California Reducing Disparities Project

Asian Pacific Islander (API)

POPULATION REPORT

In Our Own Words

Wellness 康健

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Prepared For:
Office of Health Equity
California Department of Public Health

By:
Pacific Clinics on behalf of the API-SPW
March 2013

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This API population report is one of the end products of the Phase One of California Reducing Disparities Project API Strategic Planning Workgroup (CRDP API-SPW). It is with much excitement, appreciation and gratitude that we present this population report to the community on behalf of the API-SPW. Our 55 project members, steering committee members, consultants, and staff have put in tremendous amount of hours and work for the past two and half years. This report is the culmination of this effort that documents the disparities experienced in the community. It also offers recommendations to reduce these disparities.

CRDP is funded from the Prevention and Early Intervention (PEI) portion of the Mental Health Services Act (MHSA). It was administered by the Office of Multicultural Services (OMS) of the California Department of Mental Health since 2010 and will be administered by Office of Health Equality (OHE) of the California Department of Public Health (DPH). MHSA is designed with the unserved, under-served, and inappropriately served in mind. CRDP is one of the best examples illustrating this spirit. CRDP is one of a kind and is the largest investment in the nation to look into diverse community perspectives on mental health disparities. This is a ground-breaking project and we feel fortunate to be part of this project. We have received much interest from different parts of California, and even Washington, DC, during the development of this project. People are interested in learning from our California experience.

In order to maintain the community perspective, we have selected the grassroots approach in organizing the AANHPI (Asian American Native Hawaiian and Pacific Islander) communities from five regions in California. We have used a collaborative and strengths-based philosophy to gather as much data from as many diverse sectors and representation as possible. This report is an authentic documentation of this journey and has been vetted through its members and a public review process. With the limited resources allotted, we were able to hold 30 regional meetings, 5 statewide meetings, 12 Steering Committee meetings, 23 focus groups, 8 community forums, and a statewide conference to gather information, formulate our recommendations, and share our findings.

At the dawn of the nation moving towards healthcare reform and the Affordable Care Act (ACA), we trust this report will offer helpful insights to improve our current mental health system and services. As gaining better access, providing quality services, and eventually lowering the cost in healthcare are the three pivotal principles in ACA, it will be critical to reference the key points of this report to better serve the AANHPI communities. We know the community holds a lot of experience and wisdom in working with AANHPIs. It is our hope that we will be able to continue the work via collaborating with local, regional, and statewide government entities to address and reduce the mental health disparities in the community. By working together, we have better chance of reducing disparities.

C. Rocco Cheng, Ph.D., Pacific Clinics
CRDP API-SPW Project Director

Over the last two years, the Asian Pacific Islander Strategic Planning Workgroup (API-SPW) had been given the task to engage various Asian Pacific Islander (API) communities in California to identify unmet mental health service needs and to collect community-defined strategies to address these needs. The goal was to identify the current state of disparities and to develop a strategic plan to reduce mental health service disparities in the API community based on input from community members, cultural experts, API-serving organizations, and other interested parties. During the course of the project, many individuals, agencies, and organizations have made generous contributions to this Project, including the development and completion of this report, with their time, knowledge, and expertise. Without the dedication and commitment from all those involved, this report would not have been made possible. Therefore, we would like to express our sincere appreciation to the following individuals and organizations (listed in alphabetical order by last name):

CRDP API-SPW Members:

Annie Ahn (UC Irvine Counseling Center), Ellen Ahn (Korean Community Services), Noel Alumit (Asian Pacific AIDS Intervention Team Health Center), Jay Aromin (Kutturan Chamoru Foundation), Khatera Aslami (Peers Envisioning & Engaging in Recovery Services), Kavoos Bassiri (Richmond Area Multi-Services), Leina Bell (Samoan Community Council of San Diego), Laurel Benhamida (Muslim American Society – Social Services Foundation), Ben Cabangun (Asian and Pacific Islander Wellness Center), Ramon Calubaquib (Japanese Community Youth Council), Blia Cha (Hmong Women's Heritage Association), Christine Chang (Korean Community Services), Fam Chao (United Iu-Mien Community, Inc.), H. Nhi Chau (Oakland Asian Students Educational Services), Raymond Chavarria (United Cambodian Community), Ranjeeta Cheetry (South Asian Network), Sunjung Cho (Asian American Recovery Services), Jocelyn Estiandan (Asian Pacific Health Care Venture), Marita (Merly) Ferrer (Council of Philippine American Organizations), Koua J. Franz (Hmong Women's Heritage Association), Dixie Galapon (Union of Pan Asian Communities), Terry S. Gock (Asian Pacific Family Center), Mutsumi Hartmann (Asian Pacific Community Counseling), Calvin Hsi (Tzu Chi Foundation), Rimmi Hundal (South Asian Community Representative/Tri-City Mental Health Services), Connie Chung Joe (Korean American Family Service Center), Sam Joo (Koreatown Youth and Community Center), Christine Kim (Korean American Family Service Center), Sean Kirkpatrick (Community Health for Asian Americans), Ford Kuramoto (National Asian Pacific American Families Against Substance Abuse [NAPAFASA]), Phuong Lan Le (Vietnamese Federation of San Diego), Amy Lee (Oakland Asian Students Educational Services), Beatrice Lee (Community Health for Asian Americans), Joua Lee (Merced Lao Family Community), Kirk Lee (Hmong Cultural Center of Butte County), Vivian Lee (Little Tokyo Service Center), Laura Leonelli (Southeast Asian Assistance Center), Nancy Lim-Yee (Chinatown Child Development Center), Edwin Lin (Chinese Service Center of San Diego), Jennifer Lin (Transitional Age Youth Representative/San Gabriel Valley Youth Council), Catherine 'Ofa Mann (To'utupu'o e Otu Felenite Association [TOFA]), Candice Medefind (Healthy House Within a MATCH Coalition), Marilyn Mochel (Healthy House Within a MATCH Coalition), Fawada Mojaddidi (Afghan Community Representative/Hume Center), Jeff Mori (Asian American Recovery Services), Palee Moua (Healthy House Within a MATCH Coalition), Hiroko Murakami (National Asian Pacific American Families Against Substance Abuse [NAPAFASA]), Desiree Nguyen (Vietnamese Community of Orange County), Tricia Nguyen (Vietnamese Community of Orange County), Amy Phillips (Little Tokyo Service Center), Sara Pol-Lim (United Cambodian Community),

Myron Dean Quon (National Asian Pacific American Families Against Substance Abuse [NAPAFASA]), Yasuko Sakamoto (Little Tokyo Service Center), Farhana Shahid (South Asian Network), Leena Shin (Korean Community Services), Joty Sikand (Hume Center), Talaya Sin (Cambodian Community Development, Inc.), Dolly Solomon (Punjabi Community Representative/Healthy House Within a MATCH Coalition), Sharon Stanley (Fresno Interdenominational Refugee Ministries), Lily Lue Stearns (Asian Community Mental Health Services), Dong Suh (Asian Health Services), Angela Tang (Richmond Area Multi-Services), Ge Thao (Merced Lao Family Community), Ger Thao (Fresno Center for New Americans), Kao C. Thun (United Iu-Mien Community, Inc.), Lance Toma (Asian and Pacific Islander Wellness Center), Jonathan Tran (Southeast Asia Resource Action Center), Diane Ujiiye (Asian and Pacific Islanders California Action Network), Nilda Valmores (My Sister's House), Pa Kou Vang (Hmong Women's Heritage Association), Susan Vang (Hmong Health Collaborative), Benny Wong (SteppingStone – Golden Gate Day Health), Jorge Wong (Asian Americans for Community Involvement), Mandy Wong (Chinese Service Center of San Diego), Sally Wong-Avery (Chinese Service Center of San Diego), Franklin Yang (Fresno Interdenominational Refugee Ministries), Linda Yang (Lao Family Community of Stockton), Mee Yang (Lao Family Community of Stockton), Seng Yang (Hmong Cultural Center of Butte County), Rona Yee (Cambodian Community Development, Inc.), Jane Yi (Asian Community Mental Health Services), David Yim (Asian Pacific Planning and Policy Council [A3PCON] and Special Service for Groups – Older Adults Program), Nette You (Cambodian Community Development, Inc.), and Judy Young (Vietnamese Youth Development Center).

CRDP Steering Committee:
Dixie Galapon (San Diego/Orange County Regional Lead), Terry S. Gock (Los Angeles Regional Lead), D.J. Ida (CRDP Statewide Facilitator), Beatrice Lee (Bay Area Regional Lead), Laura Leonelli (Sacramento Regional Lead), and Susan Vang (Central Valley Regional Lead).

Office of Health Equity, California Department of Public Health:
Marina Augusto (Acting Deputy Director) and Kimberly Knifong.

Other CRDP SPWs:
African American SPW (Led by the African American Health Institute of San Bernardino County), Latino SPW (Led by the UC Davis Center for Reducing Health Disparities), Native American SPW (Led by the Native American Health Center), Lesbian, Gay, Bisexual, Transgender, & Questioning SPW (Led by the Equality California Institute and Mental Health America of Northern California), CRDP Facilitator/Writer (Led by the California Pan Ethnic Health Network), and the California MHSA Multicultural Coalition (Led by the Mental Health Association in California/Racial and Ethnic Mental Health Disparities Coalition [REMHDCO]).

Mental Health Services Oversight and Accountability Commission:
David R. Pating (MHSOAC Commissioner; Chief of Addiction Medicine, Chemical Dependency Recovery Program, Kaiser Permanente).

County Ethnic Service Managers and Staff:
Myriam Aragon (Riverside County), Felix Bedolla (Napa County), Clayton Chau (Orange County), Connie Cha (Fresno County), Gigi Crowder (Alameda County), Pete Duenas (Stanislaus County), Piedad Garcia (San Diego County), Jesse Herrera (Monterey County), Jo Ann Johnson (Sacramento County), Sharon Jones (Merced County),Veronica Kelley (San Bernardino County), Gladys Lee (Los Angeles County), Edwin Lemus (San Bernardino County), Sanjida Mazid (Solano County), Imo Momoh (Contra Costa County), Janine Moore (Riverside County), Nelson Jim (San Francisco County), Moises Ponce (Riverside County), Barbara Ann White (City of Berkeley), Deane Wiley (Santa Clara County), and Chong Yang (Stanislaus County).

Others:
Mike Eng (California Assembly Member, 49th District), Rachel Guerrero (Former Chief, Office of Multicultural Services, California Department of Mental Health), Adrienne Hament (California Mental Health Planning Council), Larke Nahme Huang (Senior Advisor, Substance Abuse and Mental Health Services Administration [SAMHSA]), Lydia Ko (Team Coordinator, Asian Pacific Family Center – East), Daphne Kwok (Chair, President Obama's Advisory Commission on Asian Americans and Pacific Islanders), Susan Mandel (President/CEO, Pacific Clinics), Kim Saing (Center for Human Services,) Anne Saw (Associate Director, Asian American Center on Disparities Research, UC Davis), Winston Tseng (Research Sociologist, UC Berkeley), Diane Van Maren (Consultant, California State Senate), Simon Wai (Program Director, Asian Pacific Family Center – East), Wendy Wang (Corporate Director of Community Education, Outreach, and Public Policy, Pacific Clinics), and Nolan Zane (Chair, Department of Asian American Studies; Director, Asian American Center on Disparities Research, UC Davis).

Technical Support Team:
Ryan Gucayane (Sr. Graphic Designer, Pacific Clinics), Michael Guitron (Director of Information Systems, Pacific Clinics), and Randolph Lee Welty (Web Designer, Pacific Clinics).

Focus Group Facilitators:
Elma Bataa, Alex Baty, Olivia Byler, Supatra Chowchuvech, Sally Jue, Pa M. Khang, Napaporn Limopasmanee, Natasha Molony, Loa Niumeitolu, T. Sitra, and Paul Thao.

In particular, we would like to thank all our 198 focus group participants who shared their experience, time, and wisdom with us to ensure that direct voices from the community were represented in the report. We are immensely grateful for their trust and join them in their hope that this report will lead to significant changes in helping those in need receive the care they deserve.

Administrative Team:
Lastly, we would like to express our appreciation toward the administrative team, Dr. Liyu Su and Ms. Karen Luu for their tireless work on the project and this population report. We would also like to acknowledge Dr. Michi Fu and her research assistant, Ms. Kaitlyn Masai, who provided editorial inputs. The report would not have completed without their dedication.

BACKGROUND OF THE MHSA AND CRDP

The Mental Health Services Act

California voters passed Proposition 63, now known as the Mental Health Services Act (MHSA), in November 2004 to expand and improve public mental health services and establish the Mental Health Services Oversight and Accountability Commission (MHSOAC) to provide oversight, accountability and leadership on issues related to pubic mental health.

At that time, California's public mental health funding was insufficient to meet the demand for services and was frequently portrayed as a "fail-first" model. However, with the inception of MHSA, there was the alternative "help-first" model that promised to transform existing public mental health system. MHSA consists of five components: (1) Community Services and Supports (CSS) – provides funds for direct services to individuals with severe mental illness; (2) Capital Facilities and Technological Needs (CFTN) – provides funding for building projects and increasing technological capacity to improve mental illness service delivery; (3) Workforce, Education and Training (WET) – provides funding to improve the capacity of the mental health workforce; (4) Prevention and Early Intervention (PEI) – provides historic investment of 20% of the MHSA funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs to reduce stigma and discrimination; (5) Innovation (INN) – funds and evaluates new approaches that increase access to the unserved and underserved communities, promote interagency collaboration and increase the quality of services.

The California Reducing Disparities Project

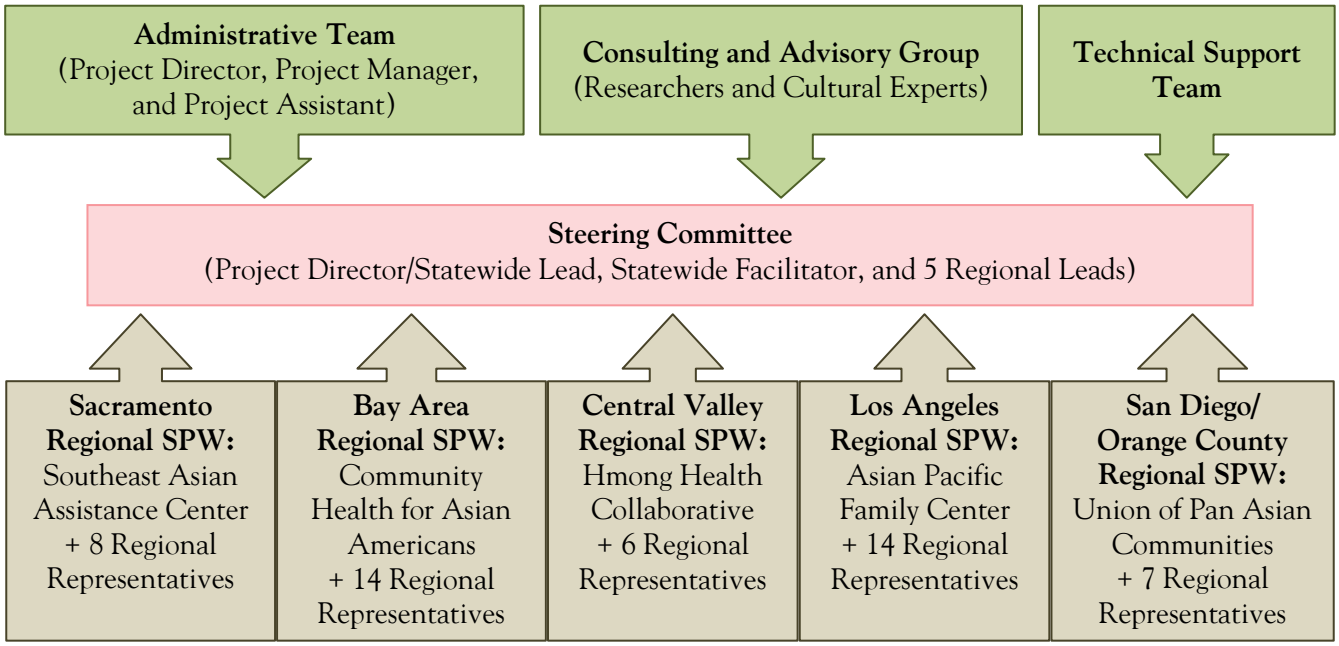
In response to the call for national action to reduce mental health disparities and seek solutions for historically underserved communities in California, the Department of Mental Health (DMH), in partnership with Mental Health Services Oversight and Accountability Commission (MHSOAC) called for a key statewide policy initiative as a means to improve access, quality of care, and increase positive outcomes for racial, ethnic, and cultural communities. In 2009, DMH launched the two-year statewide Prevention and Early Intervention (PEI) effort with state administrative funding and created this California Reducing Disparities Project (CRDP).

CRDP is funded from the PEI portion of the Mental Health Services Act (MHSA). It was administered by the Office of Multicultural Services (OMS) of the California DMH since 2010. MHSA is designed with the unserved, under-served, and inappropriately served in mind. CRDP is one of the best examples illustrating this spirit. CRDP is one of a kind and is the largest investment in the nation to look into diverse community perspectives on mental health disparities.

CRDP is divided into seven components. Five of these components covered the five major populations in California: African American, Asian/Pacific Islanders (API), Latinos, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ), and Native Americans. Each of these five populations formed a Strategic Planning Workgroup (SPW) in developing population-specific reports that will form the basis of a statewide comprehensive strategic plan to identify new approaches toward the reducing of disparities. In addition to these five SPWs, there is the California MHSA

Multicultural Coalition (CMMC) to inform the integration of cultural and linguistic competence in the public mental health system. The final component of the CRDP is the Strategic Plan writer/facilitator to integrate the five population reports into a single strategic plan to illustrate community-identified strategies and interventions that will address relevant and meaningful culturally and linguistically competent services and programs.

Figure 1: ***Asian Pacific Islander (API) Strategic Planning Workgroup (SPW) - Leadership & Organizational Structure***



OVERVIEW OF THE CRDP API-SPW

Leadership and Organizational Structure

To ensure that the input from the ethnically diverse and geographically dispersed Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities in California were adequately included in the strategic planning process, a multi-tiered leadership and organizational structure in the form of an API Strategic Planning Workgroup (hereafter called "API-SPW") was created, as illustrated above.

The Steering Committee and Regional Strategic Planning Workgroups

The Steering Committee provided leadership, oversight, and progress monitoring for the project. The responsibilities of the Steering Committee were to refine and integrate regional community-driven concerns and solutions before presenting them at the statewide API-SPW meetings for further review, discussion, and decision-making. Including the five regional lead agencies and the statewide lead agency, there were a total of fifty-five member agencies, organizations, and individuals forming five Regional Strategic Planning Workgroups in

California. Each of the five regions was led by an agency with established involvement in local communities. These regional workgroups met regularly to discuss disparity issues and to identify community-driven responses to these disparities. A total of thirty-six meetings were held, including five statewide meetings, thirty regional meetings, and one statewide project conference.

OVERVIEW OF THE ISSUES

The AANHPI populations are among the fastest growing racial groups in the United States, according to the 2010 Census. 32% of the Asian population and 23% of the NHPI population in the U.S. reside in California, where the AANHPI communities represent 15.5% of the state's population. Even though AANHPIs are thought to have low prevalence rates for serious mental illness and low utilization rates of mental health services according to some literature, there is evidence that has shown otherwise. For example, as reported by the Asian & Pacific Islander American Health Forum based on the 2008 data by the Center for Disease Control, NHPI adults had the highest rate of depressive disorders and the second highest rate of anxiety disorders among all racial groups. AANHPI women ages 65 and over consistently have had the highest suicide rate compared to other racial groups. AANHPIs may have more reluctance towards seeking help due to reasons such as stigma, language barrier, lack of access to care, and lack of culturally competent services. Moreover, even though AANHPIs are often grouped as one, many differences exist among various ethnic subgroups in areas such as language, culture, religion, spirituality, educational attainment, immigration pattern, acculturation level, median age, income, and socioeconomic status. However, the heterogeneity among the AANHPIs is rarely recognized or reflected in research and data collection, and the lack of disaggregated data continues to worsen the issues of disparity in mental health services for AANHPIs.

EXISTING ISSUES AND CHALLENGES

Nature of Disparities

Despite the diversity in the AANHPI populations and the uniqueness of each geographic region, there are many more similarities than differences as far as barriers contributing to mental health service disparities are concerned. Many of these barriers are interrelated, as one barrier frequently and consequently would add disparities to another. The following is the list of barriers identified by the API-SPW:

Lack of Access to Care and Support for Access to Care

- Logistical challenges such as transportation, hours of operation, and location.
- "Medical necessity" may not take cultural specific conditions and symptoms into consideration.
- Lack of proper insurance and affordable services.

Lack of Availability of Culturally Appropriate Services

- Challenges in finding culturally appropriate services.
- Long waiting period to receive culturally appropriate services.
- Current billing guidelines do not allow sufficient time to establish rapport and trust needed for culturally competent care.
- Culturally appropriate service components, such as interpretation and integration of spirituality, are often not "billable."

Lack of Quality of Care

- Linguistic and cultural match is important, yet often unavailable.
- Even with cultural and/or linguistic match, quality of care may still be inadequate as availability of bicultural and bilingual staff does not automatically make a program culturally appropriate.
- Cultural factors as determined by the community often are not included in the definition of quality of care.

Language Barrier

- Many AANHPIs have limited proficiency in English and thus the lack of services and workforce needed in API languages becomes a barrier to access, availability, and quality of care.
- Interpretation services are often ineligible for reimbursement and therefore may be unavailable due to funding restrictions.
- It can be challenging to find interpreters with sufficient familiarity with mental health terminology to effectively communicate the information in culturally acceptable terms.
- Many of the promotional and informational materials are not translated or the translation is not always culturally or linguistically appropriate.

Lack of Disaggregated Data and Culturally Appropriate Outcome Evaluation

- Lack of disaggregated data results in difficulties in establishing, assessing, and addressing needs.
- Many strategies have been developed by the AANHPI community, and yet there have been few resources made available to help the community assess the effectiveness of such community-driven responses from the perspective of the AANHPI community.
- Due to cultural differences, conventional assessment tools developed based on Western cultures may not be appropriate for evaluation of community-driven programs and strategies.

Stigma and Lack of Awareness and Education on Mental Health Issues

- The issue of stigma remains significant and deters many AANHPIs from seeking needed services.
- In many AANHPI languages, there is no proper translation for "mental health" without some kind of negative connotation.
- There is a lack of resources to support culturally appropriate strategies to reduce stigma and to raise awareness of mental health issues in the AANHPI community.
- There are insufficient resources to support stigma-reduction efforts such as educating and collaborating with community partners like primary care providers, spiritual leaders, and schools.

Workforce Shortage

- The development and retention of culturally competent workforce continues to be a major challenge.
- Current training models often do not encourage or include experience working with the AANHPI populations, let alone in a culturally competent program.
- Limited job opportunities and lack of supportive work environment also contribute to the shortage of workforce.
- Outreach workers are usually not supported with adequate training and resources under the current systems despite their importance and effectiveness in outreach and engagement.

Manifestations of Disparities in the AANHPI Communities

The structure of the API-SPW was designed to include representations from as many AANHPI communities as possible. Additional efforts were also made to include voices directly from the community members through focus groups. A total of 23 focus groups were conducted in five regions to capture perspectives and sectors of the AANHPI communities that may not be well represented by the 55 workgroup members. A total of 198 AANHPI community members participated in the focus groups:

Table 1: *Focus Group Participants – Gender and Age*

Female	Male	< 18	19-25	26-59	60+
118	80	13	27	118	40

Due to stigma towards mental illness and given the cultural preference for a holistic view of "health," the API-SPW deliberately chose the term "wellness" for the focus group discussions. The following are summaries of the responses from the focus group participants:

Definition of "Wellness"

As indicated by the participants, "wellness" would mean: (1) being physically healthy and active, (2) being emotionally well, (3) having good social relationship and support, (4) having good family relationship, (5) being financially stable, and (6) feeling at peace/spirituality.

Factors Affecting "Wellness"

As indicated by the participants, factors that would negatively affect "wellness" were: (1) adjustment issues such as living in a new, fast-paced environment and language difficulty, (2) family issues, (3) financial issues, (4) sense of hopelessness, and (5) health issues and high cost of healthcare.

Manifestation of Metal Health Issues

When asked how one can tell "wellness" is being compromised, the participants suggested considering the following signs: (1) acting out towards others, (2) expression of hurtful feelings, (3) sense of hopelessness, (4) poor health/eating habits, (5) disobedience, and (6) turning inwards.

Available Resources

The participants named resources they would turn to first when help is needed: (1) spirituality, such as healers, religious ritual/practice, and religious centers, (2) loved ones, (3) physical activities, (4) traditional medicine, (5) physicians, (6) mental health professionals, (7) community-based organizations, (8) family/friends, and (9) don't know where to go.

Barriers to Seeking Help

The participants identified the following barriers when they attempted to seek help for themselves or for their family: (1) lack of culturally competent staff and services, (2) issues related to stigma, shame, discrimination, confidentiality, and reluctance to "hear the truth," (3) lack of language skills, (4) lack of financial resources, (5) transportation, (6) complexity of healthcare systems and paperwork, (7) not comfortable with non-AANHPI providers, and (9) unfamiliarity with Western treatment model.

Strategies to Address Unmet Needs

The participants were asked to name services that would meet some of their needs if they could be made available: (1) programs for a specific culture, issue, topic, or age group, (2) social/recreational activities, (3) services in primary language, (4) availability and affordability, (5) more outreach effort to

counteract stigma, (6) inclusion of family, and (7) culturally sensitive/competent staff.

COMMUNITY-DEFINED STRATEGIES

Core Competencies

While it may have been a widely accepted notion that cultural competence is required when working with the AANHPI communities, the definition of "cultural competence" may still need to be further clarified. The definition of "cultural competence" may also vary from culture to culture and from ethnicity to ethnicity. As the API-SPW set out to define core components of cultural competence, the workgroup agreed on common elements and developed a list of core competencies, which was divided into eight categories with each category further divided into three levels, as shown in Table 2. The three levels were devised to highlight the importance to conceptualize cultural competence beyond the individual level, as it would take recognition and support from organizations and systems to make cultural competence possible and meaningful. While the API-SPW realized that some may view this list as too overreaching, it was hoped that this list would serve as a guideline when one considers what constitutes cultural competence. Details of each component can be found in Chapter IV: Community-Defined Strategies.

Table 2: ***Summary of Core Competencies***

	PROVIDER LEVEL	AGENCY LEVEL	SYSTEMS LEVEL
Professional Skills	▪ Must have training to provide culturally appropriate services and interventions. ▪ Ability to effectively work with other agencies and engage with community. ▪ Clear understanding of PEI strategies and relevant clinical issues. ▪ Knowledge about community resources and ability to provide proper linkage.	▪ Employ, train, and support staff that possess the necessary professional skills. ▪ Capacity to provide needed linkage to other agencies.	▪ Recognize the importance and provide support for the development and retention of professionally qualified and culturally competent workforce. ▪ Support the capacity to provide linkage.
Linguistic Capacity	▪ Proficiency in the language preferred by the consumer OR ▪ Ability to work effectively with properly trained interpreter.	▪ Employ, train, and support staff that possesses proficiency in the language preferred by the consumers. ▪ Provide language appropriate materials. ▪ Provide resources to train interpreters to work in mental health setting.	▪ Recognize the importance and provide support for the development and retention of linguistically qualified workforce. ▪ Provide resources to support bilingual staff and reimbursement for the service, including interpreters. ▪ Provide resources for preparing and printing bilingual materials.
Culture-Specific Considerations	▪ Respect for and clear understanding of cultural/historical factors including history, values, beliefs, traditions, spirituality, worldview, sexual orientation, gender identity, gender differences, cultural beliefs and practices, and acculturation level/experiences. ▪ Recognize the importance of integrating family and community as part of services.	▪ Provide ongoing training and supervision on cultural and language issues. ▪ Board members should reflect the composition of the community. ▪ Culture-specific factors should be considered and incorporated into program design. ▪ Support the integration of family and community as part of the service plan. ▪ Develop policies that reflect cultural values and needs of the community including physical location, accessibility and hours.	▪ Actively engage ethnically diverse communities. ▪ Funding should allow culture-specific factors to be considered and incorporated into services appropriate for that cultural community.
Community Relations & Advocacy	▪ Ability to effectively engage community leaders and members. ▪ Ability to form effective partnerships with family. ▪ Willingness and ability to advocate for needs of the consumers.	▪ Capacity to effectively engage the community. ▪ Credibility in the community. ▪ Capacity and willingness to advocate for systems change aiming to better meet community needs.	▪ Encourage and support culturally appropriate efforts for community outreach and community relationship-building. ▪ Recognize the importance and provide support for collaboration with community leaders. ▪ Promote cultural competency.

	PROVIDER LEVEL	AGENCY LEVEL	SYSTEMS LEVEL
Flexibility in Program Design & Service Delivery	▪ Flexibility in service delivery in terms of method, hours, and location. ▪ Understand and accommodate the need to take more time for AANHPIs to build rapport and trust.	▪ Capacity to allow flexibility in service delivery (e.g.: more time allowed for engagement and trust building for consumers/ family members; provide essential services to ensure access to services, such as transportation, available hours of operation, and convenient location). ▪ Program design should consider community-based research, culture, and traditional values so it will make sense to the consumers. ▪ Willingness to look for innovative venue for outreach, such as ESL (English as a Second Language) classes.	▪ Recognize the importance and support more time needed for engagement and trust building. ▪ Recognize the importance and support essential ancillary services needed to ensure access to services. ▪ Recognize the importance and support flexibility in service delivery. ▪ Encourage and support programs that include community-based research and/or community-designed practices. ▪ Flexibility in diagnostic criteria to accommodate cultural differences. ▪ Provide support for innovative outreach.
Capacity-Building	▪ Ability to empower consumers, family members, and community. ▪ Capacity to collaborate with other disciplines outside mental health.	▪ Capacity to educate the community on mental health issues. ▪ Capacity to collaborate with other sectors outside mental health, such as primary care and schools. ▪ Plan in place to groom the next generation leaders and staff for the future. ▪ Capacity to provide cultural competence training to mental health professionals and professionals from other fields.	▪ Provide support for capacity-building within the agency and within the community. ▪ Provide support for future workforce development. ▪ Encourage and support outreaching and educating the community on mental health issues. ▪ Provide support for cultural competency training. ▪ More involvement of the community in the policy-making process. ▪ Provide support for a central resource center.
Use of Media		▪ Capacity to utilize ethnic media and social media for outreach.	▪ Encourage and support the use of ethnic media and technology for outreach.
Data Collection & Research		▪ Collect disaggregated data. ▪ Work with researchers and evaluators to assess effectiveness of programs and services.	▪ Provide support for disaggregated data collection. ▪ Support ethnic/cultural specific program evaluation and research. ▪ Support research to develop evidence-based programs (EBPs) for AANHPI communities.

