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on

MENTAL HEALTH OF ASIAN/PACIFIC AMERICANS

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Special Populations Subpanel:
Mental Health of Asian/Pacific Americans

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OVERVIEW

INTRODUCTION

In opening the discussion of the Subpanel on Mental Health of Asian/Pacific Americans of the Task Panel on Special Populations, President's Commission on Mental Health, it may be helpful to gain a historical perspective by first considering the report of the Joint Commission on Mental Illness and Health, Action for Mental Health (1961). The Joint Commission gathered a number of prominent representatives of the mental health community and worked for an extended period on a comprehensive report to the U.S. Congress. The report states that the nature of mental health is so complex that it was impossible to confront all of the issues. Indeed, the report does not address the notion of "special populations" or specific racial minority concerns in a direct investigation. As most people are aware, the report dealt with a series of conceptual and policy issues at a level which did not specifically address various client populations. The discussion around client populations tended to be limited to diagnostic categories and did not examine racial minority issues and other demographic and cultural characteristics. It is also important to note that the report did not specifically address the impact of overt and institutional racism.

In contrast to Action for Mental Health, the Preliminary Report to the President from the President's Commission on Mental Health, September 1, 1977, makes it plain that underserved populations and the impact of racism will be addressed. The scope of the inquiry as outlined in the report reflects an expanded awareness of the context of mental health concerns. The recognition by the President's Commission on Mental Health that race and other demographic and personal characteristics are significant factors in research, services, and training is an important step forward in the national awareness of the nature of mental health. The recommendation contained in the Preliminary Report of the Commission is, of course, an initial recommendation and needs extensive expansion, but represents an extraordinarily important message to the mental health community, as well as the public at large, about how crucial racial and cultural factors are regarding mental health care. It reads:

> The Department of Health, Education, and Welfare to give further priority to training (a) minority mental health workers, (b) researchers from minority groups, and (c) persons serving bicultural and bilingual groups. (p. 15)

The Joint Commission on Mental Illness and Health was a significantly different group, and approached the subject of mental health in a different way vis-a-vis the President's Commission on Mental Health. However, there were high expectations in terms of the Joint Commission's report and the actual impact it would have on mental health care in the United States. Similarly, the American public has the same high expectations of the President's Commission on Mental Health. In an effort to help meet these public expectations and to discharge the responsibilities of the Asian/Pacific Subpanel, Task Panel on Special Populations, this final report

attempts to address the matter of "special populations" from the Asian/Pacific perspective. In the following sections, the report will briefly touch on the philosophical/cultural/political frame of reference adopted by the Asian Pacific Subpanel. Also, a discussion of the condition of Asian and Pacific Americans (AAPA) in terms of mental health, the Subpanel recommendations, a statement regarding priorities for the Asian and Pacific American population, and concluding remarks are presented.

Finally, a number of disclaimers are appropriate. First, as the Joint Commission on Mental Illness and Health stated in its report, the subject of mental health is too complex to adequately address in a single report. This is certainly true with respect to the mental health issues and concerns of Asian and Pacific American communities. The amount of time and the resources were too limited to produce a comprehensive, definitive statement on any of the relevant issues.

Second, the Asian/Pacific Subpanel was composed of a heterogeneous mixture of persons in the Asian and Pacific American mental health community. While the Subpanel members were selected by the Commission largely for their representativeness across a number of selected characteristics, the Subpanel and subcommittee process was too limited. The Asian/Pacific Subpanel members felt that the Commission should have expanded the representation. Nevertheless, the final Asian/Pacific Subpanel report probably reflects the interests and concerns of the majority of the Asian and Pacific American communities represented in the Subpanel.

Third, in addition to the short time frame and other limitations, the overall Task Panel on Special Populations process was severely hampered by the lack of a series of needed Panel meetings which precluded the extremely important sharing and collaborative process.

Fourth, it is the position of the Asian/Pacific Subpanel that its contribution was severely limited due to the exclusion of appropriate Asian and Pacific American representation on the President's Commission on Mental Health itself. Several Commissioners and Commission staff have been extremely helpful to the Asian/Pacific Subpanel. But the Subpanel is still lacking the articulation and full representation of the Asian and Pacific American perspective. This point was made repeatedly in the Commission's public hearings and elsewhere.

STATEMENT ON PHILOSOPHY AND PERSPECTIVE

This section will attempt to briefly outline the frame of reference within which the Asian/Pacific Subpanel addressed the "Charge" and specific tasks involved in the assignment vis-a-vis the Task Panel on Special Populations. As a matter of fact, this section is important because it provides an opportunity to raise yet unanswered questions regarding the nature of the Charge to the Task Panel on Special Populations. While the Charge and the papers by Dr. Delores Parron, Commission staff, of August 3, 1977--"Task Panel on Special Populations: Minorities, Women, Physically Handicapped"--address many basic issues, it is still not entirely clear to the Asian/Pacific Subpanel the exact definition of "special populations."

There still remains a question as to the exact criteria employed in classifying minorities, women, and physically handicapped as "special populations." The criteria for defining groups into the category of "special populations" become further confused when "European ethnics" are included in the category of minorities. The question at this point is not whether a specific group should or should not be included as a "special population." Rather, what is the definition of a special population group in the first place? Needless to say, the Asian/Pacific Subpanel was never totally successful in resolving this question. For practical purposes, the subpanel generally assumed that the criteria for being selected as a special population group had something to do with cultural differences, utilization of mental health services, and perceptions of relative "at-risk" status.

Another basic question was the definition of "mental health" used by the President's Commission on Mental Health. As it turns out, the Asian/Pacific Subpanel learned that the definition of mental health was one of the major subjects of debate and discussion by the Commission itself. Therefore, much of the responsibility of defining mental health rested upon the Asian/Pacific Subpanel, as it did with other panels and subpanels. As will be illustrated later, the Asian/Pacific Subpanel chose to utilize a broad definition of mental health which includes both the social services and medical arenas. The Asian/Pacific Subpanel tended to perceive mental health as encompassing a broad territory of concerns encompassing many component "turf" areas, each with its contributions to be made to the whole. In fact, the work of the various special population subpanels will probably add a great deal to the discussion around the domain and boundaries in which mental health is most relevant.

As Mrs. Rosalynn Carter has pointed out, the stigma of mental illness is one of the greatest barriers in terms of improving mental health care in the United States (New York Times Nov. 18, 1977). Mrs. Carter states that "cultural" differences sometimes prevent certain minority groups from using mental health services, and that Asians and Pacific Americans are one of the groups affected by stigma in this manner. Dr. Delores Parron's report on the Task Panel on Special Populations (August 3, 1977, page 2), states that "racism and its attendant discriminatory practices continue." In the view of the Asian/Pacific Subpanel, Mrs. Carter's statement on stigma and Dr. Parron's statement on racism are closely related. That is, certain cultural factors and racial factors are part of the same process which produces stigma and racism. At least in the case of Asian and Pacific Americans, one can never consider cultural differences without comprehending the implications of being a racial minority, i.e., Asian and Pacific American, vis-a-vis white society.

Obviously, there are individuals who experience multiple indignities due to stigma. Note, however, that Asian and Pacific Americans, as racial minorities, are part of the only class of persons in America that experiences racism. The issue of racism as an operative factor throughout the field of mental health in the United States must be emphasized. Note that the Joint Commission on Mental Health of Children also underscored the role of racism (1970). There is, in the view of the Asian/Pacific Subpanel, no content area under the rubric of mental health which is not affected in some way by racism.

Furthermore, all important national study groups, such as the President's Commission on Mental Health, are naturally incumbent on a power and political process. This being the case, it is essential to have appropriate racial minority representation at the highest levels of decision-making. Obviously, the exclusion of appropriate Asian and Pacific American representation on the President's Commission on Mental Health (as pointed out in Commission hearings) raises questions about how the Commission is confronting the issue of racism. Only the most naive person would think that the content of mental health issues is not affected by racism or that national bodies such as the President's Commission on Mental Health are not significantly influenced by power and political forces which will ultimately have an impact on the lives of Asian and Pacific Amercians.

Of course, the factors of race, culture, bilingualism, and other individual characteristics are strongly affected by related dynamics, such as socioeconomic class, sex, age, and the nature of the disability. In fact, the Asian/Pacific Subpanel is still unclear as to why the frame of reference with respect to racial minorities and other groups within the category of special populations focuses so much emphasis upon the individual characteristics of the groups within the special-population category. This emphasis seems to overlook the obvious and equally important basic societal issues and problems.

To illustrate this point, the Charge for the Task Panel on Special Populations states: "For a set of complex and varying reasons, the life chances of individuals in the special populations have been compromised in ways that have limited the realization of their full potential and deprive them of the opportunity to participate fully in American society in general and more specifically in mental health systems." The Commission's own statement is a heavy indictment against "human rights" in this country.

The Asian/Pacific Subpanel agrees with the statement. The question is, however, if the statement is known to be true, why are not the Task Panel on Special Populations and the President's Commission on Mental Health directing their energies at solving these basic societal problems? Why "study" the matter any further? Since it is agreed that Asian and Pacific Americans are deprived of certain opportunities to participate fully in American society, etc., as stated in the Charge, why are we not taking immediate action to eliminate the systematic causes of this deprivation? Further, it is stated that racism continues to exist, yet a major effort on the part of the President's Commission on Mental Health does not appear to be directed at eliminating racism in terms of mental health. Why?

The Charge for the Task Panel on Special Populations raises a number of valid points regarding the condition of minorities and other special-population categories in the United States. These points constitute, on their face, a sharp and deep-rooted indictment concerning the very nature of American society. It is, in the view of the Asian/Pacific Subpanel, a matter which is transparent, something which reached crisis proportions a long time ago and is still being ignored. While President Carter and the American people have concerned themselves with human rights around the

world, there appears to be a lack of appropriate concern about human rights related issues at home.

