COMMEMORATION

OF

THE TWENTIETH ANNIVERSARY

OF

THE ANNUAL ASIAN AMERICAN MENTAL HEALTH TRAINING CONFERENCE

1995-2014

THE CONSORTIUM ON ASIAN AMERICAN MENTAL HEALTH TRAINING

Twentieth Anniversary Planning Committee

Twentieth Anniversary Planning Committee

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Consortium on Asian American Mental Health Training
2014

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Welcome Letter

Dear Everyone,

Welcome to all of you for coming to help us celebrate our 20th birthday. It was twenty years ago that the Consortium on Asian American Mental Health Training was formed with the intention of educating clinicians and consumers about providing culturally appropriate care for this population. As the number of Asian immigrants to Southern California has grown, the need and demand for mental health services have grown proportionally.

The Planning Committee has met regularly to plan and design the annual conference so it will meet the needs of our participants. Our consortium members represent both educators and service care providers for Asian Americans. Through providing timely and culturally competent training to providers, this annual training conference has helped increase public awareness of mental health issues and needs unique to Asian Americans.

Throughout the 20 years, the conference has benefitted from the support of different mental health professionals. The late Dr. Milton Miller, chairman of the Department of Psychiatry at Harbor-UCLA Medical Center, was always willing to lend his support to us. Our past Planning Committee members had given us a lot of their time and thoughts to help in conducting each year's conferences. These include the late Lucila Rivera, Keh-Ming Lin (co-founder), Tsu-Yen Chen, Chong Suh, Mariko Kahn, Richard Kim, Youngsook Kim-Sasaki, Yoshi Matsushima, and Kathleen McQuade. All of them had given so much to help make this conference a success. We will forever be grateful for their contribution.

We are also grateful to the Los Angeles County Department of Mental Health for the funding support to this conference each year. We have also received educational grants from Kaiser Permanente, California Endowment, and Tele-Care for some of the years, to enable us to have a richer conference.

Our theme this year is "**Asian American Mental Health: Past, Present, and Future."** We want to take this opportunity to pause and reflect on the various mental health issues that have confronted Asian Americans in the past nineteen years, the progress we have made during these intervening years, and what directions we need to take in order to advance the treatment of mental health problems that we are facing today.

We are grateful that you are here today to attend and celebrate this anniversary conference with us.

Sincerely,

Freda K. Cheung, Ph.D.
Chair, Conference Planning Committee

Los Angeles County
Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

October 16, 2014

WELCOME!

ASIAN AMERICAN MENTAL HEALTH
2014 ANNUAL CONFERENCE
"PAST, PRESENT AND FUTURE"

Dear Colleagues & Friends:

On behalf of the Los Angeles Mental Health Commission, it is my pleasure and honor to welcome you to the 20th Annual Asian American Mental Health Training Conference: "**Asian American Mental Health: Past, Present, and Future**." The conference will take place October 16, 2014.

This year's training conference following the precedence of past conferences will continue to enhance and promote cultural awareness specific to Asian Americans. Los Angeles County has a rich cultural diversity, and this conference highlights the importance of acknowledging the role that culture plays in our lives and in the lives of the clients we serve. By educating ourselves and raising public awareness, we can eradicate stigma and improve the quality of mental health service provided to Asian Americans.

I look forward to joining you at the conference.

Sincerely,

Larry Gasco, Ph.D., LCSW

Chairman
Los Angeles County Mental Health Commission

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MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

October 16, 2014

Dear Participants:

On behalf of the County of Los Angeles Department of Mental Health, I would like to welcome you to the 20th Annual Asian American Mental Health Training Conference. This year the conference celebrates two decades of excellence.

Congratulations to the Conference Planning Committee for their commitment and hard work in planning the 20th Annual Conference. Many members of the planning committee have demonstrated their unwavering dedication by generously and tirelessly contributing to the event's success since the conference's inception. This year's conference theme is "Asian American Mental Health: Past, Present and Future." In keeping with the spirit of this year's theme, the conference will honor its legacy by inviting back some of the presenters who helped pioneer the conference by presenting at its inaugural session in 1994.

As we all know, life is an ever changing fluid experience but as the wisdom of a popular Chinese Proverb teaches "Consider the past and you shall know the future." As we look to the future in the present we build on the lessons we have learned from the past to transcend yesterday and create a better tomorrow. The Department of Mental Health has certainly evolved and made changes in the way we have done things over the past 20 years. At today's training conference, you will hear about what was done previously, what is currently being done, and what needs to be done in the future for effective consumer centered care that is recovery and evidence based in treating Asian American and Pacific Islander communities around issues of mental health.

Enjoy your day and I thank you for supporting and attending this conference. I hope you will continue to learn and network with others, as well as gain a better appreciation and understanding of the Asian American and Pacific Islander culture.

Sincerely,

Marvin J. Southard, D.S.W.
Director

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MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

October 16, 2014

Dear Colleagues:

Welcome to the 20th Annual Asian American Mental Health Training Conference. It's astonishing to think this conference began two decades ago! I am certain this year's event will exceed the successes of the previous 19 conferences. Congratulations to the Conference Planning Committee for its commitment and hard work in planning this milestone conference. Special thanks to those dedicated committee members who have been involved since the first conference in 1994.

As you know, the Asian American communities have increased dramatically in population, complexity, and diversity since 1994. The mental health system of care has evolved tremendously over the same 20 years starting from the implementation of the Rehabilitation Option in 1994 to the Mental Health Services Act and now the Affordable Care Act. Therefore, I think it is very fitting that the theme of this year's conference is "Asian American Mental Health: Past, Present and Future." The committee has decided to engage and bring back our esteemed colleagues to present their reflections and thoughts about present and future issues in Asian American mental health.

I appreciate your presence and participation in today's conference and your motivation to learn about Asian American mental health. I hope you enjoy your day and I thank you for attending this conference.

Sincerely,

Dennis Murata, M.S.W.
Deputy Director

A3PCON

ASIAN PACIFIC POLICY & PLANNING COUNCIL

October 16, 2014

Dear Friends,

On behalf of The Asian Pacific Policy and Planning Council (A3PCON) Mental Health Committee, we would like to congratulate you on the Twentieth Annual Asian American Mental Health Training Conference. This year's conference theme is "Asian American Mental Health: Past, Present, and Future".

The Mental Health Services Act (MHSA) has provided an unprecedented opportunity in California to enhance mental health services to underrepresented populations, including the Asian Pacific Islander (API) community. Though APIs make up 15% of the LA County population, they receive less than 5% of mental health services due to cultural, language and practical barriers to care. Through MHSA, the A3PCON Mental Health Committee has been working closely with the 40+ A3PCON member agencies and with LA County Department of Mental Health (DMH) to address this disparity and improve services to our communities.

In particular, A3PCON Mental Health Committee has spearheaded the work for APIs under the Integrated Services Management Model (ISM), an MHSA program that integrates mental health, physical health, and substance abuse services to underrepresented ethnic communities. Through A3PCON's leadership, advocacy, and collaboration, we have 4 ISM programs targeting the Chinese, Cambodian, Samoan, and Korean communities. As we proceed through our 4th and last year of this project, we have developed innovative, effective, and culturally-embedded strategies to penetrate these hard-to-reach communities that will have lasting impact on how we provide mental health services to the under-represented API community.

For the past 20 years, the Conference Planning Committee members have been working diligently to enhance mental health services to the API community, including through a culturally responsive work force. We, and all our sister agencies of A3PCON, congratulate you on your Conference and thank you for your commitment to the mental wellness of our API community.

Sincerely,

Herbert K. Hatanaka, DSW
A3PCON MH Co-Chair
Special Service for Groups

Yasuko Sakamoto
A3PCON MH Co-Chair
Little Tokyo Service Center

Connie Chung Joe, JD
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WILLIAM T FUJIOKA
Chief Executive Officer

October 16, 2014

Dear Friends:

It is my pleasure and honor to welcome all attendees to the 20th Annual Asian American Mental Health Training Conference held on October 16, 2014.

As you recognize and celebrate the countless contributions mental health educators and service care providers have provided over the years, please accept our gratitude for your efforts to provide culturally competent and appropriate services to Asian American clients.

Los Angeles County has one of the largest and most diverse Asian Pacific Islander groups in the nation. By sharing your expertise and reflecting on the mental health issues confronting Asian Americans over the years, we know with confidence the progress you have made will continue to help shape the future in a positive way and the knowledge you gain today will significantly make a difference in the lives of many in the Asian population group.

I applaud your consistent and continuous efforts to make Los Angeles County a better place to live and work.

Thank you.

Sincerely,

WILLIAM T FUJIOKA
Chief Executive Officer

WTF:er

Past Conference Pictures

Ten Years and Counting

George K. Hong, Ph.D.

Ten years are a long time, and ten years are a short time. It seems like only yesterday when our group started working together, brainstorming for ideas and searching for resources, to organize the First Asian American Training Conference. Today we are celebrating the Tenth Training Conference.

The original idea for the training conferences started in early 1995. At that time Dr. Freda Cheung was involved in developing cultural competence training for the Los Angeles County Department of Mental Health. In her informal discussions with Dr. Keh-Ming Lin concerning the project, they recognized there was a strong need to provide mental health professionals with advanced training in working with Asian Americans. The aim was to move beyond the basic level of cultural awareness, to raise the level of knowledge and skills in working with different diagnoses and different segments of the Asian American population. Under the aegis of the Research Center on the Psychobiology of Ethnicity (a National Institute of Mental Health funded research center in the Department of Psychiatry at Harbor-UCLA Medical Center), Dr. Lin as its Director, and Dr. Cheung, a Research Associate of the Center, invited a number of clinicians active in the Asian American communities and at Harbor-UCLA Medical Center to join them in this effort. This group formed the planning committee for the first conference, and eventually came to be called the "Consortium on Asian American Mental Health Training."

