

Practitioners' Essay

The Bridge Program: A Model for Delivering Mental Health Services to Asian Americans through Primary Care

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Abstract

Compared to all other racial and ethnic groups, Asian Americans have the lowest utilization of mental health services. Contributing factors include extremely low community awareness about mental health, a lack of culturally competent Asian American mental health professionals, and severe stigma associated with mental illness. This manuscript describes an innovative program that bridges the gap between primary care and mental health services. The Bridge Program, cited in the supplement to the Surgeon General's Report on Mental Health: Culture, Race and Ethnicity as a model for delivery of mental health services through primary care, has three goals: (1) to improve access by providing mental health services in primary care; (2) to improve capacity by enhancing the skills of primary care providers to identify and treat mental disorders commonly seen in primary care; and (3) to raise community awareness by providing health education on mental health and illness. Results are presented and the potential for replication is addressed.

Barriers to Mental Health Services

Compared to all other racial and ethnic groups, Asian Americans have the lowest utilization of mental health services (Sue 1985; Lin and Cheung 1999). Those who finally gain access to mental health professionals usually have the greatest delay in receiving appropriate care when a mental disorder has been identified (Lin et al. 1982). By the time Asian Americans are diagnosed with mental

illness or related disorders, they are often severely ill or in crisis (Snowden and Cheung 1990); as a result, they are more costly to treat, frequently requiring lengthy inpatient hospitalization. Although national epidemiological data are scarce, research has consistently found that Asian adults ages sixty-five and older often have the highest suicide rates in the U.S. for that age group, and Asian women between the ages of fifteen to twenty-four have the second highest suicide rate of all women in that age group in the U.S. (Diego et al. 1994; Shiang et al. 1997). In one community-based study 40 percent of elderly Asian Americans residing in New York City's Chinatown reported symptoms of depression (AAFNY 2003).

Three major factors contribute to mental health underutilization. First, there is very little community awareness about mental health and profound stigma associated with mental illness and psychiatric services. The stigma is typically heightened by Asian culture that puts tremendous emphasis on familial identity and honor, and often prevents those with mental illness from self or family-referral to mental health services (Ng 1997; Zhang, Snowden, and Sue 1998). Second, Asian Americans tend to present to their primary care providers with somatic complaints, which may not be recognized as emotional in etiology. Unfortunately, primary care providers, who are the first point of medical contact, often are not equipped to provide mental health care (Chung 2002; Leong and Lau 2001). Many primary care providers fail to recognize mental health symptoms, especially when they often appear in somatic forms (Hsu and Folstein 1997; Mark, Chen, and Chung 1999). Finally, there is a lack of culturally competent services due to a dearth of accessible bilingual/bicultural Asian American mental health professionals. Many mental health programs serving Asian Americans continually report that their caseloads are overwhelmed with acutely ill patients who have never received prior treatment (Chung et al. 2003). These general barriers were further confirmed by several local needs assessments through focus groups and surveys (WHO 2001).

There are two central concepts that guide the general approach to the problem: collaborative care and community-based services (USDHHS 1999; Kellerher, Holmes, and Williams 1994). Primary care providers (PCPs) are in a unique position to provide mental health services because of their regular contacts with patients, their knowledge of the patient's contextual factors and

other relevant medical conditions, and their role as contact and referral point for the patient within the health care system (Katon 1995). Primary care clinicians are often the only source of mental health care for many people with mental health or substance abuse problems (Katon et al. 1997; Kleinman 1986). PCPs are critical to providing mental health care to Asian Americans because the setting in which services are delivered is less stigmatizing, and because Asians tend to somatize their emotional distress. (Ying 1990; USDHHS 2001).

Use of community-based services can lead to early intervention and limit the stigma of receiving treatment. However, only when community members become aware of the prevalence of mental disorders, that they can be treated, the recovery process, and privacy rights of people with mental disorders, will they begin to utilize their health care choices and the benefits available to them (USDHHS 1999).