The Bakke case concerning "reverse discrimination" now before the Supreme Court is just one of the many examples of how American society is being sharply divided into a class and caste system on the basis of race. The President's Commission on Mental Health ought to be addressing, as one of its major priorities, why the United States can admittedly continue to exclude minorities from various occupational groups (including those related to mental health care), and at the same time, support the dominance of white society over these occupational opportunities. What will the President's Commission on Mental Health have to say about what the President and Congress, as well as other relevant parties, ought to do to correct these and similar problems?

In sum, a study focused on the specific concerns of the groups within the category of special populations is needed and should be undertaken. However, the focus for the Task Panel on Special Populations and the President's Commission on Mental Health must simultaneously confront the basic, causal, societal factors which produce the conditions which adversely affect special populations. Unless this is done, causal factors will be dismissed in favor of blaming the "victim." Examples of additional systemic societal needs include a good national health insurance program (with a full range of mental health care, including prevention programs) and a good income maintenance program (the embryonic beginnings of which would be appropriate welfare reform and reorganization of the welfare system).

If the perspective and frame of reference of the Asian/Pacific Subpanel is anywhere near "on target," the manner in which the President's Commission on Mental Health deals with the above issues could be quite revealing about the nature of the President's Commission on Mental Health itself. Will the President's Commission on Mental Health raise and confront the highly sensitive and ticklish issues around racism and other causal factors in America's social fabric? Or will the Commission only deal with relatively superficial reforms?

Finally, at least in the eyes of the Asian/Pacific Subpanel, the real intent and credibility of the President's Commission on Mental Health will be the final report that it produces and the attendant actions that it takes. It is the hope of the Asian/Pacific Subpanel that the President's Commission on Mental Health will assume a frame of reference and perspective regarding Asian and Pacific Americans (and perhaps other categories with special populations) as outlined by the Asian/Pacific Subpanel. The extent to which the President's Commission on Mental Health is able to support this frame of reference with respect to national mental health issues will be of great interest to the Asian/Pacific Subpanel.

STATEMENT ON THE CONDITION OF ASIAN AND PACIFIC AMERICANS IN TERMS OF MENTAL HEALTH

This section is a brief statement on the status of Asian and Pacific Americans vis-a-vis mental health issues. The following section on

recommendations from the Asian/Pacific Subpanel addresses the major concerns in relation to selected content areas. Therefore, this section will touch on the more general points of interest in outlining the current condition of Asian and Pacific American people in terms of mental health. Note that this topic could only be addressed in terms of existing information. The Asian/Pacific Subpanel group did not conduct new research in terms of gathering information regarding the Asian and Pacific American population of approximately 2 to 3 million in the United States with regard to mental health (Sue & Wagner 1973; Sue & Kitano 1973).

Since the first group of Asian and Pacific American immigrants began coming to the United States about 1850, the trend has been toward a larger population of Asian and Pacific Americans, as well as an increasing number of various Asian and Pacific American subgroups (Kim & Kim 1977). This rapid increase in the Asian and Pacific American populations, particularly since 1965 (and not accurately reflected in the decennial census), has created a fluid, rapidly changing mixture of people under the Asian and Pacific American rubric. In the first hundred years of Asian and Pacific American immigration to the Unites States, the newcomers were primarily Chinese, Japanese, and Filipinos. However, in the past 10 years, especially, there has been a dramatic increase in other groups including Koreans, Filipinos, Samoans, Guamanians, East Indians, and Indo-Chinese (Owan 1975).

To illustrate the increase in AAPA population, Owan estimates that by 1980, AAPA's in the United States will exceed 3 million. This figure is even more impressive when one notes that the total AAPA population in 1970 was reported to be 1.5 million, or only half of what it will be in 1980. In California the effects of the population trends are even more striking due to the large number of new immigrants to the State from Asia and the Pacific Islands. A report for Lieutenant Governor Mervyn Dymally on California's minority populations estimates that by 1990, minorities will comprise 60 percent of the State population, or nearly 20 million persons. AAPA's will constitute a substantial proportion of the projected minority population if present trends continue. For example, since 1970, the Korean population has gone from 17,000 to 150,000; the Filipino population has gone from 135,000 to 300,000; the Chinese population has gone from 170,000 to 300,000; the Japanese population has gone from 213,000 to 350,000; the East Indian population has gone from 13,000 to 30,000; and the Vietnamese, Samoan, and Guamanian populations have gone from an unknown number in 1970 to a collective population in 1977 of 160,000 in California.

The rapid increase in new Asian and Pacific American immigrants from a variety of countries has created marked differences between the old and new Asian and Pacific Americans. Some Asian and Pacific American families have resided in the United States for three or four generations, while there are, by contrast, great numbers of new immigrants who have only been in the United States for a few years. Thus, what is known about the Asian and Pacific American communities through earlier research projects may not apply to the more recent immigrant groups. Research, services, and training efforts in the mental health area will also have to recognize that the various populations to be studied, served, or trained are changing. In addition, while the Asian and Pacific American populations are

undergoing change due to immigration, relatively little within the various Asian and Pacific American cultures adds to the homogeneity between the old and the new groups. The Asian and Pacific American populations are generally becoming more heterogeneous as new immigrants change the composition of the total Asian and Pacific American population. For example, new immigrants from China may have less in common with the Chinese immigrants who had arrived in the United States several generations earlier. This of course, is due in part to the relative degree of acculturation, the course of international relations, immigration from different parts of the same country, and the impact that present-day immigration has upon newly immigrated AAPA families in the United States.

Having commented briefly on the nature of the AAPA population, the discussion will now turn to mental health issues. A number of National Institute of Mental Health (NIMH) funded projects are worth noting at this point because they have helped to develop information regarding research, services, and training in Asian and Pacific American communities. These organizations include the Pacific Asian Coalition (PAC), which is the Asian and Pacific American coalition for mental health and other human services, the only one of its kind with a national scope. PAC is a national AAPA mental health coalition with regional groups across the United States and headquarters in San Jose, California. Second, the Asian American Community Mental Health Training Center (in Los Angeles), the San Francisco Bay Area Asian American Mental Health Training Center, and the Sacramento Asian American Training Center are separate programs which provide mental health training in the Asian and Pacific American communities. Third, there is the Asian American Mental Health Research Center, based in Chicago. There are, of course, a number of other mental-health-related projects in Asian and Pacific American communities which are funded by other sources than NIMH. One example is the Pacific Asian Elderly Research Project in Los Angeles, funded by the Federal Administration on Aging.

The collective experience from these and other projects has tended to indicate that Asian and Pacific American people want a variety of choices when seeking mental health services. In this array of alternatives, it seems that most Asian and Pacific American people initially prefer to utilize indigenous community workers and natural community "caretakers." These caretakers may include ministers, relatives, prominent community members, and family physicians. Very often mental health care is provided via Asian and Pacific American primary care physicians and other health care professionals. In many cases, Asian and Pacific American people choose not to seek professional mental health care directly, except in the most extreme circumstances. In these crisis situations, it appears that most Asian and Pacific American people would prefer bilingual/bicultural staff who are oriented toward serving clients with the same background. Bilingual/bicultural factors certainly seem to be a very positive part of overcoming some of the traditional patterns of "underutilization" common in "mainstream" mental health services available to Asian and Pacific Americans. Bilingual/bicultural services tend to reduce barriers to accessibility of services and stigma attached to seeking services.

Recently, a variety of local AAPA mental health service projects have been emerging with focus specifically on the bilingual/bicultural aspects of service delivery to Asian and Pacific American clients. Examples of the services include the Asian Counseling and Referral Service, Seattle; the Richmond Maxi-Center Community Mental Health Program, San Francisco; the Chinatown Mental Health Team, Northeast Community Mental Health Center, San Francisco; the Korean American Mental Health Service Center, Los Angeles; the Los Angeles County Indo-Chinese Social Service Demonstration Project, Los Angeles; and the Asian American Mental Health Clinic, Los Angeles County Department of Health Services, Los Angeles. In these various bilingual/bicultural service programs, it often appears that certain cultural factors, e.g., family ties, are important mechanisms that reinforce positive mental health, normal functioning, and prevention of mental health problems. On the other hand, a variety of cultural factors, often specific to the particular Asian and Pacific American subgroup, make a "mainstream" mental health service program relatively ineffective. Studies have indicated that Asian and Pacific American clients will drop out of a treatment program very rapidly unless they feel that they are receiving relevant care (Sue 1977). Relevant, culturally sensitive mental health care for Asian and Pacific Americans (as is true with other minority groups) is more difficult to obtain due to a "dual system" of mental health care. This dual system often means that racial minority groups and those who cannot afford to pay for private mental health care have very few mental health service alternatives. Those few alternatives are often of the poorest quality (Fiman 1975; Chu & Trotter 1974; Gilbert 1972). Yet others who tend to be more affluent receive what is generally considered to be better quality care and have access to more service alternatives.

The rate of mental illness among Asian and Pacific Americans is difficult to analyze, particularly across all of the individual Asian and Pacific American groups, due to lack of sufficient data. At one time, it appeared that Asian and Pacific Americans historically underutilized "mainstream" mental health services. While this may still be essentially correct (with some notable exceptions, e.g., Chinese in State hospitals), more Asian and Pacific Americans are currently seeking mental health care through an expanding network of Asian and Pacific American community focused mental health and related programs. Part of the reason for the expansion in the number of Asian and Pacific American focused mental health programs is due to the NIMH funding of Asian and Pacific American training projects, as well as the influx of Asian and Pacific American foreign medical graduates (FMG's) and new immigrants with mental health training. Still, there are insufficient training sources and service programs to really serve the needs of the Asian and Pacific American communities. This includes services dealing with drug abuse, alcoholism, and physical and developmental disabilities.

