



Alameda County Behavioral Health Care Services

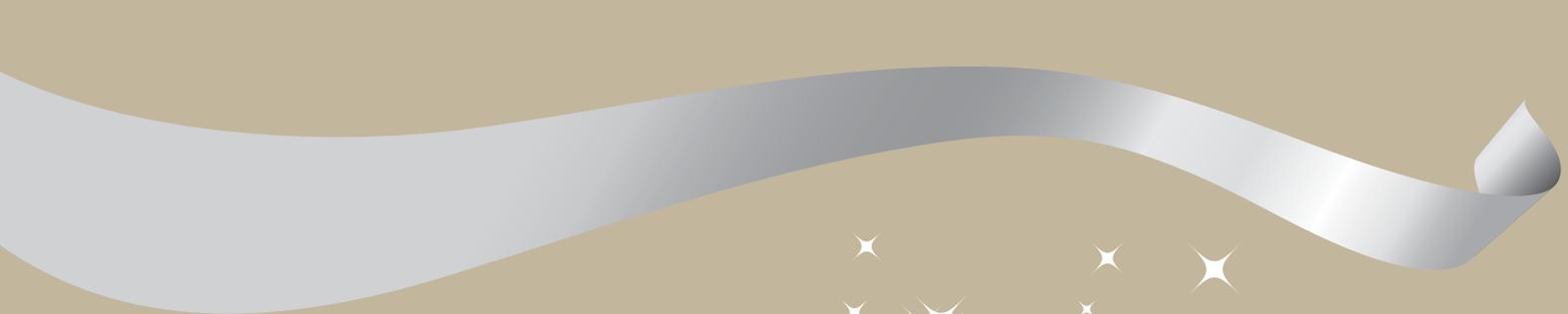
Asian American, Native Hawaiian and Pacific Islander Utilization Report

Executive Summary

Spring, 2018



Funded by Mental Health
Services Act (MHSA)



ROCCO CHENG & ASSOCIATES

Compiled by Rocco Cheng and Associates (RCA)

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**Alameda County Behavioral Health
Care Services Mission, Envision**

***Our Mission** is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing a serious mental health, alcohol or drug concern.*

***We Envision** a community where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.*



ACBHCS Values

Access

We value collaborative partnerships with consumers, families, service providers, agencies and communities, where every door is the right door for welcoming people with complex needs and assisting them toward wellness, recovery and resiliency.

Consumer & Family Empowerment

We value, support and encourage consumers and their families to exercise their authority to make decisions, choose from a range of available options and to develop their full capacity to think, speak and act effectively in their own interest and on behalf of the others that they represent.

Best Practices

We value clinical excellence through the use of best practices, evidence based practices, and effective outcomes, including prevention and early intervention strategies, to promote well being and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.



Health & Wellness

We value the integration of emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the biological, social and psychological effects of mental illness and substance use disorders.

Culturally Responsive

We honor the voices, strengths, leadership, languages and life experiences of ethnically and culturally diverse consumers and their families across the lifespan. We value operationalizing these experiences in our service settings, treatment options, and in the processes we use to engage our communities.

Socially Inclusive

We value advocacy and education to eliminate stigma, discrimination, isolation and misunderstanding of persons experiencing mental illness and substance use disorders. We support social inclusion and the full participation of consumers and family members to achieve fuller lives in communities of their choice, where they can live, learn, love, work, play and pray in safety and acceptance.



Alameda County Strategic Vision

"Our County is rich with diversity. Our communities are from diverse ethnic and cultural backgrounds, economic status and lifestyles. We celebrate our differences and appreciate our commonalities. We support and encourage the building of healthy communities where individuals, children and adults can thrive and can be all they can be. We do this by protecting the general public health, providing place/population-based services, protecting vulnerable populations, and providing a safety net for families/individuals and assistance towards self-sufficiency."

Alameda County Board of Supervisors, 2008

Foreword from County Leadership



Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI) are incredibly diverse in ethnicity, language and in their historical experiences in the United States. As many as 43 different ethnic groups have struggled as immigrants, refugees, asylees or American-born Asian Americans to overcome prejudice and discrimination on the path to achievements ranging from the building of the first transcontinental railroad to innovations in medicine and technology.

The 2014 Census found that there are 6 million people who identify as AANHPI living in California and over one in four Alameda County resident's identity as AANHPI.

AANHPI communities have many protective factors that support mental health and wellbeing, such as strong family connections and cultural practices that promote balance for better health and wellbeing. However, people from AANHPI communities, especially those who have more recently immigrated to the US, may be less likely to seek mental health support than the general population.

Unfortunately, this national and statewide trend of underutilization of mental health services is also an issue here in Alameda County. As an example of this, although more than 25% of AANHPIs are eligible for mental health services here at Behavioral Health Care, less than 2% currently access mental health services.

As the Deputy Director of Alameda County Behavioral Health Care Services, I am hopeful that this utilization report will enable us to create dialogue and action regarding solutions to reducing barriers to services, which will increase access to mental health services and ultimately increase our AANHPI communities overall health and wellbeing.

Thank you to everyone who has contributed to this report. Your participation, time, effort, collaboration and partnership has been greatly appreciated. We look forward to advancing the recommendations listed in this report.

James Wagner, LMFT/LPCC, Deputy Director
Alameda County Behavioral Health Care Services



As the Alameda County Behavioral Health Care Services' Ethnic Services Manager, I am collectively working with our department to address the mental health disparities that exist among our racial, ethnic, cultural and linguistic populations.

Mental Health services to all groups through BHCS County providers are monitored and measured through the overall system-wide penetration rate. Over the past five years, the Medi-Cal beneficiaries have increased while those served have remained relatively unchanged. The penetration rates among our Asian American population remains the lowest and yet the highest number of Medi-Cal beneficiaries. If we assume about the same percentage of Asian American Medi-Cal beneficiaries require mental health services, then we are falling behind in the provision of that care. While an increase in Medi-Cal beneficiaries and decreased in individuals served does not necessarily imply all recipients require mental health services, it does suggest an increase in more services could benefit the Asian American population.

The Office of Ethnic Services and the BHCS system of care remains committed to providing culturally and linguistically appropriate services to the Asian American community and will work to identify and rectify strategies and outcomes that do not address the efficacy of programs and services.

The OES is also partnering with the Pacific Islander (PI) Task Force to take a deeper and critical examination of the challenges and needs of their community and disaggregate data in an effort to uplift the PI's specific needs.

Javarré Cordero Wilson, MPH | Ethnic Services Manager
Office of Ethnic Services | Alameda County Behavioral Health Care Service



The Asian American, Native Hawaiian, and Pacific Islander (AANHPI) population consists of more than 49 ethnic groups and 100 languages and dialects. This diverse community ranges from Asian Americans, long term East Asian immigrants, Southeast Asian refugees, and emerging populations throughout regions of Asia. Their culture and needs differ extensively from one another.



In Alameda County, the AANHPI population represents more than thirty percent of county's total population and is the fastest growing ethnic group. Although more than 25% of API are eligible, less than 2% currently access mental health services. AANHPIs are utilizing mental health services at an alarmingly low rate.

Alameda County Behavioral Health Care Services (ACBHCS) has commissioned this AANIPI Utilization Report to better understand the reasons for the AANHPI disparity in accessing and utilizing mental health services. AANHPI consumers, family members, and community based providers gave extensive feedback through focus groups and individual interviews. This report includes a review of community based reports, and overall literature review on the AANHPI community and mental health services. In addition, ACBHCS analyzed the current trends of AANHPI utilization of mental health services within the county mental health system, which is also included in the report.

As the ACBHCS Senior Planner for Mental Health Services Act (MHSA), I will use this report as a strategic guide for future planning of MHSA programs that address AANHPI disparity and improve mental health services for community members. This report will discuss ways ACBHCS will respond to this need. MHSA Innovation monies will fund unique community based strategies and Prevention and Early Intervention (PEI) funds will increase collaboration with community based providers to address language needs and provide holistic, cultural responsive interventions to the AANIPI community. I hope this report will provide the information and data to inform and guide providers, involve AANIPI stakeholders, increase collaborations, and improve necessary services and supports to the API community.

