

Asian and Pacific Islander Mental Health Services Utilization in Alameda County

Community Reports Analysis

Prepared by Amy G. Lam and Sean Kirkpatrick, Consultants
for Alameda County Behavioral Health Care Services

February 13, 2017

About the Authors

Amy Lam, Ph.D., has a doctoral degree in Social and Cultural Psychology from UC Davis (2003) where she worked under the mentorship of Nolan Zane and Stanley Sue to understand the health and mental health risk and protective factors of Asian Americans. After her graduate work, she began working directly with Asian American and other immigrant communities to promote community health and wellness. Her expertise is in developing safety net programs to increase access for immigrants and refugees to culturally responsive health and mental health services as well as participatory methodologies that elevate the voices of marginalized communities. She brings a pan-immigrant lens including communities from Latin America, Asia and the Pacific and Africa. Ms. Lam is the primary author on five published scientific articles, and co-author on six scientific articles. Her papers have included a review of client diversity and effective therapeutic modalities, and the role of culture (e.g., loss of face, styles of coping, nonverbal communication) in influencing Asian American health and mental health behaviors. Her work in looking at cultural communication styles for sexual negotiation was one of the first to explore how non-verbal communication could be used as effective prevention strategies in Asian American communities.

Sean Kirkpatrick has worked in the East Bay non-profit sector for 14 years, with 13 years focused on community-based behavioral health and health equity for un- and underserved immigrant and refugee communities, primarily APIs. Before entering the non-profit sector, Mr. Kirkpatrick received a master's degree in Urban and Medical Anthropology, and was a doctoral candidate in Cultural Anthropology at University of Wisconsin-Madison where he focused on Southeast Asian cultures and histories and conducted three years of ethnographic and historical research in Thailand. He has led and supported local needs assessment, evaluation and research projects in the areas of community mental health and health, designed, implemented and evaluated behavioral health services and programming funded by MediCal, CSS, PEI, WET, and Innovations, and has coordinated systems change policy and advocacy efforts for area immigrant and refugee communities including with ACBHCS, Social Services Agency and Office of AIDS Administration locally, and in neighboring Contra Costa County. He is currently the coordinator of the East Bay Refugee Forum and is a co-founder of the Building Home Together collaborative. He is also supporting San Mateo County Behavioral Health and Recovery Services' Office of Diversity and Equity with their Cultural Competence Plan Update and a WET Impact Report. Mr. Kirkpatrick is also a co-author on four published scientific articles on research conducted with Bay Area API communities.

Together Mr. Kirkpatrick and Ms. Lam bring a holistic perspective of the mental health needs of API communities that incorporates a systemic view of how the Alameda County Mental Health System operates with a programmatic view of the community's needs and how to meet these needs most effectively. They also have deep community connections and experience that inform and ground this report.

Table of Contents

About the Authors	1
Table of Contents	2
Overview	4
Background	4
Consensus on Main Issues, Barriers and Needs	4
Rapidly Changing API Demographics	5
Newer Communities Face More Significant Barriers to Accessing Mental Health Services and Supports	5
Sources and Structure for this Report	6
Challenges	7
Section 1. Culture and Community Barriers to Mental Health Services Utilization	8
Cultural Influences on Mental Health Services Utilization	8
Stigma	8
Differences in Expression of Mental Health Challenges	9
Lack of Knowledge about Mental Health Services	13
Challenges for Young People	13
Cultural Competence of Providers	13
Community Barriers and the Stress of Resettlement	14
Neighborhood Safety	15
Distrust of Systems and Government	16
Lack of Awareness of How to Access Services	16
Lack of Insurance	17
Section 2. Systemic Issues and Barriers	17
Language Access	17
Limited Mental Health Workforce	21
Data Disaggregation	22
Limitations Placed on Services by Medi-Cal and Medi-Care	25
Limited Culturally-Informed Treatment Services Models	25
Insufficient Investments in API Mental Health Services	26
“Model Minority” Myth	28
Silos and Lack of Coordination between Systems	29
Section 3: Promising Cultural Practices/Approaches/Models for Connecting APIs to Mental Health Services, including Cultural/Community Strengths and Assets	30
The Importance of Social Support Networks to Mental Health Outcomes	30
Community/Culture Strengths and Assets	31
Resilience	31
Faith Organizations and Leaders	32
Strong Family Structure, Culture and Values	32

Friendship Networks	33
Community Leaders, Volunteerism, Community Self-Help and Sources of Information	33
Ethnic and Other Community-Based Organizations	33
Trusted Community Providers	34
Promising Practices, Approaches and Models	34
Models for Stigma Reduction	34
Models to Address Language Access Challenges	37
Models Leveraging Basic Needs and Concrete Skills Training	40
Models for Working with API Families and Youth	42
Models for Alternative Healing/Cultural Wellness/Innovations	44
Models for Individual, Group, Community and Collective Empowerment	47
Section 4. Structural, Cultural and Systems Improvement Recommendations	49
Overview	49
Recommendations:	51
Structural Investments:	51
Increase Investments in API Mental Health System	51
Improve and Broaden Language Access	51
Deeper Investments in API Workforce Development	52
Leverage MHSA PEI	53
Move Beyond Race/Ethnicity in Organizing Investments	54
Culturally-Responsive Program Design:	56
Invest in Social Support, Community-Building and Capacity-Building Models	56
Prioritize Investments in Stigma Reduction	57
Invest in Integration Settings and Linkage Strategies	57
Prioritize Community-Driven Models	58
Structural Competency:	59
Prioritize Data Disaggregation and Data Collection Alignment	59
Review Diversity and Equity Infrastructure, Cultural Competence and Trauma-Informed Care Commitments	60
References	62
Endnotes	67

Overview

Background

Alameda County's population stands at 1.638 million residents (US Census July 2015 estimate) and is now the fourth most diverse county in the US. With ever growing diversity, individuals of Asian descent are the fastest-growing population in the United States. According to the 2015 U.S. Census, Alameda County was home to 514,400 people who were foreign born, or 31.4% of the total population at that time. Asian and Pacific Islander communities are a growing part of the community and represent a large portion of the population in the U.S.,¹ California and the Bay Area. Asians and Pacific Islanders (APIs) now comprise 29.5% of the total population in Alameda County, an increase of 3.4% since 2010, and over 60% of the non-white population, making them the 2nd largest (after whites) and second fastest growing racial/ethnic group (also after whites) in the County. In the near future, APIs and Latinos² will share outright majority status in Alameda County.

Alameda County's API communities present a complicated demographic group about which to make general assertions. They represent one of the most diverse ethnic/racial groups, with at least 49 different ethnicities and over 100 languages and dialects. There is also a growing number of foreign-born APIs in the demographic. Large numbers of Asian Americans are recent immigrants, with one in three of the 9.2 million foreign-born Asian Americans having entered the United States in the first decade of the 21st century.⁴

Many of the issues that have led to the production of this API Mental Health Utilization study are echoed in reports and recommendations documents provided to ACBHCS during the planning process for MHSA implementation in the mid-2000s where the issue of APIs underutilizing mental health services was an important theme that came up in 2006-07 during MHSA planning.⁵ The findings of that report were that low utilization of services by API populations *"is not indicative of a low level of need, but rather a high level of unmet need."*⁶ Indeed, this and similar reports were referenced in ACBHCS' Cultural Competency Plan (2010) and CSS Plan (2010) in discussions of low penetration rates for APIs. More recently, the California Reducing Disparities Project API Strategic Planning Work Group found that Asians were *"more likely to report mental distress but less likely to use mental health services"* than their White counterparts.⁷

This present report highlights ongoing challenges as well as progress made by ACBHCS and community-based providers, especially since 2010, in understanding and identifying needs, as well as efforts made to address the equity gaps faced by increasingly diverse APIs, including U.S. and foreign-born, based on a review of community and CBO reports.

Consensus on Main Issues, Barriers and Needs

Generally, there is a high degree of consistency in the community reports reviewed for this analysis, revealing cultural, community and systems factors impacting API mental health service utilization. The 2007 findings and recommendations report on API mental health submitted to ACBHCS for MHSA planning purposes⁸ lifted up high-level barriers that were found through analysis of County penetration rate data for APIs, community focus groups and interviews with providers:

- Mental health stigma
- Lack of knowledge and readiness to address mental health issues
- Lack of bilingual/bicultural capacity and cultural competence
- Cultural barriers in the language and structure of mental health

- Fragmented, narrow range of services insufficient to address mental health needs and sustain continuity of care
- Barriers in eligibility criteria and processes as well as coverage for services that delay treatment or prevent access to care
- Lack of outreach, education and referral systems within the Asian community, foreign born and citizenship status, in addition to poverty status and region.

Continued lower than expected service utilization rates of mental health services by APIs in Alameda County suggests that, while efforts and progress has been made in some of these issue areas, communities and service providers still believe there is more work to do to address community barriers, structural issues, as well as invest in promising approaches.

Rapidly Changing and Growing API Demographics

While some progress has been made in improving access for some API communities, especially for those who speak threshold languages and that have longer histories in Alameda County and at least some providers available in the local system who can provide in-language services,⁹ Alameda County's API communities have steadily increased, both in diversity and number. While a substantial number of immigrants are long-term U.S. residents or have had many generations of their families living in the United States, the past decade has seen an influx of many new API communities into Alameda County.¹⁰ Specific communities have varying levels of available mental health resources, differing degrees of familiarity with systems in the U.S. - including mental health - differing levels of comfort with mainstream Western mental health's worldview, varying levels of social support in their communities impacting mental health, and differing levels of readiness to address mental health issues in their communities related to both stigma and cultural etiologies for mental illness. There are also great disparities in the availability of mental health resources and services depending on the size, length of time in country, and visibility of specific API communities. These are important issues that shape the issues, barriers, and challenges specific communities face in accessing mental health services, as well as the strategies for addressing them.

Newer Communities Face More Significant Barriers to Accessing Mental Health Services and Supports

Changes in demographics have resulted in many API immigrant and refugee communities being unseen by local public systems, their needs not planned for, and without any professional mental health services providers who speak their languages available in the current public mental health system. Many of these newer and smaller communities come to the U.S. as refugees, asylum-seekers and immigrants who have experienced trauma, have little or no experience with mental health services, and often do not have concepts of "mental health/illness" in their cultures that match mainstream Western biomedical concepts.¹¹ Significant stressors for newcomer communities include trauma associated with war, refugee resettlement, and adjustment to crime-ridden urban environments. One recent report observed that "In combination, these lead to even more severe mental health problems and contribute to the emergence of dysfunctional family dynamics. Community leaders have reported many mental health struggles for their community members, including PTSD, depression, and anxiety that exacerbate resettlement and healthy integration. Newcomers often keep such issues to themselves due to social/ cultural taboos and socio-cultural stigma related to mental health issues."¹²

Sources and Structure for this Report

This report's authors pulled together over 120 reports from various sources for review and analysis, including:

- Reports produced by ethnic and other Community-Based Organizations based on needs assessments conducted for specific communities or sub-demographics such as age, gender, ethnicity, and at-risk populations
- Reports produced by CBOs summarizing outcomes and lessons learned for programs or projects funded directly by Alameda County Behavioral Health Care Services, Berkeley Mental Health, and other public funders, as well as foundations
- Reports produced by advocacy organizations concerned with either API or immigrant and refugee communities' issues and wellbeing
- Planning and recommendation documents for local and statewide systems
- Focus group data for specific communities or sub-demographics such as age, gender, ethnicity, and at-risk populations
- Individual conversations to clarify systems and program understanding and prioritize reports

Data reports in this analysis roughly cover the period from 2000-2016, with one report dating 1996. This period allowed the authors to assess how API mental health needs, challenges and service utilization patterns were characterized in distinct periods:

- Before the passing of the Mental Health Services Act (MHSA) in 2004;
- Stakeholder feedback on tailoring local MHSA strategies to meet the needs of Asians and Pacific Islanders (2004-2009);
- During the early phase of implementation of MHSA-funded strategies (2010-2013); and
- The most recent phase of MHSA implementation (2014-2016)

The available data sets allowed the authors to consider developments in terms of impacts on systems transformation and emerging strategies to improve mental health services utilization over time, as well as the continued articulation of concerns about mental health services utilization by APIs. For example, our focus and framing based on MHSA will become clearer through the course of report. Many of the main areas of progress in relation to addressing equity issues in the public mental health system for APIs and other diverse communities are intimately tied to the opportunities and shaping influence of MHSA-funded efforts, and because it is the most flexible funding stream at ACBHCS' disposal, many of the issues impacting API mental health services utilization will be related to key decisions related to MHSA planning and implementation moving forward.

This report is organized into four sections:

Section 1. Culture and Community Barriers to Mental Health Services Utilization

Section 2. Systemic Issues and Barriers

Section 3. Promising Cultural Practices/Approaches/Models for connecting APIs to Mental Health Services, including Cultural/Community Strengths and Assets

Section 4. Structural, Cultural and Systems Improvement Recommendations

Additionally, the authors compiled a bibliography of the reports that were available for review (see References, beginning on page 62) at the time of this report's preparation, and created a shared [Community Reports documents folder](#) in Google Drive for future review and reference, and that includes reports the authors and funder did not prioritize and read. The final list of reports was compiled, first, through examining the archival collections of relevant reports in the possession of the authors, both of whom each have over a decade of experience working with API communities; second, identifying known relevant program reports submitted to ACBHCS and other funders for review in preparing this report; and third, outreach to API providers to round out the topics and foci of the reports reviewed in preparing this report.

Approximately 70 reports produced locally (Alameda County and the Bay Area) and other relevant sources were prioritized for review. Reports collected cover the following general topic/subject areas:

- General API (not ethnic specific)
- API Mental Health
- Specific Ethnic Communities needs assessments, including: Burma refugee, Bhutanese refugee, Mongolian, Himalayan women (Bhutanese, Nepali, and Tibetan), Pacific Islanders
- ACBHCS MHSA PEI-funded API programs Annual Reports (CBO provided), including reports submitted by *Afghan Coalition* (Afghan community), *Asian Community Mental Health Services* (underserved API communities including Cambodian, Chinese, Filipino, Japanese, Korean, Lao, Mien, Vietnamese), *Center for Empowering Refugees and Immigrants* (Cambodian), *Community Health for Asian Americans* (refugees from Bhutan, diverse refugees from Burma, Mongolian, Nepali, Pacific Islanders, Thai, Tibetan), and *Portia Bell Hume Center* (South Asian)
- Language Access
- Immigration/Refugee Status
- LGBTQI2S
- Youth
- Women
- Elders
- DV/Trafficking/Gambling
- HIV
- Reentry

Methods for review and analysis of reports involved reading for issues themes related to barriers to accessing mental health services (structural, systemic, cultural, etc.), identifying recommendations for addressing these barriers, including promising cultural practices and approaches and community strengths and assets.

Challenges

- Cooperation with requests for reports from providers on short notice without a proper introduction and request from ACBHCS about the report data collection process
- Project set-up/organizing time was more than anticipated due to volume of materials that needed to be organized before review, eating into review and writing time
- Inadequate time to review all collected materials
- Richness and complexity of issues made it difficult to adhere to page limits

Section 1. Culture and Community Barriers to Mental Health Services Utilization

“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.”¹⁴

It is important to understand from a cultural and community context why it is that API mental health services utilization is so low. Our review of community and CBO reports suggests that there are cultural differences in perceptions of mental health and mental illness that may affect how people find a way to wellness. For new immigrants and refugees, there are also many community and contextual factors that impact their prioritization of mental health service utilization as well as structural barriers that prevent them from accessing needed services, including a paucity of providers who speak their languages in the current public mental health system.

Cultural Influences on Mental Health Services Utilization

“Dan had no way of knowing that Foua and Nao Kao had already diagnosed their daughter’s problem as the illness where the spirit catches you and you fall down. Foua and Nao Kao had no way of knowing that Dan had diagnosed it as epilepsy, the most common of all neurological disorders. Each had accurately noted the same symptoms, but Dan would have been surprised to hear that they were caused by soul loss, and Lia’s parents would have been surprised to hear that they were caused by an electrochemical storm inside their daughter’s head that had been stirred up by the misfiring of aberrant brain cells.”¹⁵

Stigma

Across many API immigrant and refugee communities, the words mental health are often associated with severe mental illness (e.g., crazy, insane, abnormal thinking).^{16 17 18} In some API cultures, such mental illness is attributed to social circumstances (e.g., Chinese)¹⁹, 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 negative intentions towards others in their community.²⁰ Regardless of its cultural etiology, the perception that mental illness is associated with someone in a “crazed” state means that for many individuals from API communities, mental health is a highly stigmatized topic.²¹

Not surprisingly, the taboo nature of mental illness has a negative impact on help-seeking and utilization of mental health services for APIs.^{22 23 24 25} Participants from a Thai focus group, for example, mentioned that psychological services are only for those with severe illness:

“We don’t normally go to psychologists or psychiatrists because Thai people regard the services for severe mental illness. Thai people don’t go to psychological services because they feel they are not mentally ill.”²⁶

Among Bay Area Himalayan communities, a person who has a ‘mental health’ condition may be unable to engage in social interaction with their community.²⁷ Reports from focus groups of Southeast Asian, Chinese and Pacific Islander communities echo a similar belief that seeking mental health support may cause embarrassment to one’s family, including damaging the

reputation of the family or specific family members who have mental health challenges.^{28 29 30 31} Focus groups with Pacific Islander men identify cultural values for men to be proud warriors, thus it is a sign of weakness to be sick.³² 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.^{33 34}

While stigma reduction does not happen automatically, it can happen gradually. For example, among Himalayan women, one program found that while women were not yet ready to seek traditional mental health services (even with symptoms of depression and anxiety), they were willing to acknowledge and disclose their mental health challenges and suffering to a trusted community advocate.³⁵

Differences in Expression of Mental Health Challenges

Given the high stigma related to mental illness across API cultures, it is important to understand how mental health symptomatology is expressed in these communities. In fact, some have argued that low API mental health services utilization may be because their needs aren't being addressed adequately.³⁶ Professionals may not be trained to detect "unobvious" mental impairment and distress among APIs.³⁷ It may be that differences in expression of mental health problems mask the mental health needs in API communities. We posit that the following are socially acceptable "idioms of distress" that are common ways to express mental health challenges for APIs.

