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CHAPTER 1

Nature and Scope of Services for Asian and Pacific Islander Americans

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ASIAN AND PACIFIC ISLANDER AMERICANS

In 1980, the Asian and Pacific Islander American (APIA) population numbered about 3.7 million, with approximately 812,000 Chinese, 782,000 Filipino, 716,000 Japanese, 387,000 Asian Indians, 357,000 Koreans, 245,000 Vietnamese, 172,000 native Hawaiians, 40,000 Samoans, 31,000 Chamorros, and other groups of Asian and Pacific Islander ancestry (U.S. Bureau of the Census, 1988). Projections are that in the 20-year span from 1980 to 2000, the APIA population will more than double, making it the fastest growing ethnic minority group in the nation (Sue and Padilla, 1986). A 1987 Center for Migration Studies publication projected that the Asian populations in the United States will number 6.5 million in 1990 and 9.85 million by the year 2000 (Ponce, 1990).

The groups comprising the APIA populations are culturally and experientially diverse. The diversity is evident in such ways as their differing degrees of acculturation, migration experiences, occupational skills (Shu and Satele, 1977), worldviews and values (Mokuau, 1988), patterns of help-seeking from public services (JWK International Corporation, 1976), personality syndromes (Sue and Frank, 1973), and basic sociodemographic data including geographic residence, age, place of birth, and poverty levels (U.S. Bureau of the Census, 1988).

According to the 1980 Census, APIAs are not geographically distributed evenly across the United States. About 58 percent of the APIAs lived in the west (versus 29 percent of the total American population), particularly in California and Hawaii. Over two-thirds lived in California, Hawaii, New York, Illinois, or Texas.

The gender distribution of APIAs ranged from 48 percent female (among Vietnamese) to 58 percent female (among Koreans). This compares to 51 percent of the total U.S. population being female.

The median age of APIA groups ranged from 19.2 years for Samoans to 33.5 years for Japanese Americans. The median age for all APIA groups together was 28.4 years compared to 30 years for the total U.S. population.

The percentage of foreign-born across APIA groups varies widely. For example, 93.9 percent of the Cambodians, 90.5 percent of the Vietnamese and Hmong (from Laos), 93.7 percent of the Laotians, 82 percent of the Thai, 81.9 percent of the Koreans, 70.4 percent of the Asian Indians, 64 percent of the Filipinos and Chinese, 35.6 percent of the Samoans, 28.4 percent of the Japanese, 9.5 percent of the Chamorro, and 1.6 percent of the Hawaiians were foreign-born according to the 1980 Census. Taken together, 59 percent of the APIAs were foreign-born compared with 6 percent of the total U.S. population. A second language was spoken by over 90 percent of the Vietnamese, Laotian, Hmong, and Cambodian families, while fewer than half of the Chamorro or Japanese American families spoke a second language.

There was also a wide range of poverty rates across APIA groups. In the United States as a whole, 9.6 percent of American families lived in poverty according to the 1980 Census. Over two-thirds of the Hmong and Laotians, almost half of the Cambodians, over one-third of the Vietnamese, and between 10.5 percent and 13 percent of the Chinese, Thai, and Korean families lived in poverty. Despite the reputed "success" of APIAs, only the Japanese, Filipinos, and Asian Indians had lower poverty rates than the U.S. population as a whole. The average income for APIAs ranged from \$27,400 for Japanese families to \$5,000 for Hmongs in America.

Such diversity suggests that different groups have varying needs for social services and that services would be most effectively provided in ways that are tailored for each group. This chapter serves as a general overview of all APIA populations by exploring options for social service models that have relevance for this group of people. The specific focus is on mental health service models. Prior to an examination of these models, consideration is given to APIA needs for mental health services, the underutilization of mental health services by APIA, and the reasons for this underutilization.