Throughout 1995, the committee met regularly to plan the conference. Since this was the first attempt at organizing such a conference, there was no blueprint to follow. There were a lot of uncertainties: How many people would attend the conference? Where to hold the conference? How large a function hall do we need? Expenses? What topics? Speakers? Format of the conference? The committee brainstormed all these issues along with many other practical and logistical problems. We were fortunate that a pharmaceutical company awarded an educational grant to support the conference, which together with support from the Los Angeles County Department of Mental Health, eased our financial concerns. In terms of the conference theme, we eventually chose "Culture and Psychiatric Diagnosis: Asian American Perspectives," since DSM-IV had come out recently, and diagnosis was on the mind of many clinicians. In spite of numerous unforeseeable problems, some of which were not resolved until the very last minute, the first conference was a great success, with close to 200 attendees.

With the experience of the first conference and the positive feedback from participants, the planning committee was assured that there was indeed a need to offer the training conferences on an annual basis. Since then, we have been meeting around the year, practically every month, sometimes more often. In between meetings, committee members work individually or in subgroups on assigned tasks. With the completion of each annual conference, we would immediately perform our evaluation, which included feedback from participants, and start planning for the next conference. Our work is virtually non-stop. In the context of a changing economy, we continuously seek fiscal support from new and former sponsors, so that we can keep registration fees low and

affordable. In spite of rising costs, we have always provided lunch as an integral part of the conference, so that attendees can have the time and opportunity to network, mingle, and exchange ideas. In some years, when there was a need, we included job postings at the conference. This gave agencies serving the Asian American communities a forum to recruit clinicians and interns, as well as gave attendees information about employment options. We always make it a point that the conference is designed for all mental health professionals, Asian and non-Asian, as well as interns, trainees and students. We want to ensure that all who seek to advance their knowledge and skills in working with Asian Americans can benefit from the conference. Every year, we strive to identify critical issues in Asian American mental health services to be addressed at the conference. We also seek to invite speakers of the highest caliber to deliver keynote presentations, workshops, and interactive panels. Our topics from the Second Annual Training Conference and onwards have included: Treatment of Asian Americans; Confronting clinical challenges; Asian American families; Substance abuse and addictive behavior; Integration of treatment strategies - East meets West; Depression; Trauma; Schizophrenia; and the theme of this year, "Soma, Psyche, and Culture." A more detailed listing of each year's conference topics, speakers, and panelists is provided in a later part of this booklet.

The format of the training conference has evolved over the years. Our goal is to make certain that the conference presents both cutting-edge knowledge on the central topic and practical skills of how to address specific clinical issues in the Asian American communities. We have tried different formats at various conferences. There were conferences with two, or even three keynote speakers. One year we extended the conference to one and half day. We had included panel discussions, case presentations and workshops. In recent years, we have reduced the number of speakers so that each speaker will have more time to present his or her topic in depth. All these variations were based on feedback from attendees, and new ideas on how the conference may better achieve its goals. The current format is a result of the feedback and experience we have accumulated over the years. Overall, it appears to be the most satisfactory at this point in time. However, we will continue to strive to keep future training conferences responsive to the current needs of clinicians working in the field.

We are happy that many of the planning committee members have been with us since the very beginning: Freda Cheung, PhD, Stephen Cheung, PsyD, George Hong, PhD, Ira Lesser, MD, Keh-Ming Lin, MD, MPH, Yoshi Matsushima, LCSW, and Lucila Rivera, LCSW. Yoongsook Kim-Sasaki, RN, MSN, and Jason Huang, PhD, joined us early on. They were followed by Mitsuru Kubota, PhD, and Margaret Lin, MD, both of whom have been with us for a number of years. The Training Bureau of the Los Angeles County Department of Mental Health has always had a staff member on our committee: currently, Sam Keo, PsyD; and previously, Tsu Yen Chen, PsyD, Kathleen McQuade, RN, MN, and Jessie Tait, RN, MS. There are also others who have served in the committee for various lengths of time: Richard Kim, PhD, Wing-Ki Lee, MD, and Glenn Matsuda, PhD, among others. On the occasion of this Tenth Anniversary, we want to thank each and every one of our current and former planning committee members for his or her contribution to the success of the Consortium in achieving its goal to provide training to mental health professionals serving the Asian American communities.

Historical Perspective of the Asian American/Pacific Islanders Mental Health Movement: My Two Decades at NIMH

Freda Cheung, Ph.D.

For this commemorative article, I am pleased to have an opportunity as a former staff at the National Institute of Mental Health (NIMH) to provide an overview of the national mental health movement of the Asian Americans and Pacific Islanders (AAPIs) vis-a-vis the Minority Research Resources Branch (MRRB) at the NIMH during 1971 to 1991, a period when I worked there. It is my desire that the readers of this article will continue the momentum and push forward this movement, so that people with mental illness along with their family members will find hope in their tortuous search for effective treatment to cure the illness and/or improve their quality of life. I will identify some significant events which took place at the Federal level that were efforts to meet the identified needs and advance the mental health program of AAPIs.

Launching of AAPI Mental Health Programs

Since the immigration reforms of the 1960s, the AAPI population has increased rapidly, reaching 10,243,396 or 3.7 percent of the total U.S. population by 2000 as indicated by U.S. Bureau of Census. It is projected that this growth phenomenon will continue well into the 21st century. While the numerical growth is highly visible, an often overlooked but important factor is the broad historical, social, cultural and linguistic diversity of this population group. They represent many countries and regions, including the People's Republic of China, Taiwan, Hong Kong, Japan, Korea, Philippines, Vietnam, Cambodia, Laos, Hmong, Thailand, Malaysia, Singapore, India, Pakistan, Hawaii, Samoa, Guam, Tonga and others. Unlike the Hispanics and African Americans, AAPIs speak different languages and dialects. They represent different levels of socioeconomic status. Some are highly educated and affluent professionals, while many are illiterate, holding menial jobs. There is a considerable degree of intergroup and intragroup differences among them.

A. First National Conference on Asian American Mental Health

In 1971, the Center for Minority Group Mental Health Programs (CMGMPH) was established by Congressional mandate to serve as the focal point, stimulator and coordinator for NIMH programmatic efforts to improve the mental health of ethnic minority groups nationwide. In response to the demand of leaders in the AAPI communities, the NIMH, through the Center, convened the First National Conference on Asian American Mental Health in April of 1972 in San Francisco. This Conference was a result of collaborative efforts between the Center and Asian American mental health leaders. While only 81 participants were invited initially, over 600 attended the Conference. This Conference was of special significance in that it spearheaded a coordinated national approach/movement to meeting the mental health concerns of AAPIs. The scope and nature of the problems that were identified as impacting their lives included: underemployment and unemployment; high school dropouts and low levels of academic achievement; drug abuse; delinquent activities among ghetto youth; substandard housing;

absence of or inadequate health and social care services within Asian communities; lack of community research; lack of opportunities to enter decision-making positions; stereotyping, negative and derogatory portrayal of Asians in the mass media. Specific recommendations were made to address these concerns. It further pointed out that cultural relevance, accessibility, acceptability and effectiveness of programs for consumers and communities were of major importance for services to the different population groups which included new immigrants, senior citizens, youth, children and partners of interracial marriages. There was a strong recognition for training as an essential component in mental health programs. Specific emphasis was placed on training of bilingual and bicultural providers, researchers and planners, as well as cultural education for non-AAPI providers. Additionally, areas for research were identified which included: barriers to utilization of existing services; development of children; interracial children and their needs; correlation of physical and mental disorders with variables such as language barrier, struggle for economic survival, cultural conflicts, identity crises, stresses of coping with ghetto living; and indigenous mental health programs, etc.

Subsequently, the NIMH, through the CMGMHP, provided a 3-year grant of $453,500 to establish the Asian American Federation as a mechanism to implement the conference recommendations. The main objectives of this program were to provide a mechanism to allow representatives of the nine Department of Health, Education and Welfare (DHEW) regions to identify regional mental health needs and solutions, lay the groundwork for the establishment of a permanent Asian Pacific coalition, and provide improved services to the communities. What followed was a gradual development of mental health programs in the areas of service, research and training to meet the identified needs of the fast growing AAPI population. NIMB took the lead with a strong force of AAPI multidisciplinary mental health professionals and community leaders pushing from behind.

B. Development of Services, Research and Training Programs

During 1972-76, the CMGMHP began to take serious steps to respond to the concerns as presented by the Conference coordinators. Such steps in turn led to the development of the following programs:

1. Pacific/Asian Coalition (PAC)

PAC was established under the sponsorship of Special Services for Groups at the termination of the Asian American Federation project. It was funded initially for three years and was extended to another three-year period. John Hatabayashi was its first Director. For the second three-year period, Kenji Murasi served as its Director. The main functions of the Coalition were to serve as a communication link between NIMH and the AAPIs in the nine DHEW regions, and to conduct applied mental health research. During this six-year period, PAC made significant contributions in advocating for the mental health concerns of the AAPIs. It mounted the first series of systematic attempts to conduct applied research in service utilization and barriers to services, therapeutic approach and delivery of services.

2. National Training Center

In July 1972, the Asian American Community Mental Health Training Center was established with funding from the NIMH for a ten-year period. It was located in Los Angeles. The late Royal Morales was its

director. The primary goals were to develop mental health leadership, and to increase human resources for AAPIs. Its program covered four areas: student training, curriculum development, continuing education and community organization. The training was targeted to mental health professionals and community leaders. During these early years, the Training Center had played a significant role in developing leadership and expanding culturally relevant mental health training programs. The development and contributions of the Training Center will be further discussed in Yoshi Matsushima's article.

3. Pacific/Asian American Mental Health Research Center (P/AAMHRC)

In 1973, Casper Weinberger, then Secretary of DHEW (which has since become the Department of Health and Human Services), directed the establishment of six minority research and development centers with "seed money" to design, conduct, and implement research programs relevant to minority groups. It was intended that within this context, the centers would provide an appropriate setting for the training of minority students as research scholars. The "center" concept was designed to attract a critical mass of researchers and persons with related skills assembled together to make an impact on the special mental health needs of minorities through research. P/AAMHRC was developed and established under this funding mechanism as a research and development center devoted to conducting mental health related research. The Center was directed by an Advisory Council representing the nine DHEW regions. Both Leighton Huey and William T. Liu have served as Center Directors. It was first located in Southern California and later in Chicago. It employed a stress-coping conceptual framework to organize its research program. Besides conducting a behavioral science research program that covered the general AAPI population, it was among the first to conduct research on the plight of the Southeast Asian refugees in their transition from war-torn homelands to a totally new and strange environment. Aside from conducting research, P/AAMHRC also included in its mission the training of inexperienced researchers in research methodologies. Many promising researchers went through its intensive summer research training workshop which was conducted annually in conjunction with the Institute of Social Science Research, University of Michigan. P/AAMHRC was funded for a total of twelve years.