Selection Criteria for Promising Programs and Strategies

One of the major tasks given to the API-SPW was to identify community-defined promising programs and strategies to reduce existing disparities in the AANHPI community. Over the years, programs and strategies were developed to respond to the unmet needs in the community despite limited resources. However, not every program or strategy had been necessarily effective or culturally appropriate. Moreover, the challenge remains as to how to adequately assess the effectiveness of a culturally competent program or strategy. Therefore, based on the core competencies defined by the API-SPW, the focus group findings, and the decades of experiences serving the AANHPI community, the API-SPW set out to establish criteria to be used as the parameters for selecting culturally competent promising programs and strategies to serve the AANHPI populations. While recognizing this list may be somewhat ambitious given the limited resources available, the API-SPW aimed to create a list as comprehensive as possible. This list served as a guideline for the API-SPW to identify and collect community-defined promising programs and strategies. It was also hoped that this list would be used in the future to determine whether a program or a strategy is culturally appropriate for the intended population. The following is a summary of the criteria established by the API-SPW:

Table 3: *Selection Criteria for Promising Programs and Strategies*

PROGRAM DESIGN	
Goals/Objectives	• Does the program have clearly stated goals and objectives?
PEI-Specific	• Is the focus of the program primarily on prevention and early intervention (PEI)?
Focus on Addressing API Community-Defined Needs	• How well does the program clearly identify and address needs in the API community (as voiced by community members, leaders, and stakeholders)? • Did the program have input from the community in the design and evaluation of the program? • Does the program have relevance in supporting the overall wellness in the community?
Addressing Culture/ Population-Specific Issues	• Is the program designed for a specific target population such as gender, ethnic group, cultural group, and age group? • How well does the program integrate key cultural elements into its design (e.g.: oral history, spiritual healers, other cultural components or practices)? • How well does the program demonstrate sensitivity to cultural/linguistic/historical issues (e.g.: immigration, level of acculturation, spirituality, historical trauma, cultural identity, etc.)?
Community Outreach & Engagement	• How well does the program outreach to the community in a culturally appropriate manner (e.g.: staff who are sensitive to working with the community, use of bilingual materials, use of ethnic/mainstream media and social media, etc.)? • How well does the program promote wellness through outreach, education, consultation, and training? • How well does the program use consumers, family members, and community members in their outreach efforts?

Model	• How well does the program promote wellness and follow a strength-based model (e.g.: increase life management skills, increase ability to cope and make healthy decisions, improve communication between family members, etc.)? • How well does the program strengthen and empower the consumers and community members? • Is the program design based on a theory of change that reflects cultural values or has some cultural relevance? • Does the program provide a reasonable logic model? • How well does the program describe its various components and are they related to the stated goals and objectives?
Replicability	• Can the program demonstrate how it can be replicated (across communities that are ethnically and geographically diverse)? • Does the program have the capacity to offer training and development to other agencies if resources are made available? • Does the program have the capacity to offer culturally and linguistically appropriate PEI strategies?
Advocacy	• How well does the program empower the consumers and community members to advocate for their needs? • How well does the program address or contribute to systems change (e.g.: promote social justice, reduce disparities, reduce stigma and discrimination in the area of mental health, etc.)? • How well does the program help to generate community actions in moving towards wellness in the community?
Capacity-Building	• How well does the program develop and form community-wide collaboration with other community stakeholders (e.g.: primary care, social services, schools, spiritual leaders, traditional healers, faith-based organizations, and law enforcement)? • How well does the program lead to strengthening and empowering the community (e.g.: enhance social supports in the community, help to reduce stresses in the community such as acculturative stresses or generational cultural conflicts, develop and support leadership and ownership of the community)?
Sustainability	• How well does the program leverage existing resources available in the community? • How will the program be self-sustainable when funding ends?
Accessibility	• How well does the program address barriers to accessibility (e.g.: hours of operation, location, child care, language, transportation, etc.)?
PROGRAM EVALUATION/OUTCOME	
Program Evaluation/ Outcome	• Has the program been evaluated? • Do the outcomes support the program goals and objectives? • How were participants, providers, and cultural experts involved in the evaluation process (e.g.: testimony/endorsement/self report/satisfaction survey from consumers/families/community, observations and reports from service providers, consensus of cultural experts)?
AGENCY CAPACITY	
Staffing	• Does the program have staff that possesses the necessary professional and/or relevant skills to effectively do their job? • Does the program have staff who are culturally and/or linguistically competent? • Do the board and management of the organization reflect the community the program is intended to serve?
Staff Training & Development	• Does the program offer ongoing support and training for its staff?
Organizational Capacity	• Does the program/agency have established history of working in the community? • Is the program operated under an agency that has been consistently providing good and reliable services to the community?

Nomination, Submission, and Review of Community-Defined Programs and Strategies

With the selection criteria established, the API-SPW started the process of nominating, submitting, and reviewing community-defined, culturally appropriate programs and strategies. The process took about six months to complete. Fifty-six promising programs and strategies were submitted and reviewed by twenty-six peer reviewers. Complete submissions can be found in the Appendix Section in the API Population Report. As the needs and history of each AANHPI community vary, the programs and strategies in response may also vary in the stages of development. Therefore, four categories of submissions were devised to include programs and strategies at various stages of development, as shown in Table 4:

Table 4: ***Number of Programs/Strategies per Category***

Category	Description	Number of Programs
1	General submission of existing programs	27
2	Submission of existing programs that have been evaluated	5
3	Innovations/suggested strategies	19
4	Already recognized programs	5

The fact that almost half of the programs were in Category 1 indicates that while programs have been developed in response to community needs, many simply lacked the resources for evaluation. There are also many innovative strategies worth considering. This strongly speaks to the need to have more resources allocated to support evaluation of existing programs and to help expand innovative strategies to more comprehensive programs. The 56 submissions covered all age groups from children, youth, young adults, adults, to older adults. Together, they also served 24 distinctive ethnic groups: Afghani, Bhutanese, Burmese, Cambodian, Chamorro, Chinese, Filipino, Hmong, Indian, Iranian, Iraqi, Iu-Mien, Japanese, Korean, Lao, Mongolian, Native Hawaiian, Nepali, Punjabi, Samoan, Thai, Tibetan, Tongan, and Vietnamese. The types of promising programs and strategies collected were of a wide variety, including outreach through recreation, school-based, gender-based, faith-based, problem gambling, community gardening, alcohol and other drugs (AOD) prevention, violence prevention, suicide prevention, integrated care, parenting, family, senior, youth, training, consultation, LGBTQ, and support/social services. The large number of consultation programs collected may reflect workforce shortage and the need for collaboration. It should also be noted that this list was not exhaustive. More programs and strategies could have been included had there been more time and resources.

SYSTEMS ISSUES AND IMPLICATIONS ON PUBLIC POLICY

Over the last two years, the API-SPW has actively listened to AANHPI community representatives, community members, and community experts regarding the current state of disparities in California. Therefore, the disparities in mental health services documented in this report were primarily based on personal experiences observed and shared by the AANHPI community. Despite limited resources, the AANHPI communities had

developed responses to many unmet needs, and the 56 community-defined promising programs and strategies collected through this project were good examples of such efforts. However, to effectively and timely reduce these disparities, support and leadership from policy makers at the local, county, and state level are essential. The following are recommendations for policy considerations on how to reduce existing disparities in the API community:

Access, Affordability, Availability, and Quality of Services

Recommendation
Increase access by supporting culturally competent outreach, engagement, and education to reduce stigma against mental illness and to raise awareness of mental health issues.

Given the unfamiliarity with Western-culture based mental health concepts and the stigma against mental illness in the AANHPI community, effective outreach must incorporate cultural factors, leverage existing community resources, and include community participation.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends:

- Provision of resources and system support for culturally competent education to reduce stigma against mental illness and to raise awareness of mental health issues in the AANHPI community through established community networks.
- Support for culturally competent outreach and engagement efforts to the AANHPI community through established networks.
- Support for culturally competent collaboration with other community stakeholders.

Recommendation
Increase access by modifying eligibility requirements, by including ancillary services supporting access, and by providing affordable options.

Due to cultural differences, the manifestations of symptoms for AANHPIs with mental health issues may be different from those common in Western culture, making eligibility requirements such as meeting the medical necessity inappropriate for the AANHPI populations. Lack of adequate insurance continues to be a barrier to care for many AANHPIs. Moreover, there are other barriers such as lack of transportation and interpretation, which makes it critical for any providers and policy makers to include ancillary supportive services to make access possible.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …more flexibility in establishing eligibility for services, such as modifying the requirement to meet medical necessity.
- …inclusion of ancillary services as part of the service plan, such as interpretation and transportation.

Recommendation
Increase availability and quality of care by supporting the development and retention of a culturally competent workforce.

A culturally competent program can only be effective if those providing services are culturally competent. Mental health careers are not as well recognized or pursued in the AANHPI communities. Culturally competent training has not been sufficiently emphasized in the current training model. Providers currently

serving the AANHPI community can use more ongoing training and peer support as the community relies heavily on them for services. Lastly, cultural competence training should also include those who serve AANHPIs such as healthcare providers, school, and law enforcement.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …promotion of mental health careers through outreach to API youth and their parents.
- …mandating or at least including cultural competency as part of mental health career training at various academic levels from certification to advanced degrees.
- …creating mentorship for future workforce.
- …ongoing training and technical assistance for providers serving the AANHPI community, both in mental health and other fields.

Recommendation
Increase availability and quality of care by supporting services that meet the core competencies and program criteria as defined by the API-SPW.

Availability of culturally competent services remains a major barrier, which affects quality of care and access to care. While it may be up for debate as to what exactly constitutes "cultural competence," the API-SPW has developed a list of core competencies and a list of promising program selection criteria as a starting point based on input from the community.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …existing culturally competent programs to continue serving the AANHPI community.
- …the development of new culturally competent programs to respond to unmet and emerging needs in the community.
- …replication of community-defined programs and strategies, including technical assistance and training.
- …a written review of evidence-based practices as it relates to AANHPIs by providing training and resources for agencies to do so.
- …culturally competent models that contribute to building the alternative to mainstream mental health models for the AANHPI community.
- …programs that complement County MHSA/PEI plans, preferably models that have significant community involvement, design, and implementation.

Outcome and Data Collection

Recommendation
Reduce disparities by collecting disaggregated data to accurately capture the needs of various AANHPI communities, by supporting culturally appropriate outcome measurements, and by providing continuous resources to validate culturally appropriate programs.

A major challenge the AANHPI community faces is the lack of disaggregated data despite the heterogeneity among various ethnic groups. Though the AANHPI communities have responded to their needs by developing successful promising programs, very few of them have been evaluated, let alone been evaluated properly using culturally appropriate measures.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …mandating collection of disaggregated data to respect the diversity of AANHPI communities.
- …developing culturally appropriate outcome measurements to properly assess the effectiveness of programs aiming to serve the AANHPI community. Financial and technical resources are needed to develop ANHPI-relevant measures to ensure the efficacy of these measures.
- …validation of existing culturally competent programs, including technical support. The Phase II funding will be important in providing resources and opportunities for validation of community-defined programs.
- …culturally appropriate services in the AANHPI communities to become either promising or best-practice PEI programs.

Capacity-Building

Recommendation
Empower the community by supporting community capacity-building through efforts such as leadership development, technical assistance, inclusion of community participation in the decision-making process, and establishment of infrastructures that can maximize resource leveraging.

There are always more needs in the community than what available resources can possibly support. Thus, it makes sense for the systems and policies to help build community capacity to respond to community needs.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …community capacity-building such as leadership development so the community can be empowered to respond to its needs.
- …community capacity-building such as technical assistance to develop, refine, and validate promising programs.
- …inclusion of community participation in the decision-making process as the community understands its own needs and such inclusion can also empower the community to find its own solutions.
- …establishing or maintaining community infrastructures so resources can be shared and leveraged.
- … and provision of resources for maintaining a statewide infrastructure where agencies can share resources and provide peer training.
- …computer technology, such as social networks, podcast, and web-based blogging, to be used for outreach to AANHPI youth.

GLOSSARY

AANHPI	Asian American, Native Hawaiian, and Pacific Islander
ACA	Affordable Care Act
Acculturation	The process of adopting the cultural traits or social patterns of another group
Administrative Team	Consists of the Project Director, Project Manager, and Project Assistant
API-SPW	Asian Pacific Islander Strategic Planning Workgroup
Asian	Defined by the 2010 Census as a person having origins in peoples of the Far East, Southeast Asia, or the Indian subcontinent
CBOs	Community-Based Organizations
CDC	Center for Disease Control
CHIS	California Health Interview Survey
Consulting and Advisory Group	Consists of researchers, cultural experts, and county Ethnic Service Managers that provide inputs to CRDP API-SPW
CRDP	California Reducing Disparities Project
Disaggregated data	Instead of using API as a whole group, look at granular data by smaller subgroups (e.g., Southeast Asian) or even by ethnic groups (e.g., Samoan).
Disparity	Inequality or differential service (quality) received not due to differences in needs or preferences but due to one's demographic, geographic, or other background factors. It often can be examined through five dimensions: availability, accessibility, affordability, appropriateness, and acceptability.
DMH	California Department of Mental Health
DSM	Diagnostic and Statistical Manual of Mental Disorders, a manual used to give guidelines for diagnosing mental disorders
ESL	English as a Second Language
Gradient of Agreement	A system used to express disagreement while allowing for dialogue to continue
H.E.C.T.E.R.R. Principles	Developed by the CRDP API-SPW Project Director as a membership participation guideline to ensure a sense of safety and fairness for all API-SPW members so that they would be at ease to share their experience and knowledge on AANHPI mental health concerns and to propose creative and effective local solutions.
LEP	Limited English proficiency
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LGBTQQI	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and Intersex
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
Model Minority	An ethnic minority group that succeeds economically, socially, and educationally
Monolingual	Non English-speaking individuals
Native Hawaiian and other Pacific Islander	Defined by the 2010 Census as a person having origins in peoples of Hawaii, Guam, Samoa, or other Pacific Islands
NHPI	Native Hawaiian and Pacific Islander
OAC	Oversight and Accountability Commission
OMS	Office of Multicultural Services
PEI	Prevention and Early Intervention
PTSD	Post-Traumatic Stress Disorder
Regional SPWs	CRDP API-SPW consists of 54 member agencies, organizations, and individuals organized by 5 geographic regions: Sacramento (9 members), Bay Area (15 members), Central Valley (7 members), Los Angeles (15 members), and San Diego/Orange County (8 members)
SAMHSA	Substance Abuse and Mental Health Services Administration
Steering Committee	API-SPW's Steering Committee consists of the Project Director/Statewide Lead, Statewide Facilitator, and 5 Regional Leads

Manuia
웰니스
康健
Wellness
สุขภาพแข็งแรง
ウェルネス
សុខុមាលភាព
Olakino Maika'i
Khỏe
Kalusugan
Mo'ui Leilei
Haengh Wangc
Kev Nyob Nyab Xeeb
สุขภาพ

Chapter I

Overview of the CRDP API-SPW

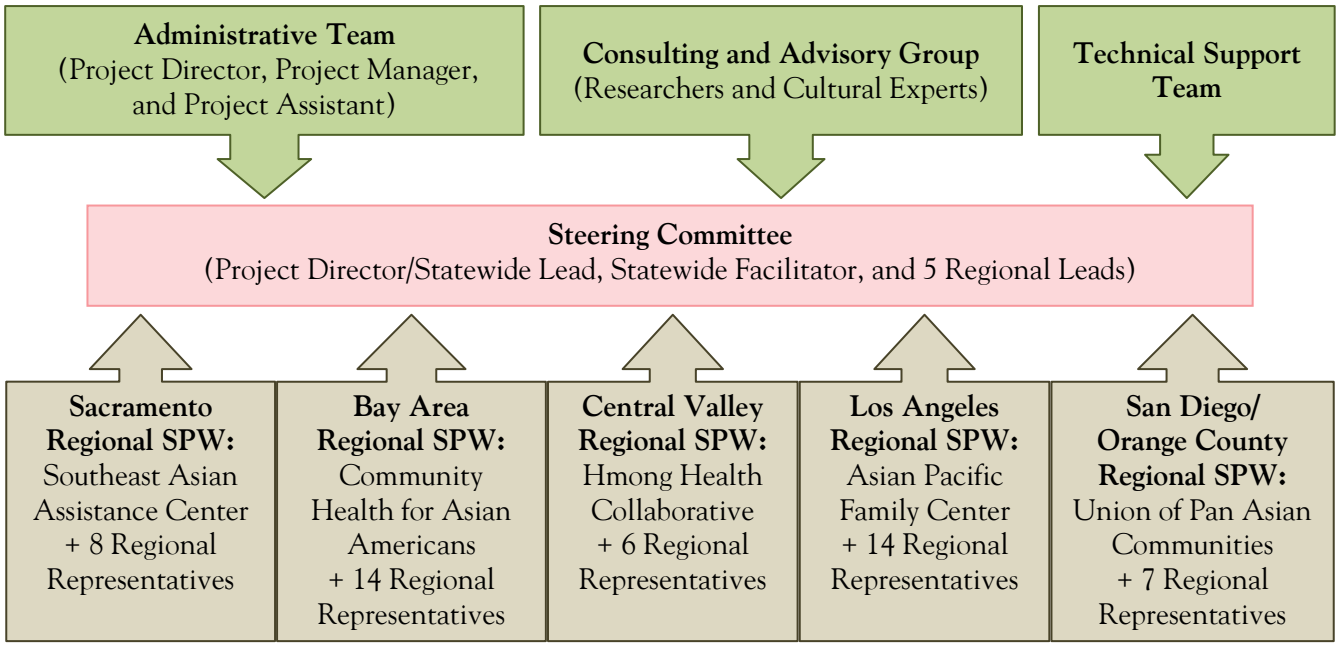
Wellness

PROJECT STRUCTURE

Leadership and Organizational Structure

To ensure that the input from the ethnically diverse and geographically dispersed Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities in California were adequately included in the strategic planning process, a *multi-tiered* leadership and organizational structure in the form of an Asian Pacific Islander Strategic Planning Workgroup (hereafter called "API-SPW") was created, as illustrated in Figure 1:

Figure 1: ***Asian Pacific Islander (API) Strategic Planning Workgroup (SPW) - Leadership & Organizational Structure***



The Steering Committee

In order to address the geographic diversity in California, the project divided the state into five regions to allow discussions relevant to local concerns. These five regions included, from north to south: Sacramento (Sacramento and neighboring counties), Bay Area (San Francisco Bay area counties), Central Valley (counties in Central California), Los Angeles (Los Angeles and neighboring counties), and San Diego/ Orange County. Each region was led by a Regional Lead who convened and facilitated regional meetings, where regional AANHPI mental health issues and recommendations to address these issues were discussed and brought back to the Steering Committee.

The Steering Committee provided leadership, oversight, and progress monitoring for the project. It was comprised of the Project Director/Statewide Lead (Dr. C. Rocco Cheng from Pacific Clinics), Project Consultant and Statewide Facilitator (Dr. D.J. Ida from National Asian American and Pacific Islander Mental Health Association), and five Regional Leads (Laura Leonelli from Southeast Asian Assistance Center, Beatrice Lee from Community Health for Asian Americans,

Susan Vang from Hmong Health Collaborative, Dr. Terry S. Gock from Asian Pacific Family Center, and Dr. Dixie Galapon from Union of Pan Asian Communities). The Statewide Facilitator was invited to be on the Steering Committee for her decades of experience and advocacy work on mental health issues in the AANHPI communities across the country. The Regional Leads were invited because of their long-standing professional reputation, community credibility, and expertise in AANHPI mental health issues in their local and regional communities.

The relatively small size of the Steering Committee was designed to allow ample discussions among its members, while the members' role as Regional Leads could ensure diverse input from the local API-SPW and community representatives would be included, discussed, and reviewed in the process. The responsibilities of the Steering Committee was to refine and integrate community-driven concerns and solutions before presenting them at the statewide API-SPW meetings for further review, discussion, and decision-making. The Steering Committee met regularly to set the agenda for regional and statewide meetings in order to maintain consistency and to monitor progress of the project. Considering the distance, time, cost, and the frequency of meetings expected by this project, the Steering Committee regularly communicated via in-person meetings, conference calls, and emails to coordinate activities for the API-SPW. Table 1 provides information and responsibilities of the Steering Committee members.

Table 1: ***Responsibility of the API-SPW Steering Committee***

Name	Title	Agency	Responsibilities
C. Rocco Cheng	Project Director/ Statewide Lead	Pacific Clinics	Oversee the California Reducing Disparities Project – API SPW
Laura Leonelli	Sacramento Regional Lead	Southeast Asian Assistance Center (SAAC)	Convene & facilitate Sacramento regional SPW meetings
Beatrice Lee	Bay Area Regional Lead	Community Health for Asian Americans (CHAA)	Convene & facilitate Bay Area regional SPW meetings
Susan Vang	Central Valley Regional Lead	Hmong Health Collaborative (HHC)	Convene & facilitate Central Valley regional SPW meetings
Terry S. Gock	Los Angeles Regional Lead	Asian Pacific Family Center (APFC)	Convene & facilitate Los Angeles regional SPW meetings
Dixie Galapon	San Diego/Orange County Regional Lead	Union of Pan Asian Communities (UPAC)	Convene & facilitate San Diego/ Orange County regional SPW meetings
D.J. Ida	Consultant and Statewide Facilitator	National Asian American and Pacific Islander Mental Health Association (NAAPIMHA)	Facilitate statewide meetings

Regional Strategic Planning Workgroups (Regional SPWs)

Including the five Regional Lead agencies and the Statewide Lead agency, there were a total of fifty-five member agencies, organizations, and individuals forming five Regional SPWs in California: Sacramento Area (9 members), Bay Area (15 members), Central Valley Area (7 members), Los Angeles Area (15 members), and San Diego/Orange County Area (8 members).

Each of these Regional SPW was coordinated and convened by the Regional Lead agency in the region, as described above. Together, these five Regional SPWs formed the Statewide CRDP API-SPW.

By using the small Regional Workgroup structure (with 7 to 15 members depending on the region) as the foundation to identify community-driven mental health concerns and to generate creative and effective local solutions, it was expected that there would be more time for the Regional SPW members to ask questions, engage in deeper discussions, and come up with effective solutions for complicated mental health service issues in their local AANHPI communities. To help the workgroup members familiarize themselves with the issues to be discussed, meeting agenda and previous meeting summaries were sent in advance so members could be prepared for meaningful discussions.

The membership of the API-SPW was determined by the Steering Committee based on the guidelines set forth in a later section of the report entitled "Process of Forming Regional and Statewide Networks." The Regional API-SPW was comprised primarily, though not exclusively, of members from local community-based organizations (CBOs) and other entities that serve the mental health and related needs of the AANHPI populations in their respective geographical areas. Through these Regional API-SPWs, it was hoped that community-driven mental health service needs and locally responsive approaches to address these needs would emerge.

Due to the fact that CRDP was a Prevention and Early Intervention project and given the amount of time commitment expected, members were mostly community representatives. There were also consumers and consumer organizations recruited for the Project. Most of the input from the consumers, family members, and caregivers were solicited via three approaches: 1) from the 55 members as they interacted directly with the community; 2) from focus groups as most of the participants were consumers, family members, and community representatives; and 3) from surveys collected at community events.

Supporting Teams to the Steering Committee and the API-SPW

To facilitate the work of the Steering Committee and the Regional API-SPWs, three support teams, the Administrative Team, the Technical Support Team, and the Consulting and Advisory Group were set up as follows:

Administrative Team

Composed of three staff: A part-time Project Director, Dr. C. Rocco Cheng, who oversaw the development and implementation of the Project. A part-time Project Manager, Dr. Liyu Su, who was responsible for the day-to-day operations of the Project. A part-time Program Assistant, Ms. Karen Luu, who provided administrative support. The Administrative Team was responsible for project planning, execution, management, reporting, and coordination of internal and external communications.

Consulting and Advising Group

Composed of the mental health experts from public and private sectors including researchers, community experts, and representatives from public entities (e.g.: County Ethnic Service Managers – hereafter referred to as County ESMs. The Consultant and Advisory Group provided relevant in-service training to Workgroup members at meetings to support their work and to facilitate better understanding of pertinent issues related to mental health

disparities in the AANHPI communities. County ESMs were also invited to regional and statewide meetings to receive updates on the project.

Technical Support Team
Composed of staff from the Information Systems Department of Pacific Clinics. The primary responsibility of the team was to support the technical aspects of the project, such as creating the CRDP API-SPW website (http://crdp.pacificclinics.org/) for the sharing of resources and dissemination of information collected by the project.

PROCESS OF FORMING REGIONAL AND STATEWIDE NETWORKS

Guiding Principles for Member Selection

CRDP members were delegates from their ethnic, cultural, and local communities. Due to limited time and resources available, it was not possible to recruit representatives from every sector and cultural group in the AANHPI communities. Hence, in order to maximize the coverage of the AANHPI communities, two guiding principles were used to select members to participate in the API-SPW:

Diversity
The CRDP API-SPW aimed to include members from different ethnic/cultural groups, geographic locations, metropolitan/rural districts, age groups (youths, transitional age youths, adults, and older adults), and service sectors (e.g.: consumers/family members, health and mental health entities, social services, community organizations, civic groups, etc.). In addition, it was crucial to include individuals from various professional backgrounds such as those in health care, education, law enforcement, and civil and legal services as part of the project either as a member, consultant, or community expert. Lastly, entities developed within the AANHPI communities and considered community strengths and protective factors (e.g.: faith based organizations and ethnic media) were also invited to be part of the API-SPW whenever feasible.

Balance
While it would have been ideal to have balance in all the diversity variables in each of the five geographic regions, the differences in size and ethnic/cultural make-up of each of the five geographic regions made it unrealistic. Thus, it was more feasible to attain overall balance at the statewide level.

For the Bay Area and Los Angeles regions, each region was allotted to recruit up to 15 members including the Regional Lead Agencies. For the Sacramento, Central Valley, and San Diego/ Orange County regions, each region was allotted up to 8 members including the Regional Lead Agencies. Given the difference in allotments, the larger regions were encouraged to make special efforts to include members representing groups such as LGBTQ, older adults, transitional age youths, South Asians, Southeast Asians, Native Hawaiians and Pacific Islanders, consumers, family members, and primary care providers.

Membership Assessment

The Steering Committee worked together to recommend potential members for the Regional Workgroup based on their knowledge of the regions. A membership assessment tool, as illustrated in Table 2, was developed to ensure all relevant factors (e.g.: age, ethnic/cultural groups) were considered in the composition of the regional and the overall statewide memberships.

Table 2: *CRDP API-SPW Membership Assessment Tool*

MEMBER INFORMATION – *Please check all that applies and specify if "other" is marked*	
Agency:	
Agency representative:	**Gender:** ❑ M ❑ F
Alternate (if applicable):	**Gender:** ❑ M ❑ F
Region represented: ❑ Sacramento ❑ Bay Area ❑ Central Valley ❑ Los Angeles ❑San Diego/Orange County	
Type: ❑ Public ❑ Private for profit ❑ Private non-profit ❑ Foundation ❑ Consumer/Community member	
Level of Focus: ❑ National ❑ State ❑ County ❑ Local ❑ Other (specify):	
Geographical community served: ❑ Urban ❑ Rural ❑ Suburban	
Number of years serving the AANHPI community:	
Number of employees: ❑ 1-20 ❑ 21-40 ❑ 41-60 ❑ 61-80 ❑ 81-100 ❑ 101+	
Member of coalition(s) – specify:	
Participated in the County's MHSA (Prop 63) planning: ❑ Yes ❑ No	
Currently sitting on the local county MHSA oversight body: ❑ Yes ❑ No	
Conducted needs assessment studies on APIs: ❑ Yes ❑ No	
Populations Served/Represented (please check all that applies):	
❑ Early Childhood (0-5)	❑ Transitional Age Youth (18-25)
❑ Children/Youth (6-12)	❑ Adults (25-55)
❑ Adolescent (13-17)	❑ Older Adults (55+)
Sectors Represented (please check all that applies):	
❑ Consumer/Family member	❑ Social service provider
❑ Faith-based organization	❑ Community development organization
❑ Ethnic-specific provider	❑ Law enforcement
❑ Health care provider	❑ Educator
❑ Mental health provider	❑ Ethnic media
❑ Traditional healing provider	❑ Other (specify):
Primary Areas of Focus (please check all that applies):	
❑ Early childhood/Early intervention	❑ Mental health promotion
❑ Prevention program	❑ Interagency collaboration
❑ Youth development program	❑ Substance abuse: Prevention Treatment Recovery
❑ Program development	❑ Crisis intervention
❑ Education/Special education	❑ Outreach
❑ Training	❑ Evaluation/Oversight
❑ Faith-based programs	❑ Research
❑ Family advocacy/involvement	❑ Technical assistance
❑ Youth advocacy	❑ Case management
❑ Health care services	❑ Support group
❑ Mental health services (treatment)	❑ Other (specify):
Ethnic/Cultural Groups Served/represented (please check all that applies):	
❑ Asian American	❑ Lao
❑ South Asian	❑ Iu-Mien
❑ Southeast Asian	❑ Indian
❑ Chinese	❑ Pakistani
❑ Japanese	❑ Sri Lankan
❑ Korean	❑ Tongan
❑ Vietnamese	❑ Samoan
❑ Cambodian	❑ Guamanian
❑ Hmong	❑ Hawaiian
❑ Filipino	❑ LGBTQQI
❑ Other (specify):	

Forming of the CRDP API-SPW

As determined by the Steering Committee, the guiding principles for member selection were diversity and balance, which were reflected in diverse representations in terms of ethnicity, culture, geographic location, age, and service sectors on the statewide level, if not on the regional level as well. With the allotment and selection principles in mind, the Steering Committee set out to recruit members for the Regional SPWs.

First, the Steering Committee reviewed a list of potential members recommended by the Project Director and the Regional Leads. Regional Leads contacted potential members in their region to introduce the project and invite them to participate in the project. For those who had indicated their support before the project was awarded, Regional Leads contacted them to reconfirm their participation in the project. Potential members were subsequently invited to attend the first regional meeting in their region in March/April 2010 to further familiarize them with the project, including the background, timeline, goals, and expectations. The first statewide meeting held in Pasadena on May 14, 2010 also provided another opportunity for potential members to learn more about the project.

After the initial membership list was established, the Steering Committee continued to examine the membership composition based on the principles of diversity and balance during subsequent meetings as the membership continued to evolve throughout the course of the first year. A few challenges surfaced in the recruitment and formation of CRDP API-SPW membership. For example, time commitment was a huge issue as many of these organizations could not afford to send staff to six meetings a year because of limited resources. Hence, there were withdrawals due to challenges such as staffing, coverage issues, or staff and organizational transition. The Steering Committee recognized these challenges and recommended continued participation by allowing an alternate to step in for the primary representative whenever needed, on the condition that both representatives would be kept updated of the progress of the project. It was also recommended to the Regional Leads to consider recruiting beyond their regional allotment given the possibility of withdrawals.

