and health careers training. In recent years, a satellite office was opened in Flushing, Queens to extend services to a major enclave outside of Chinatown.

The Bridge Program started in 1997 to provide more ethnic and language matched mental health services to the Chinese American community through an integrated service model that provides proactive mental health services in a primary health care setting. Multidisciplinary staff share physical space and treatment documents, which streamlines the referral process and facilitates the continuation of care between health and mental health providers. Support from on-site mental health professionals enables primary care physicians to expedite the identification of mental health needs. The Bridge Program has extended access to mental health care for immigrant communities (Kramer et al. 2002), and in 2009 served over 900 patients. The arrangement makes mental health care truly part of the patient's total health care.

To address the underidentification of Asian Americans with mental health problems in primary care settings (Chung et al. 2003), CBWCHC patients are routinely screened during their annual physical examinations. This screening has helped to detect depression in about 4–5 percent of the patient population and connect them to treatment (Chen et al. 2006). The following case illustrates how CBWCHC and the Bridge Program screen and treat depression within the primary care setting.

Mrs. A

Mrs. A is a 40 years old woman who emigrated from China. She first sought medical care from CBWCHC 3 years ago. At the time, Mrs. A complained of feeling very weak and lacking physical strength. She was worried by the frequent pounding of her heart and shortness of breath. She had pains and aches all over her body and complained of fatigue, and sleeplessness. Mrs. A had lost weight and thought that she was dying of some kind of disease, such as cancer because she did not have an appetite. Mrs. A had not been able to go to work for about a year because of her poor health.

Physical exams and repeated laboratory work failed to identify any significant illness. During one of her visits with her primary care physician, Mrs. A was assessed for depression with the Patient Health Questionnaire-9 (PHQ-9). Because of Mrs. A's high score on the PHQ-9, score her physician called the Bridge Program staff for assistance and within a few minutes, a clinical social worker came to greet Mrs. A and arrange an initial mental health assessment.

During the intake session, the clinical social worker found that Mrs. A had come to the US 10 years ago. Her husband worked as a cook in Chinatown, and although he did not earn much money, he took good care of Mrs. A, and their two young children. Mrs. A's stable family life was cut short by the sudden death of Mr. A of a heart attack after 5 years of their marriage. Like most of the new immigrants in Chinatown, Mrs. A had no vocational training. She worked long hours as a seamstress for a meager income. As the sole bread winner, Mrs. A. tried her best to be a good mother to her children and tried to ignore her feelings of sadness, loneliness, and helplessness. After the death of her husband, she did not have anyone to turn to for support. Mrs. A's health deteriorated after 2 years of working day and night. She found herself crying more and got upset easily. She made mistakes when sewing clothes, and had to repeat her work over and over again. Unfortunately, the slower she worked, the less she earned. She sought treatment from doctors and herbalists in the community. She even visited fortune tellers for advice. Nothing seemed to help, and she found herself too sick to go to work.

A thorough social work assessment revealed that Mrs. A suffered from severe depression as well as frequent anxiety attacks. The clinical social worker arranged for Mrs. A to see a psychiatrist and she was started on medications in order to manage her symptoms. As the coordinator of Mrs. A's care, the primary care physician received regular updates of her mental health treatment. The ability to access Mr. A's mental health and health documents through the electronic medical records facilitated coordination among all the clinicians involved in her care. Mrs. A's physician monitored Mrs. A's general health condition and helped to engage and facilitate Mrs. A to continue her mental health treatment. Mrs. A was seen by the social worker and psychiatrist on a regular basis in offices a few doors away from her primary care physician. Familiarity of the environment and staff and the coordinated care facilitated access to mental health care for Mrs. A.

Early in treatment, the social worker started helping Mrs. A plan small action steps such as starting regular physical activities to regain physical strength and energy, identifying supportive people in her environment to battle loneliness, and developing useful problem solving skills to resolve everyday difficulties. Mrs. A was invited to join a support group for women with similar life experiences. After a period of quietly sitting in the group and listening to others' life stories, Mrs. A expressed how relieved she felt to learn that she was not alone. The sense of shared experience helped decrease the stigma that Mrs. A felt toward mental illness in general.