SOCIAL AND PSYCHOLOGICAL PROBLEMS AND ISSUES AMONG ASIAN AND PACIFIC ISLANDER AMERICAN POPULATIONS

Considerable evidence suggests that mental health problems have been underestimated or go unnoticed in the APIA population. For ex-

ample, S. Sue and J. K. Morishima (1982) noted that many Asian American students exhibit higher levels of anxiety than non-Asian students. Yet, few such students ever use mental health services or come to the attention of mental health professionals. Furthermore, in comparisons between Asians and non-Asians who utilize mental health services, Asians are more severely disturbed. Asian American clients have been diagnosed as psychotic more often than white, black, Native American, or Hispanic clients (Sue, 1977). T. R. Brown, K. M. Stein, K. Huang, and D. E. Harris (1973) also found that Chinese inpatients tended to be more disturbed than a Caucasian control group. This pattern of low utilization but high levels of disturbance among users suggests that only the more severely disturbed APIAs seek treatment from mental health professionals. Those APIAs who have milder problems or who have adequate resources may avoid treatment in the mental health care systems. Furthermore, it should be noted that one particular Asian group, the Southeast Asian refugees, has been found to exhibit extremely high levels of mental disturbance, especially posttraumatic stress disorders and adjustment problems (Owan, 1985).

Although the popular belief is that APIAs experience few mental health problems, an analysis of the situation of this population would suggest that emotional disturbance may be quite prevalent. In addition to organic factors, mental health is determined by the presence of stressors and by a lack of resources or social supports.

APIAs face a number of stressors. Common stressors include conflicts between traditional Asian and Pacific Islander values and lifestyle practices with that of American norms. Cultural and intergenerational conflicts often arise from differences in acculturation between children and parents. For recent immigrants, factors common to the etiology of mental disturbance include traumas experienced before immigrating, communication difficulties, underemployment, difficulties adjusting to a new cultural milieu, separation from family, and loss of social supports.

APIAs also face identity conflicts. Even those who are Americans and whose families have been Americans for generations often are not fully accepted as Americans and are presumed to be foreign by other Americans. The American myth that the United States embraces all people and provides equal opportunity compounds the negative feelings accompanying the lack of acceptance. In addition, the APIAs have to deal with cultural stereotypes. Stereotypes of APIAs may keep people from appreciating APIAs as individuals, may confine APIAs' expression of their individuality, or may affect the APIAs' self-concepts. For example, if Asian American students study hard and receive good grades, they may feel they are reinforcing the stereotypes of Asian Americans as exceptional achievers. If they do not work hard, they may be considered a waste to society, an embarrassment to family, and an outcast to others. Many struggle over who they are as APIAs.

Finally, the issue of racism and minority status always exists. Many of the immigrant APIAs experience minority status and encounter racism for the first time when they come to the United States. Often APIAs, no matter how long they have been in the United States, whether citizens or not, have to deal with rampant cultural and institutional racism as well as individual racism.

PROBLEMS IN SERVICE DELIVERY

Underutilization of Services

The mental health needs of APIAs are largely unmet. As mentioned previously, widespread evidence indicates that APIAs do not use mental health services as much as would be expected based on the size of the APIA population (Hatanaka, Watanabe, and Ono, 1975). This underutilization does not appear to be a simple function of acculturation; there is no relationship between degree of acculturation and the tendency to use mental health services. For example, while Japanese Americans tend to be more acculturated than Chinese Americans (Sue and Kirk, 1973), the former use mental health facilities less often than the latter (Kitano, 1969a).

Furthermore, there is evidence that when Asian Americans use mental health services, they often terminate treatment prematurely. For example, in a large-scale study, S. Sue (1977) found that 30 percent of Caucasian patients failed to return for treatment after an initial contact with a mental health facility, while over 50 percent of the APIAs did so. He suggested that a mismatch between services needed and services provided may act as a deterrent to service utilization and result in premature termination.

Explanations for Underutilization of Services

The underutilization of services can be due to a number of factors. Underutilization is due partly to the characteristics of many APIAs and partly to the lack of responsiveness of the mental health service delivery system to those characteristics.

Worker-Client Mismatches in Interpersonal Styles and Values. Mental health services in the United States generally represent a particular (white, middle-class, European) worldview (Singer, 1976). The characteristics of American services may conflict with values, styles, and expectations commonly found among APIAs (Singer, 1976; Sue, 1978). This conflict may lead to underutilization of services.