The foreign medical graduates, many of whom are Asian and Pacific American, constitute a very complex issue in terms of Asian and Pacific Americans and mental health care (Wong 1977; Sata 1977). On one hand, Asian and Pacific American foreign medical graduates have constituted a major source of medical personnel for State hospitals and various other public mental health facilities throughout the country. Yet it appears that Public Law 94-484 will make it virtually impossible for foreign

medical graduates to continue practicing in the United States. This will tend to reduce the number of medical personnel in the already beleaguered State hospital systems across the United States. Foreign medical graduates who are from Asian and Pacific Island countries constitute the largest proportion of FMG's in the United States. These Asian and Pacific Island born foreign medical graduates and American born and trained AAPA mental health personnel are obviously not the same people. But together they constitute a potentially relatively rich resource of mental health care personnel for Asian and Pacific American communities.

However, the personnel picture is complex. Some Asian and Pacific American subgroups may have a relatively high number of mental health professionals in their group while other subgroups may not. But these professionals may be foreign medical graduates who are employed in geographical areas or in settings in which Asian and Pacific American clients are seldom served. Thus it should be emphasized that most Asian and Pacific American subgroups have relatively few mental health professionals (and other related personnel) who are actually available to provide bilingual/bicultural services to their respective communities. This is especially true among native Hawaiians, Filipinos, Samoans, Guamanians, Indo-Chinese, Koreans, and the newer immigrant groups.

The stereotype of Asian and Pacific Americans as the "model minority" has hindered the realization that many Asian and Pacific subgroups have few bilingual/bicultural mental health personnel with the same background. Also, for various reasons, AAPA's constitute "at-risk" groups whose needs have been largely unattended. For example, obvious "at-risk" groups within the Asian and Pacific American populations include: (1) Indo-Chinese "refugees"; (2) American servicemen's wives who are from Asian and Pacific countries; (3) recent immigrants, especially the elderly and children; (4) people from areas undergoing rapid cultural change, e.g., parts of Hawaii, Samoa, Micronesia, and other parts of the Trust Territories; and (5) individuals with multiple problems, e.g., physical and developmental disabilities concurrent with specific mental health care needs.

Finally, the future outlook for status of mental health among Asian and Pacific Americans may depend largely upon how the United States deals with the problems of: (1) new immigrants from Asian and Pacific countries; (2) the Indo-Chinese populations; (3) the impact of racism upon the delivery of mental health services; (4) the creation of new, culturally sensitive and effective mental health service, training, and research programs; and (5) the extent to which AAPA communities can amass political power to have influence over elected political officials, public agencies, and other institutions.

RECOMMENDATIONS TO THE COMMISSION

An Introductory Note

It should be noted that the recommendations are not listed in order of priority. The Asian/Pacific Subpanel quite simply chose to present the recommendations in block. The reason is that there was not the opportunity to sufficiently discuss these recommendations by the Asian/Pacific Subpanel to appropriately come to agreement on a system of priorities. Also, the Subpanel members thought that most of the recommendations were so interrelated that a system of priorities was not appropriate.

While the recommendations have background documentation, the supporting data are sometimes scanty because extensive research information does not exist. This general absence of sufficient information concerning AAPA's is an obvious reason for more research.

I. SOCIAL POLICY ISSUES[1]

Asian and Pacific Americans are one of the most complex, diverse, and misunderstood minority groups in the United States. Asian and Pacific Americans include Chinese, Japanese, Koreans, Filipinos, East Indians, Pakistanis, Thais, Hawaiians, Guamanians, and Samoans from the United States Trust Territories in the Pacific; and Cambodians, Vietnamese, and other Indo-Chinese "refugees." Thus the group consists of over 2 million people who now live in this country and who are victims of many of the same social, economic, and political inequities that have victimized Blacks, Hispanics, and Native Americans.

There is a widespread belief that Asian and Pacific Americans do not suffer the discrimination and disadvantages associated with other minority groups. The fact is that in spite of recent efforts to promote civil rights and equal opportunities for ethnic minorities in the United States, Asian and Pacific Americans have been largely neglected and ignored by governmental agencies, educational institutions, private corporations, and other sectors of society. Immigration policy is an example.

These recommendations attempt to highlight the many complex problems faced by Asian and Pacific Americans which are affecting their mental health. Further, these problems are eroding their cultural and family systems, the main tenets of their social support and survival in this

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[1]The foci of these recommendations are those broad societal institutions and problems that tend to crosscut the narrower topics of service delivery, personnel and training, and research. Note, however, that some of the recommendations are not entirely mutually exclusive. In a few instances, there are cases of partial "constructive duplication" of the Social Policy recommendations and other content areas. These recommendations are organized around selected issues.

country. It is hoped that the President's Commission on Mental Health will read these recommendations thoroughly and will provide a sensitive and concerned response.

Social problems are frequently the consequence of institutional racism, discrimination, and colonialism insofar as they fail to recognize the unique characteristics of the Asian and Pacific Americans (language, cultural values, traditions, family and community supports, etc.). Most public policies which blatantly ignore Asian and Pacific Americans in terms of their unique features are expressions of racism, colonialism, and discrimination.

The most pervasive mental health problem confronting Asian and Pacific Americans is racism. The effects of racism (e.g., colonialism and institutional racism) are viewed as being highly detrimental to the mental health of Asian and Pacific Americans. Racism adversely affects the emotional and psychological well-being of Asian and Pacific Americans, and it often restricts the resources (e.g., economic and services) available to them. Racism is manifested in discriminatory acts which often have a damaging psychological impact on Asian and Pacific Americans. These acts have frequently been codified in discriminatory legislation, which clearly violates human rights (Owan 1975). Racism is also manifested in derogatory stereotyping of Asian and Pacific Americans as something less than "American." Such stigma has followed Asian and Pacific Americans over the years, often producing a sense of inferiority and second-class citizenship. Institutional racism further operates in the mental health delivery system to ignore the distinct and diverse mental health needs of the Asian and Pacific Americans and to restrict opportunities to enter the mental health professions. The Subpanel recommends:

1. That existing and proposed mental health policies contain specific provisions which acknowledge the unique cultures, languages, and lifestyles (including immigration experience) of the Asian and Pacific Americans. The Subpanel further recommends support of those policies which recognize and reflect sensitivity to the cultural, racial, and ethnic differences of the Asian and Pacific Americans (e.g., bilingual/ bicultural education and affirmative action programs).

Many mental health problems may be prevented and ameliorated with the elimination of poverty. The U.S. economic system and its inequities create many societal problems. Mental health problems are among the social ills which are adversely affected by poverty, lack of opportunity, and alienation (Brenner 1977). The subpanel therefore recommends:

2. That the President and Congress quickly enact an income maintenance program which will ensure every person in the United States appropriate economic security, and will promote family solidarity and an opportunity for capacity building.

From a realistic viewpoint, the AAPA communities will continue to exist for many reasons and for many years to come. There has been a

phenomenal rise in AAPA populations in this country because of the increased immigration in the past several years. By 1995, it is projected that AAPA populations will rise to over 3 million. Mental health resources have been underutilized by AAPA's and the demand for appropriate and effective psychiatric services will not be satisfied for a long time without more AAPA psychiatrists and other trained personnel (Wong 1977).

Due to the passage of the Health Professions Educational Assistance Act of 1976 (P.L. 94-484), which went into effect on January 10, 1977, foreign medical graduates (FMG's) will have to limit their stay in the United States to 2 years and all exchange visitors must return home for 2 years before applying for permanent resident status. It is absurd and impossible for FMG's to complete a regular 3- to 5-year psychiatric residency training program in 2 years. Over 70 percent of all FMG's were Asians, according to a 1972 Health, Education, and Welfare publication, and the majority of Asian psychiatrists in this country are FMG's. In order to render appropriate professional care for AAPA populations, bilingual and bicultural, well-educated, and trained FMG's from Asian countries and Pacific islands are desperately needed. More will be needed in the future. The Subpanel urges strongly:

3. Repeal of Public Law 94-484 because sections of it are considered racist and discriminatory.

The recent experience of Indo-Chinese refugees has heightened the awareness of the difficulties experienced by all immigrants and refugees coming to the United States. Pending legislation proposes the withholding of basic benefits for an interim period. Such legislation would severely restrict the resources available to immigrant groups at a point in their transition into the United States when they are most vulnerable to socio-economic uncertainties (Munoz 1976). The subpanel recommends as a protective measure:

4. That immigrants and refugees coming to the United States should be allowed the same basic benefits as American citizens. Immigration laws should provide equity, efficiency, and dignity to those wanting to enter the United States.

The Health Task Force of the Pacific/Asian Coalition reported (1977) that ". . . different language needs should be taken into consideration so as to insure the maximum utilization of the program by non-English speaking populations, including the different ethnic languages of Asian Americans." The availability of mental health personnel whose language and cultural heritage are similar to the client's is obviously very significant. The failure to utilize bilingual/bicultural staff in a centralized relationship results in a disruptive process that seriously contributes to the Third World client's inability to form a positive and continuous attachment to the therapeutic relationship (Miranda and Kitano, p. 42). The Subpanel recommends:

5. That the rights of Asian and Pacific American patients in health and mental health settings be duly

recognized, particularly as they relate to their unique cultural, linguistic characteristics and historical/life experiences.

The character of mental health services in this country has been largely determined by white, middle-class standards and values. Mental health service delivery systems have failed to respond to minority groups (Asian and Pacific Americans, Blacks, Hispanics, and Native Americans). In view of this situation, support for the bill introduced by Senator Daniel Inouye calling for the establishment of a Division for Minority Group Mental Health Programs is recommended with the following suggested modifications:

6. The enactment of a bill to establish a Division for Minority Group Mental Health Programs to include Asian and Pacific Americans, Blacks, Hispanics, and Native Americans as per Senator Inouye's bill (S. 2373).