The Bridge Program

The Bridge Program was founded in 1997 at the Charles B. Wang Community Health Center (formerly the Chinatown Health Clinic) in lower Manhattan. The Bridge Program has three specific goals: (1) to improve access by providing mental health services in a primary care setting; (2) to improve capacity by enhancing the skills of primary care providers in the identification and treatment of mental disorders commonly seen in primary care; and (3) to raise community awareness by providing community health education on mental health issues. The Center has a thirty-year history of providing bilingual/bicultural primary care outpatient services to predominantly Chinese-speaking populations in the metropolitan New York area. Patients seeking bilingual health services at the health center come from all five boroughs of New York City, and from as far away as New Jersey, Connecticut, and Long Island. At the time of this writing, there were approximately 60,000 visits made to the Clinic annually.

Because of the persistent scarcity of qualified bilingual and bicultural mental health clinicians in the Asian American community, the Bridge Program started by establishing contracts with two public hospitals which had Asian mental health clinics to share bilingual certified psychiatric social workers who could be co-located part time in the primary care centers. This arrange-

ment made integrated staffing of mental health services in primary care possible and helped to smooth the inter-agency referral process. A board-certified bilingual psychiatrist was hired to provide psychiatric consultation and medication management, and to assist in quality assurance and program educational activities.

During the initial phase of the Bridge Program, the clinical social worker and the psychiatrist were responsible for all program activities including clinical service, training for primary care providers, inter-agency coordination, community education, and seeking funding and resources. As the program has grown, personnel have increased to meet the growing clinical demands and community education tasks. Currently there are eight full-time equivalent staff who are distributed as follows: one full-time adult psychiatrist, two and a half licensed clinical social workers, two full-time care managers, and one full-time program coordinator.

The program began with seed money from several local foundations and Federal and State governments. With encouraging pilot data, the Bridge Program garnered support from national funding agencies, enabling it to broaden its training curriculum to include community physicians, medical residents, and nursing students. More extensive and focused community education efforts also were implemented.

Clinical Services

The integration includes three main characteristics: co-location of mental health services in the same physical space as primary care; shared responsibilities for diagnosis and management of mental health problems; and communication through the use of a common medical record, using a problem-oriented (SOAP) format. Like their primary care colleagues, mental health professionals (MHPs) wear white coats, to legitimize that mental health problems are treatable and so that they are indistinguishable from the PCPs in public appearance. These characteristics facilitate communications. Further, the physical proximity enables “corridor” consultations, the quick and informal discussion between colleagues that occurs during the course of the work day. This enhances the level of teamwork that one expects in a primary care setting and allows for more rapid triage and consultation. Follow-up appointments are generally scheduled for thirty minutes. The increased pace and style of delivery decreases patient stigma,

particularly during the engagement process and also visibly demonstrates the collaborative “in the trench” approach that PCPs have come to expect from other medical specialists.

Patients are referred to co-located mental health providers for short-term consultation or longer-term co-management with their PCPs. Co-management is defined as primary management of the mental health condition by the mental health therapist with the option of psychopharmacological management by the PCP or psychiatrist. In all cases the PCP supports and reinforces the importance of treating the mental health condition to optimize overall health. The PCP is regularly informed of the clinical progress of the patient. Mental health clinicians and PCPs ordinarily speak the same dialect as the patient.

Consultation by mental health providers to primary care providers occurs regularly for medication management, assistance in treatment planning and, if necessary case management services. Many consultations occur informally since Bridge Program clinicians and primary care providers work in the same location and have contiguous exam rooms. If mental health clinicians are not available, immediate consultation can be obtained by paging the on-call clinician.

Using the PHQ-9, an instrument adapted from the PRIME-MD (Kroenke, Spitzer, and Williams 2001), we have screened adults (ages eighteen to sixty-five) in the primary care clinic for depressive disorders, filling the gap of those patients who are not identified by their PCPs. The PHQ-9 was selected because it provides objective baseline depression scores and can be used to monitor patient progress and to determine patient outcomes.

A care manager usually performs the screening. Care managers are baccalaureate-prepared individuals, usually in the social or behavioral sciences, who are specially trained to perform some of the routine tasks of patient care, including screening, follow-up, and monitoring medication adherence. They function as essential members of the health care team (Simon et al. 2000). The care manager plays a lead role in screening medical patients for depressive and anxiety disorders. When a positive case is identified through the screening, the care manager will share the result with the patient’s PCP and upon the PCP’s approval, immediately arrange an appointment to see the MHP.