Stress. Local surveys suggest that API individuals do respond to mental health as expressed through stress. For example, two reports from San Francisco State University with Mongolians and Himalayans (65% Tibetans and 35% other groups including Nepali, Bhutanese, Mongolian) found that anxiety and stress were among the top problems that interfered with an individual's work and family life. Over 20% of Bay Area Mongolians and 50% of Himalayan women reported that stress affected their lives.^{38 39} Those who do state that they experience stress are less likely to seek professional mental health support and more likely to pursue self-care options. For example, Mongolian focus group participants suggested talking with friends, singing, gambling, playing sports and connecting to their indigenous culture as ways to feel better when they are emotionally down.⁴⁰

Not all coping strategies to reduce stress are positive. Academic literature suggests high rates of alcohol abuse, smoking and gambling in API cultures; however, few community reports we reviewed discussed these coping mechanisms in detail. This may be due to reticence to disclose such behaviors in public. Additionally, many of the community reports we reviewed focused on mental health. Unless explicitly asked, communities may not associate mental health problems with alcohol use, smoking and gambling. The few reports we did find suggest that in the Bay Area Mongolian community, binge drinking is accepted and normalized; rates of alcohol dependency are considerably high for men (22%) in Mongolia.⁴¹ Alcohol consumption compounded with crowded living situations has resulted in domestic and neighborhood disturbance in Mongolian communities here.⁴² In the Korean community, about 10% of those surveyed in the Bay Area Korean Needs Assessment survey reported heavy drinking (5 or more drinks on a single occasion on 5 or more days).⁴³

Across various API communities, gambling is prevalent. Casinos, bingo halls and card rooms throughout the Bay Area target APIs in their advertising, and these establishments are frequented in large numbers by APIs.⁴⁴ Again, few community reports addressed this issue. Reports we did find focused on the Southeast Asian community, where gambling is normative/normalized and associated with cultural customs and social functions (e.g., gathering with friends, wakes and funerals, celebrations).⁴⁵ Informal and formal sports betting is also very common. However, when gambling becomes "problem gambling," it has been reported to be a serious individual, family and community problem, and is often connected with substance abuse, debt, social and family conflict, domestic violence, even divorce in API communities.^{46 47}

Loneliness. Social isolation and loneliness is common among newcomers, and especially seniors. In their home countries, elders are held in higher regard and respect by their families and society. This status affords seniors the empowerment they need to take leadership positions and contribute to society, as well as receive support. Here in the U.S., API seniors are more likely to live alone or are isolated, experiencing communication challenges with family members who mostly speak English, cultural clashes with their family and difficulties adapting to this new culture.^{48 49 50 51} This loneliness can contribute to high rates of psychological distress. A study conducted in 2010 found that psychological distress among Korean seniors (9%) was four and a half times higher than the state average in California (2%). Only American Indian/Alaskan Native seniors had rates as high.^{52 53}

Some seniors suggest having social groups where they could get together with others and gain health education related to mental health support. Seniors may also trust spiritual advice from shaman, monks and priests, seeking their counsel under distress.⁵⁴ In general, seniors seem to be wary of Western remedies, wanting support from people who understand natural herbal medicine.^{55 56}

Somatization. Reports of physical manifestations of distress are common in API communities, including headaches, body aches, fatigue, dizziness, sleeplessness and chest pains.^{57 58} Among Burma refugees, headaches (44%), body aches (34%), and the inability to sleep (32%) were the most often reported physical symptoms of stress/distress.⁵⁹ For survivors of war, this can be even more pronounced. A Hmong elder recounts:

“Our country was not a free country so I worked hard with the CIA in order to protect our families and friends. I got hurt from a bomb and a gun. One of my arms broke during the war. When I came to the United States, my arm started to hurt again. When my arm hurt, it made all the nerves on my back and neck hurt. Because of these problems, I became very sad.” (Hmong man)⁶⁰

Given somatization of psychological distress among many APIs, it is not surprising that APIs who have mental health diagnoses (PTSD, major depression, substance abuse) have been shown to more readily seek support from medical providers over counselors or therapists.^{61 62} A challenge in seeing a physician may be that they may not have been trained in the mental health specialty, so may not be adequately connect somatic expressions or are prepared to diagnose or treat those with mental illness from API communities.⁶³ In some communities, rates of seeing any professional mental health support may still be low; a study of Bay Area Koreans found that only 8% saw a primary care provider for mental health concerns and 1% went to a counselor or social worker.⁶⁴

Holistic View of Health. Somatization is rooted, in part, in cultural notions for many APIs where mental health is not seen as separate from physical health but is integrated into general wellness and connection of body, mind and spirit.^{65 66} In many Asian cultures, mental health is defined as “personal joy and well-being”. This well-being is influenced by:

“physical health and safety, family relationships, education and employment, housing and transportation, social recreational opportunities, faith and spirituality, culture and language.”⁶⁷

To promote wellness and relieve life stressors, individuals seek to balance physical, mental and spiritual health. In a Thai focus group, individuals suggested gaining wellness through eating well, having emotional self-control and finding ways to solve their problems.⁶⁸

APIs may seek care from traditional medicine that integrates mental and physical health. According to the Korean Needs Assessment of the Bay Area, whereas only 4% sought mental health counseling, Koreans were more likely to report seeking care through acupuncture (30%),

oriental medicine doctors (23%), massage therapy (15%) and chiropractic care (14%) for health concerns.⁶⁹

Another way to gain balance between body and mind is through spiritual means. Some APIs feel that their illness or suffering is related to bad karma.⁷⁰ In fact, APIs were very open to accept life as suffering and talk about their karma in life.⁷¹ Thus, among Buddhists, it is common for individuals and families to seek support and counsel from monks.^{72 73} Some feel that just being in the temple, with others, feels comforting and restorative.⁷⁴ One Mongolian shares how monks help:

“Usually call back Mongolian ask our family to discuss with doctors or ask them to go to temple to ask blessing and chanting. If someone sick seriously, we ask lama or fortune teller to find what reason why it happens to us and ask any other ways to cure or release the bad condition.”⁷⁵

Churches also offer solace and support to those experiencing difficult circumstances. For Pacific Islanders, church is like an extended family network outside of one’s individual family. Congregants share their problems with pastors and at some churches, adult counseling may be offered as well as youth groups.^{76 77}

Somatization as Coping. Somatization may also be an important coping mechanism. Many API newcomers have experienced a great deal of trauma in their lives (related to war, loss, personal violence).⁷⁸ One report cited that “...a shocking 87% of Afghani surveyed experienced a life-threatening situation while in Afghanistan due to war violence and 78% experienced the death of a close family member. Nearly two-thirds of all male respondents reported being held hostage.”⁷⁹ Verbally expressing this trauma may itself be re-traumatizing. A group of women from a Bay Area Himalayan Women’s Wellness Project stated they “often do not see the benefit of revisiting their experiences with anyone, much less a counselor, and many report fear of being re-traumatized by digging up the past.”⁸⁰

Delinquency. Among API youth, delinquency has been suggested to be associated with mental health challenges. Despite the model minority myth, Asian American juveniles in the California Youth Authority system increased from 2.5%-5.7% between 1989-2002. For the ‘other’ category, including Pacific Islanders, this percentage increased from 2.1%-2.4% between those years.⁸¹ Data from the 1990 census also show the Alameda County juvenile arrest rates of Lao (145.5 per 1,000) and Samoan (189.3 per 1,000) youth to be only less than that of Black youth (206.1 per 1,000). In San Francisco County, the juvenile arrest rates for the same period indicated that Samoan youth (587.5 per 1,000) had the highest arrest rates, with the next highest arrest rates being 336.2 per 1,000, found for Black youth.⁸²

A study with Oakland youth in the late 1990s found that depression was positively related to anti-social behavior. This finding was pronounced for Latino and API youth (when compared to White, African American and American Indian/Alaskan Native youth), where on average, depressed young people committed one more anti-social act than their non-depressed counterparts. API youth who are engaged in delinquent behavior should also be assessed for and, if needed, treated for mental health conditions.⁸³

The support that API parents can offer their youth may be limited. First, there may be language barriers between the generations (parents’ English is limited, children’s native language is limited) so that communication, especially around complex issues such as mental health, may be challenging. Second, for many working-class API families, parents may spend the bulk of their time at work, sometimes at 2-3 jobs, trying to provide the basic needs for their family. When parents do come home, they are exhausted from the day’s work. Parents themselves are trying to cope with the stressors of life in the U.S. (see more in the section below on the challenges of resettlement/immigration). One focus group member shared:

“parents have never taken them shopping, never taken them to a friend’s house, or met their friends, even when younger, just said they’re concerned that they do good in school, and don’t do drugs.”⁸⁴

Supports for API newcomer youth may look different than for more well-established youth (2nd, 3rd, 4th generation APIs). Not unlike their parents, newcomer youth are adjusting to a new culture, language and system. They may seek supports like English tutoring, cultural connections, preservation of their language and familiar cultural practices, learning how to navigate adolescence in a different cultural context, mentorship on how to support their family through employment and how to obtain a degree that earns enough money to support their families.

Research has found that API English language learners are disproportionately represented in school suspension and drop-out rates. Among Southeast Asian communities there are high levels of under-education and illiteracy.⁸⁵ The myth of the model minority may contribute to the lack of support for these students:

‘A recent study from the U.S. Department of Education found that two-thirds of the students in need of bilingual services did not receive them. In some cases the “model minority” myth of API exceptionalism contributes to the reproduction of API failure. A study of APIs in the California State University system found that more than 50% of incoming students who were ELL failed writing proficiency tests suggesting that teachers passed students who were conversationally but not academically fluent in English.’⁸⁶

Well-established API youth (2nd generation and later), who do not face the basic challenge of English language, may have higher-order needs such as fitting into American culture and society, looking for leadership opportunities, support for higher education or career aspirational goals, spaces to talk about intergenerational conflict with their parents, and opportunities for self-expression. Across both newcomer and well-established API communities, however, youth are negotiating between their culture of origin and American culture. Whether it be through clothing, educational goals, dating, multiple identities, the role of youth in the family, religious and cultural beliefs; these are areas where mental health support is often needed and welcomed by both parents and youth.⁸⁷

When asked about what type of alternative youth spaces they would like to see in their community, Southeast Asian youth mentioned wanting a space (especially in the evening hours) that could serve multiple roles, including helping them find jobs, be a safe space to keep them away from drugs and violence in the community, and a space youth could have fun and dance, enjoy recreational activities, sports, have a recording studio and go on field trips. Youth wanted strong adult mentors who they could develop trusting relationships with and above all, a job placement program to help keep them off the streets.⁸⁸

Violence. Domestic violence is prevalent across various API communities.⁸⁹ While disclosure of personal incidents may be stigmatized, individuals do recognize abuse and violence in their own communities. A recent study examining the health and wellness of Himalayan women (49 women, mostly Tibetan) found that 41% of women reported *knowing someone* in their community who had been physically, sexually or emotionally harmed; personal disclosure was very low, with 4% reporting physical abuse, 2% reporting sexual abuse and 16% reporting emotional abuse.⁹⁰ Another report found that Bay Area Koreans (19%) are more likely to state they were victims of intimate partner violence (IPV) than the state average (16%).⁹¹

A form of violence not usually discussed is that of hate crimes. Nationally, hate crimes against APIs have increased since the late 1990s; this is especially true for South Asians (especially Sikhs), who have experienced a significant increase in hate incidents after the September 11, 2001 terrorist attacks on the World Trade Center.⁹²

In conclusion, mental health challenges may present and be expressed by APIs in different ways. Professionals in the mental health field should become familiar with these nuances in order to better recognize and detect mental health problems among these communities so that individuals may be able to receive support earlier rather than later.

Lack of Knowledge about Mental Health Services

Given these different conceptions of mental health and wellness, those from API communities report a general lack of knowledge about mental health services in the U.S., including what constitutes a mental health issue, how mental health services can help, and how to access services.^{93 94} This lack of knowledge contributes to their low utilization.

Many are unfamiliar with the role of therapists to ask questions and how this can help solve their problems. API youth recalled their experiences:

“One respondent said it was boring, that the counselor just kept talking to them and asking questions that didn’t matter, like “what do you want to be when you grow up,” “what do you think about the army”? Respondent felt that the line of questioning had very little to do with treatment, was not useful, and they had to pay for it.”⁹⁵

Challenges for Young People

For young people, accessing support services may be challenging because of lack of family support or economic challenges. One Southeast Asian young woman notes:

“Because I am a girl, I always have to come home right after school.... My brothers could do more things....I can’t go to tutoring after school because my parents don’t trust me. They want me home right after school.”⁹⁶

Some parents may not understand the importance of extracurricular or supportive services for their children, focusing purely on academic achievement. In low-income families, parents rely on their children to help take care of their siblings or extended family and working to help increase the family’s income.^{97 98} Among Tongan families who have children who are delinquent or getting involved in drugs, parents may not be as involved with the school system because they believe it is the school’s responsibility to take care of their children.⁹⁹ A Burma refugee parent shares:

“They [parents] don’t know how to deal with fights with their children at school. They cannot speak to school teachers as they did in their country.”¹⁰⁰

Finally, “in some Asian cultures (e.g., Mien and Cambodian), there is no adolescent period comparable to adolescence in the West. So when a youth starts misbehaving there is less parental engagement.”¹⁰¹

Cultural Competence of Providers

Others feel that it is the mental health providers who do not understand them, their cultures, communication norms and family dynamics.¹⁰² Western modalities of therapy often focus on individual counseling. API community members have expressed the importance of modalities that include family members in the support and decision making (not only parents but even grandparents and other elders).¹⁰³ Interdependence in API families sometimes requires that mental health professionals work across three to four generations.¹⁰⁴

In domestic violence support, Western models value treatment options that separate and detach an individual from their family (e.g., shelter, restraining order, divorce). These treatment

options may initially be challenging for persons who hold deeply held values for collectivism, Confucian ideals of duty and obedience, or religious values that place a stigma on divorce. Thoughtfulness and care are needed to work with such clients to find treatment options that fit their needs.^{105 106}

This, however, is not the case for all communities. Among Pacific Islanders, individuals may seek out Western mental health specifically when they do not have support from their families or churches. One focus group participant states:

“I had to go see a psychiatrist. I had to go through a period by myself. I didn’t want to see anybody (PI community) or explain what happened.”¹⁰⁷

Cultural competency is needed so that mental health providers communicate about mental health in terms that are familiar and accessible to communities (“stress,” “emotional balance”), have a more holistic, integrated understanding of wellness that includes physical-emotional-mental-spiritual balance, unpack psychological and scientific terminology, demystify the purpose of “talk therapy,” and seek to understand or be open to API cultural norms, styles of and reasons for seeking help in order to bridge the gap that keeps these communities from accessing mental health support.¹⁰⁸

Socio-Cultural match with counselor. Trust is foundational for all therapeutic relationships. For many APIs, that trust is given to someone from a similar ethnic background and preference for a mental health provider who was not just culturally competent, but from the same ethnic community. Although it was noted that many fear that someone from their own community might publicize or gossip about private matters to the rest of one’s community, individuals felt it was important to have someone to talk about mental health issues who looked similar and spoke the same language.¹⁰⁹

It is not only ethnic identity that may be important, but other characteristics as well (e.g., gender, class, sexuality, experience, etc.). For example, among men in some API cultures, there is a discomfort with disclosing to female therapists.¹¹⁰ However, there are very few men who enter the mental health field.¹¹¹ For some API youth, a person’s ethnic identity was less important than their socioeconomic status. They said what was more important was to have person who understood “ghetto life.” A counselor with graduate degrees would not be able to understand them because they were from higher social economic and educational background. Most importantly, however, was to have counselors that were helping from their heart and not “doing it for the money or because it’s easy.” Building strong trusting relationship is not to be underestimated; even if youth had the emergency hotlines or Alcoholics Anonymous numbers, they didn’t feel comfortable calling someone they didn’t know.¹¹²

Community Barriers and the Stress of Resettlement

“Immigrants and refugees experience critical barriers to health care access: inadequate health coverage/insurance, excessive appointment delays and office visit wait times, transportation to service appointments, and language access. The stressors of poverty, cultural change, and linguistic isolation take a toll on the mental health of these recently arrived refugees and immigrants. Health status is often related to mental health issues developed through home country trauma and violence. Recently arrived refugees exhibit high rates of anxiety and depressive symptoms, as well as symptoms of PTSD. Domestic violence, alcohol, problem gambling, and other drugs use are also common current issues within these communities.”¹¹³

Resettlement is stressful. When asked about their top concerns, new API immigrants and refugees cited basic needs for employment, English language acquisition, affordable housing, healthcare and adjusting to a new culture and system.^{114 115 116 117 118} While mental

health support is rarely mentioned, upon further probing, one finds that it is unmet basic needs that are the root cause for so much mental and emotional stress.

“Presently, we are struggling to live day-to-day since it’s very hard to live in America. Our incomes are limited to rent and consumption for basic survival. For the first eight months we were provided with basic benefits from the government, but after the benefits were discontinued, we have been hardly managing a hand-to-mouth existence due to the cost for everything. It would be much better if we could be provided basic benefits until we are self-sufficient.” –Kala Aley, 34 year old Bhutanese woman¹¹⁹

“Along with affecting individual mental health, refugee resettlement may also heighten tension within the family.....Unfortunately, because the families are often in survival mode, they cannot pay much attention to their emotional well-being or to their family relational patterns. They lack outlets for exercise, socializing, or self-care. Social support and community institutions are needed for refugees to connect to each other and to promote wellness.”¹²⁰

Some local numbers indicate that 72% of Burmese refugees and 56% of Bhutanese refugees surveyed reported at least one stress-related symptom (e.g., body aches, headaches, or intrusive memories) that impaired their work or family life.^{121 122} An overwhelming percentage of Bhutanese refugees surveyed stated that they had “poor” (57%) or “very poor” (10%) adjustment to the U.S., with almost one in ten reporting alcohol consumption at the level of abuse (three or more alcoholic drinks daily).¹²³ Nationally, the age-adjusted suicide rate among Bhutanese refugees is nearly twice that of the general U.S. population, 24.4 Per 1,000 compared to 12.4 Per 1,000.¹²⁴

For undocumented communities,¹²⁵ stress is exacerbated by their hidden immigration status that limits their access to healthcare and other social supports.^{126 127} Women who are in abusive relationships do not call the police for fear that their families may be deported.¹²⁸

“I don’t feel well for that I am not on the same level of this society. We don’t get any support. We worry all the time about our kids work and family. Expected more but can’t see that. Undocumented status makes us feel lower. If we are documented we can be same as others...Being undocumented is giving us a lot of challenges. Feel bad for we have not many choices from this society. We can’t see our future here.”¹²⁹

Neighborhood Safety

Refugees in Oakland and other Bay Area cities begin their resettlement experience on an uphill climb. They leave their home country, which is often in political upheaval, only to land in economically depressed neighborhoods with high crime, unemployment and trauma. They must navigate their new lives with tremendous scarcity and few resources to support self-sufficiency.¹³⁰ Among those who have migrated due to war in their home countries, resettlement is even more challenging. Some Southeast Asians recall the hostility and discrimination they faced from resentful Americans for whom their presence reminds them of the Vietnam War.¹³¹

Not surprisingly, many Oakland API communities mentioned their need for safe neighborhoods as among their top concerns. In East Oakland Building Healthy Community focus groups, Burmese, Bhutanese Nepali, Cambodian, Chinese and Vietnamese participants said that neighborhood safety was among their biggest, if not the biggest concern.^{132 133 134 135} Both youth and adults spoke about being affected by hit-and-runs, shootings, robberies and gang activities.^{136 137} Community members wanted to know how to deal with robberies, how to call the police, learn self-defense, have more adequate street lighting, more speed bumps on their streets, police and safer places for youth to hang out.¹³⁸ Youth were also concerned about

being targeted and noted that the selling of drugs, even in front of their homes, was common.¹³⁹ They also felt that more trees, fewer liquor stores, more affordable housing, entertainment and recreation areas (like Six Flags) and gun free neighborhoods would contribute to the neighborhood's safety and beautification.^{140 141}

An account from Saw Mu Ler, a refugee from Burma who lives in Oakland and who was returning home after beginning community college classes when he was robbed at gunpoint, is an example:

"I had about \$60 cash in my wallet, including my bank card and Social Security card. They took out \$400 from my account even though I tried to close my account. Because of this horrible experience that I have had, I was very much discouraged. I got to know that in the U.S., nobody could get security."¹⁴²

Many accounts similar to this speak of refugees keeping small dollar bills in their pockets to ward off potential robbers. They feel trapped in their homes and are afraid to walk the streets of their neighborhoods. This type of trauma stacked on top of the already scarce resources that many new immigrants and refugees must begin with make moving towards mental health and wellness a great challenge.¹⁴³ This is not surprising, following Maslow's "hierarchy of needs" framework; addressing mental health for these communities is to first address their basic needs of health, livelihood and safety. Community members state the effective mental health services are those that integrate social adjustment, trauma and violence into their therapies.¹⁴⁴

Distrust of Systems and Government

Mistrust of government systems is common among API communities, especially those who have left their countries because of dangerous governments who suppressed and oppressed the liberties and freedom of various ethnic communities.¹⁴⁵ This is especially heightened in undocumented communities who are concerned with staying undetected from systems that they believe could potentially deport them. Whether their reactions are fear,¹⁴⁶ anger or resistance,¹⁴⁷ community members may be less likely to connect and interact with government services. In the Korean Needs Assessment of the Bay Area survey of over 340 Bay Area Koreans, 40% of Koreans surveyed stated they distrusted the government some, most or all the time. Not surprisingly, 68% of those surveyed did not know about women's health provisions within the Affordable Care Act nor eligibility criteria for the Deferred Action for Childhood Arrivals (DACA) program for undocumented young people.¹⁴⁸

It has also been reported that monolingual or limited English proficient individuals have been mistreated by government services including at SSI offices, mental health clinics, CalWORKs, and crisis clinics due to their inability to speak English well.¹⁴⁹ The power of government entities to negatively impact the lives of individuals may reinforce community members' resistance to seeking governmental help.