Worldview biases may blur the distinction between pathology and sociocultural variance (Kranz, 1973; Singer, 1976). They may also account

in part for the fact that APIAs are labeled with more severe diagnoses than Caucasian Americans. D. Li-Repac (1980) found that Chinese and Caucasian workers differed in their diagnostic ratings of Chinese and Caucasian clients, suggesting that ethnicity and background of workers affect the assessment process. It may be that when workers hold worldviews that are different from those held by their clients, are unaware of the bases for these differences, and encounter cultural practices and behaviors that are difficult to understand, the workers are apt to misinterpret behaviors as indicating psychopathology (Kitano, 1970). For example, self-deprecating statements do not necessarily reflect low self-esteem in an APIA; rather, such statements could reflect the adoption of cultural mores emphasizing modesty. That an APIA does not offer details about his or her life does not necessarily mean that he or she is resisting or denying but rather could simply reflect a cultural emphasis on not being conspicuous. Standing out is culturally frowned on by APIAs (Tung, 1985). The APIA client is often aware that the worker does not appreciate the APIA's perspective and is misinterpreting his or her behaviors.

Difficulties occur when the values, assumptions, and conceptions of mental health held by the worker and the client are conflicting. It has been noted that Asian clients often do not share in certain values that are implicitly relevant to traditional forms of intervention (e.g., valuing independence over interdependence, individualism over the family or group, verbal and emotional expressiveness over inhibition) (Sue and Morishima, 1982; Yamamoto, 1978). The worker's emphasis on Western values and Western approaches to problems frequently confuses or conflicts with the orientation of the APIA client (Tsui and Schultz, 1988). Furthermore, there may be different assumptions held concerning the need to confront conflicts (Tsui and Schultz, 1988), the strategy to achieve change (e.g., through insight or willpower), and the client's ability to initiate change (Singer, 1976). Differences may exist in expectations concerning the client's openness, psychological sophistication, willingness to verbalize difficulties, and verbal skills (Brown et al., 1973; Yamamoto, 1978). Some APIA clients may be reticent to ask what is expected of them and what they can gain from treatment because to ask may appear to be criticism of the authority figure, the worker (Tsui and Schultz, 1988). For example, APIA clients, thinking that being quiet shows respect to the workers, may expect not to talk much in treatment since they anticipate that the workers will take an active role in providing information. Simultaneously, workers may expect their clients to talk and may interpret client silence as resistance to therapy.

Western values are manifested in the expectation of adherence to strict appointment schedules and orientation toward long-range solutions. Such expectations may conflict with those of some APIAs (Sue and Sue,

the clients want. Such fears and suspicions may deter APIAs from seeking services and undermine the worker-client relationship.

Clients may also be suspicious that services from APIA workers may lead to a lack of confidentiality. Inasmuch as APIA communities are often small, with much intragroup knowledge of other members of their ethnic group (see, for example, Kitano, 1969b), some clients may be concerned that their difficulties will be known to others within the ethnic community. Thus, the problems of trying to provide effective mental health services to the APIA population are quite complex.

Cultural Inhibitions Against Seeking Mental Health Services. A number of Asian cultural values inhibit the utilization of mental health services. Some common cultural inhibitions include the following.

1. Stigma of Mental Health Problems. Many APIAs believe that having psychological problems is shameful and disgraceful (Kitano, 1970) and that the ability to control the expression of personal problems is a sign of maturity (President's Commission on Mental Health, 1978). Some interpret the need for extrafamilial intervention to resolve personal problems as especially shameful. There is a fear of stigma and a desire not to disgrace the individual or the family by going to mental health professionals. P-W. Chen (1977), for example, found that 77 percent of his respondents said that they were embarrassed to ask for needed social services. Thus, the reticence of the individual to admit to the family and the community that mental health problems exist may account in part for the lack of service utilization.

2. Expression of Mental Health Problems. Crosscultural differences have been found in symptom expressions (Marsella, Kinzie, and Gordon, 1973). Ethnic response styles may account for differences in symptoms manifested (Marsella, Sanborn, Kameoka, Shizuru, and Brennan, 1975). APIAs may not seek mental health services because there is a tendency for psychological problems to be expressed as psychosomatic symptoms (Owan, 1985). Among many Asian cultures, having a physical problem is more socially acceptable than having a psychological one. Thus, they may seek the services of acupuncturists, herbalists, or physicians rather than mental health professionals.