Throughout the treatment, the social worker's active listening and empathetic understanding of Mrs. A's suffering made her feel supported and cared for. Mrs. A started to verbalize her thoughts and feelings in the session, and the therapeutic process began to progress naturally. The social worker helped Mrs. A understand, organize, and verbalize her feelings and thoughts, such as her fear of an uncertain future, worries about practical matters, such as

money and children's behavioral problems, mourning for her husband, and her hidden anger towards her husband for abandoning her.

While the clinical social worker's role throughout the treatment process was to provide counseling and psychotherapy, case management was a crucial component to successful treatment. Mrs. A needed someone to explain letters and bills, and help make phone calls, and navigate different systems. These case management tasks were carried out by the social work clinician or the social workers from the on-site social service department. Throughout the treatment process, the term psychotherapy was not stressed. Using plain language, the social worker provided an explanation of her illness, focusing on her physical symptoms. The social worker helped Mrs. A understand that her symptoms were viewed in Western medicine as depression and anxiety, and the importance of medication treatment that was provided by her psychiatrist to control her symptoms. Adherence to medication and controlling side effects led to a decrease in acute symptoms, which in turn, further established Mrs. A's confidence in mental health care. The importance of continuing medical care with her primary health care to improve her physical health was also stressed.

For the last year, Mrs. A's depression has been in remission. Mrs. A is off medication and she terminated individual sessions with the clinical social worker. Mrs. A continues to attend the support group. While Mrs. A was a quiet observer when she first joined the group, she now actively shares her own story to help other women who are going through what she went through years ago.

Mrs. A's case illustrates the importance of evidence based practices. Mrs. A's depression was identified through routine screening using the PHQ-9. The instrument was used regularly during her treatment to evaluate her depression. Clinical work with Mrs. A consisted of action steps to mobilize improvement by promoting self care, including behavioral activation.

Social work case management is crucial part of mental health care for Asian immigrants who have to focus on how to survive in the new environment. Language barriers, lower social economic status, and limited educational attainment make the negotiation with the new systems much more difficult. Asking Asian immigrants to focus exclusively on psychological issues can hinder the therapeutic relationship and become a barrier to engagement.

Unlike in Western dynamic psychotherapy, the social worker did not address Mrs. A's emotions directly. Instead she continued to reflect on Mrs. A's somatic symptoms. This is because in East Asian cultures, an individual's experience and articulation of emotions is not accorded as much importance as it is in Euro-American cultures (Shibusawa and Chung 2009b). For example, the Chinese believe that excess emotions, both positive and negative, are injurious to one's health and spirit. Being able to regulate one's emotions to maintain harmony within oneself and with others is viewed as crucial to one's well-being (Leung 1998). Emotions are rarely talked about directly. For example, anxiety among Chinese is often expressed to social workers in the form of repetitive questions, recurrent physical complaints, or a personal dilemma. Statements by clients such as "I won't be getting much better; so you tell me what to do" reflect emotions that need to be validated in culture-specific ways (Chung 2008). While holding a Western psychodynamic understanding of attachment and separation issues that was contributing to Mrs. A's depressive symptoms, the social worker created a holding environment and engaged with Mrs. A by talking about concrete issues, offering emotional support, and finding concrete things that Mrs. A could do to decrease her feelings of depression.

Focusing on symptom relief in the early stage is an important step to engage Asian Americans. At earlier phases of treatment, discussing physical symptoms and side effects and strategies to control them in the therapy session is not only crucial for engagement, but also demonstrates the social worker's abilities to the client.