4. Minority Fellowship Program

In pursuit of its mandated goal of increasing the quantity and improving the quality of minority social behavioral scientists and mental health professionals/practitioners, the CMGMHP developed the Minority Fellowship Program (MFP) to provide support for minority graduate and predoctoral level students undertaking research and clinical training in psychology, psychiatry, psychiatric nursing, social work and sociology. Funding was awarded to the major national professional associations to recruit and select promising minority students in their respective disciplines to pursue clinical and research training in academic institutions of their choice. (The MFP has expanded since its inception and is an ongoing program.) A number of AAPI students were recipients of fellowship support from the MFP. Among these awardees, quite a few are now holding prominent and leadership positions in research, clinical services and administration on both the national and local levels.

Major National Thrusts in the 1980s

During the Reagan administration, there was a de-emphasis of social science research with a concomitant increased emphasis on biomedical model approach to investigate mental disorders. In the meantime, family members of people with serious mental illness organized nationally to express their concerns as to what and how mental health research was to be conducted. There was a demand for accountability in regard to the impact research had upon the status of those who were seriously mentally ill. Consequently, the research approach began to shift to a study of mental illness/disorder rather than mental well-being. This significantly impacted minority mental health programming, especially the AAPIs because of the large number of refugees and immigrants with adjustment problems. Due to the refocusing of the research thrust, from behavioral to biomedical, NIMH has to reprioritize its research programs.

A. Research Gap Review

In 1984, in response to the findings and recommendations of the NIMH Panel on Behavioral Sciences Research in Mental Health, the CMGMHP began to review its research program priorities to ensure continuing alignment with those of the Institute. As part of this effort, it commissioned a research review on each of the four ethnic minority groups to include a review of the literature, identification of gaps in current knowledge, and a priority list of research needs relevant to each of the four groups. It was intended that the findings and recommendations would form the basis for a series of initiatives to be developed in the next 4-5 years. However, at the completion of the review, NIMH was in the process of reorganization. Consequently, the CMGMHP was not able to implement the recommendations. Nevertheless, it is of historical interest and contextual relevance to present the summary findings of the research gap review on AAPIs here. It indicated that the AAPIs have been the most rapidly growing population group during the 70s and 80s due to the changes in U.S. immigration quotas in 1966. However, the review found that a considerable percentage of AAPIs was at risk with regards to mental disorders. Although many have adjusted to a new life in the adopted country, still many have and are experiencing stress-producing discrimination that has its roots in some form of economic competition. It further stated that due to the significant differences between the western and eastern cultures, the “culture mismatch” between the AAPIs and mainstream American would cause potential adjustment problems. It is suggested that future research should look at factors associated with both the positive and negative adaptation. It was felt that this “balanced” orientation would undoubtedly provide useful intervention information on the different aspects of adaptation. Against the backdrop of changes in viewing mental health, the NIMH underwent a complete reorganization in 1985. The CMGMHP was placed in the newly restructured Division of Biometry and Applied Sciences, and renamed the Minority Research Resources Branch (MRRB). The reorganization of the CMGMHP was intended to allow for a closer integration of the different minority training programs with the research centers while at the same time to encourage other NIMH programs to share the responsibility of funding minority research projects. As a result of the reorganization, the MRRB was to take a lead role in assisting the four ethnic minority groups to develop and conduct service research studies and funding national minority mental health research centers of

excellence. Subsequently, a research conference was convened in 1987 at the University of California, Los Angeles, to bring together a group of prominent minority mental health consultants to deliberate on minority mental health services research needs. The conference resulted in a set of constructive and targeted recommendations for a mental health service research priority agenda for the four minority groups as a whole, and for each of the ethnic minority groups in particular. It also provided the ethnic minority research community with a structural and conceptual foundation to pursue research that was appropriate, relevant and responsive to the needs of minorities nationwide. It was suggested that the approach to service research should focus on areas that would align with that of the NIMH. Three areas were identified: Economics and organizational aspects in mental health services delivery systems; services utilization and help seeking behavior; and concepts of mental health services treatment outcome.

B. Research Development

In 1986, it was deemed necessary to evaluate the five Minority Research and Development (R&D) Centers so as to make recommendations for modification of these Centers to accommodate the changes resulted from reorganization of the Institute. In response to the evaluation findings, a new announcement was issued in 1987 for the establishment of national Minority Research Centers of Excellence that would focus specifically on research and research related activities of each of the four ethnic minority groups. For AAPIs, two such centers were funded with one focusing on the specific service research of Asian American populations groups (National Research Center for Asian American Mental Health), and one focusing on the psychobiological aspects of ethnicity (Research Center on the Psychobiology of Ethnicity).

1. The National Research Center for Asian American Mental Health (NRCAAMH)

The Center was developed on a conceptual scheme that would guide research to systematically identify those particular types of cultural incongruities that could create misunderstandings Sand decrements in rapport among ethnically different clients and therapists. The research program was to directly address such issues in a series of studies focusing on treatment effectiveness for Asian American clients. During the ensuing five years (1987-1992), under the directorship of Stanley Sue at UCLA, the Center focused its research endeavors on three major areas of investigation: assessment, treatment outcomes, and mental health systems. Under each of these three areas, a number of research projects were conducted. Additionally the Center also had two other research projects to evaluate the effectiveness of drug prevention programs sponsored by Asian American community agencies.

2. Research Center on the Psychobiology of Ethnicity

Despite the fact that much understanding has been gained in the mental health of AAPIs, much remains unclear in the clinical care of psychiatric patients of Asian backgrounds. This is more so in the area of biological (specifically drug) treatment methods and studies on “biological markers” and other neurological correlates of psychiatric conditions. However, very little information was available in regard to the appropriateness of applying recent advances in biological psychiatry to ethnic minority patients in general, and Asian Americans in particular,

and in understanding how ethnic and cultural factors influence psychobiological processes and treatment outcomes. Consequently, the Center on the Psychobiology of Ethnicity was developed at Harbor-UCLA Medical Center and applied for NIMH funding. It was approved and funded in 1990 with Keh-Ming Lin as its Director. For its first five years, the Center expended its efforts in two major areas: Ethnicity and Psychopharmacology; and, "Biological Markers" and Neurobiological Correlates of Psychiatric Disorders. Three specific research projects were performed by the Center that linked the two major research areas. These were: (a) Ethnicity and Differential Responses to Tricyclic Antidepressants; (b) Ethnicity, Lithium Pharmacokinetics, and the RBC/Plasma Lithium Ratio; and, (c) Ethnicity, Biological Markers, and Depression. It was indicated that data derived from these studies would contribute to the understanding of the ethnic variation in biological variables.

3. Chinese Americans Psychiatric Epidemiological Study (CAPES)

In order to understand the mental health service needs of the AAPI communities, we need to learn more about the factors leading to the development and manifestation of mental health problems. The CAPES was the first large-scale community psychiatric epidemiological study on an Asian American ethnic group that used DSM-II1-R criteria for major depressive episodes and dysthymia. The NIMH grant was awarded to the NRCAAMH at UCLA in 1992 for a five-year period.

This study is significant as its findings has provided the research community as well as policy makers some quantitative data as to the incidence and prevalence of selected mental disorders among one segment of the AAPI population group. Additionally, it also provides us with a closer approximation about the need for mental health services, as well as a foundation for other aspects of services research.

Looking ahead to the Future: Opportunities and Challenges

As stated earlier, the AAPI population has grown rapidly since the 1960s. However, despite its projected increase, the AAPIs have remained one of the most invisible and neglected minority groups, receiving little attention from the health care system and policy makers. This is clearly reflected in the minimal reference to this minority group in major national health policy guideline and status report on minority health, such as the Healthy People 2000 (published by the Public Health Service, Department of Health and Human Services). Only 8 out of a total of 336 listed objectives were targeted to AAPIs. The stereotyping of AAPIs taking care of their own and the myth of a 'model minority' have allowed the Federal government to treat this group with benign neglect. They are viewed as highly successful, have no particular health problems or health care needs, and do not require special consideration, as do other ethnic minority groups. However, it is well-recognized that AAPIs underutilize all forms of mental health services and use the fewest services among all minority groups.

The challenge for the AAPI community is to use the combined strength of scientific knowledge, professional skill, individual commitment, community support, and political will to develop programs of action and to work for its realization. There is, therefore, a need to develop a set of priorities to include training, service, research, and advocacy strategizing. It is incumbent upon us to make the best use of opportunities afforded by national programs and policies such as the Healthy People 2000. This is the major federal health policy guideline

that has stated that the national goal is to close the gap between the health indices of whites and minorities. It is important for us to strive for the realization of these objectives even though only 8 out of a total of 336 were targeted to AAPIs. We also need to make good use of the Surgeon General's Report (2002), which presented a current health and mental health picture of each of the four minority groups.

For those of us who either have loved ones who are suffering from any form of mental disorders, or are involved in the provision of services to the mentally ill, we understand the urgency of reaching out to provide hope and efficacious treatment. We must work together to explore ways of de-stigmatizing and de-mystifying mental illness. Public and private resources must be brought together to make services accessible and compatible to those who are in need. These concerns had represented the force that ignited the First National Asian Mental Health Conference, and the energizing force that sustains us during the intervening years. We need to continue this momentum and forge ahead.

Note: Dr. Freda Cheung worked at the National Institutes of Health (NIH) and National Institute of Mental Health (NIMH) during 1972 -1991. She has served in several positions including Deputy Branch Chief and Branch Chief of the Minority Research Resources Branch (MRRB), NIMH Since her departure, the MRRB has been abolished, and all the ethnic minority programs and projects were decentralized throughout the Institute.

