Mental Health Services for Asian Americans and Pacific Islanders

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Abstract

Inquiries over the past three decades have shown that ethnic minorities drop out of treatment early and tend to have poorer outcomes in psychotherapy. Despite the widespread acceptance that culturally responsive therapy and programs will produce better treatment outcomes for ethnic minorities, few studies have empirically tested this proposition. This paper reviews two types of interventions, ethnic match and parallel programs, to make the mental health system more responsive to the needs of Asian Americans and Pacific Islanders.

Demographers predict that by the early 21st century about one-third of the population in the United States will consist of racial and ethnic minority groups.[1] The 1990 U.S. Census shows that some cities like New York and Los Angeles already surpass this predicted proportion.[2] The changing demography of the United States has turned the attention of service providers and policy-makers to an increasingly important issue: How do communities provide mental health (and other) services that are responsive to the needs of minority groups? Advocates have called for making the mental health system culturally responsive, culturally appropriate, and culturally sensitive, but few investigations have adequately examined this issue in detail. This paper reviews some attempts to make mental health services and treatment sensitive to the needs of Asian Americans and Pacific Islanders.

Asian and Pacific Islander Ethnic Groups

In the past two decades, Asian Americans and Pacific Islanders have become a growing presence in the United States. In 1980, the population of Asian Americans exceeded 3.7 million, easily doubling the 1.5 million figure in 1970.[3] By 1990, the population nearly doubled again by exceeding 7.1 million.[2] Overlooked in this population growth is the notion that Asian Americans and Pacific Islanders are often seen as a homogeneous ethnic category.[4] The category "Asian Americans and Pacific Islanders" is used primarily for political purposes or to facilitate research and discussion about a wide number of ethnic groups that typically fall under this label.[5] The ethnic groups that comprise this category are quite diverse in terms of cultural background, country of origin, and circumstances for

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This study was supported in part by the National Research Center on Asian American Mental Health (MH44331) and research grant MH47526.

coming to the United States. For example, more than 20 ethnic groups, who may speak one of more than 30 different languages, are included in the Asian American category. The three largest Asian American ethnic groups are Chinese, Japanese, and Filipinos. Koreans and Southeast Asians (e.g., Vietnamese, Cambodians, Laotians) also comprise a significant number in the Asian American population. The three largest groups among Pacific Islanders are Native Hawaiians, Samoans, and Chamorros (Guaminians).[6]

The Need for Services

One of the prevailing images of the Asian American and Pacific Islander ethnic category is their high level of economic success. This stereotype has led to conclusions that Asian Americans and Pacific Islanders are not at risk for mental health problems. However, the image of economic success is not supported under closer scrutiny.[7] Educational attainment and income levels are often used to support the argument that Asian Americans are doing well. It is usually assumed that high educational attainment leads to better paying jobs and high status and prestigious occupations. For Asian Americans, this is not often the case. A high level of education does not necessarily lead to more pay and higher status. Barringer, Takeuchi, and Xenos found that Asian Americans do not reap the same benefits of education that Whites receive.[8] This is an important finding since Asian Americans use education as the primary path for social mobility.[9]

A close examination of sociodemographic characteristics reveals that some Asian American and Pacific Islander ethnic groups may be more at-risk for health problems than others. Immigrant status is related to a number of adjustment stressors that are linked to health. A recurring hypothesis regarding immigrants is that they experience more stressors than native-born individuals. Fabrega, for example, argues that migrants encounter stressors that originate from leaving the country of origin, the difficulties of passage, the adaptation process in the host society, and the expectations of social and economic attainment.[10] More recently, investigations on Asian immigrants have documented that migrants are facing many stressors, including those created by the acculturation process, stressful life events, employment, and economic hardships.[11,12] Chinese, Filipino, Indian, Korean, and Southeast Asian are among the ethnic groups with a large proportion who were born in another country.