Lack of Awareness of How to Access Services

If the majority of community members have low knowledge about critical services and provisions such as healthcare and support for undocumented youth, one can expect that knowledge about how to access mental health services is even more limited. In the above-mentioned Korean survey, only 25% were aware that they had insurance that covered mental health care.¹⁵⁰

Among younger generation English speakers, knowing eligibility criteria, how to access services and advocate for one's self or one's family is challenging in and of itself.¹⁵¹ For monolingual individuals and seniors, this challenge is exacerbated.¹⁵² Fear is a huge barrier. Korean immigrants who are willing to seek mental health support are still unlikely to seek care

due to concerns about treatment costs (47%).¹⁵³ Among Burma refugees who had MediCal coverage, individuals were afraid to seek care from a hospital because of fear of high medical bills. They wanted to be clear what medical coverage they had.¹⁵⁴

Lack of Insurance

Uninsured immigrants are at an even greater disadvantage for accessing mental health services.¹⁵⁵ Without access to services, uninsured individuals with serious mental health challenges will go undiagnosed and untreated. Without treatment, those with mental illness can deteriorate, finding themselves in hospital emergency rooms or being treated at severe stages of a mental illness.¹⁵⁶ In California in 2013, 33% of Korean adults are uninsured, twice the state average. 34% of Vietnamese and 28% of Chinese did not have mental health coverage.¹⁵⁷

While many API families could qualify for MediCal, there are barriers to receiving public benefits. Some families, as mentioned previously, have had bad experiences with public benefits and do not want to face navigating the system. Others have stigma associated with receiving public benefits. Still others are nervous that accepting benefits will negatively impact their citizenship applications.¹⁵⁸ Locally in the Tongan community, it is estimated that 60% of Tongans do not have health insurance. For this community, many are not MediCal eligible because of their immigration status or because of high household incomes from the large number of adults living in one family.¹⁵⁹

Sometimes, restrictions on MediCal makes it difficult for individuals to qualify for mental health services. Full-scope MediCal eligibility requires a mental health diagnosis, and MediCal is needed in order for community members to qualify for county-funded programs such as EPSDT, Adult MediCal, and Wraparound.¹⁶⁰ One Alameda County behavioral health provider noted that annually 5-10% of their children/youth clients lose MediCal benefits and are unable to complete their course of treatment.¹⁶¹ As youth get part-time jobs, they too may stop qualifying for MediCal; their part-time job isn't enough, however, to pay for treatment even on a sliding scale.¹⁶² While the reasons for not having health insurance are varied across API communities, what is true across the board is that the lack of primary care or mental health coverage means many individuals are likely to not receive adequate and needed mental health care.

Section 2. Systemic Issues and Barriers

Our review suggests that, in addition to cultural and community barriers to mental health utilization, there are important systemic barriers that should be highlighted.

Language Access

“Everywhere we go – social services or the hospital or any-where 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.” Saw Khu Gey, Karen refugee from Burma¹⁶³

“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).”¹⁶⁴

One of the most commonly identified and overarching issues reported impacting APIs' ability to access mental health services is a **lack of or limited availability of in-language mental health services** for many API languages, especially for those from newer and smaller communities where high numbers of their adult population are Limited English Proficient (LEP). With regards to API languages, one report observed that "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."¹⁶⁵

The Center for American Progress notes that 'Close to 77 percent of Asian Americans spoke a language other than English at home in 2011, this was a greater percentage than that of any other population in the United States. Of these almost 11 million Asian Americans, 47 percent spoke English less than "very well"—again, a percentage higher than that of any other population, including Hispanics.'¹⁶⁶ A position paper observed that "Many of the challenges faced by immigrants and refugees in adjusting to life in the US, and gaining education and employment, are related to language barriers."¹⁶⁷

Language and API Families. Language access issues not only impact API LEP adult service utilization, but also children and youth services where parents need language assistance in order to consent to their child receiving mental health services and to adequately support the treatment and case management plans of their children. Language access is deeply connected to clients' abilities to participate in services and to advocate for their needs or for LEP adults to support and advocate on behalf of children and other family/community members. As one report noted, "Among children and youth, the group most often cited as having unmet need are children whose parents are recent immigrants and speak a primary language other than English. In school-based settings without multiple language capacities, it is often difficult to communicate with the parents in a timely way to obtain consent for their child to receive mental health counseling."¹⁶⁸ Hence, language access not only impacts services with specific clients directly, lack of language support also impacts whether a child gets services at all if LEP parents are not provided language support that assists them in understanding the situation.

Another report created by the Southeast Asian Youth and Family Alliance (SAYFA) and Asian Pacific Psychological Services (APPS) that provided feedback to West Contra Costa County Unified School District Homeless Programs in 2007 found that "Nearly all [Southeast Asian] youth respondents have at least one parent that does not speak English, and that they find it difficult at times to help their parents manage everyday issues."¹⁶⁹

Language access issues include having: 1) no or few professional mental health providers from specific communities (discussed below in more detail in a section on Workforce Development); and 2) no system for providing services with the assistance of trained and supported interpreters.¹⁷⁴

One report noted that "There is a shortage of mental health professionals for all Asian languages. The greatest unmet need is among those ethnic/language groups for whom there are the most severe shortages of mental health professionals and paraprofessionals. For example, both Tongan and Burmese focus group participants mentioned lack of services available to their community and not knowing where to go for care. "Up to 30% of survey respondents (in Bhutanese community survey) reported having no interpretation available at multiple public service sites, including health care, social service, and educational settings."¹⁷⁵

One report listed Hindi and Punjabi, Pashtu and Dari, Southeast Asian languages including Burmese, Khmu, Mien and Thai, Pacific Islander languages including Tongan and Samoan, as well as Mongolian and Tibetan as specific languages in need of attention by Alameda County's behavioral health system. "Some of these groups have immigrated to the county within the last 5 years and are not counted in 2000 census data."¹⁷⁷ Hume Center also reports that "It has been challenging to refer some of the participant's we service to other resources because of paucity of professionals who speak South Asian languages which makes it difficult for the

participants to communicate. We have been working with the participants to prepare to go to these providers with someone who speaks English and who can translate for them. There is a lack of resources available for comprehensive mental health services. It's noticeable across the spectrum of the county's system of care; there are not too many providers to serve this community."¹⁷⁸

One challenge is that there are far more API languages represented in the County than there are interpreters. 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. Alameda Health System offers interpretation services for only *26 languages*."¹⁷⁹

Of note is the **lack of a uniform strategy to provide quality interpretation support** in behavioral health treatment services funded by ACBHCS that would potentially improve the language access issues faced by some communities, especially those with no trained professional providers in the current system who speak their language.¹⁸¹ Indeed, providers report that ACBHCS has shown reluctance to include interpretation-supported treatment services as an option due to concerns about potential diminished quality of care with the addition of an interpreter to treatment service models, which unfortunately has meant that individuals with language access needs have been unable to get a service if no therapist who spoke their language was available to provide the service.^{182 183}

This issue is shared by many API communities, especially for families from newly arrived and smaller communities who do not meet threshold language numbers that better ensure services are available. "Alameda County has multiple languages that meet the criteria for a threshold language: currently Spanish, Cantonese, Vietnamese, Farsi and Mandarin (California Department of Health Care Services 2014). However, this only represents a fraction of the total number of languages spoken by residents of Alameda County."¹⁸⁴

While ACBHCS has invested since 2010 in programs directly targeting un- and underserved API communities, paraprofessional providers in these programs are taxed with navigating services in multiple systems (e.g., schools, health care settings, social services, etc.¹⁸⁵), often work part time, and are among the few available resources for families they serve, contributing to overwork and burn-out, poor professional boundaries, and impacting their abilities to provide quality supports to individuals and families with high needs in multiple domains that impact their wellbeing. We will discuss these issues in more detail in the Workforce Development section below.

ACBHCS' language access investments include ACCESS - the program that provides general mental health and substance abuse screening and referral for Alameda County residents, including a Helpline for specialty mental health services for MediCal recipients, telephone consultation to MediCal Mental Health Plan Providers, telephone psychiatric consultation services for primary care physicians, referral for mental health and drug treatment services for identified Social Services clients and referral to county-wide crisis/mobile team services - with Asian Health Services being the designated provider for API threshold languages, telephonic language line and crisis support for threshold languages provided by a third party vendor (Lionsbridge). ACBHCS contracts with four agencies to provide interpretation for community engagement events, but these interpreters are not paid to support mental health services. Apart from a pilot training in 2016 for therapists and interpreter-trainees from immigrant and refugee communities through CHAA that was not sustained, there have been a few interpretation trainings through the Ethnic Services Manager's responsibilities, but it is unclear what languages or roles were represented in those trainings.^{186 187}

ACCESS. Feedback on the effectiveness of ACCESS in connecting referrals to services in API consumer languages was mixed. For some communities - especially for threshold languages - the system for making referrals through the ACCESS line does successfully

connect them with a provider, but they are often placed on waiting lists due to the full caseloads of a limited number of in-language service providers.¹⁸⁸ There are also some examples where ACCESS has been effective. For example, ACMHS' API Connections (UELPA) team reported that they have received referrals from ACCESS for a high school student to their Early Intervention staff who were able to successfully build trust and make a referral internally to their Level I MediCal services, and for adults looking for specific languages.¹⁸⁹

For many communities, however, the referral system was consistently a dead end as there were *no providers who spoke the requested language*. One report observed that "Non-English speaking adults and seniors cannot access mental health services without assistance. Automated phone systems implanted at the city or county offices further complicates the accessibility for non-English speakers. A shortage of providers with ethnic-specific language capabilities limits not only access but impact of mental health services."¹⁹⁰

Others noted the difficulties of referring young people, stating "Youth referrals seldom work unless a provider accompanies the child/youth."¹⁹¹ Youth often also are reluctant to self-refer, even when they are aware of a resource: "Youth consumers are aware of support groups or agencies but they did not feel comfortable contacting them or seeking out the help, especially when they were in elementary and middle school."¹⁹² It is also likely that youth are unaware of the ACCESS system, which might make self-referral more comfortable for some young people.

While the County has encouraged continued use of the ACCESS referral system in order to document service and language need, even if there is no successful referral, if referrals for specific communities and languages are unsuccessful consistently, word spreads in communities and among providers and they stop using ACCESS for their referral requests. Moreover, referrers bypass the system to look for other kinds of support for potential clients, namely connecting directly to on-the-ground paraprofessionals in known locations who speak specific languages. These paraprofessionals are largely employed through one of the ACBHCS UELPA providers. As one report said, "ACCESS is sometimes a source of referrals. However, participants stated that they receive few referrals through this program and are often contacted directly."¹⁹³ Another report specific to refugee and asylee health and behavioral health needs in Alameda County, produced with the inclusion of ACBHCS leadership and ACBHCS-funded API behavioral health community-based organizations,¹⁹⁴ observed that "The County's ACCESS line for mental health provider referrals is hardly used, as it is not designed to connect individuals to culturally-competent, language-specific care."¹⁹⁵

Finally, it is unclear if the ACCESS referral system is aware of the linguistic resources available through the UELPA programs, as very few referrals are reported through ACCESS. Referrals are often made directly - provider to provider or directly from clients seeking services who are aware a specific person from their community provides support in their language. ACCESS also is likely underutilizing available Early Intervention service referrals either because the resources are not known (i.e., which languages are available, when Early Intervention the only available referral option due to workforce gaps in the treatment system, etc.) or treatment referrals are the only referral option considered by ACCESS staff. If the referral requires a language for which there is no provider or if the level of care needed is judged to be beyond the scope of a PEI program's services, this referral will often be a dead end.¹⁹⁹

Telephonic Interpretation. Community reports also share dissatisfaction with telephonic interpretation, which is the only option for many languages. Most telephonic interpretation use occurs in primary care settings and legal support settings including domestic violence support. It is not clear that telephonic interpretation is used much if at all in mental health service provision. Community members shared that they were given interpreters who did not speak their dialect, or were at times mis-assigned an interpreter that speaks a language that didn't match theirs (such as Burmese assigned to a non-Burmese speaking Karen or Karenni refugee, for example).²⁰⁰ Case workers have shared concerns that the interpreters do not know

content areas which at times leads to misinterpretation or breaches in service support protocols in sensitive topic areas such as domestic violence, for example.²⁰¹

Communities report high preference and greater satisfaction with face-to-face interpretation especially where telephonic interpretation is unclear; body language or visual pictures can assist in clarifying communication.²⁰² In a survey of 194 Burma refugees settled in the East Bay, 80% of respondents were dissatisfied with phone interpretation, compared with 13% who reported dissatisfaction with face-to-face interpretation.²⁰³ Another community report of 91 Oakland and Alameda Bhutanese refugees had similar findings with higher satisfaction using in-person interpretation (64% satisfied or very satisfied) than with phone interpretation (34% satisfied or very satisfied) in health settings.²⁰⁴

However, there are instances where individuals from small communities are reluctant to utilize an interpreter, who is likely someone they know, due to concerns about confidentiality and privacy. Partly, this reveals that there is limited awareness or confidence that interpreters have been trained to hold ethical and legal boundaries. Indeed, in some instances these concerns may be warranted when untrained people are utilized for interpretation services. It is also possible that individuals needing a service for a sensitive issue related to, for example, mental health, substance use, domestic violence, or reproductive health might not want a service due to fear, shame and stigma, knowing their issues would be exposed not only to a provider but also to an interpreter who they might know in their community.

Limited Mental Health Workforce

As the language access challenge section reveals, there is a growing need to build a diverse workforce to meet the linguistic and cultural needs of Alameda County's API immigrant and refugee communities, and may be the most salient issue at the systems change level to addressing barriers to mental health access.²⁰⁷ As one report notes, "Without a workforce development strategy that will help address the current significant gaps in a workforce from immigrant and refugee communities in the helping fields (health, behavioral health, human services, etc.), including implementing a strategy to train, certify and support interpreters and navigators from immigrant and refugee communities who will be available and working across all relevant systems (health, social services, etc.), we face the perpetuation of an inadequate workforce that will continue to be severely challenged by Alameda County's growing diversity."²⁰⁸

Specific to mental health, several reports pointed directly to the lack of or limited workforce for API communities as a significant barrier to accessing services. Some example statements from community reports:

"The lack of providers with language and cultural capacity throughout the system can present insurmountable barriers to meeting the mental health needs of Asian immigrant and refugee communities. Mental health interactions require both an ability to communicate in the language of the family and an understanding of the ways that mental health issues are expressed and understood in the different Asian cultures."²⁰⁹

"For mental health services specifically, there are few if any trained professionals from emerging API communities who can provide services in the consumer's preferred languages. Moreover, most mental health providers will not allow an interpreter, either staff or non-staff, to be present during a mainstream model mental health session, even with permission from the client, due to what is considered best practices for therapy and demands on support systems that would require significant clinical support for the interpreter. In the end, this means most emerging API community members who need mental health services and supports are unable to access any services at all."²¹⁰

API mental health provider shortages appear to be common throughout the Bay Area, impacting some communities (especially smaller and newer) most deeply.²¹¹ There is increasing awareness that the system is heavily reliant on community mental health paraprofessionals from unserved API communities to address behavioral and other health needs, and who find themselves in dual roles (service navigation, case management, and interpretation for the same client) that put them at risk for burnout. ACBHCS' investment in UELP programs includes those that provide most of their services through paraprofessionals due to a lack of or limited clinical workforce. This is especially true for refugee and asylee communities who suffer severe and often perpetual lags in having providers from their communities who speak their languages in place to meet their behavioral health needs:

“Bilingual health navigators are shining stars in a refugee or asylee’s health care experience, and their skills could be better developed and utilized. Across our health care system, non-clinical health navigators play critical roles in providing the case management, navigation support, education, interpretation, and encouragement refugees and asylees need to access quality health care, particularly during their first year in this country. These individuals enhance the effectiveness of every health care and social service delivery channel and of every clinician serving refugees, and their lived experience uniquely qualifies them for their positions.”²¹²

There is also recognition that there needs to be more investment in paraprofessionals’ skills and professional growth, as well as their support in providing and supporting behavioral health services:

“The provision of culturally and linguistically competent service and care is no simple matter in a county like Alameda; this paraprofessional workforce proves to be the most responsive and adaptive to waves of new ethnic groups as they arrive. But while natural leaders step up to serve each new community, they remain on the fringes of our service infrastructure, and investment in their skill development and professional growth has been inconsistent. At community-based agencies where they often work, resources for training, supervision, emotional support and outcomes tracking may simply not exist. Within SSA and BHCS (where Medi-Cal does not mandate interpreter services as in primary health care),²¹³ a pool of high-quality navigators and interpreters could greatly improve direct service access, particularly for newcomers and high-need cases.”²¹⁴

Finally, developing API youth who are multilingual and have access to greater educational opportunities than their parents should be a focus of behavioral health care pipeline programs. Strategies may include exposure to the mental health field, internship programs to shadow mental health professionals, as well as college and graduate level scholarships for APIs as well as multilingual individuals.²¹⁵

Data Disaggregation

Some reports discussed the relationship of data collection methods to understandings of behavioral health needs for APIs. One report observed that “disaggregated data on Asian and Pacific Islander groups are not available. Assessment of API ethnic groups versus APIs overall is essential to identifying the underlying causes to significant needs within each community (e.g., high poverty rates, linguistic isolation, and lack of health insurance).”

At the time this report was shared (2007), it was noted that “Data that are not currently available from the county include: specific ethnic and language groups within the Asian and Pacific Islander population, or citizenship status, or specific mental health needs of these

groups. Furthermore, there is limited data on the cultural and language capacity of service providers within the county mental health system.”²¹⁶

Data disaggregation must also begin to account for multiethnic APIs. A five-year Bay Area substance use and HIV prevention intervention for API young MSM (men who have sex with men) aged 18-24 found that 43% of their program’s participants in Alameda County were multi-ethnic (inter-ethnic as well as inter-racial); 34% were Chinese, 16% were Filipino and 14% were Vietnamese.²¹⁷ This phenomenon may become increasingly common for second and third generation APIs who live in a multicultural environment. For the County, this data suggests that planners must begin to think about how to account for multiethnic APIs, their needs and challenges. There has also been discussion of identifying refugee/asylee status as an important data collection need.²¹⁸

In sum, disaggregating API data reveals the need for diversifying strategies and tailoring investments based on subpopulation profiles for needs, barriers and challenges, community readiness, and the levels of social support and resources available for communities with different histories and cultures. A “one-size-fits-all” approach doesn’t work for APIs.

Different Data Collection Systems. Greater attention to collecting disaggregated data on ethnicity and language for APIs has been a focus of provider advocacy for some time. One example is the development of the Prevention Services data collection tool (see tool demographics section screenshot below) for MHSA PEI Underserved Ethnic and Language Populations programs in 2010-11, which illustrates ACBHCS’ understanding of the importance of data disaggregation to effectively planning for language and cultural competence needs in Alameda County. The tool made it possible for UELP API PEI providers to collect 38 specific API ethnicities, and 40 specific API languages, many of which would have been buried in poorly-defined, inaccurate and not useful national identities and language groups or aggregated as “API.”

For example, the tool allows providers to distinguish between specific ethnic groups from Burma. Prior to this tool’s development, diverse ethnic groups including Burman, Chin, Kachin, Karen, Karenni, Mon, Rakhaing, Shan, and others were frequently lumped together as “Burmese.” Each of these ethnic groups, however, have their own ethnic language, and many do not speak Burmese (for example, an estimated 50% of Karen, the largest refugee ethnic group from Burma resettled here in recent years, do not speak Burmese). The tool has helped ACBHCSA and its API providers to identify language access gaps and develop strategies that address them. The tool has also made it possible to identify communities specifically that are being reached (and not reached) by the UELP PEI investments made by the County, and will hopefully shape or shift future investments.

One provider report noted that there are unexplored opportunities to find services for some clients who have secondary non-English language abilities: “Some Mongolians receive services through Korean or Russian interpreters, but for most this is not of use. Nepali sometimes are given Hindi speakers. Some Burmese and Cambodian refugees speak some Thai from living in camps there, and receive services through Thai as a last resort.”²¹⁹ Secondary language is not typically collected at intake, so these additional language options often remain invisible to those looking to make a referral.