Linda Leung Flores, MSW | Senior Planner
Mental Health Services Act (MHSA) | Alameda County Behavioral Health Care Services

II. Methodology

ACBHCS contracted three parties through a request for proposal (RFP) to gather the information in this report: (1) Rocco Cheng and Associates (RCA) comprising of Dr. C. Rocco Cheng and his associates from Alameda and Los Angeles counties; (2) Dr. Rose Wong of California State University East Bay; and (3) Dr. Amy Lam and Mr. Sean Kirkpatrick. Due to different terms being used across varied literature studies referenced in the review, API and AANHPI (Asian American, Native Hawaiian, and Pacific Islanders) will be used interchangeably in this report.

The current state of mental health service utilization by AANHPI communities in Alameda County were studied between November 2016 and March 2017 via four approaches:

1. Literature review:

RCA reviewed nation-wide and statewide literature regarding the state of mental health for AANHPI and the utilization of mental health services by AANHPI members within the Bay Area and Alameda County.

2. Consumer focus groups:

RCA conducted 15 focus groups with consumers and family members of diverse backgrounds and one additional focus group with service providers to better understand the barriers for mental health utilization and brainstorm relevant strategies to improve the use of mental health services. Consumers and family members focus groups included members from the following communities: ACBHCS API Pool of Consumer Champions (POCC), Burmese, Cambodian, Chinese consumers, Chinese family members in the Alameda County South Chapter of the National Alliance on Mental Illness (NAMI), Farsi, Korean elders, Mien, Mongolian, Samoan, Samoan faith leaders, Vietnamese, youths, female youth refugees, college students.



3. Interview of key providers and stakeholders:

Dr. Rose Wong conducted 27 interviews with members of diverse agencies to learn about barriers and possible strategies for improving mental health utilization. These agencies included: Afghan Coalition, Afghan Psychological Association of America, Alzheimer's Association, Asian Health Services (AHS), Burmese Refugee Family Network, Center for Empowering Refugees and Immigrants (CERI), City of Fremont, Community Health for Asian Americans (CHAA), Dig and Demand: Queer Diasporic Vietnamese Artists for Justice, Diversity in Health Training Institute, East Bay Innovations, Filipino Advocates for Justice (FAJ), International Rescue Committee, Korean Community Center of the East Bay (KCCEB), Multi Lingual Counseling Inc., NAMI-Alameda County South, Pacific Islander consultant, Pacific Islander Task Force, Partnerships for Trauma Recovery, STARS Community Services, Washington Hospital, and Wellness in Action.

4. Community Report Analysis:

Dr. Amy Lam and Mr. Sean Kirkpatrick conducted an extensive review of 120 community reports and prepared a summary report on barriers, utilization, and recommendations for mental health services in AANHPI communities.

III. Alameda County Asian and Pacific Islander Demographic Overview

AANHPIs are quite diverse and most of them are immigrants. They account for 58% of foreign-born population in Alameda.

Alameda County is home to many Asian American, Native Hawaiian, and Pacific Islander (AANHPI) individuals and families, and the AANHPI population has grown significantly in the county over the years. According to the U.S. Census data, there was a 49% increase in the Asian population and a 51% increase in the NHPI population between 2000 and 2015 (not including AANHPI in combination) within Alameda County. As of 2015, the total population in Alameda County was 1,584,983, with 32% of the total population identifying themselves as Asian alone or in combination by selected groups, and approximately 1.5% identifying as NHPI alone or in combination by selected groups.

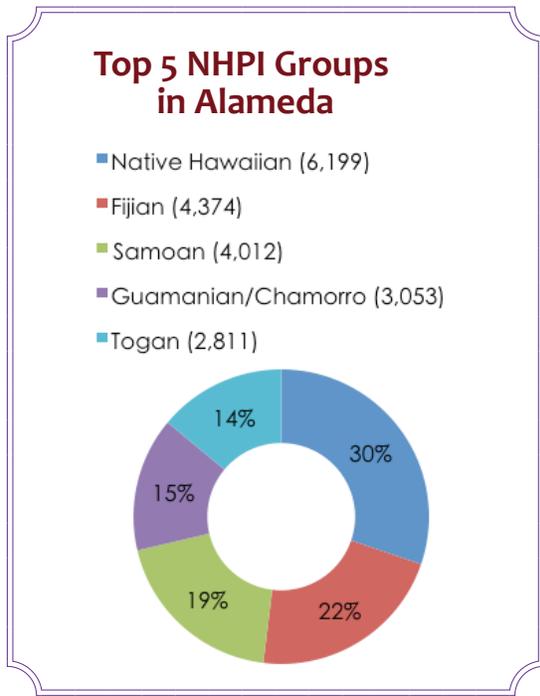
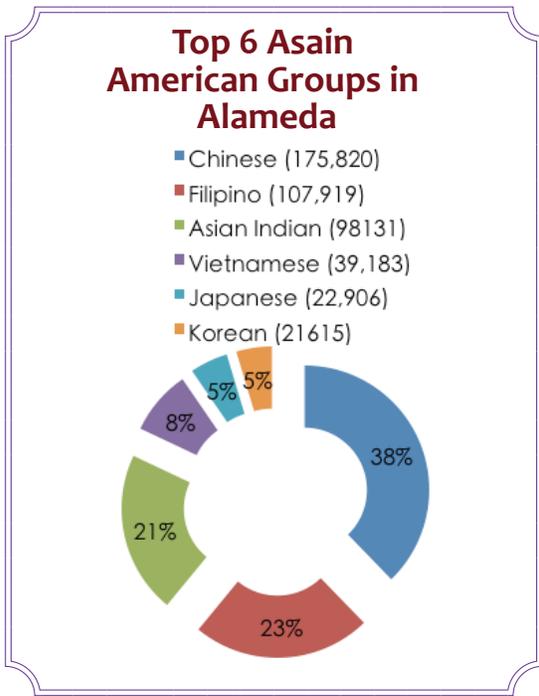


Table I provides a list of AANHPI groups that were included in the 2015 Census data for Alameda County. We should note that the group listed in table I is not an exhausted list of AANHPI communities in Alameda County. The other important fact about AANHPI is that most of them are immigrants. **The 2015 Census indicated that**

AANHPI accounted for 58% of the foreign-born population in the county. In addition, 19% of the households in Alameda County speak API languages, and of those households, 29% are limited English-speaking households.

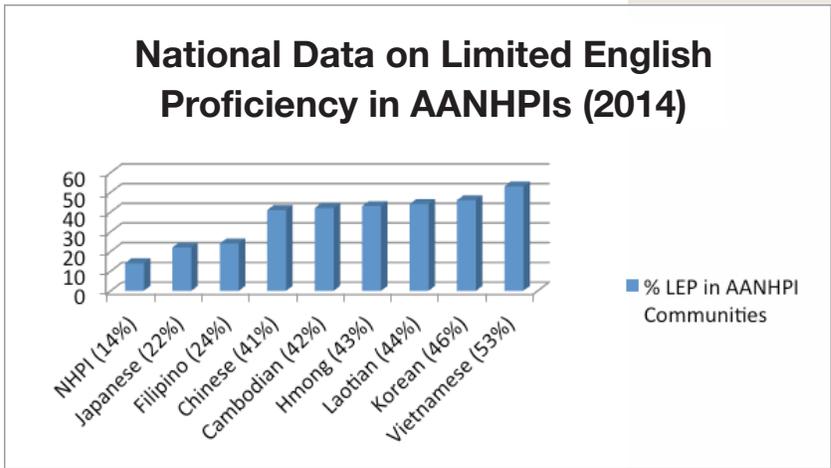
Given the diversity within the AANHPI populations, it is to be expected that there would be many differences across its ethnic subgroups. These differences could be observed in terms of language, culture, history, immigration patterns, religion, spirituality, traditions, acculturation, and socioeconomic status, just to name a few. While AANHPI (or API) is commonly used as one grouping in various governmental documents and reports, we should be mindful of the huge heterogeneity within the AANHPIs. For example, **many advocates from the NHPI communities remind the fact that their cultures and heritages are quite different from the Asian Americans and should be considered as separate groups when looking into behavioral health needs and strategies.** Many NHPI representatives advocate that they should be considered as separate from Asian Americans when looking into behavioral health needs and strategies.