A consistent finding in the social sciences is the inverse relationship between socioeconomic status and health.[13] These studies provided indirect evidence that economic factors can have pernicious consequences for the health of adults. Poverty status, per capita income, and employment status are often used as indicators of socioeconomic status. Fourteen of the 17 Asian American groups listed in the U.S. Census have poverty levels above the U.S. average (9.6%). Laotian and Cambodians have poverty levels over 45%. Per capita income is a useful measure of socioeconomic status because it takes into consideration the number of people that the household income is intended to support. In 1980, Asian Americans had an average household income of $6,900 compared to $7,400 for the U.S. average. Only Indonesian, Chinese, and Japanese groups had average per capita incomes at or above the U.S. average. Seven percent of all people in 1980 were unemployed. While the average unemployment rate for Asian Americans was below the U.S. average (5%), the Hmong (20%), Laotian (15%), Cambodian (11%), and Samoan (10%) populations had unemployment rates in double figures.[14] Thus, the demographic characteristics suggest that some Asian Americans and Pacific Islanders are at-risk for psychological problems and more serious forms of mental illness.

In a review of the minority mental health literature, Vega and Rumbaut found few studies that directly address the need for mental health services among Asian Americans and Pacific Islanders.[15] The few community studies that do exist suggest that some Asian American groups have more severe psychological problems than Whites.[16,17] In addition, Kuo found differences in levels of depression among Asian American groups.[11] For example, Korean Americans, who consist of more recent immi-

grants, had higher rates of depression than other Asian groups. For the most part, however, the number of community studies on Asian Americans and Pacific Islanders is not sufficient to adequately address the need for psychiatric services.[17]

Despite the lack of a strong empirical foundation, some evidence suggests that mental health services have been unresponsive to the needs of this ethnic category (as well as to other ethnic groups). In general, when Asian Americans use the public mental health system, they are more likely to enter outpatient care rather than inpatient or emergency services.[18] When they use outpatient care, some discrepancies between Asian Americans and Whites exist. Sue and McKinney, in their landmark study of nearly 14,000 adult clients in the Seattle-King County mental health system, not only found Asian Americans underrepresented in outpatient mental health clinics, but they also demonstrated that Asian Americans dropped out from services at a higher rate than Whites.[19] A decade later, O'Sullivan and associates replicated Sue and McKinney's study in Seattle-King County and found that, while representation and dropout rates had improved, Asian Americans still attended fewer outpatient treatment sessions than Whites.[20]

Information about the delivery of mental health services to Pacific Islanders in the United States is scant. There is an emerging literature which suggests that contemporary mental health services are underutilized and only seen as a last resort by Pacific Islander groups such as Native Hawaiians and Samoans. Higginbotham found that clinical personnel of the Division of Mental Health in Hawaii indicated that native Hawaiians found Western mental health services unacceptable and "avoided these services like the plague" (p. 46).[21] Similarly, Mokuau and Chang note that Samoans will typically turn to Western mental health services only as a last resort.[22] Samoans prefer to seek help from indigenous healing persons. They also rely heavily on advice from relatives and their pastors before seeking Western mental health services.[23] While the empirical foundation about mental health services among Pacific Islanders is smaller than the empirical base for Asian Americans, the results point to a similar conclusion: Cultural and social factors play an important role in limiting the use of mental health services in the community.

Culturally Responsive Services

As a result of various findings that suggest that ethnic minorities may receive inadequate mental health services, there has been a general appeal for efforts to make the system more culturally sensitive to the needs of ethnic minorities.[20,21] However, few studies have identified the parameters of cultural sensitivity or assessed whether these factors contribute to making the mental health system more effective for minority groups. For example, O'Sullivan and his colleagues found a significant decrease in the dropout from mental health clinics of Asian Americans over a 10-year period and concluded that these changes were a result of culturally responsive services.[20] However, no direct evidence was provided to establish that culturally responsive services actually led to the improvement in dropout rates among Asian Americans. Sue and Zane argue that the time is ripe to assess specific interventions and their relative impact on the mental health treatment provided to minorities.[24]