A Brief Background of Asian American Mental Health Services In Los Angeles County

Yoshi Matsushima, LCSW

This is a brief background story of the Asian American mental health movement and efforts in the Los Angeles County. As you read, you will notice that names of individuals and dates are not mentioned. This is an effort to avoid disrespect to persons I fail to mention, since so many people have been involved in developing the Asian American mental health system in the Los Angeles county. I hope that this brief background story will be helpful for those who are entering the mental health field, and move the mental health system to become better than what it is now. At the same time, it is important to remember how the current system has come to this stage.

The San Francisco Conference

The momentum to create mental health services for Asian Americans in the Los Angeles County started at the First National Conference on Asian American Mental Health which was held in April 1972 in San Francisco. It was funded by the National Institute of Mental Health. At this conference, issues and concerns regarding mental health services for this population were raised and discussed. Out of this conference, a $463, 5000 grant was funded to establish the Asian American Mental Health Federation. At a later date, the National Asian American Mental Health Research Center and the Asian American Mental Health Training Center in Los Angeles were established through the Federation.

The Asian American Mental Health Training Center in Los Angeles

The Asian American Mental Health Training Center in Los Angeles (AAMHTC) was the beginning of Asian American mental health services in Los Angeles County. The AAMHTC provided stipends and scholarships to qualified social work students who aspired to work in the mental health field. When this program was first started, there were only a few Asian American professionals in mental health. There was a great need to increase the number of mental health professionals who were culturally and linguistically competent to work with Asian American clients. Therefore, the stipends and scholarships were available not only for graduate students, but also for undergraduate students as an incentive for them to enter the mental health field. Another set of problems Asian Americans faced was the lack of field placement and internship training for the undergraduate and graduate students. The AAMHTC developed field placement sites in the greater Los Angeles areas, and provided the necessary supervision for interns. Through the AAMHTC, many current leaders in mental health services were trained. It laid the foundation for current mental health services for Asian Americans in Los Angeles County.

Asian Pacific Counseling and Treatment Center

The first mental health service center that catered to Asian Americans was established in downtown Los Angeles. As one of many outpatient mental health clinics of the Los Angeles County, Department of Mental Health, the Asian Pacific Counseling and Treatment Center (APCTC) was the first mental health center which

specialized in providing mental health services to the Asian and Pacific Islanders (APIs) community. The Center was staffed with mental health professionals who spoke English and one other Asian and Pacific Islanders language. It boasted a truly bilingual and bicultural Asian American mental health staff.

Prior to the establishment of APCTC, there was discussion whether mental health services for Asian and Pacific Islanders should use an integrated model or a parallel model. An integrated model, which was advocated by most of established mainstream mental health community, would be the addition of bilingual and bicultural API mental health professionals at mainstream clinics serving the general population. People who advocated the integrated model pointed out that APIs did not live in one central area, but were spread out all over Los Angeles County. It would not be fiscally feasible to have specialized mental health clinics for APIs in so many areas of the county.

A parallel model, which was advocated by many Asian community leaders, was a specialized clinic targeted specifically at serving APIs. The clinic would be staffed by API mental health professionals and support staff. The advocates of this model asserted the importance of independent, free-standing Asian mental health clinics, where APIs would feel comfortable seeking services. They asserted that one of the main reasons that APIs underutilized the existing mental health services was that many of them shied away from mainstream mental health centers where they needed to encounter non-Asian staff. For many APIs, English was their second language. Some did not speak English at all. Emotional problems were complicated issues to discuss even in their own language.

The establishment of APCTC supported the assertion of API mental health professionals for the parallel model. Right at the start, APCTC was fortunate enough to have a bilingual and bicultural API staff. When API clients and their families visited the center, they were greeted by API staff, and met by mental health professionals who understood their culture and spoke their language. The discomfort and dissonance they felt in non-API clinics became almost a non-issue.

In a couple of years, increasing numbers of API mental health clients and their families sought services from APCTC. They came not only from the vicinity of the clinic, but all over Los Angeles County. Some outside of Los Angeles County heard about the availability of mental health services for APls, and came from as far as Kern, Riverside, San Bernardino, Ventura, Santa Barbara, Orange, and San Diego counties.

Asian Pacific Family Center

The second API mental health clinic, the Asian Pacific Family Center (APFC) opened in the San Gabriel Valley. The establishment of the APFC reflected the growing API population in the San Gabriel Valley, and the new movement of contracting many government services to the private agencies. The services of the APFC flourished. Their success reflected not only the efforts made by the administrators and the staff in providing mental health services to APIs in San Gabriel Valley, but also demonstrated their creative employment of private funding sources to expand programs which government funding could not cover. The success of the APFC has

made it a model for the collaboration between public and private sectors. Coastal Asian Pacific Mental Health Center and Long Beach Asian Mental Health Center Soon after the establishment of the APFC, two more mental health centers for APIs were established in the southern region of Los Angeles County. One was the Coastal Asian Pacific Mental Health Center in Gardena, and the other was the Long Beach Asian Pacific Mental Health Center in Long Beach. Both clinics are directly operated mental health centers of the Los Angeles County, Department of Mental Health. The details of the development of these two centers are discussed by Dr. Keh-Ming Lin in the next article.

Asian Pacific Residential Program

Besides the establishment of four mental health centers for APIs in the Los Angeles County, there were other accomplishments during these years. One of them was the establishment of residential facilities for API mental health consumers. In general, API mental health consumers are different from mental health consumers of other cultures in the United States. Most API mental health consumers tend to live with their families, and only a few live in residential facilities. Many API mental health consumers expressed fearfulness of being placed in residential facilities with few API residents. Thus there was an obvious need for residential facilities for API mental health consumers. In the mid-i 980s, the Asian Pacific Residential Program (APRP) was made available for API mental health consumers. The APRP started with 3 API staff members, and it grew to 12 staff members at the present. All the staff were bilingual and bicultural, and almost all residents were APIs. This was a 60-bed facility. The APRP made special efforts to meet the needs of their API mental health consumers by celebrating many Asian holidays, such as the Lunar New Year, Moon Festival, and other national/cultural holidays for each ethnic group. Occasionally, consumers from an ethnic group would visit an ethnic restaurant and enjoy their favorite food. Above all, the most important thing for API mental health consumers and their families was the social environment that APRP provided. Since almost all residents were APIs, they seemed more comfortable being there, and developed natural peer groups supporting each other.

Metropolitan State Hospital, Asian Unit

Another accomplishment during the early days was the creation of the Asian Unit at the Metropolitan State Hospital in Norwalk. In the late 1 980s, representatives of the Los Angeles County, Department of Mental Health, the California State Department of Mental Health and the Metropolitan State Hospital got together to discuss the need for an Asian unit at Metropolitan State Hospital. At that time there were approximately 40 API patients at Metropolitan State Hospital. As a result of the collaborative effort, the Asian Unit was created almost overnight. It was staffed with the API mental health professionals who were already working in the hospital. In the 1 990s, there was a strong pressure to reduce state hospital beds. This was triggered initially by the declining mental health budget, use of atypical antipsychotic medication, and the recognition of the importance of treatment, rehabilitation, and the quality of life for mental health consumers. The API mental health professionals of both the state hospital and the community clinics worked collaboratively to move API state hospital patients out of the Metropolitan State Hospital to the community.

Tele-Care Transitional Unit

Due to the urgent need to move state hospital API patients to the community, a transitional treatment facility was deemed necessary. The Los Angeles County, Department of Mental Health, the consortium of API mental health clinics and Tele-Care Corporation agreed to create the needed transitional facility for API mental health consumers. At the Tele-Care facility in Long Beach, a special unit was created where the staff of Tele-Care and the API mental health clinic staff participated actively in the development of treatment and discharge plans of the API mental health clients. Asian food was provided every day to the delight of the consumers. Additionally, recreational programs familiar to APIs were implemented. Asian language newspapers and magazines were made available for the clients. The Tele-Care placement program helped API clients learn community living skills in preparation for them to move to the community facilities or their parents' home. They also received psychosocial education in medication compliance and the prevention of relapse.

Conclusion

It has been over 30 years since API mental health services started in Los Angeles County. It took many years and the efforts of many people to bring the API mental health movement to the current level. There are still more things to do for API mental health services. We need more residential programs, small and large, for APIs. We also need job-training programs, which will provide prevocational training, job training, employment experiences and opportunities. We need to develop psychosocial and educational programs for API consumers and their families in order to reduce misunderstanding of mental illnesses, and to educate them about the availability of effective treatment and rehabilitation programs. We need to recruit bright young APIs to enter the mental health field. There is much more work to be done.

Acknowledgement: The author wants to express his gratitude to following persons for providing time, information, and resources: Mr. John Hatakeyama, Deputy Director, Los Angeles County, Department of Mental Health; Mr. Kei Kokubun, Director, Asian Services Center, retired; Mr. Tn Le, Director, Asian Pacific Residential Program; and Mr. Bill Watanabe, Executive Director, Little Tokyo Services Center.

Note: *Yoshi Matsushima, LCSW retired as Program Manager of Coastal Asian Pacific Mental Health Center in 2001. He is currently a consultant in private practice.*

Lack of Progress Provides Opportunity for Change

Scott Hanada, LCSW, Mitsuru Kubota, PhD, Karen Lee, MD & Margaret Lin, MD

As we celebrate this year's conference, we are encouraged by the years of enthusiasm from researchers, academicians, administrators, policy makers, as well as clients and their families to invest their time and energy to advance the field of Asian American Mental Health. The increasing numbers of agencies that are now in existence with the goal of improving mental health services provided to Asian Americans are outcomes of their achievements. Furthermore, we are excited to see the success of this mental health training conference in bringing back year after year, an increasing number of attendees who are interested in finding out more about what can be done to better care for their Asian American clients. What is most invigorating, are the young, new faces we see each year, suggesting that as the new generation of clinicians graduate from their training programs, they are already cultivating a greater awareness and sensitivity to the importance of culture and ethnicity in the care of their clients. These are truly remarkable changes that have taken place throughout the past 20 years!

Even as we celebrate the changes that have taken place, humbly, we acknowledge there is still much work to be done. A review of the care and delivery of mental health services to Asian Americans suggests many identified problem areas have not seen much progress over the past 20 years. We continue to address the barriers created by both deep cultural stigma and service systems which do not always acknowledge the languages and unique traditions of our Asian American communities.