Ethnicity		Estimate #	Estimate #	Estimate #	
Asian/Pacific Islander	Asian Indian	___	Japanese	___	
	Bangladeshi	___	Kachin	___	
	Bhutanese	___	Karen	___	
	Burman	___	Karenni	___	
	Cambodian/Khmer	___	Khmu	___	
	Cham	___	Korean	___	
	Chin	___	Lao	___	
	Chinese	___	Leu	___	
	Fijian	___	Malaysian	___	
	Filipino	___	Mien	___	
	Chamorro	___	Mon	___	
	Hawaiian Native	___	Mongolian	___	
	Hmong	___	Nepalese	___	
	Indonesian	___	Rakhaing	___	
				Shan	___
				Samoan	___
				Sri Lankan Tamil	___
			Sri Lankan Singhalese	___	
			Tai Dam	___	
			Taiwanese	___	
			Thai	___	
			Tibetan	___	
			Tongan	___	
			Vietnamese	___	
			Other Pacific Islander	___	
			Other South Asian	___	
			Other Southeast Asian	___	
			Other Asian	___	
Caucasian	___		Hispanic/Latino	___	
African American	___		Other Ethnicity	___	
Native American:	American Indian	___	Unknown/Not Rep	___	
	Other Indigenous	___			
				0	

Language		Estimate #	Estimate #	Estimate #	
Bangla	___	Ilocano	___	Nepali	___
Bhutanese-Dzongkh	___	Indonesian	___	Rakhaing	___
Burmese	___	Japanese	___	Samoan	___
Cambodian-Khmer	___	Kachin	___	Shan	___
Chamorro	___	Karen	___	Sri Lankan/Singhalese	___
Chin	___	Karenni	___	Sri Lankan/Tamil	___
Chinese-Cantonese	___	Khmu	___	Tagolog	___
Chinese-Mandarin	___	Korean	___	Tai Dam	___
Chinese-Other	___	Lao	___	Thai	___
English	___	Leu	___	Tibetan	___
Fijian	___	Malay	___	Tongan	___
Hawaiian	___	Mien	___	Urdu	___
Hindi	___	Mon	___	Vietnamese	___
Hmong	___	Mongolian	___	Other	___

To appreciate how pathbreaking the Prevention paperwork is in terms of progress towards greater data disaggregation for API ethnicities and languages, a look at Early Intervention opening paperwork used in the same UELP PEI programs is illuminating.

The form offers a limited list of Primary Languages and Preferred Languages (15 specific API languages) to choose from, and an even more limited Ethnicity/Race list (13 specific API ethnicities). For many API communities, their options are reduced to “Other Non-English,” “Other Asian,” “Other Pacific Islander,” “Other Non-White” (see screenshot below from Alameda County Behavioral Health Care Services Client Registration form used for Early Intervention and Treatment Services openings). 220

3: Primary Language & Preferred Language

A	English	H	Cambodian	O	Italian	V	Mandarin	1	Thai
B	Spanish	I	Sign ASL	P	Mien	W	Portuguese	2	Farsi
C	Chinese Dialect	J	Other Non-English	Q	Hmong	X	Armenian	3	Other Sign
D	Japanese	K	Korean	R	Turkish	Y	Arabic	4	Other Chinese Dialects
E	Filipino Dialect	L	Russian	S	Hebrew	Z	Samoan	5	Ilocano
F	Vietnamese	M	Polish	T	French				
G	Laotian	N	German	U	Cantonese				

4: Ethnicity/Race— Enter up to FIVE codes which best represent the client’s ethnic group(s) as identified by the client.

A	White	G	Laotian	L	Other Non-White	Q	Korean	W	Mien
B	Black	H	Cambodian	M	Unknown	R	Samoan		
C	Native American	I	Japanese	N	Other Southeast Asian	S	Asian Indian		
E	Chinese	J	Filipino	O	Hmong	T	Hawaiian Native		
F	Vietnamese	K	Other Asian	P	Other Pacific Islander	U	Guamanian		

For example, birthplace data is collected using a list that is national identity-oriented, which effectively makes some communities invisible. Tibetans are asked to indicate where they are born (frequently in China, India, or Nepal), and those who were born in occupied Tibet are forced to identify as born in China rather than Tibet. This is deeply offensive to Tibetans who

consider China an occupying government and the reason for their seeking asylum. Other refugees, displaced peoples, and ethnic minorities (in their countries of origin) face similar inabilities to identify their ethnic identities and language needs due to the limitations of this tool. The tool also confuses ethnic identities with national identities, such that someone of Khmu ethnicity from Laos must choose “Laotian,” a national identity. Their language is not an option in the choices list. In summary, the data collected at times hides the most important need and barrier to service access - language.

Recent PEI regulations clarifications and changes will be requiring additional demographic data collection, and ACBHCS is committed currently to only meeting the minimum disaggregation standards required by the State. Nothing prevents ACBHCS from adding to the minimum lists.

Limitations Placed on Services by MediCal and MediCare

Restrictions placed on services by specific funding streams create barriers for APIs needing mental health services: “Current Medi-Cal policies for Adult Level III services have stifled the penetration rate for adult APIs by not including in the range of billable services case management, crisis intervention, and billing for therapy that was conducted through an interpreter. Although mental health providers can pay interpreters, they cannot bill Medi-Cal for their time. Not being able to bill for interpreters is an ineffective policy because it does not consider the needs of clients who do not speak English and for whom trained professionals (MFTs, MFTIs, MSWs, LCSWs, etc.) with necessary language skills are not readily available. Furthermore, consumers with Medi-Care are not permitted to receive mental health services from paraprofessionals or any licensed professional other than an LCSW. For many APIs needing services, this lack of mental health providers with their own language and cultural backgrounds means they will not be able to receive services unless the policy of receiving mental health services through an interpreter and limitations on who is qualified to provide services are revised.”²²² Medi-Cal also will not pay for interpretation as part of a service.²²³

Limited Culturally-Informed Treatment Services Models

Another systems theme that emerged from the community reports review was the limited availability of culturally-informed treatment services models aimed at API communities and clients, and is related to “cultural dissonance between systems and community concepts of mental health.”²²⁴ The 2007 MHSA planning feedback report to ACBHCS noted that “An overarching concern that came up in interviews and focus groups is that the conceptualization, language and structure of mental health in the U.S. are in conflict with the ways that many Asian cultures think about, talk about and address these issues. The language of mental health is completely foreign to some communities, and may be a deterrent for seeking care. Barriers exist in the interaction (or lack of interaction) between systems and community.”²²⁵ The report further observes that “The challenge of cultural dissonance extends beyond the individual interaction with patients and providers and is rooted in the structure of the mental health care delivery system. Participants in interviews and focus groups stated that the medical model, designed primarily around therapy and medication for individuals, is inappropriate for meeting the needs of Asian communities. Furthermore, they stated that the system of treating different family members in separate locations from one another was a barrier to retention.”²²⁶

This gap between mainstream Western treatment models and community culture are reinforced by the trend towards privileging “evidence-based practices” that are largely developed without any inclusion of APIs. One report observed that “Funding sources often require evidence-based interventions proposed and used to treat populations. Utilizing evidence-based treatment models to evaluate success may not be a fair standard to use when assessing interventions with A&PI people, given that nearly all treatment modalities are not

developed with A&PI clients in mind. Our communities would benefit from creating new evidence-based models with A&PI cultural values through practice-based evidence.”²²⁷

Insufficient Investments in API Mental Health Services

“There are a number of reasons for this vast underutilization of services. First and foremost, there is a lack of mental health services for A&PI people in San Francisco. The percentage of mental health dollars going specifically to A&PI communities is shamefully disproportionate to our population size. Without linguistically-appropriate and culturally competent services and care available, it is little wonder that A&PI people are not showing up on the service radar.”²²⁸

Resourcing mental health strategies plays a big role in penetration rates. Research conducted by AAPIP shows that foundation funding to AAPI communities from 1990–2002 amounted to no more than 0.4% of all foundation funding, despite the fact that the AAPI population had doubled in that time frame. While some funders have made efforts to include AAPI communities in their funding portfolios, as of 2012, foundation investments in AAPI communities had dropped to 0.3%. Lack of investment in AAPI communities remains an enduring challenge to philanthropy.²²⁹ The same appears to be the case with ACBHCS funding for API-targeted services. For communities with great diversity and with language access issues, workforce shortages, limited available services, and high levels of stigma such as APIs, underfunding strategies to reach them is surely contributing to low penetration rates, especially when the API category hides so much diversity and requires more complex strategies for stigma reduction, workforce development and cultural strategies for service provision.

Community reports reveal issues with perceptions that investments are concentrated mostly in large API organizations but not ethnic-specific programs, leading to issues with sustainability for smaller organizations, and inconsistent, unreliable services.²³⁰ Reports revealed the struggles faced by many smaller API CBOs due to the recession, including significant loss of funding and merger with larger organizations.

Larger organizations funded by ACBHCS have worked to support smaller ethnic CBOs, including ACMHS²³¹ for its UELP partners, and CHAA for ethnic organizations including ACHA, Bhutanese Community of California, Burma Refugee Family Network, Tibetan Association of Northern California, as well as CERI, KCCEB and FAJ successfully through partnering in Round 3 Innovations. These partnerships are critical for larger API organizations as the smaller ethnic organizations have direct access to their communities, and critical for financially challenged smaller organizations. However with limited resources, these partnerships are often difficult to manage as there is no or limited concrete incentive for the smaller organizations to collaborate without funding, and often strained relationships due to the perception of inequitable distribution of resources.

Lack of Specific Services for APIs. In addition to underinvestment in API-specific services generally, there are specific programmatic gaps that impact API communities. For example, one report noted that “There is a lack of AOD treatment resources for young adult Asians,”²³² especially those who are mandated to access such services such as those referred by juvenile probation and by courts for DUIs, for example, and who are LEP. Another report noted that “Among children and youth, the group most often cited as having unmet need are children whose parents are recent immigrants and speak a primary language other than English. In school-based settings without multiple language capacities, it is often difficult to communicate with the parents in a timely way to obtain consent for their child to receive mental health counseling. Furthermore, immigrant parents are often busy working in order to meet the family’s survival needs and have limited flexibility to focus on their children’s mental health needs.”²³³ Other gaps in services include a lack of mental health services for diverse API adults and older adults,²³⁴ domestic violence services for both API survivors and perpetrators,²³⁵ programs to address problem gambling for APIs,²³⁶ and limited direct investments in stigma

reduction targeting API communities. We include other examples based on community report recommendations in Sections 3 and 4.

Limited Investment in Services Targeting Newcomer Refugees and Asylees.

Several reports highlighted that while refugees and asylees are a relatively small population entering the County annually, they are a high-need population that challenges local systems' capacities due to the fast pace of connecting them to benefits and services imposed by Federal resettlement policy: "Within 90 days of arrival at their place of resettlement in the United States, all refugees are required to complete a Refugee Health Assessment, inclusive of health history, comprehensive screening, two medical appointments and laboratory testing."²³⁷ With regards to behavioral health, the report observed that "Often due to deferred health care and to past histories of poor nutrition, poverty, stress and trauma, refugees and asylees exhibit high rates of medical concerns such as chronic viral hepatitis, hypertension, iron deficiency, anemia, external ear disorders, diabetes and dental caries."²³⁹

"Mental health conditions are also disproportionately common among refugees and asylees, often derived from prior experiences of torture, conflict and displacement."²⁴⁰ The report observed that "There are many high-quality and culturally-competent services available; but in the absence of effective coordination and communication, refugees and asylees – lacking familiarity with U.S. service delivery systems -- fail to access care and providers lack the patient and provider information they need to guide them."²⁴¹ While RHS (Refugee Health Screening) is only providing supports for newcomer refugees and asylees in the early months post-arrival, and they do try to connect them to ongoing primary care, this report finds that "Refugees' and asylees' mental health needs go unrecognized and untreated....the County's RHS [Refugee Health Screening] process has little capacity to delve into perceived cases of trauma and emotional need: RHS staff and interpreters do not have specialized knowledge of mental health, behavioral health clinicians are not immediately available on-site, and referral mechanisms are not in place to facilitate warm hand-offs to County or community-based providers."²⁴³

As the report indicates, "Evidence from Alameda and other counties suggests that RHS may not be the most comfortable setting for refugees to divulge and discuss their mental health needs, though models exist in other regions that successfully identify and address these needs upon initial screening."²⁴⁴ What also seems to be clear is that RHS is not referring refugees and asylees who need ongoing behavioral health care to community-based providers consistently or effectively. Although it isn't clear why this may be the case, we believe that the combination of not knowing where services for specific languages and cultures are elsewhere in the system, lack of providers in the behavioral health workforce for specific communities, and perhaps giving up after unsuccessful referral attempts for specific clients or communities has meant that most refugees with behavioral health needs aren't seen early on.

Several organizations locally have tried to establish refugee/asylee-specific mental health programs, including Center for Empowering Refugees and Immigrants (CERI), International Rescue Committee of Northern California (IRC),²⁴⁵ Multilingual Counseling, and most recently Partnerships for Trauma Recovery. IRC received an MHSA Innovations grant (Round 3) for a Refugee Wellness Navigators pilot project, but has been unable to sustain the work begun through this project. However, this program's leadership helped establish the new Partnerships for Trauma Recovery organization and is building a refugee/asylee-specific mental health program building on the model piloted by IRC, but currently isn't receiving any funding from ACBHCS. Multilingual Counseling has focused on providing mental health services to primarily Latinos and Farsi-speaking clients from Afghanistan and Iran, but does not receive any funding from ACBHCS. CERI provides mental health services for primarily Cambodian refugee adult survivors of the Khmer Rouge genocide and their families, including a girls' youth group. CERI receives MHSA PEI funding from ACBHCS for these services. Additionally, several ACBHCS-funded MHSA PEI UELP projects worked with refugees and asylees through projects

that were focused on API populations, including ACMHS, CHAA, Hume Center, and Afghan Coalition.

With the recognition that there may be benefits to, and networks in place already for, shifting some resources towards a refugee and asylee experiential frame for some investments, this might help address low penetration rates for the newest API communities in Alameda County by meeting them early on and in places they already receive other types of supports, rather than waiting until they find API organizations and programs on their own or through a crisis later.²⁴⁶

“Model Minority” Myth

“Asian Americans are often considered the ‘Model Minority’ in the United States: hardworking, 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.”²⁴⁷

“Mental health among AAs and NHPs has been difficult to assess due to the combination of the model minority myth, the underrepresentation of AAs and NHPs in epidemiological studies, the lack of disaggregated data, the conceptualization of physical and mental health as one, the immigrant and refugee transitions, and the role of racial discrimination.”²⁴⁸

Multiple reports referenced continuing stereotypes that APIs, as a group, have better outcomes (health, mental health, education, juvenile and adult justice, socio-economic, etc.) than other populations - the “Model Minority” myth - as contributing to continuing disparities in resources and investments directed to address their needs and issues. Several reports pointed to the issue of aggregating all APIs into a single category and how this has hidden significant issues for API communities that have poor outcomes when examined on their own:

“While the statistics do show that taken together, Asian Americans have the highest educational attainment and the highest median family income of all ethnic groups, a closer look reveals that the model minority myth is highly inaccurate. Although it is true that some segments of the Asian American community have achieved levels above the country’s average, other segments have some of the lowest incomes and educational levels in the country”²⁴⁹

With regard to mental health issues, needs and outcomes, reports shared issues that become evident once data is disaggregated, such as high rates of suicide for Asian American females over age 65 (the highest rate for any racial group) and between ages 15-24 (ranked second for all racial groups),²⁵⁰ high rates of use of hospital-based crisis stabilization services versus pre-crisis services for API children,²⁵¹ the highest rate of API adult depressive disorders (20%) and second highest rate of anxiety disorders (15.7%) of any racial group,²⁵² and higher than average prevalence rates for Pacific Islanders,²⁵³ for example. As another report noted, even when educators stereotype Southeast Asian students, particularly Cambodian and Laotian, as “gangsters,” “at risk,” or simply as possessing limited capability because of the clothes that they wear, the music that they enjoy, and their manner of speech, etc., because they are API their needs are often ignored or minimized. “Chronic truancy and dropping out (or perhaps more appropriately termed, “being pushed out”) are the frequent outcomes of systemic neglect”²⁵⁴

Reports tend to agree that there are specific communities that are disproportionately impacted by “being unseen” due to the “model minority” stereotype, especially the economically

vulnerable communities of Southeast Asians who came to the US as refugees in the 1980s-90s,²⁵⁵ LEP API students,²⁵⁶ Native Hawaiian and Pacific Islanders,²⁵⁷ API isolated and older adults,²⁵⁸ API youth,²⁵⁹ Koreans,²⁶⁰ and new and small API communities such as those discussed above.

Silos and Lack of Coordination between Systems

Reports shared barriers created by siloed systems (school districts, probation, social services, health services, behavioral health services, adult justice system, etc.) as a theme that impacts APIs.

“Community feedback has identified a need for clearer structures and processes for addressing issues that arise in the provision of services and a higher degree of coordination. Currently, service provider contracts have no requirements that they include working with any advisory body as part of their work plan. There are no incentives or mandates for providers to share program goals or service data as part of a larger system of services. This has resulted in providers operating their individual programs in silos, making it difficult to address complex issues that affect both the service and systems levels.”²⁶¹

CBO staff funded through Alameda County Social Services Agency and ACBHCS' UELP programs “are consistently asked to provide services outside of their scopes of work, including providing interpretation for clients across multiple systems. Some CBO and ethnic community-based organization staff try to address issues that are outside their area of expertise;” “organizations funded by ACBHCS for MHSA Prevention and Early Intervention work are often called upon to provide interpretation at schools, hospitals and social services due to inadequate language access and service navigation resources for LEP clients from many communities who do not meet threshold language numbers. For example, many immigrants and refugees report that Social Services Agency (SSA) lacks the linguistic capacity to communicate with people who speak language of lesser dispersion either in person or telephonically in many cases.”^{262 263}

UELTP providers and SSA-funded Social Adjustment Counselors for newcomer clients also are called to support clients in health settings and in schools due to a lack or limited number of interpreters for clients from newer and less common language groups.²⁶⁴ With regard to refugee-specific services, another report presenting recommendations to Alameda County Social Services Agency in preparation for the 2014-17 Refugee Plan observes that “Behavioral Health Care Services also funds several Prevention and Early Intervention programs (over \$1m annually) that reach or could reach refugee and asylee populations resettling in Alameda County. These programs and issues related to the provision of mental health treatment services (lack of trained professional mental health workforce with linguistic and cultural backgrounds from relevant refugee communities, and a consequent paucity of treatment services for refugees who merit this level of care, etc.) are poorly understood and not well integrated with the overall refugee supports and services environment.”²⁶⁵

Adult APIs receiving Level III MediCal mental health services are provided limited case management as part of their mental health treatment plans²⁶⁶ and often have case managers in non-mental health organizations (sometimes several). While these workers do their best to meet the overwhelming needs of community members, it was noted that “such workers themselves may be new arrivals with incomplete information sets and in need of essential training and guidance on how to best resolve issues as they crop up.”²⁶⁷

For newcomer API immigrants and refugees served by ACBHCS' UELP programs, the combination of limited providers, needs in multiple domains and fragmented and siloed systems means that their UELP providers spend a large amount of their time helping clients with basic

needs across multiple systems and spend less time on mental health support in a more formal sense. As noted in Section 1, concrete challenges and needs have significant impacts on API immigrants and refugees, so it is no surprise that community mental health providers are often pulled in to provide supports related to these needs as part of their work. In this regard, ACBHCS' investment in API services through UELP projects has provided communities with unmet needs with a door through which to access mental health supports. But as stated above, there is still much work to do in terms of building the skills and sensibilities of UELP providers - especially paraprofessionals - so that these programs mature in terms of framing concrete support in a mental health-forward direction. We discuss what this may look like in more detail in Section 3 in relation to workforce development and support for community mental health workers.