Membership Participation Guidelines

While the API-SPW sought to ensure inclusive participation, differences of opinions were expected given the diversity within the membership. To maintain effective communication and functioning of the API-SPW, the following participation guidelines were presented and agreed to by the members:

1. **Members will uphold the H.E.C.T.E.R.R. principles throughout the project:**
   - ***Honor traditional value and life style***: Different cultural traditions and life styles will be honored.
   - ***Everyone has a voice***: Regardless of the size of agency and the ethnic/cultural group, every workgroup member will have a voice in the project.
   - ***Collaborative***: Different regions and agency representatives will work collaboratively to address the mental health disparity issues in AANHPI communities.
   - ***Transparency***: The decision making process will be transparent to all workgroup members.
   - ***Empowerment***: Each workgroup member will be empowered to advocate for the group he or she is representing.

- ***Respect differences and proper boundaries***: Differences in opinion and perspective will be respected. Professional boundaries will be observed so small groups or agencies will not be concerned of being overwhelmed or dominated by large groups/agencies.
- ***Recognize existing strengths***: The existing strength of each workgroup member and the cultural/sector he or she represents will be respected.

Consensus would be solicited from all participants based on the underlying core value: *Everyone will have equal voice and decision making power in the API-SPW regardless of the size of the community and/or agency each member represents*. Given the vast diversity within the API-SPW, differences of opinion and priorities were expected. Therefore, the H.E.C.T.E.R.R. principles were established to ensure a sense of safety and fairness for all API-SPW members so that they would be at ease to share their experience and knowledge regarding AANHPI mental health concerns and to propose creative and effective local solutions. Thus, these principles would serve as the overarching guidelines for the decision-making process throughout the project.

2. **Members agreed to participate in six regional meetings (4 hours each), five statewide meetings (six to seven hours each), and the end-of-Project conference at the end of the two years. If in-person attendance was not possible, members would participate by giving feedback to meeting summaries via conference call or e-mail. In addition, members agreed to assist with coordinating and conducting focus groups in Year One. Members also agreed to provide feedback on the population report.**

Regional API-SPW Meetings

The Regional Workgroup meetings were structured to progressively and comprehensively develop a list of local and regional API mental health disparity concerns and strategies for further review, refinement, and integration by the Steering Committee before presenting them to the entire API-SPW for final deliberation and decision-making. To encourage participation and stimulate discussion at the Regional Workgroup meetings, questions such as those listed below were used:

- What is the current state of mental health disparities in the AANHPI communities?
- What are policy and systemic factors contributing to these disparities?
- What is the systemic thinking in resolving community challenges?
- What are some culturally and linguistically appropriate strategies that may help reduce these disparities?
- How can these strategies work in the current systems (or what revision of systems and/or program is needed to implement such strategies)?
- How to build community capacity to implement and sustain these strategies?
- How to properly evaluate outcomes of these strategies?
- How to leverage and collaborate with other cultural groups and government entities to address these disparities?

Even though the overall direction and priorities for the project were to be set by the Steering Committee, it was duly acknowledged that the unique needs and circumstances of each region were to be

respected and accommodated as much as possible. Therefore, it was understood that regional membership may choose to focus their priorities somewhat differently from other regions when making decisions at the regional level, while keeping in mind that a statewide perspective was expected for the final API-population report. One example would be the selection of focus group members where each Regional SPW set their priorities and reached their initial decisions on the target populations based on their regional needs. The initial selections were shared among the API-SPW members for consideration while the Regional SPWs attempted to balance their regional needs with the overall statewide representations to be reflected in the process. With a cooperative mindset, the API-SPW was able to include small, emerging, and hard to reach populations such as Hmong, Mien, Mongolian, Punjabi, LGBTQ, and new refugee communities in the focus group selections.

Statewide API-SPW Meetings

In addition to attending three regional meetings, the API-SPW members also participated in five statewide meetings to work with members from other regions to prepare a cohesive mental health disparities reduction strategic plan in the form of this final API Population Report. As traveling outside the region was required for statewide meetings, in order to encourage maximum level of participation from all regions, the locations of these statewide meetings were rotated around the state so members would have ample opportunities to attend as many as possible given the geographic distance. Members' travel expenses were reimbursed so as not to create additional financial burden to their agencies.

Focus Groups

Although the project was designed to be as inviting and inclusive of diverse community stakeholders as possible, there could still be perspectives that would not be adequately covered by the API-SPW given the constraints of time and resources. An additional information gathering forum was sought to solicit input from interested community stakeholders through time-limited, structured focus groups conducted in participants' native languages or with interpretation. The members utilized their established relationships with the community to invite interested parties to partake in the focus groups via announcements and phone calls. As a result, participants in the focus groups included consumers, family members, community leaders, cultural experts, and service providers across a wide range of ethnicities, cultures, and age groups. They provided valuable feedback on the current state of disparities experienced and observed in their communities. A total of twenty-three focus groups were conducted in the five regions: 4 from the Sacramento region, 6 from the Bay Area region, 4 from the Central Valley region, 6 from the Los Angeles region, and 3 from the San Diego/Orange County region. The focus groups were especially critical to this project as the API-SPW sought to include input from those community stakeholders and sectors that were underrepresented or could not commit to serving on the API-SPW because of time and resources. More details about these focus groups can be found in Section V of the report.

3. **Whenever the primary representative is not available to participate in a meeting, an alternate may be sent in his or her place to**

allow maximum inclusion of representations from the entire API-SPW. Both representatives will keep each other updated on the progress of the project.

4. **Should voting be required, each member has an equal number of votes. In setting priorities for focus group selection for their region, each member was given same votes and they indicated what priority they saw as more important. In determining promising program selection criteria, a straw vote approach was used after thorough discussion.**

5. **Should disagreement occur, members would use the "Gradient of Agreement System" to express their disagreement while allowing the dialogue to continue.**

While reaching a consensus was certainly desirable, it was made clear to all members that consensus was not synonymous with unanimous agreement. Thus, the Gradient of Agreement System was introduced and agreed upon to allow full expression of dissenting opinions while permitting the decision making process to continue. Moreover, depending on the type of decision that would need to be made and the setting the process would take place in, the API-SPW would follow additional procedures to strive towards fairness, inclusiveness, safety, and efficiency while ensuring reasonable flexibility in the process. The same process would apply to priority-setting as well.

Table 3: *Gradient of Agreement System*

1	2	3	4	5	6	7	8
Endorse	**Endorse** with minor point of contention	**Agree** with reservations	**Abstain**	**Stand aside**	**Disagree** but will support the majority	**Disagree** and out from implement-tation	**Can't go forward**

Should members feel that they absolutely could not live with a certain decision, their opinions and reasoning would be sought and brought to the attention of the workgroup. In cases where there were dissenting opinions, both majority and minority comments would be recorded to reflect the diversity of opinions. In the process of CRDP, all decisions made were agreed upon by the majority of the membership. Statements, reasons, and evidence supporting differences of opinions were solicited and minority opinions were documented.

Moreover, in recognition of cultural preferences for different communication styles among the members, additional measures were taken as needed. For example, note cards and "parking lot" issues were utilized at the meetings to ensure inclusion of different opinions from those members who would prefer to express themselves in modes other than speaking. Meeting summaries were sent to members after each meeting for their review to ensure their opinions were accurately captured in the summaries. Members were encouraged to

submit comments after each meeting within a certain timeline to allow more time for them to reflect on the issues discussed during the meeting, so their thoughts could be integrated into the meeting summary. For members who appeared less vocal in the meetings, they were invited to share their opinions. In addition, whenever appropriate, individual dialogue with them were arranged outside regular meetings to see if there were reasons for their lack of participation and if there were issues that needed to be addressed to enhance their participations in the process.

Despite the differences of opinion, there were no obvious conflicts throughout the process of the project. There was an instance when members were not clear about the selection criteria and the submission process of promising programs and strategies. The Administrative Team consulted with the Statewide Facilitator and called two additional meetings with the Steering Committee to clarify any confusion and to address concerns. As a result of these communications, a revised process, including an extended timeline and expanded selection categories, was presented to members at the subsequent regional meeting. Members responded positively to the revisions. Lastly, a feedback and evaluation form was utilized at the end of each statewide meeting for suggestions to improve the communication process so potential conflicts could be minimized.

Building Networks beyond the API-SPW Membership

Since the stated goals of the CRDP were to address community-defined needs and identify community-driven strategies, the API-SPW devoted the first year of the project to creating various venues for the API-community to provide feedback at the grass-root level as much as possible through membership selection and focus groups. During Year Two, additional efforts included involvement from a wider range of interested parties, such as county and state agencies.

The regional members discussed feasible ways for productive involvement while taking into consideration their unique regional needs and circumstances. The regional workgroups also initiated contact with such interested parties based on their decisions. For example, several county ethnic service managers were invited to regional meetings for updates on the progress of the API-SPW to provide input from their perspectives.

In addition, the Project Director and Regional Leads participated in County Ethnic Service Manager meetings several times. They also presented the progress of the project at venues, such as: the Northern California Cultural Competency and Mental Health Summit, the SAMHSA Policy Summit, and the Southern California Cultural Competency and Mental Health Summit. The Project Director also attended meetings in California and Washington, DC to discuss and present on topics such as mental health service needs in the AANHPI communities, integrated healthcare, and the potential impact of the Healthcare Reform and the Affordable Care Act. Moreover, the API-SPW conducted outreach efforts to policy makers, such as: state legislators and Mental Health Services Oversight and Accountability Commission (MHSOAC) by inviting them to the statewide meetings for project updates. Regular communications were (and continue to be) maintained with other CRDP grantees as well. The Project Director attended (and continues to attend) OAC meetings and OAC Committee meetings, which provided opportunities to communicate with the Department of Mental

Health (DMH) and OAC staff regarding the project. The Project Director kept federal agencies involved by regular communications with SAMHSA Senior Advisor, Dr. Larke Huang and the National Network in Eliminating Disparities in Behavioral Health (www.nned.net). The Chair for the President's Advisory Commission on Asian Americans and Pacific Islander, Daphne Kwok, attended the second statewide meeting in Oakland where the focus group findings were presented to reflect the mental health service needs of the AANHPI community in California (http://www.whitehouse.gov/aapi). To raise awareness of the project, the Project Director also engaged in multiple interviews at a local ethnic television station to share initial findings of the project.

MILESTONES

While the project officially started in March 1, 2010, the API-SPW actually initiated its work in December 2009 as the Steering Committee gathered to discuss and plan for the tasks ahead. Table 4 (pg. 13) offers a summary of all the contributions and accomplishments by the API-SPW prior to and throughout the life of the project.

Table 4: *CRDP API-SPW Milestones*

Time/Event	Goals/Accomplishments
1st Steering Committee Meeting 12/09/09, Arcadia	• Team building • Overview of CRDP (background, timeline, expectations, goals, logistics, membership recruitment, ground rules)
2nd Steering Committee Meeting 01/22/10	• Updates (membership recruitment, schedule for the 1st regional meetings and statewide meetings in Year One) • Discussion: Agenda for the 1st regional meeting
3rd Steering Committee Meeting 03/05/10	• Discussion: Agenda for the 1st statewide meeting
1st Regional Meetings March – April, 2010	• Overview of CRDP, Team Building • Discussion: "Disparities" as experienced by the community at the regional level
4th Steering Committee Meeting 05/10/10	• Debrief: 1st regional meetings • Discussion: Finalize the 1st statewide & 2nd regional meeting agenda
1st Statewide Meeting 05/14/10, Pasadena	• Overview and vision of CRDP • Discussion: "Disparities" as defined by the community
2nd Regional Meetings May – July, 2010	• Conclusion of the discussion on disparity issues • Focus group preparation (selection, facilitation, translation, and reporting)
Focus Groups July 2010 – January 2011	• 7 facilitator training sessions were held. • 23 focus groups were conducted in five regions.
5th Steering Committee Meeting 09/22/10	• Discussion: Focus group reports • Discussion: Agenda for the 2nd statewide meeting
2nd Statewide Meeting 10/04/10, Sacramento	• Presentation: "Mental health disparities among Asian Americans," presented by Dr. Anne Saw • Presentation and discussion of preliminary focus group results • Special guests: Assemblyman Mike Eng, Marina Augusto
3rd Regional Meetings November – December, 2010	• Regional focus group updates • Discussion: Core competencies and selection criteria for promising programs/strategies to reduce disparities
6th Steering Committee Meeting 01/10/11, Arcadia	• Discussion: Preliminary focus group findings, core competency of serving AANHPIs, selection criteria for promising programs • Goal setting for the 3rd, 4th, and 5th statewide meetings
3rd Statewide Meeting 01/24/11, Oakland	• Presentation: "Mental health among California's Asian American and other diverse populations," presented by Dr. Winston Tseng • Presentation of focus group findings • Discussion on lists of core competency & selection criteria for promising programs/strategies • Special guests: Dr. David Pating, Daphne Kwok, Marina Augusto
4th Regional Meetings February – April, 2011	• Further discussion/review of the list of core competencies • Further discussion/review of the list of selection criteria for promising programs/strategies
7th Steering Committee Meeting 04/11/11	• Discussion: SAMHSA policy summit on 05/10, Northern region cultural competency summit on 06/27 • Discussion: Agenda for the 4th statewide meeting

Time/Event	Goals/Accomplishments
SAMHSA Policy Summit May 2011	• Project Director presented CRDP at the SAMHSA Policy Summit in San Diego
4th Statewide Meeting 05/19/11, Pasadena	• Presentation: Healthcare reform and its relevance to CRDP, presented by Wendy Wang • Presentations: Logic Model and examples of promising programs, presented by Dr. Terry S. Gock, Simon Wai, Dr. Dixie Galapon • Discussion and approval of core competencies and selection criteria • Presentation: proposed process for nomination/submission/review of promising programs/ strategies
Cultural Competency & Mental Health Summit June 2011	• Project Director and Bay Area Regional Lead Beatrice Lee presented CRDP at the Northern California Cultural Competency and Mental Health Summit in San Jose
8th Steering Committee Meeting 06/08/11	• Debrief: 4th statewide meeting • Discussion: Process for program selection, submission, review, and revision.
9th Steering Committee Meeting 06/21/11	• Discussion: Finalize the process for program nomination, submission, review, and revision.
5th Regional Meetings July – September, 2011	• Overview and discussion of the process of nomination, submission, review, and revision of regional promising programs and strategies
Promising Program & Strategy Submission/ Review September – November 2011	• Members submitted and reviewed community-defined promising programs and strategies. • A total of 56 submissions were received and reviewed by 26 peer reviewers.
10th Steering Committee Meeting 10/21/11	• Update and debrief on program submissions • Discussion: Agenda for the 5th statewide & 6th regional meetings • Discussion: Agenda for the project conference
Cultural Competency & Mental Health Summit November 2011	• Project Director and San Diego/Orange County Regional Lead Dr. Dixie Galapon presented CRDP at the Southern California Cultural Competency and Mental Health Summit in Ontario
5th Statewide Meeting 11/15/11, Sacramento	• Presentation: "Challenges in providing culturally informed care in evidenced psychological practices," presented by Dr. Nolan Zane • Presentation: List of promising programs and strategies • Special guests: Dr. David Pating, Marina Augusto
6th Regional Meetings December 2011	• Discussion: regional, statewide, system, and public policy issues • Debrief: participation in CRDP
11th Steering Committee Meeting 12/15/11	• Debrief: 6th regional meetings • Discussion: Agenda and preparations for the project conference
Project Conference 02/01/12, Los Angeles	• Sharing and celebrating the accomplishment of the API-SPW • Presentation: "Addressing behavioral health disparities," presented by Dr. Larke Huang • Special guest: Rachel Guerrero

Chapter II

Overview of the Issues

Olakino Maika'i

DEMOGRAPHICS

> "We came here for a better life, but with that came a lot more stress."
>
> – Focus group participant

Who are the Asians, Native Hawaiians, and Pacific Islanders? According to the 2010 Census, "Asian" is defined as a person having origins in peoples of the Far East, Southeast Asia, or the Indian subcontinent. "Native Hawaiian and other Pacific Islander (NHPI)" is defined as a person having origins in Hawaii, Guam, Samoa, or other Pacific Islands. Individuals who reported only one race category were referred to as the "race alone" population. In addition to the "Asian alone" and "Native Hawaiian and other Pacific Islanders alone" categories, Asians and Native Hawaiian/Pacific Islanders are also captured in the "Asian in combination" and "NHPI in combination" categories when a person is self-identified as multi-racial (Hume, Jones, & Ramirez, 2011).

National Data on Asian Americans, Native Hawaiians, & Pacific Islanders (AANHPIs)

As the readers may find out from the statistics, it is important not to assume that the AANHPI community is one homogeneous group. It will be crucial to look beyond the surface level of global indices and find disaggregated data at the granular level to unveil the diversity in needs, challenges, and resources.

According to the 2010 Census, out of the total U.S. population of 308.7 million, 14.67 million (4.8%) identified themselves as "Asian alone." In addition, another 2.64 million chose the "Asian in combination" category, bringing the total of "Asian alone" and "Asian in combination" populations to 17.32 million, amounting to 5.6% of the U.S. population. Although Asian populations still made up a relatively small proportion of the overall U.S. population, there had been a 45.5% increase ("Asians" and "Asians in combination" together) in the last decade, growing from 11.9 million in 2000 to 17.32 million in 2010. In terms of distribution of the total Asian populations at the state levels, 32% resided in California while New York was the distant second with 9%. There were about 540,000 (0.2%) Native Hawaiians and Pacific Islanders (NHPI alone) residing in the U.S., and an additional 685,000 included in the "NHPI in combination" category, bringing the total NHPI population in the U.S. to 1.22 million, which accounted for 0.4% of the total U.S. population. This represented a significant increase of 40% from the 874,414 NHPIs accounted for in the 2000 Census.

While all major race groups have increased in size between 2000 and 2010, the fastest growing ethnic group was the "Asian alone" population, which increased by 43.3% from 10.24 million to 14.67 million. This increase was due in part to immigration. In terms of share of the total population, the "Asian alone" group increased from 3.6% to 4.8%. Even though the "Native Hawaiians and Pacific Islanders alone" group was the smallest racial group, it had also seen an increase of 35.4% from 398,000 to 540,000 in the last decade, which doubled its share of the total population from 0.1% to 0.2% (Hume, Jones, & Ramirez, 2011).

Given the diversity of the API communities, there were many similarities and many differences among the various ethnic groups, as indicated in the 2009 American Community Survey by the Census Bureau. For example, even though the median household income for Asians was $68,780 in 2009, it varied from $90,429 for Asian Indians to $46,657 for Bangladeshi. The median income for NHPI households was $53,455. The poverty rate was 12.5% for Asians and 15.1% for NHPIs, as compared to 9.4% for non-Hispanic Whites. In addition to poverty, lack of health insurance coverage was another challenging issue for AANHPIs, as 17.2% of Asians and 17.3% of NHPIs did not have health insurance coverage. Similar to the total population, 85% of AANHPIs 25 years and older had graduated from high school. However, Asians had a higher rate of earning a college degree or higher (50%) compared to the total population (28%), while NHPIs had a lower rate of 14%. 20% of Asians and 4% of NHPIs had earned graduate degrees, compared to 10% for the total population. Even though many Asians entered the U.S. as immigrants, 3.4 million voted in the 2008 election, according to the 2008 Census Bureau records. AANHPIs also continued to make their share of contributions to the economy. As indicated in the 2007 survey of Business Owners by the Census Bureau, Asian-owned businesses in the U.S. generated $507.6 billion in 2007, a 55% increase from 2002, while NHPI-owned businesses generated $6.3 billion, a 48% increase for the same period. The 2009 American Community Survey revealed that, following English and Spanish, Chinese, spoken by 2.6 million at home, was the third most widely spoken language in the United States. Tagalog, Vietnamese, and Korean were each spoken by more than one million people. Asians had a slightly younger median age of 35.3 in 2009 as compared to 36.8 years for the overall population, with 23.6% under age 18 and 9.6% over age 65. NHPIs had a median age of 29.9, with 34% under age 18 and 6.3% over age 65. Looking ahead, the Census Bureau projected in 2008 that the Asian populations were expected to increase by 161% by 2050 compared to 44% for the total population, comprising 9% of the total population in 2050. The NHPIs were projected to grow by 132% by 2050, comprising 0.6% of the total U.S. population (U.S. Census Bureau News, 2011).

> The prevalence rates among different ethnic groups (Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and other Asians) varied widely ranging from low for Chinese and Indians to very high for Filipina, which points to the importance of recognizing the heterogeneity of various Asian populations.
>
> (Huang, Wong, Ronzio, & Yu, 2006)

In terms of distributions of Asian populations in the U.S., Los Angeles had the largest number of Asians (483,585), followed by San Jose (326,627), San Francisco (288,529), San Diego (241,293), and Fremont (116,755). In fact, nationally speaking, Los Angeles, San Jose, San Francisco, San Diego, and Fremont ranked as the 2nd, 3rd, 4th, 5th, and 9th cities, respectively, with the largest Asian populations, as indicated in Table 1. In terms of the proportion to the total U.S. population, 9 California cities ranked among the top 10 places with the highest percentage of Asian populations in the U.S., also indicated in Table 1 (Jones, 2011).

Table 1: *2010 Census – Cities with the Largest Number and Highest Proportion of Asians in the U.S. (Asian Alone and Asian In Combination)*

Rank	Cities with the Largest Number of Asians		Cities with the Highest Proportion of Asians	
#1	New York, NY	1,134,919	Urban Honolulu CDP, HI	68.2%
#2	**Los Angeles, CA**	**483,585**	**Daly City, CA**	**58.4%**
#3	**San Jose, CA**	**326,627**	**Fremont, CA**	**54.5%**
#4	**San Francisco, CA**	**288,529**	**Sunnyvale, CA**	**43.7%**
#5	**San Diego, CA**	**241,293**	**Irvine, CA**	**43.3%**
#6	Urban Honolulu CDP, HI	230,071	**Santa Clara, CA**	**40.8%**
#7	Chicago, IL	166,770	**Garden Grove, CA**	**38.6%**
#8	Houston, TX	139,960	**Torrance, CA**	**38.2%**
#9	**Fremont, CA**	**116,755**	**San Francisco, CA**	**35.8%**
#10	Philadelphia, PA	106,720	**San Jose, CA**	**34.5%**

In terms of the NHPI population distribution, 23% of the total NHPI population in the U.S. resided in California, which was second to Hawaii's 29%. Four California counties ranked among the top 10 counties with the largest number of NHPI's as indicated in Table 2 (Jones, 2011):

Table 2: *2010 Census – Counties with the Largest Number of NHPIs in the U.S. (NHPI Alone and NHPI In Combination)*

Counties with the Largest Number of NHPIs	
Honolulu, HI	233,637
Hawaii, HI	62,487
Los Angeles, CA	**54,169**
Maui, HI	42,264
San Diego, CA	**30,626**
Clark, NV	27,088
Sacramento, CA	**24,138**
King, WA	23,664
Alameda, CA	**22,322**
Salt Lake, UT	20,824

Data on AANHPI Populations in California

According to the 2010 Census, out of the total population of 37.25 million in California, 22.3 million were part of a racial or ethnic minority, which accounts for 59.9% of the total state population. The 2010 Census also revealed that there were 5.6 million Californians who identified themselves as "Asian alone" or "Asian in combination," which accounts for 14.9% of the state's population, making California the state with the largest Asian population. There were 228,946 Californians identified as "NHPI" or "NHPI in combination," which accounted for 0.6% of the state's population. In total, the AANHPI communities represented 15.5% of the population in California in 2010 (U.S. Census Bureau, 2010). An argument could be made that the actual number of the AANHPI populations might be even higher, as not all AANHPI groups were captured in the census, and there might be reluctance in the AANHPI communities to participate in the census due to reasons such as immigration status and language barriers. Nevertheless, the 2010 Census results clearly speak to the significance of the AANHPI communities in California. AANHPIs in California have also made important contributions to the Golden State's economy. According to a 2007 survey of Business Owners by the Census Bureau, California had the most Asian-owned businesses (509,097 out of 1.5 million nationwide), generating $182 billion in revenues (U.S. Census Bureau News, 2011). The AANHPI communities in California consist of many ethnic groups. Table 3 and Table 4 provide a snapshot of the various AANHPI groups accounted for in the 2010 Census. However, please keep in mind that this is not an exhaustive list of all the AANHPI communities in the state.

Table 3: *2010 Census – Asian Populations in California*

Subject	Alone	Alone or in combination with one or more other categories of same race	Alone or in any combination
Asian Indian	528,176	542,677	590,445
Bangladeshi	9,268	10,135	10,494
Bhutanese	694	732	750
Burmese	15,035	16,964	17,978
Cambodian	86,244	96,406	102,317
Chinese (except Taiwanese)	1,150,206	1,241,572	1,349,111
Filipino	1,195,580	1,233,222	1,474,707
Hmong	86,989	88,657	91,224
Indonesian	25,398	28,726	39,506
Japanese	272,528	301,074	428,014
Korean	451,892	465,314	505,225
Laotian	58,424	64,513	69,303
Malaysian	2,979	4,609	5,595
Nepalese	5,618	5,971	6,231
Pakistani	46,780	49,522	53,474
Sri Lankan	10,240	10,896	11,929
Taiwanese	96,009	104,240	109,928
Thai	51,509	57,238	67,707
Vietnamese	581,946	622,160	647,589

Table 4: *2010 Census – NHPI Populations in California*

Subject	Alone	Alone or in combination with one or more other categories of same race	Alone or in any combination
Native Hawaiian	21,423	22,940	74,932
Samoan	40,900	43,437	60,876
Tongan	18,329	19,778	22,893
Guamanian or Chamorro	24,299	24,987	44,425
Marshallese	1,559	1,592	1,761
Fijian	19,355	19,549	24,059

In terms of distribution of Asian populations in California, Table 5 provides a list of the top 15 counties with the highest percentage and number of individuals of the Asian population in the county's total population, while Table 6 captures the percentage and number of individuals represented by the NHPIs in the counties listed.

Table 5: *2010 Census – Top 15 California Counties with the Highest Proportion and Number of Asian Individuals*

Rank	County	Percentage	County	Number of Individuals
#1	San Francisco	33.3%	Los Angeles	1,345,148
#2	Santa Clara	32.0%	Santa Clara	570,125
#3	Alameda	26.1%	Orange	538,831
#4	San Mateo	24.8%	Alameda	394,180
#5	Orange	17.9%	San Diego	337,389
#6	Solano	14.6%	San Francisco	268,143
#7	Contra Costa	14.4%	Sacramento	202,886
#8	San Joaquin	14.4%	San Mateo	178,175
#9	Sutter	14.4%	Contra Costa	151,059
#10	Sacramento	14.3%	Riverside	131,378
#11	Los Angeles	13.7%	San Bernardino	128,218
#12	Yolo	13.0%	San Joaquin	98,684
#13	San Diego	10.9%	Fresno	89,323
#14	Fresno	9.6%	Solano	60,348
#15	Merced	7.4%	Ventura	55,162

Table 6: *2010 Census – Top 14 California Counties with the Highest Proportion and Number of NHPI Individuals*

Rank	County	Percentage	County	Number of Individuals
#1	San Mateo	1.4%	Los Angeles	29,455
#2	Sacramento	1.0%	San Diego	15,476
#3	Solano	0.9%	Sacramento	14,187
#4	Alameda	0.8%	Alameda	12,082
#5	Stanislaus	0.7%	San Mateo	10,058
#6	Contra Costa	0.5%	Orange	9,030
#7	Lassen	0.5%	Santa Clara	7,126
#8	Monterey	0.5%	Riverside	6,568
#9	San Diego	0.5%	San Bernardino	6,105
#10	San Joaquin	0.5%	Contra Costa	5,245
#11	Yolo	0.5%	Solano	3,720
#12	San Francisco	0.4%	Stanislaus	3,601
#13	Santa Clara	0.4%	San Joaquin	3,426
#14	Yuba	0.4%	San Francisco	3,220
#15	All other counties	$\leq$ 0.3%	Monterey	2,075

Among the 58 counties in California, the AANHPI population size varied rather widely. Los Angeles County had close to 10 million residents, while San Mateo County and Solano County have a total population of 718,451 and 413,344, respectively. Therefore, it is also important to have a sense of the number of residents identified as Asians and NHPIs at the county level. For example, while Asians only constituted 13.7% of the total population in Los Angeles County, they accounted for more than 1.3 million residents in the county, making Los Angeles the county with the largest Asian population in California. While there were more Asians, proportionally speaking, in San Francisco County, it only translated into 268,143 residents identified as Asians in the county. Thus, *both sets of data should be considered when making policies pertaining to Asian populations*.

> It is not that AANHPI populations have lower needs for mental health services. Rather, these needs have not been reflected in utilization rates of pre-crisis services.

Given the diversity of the AANHPI populations, it was to be expected that there were many differences among various subgroups. These differences could be observed in terms of language, culture, history, immigration patterns, religion, spirituality, traditions, acculturation, education level, and socioeconomic status, just to name a few. These differences may be even more pronounced when comparing information on recent immigrant populations. For example, according to data released by the Urban Institute drawn from the 2008 and 2009 American Community Survey, in the state of California, for children of immigrant parents from Southeast Asia, 28.14% lived in linguistically isolated households and 18.73% lived below poverty line. In comparison, for children of immigrant parents from East Asia and the Pacific Islands, the corresponding rates were 17.24% and 6.92%. For these immigrant parents, 66% of those who came from Southeast Asia had an educational level of high school or below, while 34% had a 4-year college degree or higher. In comparison, 68% of the immigrant parents who came from East Asia and the Pacific Islands had a college degree and higher (Urban Institute, 2011).

In terms of median age, there was also a big range among the AANHPI populations. As stated in the 2009 Ponce et al. report, according to the 2006 American Community Survey, the median age for Japanese was 39, while it was 28 for NHPIs, 25 for Cambodians, and 19 for Hmong. In terms of fertility rates, East Asians (Chinese, Korean, and Japanese) were in the mid 3% range, while Southeast Asians, South Asians and NHPIs had higher rates, such as 4.1% for NHPIs, 4.9% for Vietnamese, 5.1% for Filipino, 5.5% for Cambodians, 6.6% for Laotians, 6.7% for Indians, and 10.3% for Hmong (Ponce et al., 2009). These numbers are noteworthy as they provide reasonable predictions on future population growth for these ethnic groups.

Ponce et al. reported, as expected, most Asians in California were first generation immigrants, as 60% were foreign-born. Given the different patterns of immigration, the percentage of foreign-born varied from 28% for Japanese, 43% for Hmong, around 60% for Chinese, Filipinos, Cambodians, and Laotians, to close to 70% for Indians, Koreans, and Vietnamese. In contrast, only 19% of NHPIs were foreign-born. The heterogeneity among AANHPIs was also reflected in English proficiency and educational

attainment. While only 12% of NHPIs had limited English proficiency, the proportion of Asians with limited English proficiency ranged widely from around 20% for Japanese and Filipinos, around 45% for Chinese, Cambodians, Hmong, and Laotians, to 50% for Koreans, and 54% for Vietnamese.