If a PCP-referred patient misses the initial appointment for

mental health assessment, it is automatically noted in the medical record so that the PCP is aware of it. The next time the patient returns for medical follow-up, the provider can reinforce the need for assessment and after consultation with Bridge staff, can even elect to start treatment until the patient can engage with the mental health clinician. However, the chart note only becomes an effective means of communication when a timely reminder created by the care manager is given to the PCP on the day of the patient's primary care visit.

The care manager can use assertive follow-up to address missed appointments during the course of treatment. When a patient fails to keep a scheduled mental health appointment, the care manager will send letters or make phone calls to remind the patient who misses the appointment to reschedule for another mental health visit. To assist the follow-up effort, the care manager also has established a patient database to track and evaluate patients to ensure continuity of care.

After the PCP has reviewed the screening results, patients who screen positive are referred to the on-site mental health clinician for further evaluation. Translation of well validated instruments for particular Asian ethnic groups must be done with care to ensure their linguistic and cultural validity. The Bridge staff collaborates with local academic institutions to select and develop culturally appropriate instruments and tools for psychiatric screening and outcome evaluation.

A full range of counseling and therapy is offered by the Bridge mental health clinicians, who provide psychotropic medication treatment, individual psychotherapy, stress management, supportive therapy, and family therapy. To match patients' cultural preferences, the clinicians also explore alternative treatments such as acupuncture, relaxation therapy, exercise and behavior modification when appropriate. With the training provided by the mental health clinicians, many PCPs have improved their capacity to prescribe psychotropic medication and provide brief psycho-educational counseling.

Patients with chronic psychiatric illness, suicidal or homicidal ideation, and patients who require long-term and/or intensive psychiatric treatment and monitoring are referred to an external specialty mental health facility. Determination of the need for referral to such a service is made by the clinicians of the Bridge

Program, based on evaluation of the patient's condition. The Bridge Program staff members are responsible for both referrals and follow-ups until the referral is successfully completed or a further decision is made. After the referral the patient's primary care provider is notified, and an entry is promptly made in the patient's medical chart. When a psychiatric emergency occurs, the patient's PCP is informed immediately and takes a leadership role in managing the crisis. The mental health clinicians from the Bridge Program provide assistance or assume the responsibility when appropriate.

Training for Primary Care Providers

The Bridge Program provides periodic training for PCPs and other clinical staff on detection, treatment, and management of patients with mental disorders. Training activities are carried out in three basic formats: formal lectures, in-service training, and through use of a clinical handbook. During the initial phase of the Bridge Program, a four-part behavioral health lecture series was presented to community PCPs and nurses for continuing education (CE) credits once or twice a year. The Bridge Program's psychiatrists and psychiatric social workers organized and presented the lectures. Topics include psychiatric screening methods, counseling skills, basic principles of psychopharmacology, and advanced psychopharmacology. Reading materials and useful screening tools from various sources are distributed to participants.

In-service workshops for clinical support staff and primary care providers are organized by the Bridge Program staff or invited speakers. They typically focus on basic knowledge of mental disorders commonly seen in the primary care setting, such as depression, anxiety disorders, and attention deficit/ hyperactivity disorder in children, as well as how to use appropriate and non-stigmatizing medical terms to describe them. All clinical staff members who have constant patient contact are invited to participate. PCPs and nurses cite the importance of learning how to use culturally acceptable and familiar words to describe psychiatric disorders, discuss treatment plans, and describe the biopsychosocial basis for mental disorders. This explanation has been well received since it corresponds with the principles of yin/yang balance and the Asian holistic view of health. Patients are informed that certain brain chemicals may increase or decrease depending

on psychological stress and genetic predisposition and, if left untreated, remain “out-of-balance” and cause disruptions in sleep and appetite, nerve weakness, and heart palpitations and other somatic symptoms.