Underutilization and Poor Compliance

Underutilization of mental health services is a common theme among Asian Americans, regardless of subgroup, age, gender or geographic location. Research reveals few Asian Americans seek mental health treatment. Those who underutilize mental health services exhibit a greater level of disturbance within the client population. One explanation is that only the most disturbed Asian Americans seek mental health services. This was true 20 years ago and remains true today. **(Moon & Tashima, 1982; Yu et al., 2009)** This underutilization may be due to the lack of access to culturally appropriate care and fear of the stigma associated with mental illness. A common perception in the Asian Community is that substance abuse and mental illness are related to a lack of character, self-discipline, or willpower. **(Lum, 1982; Root, 1985; Yu et al., 2009)** Over the years, much work has been done to better educate families and their clients. Although these education efforts have been widespread, **powerful** cultural beliefs, based on a reverence for self-discipline and familial reputation, continue to contribute to the lack of active help-seeking among Asian Americans with mental health service needs. Mental illness is commonly seen as a shameful, frightening curse rather than accepted as a medical condition for which there are viable treatment options. Kharma, a common belief throughout Asian American culture, is a belief in the continual influences of past deeds and behaviors in one's present or future life and can inadvertently discourage one to seek professional help when inflicted with mental illness.

Working with a new immigrant population may pose even more communication challenges for clinicians. In the past 20 years, we have increasingly witnessed an influx of Chinese immigrants from China. Many of these new immigrants come to seek better economic opportunities without political restraints. Many of them are of the generation post the Cultural Revolution and have very little experience with expressing themselves and some are even completely foreign to the psychological idioms clinicians may be accustomed to using.

Related to underutilization is the issue of poor compliance. Even once care from a professional is initiated, the rate of drop-out from care or follow-up is high among Asian Americans. Administrative demands, lack of administrative support, and/or economic concerns result in shorter face-to-face time clinicians can spend with their clients. This is particularly detrimental to the delivery of care to Asian American mental health clients because lack of time spent can curtail valuable information that would have otherwise been communicated to clients and their families to help develop a better rapport and to provide ample education to correct any misconceptions. Despite the prevalent view of mental illness as a medical condition, even among Asian Americans, poor compliance with treatment recommendations, particularly with pharmacological treatment continues to be prevalent in the Asian American population. Medications are viewed as dangerous, damaging one's natural ability to maintain physical/mental integrity and potentially addictive or causing personality changes. Side-effects are often more pronouncedly experienced in Asian American clients due to ethno-genetic differences in how medications are metabolized. Without knowledge of this difference, some clinicians may have unknowingly contributed to adverse reactions from psychotropic medications in Asian American clients and therefore perpetuate the exaggerated belief that medications are toxic and unsafe.

The Limitations of the Public Mental Health System

The public mental health system is often an invaluable resource for those in need of mental health care among Asian Americans. However, challenges are bountiful with such a large system of care. Eligibility requirements, lack of interpreters, and medication costs are just a few of the barriers inherent in the public mental health system. In addition, many public mental health agencies are mandated to utilize "evidence based practices" which are lacking in research in the Asian community. Many of the evidence practices require the consumer to be literate, at least in their own language which is often not the case. Even for our literate, but monolingual Asian clients, clearly translated materials are often unavailable.

Hope for the Future

Despite the limited data on the mental health status of Asian Americans, there are reasons to be optimistic about the future of their mental health services. First, 2010 Surgeon General's Report on Mental Health suggests a greater awareness to pursue important scientific questions that will lead to effective interventions. Second, Affordable Care Act (ACA) provisions for integrating mental health, primary care, and the support for " behavioral health homes" have been highlighted as strategies that will improve access for Asian Americans who

more readily seek services in primary care settings. The integration of mental health care is more culturally congruent for Asian Americans as they perceive emotional illness as a part of physical illness. When depressed many Asians Americans see their primary care physicians and present physical symptoms rather than endorsing psychological explanations. The primary care physician may help to identify mental health problems early and treat or refer them to care accordingly. Furthermore, primary care physicians can help respond to the shortage of mental health professionals. In Asian American communities physicians who have support and a collaborative relationship with a mental health professional are more willing to identify their patient's mental health problems and make referrals (**Lin and Cheung, 1999; Africa & Carrasco, 2011**).

As we look forward to the next 20 years, we are cognizant of the needs and challenges, and we are optimistic that as we work together to develop a more integrated system of care., With collaborative efforts from clinicians, researchers, scholars, clients, and their families, better outreach, treatment adherence and outcomes can be accomplished. The tasks ahead may not have immediate resolutions, but these are tasks that are worth our continual efforts and dedications!

Training in Asian American Mental Health: Past, Present, and Future

Stephen Cheung, PsyD, Ira Lesser, MD, & Freda Cheung, PhD

The Consortium on Asian American Mental Health Training (CAAMHT) was formed in 1994 to meet the growing mental health needs of Asian Americans. It aimed to educate clinicians and the public about culturally congruent services for these diverse populations. Two decades of training have led to a reflection on the past, an examination of the present, and some proposed ideas for the future.

Past Efforts

In its nineteen annual conferences, the CAAMHT has covered various germane topics in training Asian American and non-Asian American mental health professionals who are responsible for providing culturally competent services to Asian Americans. It has provided a sense of belonging for Asian American (AA) clinicians. It has also helped the mental health communities and the public to recognize the unique mental health needs of this population group.

Present Situations

To date, several highly favorable phenomena are noted. For instance, many mental health agencies and academic programs have been tirelessly training the next generation of Asian American mental health professionals. In this process, community mental health centers have offered multifaceted programs and services to their clients who suffer from severe and persistent mental disorders not merely in professional offices, but also wherever the clients are. As clinicians integrate traditional clinical insights with recent recovery/wellness models, they have helped to improve the quality of care and quality of life for their clients.

During the same period, academics in educational institutions have produced a number of highly qualified researchers who have produced interesting research findings. Moreover, they have advocated diversity competence in treatment and have elaborated on several multicultural counseling and therapy (MCT) models. These models have specified key components of multicultural competence and can provide some cognitive maps to guide clinicians in their practice.

Since its inception, the CAAMHT has brought clinicians and academics together in planning the conference with the common goal of better equipping clinicians for their work. The CAAMHT comprises diverse members: several clinicians, academics, directors, program directors, clinical supervisors, and training directors of community mental health centers, Los Angeles County Department of Mental Health training coordinators, a university director of clinical training, a Psychiatry Department Chair and a clinician/scientist. In examining the progress that clinicians, academics, and the CAAMHT have made independently, a few gaps are also noted.

First, there has been very little communication or collaboration between clinicians and the academia. This is unfortunate, since many clinicians' effective interventions could contribute to the basis of more meaningful

formulation and could have been subjected to more rigorous systematic validation. Furthermore, the academia's many informative theories and useful research findings have not been considered or tested in the clinical and community setting. Academics and clinicians seem to carry out their tasks separately and as such, they have not benefited much from each other's expertise and progress.

Second, clinicians have accumulated a wealth of clinical wisdom empirically; however, owing to their work demand, they appear to lack the time to present their keen clinical acumen and skills beyond their immediate work settings. As a consequence, the larger Asian American professional community has missed their valuable contribution of clinical perspicacity because of the lack of professional presentations and publications.

Third, albeit still a minority, American-born Asian American (ABAA) mental health professionals, who seek to serve their cohort, are growing in number. They could benefit from organized support, encouragement, and guidance in developing their expertise from seasoned professionals, both clinical and academic.

Future Directions

To intentionally fill the gaps mentioned above, some ideas are proposed for consideration. First and foremost, not clinicians, or academics, or the CAAMHT alone, but all three in concert, should work together to move the field of Asian American mental health forward. For example, in addition to the annual fall conference, the CAAMHT could consider

- *Conducting a brief needs assessment on offering a one-day intensive training workshop/symposium on a specific psychotherapy approach with the purpose of providing a forum for academics and clinicians to share their respective expertise on the issues.* The goal of the workshop would be for each participant to learn not just from the expert presentations, but also from the interactional discussion with one another throughout the day.
- *Utilizing technology to create more easy accessibility for busy clinicians to collaborate with academia researchers.* For example, creating a blog to facilitate exchange of ideas, elaboration on publication ideas, and networking opportunities.

At the same time, clinicians could consider:

- *Making time to reach out to each other in the same agency even more to create encouraging and empowering teamwork for their extremely demanding and stressful work*. Counter-intuitive though it might seem to most, the extra emotional and intellectual exertion of teamwork while carrying an already huge caseload would pay enormous dividends. It is because in an intentional validating environment of small teams of two to three members, Asian American clinicians can open up to each other more easily for support, renewal, consultation, collaboration, and challenge to improve. The affirming teamwork will not only provide the needed support for clinicians and their challenging clients, but will also improve their efficacy.

- *Seeking part-time field instructor or academic positions to contribute to the training of student clinicians.* As clinicians teach, they will keep abreast of the current literature in multicultural psychotherapy that can inform them of what is helpful and spur them on to even more innovative and improved practice. By collaborating with other clinicians and academics consistently, they will further generate knowledge and skills that can lead to publications and/or conference presentations. That is, they can be astute consumers and active contributors of the current sparse clinical literature for Asian Americans.

Similarly, academicians could consider:

- *Establishing vibrant collaborative relationships with Asian American mental health agencies for their students' clinical training.* When they learn more about the needs of Asian American clients and the specific training needs of ABAA students from clinicians, they can plan their training program more effectively. They can also invite clinicians to provide pertinent clinical training for their students. Furthermore, they can collaborate with Asian American mental health agencies in clinical research so the research outcomes will be more relevant to clinicians.

Conclusion

Certainly to implement some of the ideas above requires commitment, efforts, and good planning on the part of the CAAMHT, clinicians, and academics. In fact, it requires all three parties to be open to each other's perspective and expertise. In the final analysis, those who are devoted to serving Asian Americans appear to have two choices: they could either stay in their comfort zones and continue to work separately without benefiting from each other's expertise; or they can invest new energy in collaborating effectively with one another on improving Asian American mental health. If they chose the latter, Asian American clients would receive better services and clinicians and academicians would achieve better professional fulfillment. Let us work together to help Asian American mental health thrive!