For the overall population of California in 2009, 29% had a college degree or higher. AANHPIs as a group outperformed the general population. However, as in other categories, there was a wide range when the data was broken down by subgroup. 65% of Indians had a college degree and higher, which was the highest among AANHPIs, while Laotians had the lowest rate at 11%. Compared to the 37% for Whites with a college degree and above, the percentages with a college degree or higher for Chinese, Filipinos, Japanese, Koreans, Cambodians, Hmong, and Vietnamese were 51%, 45%, 47%, 56%, 13%, 13%, and 26%, respectively. What was more troubling is the significantly higher rate for Southeast Asian populations that had less than a high school level education, such as the Cambodians (37%), Hmong (48%), Laotians (42%), and Vietnamese (26%).

Subgroup differences were also clear in terms of occupations held. More than half of Chinese (52%), Indians (61%), and Japanese (53%) were in management or professional positions, while only about 20% of Cambodians, Hmong, and Laotians held such positions. These differences might have contributed to the sizable gaps seen in per capita income, ranging from $36,791 for Indians, $34,174 for Japanese, $29,906 for Chinese, $26,900 for Koreans, $24,991 for Filipinos, $22,507 for Vietnamese, $19,674 for NHPIs, $13,914 for Laotians, $13,624 for Cambodians, and $8,470 for Hmong. Southeast Asians and NHPIs thus were more dependent on public assistance as the percentage of the populations living below poverty level were higher – 12.4% for NHPIs, 13.4% for Laotians, 14.7% for Vietnamese, 21% for Cambodians, and 31.7% for Hmong.

> The needs for mental health services have been and continue to be great in the AANHPI communities. Hence, it is important to examine the barriers that prevent AANHPIs from utilizing mental health services.

While East Asians in general reported a lower rate of mental disability, Southeast Asians under 65 reported a higher rate of mental disability at 6% as compared to the state average of 4%. For AANHPIs ages 65 and over, the mental disability rate jumped much higher. Compared to the state average of 5%, elderly Vietnamese reported 7% and other elderly Southeast Asians reported 10%. These elevated rates of mental disability might be due to war trauma and experience as refugees. Moreover, Vietnamese and NHPIs reported a higher frequency of mental distress than other API subgroups (Ponce, Tseng, Ong, Shek, Ortiz, & Gatchell, 2009).

These statistics point to the importance of raising awareness among policy makers that the AANHPI community is not merely an homogeneous group and underline the urgent need for data to be more disaggregated to adequately address the needs of various AANHPI communities.

OVERVIEW OF DISPARITY ISSUES IN THE LITERATURE

> "Living in this country, my only hope for [dealing with] an emergency situation would be to call 911."
>
> – Focus group participant

The Surgeon General Report (U.S. Department of Health and Human Services, 2001) clearly concluded that disparities exist in mental health services in the ethnic populations. Such disparities have left ethnic populations underserved, un-served, or with unmet needs. Worse yet, even when ethnic populations were served, the quality of care is often poorer than the quality of care received by Whites. In response to the call for action, the California Department of Mental Health spearheaded the efforts to address this national problem by launching the California Reducing Disparities Project.

Prevalence Rate and Utilization Rate

Asian Americans are often considered the "Model Minority" in the United States: hard-working, high-achieving academically, and successful. With such stereotypes, some may expect low prevalence rates of mental illness and low utilization rates of mental health services among Asians. According to the National Institute of Mental Health in 2008, Asian adults had the lowest prevalence rate for serious mental illness than any other race in the United States (National Institute of Mental Health, 2008). However, these rates may not accurately reflect the reality of the state of mental health needs in the Asian community, as they are influenced by cultural factors specific to the Asian community, such as cultural beliefs and stigma towards mental illness, acculturation, immigration history, immigration status, language barrier, and unfamiliarity with the mental health service system. In fact, Asian Americans with suicidal ideation or attempts were found to have perceived less need for help and would be less likely to seek help compared to Latinos (Chu, Hsieh, and Tokars, 2011). All these cultural factors similarly influence the attitudes and consequently help-seeking behaviors in the NHPI community. In examining the data released by the California Department of Mental Health based on the 2000 Census, it was estimated that Asian youths in California might in fact have a similar prevalence rate of 7.18% for serious emotional disturbance as compared to the rate of 7.51% for the total population. The Pacific Islander youths were estimated to have a prevalence rate of 7.67%. For adults with serious mental illness, Asians and Pacific Islanders were estimated to have a prevalence rate of 5.6% and 7%, respectively, compared to 6.25% for the total population in California (California Department of Mental Health, 2000). It is worth noting that, despite the stigma against mental illness, Pacific Islanders were consistently estimated to have a higher than average prevalence rate, which coincides with the national data. As reported by the Asian & Pacific Islander American Health Forum, based on the data in 2008 by the Center for Disease Control (CDC), NHPI adults had the highest rate of depressive disorders at 20% among all racial groups, and the second highest rate of anxiety disorders at 15.7%. In particular, the prevalence rates for both depressive and anxiety disorders among NHPIs were much higher in men than women – 32% of NHPI men were diagnosed with depressive disorders as compared to 5.8% of NHPI women, while 19.9% of NHPI men were diagnosed with anxiety disorders compared to 10.7% of NHPI women.

Moreover, based on the 2009 CDC data, NHPI high school students ranked the highest at 33.4% to have felt sad and hopeless every day for two or more weeks in a row (Asian & Pacific Islander American Health Forum, 2010).

Contrary to the perception that Asians have lower prevalence rates of mental illness, in reviewing the 2001 to 2002 data from the national Early Childhood Longitudinal Study-Birth Cohort (ECLS-B), it was found that Asian mothers in general had a similar prevalence rate of depressive symptoms as compared to the general population. However, foreign-born Asian mothers had a higher prevalence rate of depressive symptoms than U.S.-born Asian mothers. More importantly, the prevalence rates among different ethnic groups (Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and other Asians) varied widely ranging from low for Chinese and Indians to very high for Filipina, which points to the importance of recognizing the heterogeneity of various Asian populations (Huang, Wong, Ronzio, & Yu, 2006).

As suggested by Sorkin et al. from the study, language barriers might have increased an individual's sense of isolation, decreased social support, and resulted in less access to care.

Interviews conducted with 1,503 Chinese Americans in Los Angeles indicated that 20.5% of respondents reported having experienced an episode of at least one of psychiatric disorders such as affective disorders, anxiety disorders, and substance abuse or dependence (Spencer & Chen, 2004). Clearly, AANHPIs do not have lower prevalence rate for mental illness than other racial groups.

Despite prevalence rates of mental health challenges being comparable to other ethnic groups, the utilization rate of mental health services remains low for AANHPIs. One way to understand the low utilization rate for AANHPIs is to look at the data regarding emergency services. Looking at children receiving mental health care from California's county systems from 1998 to 2001, it was found that AANHPI children were more likely than White children to use hospital-based crisis stabilization services, which suggested that AANHPI caretakers might tend to postpone treatment until it reaches a crisis level. Delayed help-seeking may be due to stigma, mistrust of the system, and/or language barrier (Snowden, Masland, Libby, Wallace, & Fawley, 2008). Thus, it is not that AANHPI populations have lower needs for mental health services. Rather, these needs have not been reflected in utilization rates of pre-crisis services.
A study in Hawaii, a state with a large AANHPI population, on mothers with depressive symptoms revealed that AANHPIs were significantly less likely to receive services despite the presentation of symptoms (Ta, Juon, Gielen, Steinwachs, & Duggan, 2008). Furthermore, the tendency to group AANHPIs as one might have masked the reality as well. For example, from interviewing 339 Cambodian immigrants in Long Beach who were diagnosed with PTSD, major depression disorder, or alcohol use disorder, Marshall et al. found that during the previous 12 months, 70% of interviewees had sought help with emotional or psychological problems from Western medical care providers, while only 46% turned to mental health providers for services (Marshall, Berthold, Schell, Elliot, Chun, & Hambarsoomians, 2006). The need for mental health services is apparent, yet those in need are not gaining access or receiving proper care.

Despite the stigma against mental illness, Pacific Islanders were consistently estimated to have a higher than average prevalence rate, which coincides with the national data.

Lastly, it is obvious that the prevalence rates and utilization rates for AANHPIs *do not* tell the whole story about the mental health needs in the AANHPI community. Despite the low prevalence rate and utilization rate cited in some literature, the reality is that Asian American females have significantly higher suicide rates among women over 65 and women between ages 15 to 24, according to the American Psychiatric Association. The Center for Disease Control data showed that API women ages 65 and over consistently had the highest suicide rate compared to all other racial groups at 8.5% in 1990 (non-Hispanic White ranked second at 7%), 5.2% in 2000 (non-Hispanic White ranked second at 4.4%), 6.9% in 2006 (non-Hispanic White ranked second at 4.3%), and 5.2% in 2007 (non-Hispanic White ranked second at 4.4%). Moreover, in 2006 and 2007, API females ages 15 to 24 ranked second among all racial groups in suicide rate at 4% and 3.8%, respectively. The data is even more revealing when the leading causes of deaths for AANHPIs are examined. In 2007, suicide was the third leading cause of death for AANHPIs ages 10 to 14 and the second leading cause of death for ages 15 to 34 (Center for Disease Control). Furthermore, suicide is of particular concern with NHPIs. As reported by the APIAHF, the 2009 CDC national survey showed that 19.2% of NHPI adolescents had suicidal ideation, 13.2% made suicide plans, and 11.9% attempted suicide in the previous year (Asian & Pacific Islander American Health Forum, 2010). Clearly, the needs for mental health services have been and continue to be great in the AANHPI communities. Hence, it is important to examine the barriers that prevent AANHPIs from utilizing mental health services.

Barriers to Care

Given that the evidence shows that AANHPIs do not have lower prevalence rates for mental illness, yet they consistently have low utilization rates of mental health services, it is critical to understand and address barriers that deter AANHPIs from accessing and receiving mental health services. The following section outlines barriers to care identified in various studies:

Stigma

Stigma has been cited over and over again as one of the major barriers to seeking mental health services in the AANHPI communities. A 2005-2006 study focusing on older Korean Americans in Florida illustrated how stigma played a significant role in deterring those in need from seeking needed help. Out of the 472 foreign-born Korean Americans ages 60 and over, 34% had been assessed for probable depression and 8.5% reported suicidal ideation. However, only 6.5% had contacted mental health professionals, which might have been a reflection of their attitudes towards mental illness, as 71% considered depression as a sign of personal weakness and 14% stated mental illness would bring shame to the family. Moreover, the higher the levels of depressive symptoms, the more negative attitudes one would have towards mental health services (Jang, Kim, Hansen, & Chiriboga, 2007). Even for young Asian Americans, stigma towards mental illness is still a major factor affecting help-seeking behaviors. Compared to Caucasians, first- and second-generation South Asian college students reported more negative

attitudes towards mental illness and consequently greater reluctance to seeking help. These South Asian students were also found to be more likely to distance themselves socially from those with mental illnesses. Thus, stigma was significant both at a personal and social level (Loya, Reddy, & Hinshaw, 2010). Even when an individual could overcome stigma and seek help, mental health professionals often were not the first ones AANPPIs would turn to. Family, friends, community leaders, or spiritual leaders were among those AANPPIs would typically reach out to. Additionally, rather than seeking help for emotional difficulties, AANHPIs would tend to present their mental health problems as physical symptoms to their primary care providers (Zhang, Snowden, & Sue, 1998). However, primary care providers are typically not specialized in working with people who have mental health issues. They may not be properly equipped to diagnose or treat mental illnesses, which may leave some patients inaccurately diagnosed and/or therefore improperly treated for their mental illness. Chung et Al. (2003) found that being Asian, or having low acculturation levels might make it less likely for primary care physicians to detect psychiatric distress in Asian patients compared to Latino patients (Chung, Guarnaccia, Meyers, Holmes, Bobrowitz, Eimicke, & Ferran, 2003). Such strong reluctance towards help-seeking consequently could result in situations where mental health services were sought only when problems become severe (Chow, Jaffee, & Snowden, 2003), which subsequently could lead to higher health care costs, as in some cases when patients receive their mental health treatment in the emergency room. In a 2001 study analyzing 10,623 AANHPI adults admitted to emergency departments, only 35% of all those who eventually received a psychiatric diagnosis came in with complaints of emotional distress. In addition, even after arriving in the emergency department, AANHPIs may still not receive the needed help. AANHPIs with psychiatric diagnoses were found more likely to be discharged against medical advice compared to AANHPIs with physical diagnoses only and AANHPIs with both physical and psychiatric diagnoses, which suggested that stigma or lack of culturally competent care might have resulted in refusal of treatment even in an emergency (Chen, 2005). Thus, the argument can be made that stigma may have led to underestimates of the prevalence rate and utilization rate among the AANHPI's (Zhang, Snowden, & Sue, 1998).

Language Barrier

> "There are no Pacific Islander languages spoken and it's difficult to translate mental health literature in our native PI languages because we don't have words for 'bipolar' and etc."
>
> – Pacific Islander focus group participant

In an analysis of the 2001 California Health Interview Survey (CHIS) including over 4,000 AANHPI adults ages 18 to 64, it was concluded that only 33% of bilingual AANHPIs and 11% of monolingual (non-English speaking) AANHPIs who indicated need for mental health care received needed services, while 56% of English-speaking only AANHPIs received needed services. Similar patterns were found in other racial groups as well. Evidently, language was a great barrier to access to care (Sentell, Shumway, & Snowden, 2007).

As highlighted in the Ponce et al. report, the majority of Asians were foreign-born and many were recent immigrants. As a result, a significant portion (36%) of the Asian populations had limited English proficiency (Ponce, Tseng, Ong, Shek, Ortiz, & Gatchell, 2009). Consequently, language becomes a significant barrier as these Asian populations seek mental health services. For the service providers and policy makers, language barrier has serious implications to education, outreach, and service delivery. The issue of language barrier is even more relevant when older adults are concerned. In analyzing surveys responded by almost 17,000 adult Californians ages 55 and older that included 1,215 Asians, it was found that Asians were more likely to report mental distress but less likely to use mental health services than their White counterparts. Moreover, among the Asians surveyed, 81% were foreign-born and 39% had limited English proficiency (Sorkin, Pham, & Ngo-Metzger, 2009). As suggested by Sorkin et al. from the study, language barriers might have increased an individual's sense of isolation, decreased social support, and resulted in less access to care. In a study by Spencer and Chen, language barrier may have also contributed to reluctance in seeking needed care, where 13% of the 1,507 respondents reported that they were treated badly or unfairly because of language issues.

The presence of an interpreter might have increased the clients' reluctance to discuss questions about mental health. These findings clearly support rigorous training for interpreters and for clinicians to work with interpreters.

Given that culturally competent workforce shortage remains an issue, interpreters are sometimes utilized when the patients have limited English proficiency. Simply stated, the level of competence of the interpreter matters. In surveying 2,715 Asians with limited English proficiency (LEP) across the U.S. at 11 community-based health centers serving large Asian populations, it was revealed that perceived quality of the interpreter was strongly associated with the quality of care perceived by the patients, where interpretation by family members and untrained staff was associated with lower satisfaction. Even though the overall ratings on quality of care were similar between the group served by bilingual clinicians and the group served through interpreters, certain aspects of communications may have been compromised. For example, in comparison with clients treated by bilingual clinicians, clients assisted by interpreters tended to have more questions they did not ask the clinician. The difference may have been due to the time pressure and less rapport with the clinician. However, the presence of an interpreter might have increased the clients' reluctance to discuss questions about mental health. These findings clearly support rigorous training for interpreters and for clinicians to work with interpreters. Another important policy implication was that more time should be allotted when using interpreters, as the patient's ratings of interpreters were also highly correlated with feeling that there was sufficient time to explain the reason for their visit and to understand the clinician's explanation of their problems (Green, Ngo-Metzger, Legedza, Massagli, Phillips, & Lezzoni, 2005).

Lack of Insurance

Considering the diversity in the AANHPI communities, it is almost a given that there are differences in access to health care among different ethnic groups even just in terms of insurance coverage. Based on an analysis of data from the 2003 and 2005 California Health Interview Survey, as compared to non- Hispanic White children, Korean children in California were 4 times more likely to lack health insurance (2.8% vs. 12.5%). Filipino children were twice as likely not to have had recent contact with a doctor (7.6% vs.13.1%) as they were 25% more likely not to have insurance (2.8% vs. 3.5%). Lack of insurance consequently resulted in less access to care and lower utilization of services (Yu, Huang, & Singh, 2010). Furthermore, a 2009 report by the University of California AAPI Policy Research Program revealed that 33% of adult Koreans in California were uninsured, the highest rate among all ethnic groups and more than two times higher than the state average of 15%. Moreover, even though Vietnamese and NHPIs have been found to experience mental distress more frequently than other AANHPI groups, 34% of Vietnamese who were insured did not have mental health coverage. While 88% of Chinese had health insurance, 28% did not have mental health coverage (Ponce, Tseng, Ong, Shek, Ortiz, & Gatchell, 2009). Given that primary care is often the first contact for mental health issues for AANHPIs, the lack of insurance coverage presents another major challenge for AANHPIs to receive proper care. Still, even for those with health insurance, a significant portion did not have mental health coverage.

Lower Satisfaction with Quality of Care

> "Asian communities will not take Western medicine. They don't trust the medicine because the providers do not know their language and do not look like them."
>
> – Focus group participant

Even after entering treatment, AANHPIs tend to report a lower rate of satisfaction with the care they received. In surveying 138 English-speaking clients at psychiatric units in Honolulu from 2002 to 2003, including 47 Whites, 43 Pacific Islanders, and 48 Asians, it was found that AANHPIs had a lower rate of satisfaction with care than Whites. Moreover, among the various demographic variables examined, ethnicity was the only significant factor associated with the client's perception of care (Anders, Olson, & Bader, 2007). While the study did not further explore possible explanations for the results, the authors speculated that it was likely the ethnicity of the physicians, who were mostly Caucasians, might have been a contributing factor. These findings were in agreement with the results from a national survey in 2001 on health care experiences between Whites and Asian Americans, in which "Asian Americans were less likely to report that their doctors ever talked to them about mental health issues" and "more likely to report that their regular doctors did not understand their background and values" (Ngo-Metzger, Legedza, & Phillips, 2004).

Lack of Disaggregated Data and Research

The lack of disaggregated data continues to marginalize AANHPI populations and worsen the issues of disparity in mental health services.

In reviewing available literature and data with regards to the Asian American, Native Hawaiian, and Pacific Islander populations, it became abundantly clear that we have a long way to go in order to adequately identifying, assessing, and addressing the needs of various AANHPI communities in California. AANHPIs have often been grouped together, if included at all, in most studies. Even in studies that attempted to collect subgroup data, only a few major Asian groups were counted, such as Chinese, Japanese, and Korean. Even when researchers sought for disaggregated data beyond these groups, only a few additional groups were included. The reality is, as described in many of the studies cited in this section, the AANHPI communities can be rather different. The study by Huang et al. in 2006 and the report by Ponce et al. 2009 are two examples crystallizing the great variations among various AANHPI subgroups. However, the heterogeneity of the Asian populations has not been sufficiently recognized and reflected in data collection and research. The scarcity of data collection and research on Native Hawaiians and Pacific Islanders is even more troubling, as they appear to be practically non-existent. The lack of disaggregated data continues to marginalize AANHPI populations and worsen the issues of disparity in mental health services.

In addition to ethnicity, factors such as immigration history, acculturation level, socioeconomic status, and educational attainment should also be critical considerations in data collection and public policy. Although the majority of Asians are foreign-born, immigration history (and consequently level of acculturation) may result in differences among the subgroups. For instance, Chinese Americans and Japanese Americans have been immigrating to the U.S. since the 1800's, while Southeast Asians have mostly arrived within the last few decades. Differences may therefore exist between the U.S.-born and the foreign-born Asians. For example, as compared to the national average of 13.5% for suicidal ideation and 4.6% for suicide attempts, the 2,095 Asians surveyed had lower rates of 8.6% and 2.5%, respectively. However, a closer look at the data would tell a very different story. The U.S.-born Asian American women had a much higher rate of suicidal ideation at 15.9%, making the group the most at risk for suicidal behaviors (Duldulao, Takeuchi, & Hong, 2009).

A possible reason contributing to the lack of disaggregated data for AANHPIs may be the lack of infrastructure to develop and support researchers who may be interested in collecting data on AANHPIs. In analyzing lessons learned at the University of Hawaii at Manoa, which largely serves AANHPI populations, several barriers to research were identified. For example, limited physical and human resources and lack of mentors and role models made it rather challenging to attract junior researchers to conduct research that could better capture the mental health needs in the AANHPI communities (Yanagihara, Chang, & Ernst, 2009).

Strategies to Reduce Disparities

What were some of the proven strategies that studies showed to have effectively reduced mental health service disparities? From interviewing 59 county ethnic services

coordinators and analyzing data on penetration rates in California, it was concluded that having bilingual and bicultural staff significantly increased penetration rates for Asian population in California. However, merely having a bilingual/bicultural first point of contact (e.g., receptionist) resulted in lower penetration rates (Snowden, Masland, Ma & Ciemens, 2006). Unfortunately, the study did not provide possible explanations as to what made having a bicultural and bilingual staff more effective than a bilingual/ bicultural first point of contact. However, it may be reasonably speculated that the former would most likely possess a higher level of cultural competency than the latter. This finding is in agreement with the experience of the API-SPW members. As outlined in the section on "Core Competencies" in the latter part of this report, reducing mental health service disparities in the AANHPI communities requires much more than just overcoming the language barrier. Rather, it requires a keen understanding and due respect for the various aspects of a specific culture and the ability to be the true bridge between the specific culture and mainstream culture.

Even for those with health insurance, a significant portion did not have mental health coverage.

This underlines the importance of making cultural competent services available once the individuals in need have been successfully engaged by the first point of contact. Another effective strategy for culturally appropriate outreach was identified by an analysis of the 2002 and 2003 National Latino and Asian American Study, which suggested that outreach efforts should include targeting families and not just the individuals, as the use of mental health services by Asian immigrants or Asians with at least one immigrant parent was particularly influenced by their family (Ta, Holck, & Gee, 2010). After examining interviews from 161 AANHPIs and 1,332 Whites living in Los Angeles, Zhang et al. concluded that 12% of AANHPIs would talk to their friends or relatives about their psychological difficulties, while only 4% would seek professional help (Zhang, Snowden, & Sue, 1998). Considering the reluctance AANHPIs generally have about disclosing any mental health difficulties, this study clearly demonstrated the significance of inclusion of family. This also is in agreement with the Core Competencies defined by the API-SPW, which emphasizes the importance of including families in education, outreach, and treatment whenever possible, given that AANHPI cultures are very family-oriented.

Manuia
웰니스
康健
Wellness
Kev Nyob Nyab Xeeb
ウェルネス
Olakino Maika'i
Khỏe
Kalusugan
Mo'ui Leiei
Haengh Wangc

Chapter III

Existing Issues and Challenges

웰니스

NATURE OF DISPARITIES

Process of Identifying Disparities by the API-SPW

The API-SPW members were invited to participate in this project because of their extensive experiences working with various AANHPI communities, which put them in an authoritative position to speak, both personally and professionally, for the various AANHPI communities they represented about the disparities in mental health services in the AANHPI communities. The first task for the API-SPW thus was for the members to identify barriers that have contributed to disparities at the regional level during the first regional meetings. All input provided from the five regions were collected, summarized, and presented to the entire membership at the statewide meeting for further discussion and review. Despite the diversity in the AANHPI populations represented and the uniqueness of each region, there were more similarities than differences among the five regions. Moreover, these barriers were interrelated, and one barrier would frequently and subsequently add to another barrier. Below is the list of barriers identified by the API-SPW:

- Lack of access to care and support for access to care
- Lack of availability of culturally appropriate services
- Lack of quality of care
- Language barriers
- Lack of disaggregated data and culturally appropriate outcome evaluation
- Stigma and lack of awareness and education on mental health issues
- Workforce shortage

Lack of Access to Care and Support for Access to Care

> "The problems we face are the language barriers, lack of health insurance, and lack of transportation."
>
> – Focus group participant

For many AANHPIs who do not have means of transportation, the lack of support for access to care such as transportation and interpretation assistance may prevent them from seeking and receiving care. Even when consumers can come to providers for services, there are still barriers such as the need to meet "medical necessity," as symptoms may manifest differently due to cultural difference and hence such requirement may preclude people from getting into the system. Lastly, there are many AANHPIs who are not eligible for Medi-Cal or MediCare and may not have adequate healthcare insurance and coverage. Additionally, there are a significant number of uninsured AANHPIs as mentioned in the previous section of this report. Therefore, these individuals and families may not have adequate access to affordable culturally appropriate services. An example illustrating the urgent need to provide access to appropriate care is one told by a community member in the Central Valley, where AANHPIs with mental illnesses have been turning to Cambodian and Laotian temples, even though these temples and clergies are not equipped to deal with mental health issues.

Lack of Availability of Culturally Appropriate Services

> "Not feeling well physically, I see doctors. Not feeling well mentally, I go to the temple and talk to monks."
>
> – Focus group participant

Even if consumers have access to care, there remains the challenge of finding culturally appropriate services. Due to limited resources in the current mental health system, there are fewer culturally appropriate services than what the AANHPI community actually needs. In some areas where AANHPIs do not account for a significant portion of the population, there may be no culturally appropriate services available at all. Consumers sometimes become discouraged by the long waiting period to receive services even when they have been successfully outreached to. Even when consumers have been successfully connected with a provider, there remain other challenges for both the provider and the consumer. For example, given that AANHPIs place great emphasis on relationship-building, it usually takes a lot of time for a provider to establish rapport and trust, which often is not allowed under the current billing guidelines. Culturally appropriate services sometimes are not "billable," either. For example, interpretation services, while a crucial part of a culturally competent program, are often not compensated; nor are interpretation services always recognized as a valuable component of a culturally appropriate program. Spirituality is another important component of many AANHPI cultures and therefore should be incorporated into culturally competent services whenever appropriate. Unfortunately, these types of culturally competent programs are limited due to the lack of reimbursement and policies in regards to activities that are religiously affiliated. All these factors have contributed to the insufficient availability of culturally appropriate services in the AANHPI community.

Lack of Quality of Care

> "Culture has its own mechanism. Symptoms are not always the same because the culture in itself has its own language."
>
> – Focus group participant

Even if a consumer can successfully access a program targeting their culture, this does not always mean that the quality of care offered by the program is adequate. Although there may be differences in opinions as to what constitutes a culturally appropriate program, it is the consensus of the API-SPW that it takes much more than just employing bilingual staff. Some mainstream programs may have one AANHPI staff with the expectation that this employee can serve the needs of all AANHPI consumers, regardless of language or culture. To provide good quality of care to the AANHPI community, a program would need to meet many of the core competencies as identified in Chapter IV: Community-Defined Strategies. In short, cultural factors as determined by the community should be a critical part of the definition of quality of care.

Language Barriers

> "Language barrier is a problem and culture is very important when seeking help. Looking or finding a counselor is overwhelming."
>
> – Focus group participant

Many AANHPIs have limited proficiency in English, and the elderly often are monolingual. Therefore, interpretation assistance is an integral part of culturally competent services to many AANHPIs. The lack of services and workforce needed in AANHPI languages becomes a barrier to access, availability, and quality of care. However, it has been reported by many API-SPW members that interpreter services are often not eligible for reimbursement and therefore may not be made available due to funding restrictions. As a result, children sometimes are placed in the position of becoming the family's interpreters, which may have a negative impact on family dynamics. Even when interpreters are available, they may not have enough familiarity with mental health concepts and terminology to be able to effectively communicate the information in culturally acceptable terms, which can be a problem given the stigma towards mental illness in the AANHPI cultures. Interpreter training on mental health issues therefore becomes crucial, since misinterpretation may lead to misdiagnosis. Interpreters also need training on ethics and maintaining professional boundaries because many monolingual community members place so much trust and faith in these interpreters. Since interpretation is not reimbursable under the current mental health system, many AANHPI providers often are placed in the position of having to provide the interpretation service at their own expense. Furthermore, more time and consistency is often required for AANHPI consumers to establish trust with the interpreters, not to mention that interpretation can be time-consuming and thus longer session durations may be needed for adequate services to be provided. Additionally, more time is needed for the clinicians to have a pre-session and post-session meeting with the interpreters in order to ensure a proper flow of communication. The care and support of interpreters are important, yet they are often overlooked. Interpreters are affected by the difficulties consumers share, and yet, unlike service providers, there is usually little support for interpreters. Depending on the AANHPI language, some language resources are more difficult to access than others, especially for newer arrivals like the Karen and Karenni communities. Under the current system, there are very few resources for critically needed language services, which consequently lead to more disparities in mental health services in these communities.

Lack of Disaggregated Data and Culturally Appropriate Outcome Evaluation

> "We are imposing a Western approach on an Eastern population, but we are not adapting to their population."
>
> – Service Provider focus group participant

To properly assess needs in the AANHPI community, disaggregated data is required. However, it remains a challenge as the AANHPI communities continue to be treated as one homogenous group despite the obvious differences in language, culture, ethnicity,

religion, spirituality, tradition, history, and geographic location - just to name a few. Even within the same ethnic subgroup, there may be differences in language and/or culture. For example, 1st generation Chinese immigrants may be rather culturally and linguistically different from 2nd or 3rd generation Chinese Americans. Consequently, without proper data, many needs in various AANHPI communities cannot be adequately addressed and therefore remain unmet. Moreover, there is an additional issue with outcome evaluation as the AANHPI communities attempt to address their unmet needs. Many strategies have been developed by the AANHPI communities, and yet few resources have been made available to help the communities assess the effectiveness of community-driven responses from the perspective of the AANHPI community. Conventional assessment tools based and normalized in Western culture may not be suitable for AANHPIs due to cultural differences. For example, given that the AANHPI cultures are more family-oriented and less individualistic than Western cultures, the definition of "independence" would need to take into account the cultural preference for "interdependence" when assessing one's level of functioning. Culturally appropriate and relevant definitions and measurements of "wellness" should be established for and by the AANHPI communities in order to render such definitions and measurements meaningful to AANHPIs. And yet, when community-driven programs are evaluated, conventional tools continue to be used, which result in more disparities, as these programs may not receive continued funding because they do not have the appropriate tools to demonstrate their effectiveness.

Stigma and Lack of Awareness and Education on Mental Health Issues

> "There are no words for mental health in our language, so you have to describe it, but it comes out rude or harsh. It comes out as 'slow' or 'crazy.'"
>
> – Pacific Islander focus group participant

The issue of stigma remains significant and often deters many AANHPIs from seeking needed services. In many AANHPI languages, there is no proper translation for "mental health" without some kind of negative connotation. Therefore, the AANHPI communities tend to associate the phrase "mental illness" with the term "crazy," since it often is the literal translation. Lack of awareness and education on mental health issues further perpetuates the stigma. In some AANHPI cultures, illness is regarded as a physical and not a mental issue, and there is a lack of understanding that mental health is as important as physical health. More culturally appropriate strategies would help reduce stigma and raise awareness. However, few resources are available to do so. Integrating community partners such as primary care, spiritual leaders, and schools into awareness-raising efforts could be a possible solution to reduce stigma, but the challenge would be to educate these potential partners on mental health issues, however there may be limited or no resources to support such efforts.