The Bridge Program provides periodic training for primary care providers to detect, treat, and manage patients with mental disorders. Training activities are carried out in three basic formats: (1) formal lecture series, (2) in-service training, and (3) the development of a clinical handbook. During the initial phase of the Bridge Program, a four-part behavioral health lecture series was presented once or twice a year to community PCPs and nurses for continuing medical education (CME) credits. The Bridge Program’s psychiatrists and psychiatric social workers organize and present the lectures. Lecture topics include psychiatric screening methods, basic principles of psychopharmacology, counseling skills, and advanced psychopharmacology. Reading materials and useful screening tools from various sources are distributed to participants.

The second training format is the in-service workshop, organized by the Bridge Program staff or invited speakers, for clinical support staff and primary care providers. These training workshops typically focus on basic knowledge of mental disorders such as depression, anxiety disorders, and attention deficit/hyperactivity disorder commonly seen in the primary care setting, as well as how to use appropriate and non-stigmatizing medical terms for describing them. The workshops usually are scheduled on days and hours when most of the staff is present (for example, general staff meetings). Due to time constraints, they generally last between forty and sixty minutes. All clinical staff members from various departments, including social work staff, care managers, providers and receptionists who have constant patient contact are invited to participate in the mental health workshops.

The third training activity is self-learning through a handbook, which also serves as a ready reference for clinicians. A concise version of the lectures was published as a special theme issue of *The Western Journal of Medicine* (Vol. 176, 2002).

With training, many primary care providers feel increasingly more comfortable prescribing psychotropic medications for patients with mild disorders and managing these patients on their own, with occasional consultation from mental health clinicians. Most primary care clinicians, however, would rather refer their

Asian patients to the Bridge Program staff and co-manage them with mental health clinicians.

Community Education

Community education and outreach has several objectives: to increase knowledge and awareness of mental health, to reduce stigma associated with mental illness and psychiatric services, and to promote mental health services available in the community. The importance and uniqueness of a community based primary care center implementing broad based mental health education conveys a powerful anti-stigma message.

At the beginning of the Bridge Program, a strong outreach effort was made to the community through brochures, flyers and public information sessions presented by Bridge Program staff and health educators from the Clinic. In addition, the media, particularly radio and newspapers, were used and continue to be used.

Chinese educational radio programs are one of the most effective outreach mechanisms because patients often listen to the radio in the workplace as well as at home. The greater New York and New Jersey area has a well established Chinese-speaking radio system. Educational radio programs in the format of monologue presentation, interview, or call-in hotline question-and-answer sessions are proven to be one of the most effective outreach mechanisms. These programs are typically developed and delivered by both the Bridge Program staff and the Health Education Department of the center.

Newspaper articles provide another channel for disseminating basic information about particular mental health issues such as depression in elders, suicide in teenagers, and anxiety disorders. This has been especially important since the September 11th attack on the World Trade Center, which disproportionately affected the Chinatown community in New York City. The New York metropolitan area has four major Chinese language newspapers. Coordinated arrangements between the news agencies and the Bridge Program include regular submission of articles, news conferences, press releases, and development of special columns.

We found that workshops for teens, parents, elderly citizens, and service professionals are also an effective vehicle for disseminating both basic and in-depth information about mental health issues. They allow the presenter to focus on the needs of a par-

ticular group, with some reciprocal exchange and the option to distribute reading materials for reinforcement and more in-depth learning. Workshops are held in both the host clinic and community agencies, such as schools or senior citizen centers, and they consist of either a single session or a series of sessions on related topics over a period of time.

The workshops offered to health professionals from community health and social services agencies create an overlap between professional training and community education. Since the inception of the Bridge Program, the number of requests for these workshops has been overwhelming. Over the years, the community education team of the Bridge Program has worked with school guidance counselors, local mental health associations, and Asian American advocacy groups and cultural organizations. Training and educating community service providers from all disciplines seems to be one of the most effective ways to de-stigmatize and de-mystify mental disorders in the community.

We have learned that the messages concerning mental health issues are best conveyed to the Asian American community when they are combined with general health topics, such as stress management and developing a healthy lifestyle, thus further supporting the notion of integration of mental health services with general medical care.