3. Conceptions of Mental Health. Cultural differences exist in conceptions of mental health. Supernatural or spiritual events are often viewed as culturally acceptable rather than mentally dysfunctional by Southeast Asians (Owan, 1985) and native Hawaiians (Mokuau, 1990), and thus the services of priests, shamans, and other spiritual healers may be sought more than those of mental health workers. In addition, coming from a tradition in which people do not seek help for unhappiness, Southeast Asians rarely consider feelings and emotional problems to be legitimate reasons for seeking professional help (Tung, 1985).

1977). For example, native Hawaiian clients rated mental health services that were not restrained by schedules (e.g., rigid appointment schedules, long waits) higher than services that were (Prizzia and Mokuau, forthcoming). This ignorance of the cultural conflicts experienced by the APIA client in treatment may render the worker insensitive and ineffective. In turn, this may deter APIAs from seeking mental health services.

As a result of the incongruence between services conducted in a Western style and the needs of some APIAs, workers may become anxious and lose confidence with APIA clients and thus want to end the intervention as soon as possible (Tung, 1985). Meanwhile, APIA clients may also feel uncomfortable and not want to "impose" too long on workers. In fact, APIAs receive shorter-term treatment and are less likely to encounter professionals than nonprofessionals at intake (Sue, 1977).

Shortages of Culturally Sensitive Personnel. Among the cultural factors that need to be understood and accepted by mental health service providers are the history, traditions, cultural symbols, parental roles, language styles, sex role differences, functions and responsibilities of the family, belief and value systems, and religious practices and beliefs of APIAs (Sanders, 1975). There is often a shortage of personnel who are sensitive to cultural characteristics found in APIAs.

Research indicates that APIAs are more likely to use services when bilingual, bicultural personnel are employed in the service setting (Wong, 1982). When the client and the worker share ethnic language and culture, there is a decrease in the client dropout rate and care is more effective (Lee, 1985; Wong, 1982). The lack of trained, bilingual, bicultural, or culturally sensitive paraprofessional and professional mental health workers may result in culturally inappropriate services for APIAs and may thereby indirectly deter APIAs from using available mental health services. Thus, a barrier to service utilization may be the failure to recruit, train, and distribute adequate numbers of such personnel. Available evidence indicates that there is a shortage of Asian bilingual and bicultural health personnel (Sue and Morishima, 1982).

Client Fears. APIA clients may fear that workers have different conceptions of mental health and have different goals for treatment. On the one hand, clients may be concerned that workers will try to turn them into adjusted Caucasians—namely, people adapted to white, middle-class standards of mental health. The APIAs may prefer to adjust to APIA standards of behavior. For example, APIA clients may not want to become independent, open, assertive, and direct in communication style when their subculture places more value on dependence than autonomy and stresses politeness more than directness. On the other hand, APIA clients may also fear that workers presume that they want to be adapted to particular, stereotypical APIA values when that is not what

Their belief is that everyone has hardships in life, so it is indiscreet to talk about one's problems. Feelings are considered essentially private matters, and lamenting one's problems is a sign of weakness and a lack of character. Southeast Asians often define mental disorders as only those disorders that upset the group (Tung, 1985). S. Sue, N. Wagner, D. Ja, C. Margullis, and L. Lew (1976) also found ethnic differences in conceptualizations of mental health and disturbance. Compared to whites, Asian Americans were more likely to believe that mental disturbances were caused by organic or bodily factors. A belief in the organic nature of mental disorders implies that medical or physical interventions, and not necessarily psychological ones, are appropriate.