   The addition of item 6 under section 232 (b) to read: "Support other research studies which have application for practice, program design, service delivery, and preventive interventions."

   In (c) omitting "non-profit" and adding "State and local governmental and non-governmental agencies." Thus (c) would read: "The Secretary, acting through the Division, may carry out the provisions of subsection (b) by making grants to, or entering into contracts with State and local governmental and non-governmental agencies."

Resources and funding have been allocated without the consideration of Asian and Pacific American mental and physical health needs. This situation was due to neglect of input and involvement of Asian and Pacific Americans in the decisionmaking process, for example, the absence of Asian and Pacific American participation on the National Advisory Mental Health Council and the President's Commission on Mental Health. The Subpanel recommends:

7. That Asian and Pacific Americans be appointed to serve on the National Advisory Mental Health Council, NIMH, and all other Federal, State, and local governmental boards, review committees, commissions, councils, and policymaking bodies, and especially where substantial numbers of Asian and Pacific Americans are effected. As a case in point, Asian and Pacific Americans must be appointed to local and statewide advisory bodies of the Health Systems Agencies (P.L. 93-641) for involvement in planning, decisionmaking, and review approval (e.g., allocation of 314-D funds and issuances of certificates of need).

The current mental health resources and funding also have not taken into consideration the mental health needs of the Asian and Pacific

American with developmental needs. This situation is due, in part, to the lack of representation and input by Asian and Pacific Americans in key areas of decisionmaking. Presently, there are an inadequate number of Asian and Pacific American representatives who are sensitive, aware, and informed about Asian and Pacific Americans with developmental needs in the mental health and developmental disabilities agencies' top management, administration, and program planning functions at the national level.

The entire rehabilitation process is dependent upon appropriate resources within the existing institutions and within the community. Very few rehabilitation facilities throughout the Nation specialize in serving the Asian and Pacific American with developmental needs. There exist even fewer facilities and agencies that can deal with the bilingual and bicultural diversity within the Asian and Pacific American populations. The Subpanel recommends:

8. That Asian and Pacific Americans be appointed to serve on bodies such as the President's Commission on Mental Health, the President's Commission on Mental Retardation, the National Advisory Council on Developmentally Disabled, and all other Federal, State, and local policymaking bodies which affect Asian and Pacific Americans with developmental needs.

9. That Federal and State funds be specifically allocated for the development and support of bilingual and bicultural rehabilitation programs that serve the Asian and Pacific Americans with developmental needs.

II. ISSUE: DELIVERY OF MENTAL HEALTH SERVICES TO ASIAN/PACIFIC AMERICANS

The service delivery recommendations cover a range of issues from citizen/consumer concerns to the need for culturally sensitive service programs. These recommendations are organized around service delivery problem areas--from underutilization of services and catchment areas to the participation of Asian and Pacific Americans in the planning and decisionmaking concerning the services that affect them.

Underutilization of Services

Studies show that Asian and Pacific Americans (AAPA) tend to be brought to the attention of mental health services and services for the developmentally disabled only at the point of acute breakdown or crisis. For example, in Sue's study of greater Seattle, Asians were found to have a far higher proportion of the diagnosis of "psychosis" than any other group. Of Asian and Pacific American patients, 22.4 percent were diagnosed as "psychotic" compared to 12.7 percent of white patients, 17.6 percent of Native American patients, 13.8 of Black patients, and 14.5 percent of

Chicano patients (Sue 1977). Berk and Hirata (1973) reported that Chinese Americans have been admitted to State mental hospitals in California at a rate greater than that for the general population for the 100-year period 1855-1955. Brown et al. (1973), in comparing a sample of Chinese patients with a randomly selected control group, found that while the Chinese were less likely to utilize existing mental health services, those who did tended to be more disturbed than Caucasian patients.

In terms of comparative rates of utilization, in Sue's study of 17 community mental health centers in the greater Seattle area, over a 3-year period, although AAPA's were 2.4 percent of the population, they represented only .7 percent of the patient population (Sue & McKinney 1975). In Los Angeles County, which has the largest concentration of Asian and Pacific Americans, their admission rate to its mental health services in 1971 was .9 percent of the patient population, although their representation in the County was close to 4 percent (Hatanaka et al. 1975). A report of the San Francisco Community Mental Health Services (1977) program shows that for the 7-month period July 1976-January 1977, in its Northeast Mental Health Center, which includes Chinatown, although the Chinese make up 29 percent of the catchment area population, they constituted only 10 percent of the patients served. For the city as a whole, although the Chinese are close to 10 percent of the population, they make up only 2 percent of the patients served.

Huang and Grachow report that there appears to be a consistent pattern of Asian Americans doctoring themselves, using folk remedies or resorting to traditional modes of treatment such as acupuncture, and seeking the services of a physician only when they experience an acute episode of illness and then only for immediate relief of symptoms (Huang & Grachow 1974). Whatever the source of care, the number of Asian and Pacific Americans utilizing available health resources for preventive care is extremely low. For example, the Asian American Field Study (1974) indicated that, among all the Chinese surveyed, more than 20 percent of the children and about one-half of the adults had never had an eye or dental examination. Moreover, 23 percent of the adults had never had a physical examination during the period 1965 to 1973 when the survey was conducted. In a study of the Chinese community in Boston, Li (1972) reports that 61 percent of a sample of Chinese did not have a private or clinic physician. Breslow and Klein (1971), in a California study on the utilization of services by Chinese Americans and other minorities, reported that only 65 percent (the lowest of all groups) of Chinese Americans had a regular doctor. Consistent with these findings is the report of the White House Conference on Aging (1972) of a study which showed that 34 percent of the Asian and Pacific American aged who were interviewed had never had a medical or dental examination.

It is therefore clear that there is a serious need for programs of prevention and early detection of illness among Asian and Pacific Americans, particularly among the elderly and new AAPA immigrants. Part of the problem is their lack of familiarity with the health care system. The safety, shared experiences, and common language within an ethnic community tend to inhibit the elderly Asian and the new AAPA immigrant from going beyond their immediate communities for services which are available.

These groups are socially and culturally isolated from the dominant society and this isolation keeps them from becoming knowledgeable about services provided outside of their ethnic community. Thus, the provision of culturally relevant services, with bilingual/bicultural staff, located in their own communities becomes a paramount need.

Limitations in awareness and identification of specific mental health problems may also be an impediment to prevention and early treatment of mental illness. Okano's (1976) study of 235 Japanese Americans in Los Angeles reported that Japanese Americans tended to reject the personal relevance of mental health concepts and to define mental disorder narrowly in terms of extreme deviance. Other studies point to the likelihood that the extent of mental health needs and rates of psychopathology among Asian and Pacific Americans is greater than was previously assumed (Berk & Hirata 1973). Thus, the general impression emerges that Asian and Pacific Americans are characterized by low utilization of mental health facilities but a greater severity of morbidity among those diagnosed.

Barriers to Service Utilization

The problem of underutilization of services by Asian and Pacific American populations has been amply documented. Among the factors that have been identified as constituting significant barriers to the use of services by Asian and Pacific Americans have been the following: (1) cultural and linguistic constraints, (2) lack of bilingual/bicultural personnel, (3) tokenism in employment of bilingual/bicultural personnel, (4) maldistribution of service providers, (5) obstacles to credentialing/licensing of personnel among Asian and Pacific immigrants, (6) catchment area confinement, and (7) insufficiency of services due to inadequate funding by local, State, and Federal agencies.

A. Cultural and Linguistic Constraints

The low service utilization rates of the Asian and Pacific American population may be attributed to certain cultural values and practices which are characteristic of many AAPA groups. Superimposed upon these values has been their history of encounters with racial discrimination in this country. Together they may help account for not only the comparative restraint and silence of AAPA's, but also their reluctance, even in the face of dire need, to turn to providers of service for assistance.

Among the most compelling of the cultural values common to most AAPA peoples is the notion that one's capability to control expression of personal problems or troubled feelings is a measure of maturity. Such control of self-expression, in turn, is related to concepts of shame and pride, which are also paramount values that govern the behavior of AAPA's (Ho 1976). Thus, the AAPA client may perceive services, such as counseling, as shame-inducing processes and will undergo extreme stress when asking for or accepting help from anyone outside the family. In the case of the Japanese, who are bound up in an elaborate social system based on giri (reciprocal obligation), they are reluctant to take the initiative

and find it difficult to make up their minds on any questions where the decision has not been predetermined by rule or precedent or by a superior (Kitano 1969). Other operative values which influence interpersonal relationships are haji (shame, disgrace, dishonor), enryo (hesitancy, restraint, lack of assertiveness, desire not to be of trouble), and gaman (patience, endurance, self-control, forbearance).

The concept of shame is also prominent in Filipino culture, expressed as hiya. The Chinese refer to a similar sentiment as mentz (face saving) and the Korean equivalent is chaemyun. In most AAPA groups, if a personal problem or issue is not resolved within the confines of the family and requires outside intervention, the family is viewed as losing face. While interpretations may differ quantitatively among AAPA groups, they all result in making individuals reluctant to seek professional.help. This phenomenon is well illustrated by the difficulty reported by social agencies in locating handicapped AAPA's, such as the developmentally disabled, whose families have kept the afflicted member of the family at home and cared for unobtrusively. Frequently people in the AAPA community are reluctant to assist in locating handicapped persons within their areas. It is as if the community also feels a responsibility in helping to maintain the dignity of the particular family and in wanting to keep the problem within the confines of that family. The Subpanel recommends:

10. To ensure maximum utilization of mental health services by Asian and Pacific American populations, provision be made for:

    (a) culturally relevant modalities of mental health care, including traditional or folk medicine;

    (b) staffing by bilingual/bicultural personnel;

    (c) contracting to Asian community-based organizations for delivery of services, wherever such services exist;

    (d) integration of existing mental health services with other community services, such as youth services, family services, services to children, services to the aged, services for developmentally disabled; and

    (e) liaison between Asian and Pacific American community organizations and mental health service providing agencies.