Rogler and his colleagues argue that problems attributed to cultural insensitivity are partly due to the incongruency between the characteristics of the mental health system and the minority culture.[25] That is, assessment instruments, clinicians, and practices and policies in mental health programs and systems do not adequately address the needs of minority clients. It is this dissimilarity that leads to underutilization and poorer treatment outcomes among minorities. Sue made a number of recommendations to improve the delivery of mental health services to members of minority groups, including (a) making changes within existing services, such as hiring more ethnic specialists or training mental health care providers to work with minority groups; (b) establishing independent but parallel services

specifically devoted to ethnic minorities; and (c) creating new and nonparallel services that are culturally relevant.[26] These proposals are best conceptualized within a framework of match or fit where the structure and content of services can be designed to match the specific needs of a particular cultural group.[27,28] The remainder of this paper reviews two aspects of the match or fit framework, ethnic match, and parallel programs.

Until recently, few studies have addressed these questions in specific detail among Asian Americans and Pacific Islanders for several reasons. First, it has been difficult to investigate issues related to specific interventions since few have been implemented and, when they have been implemented, the programs have not been fully mature to conduct a thorough assessment. Second, advocates for ethnic minorities have been keenly sensitive to these evaluations because negative findings could endanger funding for these programs. Finally, the sheer number of Asian American and Pacific Islander ethnic groups and the relative small populations that exist in any given community make the selection of an adequate sampling frame problematic. In recent years, the number of interventions designed for ethnic minorities has increased, and advocates now realize the importance of research and evaluation in maintaining or increasing the level of funding for special initiatives targeted for minority communities. The importance of the policy questions to the provision of mental health services in Asian American and Pacific Islander communities creates a challenge for researchers to begin to examine the issue of cultural responsive services and treatment in a more systematic way.

Client and Therapist Match

Most research on cultural responsiveness has focused on ethnic match: Does similarity between therapists and clients in ethnic background result in better treatment outcomes than achieved when clients and therapists are not matched? Investigations on ethnic match have primarily assessed whether the ethnic background of a therapist plays a role in the assessment of the minority client's mental health. Sue and his colleagues conducted one of the first studies of ethnic match and its effects on utilization and outcome.[27] While different minority groups were analyzed in the study (e.g., African Americans, Asian Americans, and Mexican Americans), we report the results that are pertinent to Asian Americans.

Data for the study were supplied from the Automated Information System (AIS) which is maintained by the Los Angeles County Department of Mental Health. The AIS is designed for management information, revenue collection, clinical management, and monitoring with the potential for research. Data are routinely collected on each client who enters the mental heath system in Los Angeles County. Client information is collected on standardized forms by the therapist and then transferred to a computerized file. Analyses were limited to minority adults between 18 years and older who used outpatient services at a mental health facility in Los Angeles County between Jan. 1, 1983 and Dec. 31, 1988.

The study examined the effects of ethnic and language match on premature termination or dropout, length of stay, and level functioning. Ethnic match refers to whether or not the therapist was of the same ethnicity as that of the client (e.g., Chinese therapist-Chinese client was considered a match; Chinese therapist-Japanese client was not considered a match). A similar logic was used in conceptualizing language match. Premature termination was defined as failure to return for treatment after one session. Total number of sessions was calculated for those clients who either terminated or completed treatment. The Global Assessment Scale (GAS) rating at discharge was used as the measure of treatment outcome. The GAS is a measure of the overall functioning of clients. Ratings on the GAS are based on psychological, social, and occupational functioning. Therapists perform the ratings on a 100-point scale with "1" indicating the most severe impairment and "100" referring to good functioning in all areas of life. Analyses of the discharge GAS score controlled for GAS ratings at intake. All

analyses controlled for poverty status, severity of diagnosis, gender, and age.