There is evidence that efforts are being made to address poor cross-system coordination impacting immigrants and refugees, including APIs,²⁶⁸ in Alameda County. In 2013-14, Alameda County Health Care Services and the East Bay Refugee Forum convened several task forces to examine, problem solve, identify and prioritize strategies, and develop recommendations for improving health and behavioral health access for refugees and asylees, and ACBHCS and several of its API-serving providers participated in these conversations and in developing a report.²⁶⁹ In 2015, another such effort - the Building Home Together collaborative - which began as an advocacy group for establishing a Newcomer Immigrant and Refugee Welcome Center in Alameda County,²⁷⁰ evolved to a broader advocacy role, including asking Alameda County to sanction a planning process to review and update the County's strategies and priorities with respect to supporting immigrants, refugees and foreign born residents. This group has advocated for exploring not only a Newcomer Immigrant and Refugee Welcome Center to help with coordination of services and supports, but also for the establishment of an Office of Immigrant and Refugee Affairs housed in the County similar to offices established already in neighboring counties. Building Home Together also successfully advocated for a Welcoming County Resolution which was passed by Alameda County's Board of Supervisors in September 2016. What these efforts share in common is the recognition of the need for County systems, community-based providers and newcomer communities to work together to de-silo resources and services, and align strategies to improve outcomes - including behavioral health outcomes - for immigrant and refugee communities, including APIs.

It should also be noted that their recommendations come from significant community, community-based provider, and systems leadership stakeholder feedback, and as such should be seen as quality places to start for recommendations on how to address issues related to mental health service utilization for APIs and other immigrants and refugees in that they bring together the experiences of consumers, service providers and those who understand the limitations and possibilities of the structures and funding streams that are currently in place. We recommend that ACBHCS take advantage of the insights and recommendations of these two recent efforts in addressing API mental health utilization issues moving forward.

Section 3: Promising Cultural Practices/Approaches/Models for Connecting APIs to Mental Health Services, including Cultural/Community Strengths and Assets

The Importance of Social Support Networks to Mental Health Outcomes

Research has long shown the positive relationships between the amount and density of social support and positive health and mental health outcomes for immigrant and refugee communities, with much research in this area during the post-Vietnam War Southeast Asian refugee resettlement of the 1980s-90s. This research demonstrated "the relationship between

social support and economic self-sufficiency among refugees,” and the impacts social support networks have in serving “as a source of emotional and moral support, physical care and nurturance, information and advice, and tangible aid such as food, money, employment, clothing and shelter.”²⁷¹ Conversely, the loss of social support and social isolation has been related to the incidence of many health problems, including mental illness. Social support seems to act as a buffering mechanism in coping with negative life events and stressors.²⁷² For newer and smaller communities with fewer indigenous supports or less time in the U.S. to restore or build supports common to their cultures, risks for mental health issues in the community are higher. For newcomer refugees and asylees who arrive in the US with significant traumas, the risks are higher still.

The reports we reviewed also noted the important role of community support and connection to API wellbeing. Indeed, community-level social support is often the first and main form of help-seeking for APIs.²⁷³ For example, the California Reducing Disparities Project API Strategic Planning Work Group noted that “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.”²⁷⁴ Specific examples from community reports included the following: for Himalayan women surveyed in a community needs assessment in 2015, the top sources of help were partners (60%); friends (42%); sisters (26%) and co-workers (19%).²⁷⁵ Top sources for stress relief were time with family/friends (54%); TV/movies (42%); Internet (35%); exercise (27%); and cooking (27%).²⁷⁶ The Korean Needs Assessment observed that “Our survey also shows that more than half of Koreans form networks through Korean faith institutions, and gain health information through the internet (51%), friends and relatives (29%), primary care physician’s offices (27%), ethnic newspapers (26%), and television (22%).”²⁷⁷ For Pacific Islanders, “Current ways of finding info: Word of Mouth.”²⁷⁸

Community/Culture Strengths and Assets

We reviewed community and CBO reports for community strengths and assets identified, especially as these impacted, or could be leveraged to address, mental health outcomes and access issues and barriers.

Resilience

“Sometimes, I feel unlucky to be a refugee, but I am also fortunate because I learned how to not give up.”

“I want to become a social worker so I can help others feel safe, unlike how I felt growing up. In this country, many things are possible, and I have acquired hope. I want to be a leader and help the community.”

-Pujan & Sharpchana Mapchan, sisters, Bhutanese refugees, and Gates Millenium Scholars planning to attend Notre Dame University in Fall 2012²⁷⁹

A common theme in the reports we reviewed was the resilience of APIs despite their difficult, often traumatic, histories and the many challenges and barriers they face in addressing their overall health and wellbeing. “It was noted that Asian immigrants have tremendous resilience to survive traumatic situations, leave their homelands and find ways to fit into and function in a new culture and social hierarchy. For example, participants in the Burmese group described having their villages burned down, miserable lives in refugee camps with no future.”²⁸⁰ Examples of this resilience included connection to cultural traditions,²⁸¹ friendship support groups,²⁸² community leaders,²⁸³ skills brought from their home countries,²⁸⁴ ²⁸⁵ and clear desires to work on building strong communities.²⁸⁶ Even in parts of API communities that find themselves outside of typical supports of family and faith community, intentional support

systems are built around shared circumstances and identities, and evidence resilience: “For those PIs who do not have biological family support or support from PI church’s, they create new families with other PIs and non-PI allies who are not related to them biologically. An example of this is gay, queer and lesbian PIs who are not accepted by churches and don’t come out to their families. These PIs create support groups like OLO, One Love Oceania, a PI queer women’s group and UTOPIA, a predominantly PI gay men’s group. Another example is the participation of Pacific Islander youth in creative projects like Youth Speaks, an organization that encourages youth expression through poetry.”²⁸⁷

Faith Organizations and Leaders

Faith communities are identified as important institutions for APIs, often as important as family. Faith-based and community leaders play a vital role in trust building within various API communities as well as providing psychological and spiritual healing for their communities.²⁸⁸ Faith leadership buy-in is key to successful delivery of mental health services in some segments of the community, especially seniors. Pastors, priests or monks can help encourage individuals to seek mental health services.²⁸⁹

“Through connecting with these leaders, we are able to communicate and establish rapport with community members. Faith-based and community leaders are the gate keepers for many community. They are trusted by community member for support and guidance.”²⁹⁰

Some specific examples of communities with strong roots in their faith community include a focus group with Pacific Islanders where it was observed that “The Pacific Islander church is a family structure outside the private family home. The church includes extended relatives and new PI immigrants from the homeland.”²⁹¹ Other communities where faith communities were identified as important resources and centers of community life include Koreans,²⁹² Thai,²⁹³ and Vietnamese.²⁹⁴

Faith communities and leaders may need additional support and skills development for successful partnerships with mental health service providers:

“...faith based and community leaders may lack the skills or knowledge to understand mental health needs of community and sometimes struggle with their own biased views and stigma of mental health. Through collaboration with APIC, we are hoping to help support community leaders to be actively involved in obtaining mental health education and awareness, help mobilize community members through community advocacy and engagement to reduce stigma and better support community members in seeking mental health services.”²⁹⁵

Strong Family Structure, Culture and Values

Family - whether actual kin or by cultural extension - was also a common theme and source of strength in the reports we reviewed. For Pacific Islanders, for example, “The family is the most important and frequently used support for Pacific Islanders when they are faced with mental health issues. The Pacific Islander family is not limited to the nuclear family but includes extended relatives, in-laws, and friends, who younger Pacific Islanders call “bros” and “sis.”²⁹⁶ According to a survey of Pacific Islander adults, half of survey respondents identified that they would seek out family members for resources (e.g., emergency cash, translations, advice), while the rest identified their churches and faiths (43.9%) and friends (6.1%).²⁹⁷ Additionally, among many Asian immigrants, the multi-generational extended family unit functions to provide support in the areas of childcare, elder care and the care of mentally, physically and developmentally disabled.²⁹⁸

There is also a commonly expressed view of how older community members see their future hopes in their children. An example from the Burma refugee community: ‘As one mother stated: “Right now I just want my children to go to school. It’s up to them to pick what they want to be after they grow up. I just want them to go to school and after they can have the choice be a teacher or entrepreneur as well as take care of me. I hope my children can take care of my husband and me in the future.”²⁹⁹ An example from the Mongolian community: “We feel well when our kids do good like going to college because they are our future and we are here for them.”³⁰⁰

One report noted that “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,” and offered several examples for how to leverage family through programming, including after-school programs that introduce families to mental health services in the frame of valuing educational attainment, parenting classes framed in the context protecting and valuing the integrity of families. This report also cited parents from the Cambodian and Tongan communities expressing interest in after-school opportunities for their children and for opportunities to “do their part” to promote their children’s health and wellness.”³⁰¹

Friendship Networks

Friends were identified as important sources of information and social support,³⁰² especially for those communities that lack formal organizations, for youth,³⁰³ and for parts of the community that don’t receive support through faith and family due to discomfort and/or marginalization within their own communities, such as queer community members³⁰⁴ and women.³⁰⁵ We highlight some examples of where mental health organizations have leveraged friendship networks in designing mental health programs and services later in this Section.

Community Leaders, Volunteerism, Community Self-Help and Sources of Information

API communities show a high degree of volunteerism, often in support of community needs. As one community report noted, “there are volunteers who help the community and would be able to help the community more effectively if they received training on understanding the MH system.”³⁰⁶ Several reports indicate that working with community leaders is an effective strategy in linking community members to behavioral health supports.³⁰⁷ In communities (or parts of communities such as seniors) with low-literacy - both in native languages and in English - community volunteers and relatives play a vital role in disseminating information about available services, and when approaching community leaders is not socially appropriate due to status expectations. In these communities, traditional outreach via flyers, newspaper advertisements and other forms of printed media are limited in their effectiveness, with most information passed by word of mouth.³⁰⁸ Reports also highlighted communities utilizing several sources of information that can be leveraged for sharing information, providing education, and promoting mental health, including the internet, newspapers, television, library and community locations such as churches and temples where communities gather on a regular basis.^{309 310}

Ethnic and Other Community-Based Organizations

Community reports identified that ethnic and other community-based organizations are seen as assets, especially for newer and smaller communities who have had less time to establish social supports. Ethnic and other Community-Based Organizations were recognized as providing an array of resources to the community that contribute to community mental health outcomes, including English as a Second Language classes, citizenship, SSI applications, socialization, housing, job training, legal assistance, arts and culture, after school programs applications.

Mental health organizations have benefited from connecting with these centers and community leaders to do outreach and promote inter-agency referrals. As more trust is developed with these mental health organizations, community members begin to come on their own, even with highly stigmatized concerns.³¹²

Trusted Community Providers

Many individuals suggested that having a community advocate from their community would help their community members better access the mental health system. These advocates are most often someone with whom the community has already developed a trusting relationship. One Southeast Asian community leader suggested “Find a key community person to help outreach with community, otherwise very challenging to bring people to come seek services on their own.”³¹³ These community advocates are already often influential individuals in their communities, have had previous similar experiences/challenges in accessing the system, are conversant in English and knowledgeable or able to learn about the various systems and solutions to resolve systems problems, are good listeners and supporters.³¹⁴ These individuals have the role of disseminating informational resources to the community, linking needed resources and supports to the communities, as well as helping organizations to develop culturally resonant programs, identifying the best messages and strategies for community outreach. In addition to serving as liaisons, paraprofessional community mental health advocates also support their communities to find self-directed forms of change and empowerment.³¹⁵

The amount of social capital that these community advocates have should not be underestimated or diminished by biased perceptions that they are not “professionals.” Community groups assert that maintaining and sustaining relationships with the communities through these advocates is key to effective programs in API populations.³¹⁶ Without this buy-in from communities, even well-intentioned, well-funded programs can fail. Trust of an individual often translates into eventual trust of an organization. Mental health workers become the proxy for their organization. If trust can be built with a community worker, then trust may be possible with the organization. The reputation of the organization is held in the community worker’s name.³¹⁷ One individual from the Pacific Islander community noted:

“When the kids walked in and see PI staff, the kids cool off and ask us to be their counselors. When you trust the people you trust the agency. I light up when I see a familiar face.”³¹⁸

Thus, in order to connect with API communities, mental health service providers may seek to first hire community mental health workers who can be trusted in the community and maintain high integrity and ethics.

Promising Practices, Approaches and Models

Models for Stigma Reduction

“We are afraid of ourselves and our illnesses sometimes. I don’t even know how I will react myself, and what my next step will be.”

“If (even) my own children won’t accept me (my mental health challenges), how will outsiders?”³¹⁹

Stigma, shame and fear are powerful social motivators that prevent APIs from disclosing mental health challenges, engaging in social interaction with others, and seeking help. The

following are three models that address stigma issues in API communities at a program level, structural level and societal level. We highlight strategies that predominantly seek to reach a newcomer audience, communities that have greater barriers with regard to language, knowledge of systems and stigma. When we intentionally target the most marginalized, hard-to-reach communities, we are often simultaneously able to reach those with less barriers (i.e., English-speaking, U.S. born).

Social Inclusion Campaign—Chinese Americans³²⁰

Funded by Alameda County Behavioral Health Care Services/Mental Health Services Act

This program was designed specifically to help **reduce internalized stigma** for first-generation Chinese Americans with mental illness. The curriculum focused on: a) reducing internalized stigma; and b) improving social support with a special focus on restoring “face,” a cultural phenomenon where an individual’s sense of self is connected to their social standing in the community.³²¹

A 14-session intervention was led by a mental health provider and two consumers. A total of three groups were conducted (two Chinese-speaking groups and one English-speaking group). Sessions included 5 sessions focused on behavioral skills to cope with discrimination, 5 cognitive behavioral sessions to resist internalized stigma and 4 sessions focused on a collective group activity to promote socialization. Before the first meeting there was a 45-minute stigma assessment led by a P.E.E.R.S.’ Chinese liaison.

The role of trust building. A major finding was the importance of the initial 45-minute stigma assessment where the P.E.E.R.S. liaison was able to build a foundation of trust with the group members. She was key to many of the group members’ continued participation throughout the intervention. Even with this careful attention at trust building, four of 11 members dropped out before the first meeting due to confidentiality concerns.

This intervention showed preliminary success. Participants reported lower self-esteem decrement. With increased self-esteem, individuals were able to engage once again in their social circles including increased connection with others and seven of 13 individuals were able to begin volunteering, gain part-time or full-time employment. Two group members were even able to finally disclose their mental health status to others.

Broadening Access with UELP Programs

“A culturally and linguistically responsive prevention and early intervention service such as API Connections is invaluable to underserved Asian immigrants, many of whom are suffering from mild to moderate mental health symptoms such as anxiety, depression, PTSD due to historical trauma, acculturation issues, lack of resources and language barriers. It has helped prevent escalation to crisis and hospitalization.”³²²

The flexibility of the UELP Program has **broadened the point of entry** for mental health service access. No longer do individuals have to have a specific mental health diagnosis and health insurance and be told they must see a certain mental health professional in a sit-down 50 minute session each week.

UEL P projects intentionally offer wellness education workshops that reframe mental illnesses from a clinical frame that provides services only people with mental health diagnoses to a community mental health framework where mental health supports are provided to all those who experience mental health challenges and life stressors. At many of the organizations with UELP projects, like ACMHS, staff job titles are “Community Wellness Coordinator” or “Community Wellness Advocate.” These titles allow for supporting communities in a variety of

ways to live a healthy life where mental health is seen as an integral part to a person's well-being.³²³

The following are ways that organizations have provided non-stigmatizing mental health supports at a structural level to increase access to mental health services:³²⁴

- **No charge:** UELP providers offer their events, workshops and support groups free of charge; this is in contrast to HMO mental health providers who charge for services. There is no financial barrier or any eligibility requirements for PEI projects. Access is truly open to all, irrespective of insurance status, immigration status and ability to pay.
- **Broader access through community sites:** The UELP Program has allowed screening and early intervention services to be in other community-based locations including:
 - **Primary Care Settings** (ACMHS and AHS (Asian Health Services) had a three-year SAMHSA grant focused on primary health care integration for severely mentally ill patients; Cambodian patient support groups at AHS; John George and Highland Hospital also sometimes refer patients who have entered the hospital for psychiatric problems)
 - **Youth Development Organizations** (early intervention services at AYPAL/the Spot; workshops on mental health and bullying at the youth Afghan Soccer Club)
 - **Schools** (Community Wellness Coordinators in collaboration with EBAYC and OASES at OUSD elementary and high schools; Irvington high school (Fremont); Logan high school (Union City); St. Bede (Hayward); providing consultation to staff, screening and early intervention to students and social skills groups; Oakland International High School where newcomer youth attend high school)
 - **Community organizations** (early intervention with Filipino Advocates for Justice and Korean Community Center of the East Bay; referrals and collaboration with South Asian domestic violence clients with Narika, Maitri and API Legal Outreach; wellness workshops and early intervention referrals with Vietnamese American Community Center of the East Bay)
 - **Faith-based Organizations** (conducting outreach, holding psychoeducational classes and resource sharing at temples, gurdwaras and churches on festivals and religious holidays)
 - **Criminal justice system** (clients are referred from the courts or probation when there is domestic violence, DUIs (driving under the influence) or other behavioral health concerns)
 - **Libraries** (offering workshops on parenting, children's developmental stages, communication skills, mental disorders at Fremont and Union City libraries)
 - **Outside county** (for many communities, UELP providers are one of the only in-language service providers in the entire Bay Area. Therefore, individuals and agencies reach across County lines to find desperately needed services. These neighboring counties include but are not limited to Contra Costa, Sacramento, San Mateo, San Francisco, and Santa Clara).
- **Basic needs:** Many APIs seek support on basic needs (e.g., housing, financial, medical issues, transportation, school) before prioritizing mental health issues (see Section 1 of this report). The flexibility of the UELP Program allows organizations to assist with client basic needs while at the same time addressing mental health distress. They share how stress can impact other physical and emotional symptoms including fatigue, low energy level, feeling low/down, and flashbacks due to prior trauma.

Community Events and cultural festivals: Cultural events are one method of outreaching to the general community in a non-stigmatizing way. Seeing community mental health workers integrated into the community shows communities that there are individuals who care for them and who are accessible and approachable.³²⁵ Afghan Coalition had a Ramadan Kick-Off event.³²⁶ A total of 50 youth and their families were in attendance. Activities included team building, games that introduced mental health concepts for youth (e.g., bullying) and sharing the services of the organization. The event was successfully able to bring youth and their families to build community in a fun way, learn about wellness and find new community resources.

Media/Social Media

Through UELP, some organizations have engaged in stigma-reduction work via influencing society through local media. Media strategies can be used both for immigrants and Asian Americans alike and are useful in educating API communities about general mental health topics as well as outreaching to individuals not already connected with the mental health system but who may be looking for mental health support.

- **Ethnic language newspaper articles:** ACMHS published psychoeducational articles on “stress management,” “healthy relationships” and “positive parenting” in local Asian print outlets in Japanese, Khmer and Vietnamese. After the publication of each article, the organization received calls from Japanese, Khmer and Vietnamese speakers.³²⁷
- **Internet/app:** ACBHCS has invested in the development of an online API-focused resource directory - APIHealthSource.com - through UELP projects at CHAA and ACMHS. The structure, user experience and functionality have been user tested twice, but without resources for content development and platform support, it has not been effectively launched. Moreover, this tool is in English only.³²⁸

Chatting apps (e.g., WeChat, Kakao Talk) are commonly used within API immigrant and refugee communities to communicate in groups regionally, nationally and internationally. Tibetan mothers (CHAA) and Chinese mental health consumers (NAMI) use WeChat for peer support, parenting education and information sharing.³²⁹ ACBHCS has also recently invested in an Innovations project with KCCEB for content development of mental health messages for the Kakao Talk app.
- **“It’s OK” Facebook campaign:** In May 2013, ACMHS-APIC was one of the organizations participating in a campaign to promote mental health awareness among the Asian community. The campaign created an online forum for APIs to share about their mental health challenges and recovery stories. The campaign’s goal was to increase the positive perception of seeking mental health support and reduce isolation for APIs with mental health challenges.³³⁰
- **Popular Culture:** ACMHS supported Kristina Wong’s solo performance, “Wong Flew Over the Cuckoo’s Nest,” exploring through theater Asian American women’s mental health issues, including suicide. This was a great way to reach young adult audiences who have a strong Asian American identity and open dialogue about the taboo topic of suicide.³³¹

Models to Address Language Access Challenges

To address language access issues, an effective mental health service delivery model for multilingual newcomers must include a well-coordinated system that includes community paraprofessional workers, multilingual interpreters, and therapists who are adept at working

both with paraprofessionals and interpreters. The County must: 1) see the importance of all three roles in immigrant/refugee mental health; 2) contribute to funding the development of paraprofessional and interpreter workforce pipelines; and 3) fund this workforce at salaries that are sustainable and demonstrate commitment to these communities.