The integration of mental health and primary health care for Asian Americans addresses several cultural factors that have been known to mental health professional as barriers to accessing mental health services (Lin and Cheung 1999). As mentioned above, contrary to the dichotomized mind/body approach to illness in the West, the Eastern orientation to illness is holistic and emotional symptoms are considered to be an expected part of physical illness. In addition, many Asian Americans and Asian immigrants are unfamiliar with the concept of mental health. When depressed, Asians see their primary care physicians and present with somatic complaints, leading frequently to misdiagnosis. Even when diagnosed with a mental disorder by their primary health care physician, Asians tend to avoid mental health services because of the stigma associated with mental illness. Many new immigrants have difficulty navigating the mental health system. The primary care physician's involvement helps to detect mental problems early. Furthermore, using primary care physicians as the eyes and ears of mental health services can help respond to the chronic shortage of mental health professionals in Asian American communities. Physicians who have support from the on-site mental health staff are more willing to identify their patients' mental health problems and make referrals since they know they will not be liable for providing or finding treatment for patients. Physicians feel secure since they can get on-site mental health consultation quickly. Additionally, sharing the location and medical information facilitates case referral and information

sharing. The integrated system also addresses systemic barriers to mental health service utilization among Asian Americans. Many Asian American patients already have doubt or lack knowledge about mental health disorders and services; expecting them to actively follow up on a referral for mental health may be unsuccessful. Issues of confidentiality can also deter Asians from seeking services. Patients at the Bridge program are informed that their mental health records may be accessed by their primary care physician. Because of the integrated care system, very few patients reject the arrangement.

Future Directions

Increasingly, empirically-supported treatments (EST) are being used as practice guidelines in the provision of mental health services (Chambless and Ollendick 2001), Asian Americans have been underrepresented in clinical and effectiveness trials of psychotherapeutic interventions. The reviewed studies included 10,000 participants, yet only 11 Asian participants were identified across all the studies, raising practical and ethical issues in applying the treatment guidelines to Asian consumers (Miranda et al. 2003). The Bridge Program at CBWCHC is an example of translating a mainstream practice model for use with Asian American populations to extend access to mental health care. Mental health practice in the Asian American community has fueled research knowledge and shown positive process, treatment, and satisfaction outcomes for Asian consumers (Zane and Sue 1991). Rather than applying EST without clear knowledge of potential outcomes for Asian clients, clinicians can apply Gambrill's (2003) conceptualization of evidence based practice. Mental health professionals can use their professional judgment in evaluating the research literature in collaboration with clients to make informed decisions treatment interventions. This process can serve as a bridge while the body of knowledge of research-informed treatment with Asian American mental health consumers continues to grow, which is especially important given the limited knowledge of the extent of generalizability of findings across populations to minority groups (Sue 1999).

Policy initiatives can have a substantial effect on the delivery of public mental health services for Asian groups (Alegria et al. 2003). Further funding for research within ethnic specific communities that generate effective practices is important for the continued evolution of community-based mental health practice (Sue 2003). By increasing the availability of programs that build professional capacity to provide culturally sensitive mental health services to Asian groups, policymakers can remedy the mental health disparity. Community educational initiatives have been suggested to improve access to mental health information, which can serve as a means of primary or secondary prevention of mental health concerns.

Conclusion

Over the course of the last 30 years, interdisciplinary researchers and clinicians working with Asian American clients have developed and advanced community mental health practice within the context of changing social policies. Clinicians responding to the growing needs of Asian immigrants and refugees sought to develop and modify existing practices to deliver effective services for mental health consumers. Researchers investigating a culturally mismatched mental health system urged policymakers to support culturally appropriate mental health services, and further research. While progress has been made as research has lent empirical support to culturally sensitive interventions, further community-based research needs to be conducted to investigate ways to measure pertinent treatment outcomes for Asian mental health consumers. The lessons learned from the Bridge Program at the Charles B. Wang Community Health Clinic can inform the delivery of integrated mental health care to Asian American groups.

Asian Americans are a heterogeneous population, with diverse experiences and histories. Practitioners and researchers need to be mindful of the unique individual and group experiences when working with individuals, groups, and communities. Through collaborative relationships, information exchange can occur between clinical practice and community research, which can enhance the understanding and delivery of mental health services to Asian groups.

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Author Biographies

Duy Nguyen, Ph.D. is Assistant Professor, New York University Silver School of Social Work.

Tazuko Shibusawa, Ph.D., LCSW is Associate Professor, New York University Silver School of Social Work.

Mouchuan Teddy Chen, PhD., LCSW is Director of the Mental Health Bridge Program, Charles B. Wang Community Health Center.

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