Workforce Shortage

> "We need more API cultural training for mental health providers and LGBT providers."
>
> – Gay, Bisexual, and Transgender focus group participant

The development and retention of a culturally competent workforce continues to be a major challenge, which causes mental health service disparities in the AANHPI community. One of the difficulties is that the mental health professions are not among the popular career choices for AANHPI youth. There are not enough role models in the field to encourage interest in the field. For those who choose to enter the field, current training model often do not include experiences working with AANHPIs, and training in cultural competency is even more overlooked (let alone training in a culturally competent program). Moreover, even for those who successfully complete the necessary training, retention remains an issue due to limited job opportunities and the lack of a supportive work environment. The workforce shortage issue is not limited to professionals, such as clinicians and case managers. Outreach workers who are community gatekeepers or first points of contact are also critical in engaging reluctant community members who may not initially turn to mental health professionals for services. Despite their effectiveness, these outreach workers are often not supported with adequate resources under the current system, and therefore the low rate of retention of these individuals further contributes to disparities in mental health services the AANHPI community.

MANIFESTATIONS OF DISPARITY IN THE AANHPI COMMUNITIES

Process of Collecting Direct Input from the AANHPI Communities

The API-SPW aimed to address community-defined needs and to identify community-driven strategies. Therefore, the structure of the API-SPW membership was designed to include as many community representatives as possible. However, the diversity in the AANHPI community, the size of California, the time commitment required, and the limited resources available presented logistical challenges. As described in Section Three, the Steering Committee recruited a wide range of representatives from various AANHPI communities to form the API-SPW. Additional efforts were made to include voices directly from community members through focus groups held in different regions of California.

> The setting of the agency should convey welcoming messages by incorporating decorations and displays familiar to the consumers. Culturally important elements such as food, tradition, art, music, and dance can be used as effective tools for engagement given the issue of stigma.

Twenty-one focus groups were selected and held as part of the project. Given the diversity of cultures and languages in the AANHPI community, conducting the various focus groups required thoughtful preparations. To maintain consistency, the administrative team, under the guidance of the Steering Committee, developed a protocol for the focus group process, as described in the following:

Selection of Focus Groups

At the onset of the project, the API-SPW members discussed issues of disparity in the AANHPI community based on their decades of experience serving the community. Based on these discussions, the API-SPW proceeded to brainstorm on how best to include direct input from the community members. Regional API-SPW started the task of selecting focus groups to conduct for their respective regions to capture regional experiences of disparity. For the larger regions such as the Bay Area and Los Angeles, six focus groups were conducted. For the San Diego/Orange County region, three focus groups were hosted, while the Sacramento region and the Central Valley region each held 4 focus groups. The selection procedures of focus groups were based on recommendations by the Regional SPWs to reflect regional needs. Meanwhile, whenever possible, the administrative team kept Regional SPWs informed of selections being considered by other regions with the intention to maximize the range of community representations across the state.

AANHPIs do not have lower prevalence rate for mental illness than other racial groups.

Focus Group Questions

The design of the questions to be used during the focus groups was based on the three objectives: to identify culturally congruent definitions of mental health; to better understand barriers to receiving needed services; and to solicit strategies to reduce these barriers. Given the stigma towards mental health issues in the AANHPI community, it was decided that "wellness" may be a better term to solicit feedback from the focus group participants. Since the AANHPI cultures tend to be family-oriented and some of the participants were youth members, questions regarding family members and the impact of their mental health on the family were also included. To learn more about disparities issues, such as: stigma, access, and availability, direct input was sought from participant's personal experiences. Lastly, participants were invited to make suggestions on how to address the unmet needs of the community. A total of nine questions were designed and used. Thanks to the generous contributions from API-SPW members, these questions were reviewed and translated into several different languages in writing or verbally interpreted during the group discussion to ensure they were properly communicated to participants in a culturally acceptable manner. Table 1 shows the list of questions used during the focus group discussions.

Table 1: *Questions for Focus Group Discussion*

Q#1	**Please describe what being "Well" means to you. (The definition of mental health and the proper term)**
Follow-up	• How do you define "health" and "wellness" or feeling "well?" • How do you know you are feeling "well?" How do you know you are not feeling well? • Please describe what being "socially and emotionally well" means to you.
Q#2	**Do you feel "Well" most of the time? Some of the time? Why or why not?**
Follow-up	• Do you feel well more often than not or is the opposite the case? • What are some factors or stressors that often cause you not to be well (socially, emotionally, etc.)? (For example, for youths, it could be school pressures, peer pressures, gangs, family problems, identify confusions, relationships, socioeconomic status, etc.).
Q#3	**Are your family members "Well?" How do you know when they are not well? How does it affect you if your family member is not well?**
Follow-up	• Do your family members feel well most of the time or is the opposite the case? • What are some factors/stressors that often cause your family members not to feel well?
Q#4	**If you or your family member is not "Well," then what do you do? (Do you use any traditional/spiritual/alternative healing method to resolve the issue? What are they?)**
Follow-up	• If you or your family members have problems, where/who do you go for help/support? (For example, school programs, school counselors, clinics, community service agencies, relatives, primary care physicians, spiritual healers, church, temples, etc.) • When you are not well, what do you do to stay well or get well?
Q#5	**Do you know of any clinics or service agencies where you can go if you don't feel "Well"?**
Follow-up	• If you or your family members have problems, where do you go for help? • Who would you go to first to ask where you may get help?
Q#6	**If you are not "Well" and need help, what problems do you have in getting help?**
Follow-up	• Are there barriers/challenges to getting help? (For example, insurance, transportation, child care, confidentiality, language, etc.). • If so, what are they and how they can be overcome?
Q#7	**Do you know what "mental health services" are and where they are available?**
Follow-up	• What do you think of when you hear people talk about mental health? (leave this question open-ended so people can respond in any direction they want) • What does the term "mental health" mean to you (or other people: young, old, peers)? • What is your definition of "mental health?" • It is not uncommon for there to be stigma and shame around the topic of mental health. Why do you think this occurs? What are some of the causes of stigma/shame? How strong of an impact do you think this has on people seeking services? • What are the biggest mental health issues facing your community? Do they vary by age, gender, American-born vs. foreign born, etc.? • How do we keep our community mentally healthy to prevent or reduce mental health problems? • Do you know of any "mental health services" or support services?
Q#8	**Are there services that you would like to have but are not available now?**
Follow-up	• What do you think would be helpful for you, your family, and/or your community if you could design your own "wellness" program? • Please share any support services that you would like to have to maintain wellness or to get well, but are not available now.
Q#9	**Please add a question specific to your particular focus group – youth, domestic violence survivors, elderly, women's or men's group.**
Follow-up	• For those who experienced mental health problems: What was helpful on your road to recovery? What was not helpful? • For family members: What helped your family member to feel better? What helped you care for that family member? What made it harder in your efforts to help him/her?

Focus Group Facilitation

The focus groups were conducted in various languages by one to two facilitators per group. To ensure the consistency of facilitation of the focus groups, a protocol was developed by the administrative team. During summer 2010, seven facilitator training sessions were held by the administrative team to provide an overview of the process. For example, the length of the group session should be one and a half to two hours with an ideal size of eight to ten participants in each group. The focus group should be conducted in the preferred language of the participants, either with a bilingual facilitator or with an interpreter. Focus groups were meant to be a facilitated discussion focusing on generating and gathering as many different perspectives as possible. The location of the focus group should be comfortable and easily accessible to the participants. Participants should be those who could speak to and reflect on needs in the community. Careful thought should be given to the room set-up to make the environment safe and welcoming. Participants were asked to sign a consent form, and were given permission to discontinue participation at any time. The role of the facilitator would include closely following the script, setting the tone to encourage input, making sure everyone was heard, obtaining meaningful answers, adhering to the ground rules such as respect and confidentiality, and keeping the discussion on track.

Focus Group Reports

A template was provided for the focus group reporters to submit the feedback collected. For confidentiality reasons, the comments made during the focus group discussion were summarized. While it was encouraged for the reporters to include direct quotes, it was made clear that no identifying information would be provided to ensure safety for the participants. Confidentiality was an important issue as many AANHPI communities are very close-knit, especially in the less urbanized areas. Many may have issues of mistrust considering their experience with the systems or due to historical reasons.

Focus Group Participants

From July 2010 to January 2011, a total of twenty-three focus groups were held. In addition to the original twenty-one groups planned, the Sacramento region and the Central Valley region each held an additional focus group. A total of 198 community members participated in these 23 focus group discussions. The following are breakdowns of all the focus groups conducted by the API-SPW:

Table 2: *Focus Group Participants – Gender and Age*

Female	Male	< 18	19-25	26-59	60+
118	80	13	27	118	40

Table 3: *Focus Groups – Sacramento Region*

Group	Female	Male	< 18	19 -25	26 -59	60+	Ethnicity
Southeast Asian Youth	5	4	9	0	0	0	Hmong, Mien
Rural Elderly Hmong	4	4	0	0	0	8	Hmong
Pacific Islanders	6	3	0	3	5	1	Samoan, Tongan
Survivors of Domestic Violence	3	0	0	1	1	1	Chinese, Filipino

Table 4: *Focus Groups – Bay Area Region*

Group	Female	Male	< 18	19 -25	26 -59	60+	Ethnicity
New Refugees/Asylees	4	4	0	1	7	0	Bhutanese, Burmese, Karenni, Nepali, Rakhaing, Tibetan
Pacific Islanders	9	1	0	1	9	0	Samoan, Tongan
Thai	4	5	0	0	7	2	Thai
Mongolian	4	2	0	0	6	0	Mongolian
South Asian	9	1	0	0	10	0	Afghan, Indian, Persian-Iranian, Taiwanese
LGBTQQI	3	9	0	0	12	0	API LGBTQQI

Table 5: *Focus Groups – Central Valley Region*

Group	Female	Male	< 18	19 -25	26 -59	60+	Ethnicity
Southeast Asian Men	0	9	0	0	9	0	Cambodian, Hmong, Lao
Southeast Asian Community Leaders	0	7	0	0	3	4	Hmong, Lao
Southeast Asian Women	8	0	1	2	3	2	Hmong
Punjabi	2	4	0	0	3	3	Punjabi

Table 6: *Focus Groups – Los Angeles Region*

Group	Female	Male	< 18	19 -25	26 -59	60+	Ethnicity
Youth and Older Adult	6	4	3	3	2	2	Chinese, Filipino, Vietnamese
Cambodian	11	1	0	0	4	8	Cambodian
South Asian	6	3	0	0	6	3	Indian
Korean	6	3	0	1	6	2	Korean
Gay, Bisexual, and Transgender	1	6	0	0	7	0	Chinese, Filipino, Hawaiian, Japanese, Samoan, Thai, Vietnamese
Pacific Islanders	6	5	0	3	7	1	Chamorro, Tongan, Marshallese, Samoan

Table 7: *Focus Groups – San Diego/Orange County Region*

Group	Female	Male	< 18	19 -25	26 -59	60+	Ethnicity
Problem Gambling	4	1	0	0	3	2	Chinese, Vietnamese
Transitional Age Youth and Adult	9	2	0	2	8	1	Caucasian, Filipino, Hmong, Taiwanese, Vietnamese
Asian American College Students	8	2	0	10	0	0	Cambodian, Filipino, Korean

Definition of Mental Health by the AANHPI Communities

> "Wellness is physical, mental, and spiritual. Physical means having good food and living well with basic needs met. Emotional means having self control and not getting angry easily. For example, if something is bothering us, we have to deal with it and find ways to solve problems. Spiritually means we are Buddhist, we have to be good."
>
> – Thai focus group participant

As previously mentioned, due to issues of stigma towards mental health and given the cultural preference for a holistic view of "health," the API-SPW deliberately chose the term "wellness" for the focus group discussions. Questions 1 through 3 were designed to find out the meaning of "wellness" as defined by the participants, the factors that would affect one's wellness, and the manifestations of mental health issues. The following are summaries of the responses from the participants:

Definition of "Wellness"

As indicated by the participants, "wellness" would mean:

- Physically Healthy and Active
- Emotional Well-being
- Good social relationships and support
- Good family relationships
- Financial stability
- Feeling at peace/spirituality

Factors Affecting "Wellness"

As indicated by the participants, factors that would negatively affect "wellness" were:

- Adjustment issues: living in a new and fast-pace environment, language difficulty
- Family issues
- Financial issues
- A sense of hopelessness
- Health issues and high cost of healthcare

Manifestations of Mental Health Issues

When asked how one could tell that "wellness" was being compromised, the participants suggested considering the following signs:

- Acting out towards others
- Expression of hurtful feelings
- Sense of hopelessness
- Poor health/eating habits
- Disobedience
- Turning inwards

Gaps, Unmet Needs, and Suggestions

After the participants defined mental health and described manifestations of mental health issues, Questions 4 through 6 asked for the participant's response to mental health issues, knowledge of available resources in the community for help, and experience with barriers they had encountered when seeking help. Question 7 and 8 looked to understand the participant's attitudes towards mental health services and asked the participant to identify unmet needs and to share their thoughts on possible strategies to address these needs. The following are summaries of the responses from the participants:

Available Resources

Participants named resources they would turn to first when help is needed:

- Spirituality: healers, religious ritual/practice, religious centers
- Go to loved ones, family, and friends
- Do some (physical) activities
- Traditional medicine
- Look for physicians
- Look for mental health professionals
- Community-based organizations
- Don't know where to go

Barriers to Seeking Help

The participants identified the following barriers when they had attempted to seek help for themselves or for their family:

- Lack of culturally and/or linguistically competent staff and services
- Issues related to stigma, shame, discrimination, confidentiality and reluctance to "hear the truth"
- Lack of language skills
- Lack of financial resources
- Transportation
- Complexity of healthcare system and paperwork
- Not comfortable with non-AANHPI service providers
- Unfamiliar with Western treatment model

Attitude towards Mental Health Issues

Participants shared their understanding of mental health services:

- A place to share thoughts, feelings and get support
- Shame and stigma associated with the help seekers
- Not sure
- A place to get professional help
- Services are costly

Strategies to Address Unmet Needs

Participants were asked to name services that would meet some of their needs if they could be made available:

- Programs for specific culture, issue, topic, or age group
- Social/recreational activities
- Service in primary language
- Easily available & affordable
- More outreach effort to counteract stigma
- Include family members
- Culturally sensitive/competent staff

Quality Issues

> It requires a keen understanding and due respect for the various aspects of a specific culture and the ability to be the true bridge between the specific culture and mainstream culture.

The focus group participants have identified barriers to seeking and receiving the needed services above, which certainly have contributed to disparities in mental health services in the AANHPI community. However, even if these barriers could be overcome, there still remains the question of quality of service. While it may be a well-accepted concept that any quality program aiming to serve the AANHPI community must demonstrate cultural competence, it remains a challenge to clearly define what constitutes cultural competence. Since this is a topic meriting much more exploration, quality issues will be discussed in greater detail in the next section of this report.

Chapter IV

Community-Defined Strategies

Kev Nyob Nyab Xeeb

CORE COMPETENCIES IN WORKING WITH AANHPI COMMUNITIES

Developmental Process of Core Competencies

> For certain cultures and for certain topics, cultural attitudes towards gender and gender roles may need to be taken into account when designing a culturally appropriate program or strategy.

While it may have been a widely accepted notion that cultural competency is required when working with the AANHPI communities, the definition of "cultural competence" may still need to be further clarified. The API-SPW was interested in identifying the essential components of cultural competence not just from their decades of personal and professional experiences serving the AANHPI communities, but also by seeking input directly from the community through focus groups across the state. Following the discussions on disparity issues and focus group findings, the API-SPW set out to define core components of cultural competence. The discussion on core competence started during the third regional meetings. A preliminary list of core competencies based on these discussions from five regions was presented to the entire membership at the third statewide meeting for discussion on a statewide level. During the fourth regional meetings, the five Regional SPWs held further discussions on the topic, which were summarized and presented to the membership for review and approval at the fourth statewide meeting.

Core Competencies as Defined by the API-SPW

While the definition of "cultural competency" may vary from culture to culture and from ethnicity to ethnicity, the API-SPW agreed on common elements based on all the discussions that took place and developed a list of core competencies divided into eight categories. The API-SPW recognized that cultural competence is not only essential at the individual provider's level, but should also be crucial at the organizational and systems level to provide sufficient environmental support for fostering and practicing culturally competent services. Thus, each of the eight categories was further divided into three levels. The categories were devised to cover various areas of focus in order to provide a comprehensive list of critical components for cultural competence. The three levels were devised to highlight the importance of conceptualizing cultural competence beyond the individual level, as it would take recognition and support from the organizations and systems to make cultural competence possible and meaningful. It is our hope that this list would serve as a guideline when one considers what constitutes cultural competence. Table 1 (pg. 47) offers a summary of the core components that the API-SPW deemed essential in determining "cultural competence."

Table 1: ***Summary of Core Competencies***

	PROVIDER LEVEL	AGENCY LEVEL	SYSTEMS LEVEL
Professional Skills	▪ Must have training to provide culturally appropriate services and interventions. ▪ Ability to effectively work with other agencies and engage with community. ▪ Clear understanding of PEI strategies and relevant clinical issues. ▪ Knowledge about community resources and ability to provide proper linkage.	▪ Employ, train, and support staff that possess the necessary professional skills. ▪ Capacity to provide needed linkage to other agencies.	▪ Recognize the importance and provide support for the development and retention of professionally qualified and culturally competent workforce. ▪ Support the capacity to provide linkage.
Linguistic Capacity	▪ Proficiency in the language preferred by the consumer OR ▪ Ability to work effectively with properly trained interpreter.	▪ Employ, train, and support staff that possesses proficiency in the language preferred by the consumers. ▪ Provide language appropriate materials. ▪ Provide resources to train interpreters to work in mental health setting.	▪ Recognize the importance and provide support for the development and retention of linguistically qualified workforce. ▪ Provide resources to support bilingual staff and reimbursement for the service, including interpreters. ▪ Provide resources for preparing and printing bilingual materials.
Culture-Specific Considerations	▪ Respect for and clear understanding of cultural/historical factors including history, values, beliefs, traditions, spirituality, worldview, sexual orientation, gender identity, gender differences, cultural beliefs and practices, and acculturation level/experiences. ▪ Recognize the importance of integrating family and community as part of services.	▪ Provide ongoing training and supervision on cultural and language issues. ▪ Board members should reflect the composition of the community. ▪ Culture-specific factors should be considered and incorporated into program design. ▪ Support the integration of family and community as part of the service plan. ▪ Develop policies that reflect cultural values and needs of the community including physical location, accessibility and hours.	▪ Actively engage ethnically diverse communities. ▪ Funding should allow culture-specific factors to be considered and incorporated into services appropriate for that cultural community.
Community Relations & Advocacy	▪ Ability to effectively engage community leaders and members. ▪ Ability to form effective partnerships with family. ▪ Willingness and ability to advocate for needs of the consumers.	▪ Capacity to effectively engage the community. ▪ Credibility in the community. ▪ Capacity and willingness to advocate for systems change aiming to better meet community needs.	▪ Encourage and support culturally appropriate efforts for community outreach and community relationship-building. ▪ Recognize the importance and provide support for collaboration with community leaders. ▪ Promote cultural competency.

	PROVIDER LEVEL	AGENCY LEVEL	SYSTEMS LEVEL
Flexibility in Program Design & Service Delivery	▪ Flexibility in service delivery in terms of method, hours, and location. ▪ Understand and accommodate the need to take more time for AANHPIs to build rapport and trust.	▪ Capacity to allow flexibility in service delivery (e.g.: more time allowed for engagement and trust building for consumers/ family members; provide essential services to ensure access to services, such as transportation, available hours of operation, and convenient location). ▪ Program design should consider community-based research, culture, and traditional values so it will make sense to the consumers. ▪ Willingness to look for innovative venue for outreach, such as ESL (English as a Second Language) classes.	▪ Recognize the importance and support more time needed for engagement and trust building. ▪ Recognize the importance and support essential ancillary services needed to ensure access to services. ▪ Recognize the importance and support flexibility in service delivery. ▪ Encourage and support programs that include community-based research and/or community-designed practices. ▪ Flexibility in diagnostic criteria to accommodate cultural differences. ▪ Provide support for innovative outreach.
Capacity-Building	▪ Ability to empower consumers, family members, and community. ▪ Capacity to collaborate with other disciplines outside mental health.	▪ Capacity to educate the community on mental health issues. ▪ Capacity to collaborate with other sectors outside mental health, such as primary care and schools. ▪ Plan in place to groom the next generation leaders and staff for the future. ▪ Capacity to provide cultural competence training to mental health professionals and professionals from other fields.	▪ Provide support for capacity-building within the agency and within the community. ▪ Provide support for future workforce development. ▪ Encourage and support outreaching and educating the community on mental health issues. ▪ Provide support for cultural competency training. ▪ More involvement of the community in the policy-making process. ▪ Provide support for a central resource center.
Use of Media		▪ Capacity to utilize ethnic media and social media for outreach.	▪ Encourage and support the use of ethnic media and technology for outreach.
Data Collection & Research		▪ Collect disaggregated data. ▪ Work with researchers and evaluators to assess effectiveness of programs and services.	▪ Provide support for disaggregated data collection. ▪ Support ethnic/cultural specific program evaluation and research. ▪ Support research to develop evidence-based programs (EBPs) for AANHPI communities.

More detailed descriptions of each category are as follows:

Professional Skills

> "I went to several places where all the providers were hetero and believed you had to be hetero to be normal. I got disapproving looks and giggles, which made me close up a lot and not want to participate. They made me feel pressured and frustrated."
>
> – Gay, Bisexual, and Transgender focus group participant

It is a given that any individual provider should possess the professional skills necessary for the services provided, including a clear understanding of prevention and early intervention strategies and relevant clinical issues. The term "professional skills" is not limited to those with credentials, licensure, or degrees, such as in the case of social workers, marriage and family therapists (MFTs), psychologists, or psychiatrists. For example, the essential skills needed for case managers or outreach workers to provide effective services in their professional capacity would be considered "professional skills" for the purposes of this report. Thus, the term "professional skills" is broadly defined here to include skills that meet both established professional standards and cultural appropriateness. It is also a given that individual providers should have continuous training on relevant prevention, early intervention, clinical, and related cultural topics to provide culturally appropriate outreach, engagement, education, services, retention, and interventions.

Due to language barriers and AANHPI mental health consumers' unfamiliarity with the system, individual providers often serve as the point of contact and subsequently become the link between the consumer and other resources. Thus, appropriate referrals are often required to adequately meet the consumer's needs. As informed by the focus group findings, the AANHPI's definition of "wellness" encompasses many more areas than just mental health. Therefore, in addition to the ability to provide professional services, a culturally competent provider should also possess the ability to engage with the community, to work with other agencies, and to provide proper linkage to available resources.

At the agency level, a culturally competent agency should employ, train, and support staff that possess the necessary professional skills as indicated above. **The mere hiring of a bilingual employee is not sufficient, as cultural competence goes far beyond language. It is also insufficient to merely hire one or two bicultural, bilingual staff to work with an AANHPI population. As much as possible, it is essential to have a critical mass to support the bicultural, bilingual staff to avoid burn-out and to facilitate the effective impact of the team.** In addition, the agency should also have the capacity to work with other agencies to provide appropriate linkage services. At the systems level, it is critical for the systems to recognize the importance of cultural competence and to provide resource support for the development and retention of a culturally competent workforce. For instance, the systems can demonstrate its cultural competence by providing additional resources to encourage future workforce to enter the field and to retain the workforce with consistent funding, such as a bilingual bonus.

Linguistic Capacity

> "So lucky to have a health care provider who speaks the language."
>
> – Hmong Elder focus group participant

Many in the AANHPI community often prefer to receive services from providers who can speak their native language even if the consumers have some proficiency in English. In particular, for the elderly and the recent immigrant communities, language is a crucial engagement tool, as many individuals in these communities are monolingual. Linguistic capacity is more than the ability to speak the consumer's preferred language. It is also the ability to understand the cultural context of the language. For example, in some cultures, different mannerisms and vocabulary may be used when addressing people based on their gender, age, and relations. However, given the diversity in the AANHPI community, it may be challenging for any agency to maintain enough staff speaking all the languages preferred by the consumers. Therefore, interpreters may be used to augment service delivery, which makes the provider's ability to work with an interpreter an essential skill when rendering culturally competent services. Interpreters need to have adequate training in mental health issues to know how to properly translate mental health terms and concepts in culturally acceptable language to the consumers, as often times the literal translation of "mental health" is associated with negative connotations such as "crazy." Additionally, interpreters need to have adequate training in maintaining an appropriate code of ethics in healthcare settings, as they are often seen as community leaders, and they often represent the missing link between the community and the providers.

For agencies, employing bilingual staff is only part of the picture in providing culturally competent and effective services. Ongoing training and support of such staff are also vital to maintaining a culturally competent workforce. Moreover, written materials should also be made available in languages preferred by the consumers. The translation should also consider the cultural context and literacy level of the target community. Often, professional jargons may not be understandable to the general public, so outreach materials should use language that is understandable to lay people. Lastly, as part of the agency's ongoing efforts in providing culturally appropriate services, there should be training to foster effective working relationships between staff and interpreters. Support is therefore needed at the systems level to recruit and retain a bilingual workforce. For example, incentives should be provided to recruit and retain culturally competent workforce and resources should be set aside for interpretation both in service delivery and printed materials.

Culture-Specific Considerations

Cultural competence involves more than linguistic capacity and extends to include a clear and respectful understanding of the consumer's culture, history, values, beliefs, traditions, spirituality, worldview, sexual orientation, gender identity, gender, acculturation level, life span developmental issues, and immigration experiences, just to name a few. Needless to say, all these factors should be taken into consideration when working with the AANHPI community. Moreover, AANHPIs tend to be much more family-oriented and the AANHPI communities tend to be close-knit. Therefore, unlike

conventional services based on individualism prevalent in Western culture, family and community should also be taken into consideration when determining service plans appropriate for AANHPIs.

On an organizational level, it is important that board members reflect the composition of the community the organization aims to serve. Culture-specific or population-specific factors should be incorporated in the program design. For example, as voiced by the LGBT focus group, given the stigma against HIV/AIDS, a promising program should include components to address the issue of stigma, such as materials and intervention aiming to enhance communication skills among parents, family, peers, and social networks to discuss these topics. In addition to ongoing training and supervision on culture-specific issues, the agency itself should have policies that reflect and respect the cultural values and needs of the community. Spirituality may need to be considered or incorporated in service delivery to respect cultural practices. For certain cultures, it may be necessary to separate services based on gender. The physical location of the agency should be easily accessible to the community it serves. The hours of operation should be based on the convenience of the consumers. The setting of the agency should convey welcoming messages by incorporating decorations and displays familiar to the consumers. Culturally important elements such as food, tradition, art, music, and dance can be used as effective tools for engagement given the issue of stigma. Furthermore, the system should encourage and support culturally competent services by providing resources for programs that are designed with culture-specific considerations. For example, many ethnic community-based organizations (CBOs) have the expertise, staffing, and programs to effective reach the community. Therefore, these CBOs can be key partners for the systems to engage the community and to provide culturally appropriate services.

Community Relations and Advocacy

> "Teach the elders and parents. Talk in that generation's language. Let them know there's help out there, that it's not taboo and that it's not [the child's nor parent's] fault, and that there's no need to be ashamed."
>
> – Focus group participant

Stigma remains a big challenge for outreach as mental health issues are often considered a taboo subject in the AANHPI community. In many AANHPI cultures, mental illness is something unmentionable and often associated with shame and discrimination. Pacific Islanders, for example, believe that mental illness is a "curse" to the family, which leads to discrimination against not just the consumer but also their family. In many AANHPI languages, there is no proper translation for "mental health" without some kind of negative connotation attributed to it, which is one of the reasons the API-SPW decided to use "wellness" instead of "mental health" when conducting the focus groups. On the other hand, AANHPI cultures are family and community-oriented, which means that the ability on the part of the individual providers and agencies to effectively engage, educate, and collaborate with families and community leaders is critical in ensuring effective outreach and services. As AANHPI cultures often place great emphasis on relationship-building, it is also essential for the

individual providers and agencies to earn and establish their credibility in the community by not just engaging and serving the community, but also by advocating for the needs of the community in areas that affect the overall wellness of the community. For example, lack of adequate insurance is a major barrier to receiving proper mental health services for many AANHPIs, and overcoming such a barrier may require education and advocacy in the areas of healthcare reform or immigration policy. Of course, all these efforts in forming relationships require resources and support, which is where the systems could be of great help.

Flexibility in Program Design and Service Delivery

> "'Well' is a lying word that you tell people when they ask you how you are. It is a response when you meet someone in passing. In order to expand on the phrase, you must sit down and have a conversation. It is something people say, but may not feel because it is difficult to tell others how they are really feeling."
>
> – Hmong Women focus group participant

As previously mentioned, the AANHPI community places great emphasis on relationship-building, so consequently more time is required to establish rapport and trust. For example, for Southeast Asians, story-telling is often the preferred mode of communication when the consumers are first engaged, which means increased session length and frequency are needed before consumers will be ready to share their concerns and difficulties.

The location and operation hours should also be as accessible to the consumers as possible. For example, many AANHPI consumers need transportation assistance to receive services or can only come for services during certain hours. In some cases, field services or home-based services could provide a more natural setting for consumers due to reasons such as stigma and other logistical challenges. Moreover, while many AANHPIs may be reluctant to seek help, they often willingly utilize services such as English as Second Language (ESL) classes, computer classes, and senior group activities. These venues could serve as natural settings for outreach and engagement.

Cultural competence requires flexibility at the systems level as well. For example, more time and sessions could be allowed when engaging and serving the AANHPI community. Subsequently, the system should recognize that while these services are not traditionally "billable" under a typical program, they do not detract from the productivity, effectiveness, and the value of the program. Resources should be allocated for ancillary services such as transportation to improve access to services and for innovative and culturally appropriate outreach efforts. Moreover, flexibility should be allowed with the requirement of meeting medical necessity, since symptoms may be presented differently due to cultural differences and thus may not meet diagnostic criteria based on the Western model.

Capacity-Building

> "It's hard to find someone who understands the cultural nuances."
>
> – Focus group participant

Many agencies in the AANHPI community are relatively small in size and capacity despite the amount of services they provide and their importance to the community. There are also limited resources available to the AANHPI community despite the need. Therefore, capacity-building is a critical issue. Empowering the community and leveraging existing resources thus are important skills at the individual provider level. For agencies, several capacities are needed to demonstrate cultural competence: to educate the community on mental health issues, to collaborate with other community organizations such as schools and primary care providers, to train professionals on cultural competence, and to develop future culturally competent workforce. With support from the systems, all these capacities can significantly contribute to empowering the AANHPI community to develop the capacity to meet its needs in the future. For example, in the previous section, it was documented that Cambodian temples house the mentally ill in the Central Valley. Given that spirituality is an important cultural component reported by the community, the system could provide resources for the mental health service providers, the family members, and the temples to work together to take care of those in need. Furthermore, the system can also foster capacity-building by encouraging meaningful involvement by the community in the policy-making process to ensure that policies adequately and effectively address the needs of the AANHPI community. One effective way to do so would be to create and support infrastructures that leverage existing resources in the community. **Lastly, support for a central resource center will be a cost efficient way to take advantage of technology for outreach and linkage.**

Use of Media

Ethnic media is often one of the best channels to reach the AANHPI community, especially to those who have limited English proficiency. Individual providers are natural front-liners who are crucial in gathering stories for ethnic media, developing culturally appropriate materials to be shared with the community, or influencing ethnic media to raise awareness on mental health issues. However, support from the agency is required because usually there is no funding for such activity. Therefore, it really falls on the agency to demonstrate its willingness and capacity to engage and utilize ethnic media and even social media for education and outreach. One of the major difficulties agencies encounter is the lack of resources because such efforts involve staff time. Through work with the media, this is where systems can show their understanding of the importance of the use of ethnic media by allocating resources for such outreach.