B. Lack of Bilingual/Bicultural Personnel

Subparagraph D of section 206(c) (1) of Public Law 94-63 requires assurances from a community mental health center with a "substantial proportion of individuals of limited English speaking ability that it has (i) developed a plan and made arrangements responsive to the needs of

such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is fluent in both that language and English." The failure of community mental health facilities to comply with such existing legislation results in limiting full access to and availability of their services to Asian and Pacific American communities. This lack of compliance also results in denial of employment opportunities to qualified bilingual/bicultural persons in Asian and Pacific American communities (Nguyen 1977). The Subpanel recommends:

> 11. That mechanisms be developed at the Federal level to secure strict enforcement of, and compliance with existing legislation pertaining to all mental health facilities; and further, that there be participation by Asian and Pacific Americans in the implementation of such enforcement and compliance procedures.

C. Tokenism in Employment of Bilingual/Bicultural Personnel

Related to the problem of the lack of bilingual/bicultural personnel is the problem of tokenism when such personnel are actually employed by mental health facilities. In practice this means the employment of a minimum number of such personnel who are then widely dispersed throughout the system. Experience has shown that when Asian and Pacific American personnel are employed and deployed as teams or units, rather than singly, their visibility and effectiveness as service providers, as well as their utilization, are greatly enhanced.

For example, Sue and McKinney (1975) report that in Seattle, the number of AAPA's utilizing an Asian American counseling and referral service in 1 year was approximately equal to the total number of AAPA's utilizing a total of 18 other community mental health centers over a 3-year period. True reports that an AAPA community-based mental health program in Oakland saw 131 Chinese Americans in its first year of operation, in contrast to 3 Chinese out of a total of 500 utilizing a central outpatient facility (True 1975). Wong (1977) reports that after the establishment of a mental health center specifically designed to serve Asian and Pacific American patients, in the first 3 months of operation, more AAPA's were seen than in the previous 5 years in that catchment area in San Francisco. In Los Angeles, after a particular mental health center was designated as an Asian American mental health facility with services designed specifically to respond to Asian American needs, the number of Asian and Pacific Americans serviced increased from 36 in 1971 to 118 in 1973 (Hatanaka 1975). The Subpanel recommends:

> 12. That wherever possible, sufficient numbers of Asian and Pacific American personnel be employed to permit their assignment to teams or units, in order to maximize their visibility and impact upon service delivery to Asian and Pacific American communities. In areas with high concentrations of Asian and

Pacific Americans, facilities should be designated as providing specialized services to Asian and Pacific Americans, with appropriate bilingual/bicultural staffing.

D. Maldistribution of Asian and Pacific American Service Providers

There are at present substantial numbers of Asian and Pacific American mental health clinicians (especially psychiatrists) who are practicing in States with relatively few Asian and Pacific American people. These clinicians are unable to practice in States with large Asian and Pacific American populations because of training and licensure barriers and difficulties; e.g., California has approximately 50 percent of the Asian and Pacific Americans in the United States but only 5 percent of the Asian and Pacific American psychiatrists (Sata 1977). The Subpanel recommends:

13. That training and licensure requirements be reexamined and modified to take into account shortage of bilingual and bicultural licensed personnel to serve Asian and Pacific American communities in order to provide for the quality mental health care of Asian and Pacific American populations.

E. Lack of Credentialed/Licensed Mental Health Personnel

Among New Asian and Pacific American communities, certain Asian and Pacific American populations, such as the Indo-Chinese refugee community, the Samoans, and the Guamanians, are recent immigrants. They have not had the opportunity in this country to acquire the necessary training to obtain the credentials or licensing required for employment in the mental health field (Nguyen 1977). Some have had professional training in their native country but are not able to qualify for licensure in this country without additional training (Sue & Chin 1976). It is recommended:

14. That because of the acute shortage of credentialed/licensed mental health personnel among new Asian and Pacific American immigrant populations, such as Koreans, Samoans, and Vietnamese, and to secure maximum utilization of available bilingual/bicultural capabilities: (1) indigenous paraprofessionals from such communities be accepted for employment in the mental health field and (2) for those persons who have had training in their home country, provision be made for training with built-in career ladders to assure future career development.

F. Catchment Area Confinement

Asian and Pacific American populations are not entirely concentrated in inner-city areas. Many reside in scattered locations which may cover

several service catchment areas. In many instances, bilingual/bicultural service providers are unavailable in their own catchment area. To secure services from bilingual/bicultural providers, Asian and Pacific Americans have to travel to another catchment area, frequently involving considerable time and inconvenience. In effect, because their service needs can only be met by bilingual/bicultural providers, many Asian and Pacific American patients are denied access to treatment and services. The Subpanel recommends:

> 15. That administrative, program, and fiscal arrangements be made to allow Asian and Pacific American residents to be served across catchment boundaries when appropriate services do not exist in their catchment areas. In catchment areas with small Asian and Pacific American populations, two or more catchment areas should pool resources whenever feasible. This pooling will help avoid the duplication of existing services, which in themselves are often inadequate but could be more comprehensive if combined with services of other catchments.

G. Insufficiency of Services Due to Inadequate Funding by Local, State, and Federal Agencies

Although many Asian and Pacific American communities have established medical, social, and mental health services during the past decade, these services are under constant threat of being curtailed, or even terminated, due to instability of the funding base or lack of firm commitment by the funding sources (Wang 1977). In some communities there have been serious obstacles to the funding and development of mental health programs for Asian and Pacific American communities presented by racist local politicians and organized citizen groups who are opposed to any programs for ethnic minorities. It is therefore recommended:

> 16. That provision be made for direct Federal funding to Asian and Pacific American community groups or organizations to develop models of service delivery to their own communities, such as community-based multipurpose service delivery centers and satellite outreach centers. Provision for such direct Federal funding may be established through the creation of a Division for Minority Mental Health at NIMH, such as proposed in a bill authored by Senator Daniel Inouye (S. 2373).

H. Third-Party Reimbursements

Asian and Pacific Americans have been excluded from reimbursement for services which are culturally traditional forms of care (e.g., acupuncture, herbs, massages, meditation, holistic healing medicine, family maintenance

in the care of the sick, aged, and handicapped). Oftentimes such forms of care are preferred and very effective for Asian and Pacific Americans. The Subpanel recommends:

17. That the mechanisms for reimbursement for health and mental health services (e.g., national health insurance and Medicare) include culturally traditional forms of assistance (i.e., acupuncture, herbs, etc.). We further recommend that the legislative requirements necessary for such third-party reimbursements be studied so that these culturally traditional forms of care will be reimbursable.

Facilitation of Service Utilization

Not only do we need the measures proposed above to deal directly with the problem of barriers to service utilization, but also there need to be steps taken to facilitate and promote the utilization of services. Among them are: (1) participation of Asian and Pacific Americans in the decision-making process, (2) educational programs for non-Asian mental health service providers, (3) consultation and educational programs for Asian and Pacific American nonmental health service providers, and (4) establishment and expansion of bilingual/bicultural preventive programs.

A. Participation of Asian and Pacific Americans in the Decision-making Process

Mental health programs which deal with Asian and Pacific Americans often do not include Asian and Pacific Americans in the planning of services at the beginning stages or in the governance of mental health facilities. Under such circumstances it is not surprising that the needs and concerns of Asian and Pacific American populations may be overlooked or dismissed. The Subpanel recommends:

18. That Asian and Pacific Americans (consumers and providers) must be included at all levels of the decisionmaking process in programs which serve Asian and Pacific American clients. This means participation by Asian and Pacific Americans in: (1) the governing structure, (2) the stages of program development from planning to implementation, and (3) the program's ongoing operations. In addition, Asian and Pacific American line staff, along with consumer and community people, must be involved in planning services for Asian and Pacific American clientele within the specific community served.

B. Educational Programs for Non-Asian and Pacific American Service Providers

Numerous studies have shown that non-Asian and Pacific American service providers are unable to respond effectively to the needs of Asian and Pacific American clients, due to their lack of knowledge of the cultural and historical factors affecting these clients (Murase 1977). The reported low utilization and high dropout rates among Asian and Pacific American clients point to a conspicuous failure in engagement of such clients by non-Asian service providers. To the extent that such failure can be corrected by knowledge, educational programs must be provided. It is recommended:

19. That educational programs for non-Asian and Pacific American mental health service providers be required in all areas that serve Asian and Pacific American clientele in order to increase knowledge and sensitivity to those clients. These programs must be administered by Asian and Pacific American personnel. There must be sufficient funding for such programs.

C. Educational Programs for Asian and Pacific American Non-Mental Health Service Providers

In many Asian and Pacific American communities there exists an indigenous formal and informal community care and support system, comprised of local churches, family associations, hometown clubs and district associations, fraternal orders, credit associations, and social clubs (Murase 1977). Fundtioning as informal community caretakers are ministers, doctors, lawyers, teachers, elders, merchants, barbers, bartenders, etc. Because of stigma as well as unfamiliarity with concepts of mental health, many Asian and Pacific Americans turn to their local community support system or community caretaker for help with problems which might otherwise be taken to a mental health center.

The effectiveness of the local community support system or community caretakers could be enhanced through a program of consultation and education in mental health. It is recommended:

20. That consultation and educational programs for Asian and Pacific American nonmental health service providers be sponsored by community mental health agencies in communities with Asian and Pacific American populations. Such programs should be administered by Asian and Pacific American personnel and there must be sufficient funding for such special programs.