Culture, Ethnicity, Psychopharmacology

Keh-Ming Lin, M.D., M.P.H. & Ira M. Lesser, M.D.

It was not long ago that suggestions of cultural and ethnic differences in psychotropic responses were met with much skepticism and resistance. From its inception, modern psychopharmacology has implicitly assumed a position of "color-blindness" and has been practiced as if drugs and drug dosages should be "one size fits all." Over the last thirty years, the extent and significance of variations in drug response, both inter-individual and across populations have become increasingly widely appreciated, such that cultural and ethnic considerations have become more integrated in psychopharmacotherapy. Members of our group have played a central role in enabling such a transformation.

Around the time we started to plan for the first of our training conferences that have become such a success, we had already conducted a number of carefully designed studies demonstrating, with objective data, significant and clinically meaningful differences between Asian-Americans and Caucasian-Americans in their response to psychotropics, in terms of dosing, side effect profiles, blood drug levels, as well as drug-modulated neurohormonal alterations. Riding on the strength of these results, we applied and were awarded a center grant from the National Institute of Mental Health (NIMH) to establish the Research Center on the Psychobiology of Ethnicity, which provided the infrastructure for us to use state-of-the-art tools and methods, to systematically address many of the questions relevant to the appropriate and optimal practice of psychopharmacology in our increasingly multicultural/multiethnic communities. As is always true in medicine, and broadly, sciences in general, answers to original questions engender even more puzzling questions. Thus, even though in the 30 year span what we have learned has been truly phenomenal, many new and intriguing puzzles have emerged, awaiting a new generation of researchers and clinicians to continue to explore and decipher, not only in terms of advances in knowledge, but also in their clinical and practical applications.

In the following, we aim at providing a brief summary on why both culture and ethnicity are indispensable in pharmacotherapy (not only for psychiatry, but medicine in general; not only for those identified as "ethnic minorities," but for all patients). This is so because pharmacological agents derive their efficacies in equal part from their symbolic as well as instrumental effects. Broadly speaking, the symbolic side of pharmacological practices is influenced, if not determined by, cultural forces, and the "instrumental" ("biological") side is distinctly affected by ethnicity (“from where your ancestors came”).

"Symbolic" Aspects of Psychopharmacotherapy

On the symbolic side, the process of "prescription" and drug taking is value and meaning laden, and largely dependent on the trust and relationship between patients and clinicians. Patients' beliefs and expectations, largely shaped by their socio-cultural milieus (broadly defined), often are hidden and at odds with those of the clinicians (a "sub-culture" with beliefs distinct from even the "mainstream" general public). To the extent clinicians ignore the existence of such potential "cultural gaps" (in varying degrees of magnitude), they lose at least half of the "battle."

The most immediate consequence of such cultural gaps is "medication non-compliance,"(commonly now called “non-adherence”) whose prevalence ranges from 30-70% in the treatment of psychiatric conditions as well as other chronic medical problems. Cultural discrepancies and mismatches further aggravate the problem. Earlier studies demonstrated that patients with Asian-American and other ethnic minority backgrounds were significantly more likely to drop out of therapy, a finding echoed by recent large-scaled clinical trials including STAR*D. Ethnic and cultural matching as well as psycho-education tailored to address culturally related discrepancies significantly improve medication compliance, further highlighting the crucial importance of cultural factors in addressing this important dimension of the pharmacological care of psychiatric patients. As an example, in contrast to patients with other cultural/ethnic backgrounds, Asian-American patients typically come to appointments with one or more family members, and these patients often prefer those who accompanied them to stay in the consultation room with them. This was not primarily for interpretive purposes, as many patients themselves were American-born and more fluent in English than the family member(s). Clinicians not familiar with such expectations might worry excessively about confidentiality or "individuation," and inadvertently push patients and their families away. Many even more vivid and dire examples exist to further demonstrate similar points (e.g., Ann Fadiman: The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures).

In comparison to the issue of adherence, perhaps not appreciated as much as it should be, is the utter importance of the so-called “placebo effects” in determining pharmacotherapeutic responses, as well as the central role culture plays in enabling such effects (and, by contrast, the potential dampening influence that might arise from cultural dissonance between clinicians and patients). "Placebo" effects may account for as much as twice the improvements as compared to the "real" (i.e., biologically-based) drug effects. The power of the placebo is such that more often than not, clinical trials "failed" even with drugs that had previously been proven efficacious. This notwithstanding, "placebo" continues to be seen largely in the negative light. What little we do know indicates that such effects are highly related to patients' expectations and trust, which are contingent upon the nature and quality of their relationship with prescribing clinicians, and are significantly influenced by the clinicians' ability to explain the rationales for the use of particular medications in ways that are culturally congruent and comprehensible to their patients. Thus, to be culturally attuned and sensitive is paramount in optimizing patients' "placebo" responses and treatment responses as a whole.

"Instrumental" Aspects of Psychopharmacotherapy

In addition to our cultural backgrounds, it also matters in terms of pharmacological responses “from where our ancestors had come”. We inherit various genetic markers from our parents and those who preceded them. Such variations ensure “biological diversities” crucial for the survival of organisms, and are evident within as well as across populations. For genes encoding characteristics having to do with individuals’ interactions with environmental exposures, including toxic substances, infections and allergens, the need for diversity is even more

apparent. They help to ensure that at least some of the members of any group would survive in case of unexpected adversities. In such a manner our ancestors left "imprints" on us, making us process and react differently to "foreign" (and thus potentially toxic) substances, including modern pharmaceuticals. This is the reason for both substantial "inter-individual" and "cross-ethnic" variations in drug metabolism and responses, often up to one hundred fold. In light of this, it is particularly regretful that we continue to practice medicine that is "one size fits all" and "trial and error," rather than dealing with such variations systematically and proactively.

The literature addressing such variations ("pharmacogenomics") and the role of ethnicity in this context is vast and constantly expanding and is beyond the scope of this brief essay. Instead, CYP2D6, the most well studied "drug-metabolizing enzyme," will be briefly discussed here as an example. Due to alterations of just one or a few single base pairs (out of more than 4,000) in the gene, or gene deletion/duplication, one could end up being a "poor metabolizer" (PM; with no CYP2D6 whatsoever), a "slow metabolizer" (SM; with less than usual enzyme), an "extensive metabolizer" (EM; with the usual amount of the enzyme) or an "ultra-rapid metabolizer" (UM; with excessive enzyme). Rates of metabolism are related to side effects and clinical effects as well. Since CYP2D6 is involved in the metabolism of most psychotropics and many other commonly used medications, the consequence of such variations is substantial. As an example, more than half of those with East Asian ancestry possess SM CYP2D6 genotype, predisposing them to a higher frequency of adverse effects when treated with a "standard dose" of medications dependent on this enzyme for metabolism.

Further complicating the picture is the fact that genes are routinely turned on or off by various internal and external chemicals and signals. In the case of drug metabolizing enzymes whose original roles were to protect organisms from potentially harmful natural substances, it makes sense that they are often inhibited or induced by many natural substances, as well as by other drugs, resulting in significant, and at times lethal drug-drug, drug-herb (e.g., the inducing effect of St. John's wort on CYP3A4, another drug metabolizing enzyme) and drug-natural substances interactions (e.g., the inhibiting effect of grapefruit juice on drug metabolism). As patients from different ethnic and cultural backgrounds are exposed to different diets, phytochemicals and herbs, their drug metabolism and response profiles will also be altered accordingly.

Conclusions

In order for medications to work, we have to put patients and their relationships with clinicians at the center and be mindful of the importance of the cultural, ethnic, behavioral and personal characteristics of patients under our care. "Pharmacology" in the traditional sense provides us with a solid (and ever expanding) foundation; what we build on such a foundation is up to us in our striving to better serve our patients. The burgeoning research literature in genetics will likely allow even further refinement of our ability to deliver "personalized medicine" in the near future.

1995

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presents

The 1st ANNUAL ASIAN AMERICAN MENTAL HEALTH TRAINING CONFERENCE

sponsored by:

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Department of Mental Health

Keynote Speaker I: *George K. Hong, PhD*
Keynote Speaker II: *Francis G. Lu, MD, FAPA*
Keynote Speaker III: *Keh-Ming Lin, MD, MPH*

1996

THE CONSORTIUM ON ASIAN AMERICAN MENTAL HEALTH TRAINING

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The 2nd ANNUAL ASIAN AMERICAN MENTAL HEALTH TRAINING CONFERENCE

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and
Los Angeles County
Department of Mental Health

Keynote Speaker I: *Luke Kim, MD, PhD,*
Keynote Speaker II: *Tazuko Shibusawa, LCSW*
Keynote Speaker III: *Richard Mollica, MD*

1997

Consortium on Asian American Mental Health Training Presents

THIRD ANNUAL ASIAN AMERICAN MENTAL HEALTH TRAINING CONFERENCE

Sponsored by
Harbor/UCLA Medical Center
L.A. County Department of Mental Health
Los Angeles County MH Commission

Keynote Speaker: *Evelyn Lee, EdD*

1998

Fourth Annual Asian American Mental Health Training Conference

Sponsored by
Harbor - UCLA Medical Center
Los Angeles County - Department of Mental Health
Los Angeles County Mental Health Commission

Asian American Families Entering the New Millennium: Emerging Issues and Clinical Implications

Keynote Speaker: *Edmond Pi, MD*
Workshop Presenters: *Mayashree Bhaumik, PhD, LCSW; Freda K. Cheung, PhD; Susan Chung, MD; & Victorina Peralta, ACSW*