4. Coping with Problems. There are interethnic and intraethnic differences in attitudes toward mental health services (Chen, 1977). Grounded in the cultural value placed on self-control, many APIAs believe that mental health is enhanced by not thinking about one's problems. Indeed, Asians are more likely than whites to believe that one should avoid morbid thinking to maintain mental health. This view may influence the low utilization of mental health services. Since treatment often requires self-disclosure of personal and intimate problems (i.e., focusing on morbid thoughts), many APIA clients do not believe that treatment is helpful. They may feel uncomfortable discussing intimate problems that they have culturally learned to avoid presenting to others. Among various Asian groups and particularly among Southeast Asians, it is thought that willpower can prevent people from having "inappropriate" emotions and can help them overcome pains in life (Tung, 1985). Southeast Asian cultures emphasize patience, resignation, and stoicism. One seeks help only as a last resort. Enduring through personal suffering is promoted and admired in some Asian religions (Wong, 1985). Therefore, seeking professional mental health services may be seen as inappropriate.

A large portion of the APIA population may not think that professional mental health services per se are helpful (Kitano, 1973). Rather than seeking these services like other Americans, APIAs tend to seek help from friends, family, physicians, and clergy before turning to mental health professionals (JWK International Corporation, 1976; Kitano, 1969a; Wong, 1985). Thus, in addition to inappropriate services being offered to APIAs, a salient problem in the delivery of mental health services may be the reluctance of APIAs to seek professional mental health services from anyone.

5. Acceptance of Public Services. Many APIAs believe that, for the sake of pride and self-respect, they must not accept public health services. Services geared toward those who cannot afford private care may carry welfare (and thus shame-inducing) connotations to some pro-

spective recipients. APIAs often have cultural values dictating the need to repay obligations, and these values may conflict with receiving mental health services at less than full cost (Wong, 1985).

Since many only halfheartedly believe that mental health services can help, they also eschew expensive private mental health care. Moreover, recent immigrants frequently do not have health insurance to help cover the cost of mental health services (Wong, 1985).

6. Language Difficulties. There are also language barriers in the delivery of services for many APIAs. Difficulties with English may impede some APIAs from learning about available services, filling out forms, and interacting with personnel. Many are fearful of seeking services from people who do not speak their language (Shu and Satele, 1977). Several studies of foreign-speaking patients have suggested that the language barrier is important in the treatment process in relation to diagnosis, conversational styles, frequency of misinterpretations, client attitudes, accessibility to a range of client services, and treatment effectiveness (see, for example, Marcos and Alpert, 1976; Marcos, Alpert, Urcuyo, and Kesselman, 1973).

Furthermore, when non-English-speaking clients seek services, they are often told to come back at another time with a neighbor or a child who can translate (Office for Civil Rights, 1973). This acts as a deterrent to the delivery of services since the clients are often reluctant to disclose private information in front of their neighbors or children. The non-English-speaking client is, in effect, denied confidentiality and is embarrassed.

In addition, an interpreter may not have the linguistic or mental health background to translate adequately for the client (Citizen's Advisory Council, 1979), may make changes in translating and try to explain what the patient means, may cause subtle nuances in connotation to be lost in translation (Wong, 1985), may cause therapy sessions to take twice as long (Larsen, 1975), and may cause the worker to feel uncertain of the communication and unsure of his or her own adequacy in the therapeutic situation. This in turn could lead the worker to drive the client away because of the worker's frustration, annoyance, and loss of interest (Larsen, 1979). These problems with interpreters are significant insofar as language plays a role in manifestations and diagnoses of disorders, effectiveness of treatment, and willingness to receive services. It appears that the problem of the shortage of bilingual personnel cannot be satisfactorily assuaged by the use of interpreters.

7. Knowledge of Available Services and Geographic Inaccessibility. Ignorance of the availability of services has been a prevalent reason social services have not been sought by APIAs (Division of Asian American Affairs, 1977; Chen, 1977). It is largely due to a lack of coordination

between mental health services and other religious and health services within the ethnic communities that could act as referral resources for mental health services.

The location of mental health services and the inadequacy of public transportation that feeds into the site of the local mental health facility may also be barriers to service utilization (Lum, 1985). Little consensus exists regarding where facilities would be most effectively located. Some suggest that the delivery site should be within the ethnic community, immediately visible, accessible, and integrated into the community. Others suggest that the mental health centers should be located near but not in the ethnic community since potential clients are ashamed and embarrassed by their need for services and do not want others in the ethnic group to see them receiving services.