The analyses show that among Asian Americans, ethnic match had significant effects in reducing premature termination and increasing length of treatment when controlled for other sociodemographic and clinical variables. In fact, when Asian Americans were matched with a therapist of the same ethnicity, they were five times less likely to leave prematurely from mental health treatment than when they were not matched. Ethnic match did not have a similar effect on the Global Assessment Score (GAS) ratings. Since language match is intertwined with a person's ethnicity, the research study examined the effects of language match in conjunction with ethnic match. The results indicate that language match alone, ethnic match only, and a combination of language and ethnicity all resulted in reducing dropouts and increasing the number of treatment sessions than when clients were not matched on these variables. Although the analyses do not demonstrate that matching clients on language or ethnicity improves the treatment outcome of the clients, they do show that matching can at least have beneficial effects in improving the utilization of mental health services for Asian Americans. Thus, policy-makers have some initial evidence that the hiring of bilingual and ethnic staff can have important consequences above and beyond improving the representation of ethnic minorities on the professional staff in the community mental health system.

Parallel Programs

The match concept underlies the whole development of services in the parallel service delivery model. Parallel models refer to programs that are similar to existing, more mainstream programs but that are devoted to ethnic minority groups (e.g., a mental health clinic that serves Asians versus one that serves mainstream Americans). When applied to Asian populations, parallel models attempt to achieve various types of service and organizational matches. Clients and therapists are usually matched on ethnicity and language preference. Mental health services are often provided with other health services (e.g., South Cove Health Center in Boston) to fit the Asian tendency to not distinguish sharply between health and mental health problems. Therapists purposely assume more case management functions because for many Asian clients, particularly refugees and recent immigrants, mental health difficulties are intertwined with a number of other human service needs.

The literature on parallel clinics suggest three features are important in creating a match with the needs of minority groups: accessibility, appropriate services, and community involvement. Accessibility refers to the provision of services within the community of the targeted ethnic group.[22,29,30] The service hours of these programs are extended into the evenings and weekends since many minority clients work at more than one job and find it difficult to take time off from work to visit a center during the regular weekday hours. Walk-in appointments are also known to increase the utilization of mental health services in minority communities.[31]

A second characteristic of parallel programs is the provision of appropriate services. The most frequently cited aspect of appropriate services is the availability of bilingual and bicultural services. We have previously discussed the rationale for the matching of ethnic clients with a therapist from the same ethnicity. Another component of appropriate services is the capability to provide or refer clients for other types of nonpsychological services such as social, financial, economic, legal, medical, and educational.[29,32] Appropriate services may also include the effective utilization of the existing natural support systems in the client's community such as his family and relatives, pastor, indigenous healer, or respected community leaders. Their participation in the treatment has been known to reduce the client's and/or his family's resistance to psychological treatment and thus plays a critical role in the duration and outcome of treatment.[29,33] It also makes it possible for the agency to assess and control the quality and legitimacy of its help and services.

The third characteristic of ethnic-specific programs includes the participation of community mem-

bers in the planning and evaluation of services.[22,30,34,35] This process is accomplished through the involvement of community leaders, mental health professionals, indigenous healers, administrators, and community members on policy and advisory boards and in community forums. Community participation is also achieved by publicizing the available services in community and ethnic media to increase the utilization of services. This participation of community members helps to ensure the cultural relevancy and responsiveness of the services provided by the program.

Some evidence indicates that parallel programs can effectively change usage patterns in Asian American communities.[30] After a mental health facility opened its doors in San Francisco, more Asian and Pacific Islander clients were seen during the first three months of operation than were seen the previous five years.[30] In addition, more than 90% of the clients showed up for their scheduled appointments at the facility — the highest rate of comparable outpatient units in San Francisco. Evaluations in other geographic areas report similar findings.[36,37]

Zane and Hatanaka examined another critical issue related to ethnic-specific programs: Can parallel services provide effective services for ethnic minorities without creating inequities for nonminorities?[38] In a study based at one parallel clinic in Los Angeles County, the investigators assessed the types of services and dropout rates for specific Asian American ethnic groups (e.g., Chinese, Japanese, Filipino, Korean, Vietnamese, Lao, and Cambodian) and Whites. Within this clinic, no differences were found between Whites and Asians with respect to the types of services provided, premature termination, and clinical outcome. While the study needs to be replicated across other facilities and geographic sites, the research is the first to indicate that parallel programs can be effective for Asian Americans without diminishing the effectiveness for Whites.