Personnel and Training

Traditional training programs in the mental health disciplines of psychiatry, psychology, social work, and psychiatric nursing have not

significantly increased the number of Asian and Pacific American graduates nor adequately equipped them to serve the mental health needs of Asian and Pacific American populations. The vast majority of the traditional training programs have been lacking in the necessary expertise, interest, and qualified AAPA staff. They have tended to provide little opportunity for contact with Asian and Pacific American clients and communities. This situation indirectly discourages Asian and Pacific American trainees interested in working with Asian and Pacific American populations and denies these students the necessary training during a critical phase in their professional careers.

The catchment area concept is not applicable to most Asian and Pacific American communities, which usually constitute much less than a majority of catchment area populations and thus can be easily ignored in the planning of community mental health centers organized around the catchment area principle. Within a larger geographic or demographic area, such as a county or metropolitan area that encompasses many catchment areas, the number of Asian and Pacific Americans often becomes significant. It therefore is far more efficient and logical, from an organizational framework, to pool minority staff and expertise to establish a regional Asian and Pacific American Multidisciplinary Mental Health Training Center and service program than to attempt to reduplicate efforts within several community mental health centers which have limited resources. The typical community mental health center employs few bicultural and bilingual staff, which tends to discourage Asian and Pacific Americans from seeking mental health services. Regional training/service centers are desirable because they would maximize the number of faculty, trainees, and Asian and Pacific American clients within a geographical area to efficiently operate a high caliber training program. Training centers, such as the San Francisco Bay Area Asian American Community Mental Health Training Center, the Korean Community Service Center in San Francisco, and the Asian American-Mental Health Training Center in Los Angeles have demonstrated that increases in the bicultural, bilingual staff correlate with significant increases in Asian and Pacific American client loads. Where there is adequate minority staffing, e.g., at a regional training/service center, one finds a greater utilization of mental health services by Asian and Pacific Americans. Conversely, it is necessary to have utilization by the Asian and Pacific American community of mental health services in order to provide training and research opportunities for Asian and Pacific American mental health professionals.

To maximize training and research opportunities and fiscal resources, regional training/service centers should be located in geographic areas with large Asian and Pacific American populations. The centers should have as one of their major objectives the training of Asian and Pacific American mental health faculty who will be able to leave the area and to form a cadre of faculty to provide training and mental health services for Asian and Pacific Americans in areas throughout the country. Also programs could bring students to these centers from around the country for continuing education seminars.

These regional training/service centers should have operational affiliations with university or medical school institutions to maintain

the highest educational and training standards. Individuals from such programs should be academically qualified within their disciplines and not necessarily be restricted to their areas of special interest. In order to maintain the integrity of the goals and objectives in terms of the Asian and Pacific American populations they serve, the centers should have significant representation from the AAPA communities in the governing board of directors.

Finally, a regional Asian and Pacific American Multidisciplinary Mental Health Training/Service Center would be a natural focal point for the training and utilization of paraprofessionals. Their contributions to mental health service delivery are most valuable. The Subpanel recommends:

> 21. That regional Asian and Pacific American Multidisciplinary Mental Health Training Centers be developed which also render comprehensive mental health services to AAPA target populations. The training within the center must include continuing education, bilingual/bicultural training, fieldwork experience, specific training seminars, curriculum development, recruitment, research, and evaluation. Such training centers, whenever feasible, should be independent of existing institutions. The centers should have a board of directors representative of the AAPA communities. However, this does not preclude establishing mutually beneficial, operational affiliations with academic institutions.

Input and feedback from the community augments the training-center's sensitivity to the community needs and maximizes effective impact. Historically, medical training centers and hospitals have tended to ignore the needs of the local community in favor of the educational objectives of the institution.

> The mental health professionals are not to be regarded as guardians of mental health, but as agents of the community--among others--in developing and conserving its human resources and in restoring to more effective functioning people whose performance has been impaired. Professional people are valuable allies in the community's quest for the health and well-being of its members, but the responsibility of setting goals and major policies cannot be wisely delegated (Smith, M. B. and Hobbs, N. 1966).

The Subpanel recommends:

> 22. That the development, planning, and implementation of the Asian and Pacific American Multidisciplinary Mental Health Training Centers concept involve and actively seek input from the AAPA communities they are to serve.

Universities need to be supplemented by other types of training programs. Due to the bilingual/bicultural complexities in training Asian and Pacific American service personnel, these innovative options must be made available. Funding must include appropriate support for citizen and self-help groups to train and educate their own members, the service providers, and the general public in a given community.

Flexible schedules (e.g., classes at night, weekends, and "intensive semesters") for training programs are needed to permit those who cannot attend training programs on a full-time basis and/or need to continue working to obtain further training. These flexible schedules would promote the "career ladder" concept.

Until recently, few Asian and Pacific American mental health paraprofessionals and professionals have been in service settings and in leadership roles. The scarcity of successful role models with which to identify has tended to discourage Asian and Pacific American trainees from pursuing careers in the mental health field. It is, therefore, urged that qualified Asian and Pacific American paraprofessionals and professionals be identified and considered for appointment to national, State, and local committees within their professional organizations in order to enhance the number of candidates entering training.

A long-range AAPA recruitment program should be instituted beginning at the public school level. But the use of affirmative action must be encouraged because emphasis on long-term recruitment alone will result in inadequate mental health services for Asian and Pacific Americans for many years to come. For example, although there are approximately 1,100 identified Asian psychiatrists in this country, only 100 are U.S. medical school graduates. Further, only a relatively small number of these 100 U.S.-trained psychiatrists treat Asian and Pacific American patients. Recruitment should be aimed at recruiting and supporting well-qualified, high-caliber Asian and Pacific American individuals to enter the mental health field as paraprofessionals and professionals. The objective is that these persons will effectively provide high quality services to their AAPA communities.

The establishment of regional Asian and Pacific American Multidisciplinary Mental Health Training Centers would be one means of recruiting individuals to pursue careers in mental health as paraprofessionals and professionals. This is because the program of these centers would be highly relevant to potential students, their families, and their AAPA community needs.

There needs to be increased emphasis on relevant mental health consultation and education with Asian and Pacific American communities. This stress on prevention should be used to help undo many of the cultural taboos and stigma associated with mental illness. Cultural norms continue to greatly influence Asian and Pacific Americans against the choice of a career in the mental health field. The Subpanel recommends:

23. Development of State and national recruitment mechanisms to identify, inform, and select potential mental

health service caregivers for Asian and Pacific Americans in all mental-health-related fields, because existing recruiting mechanisms are totally inadequate.

24. Training programs for Asian and Pacific Americans that include support for programs which are community-based. That is, in addition to university-based training, programs supporting community agencies and self-help groups must be created. Training programs, regardless of their sponsors, must include schedules which offer the option of participation on a part-time and/or flexible schedule basis.

Federal, State, and local training funds for all the mental health disciplines have steadily declined and may cease. It is estimated that the vast majority of Americans are still underserved by the mental health professions. This is particularly true for Asian and Pacific American groups. Traditional training programs have not effectively met the personnel and training needs of Asian and Pacific American individuals, despite data supporting the need for such training and services.

AAPA clients generally do not have recourse to third-party payers for financial resources, unlike other Americans who are able to use traditional mental health facilities staffed by personnel trained with public monies. AAPA persons must go to great lengths to find mental health services capable of responding to their unique treatment needs. The Subpanel recommends:

25. That training funds specially designated for the development of AAPA mental health paraprofessionals and professionals to serve Asian and Pacific Americans be increased. Such funds should provide for training in all mental health disciplines. These funds should include support for freestanding training centers, faculty costs, stipends, and continuing education.

A study of federally funded projects on curriculum and manpower training of minorities in mental health disciplines indicated scarcity and inadequacy of minority content in curriculum materials.

There is a massive body of literature which positively confirms that culture does make a difference in mental health. Culture is an important factor not only for service delivery but also in understanding the etiology, incidence, and symptomatology of mental illness.

Israel Zangwill, the author of the famous play, "The Melting Pot," after giving more and more of his energy to his cause, retreated from his earlier position of racial and religion mixture. Eight years after the opening of "The Melting Pot," he wrote that

> It was vain for Paul to declare that there should be neither Jew or Greek. Nature will return even if driven out with a

pitchfork, still more if driven out with a dogma (as noted by Glazer and Moynihan 1970).

The Subpanel recommends:

26. That Asian and Pacific American focused curriculum and teaching materials be developed and implemented in all mental health disciplines.

The present Federal, State, and local mental health service systems do not have a sufficient number of Asian and Pacific Americans on staff who are bilingual and bicultural to effectively deal with the current diversity and size of the Asian and Pacific American popultion with developmental needs. The statistics are well documented in California, where a large population of Asian and Pacific Americans reside. The Subpanel recommends:

27. That agencies hire bilingual/bicultural Asian and Pacific American developmental and physical disabilities staff at the administrative, management, planning, and supervisory levels.

28. That agencies hire bilingual/bicultural Asian and Pacific American developmental and physical disabilities case managers in numbers at least proportional to the number of Asian and Pacific Americans in the general population.

29. That recruitment mechanisms be developed to identify and select potential Asian and Pacific American staff to work with Asian and Pacific Americans with developmental needs to increase the number of appropriate staff resources.

30. That training funds be specifically designated to deal with the special needs of the Asian and Pacific American with developmental needs to train more bilingual/bicultural AAPA staff, and to support the growth of consumer and self-help groups.

While it is important that adequate screening of foreign medical graduates be continued, the newly formulated prerequisites (i.e., P.L. 94-484) are regarded as unduly stringent and carry racist implications. Restrictions such as the "2-year rule" create an impediment to sustained learning and prevent individuals entering psychiatric residency training from completing their programs. Such a rule is irrational for trainees in psychiatry. It is a fact that large numbers of American citizens who are poor, from minority groups, and those who are socially disadvantaged receive psychiatric care from foreign medical graduates. Any restriction at this time on this source of professional personnel will lead to the abandonment of people in need of care unless they can be served by qualified U.S. medical graduates.