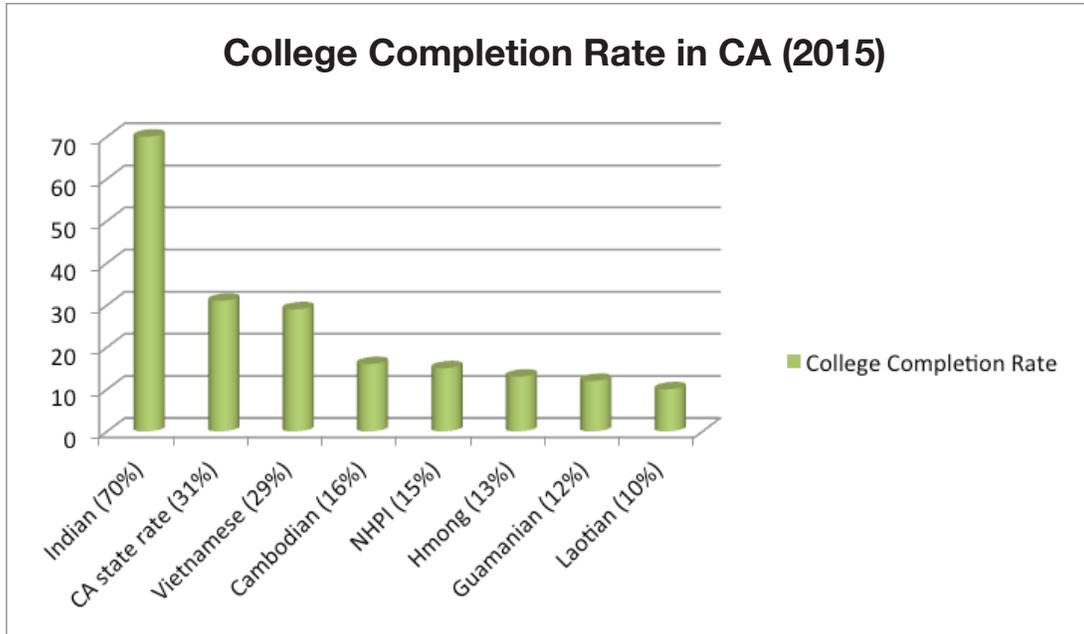
Many NHPI representatives advocate that they should be considered as separate from Asian Americans when looking into behavioral health needs and strategies.

The heterogeneity among AANHPIs was also reflected in the differing rates of limited English proficiency (LEP) and the highest educational level attained across subgroups. We can expect a similar trend in Alameda County as we observe it in the nation.

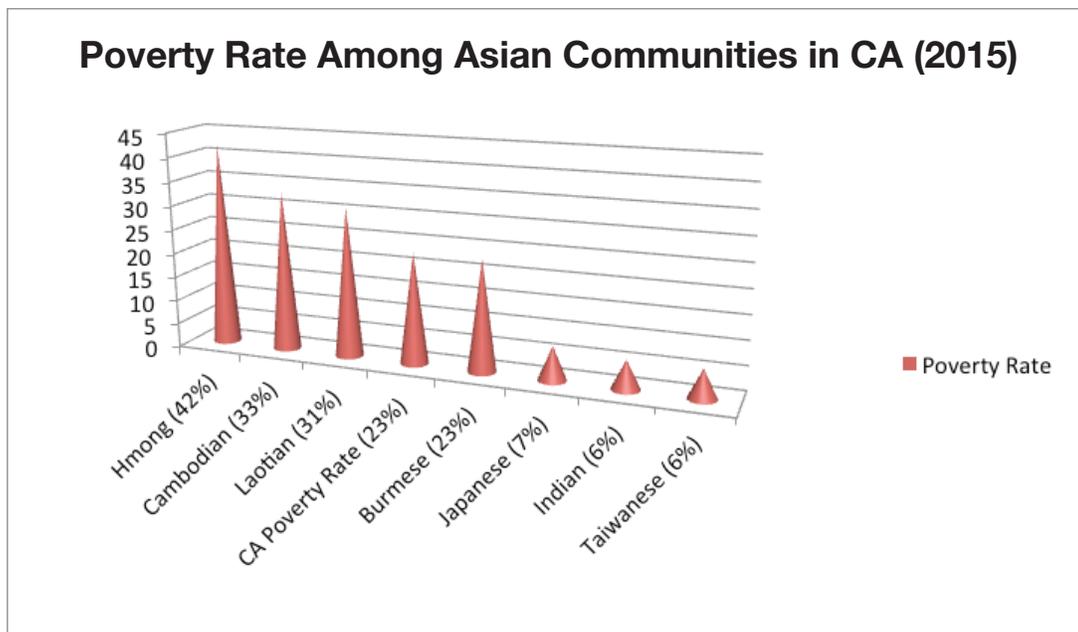


Nationally, while 14% of NHPIs reported limited English proficiency, the proportion of Asians with LEP ranged widely from around 22-24% for Japanese and Filipinos; around 41-46% for Chinese, Cambodians, Hmong, Laotians, and Koreans to 53% for Vietnamese (Ramakrishnan & Ahmad, 2014). In terms of educational attainment, about 70% of Indian adults who are 25 years and older have a college degree, while several AANHPI ethnic groups fall below the state average (31%) of adults 25 years and older with a college degree, including Vietnamese (29%), Cambodian (16%), Hmong (13%), NHPI (15%), Laotian (10%), as well as Guamanian/Chamorro and Samoan (12%) (The Campaign for College Opportunity, 2015).





Contrary to the common stereotype of the model minority, many AANHPIs do struggle with poverty. Of the individuals who live below the poverty level in Alameda County, 9.4% of them identified as Asian alone and 11.9% identified as NHPI alone in the 2015 Census. Specifically, poverty rates for many Southeast Asian groups are equal or higher than the state average of 23%, including Hmong (42%), Cambodian (33%), Laotian (31%), and Burmese (23%), while other AANHPI subgroups enjoy much lower rates of poverty than the state average, including Indian (6%), Taiwanese (6%), and Japanese (7%);The Campaign for College Opportunity, 2015)



**Table I: 2015 Census in Alameda County
Asian Population**

Subject	Alone	% of the total population in Alameda County	Alone or in combination with one or more other categories of same race	% of the total population in Alameda County
Total:	439,055	27.7%	507,029	31.99%
Chinese, except Taiwanese	149,683	9.44%	170,413	10.75%
Filipino	88,349	5.57%	107,919	6.81%
Asian Indian	93,212	5.88%	98,131	6.19%
Vietnamese	33,949	2.14%	39,183	2.47%
Japanese	13,100	0.82%	22,906	1.45%
Korean	18,428	1.16%	21,615	1.36%
Afghani *	8,958	*0.56%		
Iranian*	6,220	*0.39%		
Taiwanese	5,088	0.32%	5,407	0.34%
Cambodian	4,210	0.26%	5,176	0.33%
Pakistani	4,751	0.29%	5,102	0.32%
Laotian	3,960	0.25%	4,492	0.28%
Burmese	2,249	0.14%	2,962	0.19%
Thai	2,180	0.14%	2,815	0.18%
Indonesian	1,298	0.08%	2,336	0.15%
Nepalese	1,699	0.1%	1,763	0.11%
Mongolian	1,109	0.07%	1,343	0.08%
Sri Lankan	796	0.05%	928	0.06%
Hmong	708	0.04%	737	0.05%
Bangladeshi	467	0.03%	539	0.03%
Malaysian	314	0.02%	518	0.03%
Bhutanese	103	0.006%	332	0.02%
Okinawan	0	0	96	0.006%
Other Asian, specified	131	0.008%	157	0.01%
Other Asian, not specified	1,507	0.09%	12,159	0.77%

NHPI Populations

Total:	13,760	0.87%	24,698	1.56%
Native Hawaiian	2,326	0.15%	6,199	0.39%
Fijian	3,245	0.2%	4,374	0.28%
Samoaan	2,846	0.18%	4,012	0.25%
Guamanian or Chamorro	1,500	0.09%	3,053	0.19%
Tongan	2,176	0.14%	2,811	0.18%
Marshallese	141	0.009%	141	0.009%
Other Polynesian	126	0.008%	177	0.01%
Other Micronesian	125	0.008%	154	0.01%
Other Melanesian	18	0.001%	18	0.001%
Other PIs, not specified	1,030	0.06%	3,759	0.24%

*Afghani and Iranian data accessed from different source and did not have complete information.

IV. AANHPI revalence

AANHPI females aged 15 to 24 ranked second among all racial groups in suicide rates

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 for mental illnesses and low utilization rates of mental health services among Asians. However, a closer look at the data suggests a different picture.