The lead author is currently engaged in research examining some effects of parallel programs. By use of the same source of data that was used to investigate ethnic match by Sue and his colleagues,[27] the effects of parallel programs are being examined for premature termination, length of treatment, and treatment outcome. Preliminary analyses indicate that parallel programs are more effective than mainstream programs at reducing premature termination and increasing number of treatment sessions. For example, Asian Americans who enter ethnic programs are 33 times more likely than Asian Americans in mainstream programs to return after the first session. Since parallel programs are more likely than mainstream programs to match clients and therapists on the basis of ethnicity, we are examining whether the effects of parallel programs remain when ethnic match is controlled. Initial analyses indicate that parallel programs have an effect on the utilization variables independent of ethnic match. Parallel programs did not show a consistent advantage over mainstream programs in the GAS score at discharge.

Special Programs

A variation of parallel programs is special programs that include another facet. In addition to the use of Western approaches to psychiatric treatment, these programs also incorporate indigenous healing practices culled from the cultural traditions of a particular ethnic group. Special programs are not common partly because they represent a special risk for mental health administrators especially when funding for mental health programs is particularly strained. In addition, insurance companies do not normally support the use of indigenous treatment for mental health problems. Accordingly, little documentation is available on the effects of special programs that serve Asian Americans and Pacific Islanders.

One program designed for native Hawaiians began on the Wai'anae Coast on O'ahu, Hawai'i, Hale Ola' o Ho'opakolea. The program is referred to as a healing center and is considered a one-stop facility where professional staff work with clients to resolve social, economic, health, and mental health needs. A number of indigenous Native Hawaiian methods are used to assist clients in the

resolution of individual problems including a form of family therapy called ho'oponopono, a method of physical therapy or massage called lomilomi, and a kind of healing conference or council called kukakuka.[39] These indigenous methods are undergirded by basic cultural values of harmony, self-respectability, patience, and shared love. The unique nature of programs like Hale Ola make it difficult to conduct a standard evaluation. Past studies have shown that the program has increased utilization of mental health services and clients have expressed satisfaction with the services provided at the facility.[40] However, it is clear that new evaluation methods must be designed to accommodate the unique purpose and goals of programs such as Hale Ola.

Discussion

Sue and his colleagues' investigation[27] and Takeuchi's current study suggest that ethnic match and parallel programs seem to reduce premature termination and increase the length of treatment in community mental health clinics. These efforts at cultural responsiveness do not demonstrate a consistent effect on the outcome measure. It is likely that the GAS is not an ideal outcome measure for these two studies. While the GAS has demonstrated high reliability when raters are well-trained,[41] it may not be a useful measure when used across a number of programs and raters. While the GAS may be a good measure of outcome when used properly, more research is needed to examine its reliability and validity in ethnic minority populations. Similarly, studies are also warranted that investigate alternative measures of treatment outcome.

The available data were not sufficiently robust to provide an understanding about the precise reasons ethnic match produces positive utilization results. A therapist of the same ethnicity as the client may produce better rapport with the ethnic client or the therapist may have a better intuitive understanding about the nature of the client's problem than a person from a different cultural background. It is critical that research extend beyond the notion of ethnic match to examine the interaction between ethnic therapist and client that may be of value in developing training programs for ethnic and nonminority mental health professionals. For some ethnic groups such as Native Hawaiians and Southeast Asians, the number of ethnic therapists is relatively small to meet the potential demand for treatment.