Consortium on Asian American Mental Health Training Presents

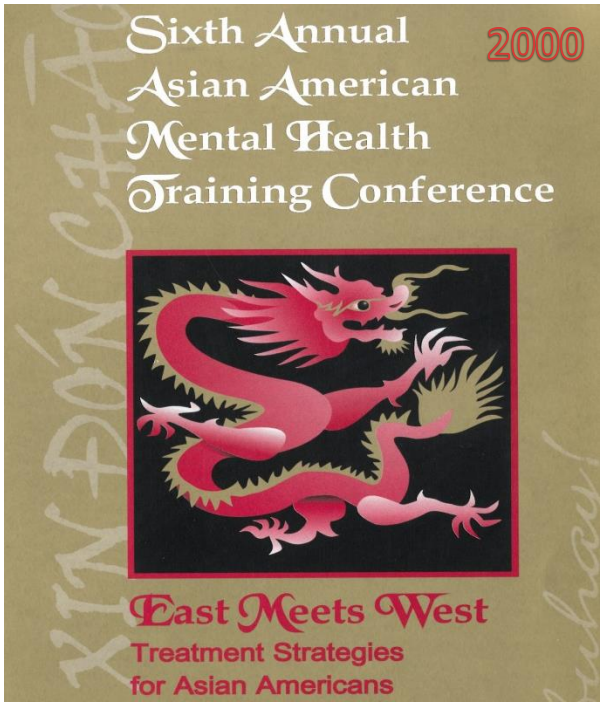
1999

Fifth Annual Asian American Mental Health Training Conference

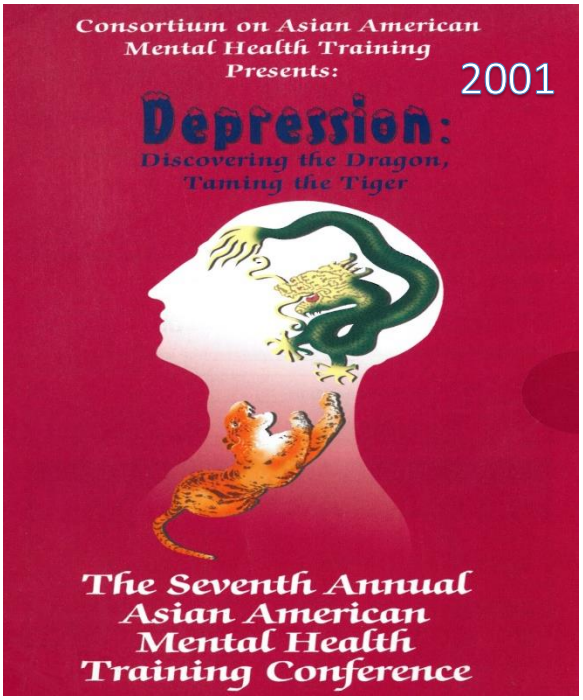
Sponsored by
Harbor/UCLA Medical Center
Los Angeles County – Department of Mental Health
Los Angeles County Mental Health Commission

Substance Abuse and Addictive Behavior Among Asian Americans

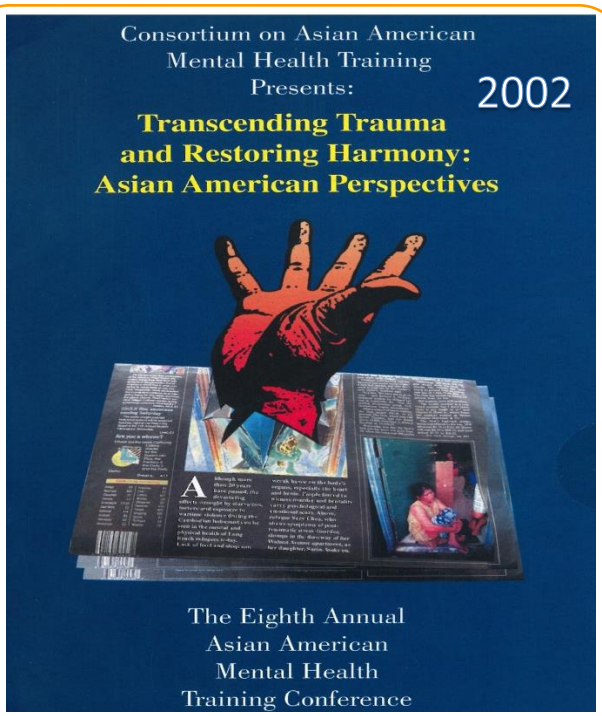
Keynote Speakers: *Darryl S. Inaba, PharmD & Matthew R. Mock, PhD*
Workshop Presenters: *Matthew R. Mock, PhD; John W. Tsuang, MD, MS; Benjamin Marte, MD; & Darryl S. Inaba, PharmD*



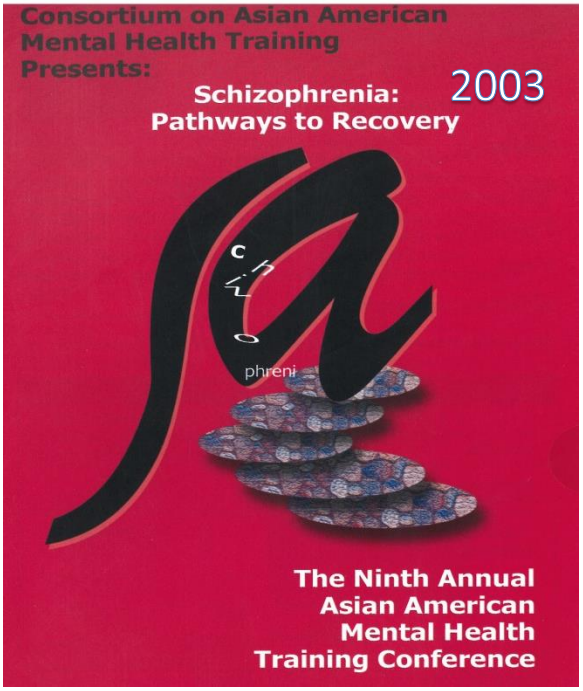
Keynote Speaker: *J. David Kinzie, MD*
Workshop Presenters: *Rev. Chhean Kong, PhD; Ven. Hye Wol Sunim; Siang-Yang Tan, Ph.D; Marshall Jung, DSW; Joselyn Geaga-Rosenthal, LCSW; & Michael W. Smith, MD*



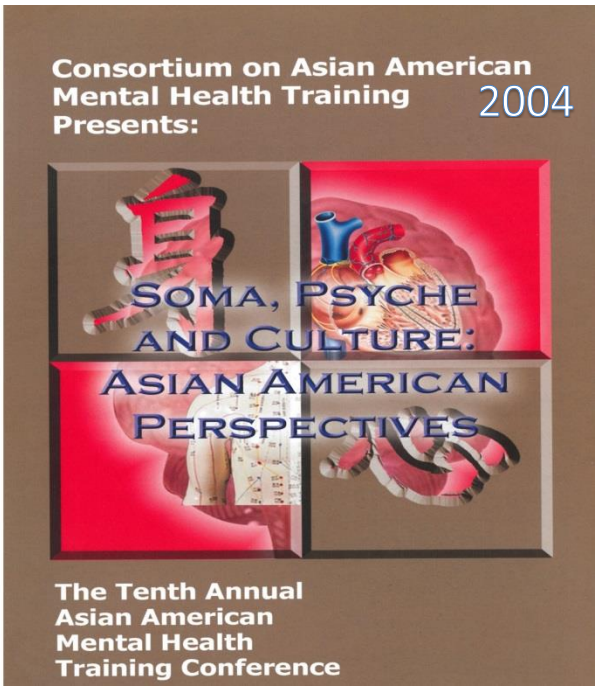
Keynote Speaker: *Arthur Kleinman, MD, MA*
Workshop Presenters: *Ira Lesser, MD; Lobsang Rapgay, PhD; Joseph Chen, MD; Trang Thi Nguyen, MD; & George K. Hong PhD*



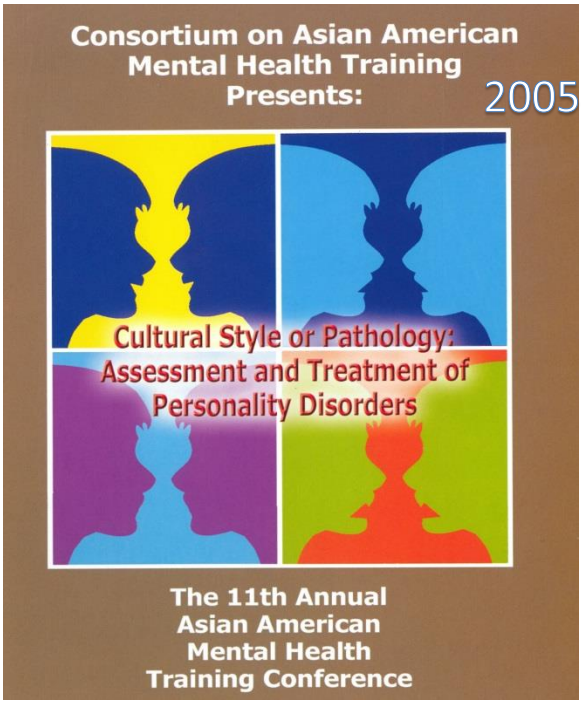
Keynote Speaker: *Steven Shon, MD*
Workshop Presenters: *MaryAnn Seng, MA; Stephen Cheung, PsyD; Marshall Jung, DSW; & Yoshi Matsushima, LCSW*



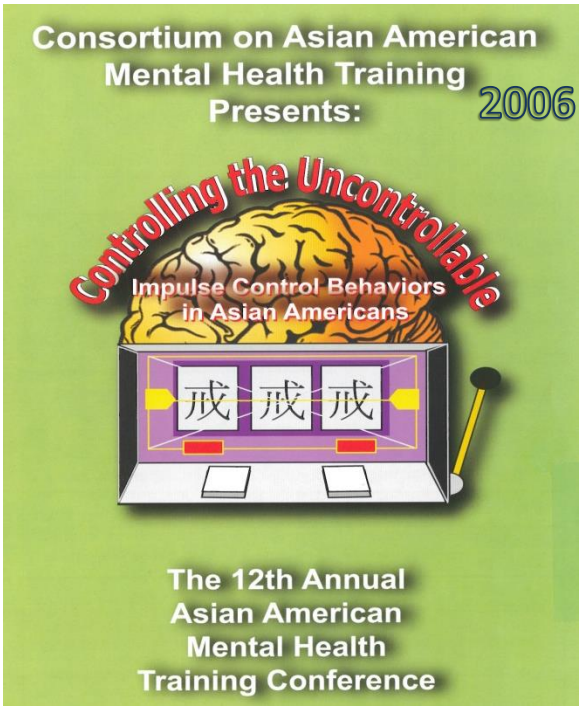
Keynote Speaker: *Albert Gaw, MD*
Workshop Presenters: *Jambur Ananth, MD; Winnie W. Kung, MSW, PhD; Michael Green, MD; Chong Suh, PhD and Elvira Quintos, RN, MN*