The 2000 Census and the California Department of Mental Health showed that prevalence rates of mental illness for Asian Americans were similar to the general population when looking at AANHPI children, youths, and transitional age youths (TAYs, age 16 to 25 year old). For example, 7.18% of Asian youths and 7.67% of Pacific Islander youths were estimated to have a serious emotional disturbance, compared to 7.51% of the total youth population in California. **The prevalence rate is similar in Alameda County, where 6.95% of Asian youths and 7.53% of Pacific Islander youths were estimated to have a serious emotional disturbance, compared to 7.13% of the total youth population in Alameda County.** Given similar prevalence rates of emotional disturbances, it is helpful to examine the data on the leading causes of deaths for AANHPIs. In 2007, suicide was the third leading cause of death for AANHPIs ages 10 to 14 (Center for Disease Control). Moreover, AANHPI females aged 15 to 24 ranked second among all racial groups in suicide rates, at 4% in 2006 and 3.8% in 2007. Suicide is also alarmingly common among NHPI youths. The 2009 CDC national survey showed that 19.2% of NHPI adolescents had suicidal ideations, 13.2% made suicide plans, and 11.9% attempted suicide in the previous year (Asian & Pacific Islander American Health Forum,

2010). It is important to look at the data on emergency services to better understand help-seeking behaviors in the context of mental health service utilization. Among children receiving mental health care from California’s county systems between 1998 and 2001, AANHPI children were more likely than White children to use hospital-based crisis stabilization services. This suggests that AANHPI caretakers tended to postpone treatment for mental illness until it has reached a critical level and became a crisis. Delayed help-seeking may be due to stigma, mistrust of the system, and/or language barriers (Snowden, Masland, Libby, Wallace, & Fawley, 2008).

Despite comparable or higher prevalence rates of mental illness, AANHPIs continue to utilize mental health services at a low frequency.

For AANHPI adults and older adults, 5.6% of Asian adults and 7% of Pacific Islanders adults were estimated to suffer from serious mental illness, compared to 6.25% of the total adult population in California (California Department of Mental Health, 2000). In 2007, suicide was the second leading cause of death for individuals aged 15 to 34 (Center for Disease Control). Additionally, the Center for Disease Control data showed that compared to all other racial groups, AANHPI women aged 65 and over consistently had the highest suicide rate in 2006 (6.9% v.s. non-Hispanic White ranked second at 4.3%) and in 2007 (5.2% vs. non-Hispanic White ranked second at 4.4%). The 2000 Census estimated that 6.1% of the total population in Alameda County were experiencing a serious emotional disturbance or serious mental illness at one time. Another report estimated that **5.39% of Asian adults and 6.79% of Pacific Islanders adults suffered from a serious mental illness compared to 5.76% of the total adult population in the county** (California Department of Health Care Services, 2000).

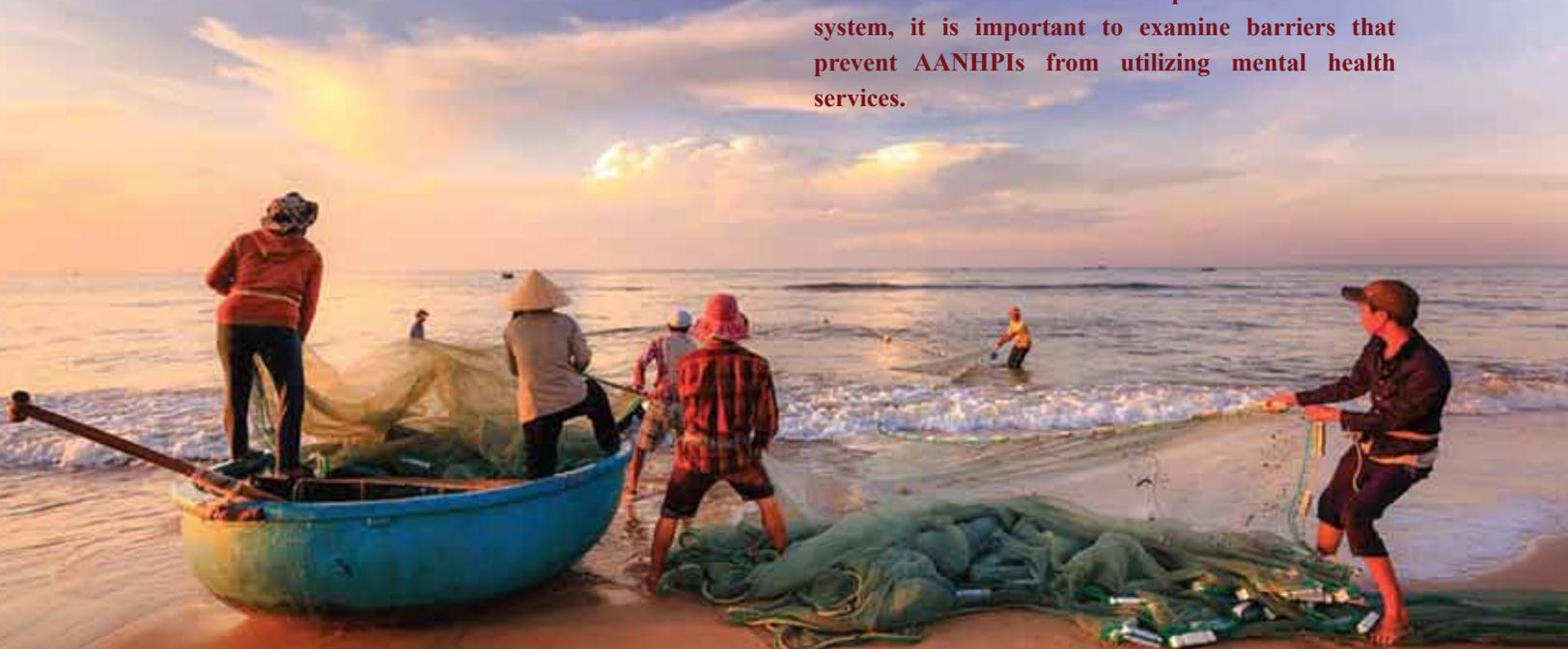


Despite comparable or higher prevalence rates of mental illness, AANHPIs continue to utilize mental health services at a low frequency. A study conducted in 2011 found that Asian Americans who had attempted suicide were less likely to seek help and less likely to perceive a need for help when compared to Latinos (Chu, Hsieh, & Tokars, 2011). The authors of the study suggested that Asian Americans with suicide ideations may underestimate the severity of their condition or have different ways of understanding or coping with suicidal ideations. Another study focusing on Cambodian immigrants also revealed low rates of service utilization. Marshall et al. (2006) interviewed 339 Cambodian immigrants in Long Beach diagnosed with PTSD, major depression disorder, or alcohol use disorder, and found that while 70% of interviewees sought help from Western medical care providers for emotional or psychological problems in the past 12 months, only 46% turned to mental health providers for services. The need for mental health services is apparent, yet those who are in need are not gaining access or receiving proper care.

There are 33.5% of AANHPIs in Alameda County but only less than 3% of the consumers in the public mental health system are from AANHPI background.

Only a handful of studies and reports are available that examine mental health service utilization among AANHPIs in Alameda County. A recent study conducted

by the Korean Community Center of the East Bay (KCCEB) and the Health Research for Action (HRA) center at UC Berkeley examined the health and social needs of Korean communities in the five counties of the Bay Area including Alameda County (Ivey et al., 2016). The results revealed that **13% of their survey participants reported serious psychological distress (SPD) and 28 % were at a high risk of developing SPD. Many participants also reported that their emotional distress had severely or moderately interfered with their work, daily, and social functioning.** Nevertheless, of those who reported impaired functioning due to SPD, **only 9% felt that they might need help and only one respondent actually sought help from healthcare professionals** (Ivey et al., 2016). Other reports based on data from Alameda County have raised the issue of mental health disparities in local underserved communities, such as refugees, recent immigrants, and older Asian adults with serious mental illness (Afghan Coalition, 2007; Community Health for Asian Americans, 2015). Clearly, the need for mental health services has been and continues to be pressing for AANHPIs nationwide including those who reside in Alameda County. **With AANHPIs making up 33.5% in the County but less than 3% of the consumers in the public mental health system, it is important to examine barriers that prevent AANHPIs from utilizing mental health services.**



V. Challenges

Overview

A person who has a 'mental health' condition may be excluded from social interactions with their community.