MODELS FOR SERVICE DELIVERY

Underutilization of services does not necessarily imply an incompatibility between intervention and APIA clients. Rather, it highlights the need for modification in services and service delivery such that cultural compatibility of service and client is assured. The question is, what types of resources in the way of facilities and personnel can most effectively make these modifications?

A range of mental health service delivery system options exists (Uba, 1980). Three prototypes of culturally sensitive mental health service delivery systems for APIAs include: (a) mainstream facilities in which there are no specific personnel assigned to working with APIAs, (b) mainstream facilities in which specific personnel are trained to provide culturally sensitive services to APIAs, and (c) facilities that are physically separate from mainstream facilities and in which all of the personnel specialize in providing culturally sensitive services to APIA clients.

Mainstream Facilities and General Personnel

Services for APIAs may be integrated into mainstream facilities in which all of the personnel would be trained to provide culturally sensitive services. For example, staff at a community mental health center could receive inservice training on how to work with APIA clients.

There are limitations to this approach. For all personnel to be able to provide culturally sensitive services, a major revamping of traditional mental health service training (to include instruction on numerous APIA cultures and values) would be required. Such change may be resisted by professional organizations, universities, and students. The structural changes needed for training would elevate costs and require new training materials on cultural factors and would be considered major obsta-

cles. In addition, this policy of embedding culturally appropriate services within mainstream facilities may compound consumer ignorance of mental health services for APIAs by minimizing the visibility of such services and serve to limit service accessibility (Gilbert, 1972).

Nevertheless, advantages to this approach are apparent. Since APIAs exhibit a great deal of heterogeneity, staff can provide services that are appropriate for unacculturated as well as acculturated APIAs. The services would not be segregated, in that a mental health facility could serve a wide range of culturally diverse clients, and staff would increase their ability to work with different kinds of clients.

Mainstream Facilities and Special Personnel

Within mainstream facilities, there may be culturally sensitive teams of service providers to provide services for APIAs. In this model, bilingual and bicultural workers would be employed to work specifically with certain populations.

A disadvantage to this approach is that the establishment of culturally sensitive teams within centralized, mainstream services may create internal contentiousness, administrative confusion, and unnecessary duplication of services between the mainstream and the semiautonomous, pluralistic services (Anders, Parlade, Chatel, and Peele, 1977). Moreover, difficulties may exist in finding personnel who can work with specific Asian and Pacific Islander groups.

There are many advantages to this approach as well. The lack of culturally sensitive personnel could be alleviated by judicious use of extant culturally sensitive personnel. Furthermore, rather than automatically and indiscriminately being sent to separate APIA facilities without considering the appropriateness of such services for the individual client, having both mainstream and culturally specialized services available within the same setting gives consumers a clear choice of services. Offering a choice of services may increase the chance of an effective matching of needs and services and increase the use of services by APIAs. In addition, fewer changes in mental health training would be called for because only those who worked with APIAs would need to receive special training. Thus, this option would also be more economical for the delivery system than either of the other options. Finally, the cultural sensitivity of all personnel in mainstream facilities may be heightened by having the special unit housed within the mainstream facilities.

Segregated Facilities

Services for APIAs may be provided in culturally sensitive facilities that are in a different location than the mainstream services (perhaps

under an umbrella of social services for APIAs). Separate facilities would probably focus their limited resources on those APIAs who most need culturally sensitive and bilingual services (e.g., immigrants).

Several drawbacks exist in this approach. Concentrating a large portion of the mental health service providers trained to work with APIAs in segregated facilities would limit opportunities to promote understanding of APIAs among service providers in mainstream facilities. The APIA clients who appear at mainstream facilities may be referred to a segregated facility or may receive culturally unresponsive treatment. On the other hand, more acculturated APIA clients who are referred to separate facilities for APIAs may not benefit from these specialized services. Thus, the more acculturated APIAs may fall through the service delivery cracks in that mainstream facilities are unprepared to deal with cultural issues, while segregated services are not geared for those who are highly acculturated. In addition, the number of these specialized, segregated centers would be small. Clients who need the services may find them located far from where they reside. Moreover, adopting this option could, in the long run, leave APIAs without culturally sensitive services inasmuch as when there are budgetary cutbacks, these programs may lose their funding if separate services for APIAs are perceived as secondary or superfluous.