Paraprofessional mental health workers

Funded by UELP

“When she saw other refugees Burma coming who faced similar issues and needed assistance, Su Lay became very involved with her community. She began accompanying people to their appointments and helping to interpret.

‘When I came here, I had lots of needs. It was really difficult for us to get into the system. When people came after us, who don’t speak English, they really needed some help. We went with them everywhere. They didn’t have translators.

We took lots of people to social services or hospitals. When we asked for translators, they yelled at us! It was lots of struggle. They don’t understand our culture, our background.’”³³²

Through the UELP Programs, organizations have been able to reach un- and underserved communities ³³³ through diversifying available staff. For more established API communities who have a longer history in the Bay Area, agencies have been able to hire trained mental health professionals. However, for newer communities with limited trained workforce, organizations have developed models where paraprofessional community mental health staff provide community outreach and early intervention services. While these programs are not a substitute for mental health treatment, these programs and services are often the only ones accessible to individuals from communities with no trained mental health professionals.³³⁴

Paraprofessionals have a particularly important role in that they serve as the liaison between their ethnic community and the organization/system. This paraprofessional often serves as the community’s advocate, building deep, meaningful relationships with families and leaders in a community and are the point person for community concerns, not limited to migration, resettlement, cultural adjustment, and systems and resource navigation. There is a deep trust in these community advocates.³³⁵ For UELP providers, these cultural wellness advocates integrate and weave mental health concepts into culturally acceptable frameworks for clients and work with individuals to learn self-care and self-empowerment strategies to cope with stress and mental health challenges. All UELP providers gave examples of paraprofessionals, whether they were navigators, peer supporters or advocates. At the Afghan Coalition, they share:

‘The program worked with a client this year that came to the program seeking social services. She had little understanding of mental health issues and was very uncomfortable talking about the topic. Using this “current problem” approach she began to share with us her situation. She lived in a one bedroom with her adult daughter and husband. It was clear through her sharing that she was depressed and the look of hopelessness on her face was evident. She would often cry in the sessions with the navigator and would say she wants to return back to Afghanistan because she can’t see her situation improving. During her time with the program she learned that mental health is not about being “crazy”. She learned how much her current situation was affecting her mental health. She learned about self-care and problem solving through these “everyday conversations.’”³³⁶

Two major challenges in working with paraprofessionals focus on structural issues of professionalizing the role of community workers including offering formal training or certification for their work and integrating the mental health paraprofessional into the mental health services model so that they are adequately compensated and valued for their role by the mental health system.

Paraprofessionals need adequate support and should be empowered for their expertise in working with their communities. However, it is key for employers and paraprofessionals to be educated on the role and limitations of a community mental health worker and find ways to support the mental health issues that clients often bring with them.³³⁷ There are currently very few mental health paraprofessional training models.³³⁸ In addition to formal training, organizations should provide supervision and clinical consultation for paraprofessionals, especially for times when concerns rise above merely information sharing.³³⁹ Paraprofessionals also are continually interested in gaining more resources and understanding the systems that impact their communities, especially for community members who do not have insurance or are undocumented.³⁴⁰

A serious concern raised by UELP providers was that paraprofessionals were part-time staff (usually less than .5FTE). In this limited time, paraprofessionals are asked to work with high need clients (oftentimes the paraprofessional is one of few in-language supports available in the entire county for their community), complete County paperwork, meet with their supervisor and have staff meetings.³⁴¹

With a formalized role in the mental health service delivery system, the paraprofessional model can be key for making linkages to new API immigrant and refugee communities and for providing community mental health prevention and early intervention services to communities who are weary of seeking mental health support. A stronger link needs to be made so that paraprofessionals can connect their clients to therapists who, with interpreter support, can work with clients of higher mental health needs.

*Mental Health Interpreter Training*³⁴²

Funded by Alameda County Behavioral Health Care Services

A therapist model that includes interpretation is necessary for underserved newcomer communities where there are limited, if any, professional mental health counselors. Within API communities, there are master's level therapists within County-funded agencies for only the Cantonese, Dari, Farsi, Hindi, Japanese, Khmer, Korean, Lao, Mandarin, Punjabi, Tagalog, Tamil, Thai, Urdu and Vietnamese speaking populations.³⁴³ Moreover, the number of therapists representing each of these language groups is usually less than 5 and must serve the entire county. The need for interpreters is great, especially for communities not represented in this list, many of which have been here less 10 years and have migrated to the U.S. with moderate to severe levels of trauma.

While there have been a growing number of health interpreter certificate programs in the Bay Area, this is one of the only mental health interpreter training models in Alameda County.³⁴⁴ This pilot training was developed to build a growing pipeline for mental health interpreters in under and unserved language groups. The intention for this project was also to pay these trained interpreters (through ACBHCS) to provide on-call interpretation services in mental health services with CHAA therapists stationed at CERI.³⁴⁵

The model included: exploration of roles and best practices for interpreters and therapists in mental health services (including the challenge of dual roles that individuals often encounter as interpreter/advocate/case manager), discussion of professional boundaries including distinguishing the role of interpreter and therapist, and exploring how to do therapy with an interpreter in the room.

The two-day training was aimed at multilingual paraprofessionals interested in working as interpreters in mental health settings, as well as clinicians³⁴⁶ who expressed interest in learning about how to work in an interpretation-supported model. This program successfully recruited 33 participants from 20 communities who spoke 22 languages.³⁴⁷ Participants' response to the training was overwhelmingly positive, with feedback that it was a particularly unique training because it brought together providers and paraprofessionals to learn fundamentals of interpretation in the same room. Participants also left challenging their own biases around mental illness.

One of the greatest lessons learned from the perspective of the trainers was that interpretation must be seen as a profession, in and of itself. One recommendation for onboarding mental health interpreters is to support these interpreters in first obtaining basic interpretation training (e.g., CCSF certificate course) with an additional *mental health specialty* education including continuing education.³⁴⁸ This type of professionalization will build infrastructure for mental health interpreters to be an integrated part of the mental health model.

Refugee Wellness Navigators - International Rescue Committee

Funded by Innovations (Round 3) pilot program³⁴⁹

While no longer funded, the Refugee Wellness Navigator (RWN) program aimed to “build healthy communities where refugees, asylum seekers, and SIVs are resettled through a focus on improving community health and wellness. This model is an example of training paraprofessionals interpreters in aspects of service navigation (i.e., home visits, case management). Given that the IRC is the first touch point for newcomers in their first 8 months of arrival, integrating mental health support is critical. The RWN program was designed to:

- (1) Reduce isolation of socially isolated refugee adults through home-based peer outreach;
- (2) Improve self-esteem of socially isolated refugee adults; and
- (3) Improve quality of life of socially isolated refugee adults.

The program trained interpreters as community Navigators through an 8 week Wellness Training, home-based visits for refugee clients, and ongoing support for Navigators. The Navigators participated in an 8 week Wellness Training which included topics such as emotional well-being and understanding trauma. The trained Navigators then engaged in home-based outreach and intervention to refugee adults being resettled in Alameda County which included both case management components as well as psycho-social support. IRC says that “The RWN program is innovative as it trains refugees to be community Navigators and through this method, strives to maintain a high level of cultural sensitivity and draw from community strengths (Measham et al., 2014).”

Models Leveraging Basic Needs and Concrete Skills Training

As noted in Section 1, API communities, especially newcomers, have many unmet basic needs. These concrete needs are often part and parcel to the distress faced by these communities. UELP providers have astutely recognized this and intentionally made an effort to support their communities in addressing these concrete needs. This strategy has a two-fold purpose: 1) From a community perspective, meeting basic needs “meets communities where they are at” and builds trust and relationship by demonstrating concrete ways in which these agencies can support and individual or family; and 2) From a provider perspective, they can use these concrete needs to integrate mental health and emotional wellness topics. Whether it is English class, health care enrollment, housing support, these practical forms of support open the doors to deeper conversations about mental health.³⁵⁰

ESL

According to a local report,³⁵¹ the number one priority of Burma refugees in Alameda County is English language skills. Over 80% of 111 survey respondents ranked learning English as their top ranked problem. The second most ranked problem was unemployment, at just under 50% (see Chart 2 “Top Ranked Problem”).

In order to bring people into accessing mental health supports, ACMHS adapted their Burmese wellness classes by integrating practical skills (ESL) into wellness groups to increase self-efficacy and reduce isolation and depression. They have introduced “feeling words or sentences” in English to meet their felt needs and also to provide psychoeducation related to emotional well-being.³⁵²

CPR Certification

Most newcomers do not know how to get help here in the U.S. in the case of emergency situations (medical/psychiatric). For those who are in caretaker/nanny jobs, having this knowledge is not only important for themselves and their families, but also their livelihoods. CHAA partnered with a licensed bilingual (Nepali/English) CPR certification trainer to conduct a workshop for the predominantly Nepali-speaking Bhutanese and Nepali refugee/immigrant women. In addition to informational material about CPR, the women learned what to do in emergency crises in the U.S. This was a practical yet important lesson that newcomers needed to learn.³⁵³

Reproductive Health Workshops

CHAA received funds for one-year from the Office of AIDS Administration to offer HIV Testing and Prevention Education to hard-to-reach API and African immigrant women. The workshops focused on women’s health (information about breast and cervical cancer), health insurance enrollment, healthy eating and exercise, mental health and stress reduction, in addition to STD and safer sex information. This community outreach and education strategy incorporated practical needed information (such as health care enrollment, cervical cancer screening) with more taboo topics (mental health, HIV testing), and was found to be an effective strategy with over 80% of participants voluntarily agreeing to get HIV tested on the day of their event.³⁵⁴

Tutoring

Tutoring is a way to support families who have children who seek education as well as behavioral support. For immigrant families, this is an especially welcome concrete support due to language barriers. At Afghan Coalition, mentors came from the community and were able to be a bridge between parents and children, helping to mediate intergenerational misunderstandings and conflict. This program was successful as both prevention and early intervention; it “not only enabled us to provide the academic support to families, but the close interaction with students helped the program identify students who were having behavioral issues and allowed us to work closely with parents to refer them to appropriate services.”³⁵⁵

Early Intervention and Case Management

Among all UELP providers, early intervention was key in providing an integrated mental health support with basic needs/case management. At ACMHS, early intervention was used to offer therapy for uninsured clients who would otherwise have no access to mental health services.³⁵⁶ At CERI, early intervention is used to address the multiple barriers to a family’s health (including housing, MediCal enrollment, access to mental health and psychiatry services, and peer group support).³⁵⁷

Often, the complications of resettlement cause API community members to suffer from sleepless nights, anxiety and depression. Clients come to see community mental health advocates stressed out about benefit problems and medical bills³⁵⁸ because available face-to-face in-language supports for newcomer communities in the County are often only found through UELP programs. While all UELP providers try to support their clients individually to resolve cases, there are also systemic issues and gaps that cause the unnecessary stress clients face. A model that worked very well in the past couple years is to coordinate with East Bay Refugee Forum and Bay Area Legal Aid's Equal Justice Works Fellow who sorted out the many challenges clients were having with benefits (e.g., social services, Medi-Cal, and housing). Ultimately however, there needs to be a system's coordinator who fully understands and can resolve the unique refugee/asylee issues and can see how social services and mental health problems are overlapping and complex. A three-systems fix (SSA, HCSA and BHCS) is desperately needed.³⁵⁹

Models for Working With API Families and Youth

"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."³⁶⁰

Given the strong sense of interdependence in API families, nurturing this family structure and using it as a source of support for mental health and wellness is encouraged.³⁶¹ Mental health services that center on families are successful PEI models across all the UELP providers. Parenting support, children's psychosocial-emotional development, bullying and intergenerational conflict are topics that seem to draw in community members to participate and learn about mental health from a prevention and wellness framework.³⁶² The following are a few examples of creative projects that have been successful from the community perspective. Many of these programs would not be possible were it not for the flexible funding parameters of the UELP program.

School- and Community-Based Wraparound

Wraparound services provide children and families an individualized mental health treatment plan that focuses on the strengths and needs of the child and family. Wraparound services are unique in that: 1) Treatment plans are developed collaboratively and include service providers, teachers, and family members; 2) Services happen in community and home settings at times that are convenient for the family rather than in an office with a 9-5 schedule; 3) Empower the client by focusing on life skills and engagement with prosocial behaviors with family and community.³⁶³ This model has been shown to be a strong cultural match for API communities in Contra Costa County with Southeast Asians (Lao, Mien, Khmer, Vietnamese, Cambodian) and Pacific Islanders by APPS/CHAA because it supports the family as a unit.³⁶⁴ According to one community leader, "That's the best, best program in Lao community."³⁶⁵

Children's Education

While parenting education is a common form of psychosocial education, the Children's Ethics Classes in the Thai community focused on "childrening education". Specifically, children were taught to understand their parents' generation, including their beliefs, values and thoughts. The premise of these classes were that family relationships are a two-way interaction and children have the emotional intelligence and capacity for understanding their parents.³⁶⁶

In another segment of the API community, the Hume Center organized a bullying town hall panel focused on the Sikh community with the other social service agencies like the police department, restorative justice department, psychologists, parents, school,

MySahana and Sikh Coalition. The Hume Center also created an art activity to address and identity issues and bullying with Sikh children. They have also used board games and apps to engage children and introduce concepts of emotion expression and regulation, as well as how to cope with challenging feelings.³⁶⁷

In the Cambodian community, mental health is framed as wellness in their young children's program. They take trips that they may not otherwise be able to go on (e.g., library, garden, children's farm, bouncy house). They begin to learn how to express their emotions through "mood checks", art activities and drama. They also connect physical and mental health through healthy eating and playing soccer.³⁶⁸

Afterschool Programs

Through a partnership with East Bay Asian Youth Center's (EBAYC) afterschool program at Garfield Elementary School, ACMHS APIC staff offered a Khmer culture program.³⁶⁹ This program targeted at-risk families with exposure to gang violence and family conflict. Children learned Khmer language and arts, cultural identity and family bonding as well as learning socioemotional concepts to foster healthy communication. This program was also able to support and provide concrete supports to monolingual Khmer parents and monitor any socioemotional or behavioral problems the children might be facing.

"One Khmer student reported that her grandfather was so "happy and proud" that she was learning Khmer. The student proudly shared that she practiced Khmer with her grandfather and other family members."

The API Youth Collaborative connects with API youth who may need mental health services. It is a partnership of two mental health organizations (ACMHS, CHAA), youth organizations (AYPAL, the Spot) and Asian Health Services. Clinical staff were onsite at the SPOT/AYPAL location to engage with youth in their natural setting. Wraparound services for youth were also offered (including academic, employment, housing, health and mental health). In one year, early intervention services to these youth increased from 2 to 12. Clearly being in community/school settings increases the likelihood that individuals receive the support they need.³⁷⁰

Peer Support/Counseling

Group support works especially well in tight-knit communities. Community reports suggest that these groups can be identity-based (gender, sexual orientation, age), topic based (parenting, work) or activity (sewing, cooking gardening). Some groups meet at an agency, however for communities with transportation access challenges, meeting at a home/apartment with a concentrated ethnic community, or meeting at a faith center or community center are other options.^{371 372}

In the Cambodian community, weekly peer support groups have helped youth through graduating middle and high school, navigating cultural and sexual orientation identities, and coping with negative impacts of community and gang violence. This group identity is especially helpful for youth who are at risk of becoming involved with gangs. Positive group affiliation is important in environments where collective identity (e.g., tribes, neighborhoods, clans) determines status, resources, networks and protection.³⁷³

For youth, physical activities (e.g., walking, hiking, playing paintball, rowing) provide a natural setting to share and disclose personal information. Bringing in other young adults from the community who have been through similar challenges and can offer advice is also something that youth in the Cambodian group appreciate. Youth are especially inspired by mentors and role models who have beaten the odds or risen about the challenges.³⁷⁴

For adults/older adults in the Cambodian community, the collective identity around PTSD from the Khmer Rouge genocide allows people to come together. Group settings validate and normalize the PTSD symptoms that many clients experience. One unique way CERI has integrated psychiatry in their groups is to have a community day event (food, coffee, tea) where members socialize with each other as they wait to see the psychiatrist. This strategy works especially well for the CERI community where the group cohesion is very strong.³⁷⁵

A dad's group was formed in the Tongan community to support men in knowing how to best support their children and families. Topics of interest to 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.³⁷⁶ In other communities, it was suggested that programs addressing the needs of men including anger management, alcohol abuse, domestic violence and recreation needs are needed.³⁷⁷

Intergenerational Work

SAUCE, a program of Banteay Srei (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."³⁷⁸ 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 of the refugee and resettlement experience." Banteay Srei's SAUCE program is also a good example of story sharing: "Not only do the young women learn to cook, listen to stories, share their experiences of growing up in Oakland with each other, but they also learn and explore different herbs, spices, fusion recipes, healthy foods and sustainable living."³⁷⁹

Models for Alternative Healing/Cultural Wellness/Innovations

"Healing for mental health does not always need to occur in a clinic setting through psychotherapy or according to western medical treatment model. Wellness can be achieved through community gathering and celebrations, cultural specific activities such as cooking or gardening groups or other social support groups where community members are able to share experiences and remedies natural to their cultural practices to cope with trauma, loss or other mental health related issues."³⁸⁰

The following examples provide highlights of innovative UELP projects that have integrated healing and cultural wellness into their mental health models. Given the exposure to violence that many API communities have experienced either in their home country, in their neighborhoods here in Alameda County, or in their schools and homes, healing and cultural wellness programs are essential. These examples are not meant to be exhaustive but to illustrate how different communities find healing, especially from traumatic situations.

Healing against Community Violence

Cambodian Peace March. In 2012, the Cambodian community organized a peace march related to their experiences with community violence and need for safety and peace. One hallmark of this event was that two Oakland Cambodian temples came together, laying aside their differences, to have a unified Cambodian community voice. The march also brought together local and state legislators to discuss how to improve neighborhood safety.³⁸¹

Healing and Resiliency Summit. In the same year, an inter-community summit was developed to promote healing after the shootings on Oikos University campus in April of that year. Seven individuals were shot and the shooter was Korean. Over 10 participating agencies came together to discuss mental health issues in the API community and organized the Healing

and Resiliency Summit to promote healing and encourage dialogue on mental health issues among the Korean and other API communities. This was one of the first times that there was an inter-community and inter-faith effort in the API community in Alameda County. Seeing that communities could come together despite language and cultural differences planted a seed in the organizers' mind that grew into the work of the API Women's Summit efforts.³⁸²

API Women's Summit and International Women's Day Events

From 2013-2016, CHAA, ACMHS and CERI co-hosted yearly inter-community women's events to promote healing and connection among diverse API immigrant and refugee women communities. Annually between 80-150 women from over 12 ethnic groups share their personal immigration stories, intergenerational struggles, hopes and dreams for their communities through storytelling, art-making and movement.