Based on interviews with providers and stakeholders, Dr. Rose Wong's report revealed 14 major barriers to the utilization of mental health services in the AANHPI community. They can be grouped into three general themes:

Social and cultural factors:

1. Stigma, shame, & denial of mental illness
2. Lack of understanding and education about mental illness, symptoms, and treatment
3. Difficulties adjusting to new environment and language and complex mental health system
4. Lack of trust in mental health providers and organizations
5. Poverty, difficulties accessing mental care, and low priority for mental health services while experiencing the need for multiple services
6. Lack of mobility, transportation, time, or family support that lead to extreme isolation

Service provision gaps:

7. Culturally insensitive services that do not integrate ethnic healing practices & culturally based mental health and wellness constructs
8. Insufficient providers with appropriate linguistic/cultural skills available in smaller communities
9. Insufficient providers with appropriate linguistic/cultural skills when clients seek help
10. Insufficient interpreters available to aid service delivery and insufficient training in mental health for interpreters

Lack of funding support for quality services:

11. Health insurance coverage problems and difficulty finding available providers
12. Lack of affordable mental health services
13. Low resources to perform outreach and bridge communities to services
14. Dependence on MediCal standards, which prevents increments to the provider pool and delivery of services.

Stigma

"... people don't go to psychological services because they feel they are not mentally ill"

Stigma was significant both at a personal and social level for first- and second-generation South Asian college students (Loya, Reddy, & Hinshaw, 2010). Compared to Caucasians, they reported more negative attitudes towards mental illness, and greater reluctance to seek help. They are also more likely to distance themselves socially from those with mental illnesses.

A 2005-2006 study on older Korean Americans in Florida illustrated how stigma deterred those in need from seeking help (Jang, Kim, Hansen, & Chiriboga, 2007). Out of 472 foreign-born Korean Americans aged 60 and over, 34% reported probable depression and 8.5% reported suicidal ideation. However, only 6.5% have contacted mental health professionals in the past. This might reflect their attitudes towards mental illness, as 71% considered depression a sign of personal weakness and 14% stated that mental illness would bring shame to the family. Even when an AANHPI individual is able to overcome stigma and seek help, approaching mental health providers may be one of the last resorts after exhausting the option of consulting community faith leaders, family members, friends and other primary care providers.



Cultural Barriers

The AANHPI communities understand mental illness and seek help differently from typical Americans. The concept of ‘mental health’ or ‘mental illness’ is foreign or inexistent to many AANHPI members. They avoid talking about myths and misconceptions associated with mental illness due to fear of stigma and discrimination. Many believe that symptoms of mental illness are to be endured as part of life rather than effectively treated.

Differences in culture and worldview play an important role in the low utilization of mental health services. Mental health interventions are typically derived from a Western approach (e.g., “talking cure”) and does not necessarily match the culture or worldview of the community member. Interventions that are not understood and accepted by AANHPI consumers will likely be utilized less often (e.g., high attrition rates) and less effective when utilized (e.g., poorer outcomes).

Individuals conceptualize their experience in varied ways based on their cultural and spiritual worldviews. In some cultures, mental illness may be connected to spiritual beliefs such as “karma” or spiritual phenomena (e.g., being possessed). They may turn to faith leaders to help them alleviate their pain or suffering and avoid going to mental health professionals for help due to stigma. They may use spiritual practices such as prayers or rituals and ceremonies to help them overcome their difficulties.

AANHPIs also tend to present their mental health problems as physical symptoms to their primary care providers rather than seek help for emotional difficulties (Zhang, Snowden, & Sue, 1998). However, primary care

providers do not typically specialize in working with people who have mental health issues and may lack the proper tools and training to diagnose or treat mental illnesses.

Such strong reluctance towards help-seeking could, in turn, result in situations where mental health services are sought only when problems become severe (Chow, Jaffee, & Snowden, 2003). **Across many AANHPI immigrant and refugee communities, the words “mental health” are often associated with severe mental illness** (e.g., crazy, insane, abnormal thinking). In some AANHPI cultures (e.g., Chinese), mental illness is attributed to social circumstances (e.g., trauma events, loss of a family member), while in other cultures (e.g., Pacific Islands), mental illness is thought to be caused by a person’s (or their family’s) negative thoughts and intentions towards others in their community. Regardless of its cultural etiology, **the perception that mental illness is associated with someone in a “crazed” state means that for many individuals from AANHPI communities, mental health is a highly stigmatized topic.** Not surprisingly, the taboo nature of mental illness has a negative impact on help-seeking and the ability to utilize mental health services for AANHPIs. **Therefore, non-stigmatizing psycho-education will be essential to address cross-cultural differences in understanding mental illness and increase acceptance of Western interventions.**

The feedback below illustrates how mental health is viewed by several focus group participants:





“We don’t normally go to psychologists or psychiatrists because Thai people regard the services to be for severe mental illness. Thai people don’t go to psychological services because they feel they are not mentally ill.”

“Within the Bay Area Himalayan communities, a person who has a ‘mental health’ condition may be excluded from social interactions with their community.”

“Focus groups with Pacific Islander men identify cultural values for men to be proud warriors, which leads to their perception that being sick is a sign of weakness.”

“The potential to be shunned in various API cultures that value interdependence and collectivism is often unbearable and causes deep shame for those with mental health issues.”

Pacific Islander men identify cultural values for men to be proud warriors, which leads to their perception that being sick is a sign of weakness.

Language barriers

Asian households have the highest levels of linguistic isolation in Alameda County.

More than half of Asians in California are foreign-born and many were recent immigrants (Ponce et al., 2009). As a result, **a significant portion (36%) of the Asian population had limited English proficiency (LEP), making it difficult for them to seek mental health services.** In Alameda County, the pattern holds similar and older adults seem to experience the most difficulties with language barriers. A study of 17,000 Californians aged 55 and older (Sorkin, Pham, & Ngo-Metzger, 2009), of which 1,215 were Asians, showed that Asians were more likely to utilize mental distress but less likely to use mental health services compared to Caucasians. Moreover, 81% of Asians surveyed were foreign-born and 39% had LEP. Authors of the Sorkin et al. (2009) study suggested that language barriers might increase an individual’s sense of isolation, decrease social

support, and result in less access to care.

While a multilingual and culturally competent workforce may help target linguistic difficulties, there continues to be a shortage of workers who are well-versed in the diverse languages, cultures, and unique skill sets required to navigate the wide range of challenges posed by a heterogeneous Asian population. For example, training programs for mental health professionals typically do not teach in languages other than English nor do they provide additional resources for students who may wish to work with an Asian population.

“Anywhere we go – we worry about interpretation because sometimes they don’t provide interpreters. Everywhere we go, we have to get someone to go with us and translate for us.”

Interpreters are sometimes used to communicate with clients of poor English proficiency. The quality of the interpreter matters. Interpreters are often not sufficiently trained in mental health concepts and terminology. **Similarly, clinicians who have not been trained in the use of interpreters may make mistakes that reduces treatment efficacy.** For example, they may have trouble establishing rapport and trust with clients when they speak to the interpreter who shares their language



instead of speaking directly to the consumer. In surveying 2,715 LEP Asians at 11 community-based health centers serving large Asian populations across the U.S., perceived quality of the interpreter was strongly associated with the quality of care perceived by patients, while receiving interpretation by family members and untrained staff was associated with lower satisfaction (Green et al., 2005). Therefore, **it is important to provide rigorous training for interpreters, and for clinicians to work with interpreters, instead of depending on family members of clients for translation.**

Clinicians require training to effectively utilize interpreters while maintaining the integrity of their service.

More languages are used in Alameda County than there are available interpreters. Language access impacts children and youth services where parents require language assistance to consent to their child receiving mental health services and to adequately support the treatment and case management plans of their children. One report states, “According to the Centers for Disease Control, as of 2007, there are over 100 languages other than English spoken in Alameda County. According to the California Department of Education, **53 languages were spoken by English-language learners in the K-12 public school systems in Alameda County in 2008-09. On the other hand, Alameda Health System offers interpretation services for only 26 languages.**”

Communities reported a high preference for and greater satisfaction with face-to-face interpretation compared to telephone interpretation, as body language or visual social cues may help communicate nuances and clarify interactions. Most uses of telephonic interpretation occur in primary care and legal support settings, including support for domestic violence. Despite being the only option for many languages, community reports revealed dissatisfaction with interpretation done over the phone.