In addition to ethnic media, social media and blogging can also be used to reach the younger generations and the general public who may utilize computers as resources in their daily life. Additionally, web-based information sharing can also be an effective way for outreach and education.

> "In the beginning, I didn't know what to do. I learned about this [agency] in the Chinese newspaper. I feel relieved to know this place is here. Before that, my son started hitting people and I had to call 911 and have him committed."
>
> – Focus group participant

Data Collection and Research

As mentioned in previous sections, there are significant differences among the various AANHPI communities, such as in the areas of immigration history, educational attainment, and socioeconomic status. These differences need to be recognized in data collection so the needs of each community can be accurately reported. As the lack of disaggregated data continues to be a contributing factor to disparities in the AANHPI community, a culturally competent agency should possess the capacity to collect data to demonstrate the needs of the community and to assess the effectiveness of its programs. Needless to say, support is required from the agency for individual providers to appropriately document cultural findings in data collection and evaluation. This may involve working with researchers or external evaluators for consultation and technical assistance. In addition, modifications and accommodations may be needed to adequately evaluate culturally appropriate programs. Since data collection and evaluation requires expertise and resources not readily available to agencies, support from the system becomes vital for such an effort.

When doing program evaluation, selecting approaches and measures that are culturally and linguistically appropriate can make a big difference in outcomes. A traditional paper and pencil survey approach may not work that well for AANHPIs due to factors of social desirability. Hence, it may be important to combine both quantitative and qualitative approaches in collecting data and outcomes. As noted in previous sections, story-telling is important in many Southeast Asians communities. Hence, case studies, in-depth interviews, or focus groups may provide additional data that are not observed or measured by self-report scales. Community-based participatory research is another viable approach to actively engage the community in designing and gathering more accurate data.

TYPES OF COMMUNITY-DEFINED STRATEGIES

Selection Criteria for Promising Programs and Strategies

> Although there may be differences in opinions as to what constitutes a culturally appropriate program, it is the consensus of the API-SPW that it takes much more than just employing bilingual staff.

One of the major tasks given to the API-SPW was to identify community-defined promising programs and strategies to reduce existing disparities in the AANHPI community. Over the years, despite limited resources and many other barriers, programs and strategies had been developed in the attempt to respond to the unmet needs in various AANHPI communities. However, not every program or strategy was necessarily effective or culturally appropriate. The challenge remains as to how to adequately assess the effectiveness of a culturally competent program or strategy. Therefore, based on the core competencies defined by the API-SPW, the focus group findings, and decades of experience serving the AANHPI community, the API-SPW set out to establish criteria to be used as parameters for selecting culturally competent promising programs and strategies to serve the AANHPI populations.

The API-SPW aimed to create a list as comprehensive as possible, while recognizing that this list may be somewhat ambitious given

the limited resources available. This list served as a guideline by the API-SPW in identifying and collecting community-defined promising programs and strategies. It was also hoped that this list would be used in the future by practitioners and policy makers to determine whether a program or a strategy is culturally appropriate for the intended population.

Additionally, although the list of selection criteria was created for prevention and early intervention programs, many of the same criteria could be used to examine promising practices for treatment programs for AANHPIs. Table 2 is a summary of the criteria with more detailed discussions to follow:

Table 2: *Selection Criteria for Promising Programs and Strategies*

PROGRAM DESIGN	
Goals/Objectives	• Does the program have clearly stated goals and objectives?
PEI-Specific	• Is the focus of the program primarily on prevention and early intervention (PEI)?
Focus on Addressing API Community-Defined Needs	• How well does the program clearly identify and address needs in the API community (as voiced by community members, leaders, and stakeholders)? • Did the program have input from the community in the design and evaluation of the program? • Does the program have relevance in supporting the overall wellness in the community?
Addressing Culture/ Population-Specific Issues	• Is the program designed for a specific target population such as gender, ethnic group, cultural group, and age group? • How well does the program integrate key cultural elements into its design (e.g.: oral history, spiritual healers, other cultural components or practices)? • How well does the program demonstrate sensitivity to cultural/linguistic/historical issues (e.g.: immigration, level of acculturation, spirituality, historical trauma, cultural identity, etc.)?
Community Outreach & Engagement	• How well does the program outreach to the community in a culturally appropriate manner (e.g.: staff who are sensitive to working with the community, use of bilingual materials, use of ethnic/mainstream media and social media, etc.)? • How well does the program promote wellness through outreach, education, consultation, and training? • How well does the program use consumers, family members, and community members in their outreach efforts?
Model	• How well does the program promote wellness and follow a strength-based model (e.g.: increase life management skills, increase ability to cope and make healthy decisions, improve communication between family members, etc.)? • How well does the program strengthen and empower the consumers and community members? • Is the program design based on a theory of change that reflects cultural values or has some cultural relevance? • Does the program provide a reasonable logic model? • How well does the program describe its various components and are they related to the stated goals and objectives?
Replicability	• Can the program demonstrate how it can be replicated (across communities that are ethnically and geographically diverse)? • Does the program have the capacity to offer training and development to other agencies if resources are made available? • Does the program have the capacity to offer culturally and linguistically appropriate PEI strategies?

Advocacy	• How well does the program empower the consumers and community members to advocate for their needs? • How well does the program address or contribute to systems change (e.g.: promote social justice, reduce disparities, reduce stigma and discrimination in the area of mental health, etc.)? • How well does the program help to generate community actions in moving towards wellness in the community?
Capacity-Building	• How well does the program develop and form community-wide collaboration with other community stakeholders (e.g.: primary care, social services, schools, spiritual leaders, traditional healers, faith-based organizations, and law enforcement)? • How well does the program lead to strengthening and empowering the community (e.g.: enhance social supports in the community, help to reduce stresses in the community such as acculturative stresses or generational cultural conflicts, develop and support leadership and ownership of the community)?
Sustainability	• How well does the program leverage existing resources available in the community? • How will the program be self-sustainable when funding ends?
Accessibility	• How well does the program address barriers to accessibility (e.g.: hours of operation, location, child care, language, transportation, etc.)?
PROGRAM EVALUATION/OUTCOME	
Program Evaluation/ Outcome	• Has the program been evaluated? • Do the outcomes support the program goals and objectives? • How were participants, providers, and cultural experts involved in the evaluation process (e.g.: testimony/endorsement/self report/satisfaction survey from consumers/families/community, observations and reports from service providers, consensus of cultural experts)?
AGENCY CAPACITY	
Staffing	• Does the program have staff that possesses the necessary professional and/or relevant skills to effectively do their job? • Does the program have staff who are culturally and/or linguistically competent? • Do the board and management of the organization reflect the community the program is intended to serve?
Staff Training & Development	• Does the program offer ongoing support and training for its staff?
Organizational Capacity	• Does the program/agency have established history of working in the community? • Is the program operated under an agency that has been consistently providing good and reliable services to the community?

Program Design

The first area to examine when determining whether a program or a strategy is culturally competent is the program or strategy itself. The API-SPW identified the following eleven areas to consider:

Goals/Objectives

In order to determine what a program is designed for and whether it is effective, the goals and objectives should be clearly stated. For example, what specific population is the program or strategy aiming to serve in terms of ethnicity, culture, age, and gender? What specific needs or problems does the program or strategy hope to address? What are the results the program or strategy hopes to achieve? In other words, what objectives are to be met for the program or strategy to measure its success by? Do the goals and objectives make sense given the target population and the problem?

PEI-Specific

While the membership recognizes the importance and the need for treatment programs, the focus of the project would be on Prevention and Early Intervention since the California Reducing Disparities Project was funded by this component of the Mental Health Services Act. Moreover, the focus on PEI was of particular importance for reaching historically un-served and under-served communities.

Focus on Addressing Community-Defined Needs

Given that the API-SPW was charged with the task of addressing community-defined needs and identifying community-driven solutions, the promising programs and strategies collected by the API-SPW would have to focus on AANHPI issues. Since the needs to be addressed were to be defined by the community, input from community leaders, stakeholders, and members were solicited and respected. Such efforts would also be extended to areas such as program design and evaluation. If existing programs and strategies had been used for other ethnic/cultural groups, they would have to have been successfully replicated in the AANHPI communities and had promising outcomes in order to be reviewed and listed. Lastly, a culturally competent program would have relevance in supporting the overall wellness in the community, since, according to the focus group findings, good mental health could ultimately be achieved through overall wellness in many interdependent areas in life.

Addressing Culture/Population-Specific Issues

The promising programs and strategies collected should address and incorporate culture-specific issues. For example, for programs aiming to serve Southeast Asian communities, sensitivity and understanding of the history and experience of war and the resulting trauma should be reflected in the program design. For the Hmong community, traditional healers and clan leaders have a significant role in their way of life. Therefore, efforts should be made to outreach to them and traditional practices should be integrated into program design. The Shamans program in Central Valley serves as a good example where shamans were incorporated as part of the treatment procedure for Hmong patients. For the immigrant population, the program or strategy should consider immigration and acculturation issues. Given that the AANHPI community is very family-oriented, it would be important to consider this factor and address how and when family should be part of the service plan. For certain cultures and for certain topics, cultural attitudes towards gender and gender roles may need to be taken into account when designing a culturally appropriate program or strategy. For example, for certain Southeast Asian communities, it may be appropriate to have separate groups for men and women on certain issues, as women may not feel completely free to speak their mind in the presence of men given the gender roles dictated by their culture.

> "We consult with our spiritual healer. We talk among our family to try to release our tension by sharing our problems with our spiritual counselor or try to go to community service agencies to get help."
>
> – Focus group participant

Community Outreach and Engagement

Effective outreach and engagement with the AANHPI community must be conducted with sensitivity to cultural considerations. For example, outreach materials should be provided

in the language preferred by the consumers. Literal translations from English may not be sufficient, as consideration needs to be given to the content, vocabulary, literacy level, and cultural attitudes toward subject matters. This also would apply to the staff's ability to not just speak the preferred language but also to appropriately address the consumers. Given that stigma towards mental health issues remains a challenge in the AANHPI community, a culturally competent program should include components providing education, consultation, and training to the consumers and/or the community to reduce barriers resulting from stigma. Another strategy to minimize stigma may be to utilize venues such as cultural events and community centers. Lastly, given that the AANHPI cultures are family and community-oriented, outreach through family and community members would be essential.

> "I went to a Korean festival and took a survey there that told me I had depression. When I heard that, so many things now made sense. I was spending all my time taking care of my child and not myself. I didn't even realize I needed help until I took the survey and they explained what it meant."
>
> – Korean "sandwiched generation" focus group participant

Model

A culturally competent program or strategy should include components that were based on a reasonable logic model that could articulate the problem it aimed to address, the goals it aimed to achieve, the protective factors it aimed to reinforce, the risk factors it aimed to decrease, and the components it intended to utilize to reach the stated goals. Moreover, cultural considerations should be embedded in the design of the program or strategy to maximize its effectiveness. **There may be many viable programs or strategies to address a problem. However, an effective program or strategy should ultimately strengthen and empower the consumers and the community.**

Replicability

The AANHPI community is very diverse, as reflected in the API-SPW membership. While every culture is unique in its own way, there are also many commonalities. To develop and test an effective program would often require significant resources and time, both of which have been very limited in the AANHPI community. Therefore, it would make sense to replicate effective programs and strategies to increase community capacity to address the existing disparities. Thus, the replicability of a program was considered essential by the API-SPW members. However, the API-SPW recognized that modifications may be needed based on cultural, ethnicity, and geographical factors. Based on existing models, the program, with proper resources to support the efforts, should also have the capacity to assist interested organizations with the training and development of a similar program to suit a specific community. Lastly, since the focus of CRDP was on prevention and early intervention, it would be important for the program to be able to offer culturally and linguistically appropriate PEI strategies.

Advocacy

The design of the API-SPW reflected its belief that the community must be an integral part of the efforts to address disparity issues. Thus, an

effective program or strategy should be able to empower the community to advocate for their needs and to help generate action within the community to achieve wellness. In addition, as community-based organizations often are the links between the community and the systems, they possess the knowledge and expertise to help the community promote necessary systems change in response to the needs of the community. Such capacity and commitment should be reflected in an effective program or strategy.

Capacity-Building

Community capacity-building is critical in addressing disparities, since the needs are too many and the available resources are too few. This is particularly true of the emerging AANHPI communities. The wellness of the AANHPI community is to be achieved through wellness in many areas of life, as good mental health comes from an overall sense of wellness in one's life. Since mental health cannot be isolated from other aspects of life, it then becomes crucial for an effective program to develop and form community-wide collaborations with other community members and organizations, such as healthcare providers, social services, schools, spiritual leaders, traditional healers, faith-based organizations, and law enforcement. Such collaborations can help build capacity through supporting strong community leadership and ownership, which activates native capacity to participate in their own health and wellness. Community capacity-building can be seen as creating the scaffolding needed to help put healthy communications in place so that communities can move forward in a manner that supports wellness efforts, using tools such as Community-Based Participatory Research to engage community members and leadership in ways that reveal their expertise and to partner with them in identifying root causes and potential, doable actions.

Sustainability

> "Staff turnover is a problem for continuity. It's harder for us as AANHPIs to trust other people enough to share our feelings because that goes against our culture, so it's hard when someone we do finally trust leaves [the agency]."

One of the major challenges a community-defined program often faces is the lack of consistent and sufficient resources to sustain the program despite its effectiveness in meeting certain needs in the community. Often times funding is made available on a short-term basis or is subject to renewal every year, and yet a program needs to have financial stability to operate and to retain staff, especially when the community has grown to depend on its services. Since it is unrealistic to expect any type of funding to continue on a long-term basis, it becomes vital for a program to be able to leverage existing resources available in the community. Thus, one of the criteria of an effective program would be how well the program can demonstrate its ability to sustain itself beyond its initial or existing funding.

Accessibility

As voiced by an API-SPW member, "We do not work from nine to five because the community needs us 24/7." Access to care has been named over and over again as one of the major barriers to receiving proper care in the AANHPI community. CBOs are often one of the few places community members can turn to for help.

Therefore, accessibility is a key component in identifying an effective program. After all, a program is only as good as the services consumers can receive from it.

Accessibility may be assessed in areas such as hours of operation, location, linguistic capacity, transportation, and ancillary services. For example, are the hours of operation convenient for the community members? Many consumers may need evening or weekend hours. Given that many community members may not have means of transportation, transportation assistance may be important, which can be provided either by offering to transport the consumers to the location of service or by teaching monolingual consumers how to use the public transit system. By the same token, location of service is also another consideration. Is it located at or near a place near where the community usually gathers? Is it on or near a bus route? Are field-based services more feasible? If so, does the program have the capacity to offer field-based services? In terms of language, does the program have the sufficient number of bilingual and bicultural support and professional staff?

> "There is no translated health service information. We can't get the services due to transportation, work schedule, no health coverage, and language problem."
>
> – Focus group participant

Program Evaluation/Outcome

Although there may be different perspectives on how to adequately measure outcomes of a culturally competent program, it is agreed that a program should be expected to demonstrate whether and how it has effectively met its stated goals and objectives. Moreover, since the evidence of culturally competent programs is to be community-defined in the spirit of CRDP, the degree of community stakeholder involvement in the evaluation design and process, such as input from consumers, providers, and cultural experts should be considered.

Agency Capacity

While there may be many factors contributing to the effectiveness of a promising program or strategy, the agency carrying it out plays a critical role in ensuring its success. The API-SPW has identified the following three areas to consider when assessing an agency's capacity to operate a culturally competent program or strategy:

Staffing

Even with the best program design, the effectiveness of a culturally competent program must rely on the staff who carries out the program as it is intended. Therefore, the agency's capacity to maintain a sufficient number of culturally competent staff becomes one of the keys to ensure the success of the program. As previously stated in the report, creating a culturally competent workforce involves more than just employing bilingual staff. Staff members also need to be bicultural and possess the relevant and necessary skills to perform their jobs. Lastly, the board and the management of the agency offering the program should reflect the community they serve.

Staff Training and Development

On any job, it is important for staff to have ongoing training to sharpen their skills, so it is no surprise that the API-SPW also deems this important in considering the cultural competency of a program. Examples of trainings

may include: training for interpreters, training for staff on how to work with interpreters, and also ethical and professional boundaries in working with community members and clients. Staff training should include both professional training and cultural competency training, and it should not be limited to just staff who serve the AANHPI populations if the agency also serves other populations. Furthermore, it is also essential for an agency to provide and maintain a support system for its staff, as many of those who serve the AANHPI community often feel overwhelmed by the needs of the community, given the ongoing workforce shortage. The support system can even utilize external sources, such as linking the AANHPI-serving staff with their counterparts in other organizations.

Organizational Capacity

> The board and the management of the agency offering the program should reflect the community they serve.

The AANHPI cultures place great emphasis on relationship building. Therefore, whether an agency has established trust and credibility with the community can impact the effectiveness of the program. The ability of the organization to establish trust and credibility also serves the organization well as it helps increase its capacity through collaborative relationships formed with peer organizations and community networks. Collaborative relationships allow organizations to leverage resources and expertise so that the needs can be addressed accordingly.

Nomination, Submission, & Review of Community-Defined Strategies

With the selection criteria firmly established, the API-SPW started the process of nominating, submitting, and reviewing community-defined, culturally appropriate strategies to reduce disparities in the AANHPI community. Since the needs and history of each AANHPI community vary, it is recognized that the programs and strategies in response may also vary in the stages of development as well. For instance, many promising programs in the API community lacked the resources for evaluation. Therefore, four categories of submissions were devised to include strategies at various stages of program development. It is important to note that programs and strategies in a certain category were not necessarily better or worse than others in different categories. It was due to variations in program resources and differences in program development that they were grouped in different categories. The following outlines a summary of the categories:

1) **General submission of existing programs**
   This category is for programs that:
   - have met some of the criteria of core competencies as defined by the API-SPW
   - have met some of the promising program selection criteria as defined by the API-SPW
   - may not have been developed based on the Logic Model
   - have not been formally evaluated or do not have a program evaluation component

2) **Submission of existing programs that have been evaluated**
   This category is for programs that:
   - have met most of the criteria of core competencies as defined by the API-SPW
   - have met most of the promising program selection criteria as defined by the API-SPW

- can be articulated based on the Logic Model
- have been formally evaluated and can articulate its evaluation component/process

3) **Innovations/suggested strategies**
   This category is for innovations and/or strategies that:
   - have not been fully developed or formally implemented as a program (but have the potential to address certain needs in the AANHPI community)
   - have included most of the criteria of core competencies as defined by the API-SPW
   - have included most of the promising program selection criteria as defined by the API-SPW

4) **Already recognized programs**
   This category is for programs that:
   - have been formally evaluated and deemed effective by credible entities such as SAMHSA, local counties, research groups, or professional associations.
   - have met most of the criteria of core competencies as defined by the API-SPW
   - have met most of the promising program selection criteria as defined by the API-SPW

A template for submissions under each category was also devised to ensure consistency in submissions and to capture the selection criteria established by the API-SPW. All together, four templates were utilized. The Regional SPWs, as experts on the AANHPI communities, were called upon to nominate culturally appropriate promising programs and innovations to address regional AANHPI community needs.

Nominated programs and innovations were asked to submit a description of the program or innovation by using the required templates. Members were also enlisted to be peer reviewers to lend more credibility to the process. A total of twenty-three members agreed to be peer reviewers, in addition to the 3 administrative team reviewers. After all submissions were collected, the administrative team conducted initial reviews, and then carefully assigned each submission to one to three peer reviewers based on the following considerations:

- Type of program or innovation: For example, parenting programs were reviewed by those who have run parenting programs. Community gardening programs were reviewed by those who are familiar with similar programs.
- The target population in terms of ethnicity, culture, age, and gender: For example, programs serving older adults were reviewed by those who have expertise working with the population. Programs serving the Southeast Asians were reviewed by those who also serve the population.
- The reviewer's expertise: Some members have expertise in program evaluation and therefore were assigned submissions that have been evaluated.
- The reviewer's interests: Some members have indicated interests in developing programs serving a specific population or based on a certain model. Whenever possible, review assignments were matched with known interests.

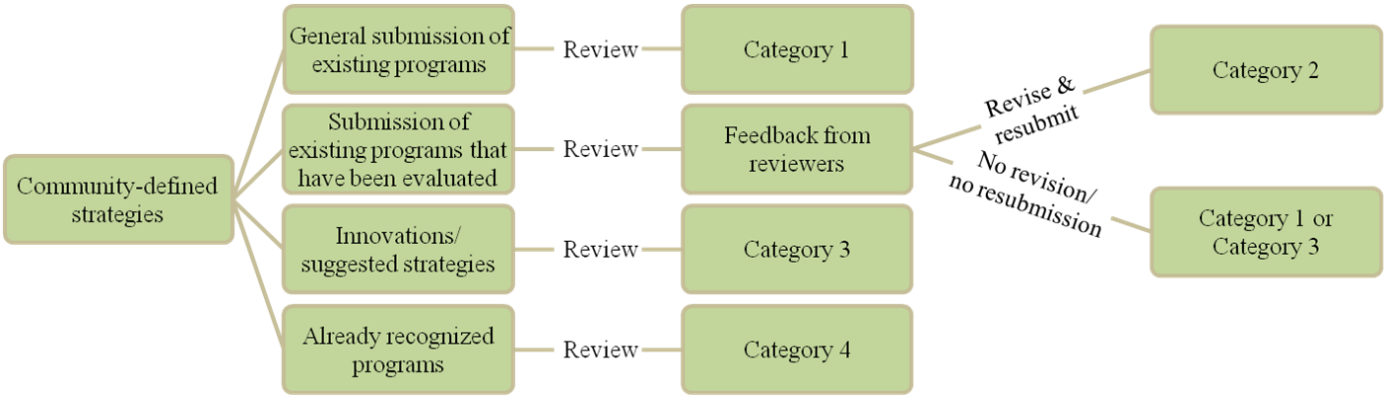
Moreover, geographic factors were also taken into account in reviewer's assignments. Each submission was reviewed by peers within the same region and outside the region. This was done with the hope that more diverse

perspectives could be provided in the feedback from those who are knowledgeable about the region and those who may have similar or different experiences. Whenever possible, the administrative team also made the effort to match the region the peer reviewers represent and the location of the program. For example, for small regions such as Sacramento, Central Valley, and San Diego/Orange County, priorities were given to reviewers from regions of similar size, as regional issues in these regions may be more similar. Overall, each submission was reviewed by three to six reviewers. The majority of submissions were reviewed by at least five reviewers.

Each reviewer was provided with a template for review (please see Appendix B). Reviewer feedback was forwarded to the agency that submitted the program or innovation for revision. The purpose of the reviewer feedback was to offer constructive feedback on how the agency could better articulate its program or innovation for others to learn from. The design of the submission and review process was meant to create a mutually meaningful learning experience for all involved, in addition to the project's goal of collecting community-defined strategies. Many API-SPW members reflected upon the process and shared that they have benefited from the experience as reviewers or as those who completed the submissions. The review process was also very challenging given the constraints of time and resources. Some members had to decrease productivity time so their staff could work on the submissions while other members reported that their staff volunteered their own time to do so. While many of these programs submitted for review have been in existence for years, some reported that this was a useful experience for them to articulate their programs in such a specific format. Some also expressed their regrets that they could not complete the submissions due to limited resources. Therefore, what is presented is not an exhaustive list, rather an initial sampling.

The API-SPW certainly recognizes that this process of identifying community-defined promising programs and innovative strategies is only the beginning of such an effort, and hopes there will be additional resources in the future to continue this process. A quick summary of the process of nomination, submission, and review of community-defined promising programs and innovative strategies is provided as follows:

Diagram 1: ***Process of Nomination, Submission, and Review of Community-Defined Promising Programs and Strategies***



The preliminary list of 56 submissions included seven submissions from the Sacramento region, 18 submissions from the Bay Area region, eight submissions from the Central Valley region, 14 submissions from the Los Angeles region, and nine submissions from the San Diego/Orange County region. The larger regions such as Los Angeles and the Bay Area have more members, more established AANHPI communities, more resources, more existing programs, and more programs that have reached the evaluation stage.

In terms of categories, there were 27 submissions under Category 1, five submissions under Category 2, 19 submissions under Category 3, and five submissions under Category 4. The fact that almost half of the submissions were in Category 1 indicates that while programs have been developed and implemented in response to community needs, many simply lacked the resources for evaluation, as demonstrated in the number of programs submitted under Category 2 and Category 4. There are also many innovative strategies worth noting. This strongly speaks to the need to have more resources allocated to support evaluation of these existing programs and to help expand innovative strategies to become comprehensive programs. Table 3 is a summary of the submissions based on region and category:

Table 3: *Total Submissions per Region and Category*

REGION	CATEGORY 1 General submission of existing programs	CATEGORY 2 Submission of existing programs that have been evaluated	CATEGORY 3 Innovations/ suggested strategies	CATEGORY 4 Already recognized programs	TOTAL
Sacramento	4	0	3	0	**7**
Bay Area	13	2	3	0	**18**
Central Valley	3	1	4	0	**8**
Los Angeles	5	1	3	5	**14**
San Diego/ Orange County	2	1	6	0	**9**
TOTAL	**27**	**5**	**19**	**5**	**56**

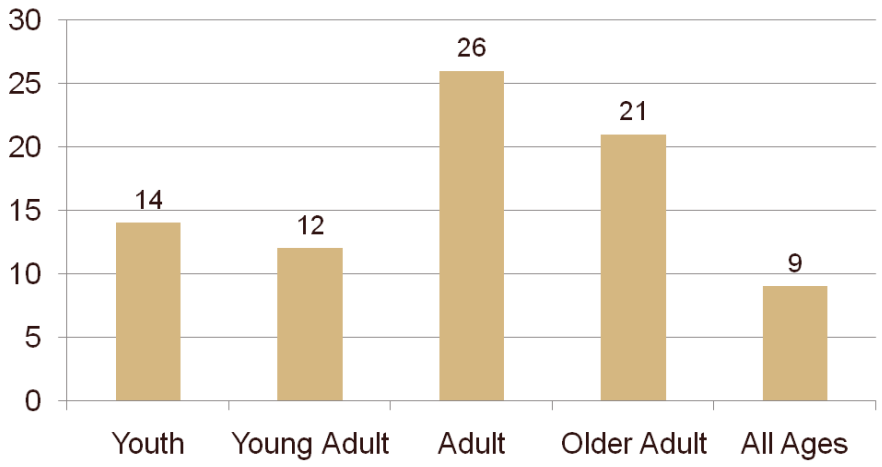
Given the diversity in the AANHPI community, it was not logistically possible to collect programs serving all AANHPI populations given the resources of this project. However, the 56 submissions collected not only covered the Asian American, Pacific Islander, South Asian, and Southeast Asian populations, but also 24 distinctive ethnic groups, which include Afghani, Bhutanese, Burmese, Cambodian, Chamorro, Chinese, Filipino, Hmong, Indian, Iranian, Iraqi, Iu-Mien, Japanese, Korean, Lao, Mongolian, Native Hawaiian, Nepali, Punjabi, Samoan, Thai, Tibetan, Tongan, and Vietnamese. Table 4 shows the number of submissions serving the ethnicities covered.

Table 4: *Number of Submissions per Ethnicities Served*

Ethnicities	Number of Programs/ Innovative Strategies	Ethnicities	Number of Programs/ Innovative Strategies
Asian American	**13**	Iraqi	1
Pacific Islander	**9**	Iu-Mien	5
South Asian	**4**	Japanese	2
Southeast Asian	**3**	Korean	12
Afghani	2	Lao	5
Bhutanese	1	Mongolian	1
Burmese	2	Native Hawaiian	1
Cambodian	7	Nepali	2
Chamorro	1	Punjabi	3
Chinese	24	Samoan	3
Filipino	6	Thai	3
Hmong	12	Tibetan	1
Indian	2	Tongan	2
Iranian	2	Vietnamese	14

The target populations in the submissions included all age groups from infants to older adults. Given that many older adults are monolingual or with limited English proficiency, it makes sense that there are more older adult programs available in the AANHPI community. Graph 1 shows the number of programs that serve a particular age group:

Graph 1: *Age Groups Served*



The types of promising programs and strategies collected were of a wide variety, including LGBTQ, suicide prevention, violence prevention, alcohol and other drugs (AOD) prevention, problem gambling, recreation, community gardening, gender-based, school-based, faith-based, parenting, integrated care, senior, youth, family, training, consultation, and support/social services. It is important to note that there were more consultation and support services in this collection. The higher number of consultation services may reflect workforce shortage issues and the need for collaboration. Even when community organizations, such as the school districts, recognize the need to engage the AANHPI community using culturally competent staff, there may not be a sufficient number of these staff in the workforce. Thus, consultation services allow the opportunity to leverage existing resources and extend knowledge and expertise of API providers through training and collaboration with community organizations. It is important to recognize that the point of entry to mental health may include other programs and strategies that provide basic social services. As the community is struggling with meeting basic needs, these types of services often provide a viable door of entry to the mental health system, making support services critical in outreach to AANHPIs. Summaries of these submissions can be found in Table 5.

Details of these programs can be found in Appendix D through Appendix G in a separate publication (Appendices: Community-Defined Promising Practices).