These summits are an especially powerful display of how art can bring people together to heal. Despite speaking different languages and coming from different cultures, through nonverbal forms of communication (making community boats, movement and performance) women began to see that their struggles were similar. They also saw the healing power of sharing stories and creating new stories.³⁸³ One year, the summit planning committee collaborated with Asian American Women Artists Association's Cynthia Tom to create community boats. Each community made a boat that celebrated women, their journeys to the U.S., as well as the goals and hopes they had for their communities.³⁸⁴ The day opened by honoring different cultural ceremonies for gratitude and giving thanks to the ancestors and Mother Earth. These grounding ceremonies and rituals are healing practices in many cultures. After the morning boat making session, women participated in afternoon workshops on empowerment, community leadership and personal and community wellness. The day ended with presentations by each community, sharing their boats and aspirations.³⁸⁵

These more formal summits were complemented with social gatherings on International Women's Day to celebrate the lives of women. International Women's Day is celebrated across many countries around the world and many different countries have different ways of celebrating this international day. The communities were happy to celebrate this international holiday here in the U.S. with other women. CHAA, ACMHS and CERI organized the events where women would bring potluck dishes to share, have cultural dances to teach each other, singing, show off their cultural dresses and play games. Again, while women did not speak the same language, they had an opportunity to connect through laughter, dance, ritual and play, putting aside the stressors of their lives for that one day.³⁸⁶

Cultural Wellness Projects

API communities are active in cultural and recreational activities that serve as powerful preventive resources that offset potential risk factors impacting behavioral health.³⁸⁷ Providers have leveraged these community assets in support of improving mental health outcomes, including organizing activity-based mental health interventions,³⁸⁸ community events,³⁸⁹ and popular activities such as gardening,³⁹⁰ cooking,³⁹¹ and story sharing.³⁹²

From an API cultural perspective, these practices are, in and of themselves, legitimate forms of healing, mental health support and stress reduction while also offering opportunities to talk about health and wellness. These activities are also valued because they stimulate the mind (e.g., learning new skills, incorporating physical movement and coordination, exercising creativity). Finally, because these activities are conducted in groups they are an effective means to reduce social isolation and build community. A holistic model of mental health services must include wellness activities; they are preventative and destigmatizing for those with experience normal life stress and an important supplement for those with more moderate/severe mental health struggles.

Physical Activity. Whether it is yoga, Zumba, tai chi or walking, physical activity is a very concrete self-care activity that all UELP providers integrated into their groups with clients. Participants enjoy it because they feel the effects of these activities in reducing stress. For cultures that value tangible support over talk therapy, these activities “teach” a useful skill that participants are excited to learn.³⁹³

Arts and Crafts

“The ability to create translates into members believing they have the ability to create what they dream of achieving in life.”³⁹⁴

Arts and crafts is form of wellness that allows individuals to connect with their creativity as well as emotions. As mentioned in the above quote, creating allows individuals to connect with their own empowerment. They can see in a small way that they can contribute and make something with their hands. This, in turn gives confidence to create the change they want to see in their lives.

One model for integrating arts with mental health is to have a co-led team with a therapist and an artist. ACMHS offered such a model with their 8-week Art and Wellness groups for isolated seniors in senior housing. The groups were co-led by a clinician and an artist/art therapist. Seniors had an opportunity to connect with other individuals (reduce isolation), learn gentle physical exercises, gain mental wellness tips, and have pride in their art work.³⁹⁵

Cooking and Gardening. For API communities who come from agricultural backgrounds, gardening is an economic activity that provides sustenance, a cultural activity where traditions are passed down and a healing activity that reconnects a person to the land.³⁹⁶ CERI, CHAA and IRC have all incorporated gardening into their mental health work.³⁹⁷ In addition to planting and growing food, gardens are a location where mental health support and healing happen. At CHAA, the Tibetan advocate used the garden as a place to teach community members somatic centering and breathing yoga to reduce stress. She also worked with Native American youth and shared spiritual healing practices with them at the gardens.³⁹⁸

Cooking is another activity that is economic, cultural and healing. For women who are busy working and taking care of their families, a Tibetan momo (dumpling)-making event was created at CHAA as a way of reducing social isolation and stress among women who usually do not take time for self-care. Other times, the community gathers and makes large quantities of momos to sell for fundraising events in their community.³⁹⁹ In the Cambodian community, cooking is also sacred. They regularly chant with Buddhist monks where their offering is also to cook and prepare meals for the monks who must eat before noon. Offering food to monks is a common form of merit making. Food is essential for life and health and in many API communities eating together is a celebratory event. The daily life practices are what help API individuals find balance especially when experiencing trauma or mental health challenges.⁴⁰⁰

Spirituality. For many communities, religion and spirituality are a great form of strength during difficult times and is integral to their mental health (see the beginning of this section on Community strengths, resources and assets).^{401 402} Through the PEI funds, integrated mental and spiritual health projects have been developed across many different API communities. The following models are distinct innovative interventions demonstrating how communities use religion and spirituality to heal, to connect and to gain a deeper understanding of mental health:

Tibetan Chanting. Tibetan sacred rituals and chants are used across the globe to center and ground individuals and to help one live with an openness and commitment to think beyond one’s small self. At CHAA, the Tibetan advocate taught regular chants (e.g., Five

Element chant) to bring balance between outer and inner self. According to Tibetan Bon tradition, this practice is not only beneficial for the individual's physical-mental-spiritual state, but also promotes wellness for the planet.⁴⁰³

Community Talks. In some communities, issues are discussed in large group formats. A Talanoa Circle ("talk" or "discussion" in Fijian, Samoan and Tongan) is a Pacific Island form of dialogue bringing together people to share opposing views. There is no set resolution that is needed like in Western processes. Talanoa participants set the parameters for their discussions: inclusion, reconciliation and mutual respect. At CHAA, a Talanoa circle was developed to talk about taboo mental health topics (e.g., domestic violence, sexual abuse). Specifically, the Tongan community was debating about whether or not Tonga was going to ratify CEDAW (United Nations Convention on the Elimination of Discrimination Against Women). People had very different opinions; The Pacific Islander advocate used this controversy to bring together church groups, and especially men, to talk about the issue of domestic violence against women and children. A total of 8 Talanoa Circles were offered with 66% of the participants being men. This was a huge success, given the difficulty of reaching men to discuss mental health issues.⁴⁰⁴

Persian literature. In the Afghan community, navigators would offer presentations on mental health themes and cite classical scholar, poets, mystics, thinkers and historians to help create an accessible, stigma-free environment for talking about psychology and mental health.⁴⁰⁵

Models for Individual, Group, Community and Collective Empowerment

Empowerment is key to an individual's felt sense of agency to act, create and make things happen in their lives. API communities may have lower sense of empowerment due to economic status (e.g., low-income jobs, jobs that are a mismatch for their educational level), limited English proficiency, tentative immigration status (e.g., undocumented, visa status, asylum applicants), and personal mental health challenges. Therefore, it is critical to develop models that increase their sense of self-sufficiency and agency. The following models show examples of how organizations cultivate empowerment in API communities.

Individual Empowerment-Early Intervention Model

All UELP providers integrated basic needs support for API clients, whether it was helping with filling out government forms, applying for health insurance, enrolling children in school, connecting individuals with jobs, helping resolve transportation issues. The challenge and opportunity is how can this moment become one of empowerment for a newcomer.

At Afghan Coalition, they share how they focus their early intervention on problem solving with a client:

"Every visit, the client came with her mail in hand. In the one on one's that followed, she would emphasize that her current mental health needs were being met by our referrals to the appropriate resources, but that she needed the AMHP in assisting her read and understand her mail due to language barriers. She insisted that there was no one who could help her with this task...Continuing the one on ones with her the program discovered that she had a 16-year-old son who was fluent in English. The navigator on several occasions articulated to her that this would be an excellent way to teach him some responsibilities, as well as help put her mind at ease knowing that there would be someone at home to help her address this issue. She was incredibly resistant to

assigning any responsibilities to him and kept making excuses for him. Our youth navigator worked closely with the client and her son to help bring understanding and attention to the importance of delegating responsibilities. By the end of her time with the program the client felt comfortable enough to transition this responsibility to her son. We worked with both mother and son to teach them the necessary skills to be their own problem solvers. ...She has stated that because of their time with the program she feels comfortable communicating with her son and feels that she has someone to turn to for help when she needs it. This case is perfect example of navigators using creative solutions to help clients seek long-term solutions.”⁴⁰⁶

In this example, the program staff *identified the problem* with the client, offered an *opportunity for growth*, worked with the client and her son to *develop skills* necessary to solve the problem, and then *empowered the client* and her son to make the changes in the lives to be more self-sufficient.

Group Empowerment- PhotoVoice

PhotoVoice has been a powerful tool for storytelling. It can be used in a mental health context as part of stigma-reduction campaigns, creating more empathy and understanding for mental health and illness. as well as empowering consumers to tell their recovery stories.⁴⁰⁷ Baneay Srei has used PhotoVoice to empower their youth through the HOLGA project (Hopes, Obstacles, Love, Giving, And ...Holga). Using Holga cameras, the project gives young women an opportunity to express their feelings and share what's meaningful and important to them through capturing pictures and showcasing their photos in a community setting. For youth who live in violent neighborhoods and who are exposed to sexual exploitation, this photo-documentary project captures important community mental health themes and lifts up the concerns and solutions these youth have for a better world.⁴⁰⁸

Community Empowerment-Leadership for Community Wellness, A Workforce Development Pilot⁴⁰⁹ Funded by Alameda County Behavioral Health Care Services UELP/MHSA PEI

Many community leaders wanting to be of service to their communities seek trainings in how to support community members who may have mental health challenges. Leadership for Community Wellness was a 26-week training program held at CHAA for one year (FY2015/16) aimed at providing basic competencies for entry-level Community Mental Health Advocates from indigenous, immigrant and refugee communities. Using a popular education framework, the program created a learning space that empowered these leaders to be change agents for mental health and wellness. Topics included: Leadership Development, Communication Skills Building, Mental Health Basics, Trauma for Immigrants and Refugees, Mental Health Stigma, and a Systems Perspective on Mental Health. A final Community Immigration Stories presentation was delivered by all participants at the end of the first semester.

A total of 14 individuals from nine distinct Bay Area communities participated, including 7 API communities⁴¹⁰; they ranged from living in the U.S. for 20 years to someone who immigrated within the past year. Ninety-three percent of participants were satisfied or very satisfied with the course at the mid-point. Eighty-five percent reported an increase in knowledge areas: popular education, communication skills, mental health stigma, the mental health continuum, and wellbeing and wellness.

“It taught me to listen n understand the matter before I speak out on behalf. It gave me confident to talk in front of mass. It gave me an opportunity to share about who m i n which community I belong to, The problems of me n my community.”

Three major lessons learned from the program included: 1) More free training: Participants were very interested in gaining additional training related to mental health topics; 2) Workforce Development: Beyond the training, participants were eager for job placements and opportunities within the County to serve as community mental health advocates and support their communities; 3) Continuation: The pilot only trained 14 individuals and there were many more leaders from other communities who were interested in participating.

Community Empowerment-Wellness in Action⁴¹¹
Funded by Alameda County Behavioral Health Care Services

There are few empirically-supported community mental health models for API communities, and likely none that have been developed with recently arrived API communities. Wellness in Action at CERI is a 10-month program that supports community leaders to develop community-driven mental health projects while testing a model for training and supporting community mental health workers in un- and underserved multilingual communities. This project explores how the County can continue to increase the mental health pipeline for immigrants and refugees.

Using a popular education and transformative learning framework, the program includes: specific trainings (community mental health topics, community needs assessment, program development and evaluation), technical assistance to develop community interventions that support mental health and wellness of immigrant, refugee and indigenous communities, and mini-grant awards for on-the-ground community mental health interventions. Currently completing the first semester with 10 individuals from 6 communities, including 5 API communities.⁴¹²

Collective Empowerment-Mental Health Advocacy

ACMHS and CHAA have been active in advocating for continued mental health services to the public mental health system both locally and at the state level. In September 2013, they spoke before the Alameda County Board of Supervisors Health Committee on how effective MHSA-PEI programs have been for underserved and unserved API communities. In February 2014, CHAA and ACMHS hosted a site visit by the California State Mental Health Services Oversight and Accountability Commission. Together, these organizations shared the impact that MHSA funded PEI services have made in their communities. Some staff participated in the Know the Signs focus groups to help make the statewide suicide prevention campaigns more culturally relevant for APIs.⁴¹³ Additionally, CHAA presented its PEI work at a discussion of PEI regulations in 2016.⁴¹⁴

Section 4. Structural, Cultural and Systems Improvement Recommendations

Overview

The community reports reviewed in this report reveal multiple factors that continue to impact mental health utilization for APIs in Alameda County. We outline them briefly here.

API Diversity. Growth both in the number and diversity of API communities since 2000 has stressed the County's capacity to meet language and cultural competence needs for providing mental health services effectively for these communities. Additionally, newcomer communities are at a lower stage of readiness for mental health services due to stigma, lack of awareness, and cultural etiologies for distress that do not match mainstream Western mental

health concepts and models for intervention. Finally, these same communities, though relatively small in overall numbers, often come with high levels of trauma, making them high need communities (especially refugees and asylees).

Workforce/Language Access shortage. We found evidence of critical and persistent workforce and language access shortages, especially for newer and smaller API communities. There are no therapists in some API communities within the county and even for communities who meet County threshold language criterion, there are still reported difficulties in locating providers in mental health service settings. Thus, even if a community member has overcome cultural and community barriers and is eager to find a service, there are often few, if any, culturally competent services available. Both community members and those making referrals eventually realize this, and stop using the structures ACBHCS has in place for finding mental health services such as ACCESS. We also found that it is likely ACCESS is not aware of API UELP program providers, and may not be connecting clients to the few available in-language supports in the current system for many communities.

UEL P Programs. Many API communities, especially the unserved, are making connection with ACBHCS through the UELP program investments since 2010 when the programs were launched. However, while they have access to prevention and early intervention, some of these communities have no available in-language therapists to serve them beyond early intervention needs. The County has only just begun in 2015 to make investments for training for therapists and interpreters and resourcing for paid interpretation services. Thus, without a sustainable County language access strategy for how to support LEP clients with paid interpreters, low utilization of mental health treatment services will persist.

While stigma would likely limit the number of API clients who would initially accept mental health services from therapists, there are examples that with trusting relationships, API individuals do seek therapists with the support of interpretation (CERI, Partnerships for Trauma Recovery, both organizations set up their models independent of the County's establishing a uniform language access strategy). However, PEI investments do not seem to be well integrated with the treatment system or MHSA CSS, except when there is an effort within an organization that has a continuum from prevention to treatment at its disposal.⁴¹⁵ We see little evidence that UELP programs utilized CSS resources in the reviewed reports, and note the challenges for many API communities in accessing treatment.

The UELP program efforts have allowed for more creative and adaptive community-based, culture-driven models. Community reports have shown promise in using these funds to offer destigmatized contexts where mental health services can be embedded in non-threatening and safe ways, as well as models that provide supports through culturally-informed design. Through UELP, Innovations and WET-funds, community reports have also lifted up the importance of engaging trusted lay mental health workers/ community wellness advocates, and having communities design mental health programs that work for them. There is a growing number of API community leaders who are eager to be more involved in mental health work; the paraprofessional training pilots along with interpreter trainings suggest that a pipeline for API mental health workers is ready to be fostered.

Taken together, these observations lead to investment and systems change/redesign recommendations that address community/cultural issues/barriers and systems barriers through the lens of community assets and strengths, and opportunities presented by the promising practices we found in the reviewed reports.

Recommendations

Structural Investments

Increase Investments in API Mental Health System

Alameda County has woefully underinvested in the API community. The current API population is around 29.5% of the total population (US Census Update 2015). As of 2010, the projected API SMI/SED population that BHCS is charged to serve is 26%⁴¹⁶; in contrast APIs comprised only 16% of the BHCS workforce.

ACBHCS' investment in mental health services through contracted community-based organizations is only **5%-8% of ACBHCS' overall investment**. In FY 2015/16, out of a total amount of \$128,504,463^{417 418}, investment in the four largest API-serving organizations was \$10,688,973 of the total (8%).^{419 420 421} These calculations are likely overestimates as these organizations serve a sizable number of non-API clients.

Key Investments:

Address gaps in specific services noted in review of community reports, including:

- AOD programming for APIs, youth and adult
- Problem gambling support for APIs
- Programming and services for API Older Adults⁴²²
- Domestic violence support for APIs including anger management for perpetrators⁴²³

Key Systems Changes:

- Examine level of investment in API mental health services and supports in relation to population size and penetration rates expectations, and in relation to similar ratios targeting other ethnic/racial subpopulations served by ACBHCS
- Review how investments are determined by ACBHCS in rationalizing resource allocations
- Address high need communities identified in this report in planning for strategies including:
 - refugees/asylees, other newcomer communities
 - high disparities communities such as Pacific Islanders, Southeast Asians, API children and youth, LGBTQI individuals, women

Improve and Broaden Language Access

Given the important barrier that language access represents for APIs in utilizing mental health services, there is a tremendous need for the ACBHCS to develop a system-wide language access plan that will adequately meet the needs of this multilingual community and that is regularly reviewed for missing languages.

ACBHCS' Cultural Competency Plan (2010) noted that "There is a dramatic need for staff that speak threshold API languages: Cantonese (roughly 86 staff needed), Vietnamese (39 needed), Mandarin (31 needed) and Farsi (19 needed). There is very little or no local capacity in

languages including, but not limited to: Arabic, Cambodian, Hmong, Lao, Mien, and Thai.”⁴²⁴ As community reports reviewed here suggest, there are other API languages with very little or no capacity in the current public mental health system, including Burmese, Karen, and other languages spoken by refugees from Burma, Korean, Mongolian, Nepali, Samoan, Tibetan, Tongan, to name a few. Furthermore, communities are not satisfied with telephonic interpretation, especially for mental health needs. ACBHCS has made important investments such as the UELP programs targeting un- and underserved APIs, a dedicated Asian ACCESS Program⁴²⁵ (with noted limitations), and some investment in training and deploying interpreters.⁴²⁶ It is time for the County to make additional investments and bring them together in an integrated way.

Key Investments:

Invest more intentionally in language access strategies

- Invest in mental health models that include a therapist, paraprofessional community advocate and interpreter; train mental health workforce in how to work in this model
- Implement a strategy for a face-to-face paid interpreter model for mental health, including training and supervision, with attention to Alameda County threshold and non-threshold API and other languages
- Develop an in-person language pool or language bank of interpreters who make a sustainable wage and are available to work across systems (health, social services, education)
- Mandate that all agencies using interpreters or paraprofessionals have clinical supervision or consultation available
- Invest in translation of materials into more than just the minimum threshold languages to be used at API and non-API organizations

Key Systems Changes:

Review structure of ACCESS and Hotline

- Convene a planning group to redesign and reassess the ACCESS referral system including:
 - Effectiveness of ACCESS for LEP clients to access, utilize and connect to provider
 - How ACCESS can be linked with PEI services or organizations, including resourcing more ethnic community-based organizations as part of the ACCESS network, especially for non-threshold languages
 - Whether the investment in ACCESS better utilized in other more effective ways. Examination of alternative or complementary strategies
- For refugees, invest in Behavioral Health Coordinator role to hold refugee and asylee requests and referrals, and interagency navigators, leveraging the East Bay Refugee Forum network and structure that is connected to resettlement and social adjustment services for these newcomers
- Conduct annual assessments (including CSS, PEI, WET, Innovations, etc.) to determine what new communities are emerging in the system and who has early contact
- Develop language access priorities based on this assessment including ensuring there is a paraprofessional community advocate and adequate interpretation resources available for every newcomer community in Alameda County

Deeper Investments in API Workforce Development

As community reports reveal, limited workforce in behavioral health settings for all API communities is a major issue impacting utilization of mental health services by APIs in Alameda

County. Nearly all of ACBHCS' WET investments to date have focused primarily on those already in mental health fields.⁴²⁷ The API mental health workforce is currently concentrated at entry-level and stipend/volunteer positions, especially those that require little prior mental health training. While well-established communities are represented in therapist positions, few of these positions are held by newcomer community providers. Finally, the number of administrative and County-level positions held by APIs is extremely low.

Key Investments:

Invest in Workforce Development

- Develop interpreter as well as paraprofessional mental health advocate certificate training programs for diverse APIs (including hard skills, leadership development, and stigma-reduction values) that professionalize and legitimize these roles as essential to the mental health system of care⁴²⁸
- Support the development of scholarship/mentorship programs for multilingual youth and immigrant/refugee adults who are interested in pursuing the mental health field to enter higher education⁴²⁹
- Offer stipends for intensive English language training for mental health professionals who want to improve their language skills
- Invest in local immigrant and refugee health workforce development organizations such as Diversity in Health Training Institute to expand workforce development capacity to include mental health fields

Key Systems Changes:

Entry-level positions

- Work with other systems to create a scale for investment for trainings across multilingual communities (not only API communities) to obtain more resources and have better quality and more systematic trainings for the diverse language communities of the county
- Mandate that all agencies use interpreters and paraprofessionals who have received training for their job (or that these individuals must complete the County's training)
- Integrate WET-funded projects into organizations with UELP projects so that these organizations can serve as a site for training, practice and support

Middle Management positions

- Provide County internships/shadowing programs to transition immigrant/refugee entry-level County workers to middle-management County workers
- Offer a monetary incentive/bonus for County workers who are multilingual

Leverage MHSA PEI

Of all ACBHCS' current investments, MHSA PEI UELP has been the clearest and most dedicated strategy for addressing the issues, barriers and challenges discussed in this report. Additionally, 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 APIs in Alameda County.