There are advantages to this approach. Some APIAs feel welcome or understood only in facilities that are specifically for APIAs. Another advantage to this approach is that it may afford institutional flexibility to meet the needs of APIAs: receptionists who can speak more than one language, scheduling that accommodates the patterns and needs of APIAs, locations near or in APIA communities, service delivery centers that provide training, and so on. The high visibility of separate facilities may increase public awareness of services and may attract potential APIAs into mental health service delivery. Concentrating culturally sensitive personnel in a few facilities may circumvent shortages of culturally sensitive service providers (President's Commission on Mental Health, 1978). The opportunity for community involvement in the planning and implementation of services for APIAs may be increased when there are separate facilities, presumably run by APIAs (Lum, 1985). Services that are effective and frequently used tend to be community based with providers being either members of or known in the ethnic community (Wong, 1985).

Appropriateness of Models

Not all APIAs are equally subject to barriers to service delivery. There are large interethnic differences in terms of acculturation, mental health service needs (Kim, 1973), and patterns of help-seeking (JWK Interna-

tional Corporation, 1976), as well as intraethnic differences in attitudes toward the treatment of mental disorders (Chen, 1977). Furthermore, the relevance of ethnicity in the development, manifestation, or treatment of mental disorders may vary widely across individual members of the heterogeneous APIA population.

Experience and research have shown that one form of service delivery is not clearly and always preferable to another, although it is clear that culturally sensitive services are needed. Work in Los Angeles (Hatanaka et al., 1975), San Francisco (Kitano, 1969b), and Seattle (Sue and McKinney, 1975) has demonstrated that culturally relevant services dramatically increase APIA use of mental health services.

The first mainstream option would be most apt when there are few APIAs in the service area, when there are few who need bilingual services, and when many of the existing mental health providers are culturally sensitive. The mainstream facilities could also have special teams to serve APIAs. The special teams options, a variation of which has been adopted by the Asian American Task Force of the County of Los Angeles/University of Southern California Hospital Mental Health Services, would be particularly appropriate when financial and spatial resources are limited and when there are only a limited number of people who could provide services in a culturally sensitive way. The teams have an advantage over simply having one ethnic specialist, in that efforts would not be limited to one person, and the team could represent different ethnic groups. In the past, services that have provided one specialist in minority mental health care have not had much impact (Wu and Windle, 1980).

The segregated services option, which has been adopted at a number of places including the Asian/Pacific Counseling and Treatment Center in Los Angeles and the Richmond Maxi-Center in San Francisco, would be particularly apt when APIAs are concentrated in a small area, when mainstream facilities are situated far from APIA populations, or when there are many immigrant APIAs needing services.

The existence of separate mental health facilities for APIAs has increased utilization rates. For example, when San Francisco's Richmond Maxi-Center was established, more patients were seen in the first three months than were seen in the previous five to six years in that catchment area (Murase, n.d.; Wong, 1977). In Seattle, an APIA counseling and referral service was used as much in one year as eighteen other community mental health centers were used by APIAs over a three-year period (Sue and McKinney, 1975). During the two years that H. L. Kitano (1969b) worked at a child guidance clinic serving San Francisco public schools, there were no cases of children of Japanese ancestry being referred. In contrast, a family service agency developed by the Japanese community served an average of thirty active counseling cases per

month. Similar findings for Asian American mental health facilities in Los Angeles have been reported (Hatanaka et al., 1975).

CONCLUSION

The policy options presented here are not mutually exclusive. A combination of these delivery systems is probably needed to meet the heterogeneous range of APIA needs. Since APIAs are generally reticent to seek mental health services, it may be premature to stress outpatient treatment and overlook the importance of outreach. Whether mainstream or segregated services are established, there is a need for adjunctive measures including educating the APIA public about mental health services.

The 1990s will be a period of increased growth for APIA populations, and social service professionals must make a concerted and responsive effort to enhance and increase the accountability of services to this diverse population.

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