Graph 2: ***Types of Programs and Innovative Strategies***

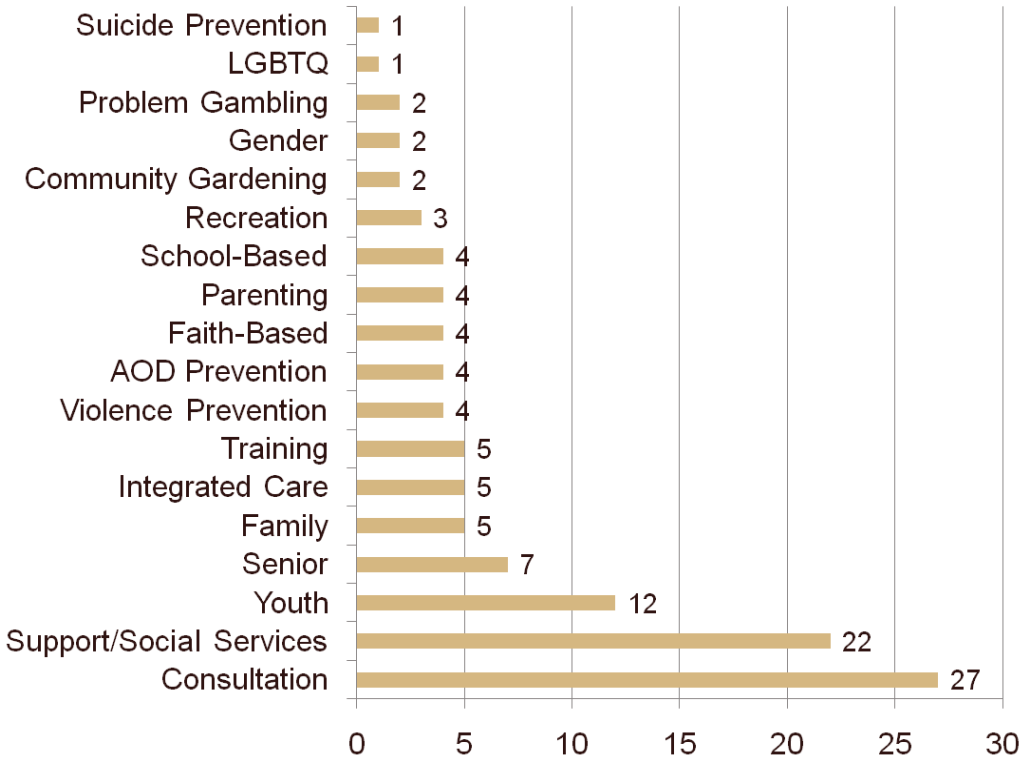


Table 5: *Summary of Promising Program and Strategy Submissions*

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
Sacramento	Parenting Education	Asian Pacific Community Counseling	API and all other cultural groups	Cantonese, English, Hmong, Japanese, Mien, Tongan, Vietnamese	All	Parents of children 0-teenager	Parenting	Focuses on reducing and coping with stress in parents due to parent-child conflicts and reinforce alternative ways to discipline children by strengthening existing positive parenting skills. Promotes understanding the child's perspective and taking control of one's emotions and stress that is caused by parenting.	D-62
Sacramento	Youth AOD Prevention	Asian Pacific Community Counseling	API	English	All	Youth (K-12)	AOD Prevention, Youth	Aims to help low-income, urban youth, who are at risk, make positive and healthy decisions when alcohol and other drugs are introduced. The Second Step (EBP) curriculum is used in classrooms with elementary to middle school youth and the Life Skills curriculum (EBP) is used at school or agency with middle to high school youth.	D-69
Sacra-mento	Hmong Talk-Line	Hmong Cultural Center of Butte County	Hmong	Hmong, Spanish	All	All	Consultation	Confidential, over-the-phone support system, aiming to provide support for individuals going through the process of recovery from mental illness.	F-12
Sacra-mento	Promotores	Hmong Cultural Center of Butte County	Hmong, Latino	English, Hmong, Spanish	All	All	Support Services	Provides support for individuals and family in linkage to community resources on mental health illness and isolation.	F-28
Sacra-mento	Zoosiab	Hmong Cultural Center of Butte County	Hmong	Hmong	All	Older Adult (50+)	Consultation, Recreation	Focuses on Hmong survivors of trauma living in Butte County, offering consultation services and recreational activities.	F-35
Sacramento	Family Development Project	Muslim American Society – Social Services Foundation	API and all other cultural groups	English (Arabic, Dari, Farsi, Hindi-Urdu, Pasho, and/or Punjabi may be added in the future)	All	All	Faith-Based, Information and Referral, Family, Peer Counseling, Social Services	With the intention of increasing the number of emotionally and spiritually healthy Muslim families and individuals, this program helps prevent domestic violence, divorce, alienation of youth from family and faith community, developmental trauma, abuse of and addiction to alcohol, illegal and prescription drugs, and addiction to gambling.	D-36

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
Sacra-mento	Iu-Mien Senior Social Group	United Iu-Mien Community	Iu-Mien	Mien	All	Older Adult (60+)	Senior, Support Services	Aims to support the physical and mental well-being through activities and provision of information and resources.	D-51
Bay Area	Center for Addiction Recovery and Empowerment (CARE)	Asian Americans for Community Involvement (AACI)	API and all other cultural groups	Cantonese, English, Hindi, Mandarin, Punjabi, Spanish, Tagalog, Taiwanese, Toishanese, Vietnamese	All	All	Problem Gambling	Aims to outreach and educate the community at large about the signs and symptoms of problem gambling (PG) and the available treatments, while also providing support services available for individuals and significant others affected by PG. Program will also educate and train gaming establishment workers, law enforcement and behavioral health clinicians and/or clinicians in training about PG.	D-9
Bay Area	Center for Healthy Independence (CHI)	Asian Americans for Community Involvement (AACI)	AAPI	Cambodian, Cantonese, English, Mandarin, Tagalog, Vietnamese	All	Adult, Older Adult	Support Services	Focuses on populations who are Severely Mentally Ill (SMI) and presently receiving Specialty Mental Health Services from Santa Clara County Mental Health Department.	D-15
Bay Area	Center for Survivors of Torture - New Refugee Services	Asian Americans for Community Involvement (AACI)	Afghani, Bosnian, Burmese, Cambodian, Eritrean, Ethiopian, Iranian, Iraqi, Vietnamese	Afghani, Bosnian, Cambodian, Eritrean, Ethiopian, Iranian, Iraqi, Vietnamese	All	Adult, Older Adult	Consultation, Social Services	Aims to reduce the cultural stigma accompanying mental illness in recently arrived ethnic refugee groups and address the range of physical and mental health problems often exacerbated by legal, economic, and acculturation challenges.	D-20
Bay Area	Club IMPACT	Steve and Sela Teu (Submitted by AARS)	Pacific Islander	Chamorro, English, Fijian, Guamanian, Native Hawaiian, Samoan, Tongan	All	Youth, Young Adult (9-24)	AOD Prevention, Consultation, Youth	Serves PI youth and young adults in the San Mateo County and aims to prevent and reduce the high school dropout rates and substance use/abuse.	D-28
Bay Area	Em-Power	Asian American Recovery Services (AARS)	AAPI	English	F	Youth (11-13)	School-Based, Youth	Designed to serve girls ages 11-13, who are attending Morrill Middle School in Santa Clara County. Program addresses the specific needs of AAPI girls who experience acute intergenerational conflict due to differential acculturation between their parents and themselves.	E-2

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
Bay Area	Filipino Mental Health Initiative	San Mateo County Health System (Submitted by AARS)	Filipino	English, Tagalog	All	All	Training	Targets behavioral health clinicians who work with Filipino clients, parents of middle school students who attend a high Filipino-populated school, and attendees at a widely attended annual Filipino festival. Activities include provider trainings, family nights, and community outreach.	D-37
Bay Area	Asian Primary Care Integration	Asian Community Mental Health Services	API and all other cultural groups	Chinese, Korean	All	Adults, Older Adults	Integrated Care	Aims to improve the overall wellness and physical health status of the SMI Asian and Pacific Islander population in Alameda County by making available coordinated primary care services.	F-2
Bay Area	Lotus Bloom	Asian Community Mental Health Services	Asian, Latino/ Hispanic, White, African American	Cambodian, Chinese, English, Spanish	All	Youth	Family, Support Services	Provides parent-child playgroup programs six days per week, Monday through Saturday, for low-income and immigrant families at four locations: two in San Antonio neighborhoods and two in East Oakland neighborhoods.	D-55
Bay Area	Qi-Gong	Asian Community Mental Health Services	Asian	Cantonese, Mandarin	All	Older Adult (65+)	Senior	The activities for this project include holding three series of eight two-hour workshops, co-led by Qi-Gong monks and the ACMHS' mental health consultants. Each workshop concentrates on Qi-Gong practice integrated with psycho-education on mental health symptoms and issues, followed by a group support and discussion.	F-33
Bay Area	Incredible Years - BASIC Preschool Program	Chinatown Child Development Center	Chinese	Cantonese	All	Adult	Parenting	Focuses on helping parents attain skills known to promote children's social competence and reduce behavioral problems, as well as teaches parenting strategies for managing problem behaviors. Cultural and linguistic adaptations of Incredible Years have been made to serve the specific target population.	D-47
Bay Area	API Connections	Community Health for Asian Americans (CHAA)	Bhutanese, Burmese, Chin, Kachin, Karen, Karenni, Mon, Mongolian, Nepali, Shan, PI, Rakhaing, Thai, Tibetan	Burmese, English, Mongolian, Nepali, Rakhaing, Thai, Tibetan, Tongan	All	All	Consultation	Aims to promote wellness in API communities living in Alameda County and help overcome stigma through culture-based outreach and consultation.	D-2

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
Bay Area	Mental Health Consultation School Based Program	Hume Center	API and all other cultural groups	Bengali, English, Cantonese, Farsi, Hindi, Spanish, Vietnamese, Dari, Urdu, Mandarin, Tamil, Punjabi, Singhalese	All	Adult	Consultation, School-Based	Intended to serve first responders to mental health related challenges of the youth/student, which promotes psychological understand of common student difficulties.	F-19
Bay Area	PEI for the South Asian Community	Hume Center	South Asian	Bengali, English, Cantonese, Farsi, Hindi, Spanish, Vietnamese, Dari, Urdu, Mandarin, Tamil, Punjabi, Singhalese	All	All	Consultation, Social Services	Aims to increase access to services by decreasing stigmatization of mental health through addressing individual issues and needs.	D-63
Bay Area	Asian Youth Prevention Services	Japanese Community Youth Council (JCYC)	API and all other cultural groups	Cantonese, English, Mandarin, Samoan, Tagalog, Vietnamese	All	Youth (12-16)	AOD Prevention, Support Services, Youth	Aims to prevent, delay, and reduce the use and abuse of alcohol, tobacco and other drugs among Asian youth in San Francisco.	D-7
Bay Area	Asian Youth Prevention Services - Strengthening Chinese Families Program	Community Youth Center (Submitted by JCYC)	Chinese	Cantonese	All	Youth, Young Adult	AOD Prevention, Consultation, Violence Prevention, Youth	Provides school-based support groups for at-risk youth in middle and high schools to prevent, delay, and reduce the use and abuse of alcohol, tobacco and other drugs (ATOD) among Asian youth in San Francisco.	D-30
Bay Area	Asian Youth Prevention Services - Strengthening Families Program	Samoan Community Development Center (Submitted by JCYC)	Samoan	English, Samoan	All	Youth, Adult	Youth, Family, Consultation	Targets youth who are identified as being more at risk of being involved or are involved with the juvenile justice system, on the verge of dropping out of school, involved in unlawful activities, and have family issues. Facilitates group meetings with parents, youth, and a convening with both youth and their parents.	D-65
Bay Area	Fu Yau Project	Richmond Area Multi-Services (RAMS)	API and other cultural groups (African American, Latino)	Chinese, Spanish	All	Youth, Adult	Consultation, Family, Support Services, Youth	Provides mental health services and consultation to the childcare community for children ages 0-5, targeting child care centers and family resource centers that serve children and families of color or otherwise marginalized communities.	D-41

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
Bay Area	Wellness Centers	Richmond Area Multi-Services (RAMS)	API and all other cultural groups	Cantonese, English, Gujerti, Hakka, Hindi, Mandarin, Spanish, Taiwanese	All	Youth	Consultation, Family, School-Based, Youth	Focuses on students with behavioral health concerns who may benefit from intensive case management and behavioral health services, who may be dealing with trauma/grief & loss, or families with limited resources.	E-21
Central Valley	Living Well	Fresno Center for New Americans	Southeast Asian	Cambodian, English, Hmong, Lao	All	All Adults (18+)	Consultation, Support Services, Training	Provides workforce development for mental health clinicians, cross-cultural training workshops for health providers, increase accessibility to mental health services for the Southeast Asian population, and help decrease stigma on mental health.	E-6
Central Valley	Horticultural Therapeutic Community Centers	Fresno Inter-denominational Refugee Ministries (FIRM)	Hmong, Lao, Southeast Asian	Hmong, Lao	All	Older Adult	Community Gardening	Aims to enhance existing community gardens as a platform for peer support, mental health delivery and engagement on matters that relate to mental well being and mental health services.	F-13
Central Valley	Elders Health Project	Healthy House within a MATCH Coalition	Hmong, Punjabi	Hmong, Punjabi	All	Older Adult (55+)	Faith-Based, Integrated Care, Senior, Support Services	Assists Hmong and Punjabi elders identify, understand, and seek resources for mental health issues, including access to shamans/priests, but also educating on physical basis for conditions, medications, etc. Home visits are provided.	F-9
Central Valley	In-Home Mental Health Support Training	Healthy House within a MATCH Coalition	Latino, South Asian, Southeast Asian	Hmong, Punjabi, Spanish	All	All	Support Services, Training	In-home training providing information regarding the physical basis of mental illness, in essence, redefining it as an illness rather than just a condition indicating spiritual discord.	F-15
Central Valley	Partners In Healing	Healthy House within a MATCH Coalition	Hmong	English, Hmong	All	All	Faith-Based, Integrated Care, Training	An orientation class for Hmong shaman to integrate them into the Western medicine system. It is also intended to give Western providers some cultural competency regarding Hmong spiritual and physical healing processes.	F-26
Central Valley	Southeast Asian Support Group	Healthy House within a MATCH Coalition	Hmong, Lao, Mien	Hmong, Lao, Mien	All	All Adults (18-65)	Recreation, Support Services	Provides an opportunity for participants to learn about mental wellbeing, serves as a place to let go of depression and ease stress, and offers recreational activities.	D-67

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
Central Valley	Integrated Primary Care & Mental Health Services	Merced Lao Family Community	Hmong, Lao, Mien	Hmong, Lao, Mien, Thai	All	Adult (18+), Older Adult	Consultation, Integrated Care, Support Services	Augment services available at existing primary care centers to help ensure that they are more able to provide early intervention for mental health issues, such as depression, anxiety, and suicide ideation in older adults.	D-49
Central Valley	Southeast Asian Consumer Advocacy Program (SEACAP)	Merced Lao Family Community	Hmong, Lao, Mien	Hmong, Lao, Mien	All	TAY, Adult, Older Adult	Consultation, Support Services	Incorporates cultural understanding and individualization to ensure the effective treatment of the unique mental health issues of the SEA community. Consumer issues include PTSD due to their war and refugee experience, and stress and depression from poor adjustment and coping skills.	D-66
Los Angeles	Chieh Mei Ching Yi (Sisterhood)	APAIT Health Center	Chinese	Cantonese, Mandarin	F	Adult	Consultation, Gender-Based	Intended for women working in settings where they are at risk of HIV exposure, wage theft, and violence through sex work, namely massage parlors, acupuncture and aromatherapy businesses, and chiropractic clinics.	F-6
Los Angeles	Mind, Body, Spirit, Wellness	APAIT Health Center	API	English, but can be made available in other languages (e.g. Cambodian, Chinese, Filipino, Thai, Vietnamese)	M	Adult	Consultation, Gender-Based, LGBTQ	Designed to provide a sense of emotional well-being to HIV positive individuals with the knowledge that the mind, body, and spirit are all connected in each person. The program deals with issues such as sexual identity, teach them skills to disclose HIV status to loved ones, increase support system, and help them adhere to medications.	D-58
Los Angeles	Asian American Family Enrichment Network (AAFEN)	Asian Pacific Family Center (APFC)	Asian	Korean, Mandarin, Vietnamese	All	Adult	Parenting	Achievements made through participation in this program include increasing the emotional and behavioral self-efficacy of the Asian immigrant parents and/or primary caregivers as well as enhancing the safety and healthy development of Asian immigrant youths.	G-2
Los Angeles	Asian Mentoring and Advocacy Support to Enhance Resiliency in Youth (MASTERY)	Asian Pacific Family Center (APFC)	Asian	Chinese, Vietnamese	All	Youth	Consultation, Youth	Targets youth who have engaged in some violent or delinquent act, experienced truancy and failure at school, and/or been living by themselves in this country with very little or no adult supervision after school.	G-5

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
Los Angeles	Inspire and Mobilize People to Achieve Change Together (IMPACT!)	Asian Pacific Family Center (APFC)	Asian	Chinese, Korean	All	Youth	School-Based, Youth	Assists youths in their development of such functional skills such as goal setting, effective communication and problem solving. Also addresses such issues as substance use and HIV to facilitate peer refusal skills development, and explores such topics as peers, family, and culture to enhance pro-social life choices.	G-8
Los Angeles	Resilience and Effectiveness of Asian Adolescents in Countering Hostility (REAACH)	Asian Pacific Family Center (APFC)	Asian	Chinese, Korean	All	Youth	Consultation, Violence Prevention, Youth	Targets youth who are often themselves the victims of peer violence (such as bullying) and hostility because of their racial/ethnic background, inadequate English-speaking capability, and limited access to responsive and supportive services at home, at school, and in the community.	G-10
Los Angeles	School, Community, and Law Enforcement (SCALE)	Asian Pacific Family Center (APFC)	Asian	Chinese, English, Korean,	All	Youth	Consultation, Youth	Addresses behavioral problems including, but are not limited to, school truancy, academic failure, association with gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers).	G-12
Los Angeles	Strengthening Intergenerational / Inter-cultural Ties in Immigrant Families (SITIF)	Yu-Wen Ying (Submitted by APFC)	Chinese, Korean, Spanish, Vietnamese	Chinese, English, Korean, Spanish, Vietnamese	All	Adult	Parenting	Aims to improve the intergenerational relationship of the target families by increasing the target parents' sense of self-efficacy and effective parenting of their children.	E-18
Los Angeles	Keeping Cool	Korean American Family Service Center	Korean	Korean	All	Adult (30-55)	Consultation, Violence Prevention	Increases ability of Korean immigrant adults to manage stress and anger, and communicate more positively, thereby reducing incidents of household violence, depression/suicide, and increasing daily functioning.	D-52
Los Angeles	From Killing Fields to Growing Gardens	Little Tokyo Service Center	Cambodian	Cambodian	All	Older Adult (55+)	Community Gardening, Senior	Aims to improve the mental and physical health of Cambodian seniors through an integrated approach that taps into their existing skills (an improved sense of well-being as they feel productive and useful) and encourages them to talk about their experiences.	D-39

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
Los Angeles	Nikkei Tomodachi (Friendly Visitors)	Little Tokyo Service Center	Japanese	Japanese	All	Older Adult (60+)	Senior, Support Services	Provides companionship to seniors at their home with goals of increasing socialization, supporting independent living and delaying nursing home care via weekly home-visit or telephone calls by trained Japanese speaking senior volunteers. In return, the volunteers gain enriched retired lives by providing needed services to peers.	D-60
Los Angeles	Chinese Community Problem Gambling Project (CCPGP)	NICOS Chinese Health Coalition (Submitted by NAPAFASA)	Chinese	Cantonese, English, Mandarin	All	Adult	Consultation, Problem Gambling	Seeks to address problem gambling in the Chinese community by building awareness of problem gambling and of resources available to address problem gambling and providing prevention education and intervention through individual, group and phone-based counseling.	D-26
Los Angeles	Saving Earth and Healing Hearts	Tzu Chi Foundation	API and all other cultural groups	Mandarin, Taiwanese	All	Adults (21-65)	Faith-Based, Support Services	This recycling project is a humanistic approach targeting those who have symptoms of social isolation or depressed mood. The strategies are to engage the targeted population to perform simple task activities to collect recyclable materials and sorting the recyclables in a protective, caring, welcoming and spiritual environment.	F-29
Los Angeles	Maeta (Mercy Health)	United Cambodian Community	Cambodian	Cambodian	All	Adults (40-75)	Consultation, Support Services	Focuses on survivors of the Killing Fields in Cambodia by helping to sustain emotional and mental wellness of the refugees.	F-18
San Diego	Health Navigation	Korean Community Services (KCS)	Korean	Korean	All	Adult	Consultation, Support Services	Aims to educate individuals about federal health assistance programs such as Medi-Cal, Medicaid, MSI and others, and provide assistance to those seeking to apply to such programs, serving those who have difficulty navigating through the federal health assistance programs due to language barriers.	F-11
San Diego	Integrated Care Center	Korean Community Services (KCS)	Korean	English, Korean	All	All Adults (18+)	Integrated Care	Consumers in this program will be able to receive a combination of medical care and mental health services. Mental health assessments will be made for those individuals at-risk of suffering from mental health issues, in order to identify potential diagnoses early on.	F-17

Region	Program Name	Agency	Ethnicity Served	Languages Available	Gender Served	Age Group Served	Program Type	Brief Description of Program	Page Listing in Appendix
San Diego	Mental Health Worker Training Program	Korean Community Services (KCS)	Korean	Korean	All	Adult	Training	Aims to educate the consumers and family members with information about mental health issues, as well as to empower those individuals to give back to the community once they are able to self-maintain.	F-22
San Diego	Suicide Prevention	Korean Community Services (KCS)	Korean	Korean	All	All	Consultation, Suicide Prevention	Intended for Koreans at risk of suicide and/or lost their family members to suicide, and includes support groups as well as individual counseling sessions.	F-31
San Diego	Outreach Groups	University of California, Irvine	API and all other cultural groups	English	All	Young Adult	Consultation, Support Services	Aims to reach vulnerable populations based on ethnicity, culture, gender, sexual orientation, and academic status by providing support, consultation, and helping the individual get a sense of their community. Groups may center on mentorship, skills, food, music, dance, art, and spoken word.	F-24
San Diego	Elder Multicultural Access and Support Services Program (EMASS)	Union of Pan Asian Communities (UPAC)	African American, Filipino, Latino, Somali	English, Tagalog, Somali, Spanish	All	Older Adult (60+)	Senior, Support Services	Utilizes a promotoras or "community health workers" as health care liaisons to assists seniors who have limited access to physical and mental health care due to cultural/linguistic barriers, financial and transportation barriers.	D-32
San Diego	Helping to Empower Authentic Relationship for Teens (HEART)	Union of Pan Asian Communities (UPAC)	API and all other cultural groups	English	All	Youth, Young Adult (13-24)	Consultation, Violence Prevention	Focuses and works with a multicultural population of youth who are exposed to dating violence, or are at risk of dating violence.	D-45
San Diego	Positive Solutions	Union of Pan Asian Communities (UPAC)	API and all other cultural groups	Chinese, English, Korean, Spanish, Vietnamese	All	Older Adult (60+)	Senior, Support Services	Created to prevent depression with older adults who are homebound due to illness and/or disability. These seniors are unable to leave their home for activities of daily living without assistance from another caregiver or professional.	E-12
San Diego	Bridge-Culture Generation	Vietnamese Federation of San Diego	Vietnamese	Vietnamese	All	Adult	Recreation	Strategy intended to target Vietnamese immigrants by providing programs and activities that cater to their specific needs and by promoting the concept of living independently in their own home for as long as they can, with the support of our programs to maintain a well balanced mental and physical wellness as an alternative to the typical retirement environment.	F-5

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Chapter V

Systems Issues and Implications on Public Policy

Kalusugan

Over the last two years, under the guidance of the Steering Committee, the API-SPW has actively listened to API community representatives, community members, and community experts regarding the current state of disparities in California. Therefore, the disparities in mental health services documented in this report are primarily based on personal experiences observed and shared by the AANHPI community. It is evident that there are many unmet needs resulting from these disparities, to which the AANHPI community has attempted to respond by leveraging its own resources, despite the limited resources available to address their needs. The 56 community-designed promising programs and strategies collected through this project are good examples of such efforts. However, to effectively reduce these disparities in a timely manner, support and leadership from policy makers at the local, county, and state level are essential. The following are recommendations for policy considerations on how to reduce existing mental health service disparities in the AANHPI community:

HOW TO REDUCE EXISTING DISPARITIES IN THE AANHPI COMMUNITY

Access, Affordability, Availability, and Quality of Services

Recommendation
Increase access by supporting culturally competent outreach, engagement, and education to reduce stigma against mental illness and to raise awareness of mental health issues.

Before any services can be provided, consumers will have to be engaged in order to become aware of mental health issues and resources available to them to deal with these issues.

However, many mental health concepts are based on Western cultures and thus are not necessarily common knowledge in many AANHPI cultures. Thus, efforts are needed for education on mental health issues. Furthermore, in many AANHPI languages, the literal translation of mental health is often associated with negative connotations such as "crazy," which results in stigma and discrimination. Therefore, for outreach and engagement to be effective, such cultural factors will need to be taken into consideration. While the lack of a culturally competent workforce remains an issue, one viable option is to take advantage of existing relationships community-based organizations have already established within the community. These CBOs can leverage existing relationships and resources to work with the community. Existing community programs can also be utilized as culturally appropriate venues for outreach given that AANHPIs may not readily acknowledge mental health issues. Whenever appropriate, input from the community should be solicited and encouraged in outreach efforts, such as through community-based participatory methods. It also important to integrate existing community resources into outreach and engagement efforts to maximize effectiveness and efficiency, including collaboration with community gatekeepers and organizations, such as: schools, healthcare providers, faith-based organizations, law enforcement, businesses, and ethnic media.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends:

- Provision of resources and system support for culturally competent education to reduce stigma against mental illness and to raise awareness of mental health issues in the AANHPI community through established community networks.

- Support for culturally competent outreach and engagement efforts to the AANHPI community through established networks.
- Support for culturally competent collaboration with other community stakeholders.

Recommendation
Increase access by modifying eligibility requirements, by including ancillary services supporting access, and by providing affordable options.

Due to cultural differences, the manifestation of symptoms for AANHPIs with mental health issues may differ from those commonly observed in Western culture. Therefore, the eligibility requirements under the current system such as meeting medical necessity as defined in the DSM may not be appropriate for the AANHPI community. While there is no funding in Medi-Cal for PEI-oriented services, there are possible resources through MHSA funding to support PEI efforts. This is important as many AANHPIs may not qualify for Medi-Cal or Medicare, and yet there may be no affordable options for them when help is needed. Lack of adequate insurance continues to be a barrier to care for many AANHPIs. It has been observed by many API-SPW members that consumers sometime receive their first intervention in the emergency rooms, which results in much higher personal and financial costs than necessary for the consumers, their family, and society.

As detailed in previous sections, besides the issue of affordability and eligibility, there are other barriers to access such as lack of transportation in rural counties and some urban areas. This makes it critical for providers and policy makers to include ancillary supportive services to make access possible. Language is also another major barrier. Resources must be made available to support such needs, not just in terms of compensation for interpretation services, but especially in terms of training and certification of interpreters and allowance for increased session duration so interpretation cannot occur at the expense of a reduction in quality of care.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …more flexibility in establishing eligibility for services, such as modifying the requirement to meet medical necessity.
- …inclusion of ancillary services as part of the service plan, such as interpretation and transportation.

Recommendation
Increase availability and quality of care by supporting the development and retention of a culturally competent workforce.

A culturally competent program can only be effective if those providing services are culturally competent. As described in previous sections, linguistic capacity is only one of the qualities required of a culturally competent workforce. The providers need to possess professional competency, have a keen understanding of the culture and history of the community, demonstrate the ability to leverage and collaborate with other community resources, and empower and advocate for the needs of the community.

It also requires support and commitment to developing and retaining a culturally competent workforce at the organizational level and the systems level, as careers in mental health services are not as well recognized or pursued in the AANHPI community. Moreover, the existing training model for future workforce

often does not require or even include training in cultural competency. While community helpers are often utilized as a resource to cover for workforce shortages, it is important to provide them with adequate support as they are often the first point of contact and have to deal with highly stressful situations. Ongoing training and peer support structure are two useful modalities of support. Lastly, cultural competence training should not be limited to mental health providers and should also include those who serve the AANHPI community, such as healthcare providers, school, and law enforcement.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …promotion of mental health careers through outreach to API youth and their parents.
- …mandating or at least including cultural competency as part of mental health career training at various academic levels from certification to advanced degrees.
- …creating mentorship for future workforce.
- …ongoing training and technical assistance for providers serving the AANHPI community, both in mental health and other fields.

Recommendation
Increase availability and quality of care by supporting services that meet the core competencies and program criteria as defined by the API-SPW.

Availability of culturally competent services remains a major barrier to quality care. In many areas, there are very few culturally appropriate services available despite the vast needs in the community. Even when these services are available, there tends to be a long waiting period, which could be discouraging or fatal to those in need. The current funding systems are mostly based on the conventional service model, which often do not meet the unique needs of the AANHPI community. While it may be up for debate as to what exactly constitutes "cultural competency," the API-SPW has developed a list of core competencies and a list of selection criteria for promising programs as a starting point. These lists were based on the focus group findings and the API-SPW members' decades of experience serving the community. One example of demonstrating cultural competence is to incorporate cultural values into service delivery. For AANHPIs, it will be important to work closely with family members as AANHPIs are very family-oriented. We hope that the list will serve as a resource for those who are interested in effectively serving the AANHPI community.

For some AANHPI communities with few resources, such as the more recent emerging communities, it may be much more challenging to develop community-defined responses to meet their needs. Thus, support for program development may be even more critical for these communities. Lastly, some promising programs may be replicated or modified for other similar AANHPI communities, so precious time and resources can be conserved to meet other needs in the community.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …existing culturally competent programs to continue serving the AANHPI community.
- …the development of new culturally competent programs to respond to unmet and emerging needs in the community.
- …replication of community-defined programs and strategies, including technical assistance and training.
- …a written review of evidence-based practices as it relates to AANHPIs by providing training and resources for agencies to do so.
- …culturally competent models that contribute to building the alternative to mainstream mental health models for the AANHPI community.
- …programs that complement County MHSA/PEI plans, preferably models that have significant community involvement, design, and implementation.

Outcome and Data Collection

Recommendation
Reduce disparities by collecting disaggregated data to accurately capture the needs of various AANHPI communities, by supporting culturally appropriate outcome measurements, and by providing continuous resources to validate culturally appropriate programs.

One of the greatest challenges the API community faces is the lack of disaggregated data. Even though there are many similarities among the various AANHPI communities in California, there are also many significant differences in terms of culture, language, religion, history, and available resources. Thus, treating all AANHPI communities as one is overlooking the unique and possibly drastically different needs of each community. Despite the fact that the communities have responded to their needs by developing successful promising programs, as collected in this report, very few of them have been evaluated at all, let alone been evaluated properly using culturally appropriate measures.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …mandating collection of disaggregated data to respect the diversity of AANHPI communities.
- …developing culturally appropriate outcome measurements to properly assess the effectiveness of programs aiming to serve the AANHPI community. Financial and technical resources are needed to develop ANHPI-relevant measures to ensure the efficacy of these measures.
- …validation of existing culturally competent programs, including technical support. The Phase II funding will be important in providing resources and opportunities for validation of community-defined programs.
- …culturally appropriate services in the AANHPI communities to become either promising or best-practice PEI programs.

Capacity-Building

Recommendation
Empower the community by supporting community capacity-building through efforts such as leadership development, technical assistance, inclusion of community participation in the decision-making process, and establishment of infrastructures that can maximize resource leveraging.