On the other hand, **individuals from small communities are often reluctant to utilize a face-to-face interpreter due to concerns about confidentiality and privacy.** This speaks to the strong stigma towards



mental health, and communities’ limited awareness of or confidence in the ethical and legal boundaries that interpreters are trained to keep. In some instances, these concerns may be warranted when untrained people are utilized for interpretation services.

The feedback below from focus group participants illustrates the challenges of working with interpreters:

“Everywhere we go – social services or the hospital or anywhere we go – we worry about interpretation because sometimes they don’t provide interpreters. Everywhere we go, we have to get someone to go with us and translate for us.”

“Asian households have the highest levels of linguistic isolation in Alameda County. Language and cultural capacity of service providers was also the most frequently mentioned issue in focus groups and interviews conducted with providers.”

“One challenge is that there are far more API languages represented in the County than there are interpreters.”

ACBHCS has invested in programs such as ACCESS to provide language-matching access to targeted unserved and underserved AANHPI communities since 2010. However, paraprofessional providers in these programs are taxed with navigating services in multiple systems (e.g., schools, health care settings, social services, etc.), despite typically working in a part-time capacity. This adds to the probability of overwork, burn-out, and poor professional boundaries, which in turn impact their ability to provide quality support.

In sum, the need for appropriate linguistic and cultural services is multi-faceted. It includes, and is

not limited to, linguistic support for current mental health service workers (e.g., supervision in appropriate languages), **recruitment of more multi-lingual workers, and provision of appropriate translation services** (e.g., translators trained in mental health terms and concepts; mental health service workers trained in the use of translators).

Service Availability

AANHPI individuals may find mental health services to be inaccessible due to the shortage of a competent, qualified workforce that is both bi-cultural and bi-lingual.

The language diversity in AANHPI communities makes it difficult for agencies to have an adequate workforce to cover all the language needs of the community. Staff or interpreters who match the culture and language of potential consumers may have limited availability as they are overloaded by demands from the community. The strain of being one of the very few service provider, advocate, and resource of a community with high needs may quickly lead to burnout, poor boundaries, and other negative consequences that further eat away at the competent workforce.

While workforce challenges directly impact service availability, the location of the service provider can add another layer of difficulty for accessing services. At times, the agency providing appropriate mental health services may not be located in the vicinity of the AANHPI community, making it harder to get services. Many AANHPI community members are dependent on public transportation for various reasons (e.g., age, immigrants who are used to public transportation in country of origin, etc.), and are unable to travel with the ease of driving. **In addition to being costly, transportation over a long distance takes a lot of time and energy, making it extremely challenging to access services regularly.**

In sum, the need for appropriate linguistic and cultural services is multi-faceted. It includes, and is not limited to, linguistic support for current mental

health service workers (e.g., supervision in appropriate languages), **recruitment of more multi-lingual workers, and provision of appropriate translation services** (e.g., translators trained in mental health terms and concepts; mental health service workers trained in the use of translators). Unfortunately, these efforts may not meet the criteria for funding in mental health. Thus, many communities continue to struggle with having adequate materials and activities that are linguistically and culturally appropriate for orienting and educating community members about mental health.

For AANHPI communities, the gateway to receiving mental health support may lie in areas outside of mental health, including needs in social service, language development and/or citizenship acquisition, employment attainment and so on. If agencies only look to engage AANHPI community members through the narrow “entryway” of mental health, their success rate may be much lower than if needs in other areas are considered and integrated in outreach efforts.

Services under Underserved Ethnic Language Population (UEL) MHPA Prevention and Early Intervention (PEI) staff and SSA-funded Social Adjustment Counselors are often called upon to provide interpretation at schools, hospitals, and social service settings because of inadequate language access and service navigation



resources for LEP clients from AANHPI communities that do not meet threshold numbers for language translation to be provided. These clients include new immigrants, less common language groups, and refugees.

For new AANHPI immigrants and refugees served by the ACBHCS' UELP programs, the combination of limited providers, needs in multiple domains, and fragmented resource systems means that their UELP providers spend a large amount of their time helping

clients to access basic needs across multiple systems and less time on formal mental health support or treatment. Therefore, it is no surprise that community mental health providers are often pulled to provide support related to a whole range of complex needs as part of their work.





Age-Appropriate Services:

One challenge of working with AANHPI communities is access to age-appropriate services. From conversations in the focus groups, many youths expressed the wish to have a safe space and positive role model for them to develop a positive identity and a strong sense of wellness. **Interdependence is highly valued in AANHPI families. Therefore, it would be beneficial to strengthen the family structure and use it as a source of support for promoting mental health and wellness.** Indeed, parenting support, socio-emotional development in children, bullying, and inter-generational conflict are all topics that seem to attract community members to participate in conversations and learn about mental health from a framework that focuses on prevention and wellness.

We also need to consider the specific needs of AANHPI elders and to help them deal with changes in roles and needs as they progress into the different phases of life. **Social isolation and challenges in managing transportation are just some of the issues that need to be considered when implementing programs for the**

elderly. Other considerations for AANHPI elders may include a cultural understanding of their role in the community, as well as sensitivity to their acculturation process and any cultural adaptation that elders may need to make as their role is redefined within their new environment and shifting family landscape. As one focus group member reflected:

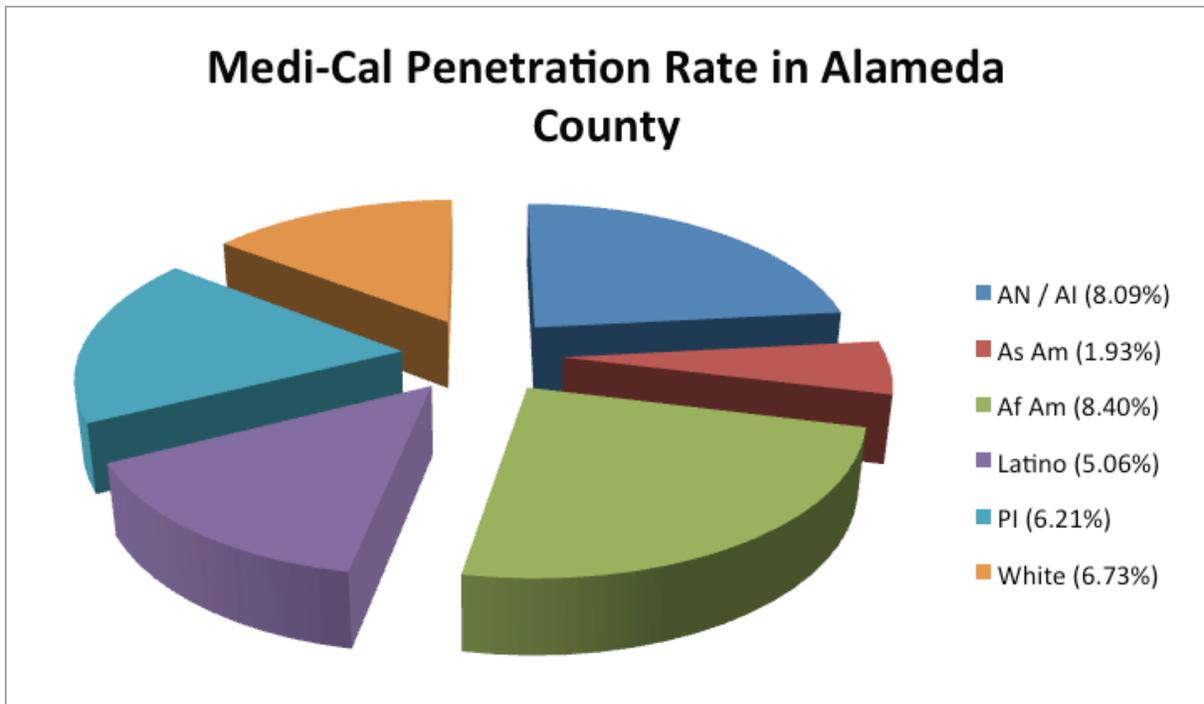
“The values of protecting families, supporting community, honoring elders, and educational achievement provide strength for the communities, as well as potential pathways to overcome stigma around mental health services.”