Accordingly, one strand of research that is currently under way at the National Research Center on Asian American Mental Health (NRCAAMH) is an investigation of cognitive match. It is hypothesized that, if therapists have similar conceptualization of mental health problems, goals for treatment, and means for resolving problems as their clients, the clients would utilize the service more often and have better treatment outcomes than those clients that do not cognitively match with their therapists. It is the first empirical investigation that operationalizes cultural "world views" and systematically examines their effects in therapy. The research is guided by the match or fit principle and is based on a conceptual model that articulates specific domains in which therapy-relevant cultural differences can occur.

The ideas presented in this paper have applications beyond Asian American and Pacific Islander populations. As communities increasingly become ethnically diverse, planners will be confronted with making the mental health system more responsive to the needs of ethnic minorities. Cultural responsiveness is often cited as a necessary feature in providing mental health services to minority clients. However, it is a difficult concept to operationalize. In this paper, we have described two features of cultural responsiveness: ethnic match and parallel programs. These studies have assessed the effects of ethnic match and parallel programs on measures typically used in the evaluation of mental health interventions (e.g., length of treatment, dropout, and treatment outcome). While more investigations are essential in this area, there is also an important need to examine how community

residents define cultural responsiveness and what they expect of mental health programs.[42] It is only through these joint efforts that researchers and policy-makers can provide more clarity and depth to the understanding of the promise and limits of cultural sensitivity in mental health interventions.

References

1. Jones JM: A call to advance psychology's role in minority issues. *APA Monitor* 1991; 21:23.
2. *Asians in America: 1990 Census Classification by States*. San Francisco: Asian Week, 1991.
3. O'Hare W, Felt J: *Asian Americans: America's Fastest Growing Minority Group*. Washington, D. C.: Population Reference Bureau, 1991.
4. Chen S: *Asian Americans: An Interpretive History*. Boston: Twayne, 1991.
5. Takaki R: *Strangers from a Different Shore*. Boston: Little, Brown, 1989.
6. Mokuau N (ed.): *Handbook of Social Services for Asian and Pacific Islanders*. Westport, Conn.: Greenwood Press, 1991.
7. Suzuki B: Education and socialization of Asian Americans: a revisionist analysis of the 'model minority' thesis. *Amerasia* 1977; 4:23-51.
8. Barringer H, Takeuchi D, Xenos P: Education, occupational prestige, and income of Asian Americans: evidence from the 1980 Census. *Sociology of Education* 1990; 63:27-43.
9. Sue S, Okazaki S: Asian American achievement: a phenomenon in search of an explanation. *American Psychologist* 1990; 45:913-920.
10. Fabrega H: Social psychiatric aspects of acculturation and migration: a general statement. *Comprehensive Psychiatry* 1969; 10:314-392.
11. Kuo WH, Tsai YM: Social networking, hardiness, and immigrant's mental health. *Journal of Health and Social Behavior* 1986; 27(2):133-149.
12. Lin KM, Masuda M, Tazuma L: Adaptational problems of Vietnamese refugees. Part IV: three year comparison. *Psychiatric Journal of the University of Ottawa* 1984; 9:79-84.
13. Kessler RC, Price R, Wortman C: Social factors in psychopathology: stress, social support, and coping processes. In: Rosenzweig MR, Porter LW (eds.): *Annual Review of Psychology*. Palo Alto, Calif.: Annual Reviews, 1985.
14. Bureau of the Census: *We, the Asian and Pacific Islander Americans*. Washington, D.C.: U.S. Department of Commerce, Bureau of the Census, 1988.
15. Vega W, Rumbaut R: Ethnic minorities and mental health. In: Scott WR, Blake J: *Annual Review of Sociology*. Palo Alto, Calif.: Annual Reviews, 1991.
16. Leong F: Counseling and psychotherapy with Asian Americans: a review of the literature. *Journal of Counseling Psychology* 1986; 33:196-206.
17. Sue S, Morishima J: *The Mental Health of Asian Americans*. San Francisco: Jossey-Bass, 1982.
18. Hu T, Snowden L, Jerrell J, et al.: Ethnic populations in public mental health: services choice and level of use. *American Journal of Public Health* 1991; 81:1429-1434.
19. Sue S, McKinney H: Asian Americans in the community mental health care system. *American Journal of Orthopsychiatry* 1975; 45:111-118.
20. O'Sullivan M, Peterson P, Cox G, et al.: Ethnic populations: community mental health services ten years later. *American Journal of Community Psychology* 1989; 47:17-30.
21. Higginbotham N: The cultural accommodation of mental health services for Native Hawaiians. In: Robillard AB, Marsella AJ (eds.): *Contemporary Issues in Mental Health Services in the Pacific Islands*. Honolulu: University of Hawaii, Social Science Research Institute, 1987.
22. Mokuau N, Chang N: Samoans. In: Mokuau N: (ed.): *Handbook of Social Services for Asian and Pacific Islanders*. Westport, Conn.: Greenwood Publishing, 1991.
23. Mokuau N, Tauiliili P: Families with Native Hawaiian and Pacific Island roots. In: Lynch E, Hanson M (eds.): *Developing Cross Cultural Competence: A Guide for Working with Young Children and Their Families*. Baltimore: Brookes Publishing, In press.