Often, foreign medical graduates have had limited access to high quality training institutions and academic centers. The training of FMG's has sometimes been deficient because of poor facilities, a lack of varied clinical experiences, inadequate supervision, and excessive service expectations. FMG's are not usually trained to work with private psychiatric patients in an office setting. Further, FMG's are generally not equipped to understand the problems of Asian and Pacific Americans (who have an advantage in being more acculturated to American society in contrast to foreign medical graduates). Thus, it is not surprising that many FMG's experience professional identity crises and disillusionment with American psychiatric training.

In order to prevent undue discrimination against foreign medical graduates and to promote the interest of the United States (and relations with countries from which foreign medical graduates emigrate), there should be increased liaison with foreign medical schools and institutions for graduate education in psychiatry. The image of the foreign medical graduate must be improved by more careful selection, preparation prior to entry into the United States, and equal opportunities in quality educational programs. There should be bilateral training agreements with psychiatric training institutions in other countries to make this a truly academic endeavor (Garetz and Garetz 1973). The Seven Center Study and survey compiled by Dr. Ronald Chen (1976) reveals the foreign medical graduates in psychiatry can be as effective and well regarded as their American counterparts. Weaknesses in practitioners cannot simply be reduced to equating inadequacies with being a foreign medical graduate.

It should be recognized that the needs of foreign medical graduates who plan to return to their home country to teach or practice differ from those who are immigrants intending to remain in the United States to practice American psychiatry. As such, training programs must be responsive to their individual needs. The Subpanel recommends:

> 31. That Asian and Pacific foreign medical graduates (FMG's) who are already in this country be provided with orientation programs including language, multicultural sensitivity, and preparation for licensing and specialty training.

Underserved Groups within Asian/Pacific American Communities

A. Trust Territories of the Pacific

U.S. citizens and subjects of the Pacific Islands of Guam, American Samoa, the Commonwealth of Northern Marianas, and the Trust Territories of the Pacific are extremely isolated from the decisionmaking process of the United States. As a result, their mental health needs, as well as other needs, are seriously neglected (Munoz 1976).

There has been a serious neglect on the part of the United States in paying attention to the effects of rapid social changes and colonialism on the lives and conditions among the people of the Territories. The

Islands, which were primarily a traditional, subsistence economy, have in the last 30 years undergone rapid social-economic changes as a result of increased occupation of the Islands by the military. This has eroded much of the traditional cultures and lifestyles, resulting in many problems of acculturation, culture conflict, and the ensuing problems of mental health. There are no mental health services which adequately provide for the needs of the Islanders which recognize the cultural and linguistic aspects of their mental health service needs. There have been no research data which examine the mental health or related problems of the Islands, i.e., suicide, homicide, and divorce, which are very high on the Islands. The Subpanel recommends:

32. (a) That a special task force of key mental health leaders, especially those knowledgeable of developing countries, and Island leaders in the field of mental health be established to examine the mental health needs and problems of the Islanders and to propose programs which will assist the Islands in solving and dealing with their mental health needs.

(b) That funds be appropriated to study the impact of change, racism, and colonialism on the mental health conditions of the Islanders.

(c) That funds be provided to develop mental health programs for training and service delivery which are relevant to the Islanders' needs and resources.

B. Mental Health Problems of Asian and Pacific American Wives of U.S. Servicemen

There are approximately 200,000 Pacific and Asian American wives (born in Japan, Korea, Philippines, Thailand, and Vietnam) of U.S. servicemen who may in acute distress due to geographical isolation and psychological alienation from their families and their own ethnic communities. Further, frequent reports of suicide and physical and psychological abuse suffered by these women point to the likelihood of many undetected or unreported instances of distress or abuse. Unfortunately, their plight is hidden from the larger society, as well as their own communities, because of their marginal status and geographical isolation. In addition, language and cultural barriers act as a strong deterrent for these women in seeking and receiving assistance from professional sources and from their own Asian and Pacific American communities (Kim 1972 & 1975).

To respond to the mental health needs of Asian and Pacific American wives of U.S. servicemen, the following recommendations are made:

33. That a nationwide crisis line service be established and maintained in the several languages of the Asian

and Pacific American wives. (Collaborative arrangements could be made with existing hotlines for abused wives and rape victims.)

34. That orientation materials be developed and disseminated to Asian and Pacific American military wives, their spouses, and service providers. Such materials should include a general introduction on "how to survive" in American society, as well as a directory of community resources and how to use educational, health, social service, and legal aid services in their communities.

35. That the U.S. Department of Defense be urged to develop and provide orientation programs for Asian and Pacific American wives and their husbands prior to their arrival in the United States. Such programs should include language training (English for wives and wives' language for husbands) and cultural, health care, education, housing, social services, consumer practices, and legal services information, etc. Remedial and preventive services should be available through military installations for these Asian women as spouses of U.S. servicemen.

C. Asian and Pacific Americans With Developmental Disabilities

The current Federal, State, and local administrations are not serving an adequate number of Asian and Pacific Americans with developmental needs. The underutilization of regional services for the developmentally disabled by the Asian and Pacific Americans is documented. The factors that are significant constraints in the use of these regional rehabilitation services are: racist local politicians, language barriers, physical difficulties due to the individual's disabilities, cultural issue of shame, and community stigma (California Department of Rehabilitation 1977; Chan 1977). The Subpanel recommends:

36. That the Carter administration, in compliance with the Civil Rights Act, take whatever administrative actions are necessary to resolve the discrepancy between the percentage of Asian and Pacific Americans in program caseloads and their percentage in the general population.

37. That a federally funded outreach program be established to serve communities with a substantial concentration of Asian and Pacific Americans with developmental needs. This program may be facilitated through the development of a multipurpose service delivery center. Such provisions can be implemented through the creation of the Division for Minority Group Mental Health Service Programs at NIMH, as per Senator Inouye's bill.

38. Further, that the outreach program have the following components:

    (a) Bilingual/bicultural counselors and professional staff

    (b) Location of such facility in the Asian and Pacific American community

    (c) Asian and Pacific American counselors to provide consultation and training in cultural awareness to non-Asian and Pacific American staff

    (d) Assignment of Asian and Pacific American bilingual/bicultural counselors and professionals to their respective ethnic group to provide liaison between Federal, State, community, and consumer groups.

39. That current administrative standards for production of mental health plans and the assessment of rehabilitation be modified so that they support rather than discourage effective outreach efforts to the Asian and Pacific American community.

40. That the current administration encourage and support innovative service delivery approaches to Asian and Pacific Americans with developmental needs (example: Asian Rehabilitation Services in Los Angeles and "Hand-in-Hand" family group of Chicago).

III. ISSUE: RESEARCH ON MENTAL HEALTH OF ASIAN/PACIFIC AMERICANS

There exists a great need for research on the mental health difficulties, service needs, and service usage patterns among Asian and Pacific American (AAPA) communities. Research needs range from explanatory analysis and theory development to systematic examination of alternative interventive models and community needs assessment. The absence of adequate research data concerning Asian and Pacific Americans has been a major barrier to "capacity building," creation of new services and training programs. These concerns are addressed in the following recommendations.

The recommendations are divided into two categories: (1) recommendations regarding content and methodological issues; and (2) recommendations regarding facilitative mechanisms deemed necessary for equitable funding and efficient dissemination of information and communication among community persons, researchers, and practitioners.

As a context for the following recommendations it must be recognized that mental health research has been of limited value to AAPA communities. In the few instances where research was targeted at AAPA communities, such efforts have usually lacked community legitimation and sanction. We believe that there must develop effective collaboration between community persons,

researchers, and practitioners in order for mental health research to be of greater value to AAPA's. As an overall policy recommendation, community-based organizations and individuals representing the AAPA community being researched must be involved in all phases of the development and conduct of the research. Throughout the research process, continuous community sanction and legitimation must be maintained.

There has been little systematic investigation of the role of racism, both individual and institutional, on various AAPA communities and individuals. Racism exerts a pervasive influence on all aspects of the individual and community functioning of AAPA's. For example, racism influences educational opportunities, occupational choices, therapist-client interaction, and mental health delivery systems. The nature and the extent of these influences must be systematically examined. The Subpanel recommends:

41. That there be substantial investigation of ongoing racism and its effects on AAPA communities and individuals.

Most of the research which has been done to date either fails to consider the unique contributions of culturally inculcated values and norms or emphasizes only those ethno-social pathology models in which behavioral patterns that vary from the norms of the majority society are viewed as deficient.

It is appalling that we lack basic and detailed sociodemographic information on AAPA groups and that these groups continue to be ignored or inappropriately lumped together. The Subpanel recommends research to be focused on:

42. Studying and identifying normative patterns of functioning among and within AAPA communities.

43. Identifying and remedying information gaps, especially those pertaining to such baseline data as census information, current population status, service utilization patterns, and service needs.

The inadequacy of the currently available data on underserved groups in Asian/Pacific American communities has been pointed out by community leaders and researchers. The Subpanel recommends:

44. That information gaps pertinent to special population groups within the Asian and Pacific American communities be identified and remedied. Groups that require special attention include: women, children, refugee groups, rural and urban populations, Pacific Island communities, the developmentally disabled population, and the Asian wives of U.S. servicemen.

Better understanding of factors associated with the underutilization of existing services, the use of alternative services, and the role of

factors such as bilingual and bicultural service provision, accessibility, and community acceptability is necessary for the further development of responsive services. Past and present assessment practices have been inappropriate. The Subpanel recommends:

45. Research efforts to identify gaps in services available to AAPA communities and individuals.

46. Development of culturally appropriate and relevant psychological assessment and tools.

Current research has tended to neglect longitudinal research strategies. Furthermore, inappropriate generalizations have been made from research on highly limited and biased samples. There has been inadequate research conducted with community relevance, sanction, and applied values. In addition, there is little reliable information currently available regarding diverse AAPA family types and networks. In order to build a reliable data base the Subpanel recommends:

47. More varied research strategies.

48. Greater attention paid to the functioning family and the identification of various family configurations among AAPA groups.