As a result of the initial educational programs, patients began to come to the clinic requesting mental health services, which was unusual. PCPs became more aware of mental health problems, and there was increased demand at annual continuing medical education programs, such as the one sponsored by the Chinese American Medical Society, for education about mental health and the treatment of mental health problems.

Results

The Bridge program has grown significantly in its six years of operation. The number of mental health patients has nearly quadrupled since 1998 (Figure 1), suggesting a progressive success of the program in detecting and engaging patients with mental health needs. The number of mental health encounters (billable visits) with both PCPs and MHPs continues to grow rapidly. At present, approximately 5 percent of current visits (12,000) involve some type of mental health care. The number of encounters with men-

tal health personnel has far outpaced those with PCPs (Table 1). This probably is due to the ease of in-house referral resulting from the co-location of mental health and primary care, and the general reluctance of PCPs to comprehensively treat mental health patients when in-house consultation and referral is so convenient. The average number of visits per patient per year has increased slightly over the years, from a low of 4.4 in 2000 to 6.3 in 2002. Our impres-

Figure 1. Numbers of Mental Health Patients Over Time

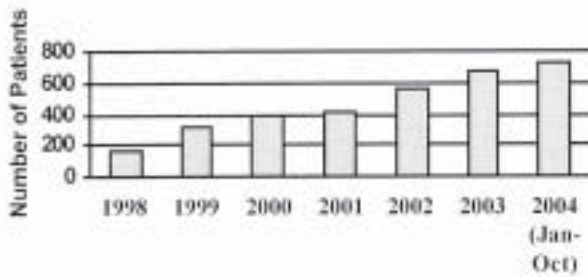


Table 1. Numbers of Encounters ¹ with Patients of Mental Health Needs

	1998	1999	2000	2001	2002	2003	2004 ²
Encounters made by MHPs	880	1517	1748	1950	3532	4350	4130
Encounters made by PCPs	402	522	594	698	924	1053	1067
Total Encounters	1282	2039	2342	2648	4456	5403	5197

1. Billable visits

2. 2004 data are based on ten months.

Table 2. Distribution of Psychiatric Diagnoses by Total Encounters ¹

Diagnosis	1998	1999	2000	2001	2002	2003	2004 ²
Depressive Disorders	55%	42%	45%	51%	46%	41%	40%
Anxiety Disorders	16%	20%	17%	13%	19%	17%	18%
Psychotic Disorders	19%	19%	21%	19%	18%	9%	11%
Adjustment Disorders	3%	7%	9%	7%	10%	24%	21%
All Other Disorders	7%	12%	8%	10%	7%	9%	11%

1. Billable visits.

2. 2004 data are for 6 months only.

sion is that we are seeing more depressed and anxious patients as a result of the use of PHQ screening and our PCPs' increased ability to detect these conditions in their patients.

The numbers presented in the tables should be interpreted with caution as the data were obtained from the Center's management information system, which was not designed for research or evaluation purposes and has been modified several times over the life of the project. The mental health encounters with PCPs were derived by using DSM codes to generate all mental health encounters and then subtracting those with MHPs. As a result the number of encounters may be underestimated especially among patients with co-morbid chronic illness.

The Bridge Program, as originally designed, did not use metrics to track patient outcomes over time. An additional limitation of the management information system we use is that it precludes breakdowns by types of encounters (for example, medication management, psychotherapy, psychoeducation, care management, etc.). However, we recently analyzed our data on the subset of patients with major depression using the PHQ-9 depression severity tool and found robust declines in scores over time with treatment. These data are being submitted for publication.

Some changes indicate a natural adaptation to program development. For instance, in 2002 the management information system was changed to better differentiate the proportion of patients who experienced adjustment disorders, which are quite common in this community, from those who suffered from major depression and severe anxiety disorders. Nonetheless, depression remains the most prevalent problem (Table 2).

Following the September 11, 2001 disaster, a tremendous effort was made to improve outreach to the community to locate those suffering from PTSD and depression. Additional staff members were hired at this time. While the increase in the number of encounters for depressive disorders in 2002 may have resulted from the sequelae of September 11th, it is not possible to sort out what proportion the disaster itself played and how much should be attributed to capacity expansion within the program.