VI. Alameda County API Mental Health Utilization Data

Due to various barriers and challenges outlined above, the mental health utilization rate is much lower in the AANHPI community than **the prevalence rate**. **Even when AANHPI members come through the door to receive mental health services, they are likely to drop out prematurely if the service does not make sense to them or is too difficult to access.** County service data showed a much lower rate of utilization and community penetration compared to numbers from the demographics. Here are some of the existing service data available:

For Medi-Cal penetration rate (2015-16):

Alaska Native or American Indian	8.09%
Asian American	1.93%
Black or African American	8.40%
Hispanic or Latino American	5.06%
Pacific Islander	6.21%
White	6.73%



VII. Recommendations

Children/Youth and TAY

When designing programs for children, youths, and transitional aged youths (TAY), it is important to factor in the role of peer groups, family, and school. School- and community-based programs are important and often effective when focused on the strengths and needs of the child and family. Some effective strategies include school- and community-based Wraparound services, after-school programs, parenting workshops, art/music/video projects, mentoring, and opportunities to learn about their own culture. Gender-specific programs may be helpful for engaging youths and encouraging the development of their identity. It is important to have a safe space (such as a teen center) where young people can gather and learn from positive role models about life skills and the development of a positive identity.

For youths, physical activities (e.g., walking, hiking, playing paintball, rowing) provide a natural setting to share and disclose personal information. Youths may appreciate the opportunity to connect with other young adults from the community who have been through similar challenges and can offer mentorship or advice. This is especially true as youths are often inspired by mentors and role models who have beaten the odds or risen above the challenges.

Parents and caregivers are an important population to target when attempting to improve the wellbeing of children and families. For example, a father's group was formed in the Tongan community to support men on how best to take care of their children and families. Topics of interest for the group include domestic violence, parenting tips, how to support your child in school, and how to be a good partner. Many wives were pleased that their husbands were coming together to focus on the family and looked forward to joining the group conversations as well. In other communities, it was suggested that programs addressing the needs of men (e.g., anger management, alcohol abuse, domestic violence, and recreation needs) are needed.

Other innovative programming can help to improve intergenerational cohesion within a community. SAUCE, a program by Banteay Srei (a youth development organization), is a "peer and intergenerational cooking class, where young Southeast Asian women learn about traditional recipes and herbs in traditional Southeast Asian cuisine." The focus of this program is intergenerational dialogue, where older and younger Southeast Asians connect and foster healthy relationships with one another through cooking and eating traditional foods along with sharing stories about the refugee and resettlement experience.

"Not only do the young women learn to cook, listen to stories, and share their experiences of growing up in Oakland with each other, they also learn and explore different herbs, spices, fusion recipes, healthy foods and sustainable living."



Adults and Older Adults

For adults and older adults, we need to put in extra effort in ensuring that the program design is relevant culturally and linguistically.

It is necessary to have appropriate outreach, engagement, and educational materials, as well as professional staff with native language capacity and cultural abilities. **Given that stigma is one of the major barriers for seeking mental health help, it is important to hold anti-stigma campaigns** involving public figures, conduct non-stigmatizing educational workshops about mental health and mental illness, and collaborate with agencies or programs providing services for needs other than mental health. Some of these programs may include, but are not limited to: English as Second Language, employment training, social services such as citizenship class and application, social security and Medi-Cal application, nutrition/health and wellness workshops, as well as programs about traditional culture and art.

Similarly, creating community connections within a group setting can help validate and normalize symptoms of the Post Traumatic Symptoms Disorder (PTSD) that many clients experience. One unique way that Center for Empowering Refugees & Immigrants (CERI) has integrated psychiatry in their groups is to have a community day event where members socialize with each other while consuming food, coffee, and tea, and as they wait to see the psychiatrist. This strategy works especially well for the CERI community where the group cohesion is very strong.

Capacity Building

Many agencies in the AANHPI community are relatively small in size and capacity despite the amount of services they provide and their level of importance to the community. There are limited resources available to the AANHPI community in spite of their great need. **Alameda County has several AANHPI communities with less than 3,000 individuals who experience high needs across multiple domains. The task of supporting these smaller communities and the agencies that serve them is vital.** Therefore, capacity-building is a critical issue to consider.

At the individual provider level, it is essential that providers develop skills that help to empower the community and fully utilize existing resources. For agencies, we need to demonstrate cultural competence in several capacities, including the ability to educate the community on mental health issues, to collaborate with other community organizations such as schools and primary care providers, to train professionals and paraprofessionals on cultural competence, and to develop a future workforce (e.g., psychologists, mental health providers, interpreters) that is culturally competent.

With sufficient support from various systems, all these capacities can be developed to meet the needs of the AANHPI community, and can significantly contribute to its empowerment. For example, it was documented that some Cambodian temples housed the mentally ill. 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. This may include a leadership program for consumers so they can be the advocates and spokespeople for the consumers. The existing Pool of Consumer Champion (POCC) is a good example of a

program that fosters consumer leadership. More effort can be invested in nurturing mental health advocates and leaders from diverse AANHPI communities. One effective way to do so would be to create and support infrastructures that make good use of existing strengths and resources within the AANHPI communities. For example, local social and recreational programs may appear at first to have little direct relevance to mental health, but their non-stigmatizing nature can help engage individuals and communities, and provide social support in a way that fully utilizes limited resources and strengths of the community. Lastly, support for a central resource center will be a cost-efficient way to take advantage of technology and resource-sharing to facilitate outreach and linkage.



VIII. Short term / Long term Goals and Recommendations

With the challenges identified above, we also found some strategies that may help improve the low utilization of mental health services experienced by AANHPI members. Here are some likely strategies:

Community Provider Interpreter Team

While access to resources may be limited to different staff, a collaborative provider team can bypass these limitations. **The provider team may include community mental health workers, interpreters, and clinicians. In addition to mental health interventions that are provided by clinicians, we have established that outreach, engagement, and education are very important steps to take when working with AANHPI communities.** Hence, community mental health workers or health navigators are well-positioned to conduct outreach, engagement, and education with the target community. While doing outreach and engagement activities, it will be important to invest sufficient resources to ensure that outreach efforts are culturally and linguistically appropriate. At the very least, this will include documents and marketing materials in the native AANHPI language. These outreach, engagement, and education efforts are essential to raise the awareness of mental health, and to reduce stigma and discrimination related to mental illness. If the community mental health worker does not speak the language of the target community, it will be important to work with interpreters. Here, **the interpreters should be properly trained in mental health concepts so that they will be able to interpret the communication between consumers and mental health workers effectively. Not only are trained interpreters critical in outreach and engagement efforts, they are also essential to clinical interventions.**



Mental Health Interpretation Training

As indicated above, interpreters are crucial in reaching out to and working effectively with AANHPI communities, and should receive proper training and support. Currently, the mental health workforce has a long way to go before becoming culturally and linguistically responsive towards AANHPI needs. Therefore, it is important to expand the workforce by including community members who can serve as interpreters for mental health services. **Trained community members can become great assets to serve the community with their shared cultural experience and language skills. They are often more familiar with the challenges and struggles that consumers and family members are going through. They are also familiar with the community and it is much easier for them to establish a trusting relationship, given similar backgrounds and experiences.**

One of the greatest lessons learned from the perspective of the trainers was that interpretation must be viewed as a profession. One recommendation for hiring and on-boarding mental health interpreters is to support these interpreters in obtaining basic interpretation training with an additional mental health specialty, including continuing education to maintain an updated knowledge base. **Creating professional standards and training these mental health interpreters will help them become an integrated part of the mental health service system. This type of professionalization will build much needed infrastructure for mental health interpreters to be an integrated part of the mental health model.**

Cultural Responsive Outreach in Community

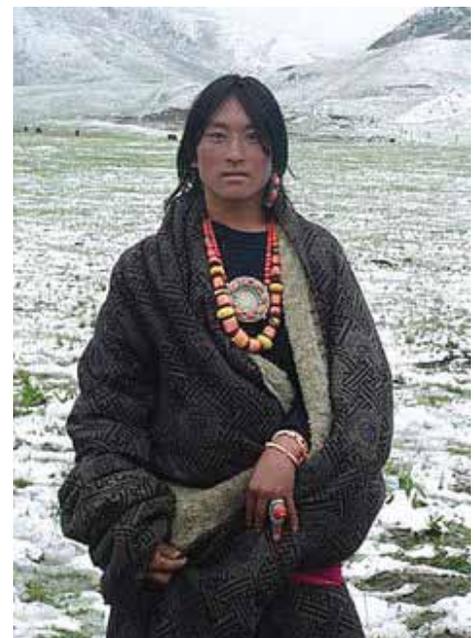
Given the diversity in AANHPI communities, the public mental health system must invest resources in the community to provide culturally and linguistically appropriate outreach efforts. To many community members, this can be the gateway to mental health services. Not only do materials and signage need to be culturally relevant and linguistically appropriate, they will also need to use community-friendly terms and format so that people are more likely to respond to these efforts. For outreach efforts to be non-stigmatizing, they can be integrated with cultural events or activities. While some of these efforts can be aimed at a more general or cross-cultural setting, it often pays off to have a targeted outreach to a specific cultural group to maximize its impact and relevance. There have been effective efforts made to promote mental health education within the context of traditional celebrations and cultural holidays. When designing these events, resources should be allocated for food and snacks, which are considered culturally congruent and a friendly gesture within the AANHPI communities.