49. Development, implementation, and evaluation of preventive programs. Such programs may include prevention work with AAPA families.

50. In addition to treatment, identification and assessment of the role of informal cultural supportive networks as possible preventive and therapeutic resources.

51. That research monies never compete with the meager level of funding available for service delivery.

In order for Asian and Pacific Americans to realize maximum benefits from research efforts the Subpanel recommends:

52. That policymakers for service delivery and research programs, as well as grant reviewers, include Asian and Pacific American persons who are sensitive to the special needs of the AAPA communities. Furthermore, the conduct of research and the dissemination of findings must be made by such persons.

53. That in view of past inequities experienced by Asian and Pacific Americans, special earmarked funds for AAPA research at all levels of government be provided and maintained. In order to ensure sufficient allocations for each, it is necessary to continually monitor the distribution of funds for research.

54. Support for the bill entitled "Minority Group Mental Health Program Act of 1977," by Senator Daniel Inouye (S. 2373), which proposes the establishment of a division in NIMH with earmarked funds for minority research.

55. That regular conferences and workshops regarding all aspects of Asian and Pacific American research be established and maintained.

56. That an effective national clearinghouse for mental health research information regarding Asian and Pacific American communities be established and maintained.

57. That journals and other publications on Asian and Pacific American mental health, focusing on research, training, and service delivery be established and maintained.

58. That adequately funded research training programs be developed to create research capabilities within the AAPA communities. Priority for research training should be given to researchers who are uniquely qualified but who may not have the traditional academic credentials.

A basic research issue is the lack of data to conduct adequate needs assessments and program planning and evaluations. Asian and Pacific Americans with developmental needs often have mental health needs as well. The demographic data, available through the U.S. Bureau of the Census, used to document the need for services among the disabled population undercounts the Asian and Pacific Americans. The decennial census also fails to specifically identify the major Asian and Pacific American subgroups, i.e., Chinese, Japanese, Korean, Pacific Islanders, Filipinos, and Southeast Asians (Vietnamese, Cambodians, Laotians, and Thais). The Subpanel recommends:

59. That the Carter administration and Congress recognize the shortcomings of the present census process and take steps to update current statistical data on Asian and Pacific Americans with developmental needs.

60. That exploratory research be conducted in the areas of:

    (a) Geographic location of Asian and Pacific Americans with developmental needs

    (b) Incidence and prevalence data concerning Asian and Pacific Americans with developmental needs

(c) Types of developmental needs and disabilities affecting the Asian and Pacific American population

(d) Types of physical problems of Asian and Pacific Americans with developmental needs

(e) Types of mental health needs of the Asian and Pacific Americans with developmental needs.

61. That adequate demographic data be made available to service delivery agencies and the general public in the following areas:

(a) Ethnic breakdown of individuals with developmental needs

(b) Age and sex of Asian and Pacific Americans with developmental needs

(c) Major disabilities among the Asian and Pacific Americans with developmental needs

(d) Statewide and countywide directories of bilingual/bicultural Asian and Pacific American agency services focused on individuals with developmental needs.

(e) Statewide and countywide directories of bilingual/bicultural Asian and Pacific American professionals and paraprofessionals who service the developmentally disabled population.

62. That negative labeling of Asian and Pacific Americans be eliminated. Terms that are derogatory to one specific ethnic minority group should not be used. For example, it is recommended that the current use of the word "mongoloidism" be changed to "Down's Syndrome."

IV. ISSUE: STRATEGIES FOR THE PREVENTION OF MENTAL DISORDERS

Western modalities of treatment are often insensitive to the problems and needs of the Asian and Pacific Americans. Prevention has been neglected. Furthermore, insensitive policies and services are producing mental stress rather than improving the mental health status of Asian and Pacific Americans.

Asian and Pacific Americans generally have strong attitudes of shame, fear, guilt, ridicule, and rejection toward the mentally and emotionally disturbed member(s) of the family. AAPA families have the tendency to hide and to deny the existence of mentally and emotionally disturbed

persons. This is because of the real threat of the loss of family status, the choices of vocations, as well as marriage partners for the other family members. Too often, AAPA's tend to keep the mental health problems an intrafamilial affair by retaining the disturbed patients at home, delaying usage of mental health services until an unbearably chaotic situation arises. This is often due to the strong stigma surrounding "mental" health and "mental" illness. By the time they seek outside help at mental health facilities, family resources are depleted and the family unit is exhausted. Often, intramarital and intrafamilial strife have become overwhelming. As a result, an appeal for help from outside of the family often signifies a rejection of the sick member by the family and community. AAPA patients tend to stay longer at the mental institutions as inpatients, and the rate of institutionalization, chronicity, and readmissions among AAPA patients has been relatively high. This pattern has been clearly observed in the data from Hawaii.

Efforts to prevent problems before they occur or before they become too big are necessary ingredients of a systematic approach to promoting mental health among AAPA's. AAPA's are becoming aware of the need for greater understanding of mental and emotional problems and the value and efficacy of various modern methods of treatment. AAPA's are also increasing their understanding of the stigma and fear about mental illness deeply ingrained in AAPA communities.

There is a need for community education through mass media (radio, TV, newspapers and lay magazines, etc.) in Asian and Pacific Americans' native languages. Those who are elderly and recent immigrants need services by bilingual and bicultural professionals and paraprofessionals. Bilingual/bicultural services will help change Asian and Pacific Americans' preconceived and stigmatized image of the therapist. Also, community education is important in helping the total community with mental and emotional problems by using mental health services. The Subpanel recommends:

63. That prevention services in health and mental health programs be provided adequate resources. It is further recommended that prevention services be an integral component of any health or mental health planning, services, and research. An important aspect of prevention services is community education.

Experience has shown that Asian and Pacific Americans tend to be brought to the attention of mental health services only at the point of acute breakdown or crisis (Berk & Hirata 1973). Fear of community stigma and dread of shame and dishonor lead families to conceal the existence of mental health problems or to avoid recognition of incipient signs of mental disturbance. Furthermore, Asian and Pacific Americans face, from birth to death, the reality of having to cope with a hostile environment which is not supportive of a bicultural lifestyle. Asian and Pacific Americans have evolved positive indigenous support systems which have not been sufficiently recognized; these systems should be encouraged and maintained. The Subpanel recommends:

64. That there be establishment and expansion of preventive programs of consultation and education

which would impart bilingual/bicultural mental health and developmental disability information to Asian and Pacific American families and individuals, as well as community organizations and service providers, to: (a) promote the mental health of Asian and Pacific Americans; (b) prevent the development of mental, emotional, and developmental disabilities; and (c) facilitate the early detection and treatment of such disabilities. Such preventive programs of consultation and education must be staffed with bilingual/bicultural personnel and be adequately funded.

V. ISSUE: FOLLOWUP TO THE ASIAN/PACIFIC SUBPANEL REPORT

These recommendations are especially focused on the issue of followup to the workshop report. Given the exclusion of appropriate Asian and Pacific American participation on the President's Commission on Mental Health, the Subpanel members think that these recommendations particularly need to be implemented:

65. That the President's Commission on Mental Health urge the Public Committee for Mental Health, Inc., to involve minority representatives on its board of directors, including Asian and Pacific Americans.

66. That the White House create a process to further assess and take action on the mental-health-related needs of Asian and Pacific Americans. Given the limitations of the Asian/Pacific Subpanel, the White House should provide for extended study and action planning. This effort should begin soon after the President receives the final report from the President's Commission on Mental Health, and should involve a much broader participation from AAPA communities than did the Asian/Pacific Subpanel.

    The further study and action planning should include the following: (1) an assessment of the impact of relevant Federal programs and policies on the mental health of AAPA's, and how to make these programs and policies more responsive; (2) action planning in terms of reducing the impact of racism on AAPA's; (3) a series of regional and national AAPA mental health conferences; and (4) the creation of a national AAPA coordination and implementation body, staffed by White House personnel, to carry out the aforementioned over a 3-year period. This effort should supplement the work of the Public Committee for Mental Health, Inc.

67. That President Carter appoint an appropriate Asian and Pacific American as a White House special assistant for liaison with AAPA communities regarding mental health and other AAPA concerns.

VI. CONCLUDING COMMENTS

The Asian/Pacific Subpanel wishes to express its appreciation to the Commission and staff for the opportunity to submit this final report. The Subpanel also appreciated the opportunity Dr. Ford Kuramoto, Subpanel Coordinator, and Professor Bok-Lim Kim had to personally make a presentation to the Commission in Washington, D.C., on January 16, 1978. There were a number of difficulties inherent in the scope of the President's Commission on Mental Health and its mandate. But the Asian/Pacific Subpanel believes that the President's Commission on Mental Health can potentially have a real impact upon the executive and legislative branches of the Federal Government, the private sector, and other levels of Government. The best way to measure the effectiveness of any effort is to look at the "outcomes," the concrete results. The Asian/Pacific Subpanel eagerly looks forward to the time when the members will be able to assess the actual outcomes of the President's Commission on Mental Health effort, particularly with respect to the impact on the Asian and Pacific American communities.

The Asian/Pacific Subpanel would heartily support a final President's Commission on Mental Health report that adequately addresses Asian and Pacific American issues. However, if the Commission's final report does not adequately address AAPA concerns, this action by the Commission will have to be interpreted by the Asian/Pacific Subpanel as another example of how AAPA's have been excluded from crucial aspects of the Commission's activities.

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