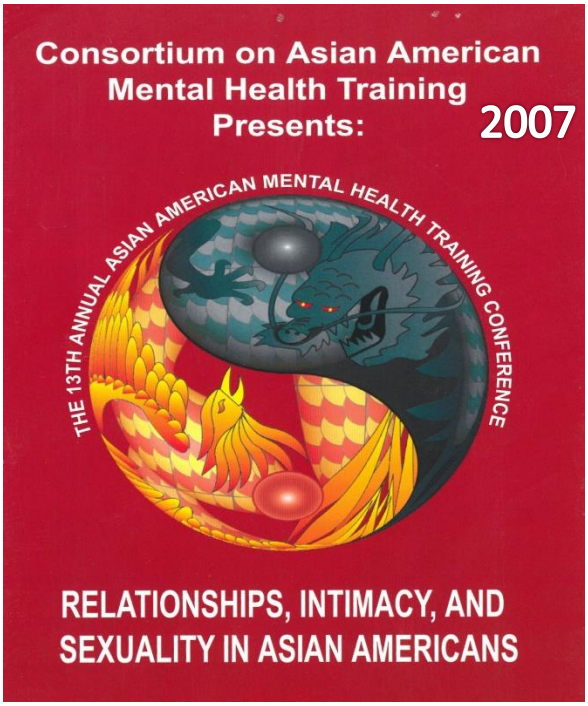
Keynote Speaker: *Laurence J. Kirmayer, MD*
Workshop Presenters: *An-Fu Hsiao, MD; Margaret T. Lin, MD; & Karen M. Johnson, MD*



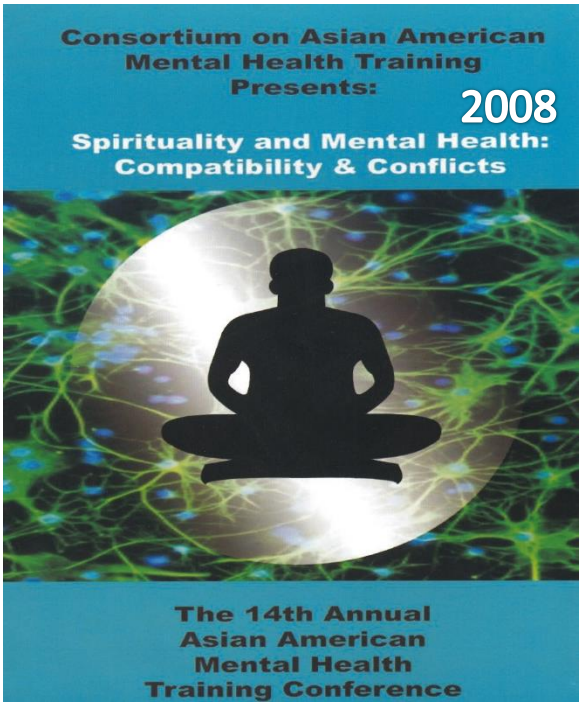
Keynote Speaker: *Renato D. Alarcon, MD, MPH*
Workshop Presenters: *Christopher K. Chung, MD; Lynn Marcinko-McFarr, PhD; & Chao-Ying Wang, PhD, PsyD*



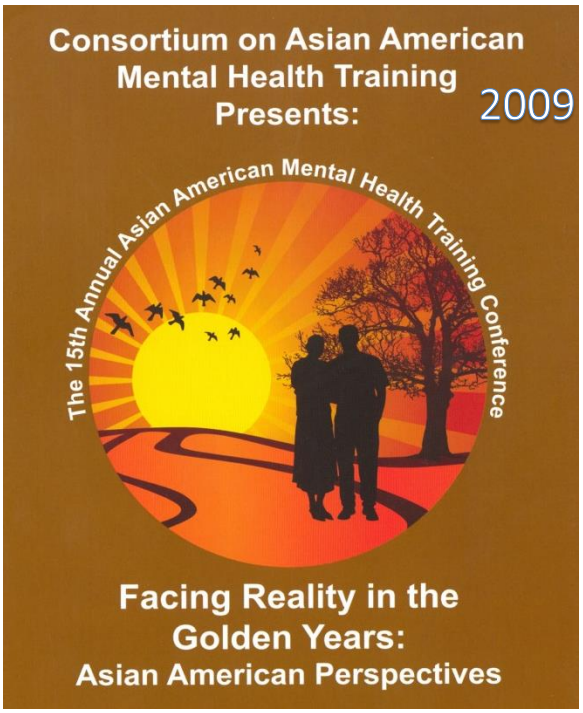
Keynote Speaker: *Suck Won Kim, MD*
Workshop Presenters: *Timothy W. Fong, MD; Glenn I. Masuda, PhD; & Stephen Cheung, PsyD*



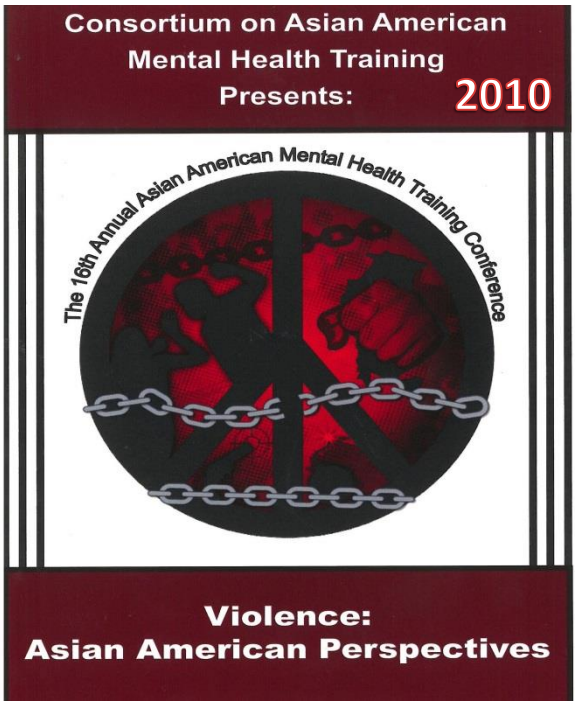
Keynote Speakers: *Waguih W. IsHak, MD & Terry S. Gock, PhD, MPA*
Workshop Presenters: *Brett Sevilla, MD; Florentius Chan, PhD; Freda K. Cheung, PhD; Jason Huang, PhD; & Silvia Yan PhD*



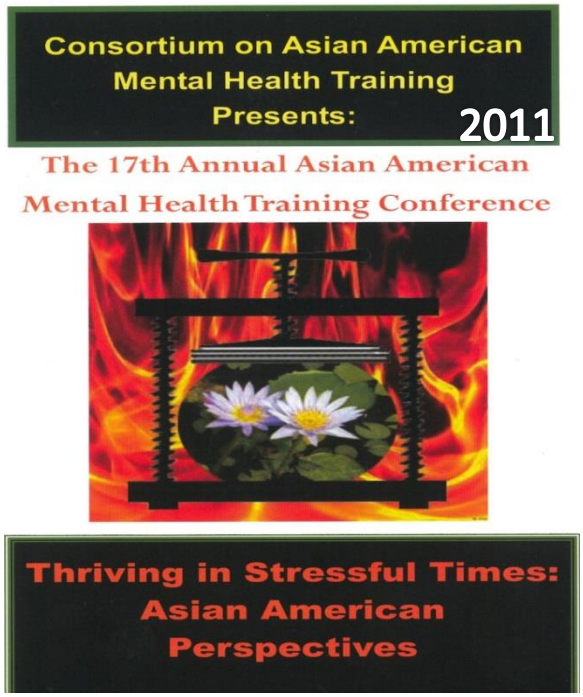
Keynote Speakers: *Francis Lu, MD & Hanh Truong, PhD*
Workshop Presenters: *Rocco Cheng, PhD; Jae Son, LMFT; Joe Jo, PhD; Margaret Lee, MSW; & Mark Stanton, PhD, ABPP*



Keynote Speakers: *Gwen Yeo, PhD, AGSF & Bruce Miller, MD*
Workshop Presenters: *David Yim, MSW; Yvonne Sun, MSW; Janet Yang, PhD; & Descartes Li, MD*



Keynote Speakers: *Michael P. Maloney, PhD, ABPP & Robert Geffner, PhD, ABPP*
Workshop Presenters: *Jay Nagdimon, PhD; Glenn Masuda, PhD; & Col. Valvincent Reyes, LCSW, BCD*



Keynote Speakers: *George K. Hong, PhD, ABPP & Michael Irwin, MD*
Workshop Presenters: *Timothy Chiang, PhD; Ira Lesser, MD; & Joanne Ng, MD*

Keynote Speaker: *Anthony Back, MD*
Workshop Presenters: *Julie Wetherell, PhD; Nina J. Gutin, PhD; & Freda K. Cheung, PhD*

Keynote Speakers: *Christopher K. Chung, MD*
Workshop Presenters: *Siang Yang Tan, PhD; Richard Lieberman, MA, LEP, NCSP; & Lan Nguyen-Chawkins, PhD*

Keynote Speakers: *Keh-Ming Lin, MD, MPH; Francis Lu, MD; & Jeffrey R. Cugno, FBI Special Agent*
Workshop Presenters: *Stephen Cheung, PsyD; Clayton Chau, MD; Suzie Dong-Matsuda, PsyD; & Tim Fong, MD*

2014 Planning Committee members of the Consortium on Asian American Mental Health Training

From Left to Right: Jae Kim, Sam Keo, Mitsuru Kubota, Lisa Song, Stephen Cheung, Freda Cheung, Jason Huang, Margaret Lin, Ira Lesser and Silvia Yan (Not in the picture: Scott Hanada, George Hong and Karen Lee)

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Thank you for your support

in attending today's conference!