Since many AANHPI community members and consumers are immigrants, understanding the immigrant experience is important. Many of them also come as refugees and/or asylee and have experienced tremendous amounts of trauma and torture. Hence, it will be important to consider a trauma-informed approach and to seek understanding of these immigration experiences when working with the AANHPIs.

A culturally responsive outreach must also include consideration for the age group and characteristics of a specific subgroup (e.g., gender expression and sexual orientation). When conducting outreach to youths and TAYs, utilization of social media and youth cultural activities (e.g., music, dance, art) should be considered. As for outreach to LGBTQ groups, a gender-neutral and affirming attitude will be of utmost importance, while maintaining sensitivity to traditional views of gender in each culture.

Holistic Services to Decrease Mental Health Stigma

One consideration of decreasing mental health/illness stigma is integrated care. It will be meaningful to consider embedding mental health service in holistic full-service environments whenever possible. Many people communicated the need for an integrated service that targets both physical health and mental health. They considered this a good way to deal with stigma associated with mental health issues. When mental health referrals come from primary care providers, people may be more likely to follow through as they are more accustomed to follow “the doctor’s order.” When physical and mental health care are co-located, people are less likely to feel burdened as others may not immediately associate it with mental health service. This will also help address the stigma of going to a mental health service agency. When designing a program to help address mental health issues, one may also consider integrating traditional healing and herbs as supplemental components to help people deal with stigma, as they are more familiar with and bought into this traditional healing approach. When indicated, programs should also consider integrating the spiritual component of healing, because spirituality is a prominent factor in the AANHPI experience.



Collaborations Between Prevention and Early Intervention (PEI) Providers and Medi-Cal Treatment Providers

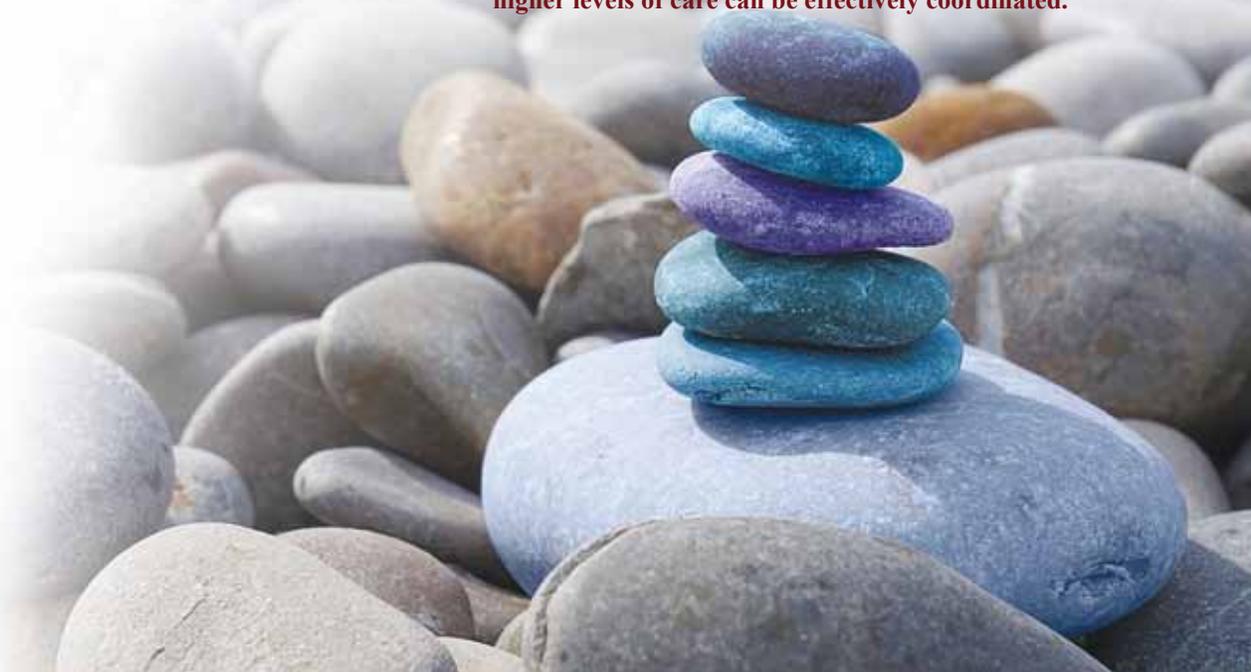
MHSA PEI Underserved English Language Population (UELP) has been the clearest and most dedicated strategy in ACBHCS's efforts to address the issues, barriers, and challenges discussed in this report. It is the most flexible funding stream in the current system in terms of redesign potential, and should be central to strategies for increasing the utilization of mental health services by AANHPIs in Alameda County.

UELP could serve a critical role in connecting community members to appropriate levels of care beyond prevention and early intervention. UELP programs have already successfully modeled strategies for engaging AANHPIs and reducing stigma by pulling from culture, expressive arts, traditional healing, and individual/group/community/collective empowerment. These programs were able to bring communities into the public mental health system in a safe and culturally aligned manner. These strategies should continue to be supported and valued for their effectiveness with AANHPI communities. Several UELP programs have been able to use their UELP funds to provide culturally and linguistically responsive mental health services to individuals regardless of their ability to pay or their mental health diagnosis. Thus, these programs are

essential safeguards and mental health supports for those who are ineligible for Medi-Cal or other forms of health insurance.

It is important to continue investing in prevention and early intervention (PEI) models and providers. It is also important to continue investing in non-mainstream mental health models and providers that involves culturally relevant, innovative strategies that promote cultural wellness. **PEI programs may include these modalities: expressive arts, empowerment, traditional healing and cultural preservation; peer support groups that leverage community resources; interventions that integrate concrete basic needs and skills development; as well as inter-community work and community events.**

In other words, it will be very beneficial to focus on PEI as a key node in the system to improve mental health service utilization for AANHPIs. It is important to protect PEI funding as it is often the only resource for serving immigrant communities, including the undocumented and uninsured who do not qualify for MediCal or other health insurance. **It is also essential to encourage organizations that hold PEI contracts to work with organizations that hold MediCal contracts so that referrals for individuals who need higher levels of care can be effectively coordinated.**



IX. County Response – next steps

Innovation Grant Projects

The current AANHPI Mental Health Utilization study points to several areas of focus that could improve the service utilization of AANHPI communities. Alameda County is working on addressing some of these areas through its Innovation Grants Program funded by the Mental Health Service Act. ACBHCS is planning to issue a Request for Proposal (RFP) for pilot projects to implement innovative and culturally responsive strategies and programs that address barriers for accessing mental health services in AANHPI and refugee/aslyee communities.

Stakeholder Involvement

As the needs of the AANHPI communities are much greater than the current system can address, it is important to continue seeking input from stakeholders in the system. The crucial involvement of stakeholders in discussing, brainstorming, reviewing, and monitoring service plans and delivery can help to ensure that limited resources for the community are best utilized and to reduce wasteful or ineffective efforts. A committee of culturally responsive AANHPI stakeholders comprised of community experts, consumers, family members, and county staff should be consulted at various stages of the service planning and delivery. This group can provide the leadership and influence to help Alameda County work more collaboratively with the community to address potential issues that challenge the invisible, un-served, underserved, and inappropriately-served API communities.





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ROCCO CHENG & ASSOCIATES



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