There are always more needs in the community than what available resources can possibly support. Thus, it makes sense for the systems and policies to help build community capacity to respond to community needs. Given limited resources, it is essential to leverage existing community resources for capacity-building, such as utilizing existing networks, leadership, and infrastructures. Moreover, the community probably is in the best position to know its own needs and how to respond to the needs appropriately, which makes community participation invaluable in the decision-making process.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends support for:

- …community capacity-building such as leadership development so the community can be empowered to respond to its needs.
- …community capacity-building such as technical assistance to develop, refine, and validate promising programs.
- …inclusion of community participation in the decision-making process as the community understands its own needs and such inclusion can also empower the community to find its own solutions.
- …establishing or maintaining community infrastructures so resources can be shared and leveraged.
- … and provision of resources for maintaining a statewide infrastructure where agencies can share resources and provide peer training.
- …computer technology, such as social networks, podcast, and web-based blogging, to be used for outreach to AANHPI youth.

Chapter VI

Limitations

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This report is meant to document the input collected from all those participated in the project based on very limited funding. It is by no means a comprehensive report of all the issues of disparity in the AANHPI community, given the limited time and resources available. If more resources are to be made available in the future, there are other areas that also deserve attention:

Determination of Threshold Languages
First-generation immigrants account for a significant proportion of the AANHPI population. Therefore, language barrier will continue to be a challenge in providing culturally competent services. The determination of threshold languages definitely has a significant impact on how resources will be made available, especially to the smaller and emerging communities that arguably would need even more support. Thus, it will be important to look into how the policy-making process on threshold language decisions could better meet the needs of the AANHPI community, as a lower threshold may be needed to provide adequate support for certain AANHPI communities.

Connection with the Affordable Care Act
Although information on the Healthcare Reform was presented at a statewide meeting, the API-SPW did not have enough opportunities to further discuss the impacts of ACA to the API community. Most AANHPI providers also have not had opportunities to contribute to the policy language due to difficulty in understanding public policy verbiage and the lack of resources to devote staff time to distill implications of such policy. It has been widely documented in this report that AANHPI CBOs do have access to the community, based on established relationships and trust. The effectiveness of their services can be observed in the promising programs and strategies in this report. However, due to lack of resources and expertise on program evaluation, most of these programs do not have "scientific" evidence that they are effective and they can help lower healthcare costs for the systems. Another important component under the ACA is integrated care, which was presented at the Project Conference, but unfortunately there was no opportunity for further discussions.

Unique Experiences and Special Needs for Ethnic/Population Groups
Given the diversity in the API community, it is difficult for this report to include all possible culture-specific factors that need to be considered. For example, when serving the Southeast Asian communities, war trauma and Post-Traumatic Stress Disorder (PTSD) must be taken into consideration. The same is true for the newest wave of Asian refugees from war-torn areas such as Iraq and Afghanistan, who also face the unique challenge of being Muslim. Other examples include unique needs of those who were born in America as well as multiracial AANHPIs and AANHPI LGBTQs who face additional challenges, potential stigma, and discrimination due to their ethnic identity, gender identity, and sexual orientation. Homeless AANHPIs are another population that deserves more attention.

Regional and Ethnic Differences
The project has started collecting some regional and ethnic differences. For example, more disparities and fewer resources were observed in rural communities. However, due to lack of resources, we were not able to complete such efforts. Therefore, this final report does not include the specific characteristics and unique challenges experienced by various ethnic and regional communities. It is our hope that the project will have access to additional funding in

the future to further report needs, barriers, and strategies in these areas.

Immigration Policy

Since this report focused on disparity issues in California, the discussions were more from the regional and statewide perspectives. However, federal policy issues such as immigration, though not much discussed, have significant impact on the wellness of the AANHPI community and therefore should be included in future conversations. For example, the 5-year waiting period restricting legal immigrants from accessing federal public benefits makes much-needed mental health care beyond reach for many AANHPIs and therefore is a barrier to care that this report did not have a chance to sufficiently cover.

Multiracial Population

Another area this report did not have the opportunity to adequately address is that of multiracial individuals of Asian descent. This is an area for continued growth that we ask readers to consider. According to the U.S. Census Bureau (2001), 14% of Asian Americans and 54% of Native Hawaiian and Pacific Islanders (NHPI) are multiracial. California has the third largest multiracial group at nearly 5% (Hill, Johnson, & Tafoya, 2004). Mixed-race individuals are a significant group in California with unique health characteristics. Unfortunately, multiracial Asian Americans are vastly understudied and health information specific to this group is nearly nonexistent.

Although there is no research specifically on multiracial Asian Americans and health disparities, the limited research on multiracial people in general shows that health disparities for this group are an area of concern. Multiracial children were found to have lower levels of good physical and dental health as well as exhibit more digestive allergies and disabilities than white children (Flores &Tomany-Korman, 2008). Lau, Lin, and Flores (2012) found that multiracial youth were eight times more likely than Caucasian adolescents to not be receiving the medical care they needed due to an issue with their health care plan. Bratter and Gorman's (2011) found that individuals who are mixed-race NHPI and Caucasian reported greater disparities than did single race NHPI individuals.

> The setting of the agency should convey welcoming messages by incorporating decorations and displays familiar to the consumers. Culturally important elements such as food, tradition, art, music, and dance can be used as effective tools for engagement given the issue of stigma.

Mental health disparities appear to be a concern for the multiracial population, in addition to physical health problems. Flores and Tomany-Korman (2008) found that when compared to Caucasian children, multiracial children had greater problems with social relationships, behavior, attention, and emotions. Multiracial youth were more likely to use marijuana than Asian Americans and were also more at risk for violence and alcohol use than Caucasian adolescents (Choi, He, Herrenkohl, Catalano, & Toumbourou, 2012). Additionally, their ethnic and racial identity development can be more complicated than their peers, thus leading to potential confusion regarding identity issues or leave them at-risk of being bullying victims.

Despite evidence of multiracial health disparities from the studies previously

mentioned, there is no information about why these disparities exist or recommendations for how to address the issue. Due to the growing diversity of the U.S., it is imperative that more research be done in this area. Current growth patterns indicate that Asians are expected to be about 35%of this mixed-race population making them one of the largest multiracial groups, second only to Hispanics (Waters, 2000). Multiracial Asian Americans have unique problems and needs that are not completely captured or addressed by current practices designed for single race Asian Americans.

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Selected Appendices

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Asian Community Mental Health Services
310 8th St., Suite 201
Oakland, CA 94607
Tel: (510) 451-6729
Fax: (510) 268-0202
www.acmhs.org

ASIAN HEALTH SERVICES
Main Clinic:
818 Webster St.
Oakland, CA 94607
Tel: (510) 986-6800
www.asianhealthservices.org

APAIT Health Center
1730 W. Olympic Blvd., #300
Los Angeles, CA 90015
Tel: (213) 553-1830
Fax: (213) 553-1833
www.apaitonline.org

Asian Pacific Community Counseling
Asian Pacific Community Counseling
7273 14th Ave., Suite 120-B
Sacramento, CA 95820
Tel: (916) 383-6783
Fax: (916) 383-8488
www.apccounseling.org

Pacific Clinics

Asian Pacific Family Center
9353 E. Valley Blvd.
Rosemead, CA 91770
Tel: (626) 287-2988
Fax: (626) 287-1937
www.pacificclinics.org

華埠兒童培育中心

Chinatown Child Development Center
720 Sacramento St.
San Francisco, CA 94108
Tel: (415) 392-4453
Fax: (415) 433-0953

chaa

Community Health for Asian Americans
268 Grand Ave.
Oakland, CA 94610
Tel: (510) 835-2777
Fax: (510) 835-0164
www.chaaweb.org

Fresno Center for New Americans
4879 E. Kings Canyon Rd.
Fresno, CA 93727
Tel: (559) 255-8395
Fax: (559) 255-1656
www.fresnocenter.com

Cambodian Community Development, Inc.
1909 International Blvd., Suite 3
Oakland, CA 94606
Tel: (510) 535-5022
www.ccdinc.org

Chinese Service Center of San Diego
5075 Ruffin Rd., Suite A
San Diego, CA 92123
Tel: (858) 505-9906
Fax: (858) 278-8899
www.cscsandiego.org

May Lakas sa Pagkakaisa

Council of Philippine American Organizations
832 E Avenue
National City, CA 91950
Tel: (619) 477-4090
www.copao-sandiego.org

Fresno Interdenominational Refugee Ministries
1940 N. Fresno St.
Fresno, CA 93703
Tel: (559) 487-1500
www.firminc.org

Healthy House within a MATCH Coalition
1729 Canal St.
Merced, CA 95340
Tel: (209) 724-0102
Fax: (209)724-0153
www.healthyhousemerced.org

Hmong Cultural Center of Butte County

1940 Feather River Blvd., Suite H
Oroville, CA 95965
Tel: (530) 534-7474
Fax: (530) 534-7477
www.hmongccbc.net

Hmong Health Collaborative
4879 E. Kings Canyon Rd.
Fresno, CA 93727
Tel: (559) 970-9299
Fax: (559) 255-1656
www.hmonghealthcollaborative.com

Hmong Women's Heritage Association
7275 E. Southgate Dr., Suite 306
Sacramento, CA 95823
Tel: (916) 394-1405
Fax: (916) 392-9326
www.hmongwomenheritage.org

Japanese Community Youth Council
2012 Pine St.
San Francisco, CA 94115
Tel: (415) 202-7900
Fax: (415) 921-1841
www.jcyc.org

Portia Bell Hume Behavioral Health and Training Center
Fremont location:
39420 Liberty St., # 140
Fremont, CA 94538
Tel: (510) 745-9151
Fax: (510) 745-9152
www.humecenter.org

Korean American Family Service Center
3727 W. 6th St., Suite 320
Los Angeles, CA 90020
Tel: (213) 389-6755
Fax: (213) 389-5172
www.kafscla.org

Children & Family Services: Wilton Site
680 South Wilton Place
Los Angeles, CA 90005
Tel: (213) 365-7400
Fax: (213) 383-1280
www.kyccla.org

Lao Family Community of Stockton, Inc.
8338 West Ln., Suite 101
Stockton, CA 95210
Tel: (209) 466-0721
Fax: (209) 466-6567
www.laofamilyofstockton.org

Merced Lao Family Community, Inc.
855 W. 15th St.
Merced, CA 95340
Tel: (209) 384-7384
Fax: (209) 384-1911
www.laofamilymerced.com

Korean Community Services
7212 Orangethorpe Ave., Suite 9A
Buena Park, CA 90621
Tel: (714) 449-1125
Fax: (714) 562-8729
www.koreancommunity.org

Kutturan Chamoru Foundation
Tel: (562) 972-0969
www.kutturanchamoru.org

Little Tokyo Service Center
a Community Development Corporation
231 E. 3rd St., Suite G-106
Los Angeles, CA 90013
Tel: (213) 473-3030
Fax: (213) 473-3031
www.ltsc.org

Muslim American Society
Social Services Foundation
3820 Auburn Blvd., Suite 83
Sacramento, CA 95821
Tel: (916) 486-8626
www.mas-ssf-sac.org

My Sister's House
3053 Freeport Blvd., #120
Sacramento, CA 95818
Tel: (916) 930-0626
Fax: (916) 930-0086
24-Hour Help Line: (916) 428-3271
www.my-sisters-house.org

Oakland Asian Students Educational Services
196 Tenth St.
Oakland, CA 94607
Tel: (510) 891-9928
Fax: (510) 891-9418
www.oases.org

Richmond Area Multi-Services
3626 Balboa St.
San Francisco, CA 94121
Tel: (415) 668-5955
Fax: (415) 668-0246
www.ramsinc.org

18173 S. Pioneer Blvd., Suite I
Artesia, CA 90701
Tel: (562) 403-0488
Fax: (562) 403-0487
www.southasiannetwork.org

National Asian Pacific American Families Against Substance Abuse
340 E. 2nd St., Suite 409
Los Angeles, CA 90012
Tel: (213) 625-5795
Fax: (213) 625-5796
www.napafasa.org

Peers Envisioning & Engaging in Recovery Services
333 Hegenberger Rd., Suite 250
Oakland, CA 94621
Tel: (510) 832-7337
Fax: (510) 452-1645
www.peersnet.org

Samoan Community Council
404 Euclid Ave., Suite 301-2
San Diego, CA 92114
Tel: (619) 888-1037
www.samoancommunitycouncil.org

Southeast Asia Resource Action Center
1225 8th St., Suite 590
Sacramento, CA 95814
Tel: (916) 428-7769
Fax: (916) 428-7293
www.searac.org

Southeast Asian Assistance Center
5625 24th St.
Sacramento, CA 95822
Tel: (916) 421-1036
Fax: (916) 421-6731
www.saacenter.org

Special Service for Groups
605 W. Olympic Blvd., Suite 600
Los Angeles CA, 90015
Tel: (213) 553-1800
Fax: (213) 553-1822
www.ssgmain.org

Golden Gate Day Health
350 Golden Gate Ave.
San Francisco, CA 94102
Tel: (415) 359-9210
www.steppingstonehealth.org

TOFA of Sacramento
2730 Florin Rd.
Sacramento, CA 95822
Tel: (916) 681-4635
www.tofainc.org

Tzu Chi Foundation
1100 S. Valley Center Ave.,
San Dimas, CA 91773
Tel: (909) 447-7799
Fax: (909) 447-7948
www.us.tzuchi.org

Union of Pan Asian Communities
1031 25th St.
San Diego, California 92102
Tel: (619) 232-6454
Fax: (619) 235-9002
www.upacsd.com

University of California, Irvine
Student Counseling Center
203 Student Services 1
Irvine, CA 92697
Tel: (949) 824-6457
www.counseling.uci.edu

2201 E. Anaheim St., Suite 200
Long Beach, CA 90804
Tel: (562) 433-2490
Fax: (562) 433-0564
www.ucclb.org

United Iu-Mien Community
6000 Lemon Hill Ave.
Sacramento, CA 95824
Tel: (916) 383-3083
www.unitediumien.org

Vietnamese Community of Orange County
1618 W. 1st St.
Santa Ana, CA 92703
Tel: (714) 558-6009
Fax: (714) 558-6120
www.thevncoc.org

Vietnamese Federation of San Diego
7833 Linda Vista Rd.
San Diego, CA 92111
www.vietfederationsd.org

Vietnamese Youth Development Center
166 Eddy St.
San Francisco CA 94102
Tel: (415) 771-2600
Fax: (415) 771-3917
www.vydc.org

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
GENERAL SUBMISSION OF EXISTING PROGRAM (CATEGORY #1)
REVIEWER FEEDBACK

REVIEWER'S NAME:		
DATE:		
REVIEWER'S RECOMMENDATION: Please mark the appropriate category the program should be submitted under.		Category #1
		Category #2
		Category #3
		Revision and resubmission

1. NAME OF PROGRAM		
2. TYPE OF PROGRAM: Please mark the appropriate type of program the program should be submitted under.		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		
No need to assess this item. Please skip.		
4. TARGET POPULATION		
Target population must be API-specific and submission should include the following information: • What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.) • In what language(s) is the program provided? • Is the program intended for people with specific needs or risks? • Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
5. WHAT ARE THE GOALS OF THIS PROGRAM?		
Submission should include the following information: • What are the specific problems this program aims to prevent or address? • What are the protective factors this program aims to enhance? • What are the risk factors this program aims to reduce? • What are the specific goals this program aims to achieve? (Do the goals make sense given the problem?)		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
6. CULTURAL RELEVANCE		
How well does the program address cultural relevancy in its components? How are cultural elements considered and incorporated in the program components/design? What makes this program an API-focused and culturally relevant/appropriate beyond bi-lingual/bi-cultural? • What strategies does this program use to outreach to the target population? • How does the program incorporate the target population's traditions, beliefs, and customs? • How does the program incorporate cultural elements regarding mental health and well-being? • How does the program demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)? • Please describe the history of the development of this program. Has the program had input from the community in the design and/or evaluation of the program?		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
7. ADDITIONAL COMMENTS - Please comment on the overall strengths and weaknesses of the program.		
REVIEWER'S COMMENTS:		

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
SUBMISSION OF EXISTING PROGRAM THAT HAS BEEN EVALUATED (CATEGORY #2)
REVIEWER FEEDBACK

REVIEWER'S NAME:		
DATE:		
REVIEWER'S RECOMMENDATION: Please mark the appropriate category the program should be submitted under.		Category #1
		Category #2
		Category #3
		Revision and resubmission

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
2. TYPE OF PROGRAM: Please mark the appropriate type of program the program should be submitted under.		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		
No need to assess this item. Please skip.		
4. TARGET POPULATION		
Target population must be API-specific and submission should include the following information: • What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.) • In what language(s) is the program provided? • Is the program intended for people with specific needs or risks? • Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
5. WHAT ARE THE GOALS OF THIS PROGRAM?		
Submission should include the following information: • What are the specific problems this program aims to prevent or address? • What are the protective factors (factors shown to reduce the likelihood of risky behaviors) this program aims to enhance? • What are the risk factors (factors shown to increase the likelihood of risky behaviors) this program aims to reduce? • What are the specific goals this program aims to achieve? (Do the goals make sense given the problem?)		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
6. CORE COMPONENTS		
Do the program components match the stated goals? Are there enough details about the program for the reader to get a good sense of the program? How well does the program articulate the following? • What are the essential elements of this program? (e.g.: group size, accessibility, address issues on multi-levels, promote system change, etc.) • Why are these essential elements important? (Do these elements make sense given the goals?) • Have these essential elements been formulated (e.g.: manual, curriculum, specific skill set, etc.)? Is there a curriculum so that training and development can be offered to others? Please attach documents when applicable. (Are the materials linguistically/culturally/age/gender appropriate?) • When applicable, describe the model in terms of number of sessions required, frequency/ duration of sessions, number of consumers served, etc. • How well does the program demonstrate how it can be replicated?		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		

7. CULTURAL RELEVANCE

How well does the program address cultural relevancy in its components? How are cultural elements considered and incorporated in the program components/design? What makes this program an API-focused program and culturally relevant/appropriate beyond bi-lingual/bi-cultural?

- What strategies does this program use to outreach to the target population?
- How does the program incorporate the target population's traditions, beliefs, and customs?
- How does the program incorporate cultural elements regarding mental health and well-being?
- How does the program demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)?
- Please describe the history of the development of this program. Has the program had input from the community in the design and/or evaluation of the program?

WAS THE INFORMATION PROVIDED ADEQUATE?	Yes ☐	No ☐
REVIEWER'S COMMENTS:		

8. STAFFING

Does the staffing plan make sense given the program design?

- How many staff members are needed to run the program?
- What would be each staff member's responsibilities?
- What kind of training/education/experience is required for each staff? (Staff trained in cultural competency or members of the population/community?)
- Does each staff need to be bi-lingual and/or bi-cultural? In what languages/cultures?
- What is the ratio in terms of staff to caseload?

WAS THE INFORMATION PROVIDED ADEQUATE?	Yes ☐	No ☐
REVIEWER'S COMMENTS:		

9. PRACTICE SETTING – What type of setting is needed for service delivery?

Did the submission state what type of setting is needed?

10. INDICATIONS OF EFFECTIVENESS

Is the program effective? Is there sufficient information provided to support the effectiveness of the program?

- Has the program been evaluated or is currently being evaluated?
  - If so, please describe the evaluation design including methods and components (e.g.: individual/ group interviews, surveys, pre-post tests, consumer satisfaction surveys, Community-based Participatory Research, mental health screening/re-screening, etc.) (Are the evaluation methods and instruments appropriate for the target population/community?)
  - Do these methods involve the target participants in active reflection to allow the community to identify what is important to them? (Was there opportunity for the target community/population to provide input/feedback on program design, implementation, and evaluation?)
  - Was the evaluation conducted internally (by staff) or externally (by contract evaluator)?
- If data (quantitative and/or qualitative) has been collected, what measurements were used?
- What were the biggest barriers in the data collection process, if there was any?

WAS THE INFORMATION PROVIDED ADEQUATE?	Yes ☐	No ☐
REVIEWER'S COMMENTS:		

11. AGENCY INFORMATION

Please include the following information and be as specific as possible:

- Please provide name/contact information.
- How do the board, management, and staff of the agency reflect the community the program intends to serve? (Are members of the target population/community represented at these levels?)
- How does the agency provide ongoing support and training for its staff?
- Please describe your history working with the target population or the community. (Was there any documented history of positive involvements with the target community/population?)

WAS THE INFORMATION PROVIDED ADEQUATE?	Yes ☐	No ☐
REVIEWER'S COMMENTS:		

12. ADDITIONAL COMMENTS - Please comment on the overall strengths and weaknesses of the program.

REVIEWER'S COMMENTS:

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
INNOVATION/STRATEGY (CATEGORY #3)
REVIEWER FEEDBACK

REVIEWER'S NAME:		
DATE:		
REVIEWER'S RECOMMENDATION: Please mark the appropriate category the program should be submitted under.		Category #1
		Category #2
		Category #3
		Revision and resubmission

1. NAME OF INNOVATION/STRATEGY:		
2. TYPE OF PROPOSED STRATEGY: Please mark the appropriate type of proposed strategy the strategy should be submitted under.		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information		
No need to assess this item. Please skip.		
4. TARGET POPULATION		
Target population must be API-specific and submission should include the following information: • What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.) • In what language(s) is the program provided? • Is the program intended for people with specific needs or risks? • Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
5. WHAT ARE THE GOALS OF THIS STRATEGY?		
Submission should include the following information: • What are the specific problems will this proposed strategy aim to prevent or address? • What are the protective factors will this proposed strategy aim to enhance? • What are the risk factors will this proposed strategy aim to reduce? • What specific goals will this proposed strategy aim to achieve? (Do the goals make sense given the problem?)		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
6. CORE COMPONENTS/CULTURAL RELEVANCE		
Do the core components match the stated goals? Are there enough details about the strategy for the reader to get a good sense of the strategy? How well does the strategy articulate the following? • What will be the essential components of this proposed strategy? (e.g.: group size, accessibility, address issues on multi-levels, promote system change, etc.) • Why are these essential elements important? (Do these elements make sense given the goals?) • When applicable, describe the proposed strategy in terms of number of sessions required, frequency/ duration of sessions, number of consumers served, etc. How well does the proposed strategy address cultural relevancy in its core components? How are the cultural elements considered and incorporated in the components/design? What makes this strategy API-focused and culturally relevant/appropriate beyond bi-cultural/bi-lingual? • How will the proposed strategy outreach to the target population? • How will the proposed strategy incorporate the target population's traditions, beliefs, and customs? • How will the proposed strategy demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)? • How will the proposed strategy incorporate cultural elements regarding mental health and well-being?		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
7. ADDITIONAL COMMENTS - Please comment on the overall strengths and weaknesses of the strategy.		
REVIEWER'S COMMENTS:		

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
GENERAL SUBMISSION OF EXISTING PROGRAM (CATEGORY 1)

1. NAME OF PROGRAM:		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		
4. TARGET POPULATION		
Please include the following information and be as specific as possible: • What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.) • In what language(s) is the program provided? • Is the program intended for people with specific needs or risks? • Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)		
5. WHAT ARE THE GOALS OF THIS PROGRAM?		
Please describe the goals the program aims to achieve and include the following information: • What are the specific problems this program aims to prevent or address? • What are the protective factors this program aims to enhance? • What are the risk factors this program aims to reduce? • What are the specific goals this program aims to achieve?		
6. CULTURAL RELEVANCE		
Please describe the cultural relevance of the program and include the following information: • What strategies does this program use to outreach to the target population? • How does the program incorporate the target population's traditions, beliefs, and customs? • How does the program demonstrate sensitivity to historical issues (e.g.: immigration, war trauma, etc.)? • How does the program incorporate cultural elements regarding mental health and well-being? • Please describe the history of the development of this program. Has the program had input from the community in the design and/or evaluation of the program?		

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
SUBMISSION OF EXISTING PROGRAM THAT HAS BEEN EVALUATED (CATEGORY 2)

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		

4. TARGET POPULATION

Please include the following information and be as specific as possible:

- What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.)
- In what language(s) is the program provided?
- Is the program intended for people with specific needs or risks?
- Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Please describe the goals the program aims to achieve and include the following information:

- What are the specific problems this program aims to prevent or address?
- What are the protective factors this program aims to enhance?
- What are the risk factors this program aims to reduce?
- What are the specific goals this program aims to achieve?

6. CORE COMPONENTS

Please describe core features of the program that are essential to its implementation and include the following information:

- What are the essential elements of this program? (e.g.: group size, accessibility, address issues on multi-levels, promote system change, etc.)
- Why are these essential elements important?
- Have these essential elements been formulated (e.g.: manual, curriculum, specific skill set, etc.)? Is there a curriculum so that training and development can be offered to others? Please attach documents when applicable.
- When applicable, describe the model in terms of number of sessions required, frequency/ duration of sessions, number of consumers served, etc.
- How well does the program demonstrate how it can be replicated?

7. CULTURAL RELEVANCE

Please describe the cultural relevance of the program and include the following information:

- What strategies does this program use to outreach to the target population?
- How does the program incorporate the target population's traditions, beliefs, and customs?
- How does the program incorporate cultural elements regarding mental health and well-being?
- How does the program demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)?
- Please describe the history of the development of this program. Has the program had input from the community in the design and/or evaluation of the program?

8. STAFFING

Please describe staffing needed and include the following information:

- How many staff members are needed to run the program?
- What would be each staff member's responsibilities?
- What kind of training/education/experience is required for each staff?
- Does each staff need to be bi-lingual and/or bi-cultural? In what languages/cultures?
- What is the ratio in terms of staff to caseload?

9. PRACTICE SETTING – What type of setting is needed for service delivery?

10. INDICATIONS OF EFFECTIVENESS

Please describe evidence of effectiveness of the program and including the following information:

- Has the program been evaluated or is currently being evaluated?
  - If so, please describe the evaluation design including methods and components (e.g.: individual/ group interviews, surveys, pre-post tests, consumer satisfaction surveys, Community-based Participatory Research, mental health screening/re-screening, etc.)
  - Do these methods involve the target participants in active reflection to allow the community to identify what is important to them?
  - Was the evaluation conducted internally (by staff) or externally (by contract evaluator)?
- If data (quantitative and/or qualitative) has been collected, what measurements were used?
- What were the biggest barriers in the data collection process, if there was any?

11. AGENCY INFORMATION

Please include the following information and be as specific as possible:

- Please provide name/contact information.
- How do the board, management, and staff of the agency reflect the community the program intends to serve?
- How does the agency provide ongoing support and training for its staff?
- Please describe your history working with the target population or the community.

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
INNOVATION/STRATEGY (CATEGORY 3)

1. NAME OF INNOVATION/STRATEGY:		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information		

4. TARGET POPULATION

Please include the following information and be as specific as possible:

- What specific population is this proposed strategy intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.)
- In what language(s) will the proposed strategy be provided?
- Is the proposed strategy intended for people with specific needs or risks?
- Is the proposed strategy intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)

5. WHAT ARE THE GOALS OF THIS STRATEGY?

Please describe the goals the proposed strategy aims to achieve and include the following information:

- What specific problems will this proposed strategy aim to prevent or address?
- What protective factors will this proposed strategy aim to enhance?
- What risk factors will this proposed strategy aim to reduce?
- What specific goals will this proposed strategy aim to achieve?

6. CORE COMPONENTS/CULTURAL RELEVANCE

Please describe the core features and cultural relevance of the proposed strategy and include the following:

- What will be the essential components of this proposed strategy? (e.g.: group size, accessibility, address issues on multi-levels, promote system change, etc.)
- Why are these essential elements important?
- When applicable, describe the proposed strategy in terms of the number of sessions required, frequency/duration of sessions, number of consumers served, etc.
- How will the proposed strategy outreach to the target population?
- How will the proposed strategy incorporate the target population's traditions, beliefs, and customs?
- How will the proposed strategy demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)?
- How will the proposed strategy incorporate cultural elements regarding mental health and well-being?

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
COMMUNITY-DEFINED PROMISING PROGRAM (CATEGORY 4)
RECOGNIZED BY: _____

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		

4. TARGET POPULATION

Please include the following information and be as specific as possible:

- What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.)
- In what language(s) is the program provided?
- Is the program intended for people with specific needs or risks?
- Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Please describe the goals the program aims to achieve and include the following information:

- What are the specific problems this program aims to prevent or address?
- What are the protective factors this program aims to enhance?
- What are the risk factors this program aims to reduce?
- What are the specific goals this program aims to achieve?

6. CORE COMPONENTS

Please describe the core features of the program that are essential to its implementation and include the following information:

- What are the essential elements of this program? (e.g.: group size, accessibility, address issues on multi-levels, etc.)
- Why are these essential elements important?
- Have these essential components been formulated (e.g.: manual, curriculum, specific skill set, etc.)? Is there a curriculum so that training and development can be offered to others? Please attach documents when applicable.
- When applicable, describe the model in terms of number of sessions required, frequency/ duration of sessions, number of consumers served, etc.
- How well does the program demonstrate how it can be replicated?

7. CULTURAL RELEVANCE

Please describe the cultural relevance of the program and include the following information:

- What strategies does this program use to outreach to the target population?
- How does the program incorporate the target population's traditions, beliefs, and customs?
- How does the program incorporate cultural elements regarding mental health and well-being?
- How does the program demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)?
- Please describe the history of the development of this program. Has the program had input from the community in the design and/or evaluation of the program?

8. STAFFING

Please describe staffing needed and include the following information:

- How many staff members are needed to run the program?
- What would be each staff member's responsibilities?
- What kind of training/education/experience is required for each staff?
- Does each staff need to be bi-lingual and/or bi-cultural? In what languages/cultures?
- What is the ratio in terms of staff to caseload?

9. PRACTICE SETTING – What type of setting is needed for service delivery?

10. INDICATIONS OF EFFECTIVENESS

Please describe evidence of effectiveness of the program and including the following information:

- Has the program been evaluated or is currently being evaluated?
  - If so, please describe the evaluation design including methods and components (e.g.: individual/group interview, surveys, pre/post tests, Community-based Participatory Research, mental health screening/re-screening, etc.)
  - Do these methods involve the target participants in active reflection to allow the community to identify what is important to them?
  - Was the evaluation conducted internally (by staff) or externally (by contract evaluator)?
- If data (quantitative and/or qualitative) has been collected, what measurements were used?
- What were the biggest barriers in the data collection process, if there was any?

11. AGENCY INFORMATION

Please include the following information and be as specific as possible:

- Please provide name/contact information.
- How do the board, management, and staff of the agency reflect the community the program intends to serve?
- How does the agency provide ongoing support and training for its staff?
- Please describe your history working with the target population or the community.

Manuia
웰니스
康健
Wellness
สุขภาพแข็งแรง
ウェルネス
សុខុមាលភាព
Kev Nyob Nyab Xeeb
Olakino Maika'i
Khỏe
Kalusugan
Mo'ui Leiei
Haengh Wangc

Prepared for the:
Office of Health Equity
California Department of Public Health
Under California Department of Public Health contract: #12-10319
Through funds made possible by the Mental Health Services Act

Through a collaborative arrangement between:
Pacific Clinics
http://www.pacificclinics.org/

and

the Asian Pacific Islander Strategic Planning Workgroup
http://crdp.pacificclinics.org/

March 2013