The Bridge Program has been cited as the national model for delivery of mental health services through primary care in the Surgeon General's Report Special Supplement on Mental Health: Culture, Race and Ethnicity (2001, 163). In 2000, it was one of four

recipients of the Bureau of Primary Health Care (BPHC) and Health Resources Services Administration (HRSA)'s competitive award for "Models That Work."

The program has been operating more than three years since the initial funding ended. About two years following inception, revenues generated from Medicaid, Medicare, and commercial insurance began to demonstrate program viability for the clinical services. The financial case mix was 43 percent Medicaid, 14 percent Medicare, 12 percent commercial health insurance, 19 percent self-pay with a sliding scale fee schedule, and 12 percent Child Health Plus. Overall, this revenue barely covers the cost of the on-site psychiatrist and psychiatric social workers. Extra funding of ten is needed to cover the costs of support services, overhead, and administrative leadership as well as enhancement of certain program components. The revenue picture is complicated by the increasing penetration of behavioral health carve-out companies that use pre-certification and utilization management approaches for outpatient services. Since most of the patients have high care management needs, the addition of a utilization management approach can be overwhelming to staff. We hope to demonstrate that the program is cost-effective, as we attempt to work with companies that will modify the pre-certification requirements.

Concluding Remarks

A number of factors combine and synergize to make a program such as the Bridge Program work. The essential determinants of success are: (1) strong commitment from the organization's Board of Directors and senior management; (2) a plan for sustainability that is developed during the planning process; (3) culturally and linguistically competent staff and a program that is syntonetic with patients' beliefs, and (4) relentless community education and buy-in from the community who help to support it.

Because of the promising results, there have been efforts to replicate the Bridge Program in a number of Asian and non-Asian community based organizations through dissemination from the Bureau of Primary Care, Models that Work Program, and the efforts of grant making agencies. To fulfill the increasing number of requests for technical assistance, we have developed a detailed Strategy Transfer Guide for the Bureau of Primary Health Care, which is available on at <http://www.bphc.hrsa.gov/mtw/STGs.htm>. How-

ever, the degree of replication in organization and outreach, the growth of the programs and their ability to be self-sustaining after initial funding has not been determined. Future comparative studies of patient outcomes in various sites to determine the most significant factors for success also are needed.

Despite the improvements brought about by the Bridge Program, there are still a number of ongoing and future challenges, including continued stigma, the chronic shortage of bilingual mental health professionals, and sharing of treatment responsibility and model fidelity. Many of the Bridge strategies are successful examples of both working *around* the stigma and attempting to minimize it. Continuous effort will be needed for community education and innovative strategies to influence people beyond the primary care setting and help them to reveal mental health symptoms. Innovative strategies that can pull various types of educational resources together must be applied to train linguistically and culturally competent mental health professionals and to involve paraprofessionals from health and social services in the community. Many PCPs still prefer to use direct referral to the MHP; they may feel constrained by their training and find it simpler to have the MHP follow the patient. Although widely promoted as a partial solution to increasing access to mental health care for all population groups, integrated service models must consider the variation of interests and capacity to handle mental health problems among PCPs, and how much the change of their preferred practice would affect the fidelity of an established, integrated mental health and primary care program.

Integration of mental health with primary care undoubtedly has created new opportunities for improving access to mental health care, but integration in essence is a compromise between two types of care. While the benefits of collaborative service models have been increasingly recognized, we should never ignore the need for specialty care. It is possible that the most feasible collaborative care model is to have maximum physical proximity and moderate clinical collaboration between primary care and on-site mental health services. The degree of moderation, of course, should always be subject to the specific medical, social, and cultural characteristics of the patient population and the clinical community.

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Acknowledgements

The authors are grateful to the Robert Wood Johnson Foundation Local Initiatives Funding Partners Program, the Bureau of Primary Health Care, Health Resources and Services Administration, the Pfizer Foundation, the Van Ameringen Foundation, the United Hospital Fund of Greater New York, the New York Community Trust and the Sergei S. Zlinkoff Fund for Biomedical Education for making this program initiative possible. We also want to thank Susan Seto-Yee, RN, MPA, Clinical Director of Charles B. Wang Community Health Center, and Theresa Jung for their help and support.

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