24. Sue S, Zane N: The role of culture and cultural techniques in psychotherapy: a critique and reformulation. *American Psychologist* 1987; 42:37-45.
25. Rogler L, Malgady R, Costantino G, et al.: What do culturally sensitive mental health services mean?: the case of Hispanics. *American Psychologist* 1987; 42:565-570.
26. Sue S: Community mental health services to minority groups. *American Journal of Psychology* 1977; 32:616-624.
27. Sue S, Fujino D, Hu L, et al.: Community mental health services for ethnic minority groups: a test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology* 1991; 59:533-540.
28. Flaskerud J: The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal* 1986; 22:127-141.
29. Child and Adolescent Service System Program (CASSP): *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.* Washington, D.C.: CASSP, 1989.
30. Owan T: Neighborhood-based mental health: an approach to overcome inequities in mental health services delivery to racial and ethnic minorities. In: Bregal DE, Naparstek A (eds.): *Community Support Systems and Mental Health: Practice, Policy, and Research.* New York: Springer Publishing Company, 1982, pp. 282-300.
31. Hallowitz D: Counseling and treatment of the poor Black family. *Social Work* 1975; 56:451-459.
32. Tolmach J: There ain't nobody on my side: a new day treatment program for Black urban youth. *Journal of Clinical Child Psychology* 1985; 14:214-219.
33. Lin T: Psychiatry and Chinese culture. *Western Journal of Medicine* 1983; 139:868-874.
34. Polk S: Helping our children. *Children Today* 1987; 16:19-20.
35. VanDenBerg J, Minton BA: Alaska native youth: a new approach to serving emotionally disturbed children and youth. *Children Today* 1987; 16:15-18.
36. Hatanaka H, Watanabe BY, Ono S: The utilization of mental health services in the Los Angeles area. In: Ishikawa W, Hayashi N (eds.): *Service Delivery in Pan Asian Communities.* San Diego: Pacific Asian Coalition, 1975.
37. True R: Mental health services in a Chinese American community. In: Ishikawa W, Hayashi N (eds.): *Service Delivery in Pan Asian Communities.* San Diego: Pacific Asian Coalition, 1975.
38. Zane N, Hatanaka H: Ethnic-specific mental health services: evaluation of the parallel approach for Asian American clients. Unpublished manuscript.
39. Prizzia R, Mokuau N: Mental health services for Native Hawaiians: the need for culturally relevant services. *Journal of Health and Human Resources Administration* 1991; 14:44-61.
40. *Hale Ola Ho'opakolea: Wai'anae Coast Children and Youth Mental Health Services.* Honolulu: Management Planning and Administration Consultants, 1988.
41. Endicott J, Spitzer RL, Fleiss JL, et al.: The Global Assessment Scale. *Archives of General Psychiatry* 1976; 33:766-771.
42. Vega WA, Murphy JW: *Culture and the Restructuring of Community Mental Health.* New York: Greenwood Press, 1990.