UEL P could serve a critical role in connecting community members to higher levels of care if interpreters and therapists were in place to provide services. UELP programs have already successfully modelled strategies for engaging APIs in manners that reduce or eliminate stigma (including leveraging culture, expressive arts, traditional healing and individual/group/community/collective empowerment) and 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 API communities.

Given that WET and Innovations funding is time limited, PEI is a natural funding stream for incorporating and sustaining WET functions and successfully piloted culturally-informed models into the design of UELP models. It is also a natural setting for developing community capacity through building the behavioral health and interpretation workforce needed to improve access.

Finally, as mentioned in earlier sections, one of the greatest challenges is how to provide mental health services to those who do not have access due to lack of insurance coverage. Several UELP programs have been able to use their UELP funds to provide culturally and linguistically responsive mental health services to individuals irrespective of their ability to pay or their mental health diagnosis, and thus are vital safety net mental health supports for those who are ineligible for Medi-Cal or other forms of health insurance.⁴³⁰

We recommend that ACBHCS leverage MHSA PEI, specifically UELP program investments, as follows:

Key Investments:

Continue to invest in early intervention models and providers

- Including the integration of case management of basic needs with mental health education, skills for self-care and self-sufficiency.
- Embed mental health in holistic full-services environments when possible⁴³¹

Continue to invest in non-mainstream mental health models and providers

- Including culturally relevant innovative strategies that promote cultural wellness, expressive arts, empowerment, traditional healing and cultural preservation, peer support groups, interventions that integrate concrete basic needs and skills development, inter-community work and community events

Key Systems Changes:

PEI Redesign - Leverage PEI as a key node in the system to improve mental health services utilization for APIs

- Ensure that PEI is a protected safety net for immigrant communities as it is the only resource serving the undocumented and uninsured who do not qualify for MediCal or other health insurance
- Sustain successful Innovations pilot models through PEI
- Encourage organizations that hold PEI contracts to work with organizations that hold MediCal so that referrals for individuals who need higher levels of care can be effectively coordinated
- Integrate workforce development into PEI models, especially for smaller and newer communities with limited or no workforce in the current system
- Build interpretation training, deployment and support into PEI models for LEP communities
- Consider having therapists play a role in providing Early Intervention services for high need uninsured clients

Move Beyond Race/Ethnicity in Organizing Investments

There may be some benefit to moving programming away from only racial/ethnic-defined to shared experience-based models such as immigrant and refugee models that are not racially specific. For refugees, many are already receiving services in multicultural settings such as refugee resettlement organizations, social adjustment programs, and refugee health settings.

The authors suggest that the County consider a broader strategy focused on immigrants and refugees or the foreign born rather than addressing them piecemeal on a community-by-community or race-based basis only.

Such a strategy would recognize that there are other communities impacted by issues similar to those confronted by API communities in terms of language access, cultural competence, and limited workforce. Further, newcomer communities do not always immediately identify with the larger category of “API” that frames how services and advocacy are shaped in the U.S., often identifying only or mostly with their own ethnic and language identities and communities. Hence, it shouldn’t be assumed that they will be aware of or drawn to “API”-identified organizations based on their name or a racial identification which is not a meaningful part of how they conceive their identities upon arrival.

Many of the current UELP projects co-mingle services for newcomers with services for communities that have been here for generations and who often identify as Asian American. CHAA, for example, made efforts to extend its UELP work to benefit African refugees and immigrants as possible. Newcomer communities have distinct issues and challenges that may merit dedicated resourcing. Such a strategy will also help ACBHCS reach unserved new communities from Africa and the Middle East, for example, that do not have large mental health services organizations or targeted UELP programs meeting their needs.

This approach would reach more communities in need, identify additional sites of contact to leverage mental health services through, identify a scale of need that justifies the investment, and lessen some of the sense of competition for limited resources. The authors have also seen the effectiveness of multicultural community mental health approaches for reducing isolation, building connections and new sources of social support, reducing stigma, and building hope.

Key Investments:

- Invest in refugee/asylee strategies through UELP
- Work with Social Services Agency and Refugee Health to leverage PEI supports in resettlement settings to broaden reach of mental health support and extend and diversify available languages for a broader language access strategy

Key Systems Changes:

- Work with Social Services Agency to explore how ACBHCS can develop closer relationships with refugee resettlement organizations, East Bay Refugee Forum and Refugee Health in the following ways:
 - Dedicate resources to a Refugee Behavioral Health Coordinator/Manager who works closely with Refugee Health to ensure that refugees are adequately screened, referred and receive the behavioral health services they need. This can be accomplished through a refugee/asylee/immigrant-targeted UELP program.
 - Dedicate ACBHCS staff to membership on the East Bay Refugee Forum’s Steering committee to better understand mental health issues encountered by non-mental health providers in the collaborative, and contribute to systems improvements related to mental health services for refugees and asylees. This seat has already been approved as a permanent non-voting systems member in EBRF’s bylaws.

Culturally-Responsive Program Design

Invest in Social Support, Community-Building and Capacity-Building Models

Individuals across many API communities and sub-groups (youth, elders, families) talk about the importance of self-sufficiency and self-determination for their own health and wellness. This is important at the individual and community level. To nurture the strengths and resources of API communities, we recommend the County develop opportunities for APIs to find solutions to improve their own health, wellbeing and sense of hope and belonging.

Key Investments:

Individual-level

- Support the implementation of community evidence-based participatory models of leadership development similar to Innovations investments and the Wellness in Action model through PEI
- Support the development of community-led participatory mental health intervention and empowerment models and mental health advocacy (including PhotoVoice, Community-based Participatory Research models, Popular Education, Digital Storytelling, Integrated Arts and Healing models), critical analysis of social determinants of mental health (e.g., housing, work, immigration)
- Support concrete basic needs and skills development integrated with mental health and wellness education/outreach (ESL, computer skills, understanding systems, know your rights, U.S. job readiness skills, parenting skills, etc.)

Community-level

- Consider investing capital funds to support a bricks and mortar community center space for newcomers⁴³²
- Support Innovations projects that pilot how technology (apps, chat platforms, web resources) can build social support, resource sharing and referral/services access among API communities

Key Systems Changes:

- Invest with Social Services Agency in a planning process to create a newcomer hub that is a one-stop for resources, services, recreation and community building for communities who are new to Alameda County
- Consider sustained investment in APIHealthSource.com and leverage this online site as a resource directory, a support space for APIs looking to learn more about mental health in their communities, and storytelling anti-stigma campaigns^{433 434 435}
- Continue funding projects (e.g., through WET, Innovations) that support community-participatory models of leadership development for community leaders including development of community-driven mental health intervention models and mental health advocacy for API and immigrant/refugee communities

Prioritize Investments in Stigma Reduction

Stigma, shame, and fear, as well as differing conceptions of mental health and wellness remain significant barriers affecting utilization of mental health services for APIs. There have been minimal direct investments in anti-stigma efforts targeting APIs, and, while UELP programs have played a role in anti-stigma efforts, their full potential hasn't been tapped. Linking UELP programs to community institutions such as faith organizations, community centers, senior centers,

Key Investments:

Invest in more API-targeted stigma reduction work

Individual-level

- Pilot anti-stigma interventions for mental health consumers in other API communities (such as the Social Inclusion Campaign developed by Dr. Lawrence Yang and run by P.E.E.R.S. with support from ACMHS and NAMI)

Community-level

- Require UELP programs to set aside a portion of their annual budgets for stigma-reduction work (including media/social media efforts, connections with faith-based organizations, small ethnic providers, libraries, schools etc.)
- Provide Mental Health trainings (e.g., Mental Health First Aid, WRAP) for community leaders led by API trainers
- Invest in more outreach through social media, radio, television, newspapers, faith communities, youth centers, senior centers, community centers, libraries and schools
- Invest in outreach workers for communities with low literacy

Key Systems Changes:

- Develop strategies for UELP program providers who are intimately connected to their communities to be intentionally integrated into stigma reduction and social inclusion efforts led by P.E.E.R.S.

Invest in Integration Settings and Linkage Strategies

“No wrong door” strategies are important to broaden reach and de-stigmatize mental health help-seeking in API communities. The following have been suggested by consumers and community members as effective “front doors”.^{436 437 438}

Key Investments:

Investments in integration leverage sites where communities already seek supports and services⁴³⁹

- Newcomer Immigrant and Refugee Welcome Center
- Youth Centers
- Senior Centers
- Non-mental health ethnic and other CBOs
- Refugee resettlement organizations

Key Systems Changes:

Examine parallel systems not funded directly by ACBHCS that reach APIs to better coordinate care and services in a more efficient manner⁴⁴⁰ including:

- Primary Care funded primarily through ACHCSA

- Human Rights Clinic at Highland⁴⁴¹
- AHS satellites in Tri-City area⁴⁴²
- CAMHN
- John George
- Refugee Health
- Community Clinics
- Social adjustment services funded by ACSSA
 - Refugee Health⁴⁴³
 - Partnerships for Trauma Recovery
 - Multilingual Counseling Center
 - Interpreters trained at International Rescue Committee
- Youth Programs, Sites and Centers
 - Banteay Srei
 - The Spot
 - EBAYC/OASES
- Senior Center(s)
- Faith community sites⁴⁴⁴

Prioritize Community-Driven Models

API-specific mental health treatment and intervention models are those that are first and foremost community-driven. They also elevate the concept of physical-mental-spiritual wellness, integrate the family unit and even the broader community in treatment, wellness and support.

Key Investments:

Invest in Holistic Health Models

- Cultural Wellness models (yoga, tai chi, gardening, cooking, sports, dance, hiking and camping)
- Traditional healing (ayurvedic, herbal, acupuncture, energy/prana, massage, meditation)
- Spiritual healing (integrating temple/church, and spiritual leaders)

Invest in Family-Centered Models

- Wraparound for API children, youth, and families funded through CSS⁴⁴⁵
- Parenting, childrening and intergenerational models that help different generational bridge cultural gaps

Invest in Community-Centered Models that Incorporate Mental Health Concepts

- Expressive Arts and Storytelling
- Cultural preservation
- Inter-community work, community events

Key Systems Changes:

- Consider capital investment in an immigrant/refugee community center that includes programming for youth, families and seniors

Structural Competency

Recognizing systems design as critical to outcomes, we offer some recommendations that can improve API mental health utilization.

Prioritize Data Disaggregation and Data Collection Alignment

Data disaggregation is important for ACBHCS' planning purposes. When data isn't collected in a manner that allows for clearer understanding of needs, it cannot effectively be utilized for rationalizing levels or kinds of investments, which in turn impacts API service utilization.⁴⁴⁶ For APIs and other diverse immigrant and refugee communities, a lack of attention to the collection of disaggregated data has resulted in poorly rationalized investment (indeed, underinvestment) in services for many API communities living in Alameda County.⁴⁴⁷

One report observed that "Accurate data collection and monitoring are key components to strategic planning for public health systems. Just as epidemiologists help to track disease patterns to predict the onset of outbreak and inform where programmatic funds should be allocated/ re-allocated, we argue that data should help to drive resources and programming for newcomer immigrant and refugee communities."⁴⁴⁸ Data disaggregation should inform levels of investment in API-specific mental health services and programming. We identify data detail and quality as a potentially significant factor in achieving improved penetration rates and greater equity for APIs in accessing mental health services sought by ACBHCS, and note here the connection of quality data collection in informing and shaping investments. "The inability of these data forms to be specific cause inaccuracies in the reported number of foreign-born residents residing in our county as well as the language needs of these residents. These inaccuracies have a domino effect on funding allocation as well as blindness as to what types of cultural and linguistic competency is needed to support the health of these communities."⁴⁴⁹

Key Investments:

- Support community-defined treatment and intervention models including program evaluation for these models
- Fund community-driven needs assessments for recently arrived and/or recently served communities

Key Systems Changes:

Data Disaggregation

- Collect accurate, locally relevant disaggregated data for ethnicity, language, and country of origin/nativity (similar to the tool used for UELP Prevention Services reporting form) across the entire system of care (including specifics for African and Middle Eastern immigrants/refugees)
- Collect both primary and secondary or other language to increase the likelihood that interpretation supports can be identified
- Align data collection accordingly across BHCS, and examine alignment across HCSA and with SSA

- Mandated state data collection of gender identity and sexual orientation need deeper conversations about using Western categories that don't match specific cultural categories for many API immigrant/refugee communities
- Review PEI data for evidence of community reach and plan investments according to evidence of community population size

Review Diversity and Equity Infrastructure, Cultural Competence and Trauma-Informed Care Commitments

Given Alameda County's growing number and diversity for API and other immigrant and refugee communities, and that the twin priorities of cultural competence/humility and trauma-informed care are important foundations for ACBHCS' planning, we recommend reviewing the adequacy of current commitments and investments that support them within the organization. As our report reveals, there are intersecting issues and barriers that would be the concern of disparate parts of ACBHCS' structure potentially, and there is evidence that many issues arise from unaddressed coordination, information sharing, and data integration, for example, as well as under-resourcing and rationalization of the system as a whole.

We recommend that ACBHCS consider realigning internal teams with overlapping and dependent resources and expertise in a manner that will improve the effectiveness and cultural competence of the overall system, towards improving mental health services utilization for APIs, including current functions of the Ethnic Services Manager, MHSA Manager, and other key positions and teams.

Additionally, we make specific recommendations for cultural competence trainings, contract and RFP requirements that we feel will improve the planning and implementation of services targeting APIs and impact the system's ability to reach service utilization goals.

Key Investments:

- Biannual training similar to harassment training requirements for API and non-API providers on cultural competence in working with:
 - API Youth,⁴⁵⁰ 451 Juvenile Justice⁴⁵² APIs,⁴⁵³ LGBTQI, refugee/asylee/immigrant needs,⁴⁵⁴ women, isolated seniors, TAY, alcoholism, problem gambling and smoking in API communities
 - Physicians learning about mental health diagnosis and treatment for API communities⁴⁵⁶ 457

Key Systems Changes:

Cultural Competence Standards

- Make cultural competence standards explicit via requiring plans in RFPs and in contract monitoring
- Make cultural competency and trauma informed care the platforms for program design and contract monitoring
- Engage in an internal legitimization process for cultural competency as a key factor across the entire system in shaping the culture of ACBHCS, similar to current efforts in trauma-informed care that are intended to reach all parts of the organization⁴⁵⁸

Establish an Office of Diversity and Equity within ACBHCS

- Similar to the investment made by San Mateo County Behavioral Health and Recovery Services:
 - Ethnic Services Manager is also Director of Office of Diversity and Equity (ODE);
 - MHSA Manager and WET Coordinator are part of the ODE team

- Current team is 12 members, deployed in support of specific Health Equity Initiatives (ethnic/race based, mental health first aid, suicide prevention, stigma reduction, PRIDE initiative, Digital Storytelling, Cultural Competence Stipends internships, etc.)

REFERENCES

- API Youth Violence Prevention Center: National Council on Crime and Delinquency, "Under the Microscope: Asian and Pacific Islander Youth in Oakland," November, 2003.
- ASNAP, "Focus Group Note," July, 2010.
- Afghan Coalition, "FY 2013-2014 Annual Report," UELP PEI Programs.
- Afghan Coalition, "FY 2014-2015 Annual Report," UELP PEI Programs.
- Afghan Coalition, "FY 2015-2016 Annual Report," UELP PEI Programs.
- Ahmed, F. Z. and Weller, C. E., "Reading Between the Data: The Incomplete Story of Asian Americans, Native Hawaiians, and Pacific Islanders, Center for American Progress," March 2014.
- Ahuja, S. & Chlala, R., "Widening the Lens on Boys and Men of Color: California AAPI and AMEMSA Perspectives," Asian Americans and Pacific Islanders in Philanthropy, June 2013.
- Alameda County Behavioral Health Care Services, "Cultural Competency Plan", 2010.
- Alameda County Behavioral Health Care Services, "Tongan Focus Group," October 11, 2007.
- Asian American Coalition, "Are We Caring for Our Elderly?: Health and the Aging Laotian," June 2001.
- Asian American Recovery Services, a program of HealthRight 360 (AARS/HR360), RTR/ "Project 4PLAY (4 County Prevention and Leadership for Asian and Pacific Islander Young Adults): Final Report," December 2015.
- Asian American Women Artists Association, "Creative California Communities Program Asian American Women Artists Association Application," March 29, 2014.
- Asian Americans and Pacific Islanders in Philanthropy, "A Call to Action: Aligning Public and Private Investments in Asian American, Native Hawaiian and Pacific Islander Communities," 2013
- Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), "Mental Health Services in San Francisco's Asian American and Pacific Islander communities," July 2005.
- Asian Community Mental Health Services, "FY 2011-2012 Annual Report," UELP PEI Programs.

Asian Community Mental Health Services, "FY 2012-2013 Annual Report," UELP PEI Programs.

Asian Community Mental Health Services, "FY 2013-2014 Annual Report," UELP PEI Programs.

Asian Community Mental Health Services, "FY 2014-2015 Annual Report," UELP PEI Programs.

Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," 2007.

Asian Health Services, "Alameda County Mongolian Community Profile and Health Needs Assessment," June 2009.

Asian Pacific Fund and Asian Pacific Psychological Services, "Asian Pacific Fund MHSA planning Focus Group - Community Leaders-Respondent A Transcript," November 30, 2005.

Asian Pacific Fund and Asian Pacific Psychological Services, "Asian Pacific Fund MHSA planning Focus Group - Senior Advocates Transcript," December 9, 2005.

Asian Pacific Islander American Health Forum, "Report to MHSA Santa Clara County Mental Health Department," September 1, 2005.

Asian Pacific Psychological Services, "API Youth Focus Group Summary #1," June 19th 2006.

Asian Pacific Psychological Services, "API Youth Focus Group Summary #2," June 21st 2006.

Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," December 2006.

Asian Pacific Psychological Services, "Asian Pacific Fund MHSA Planning Focus Group - Youth Leaders Summary," November 18, 2005.

Asian Pacific Psychological Services, "Asian Pacific Fund MHSA Planning Focus Group - Youth Mental Health Services Consumers Summary," December 2, 2005.

Asian Pacific Psychological Services, "Focus Group for Community Needs-Burmese Community," December 4, 2007.

Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, "Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California," June 2012.

Burma Refugee Family Network and San Francisco State University, "From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma," 2011.

California Reducing Disparities Project API Strategic Planning Workgroup, "Focus Group Summary Mongolian," September 26, 2010.

California Reducing Disparities Project API Strategic Planning Workgroup, "Focus Group Summary Pacific Islander," September 17, 2010.

California Reducing Disparities Project API Strategic Planning Workgroup, "Focus Group Summary Thai," September 25, 2010.

California Reducing Disparities Project API Strategic Planning Work Group, "In Our Own Words: California Reducing Disparities Project API Population Report," March 2013.

Center for Empowering Refugees and Immigrants, "FY 2014-2015 Annual Report," UELP PEI Programs.

Center for Empowering Refugees and Immigrants, "FY 2015-2016 Annual Report," UELP PEI Programs.

Center for Empowering Refugees and Immigrants, "Workforce, Education and Training for Indigenous, Refugee and New Immigrant Communities Wellness in Action Program Proposal," August 2016.

Community Health for Asian Americans, "API Adult Mental Health Needs and Potential Solutions," 2013.

Community Health for Asian Americans, "FY 2013-2014 Annual Report," UELP PEI Programs.
Community Health for Asian Americans, "FY 2014-2015 Annual Report," UELP PEI Programs.

Community Health for Asian Americans, "Leadership for Community Wellness: Mid-term report," January 2016.

Community Health for Asian Americans, MHSR Regulations Presentation, Spring 2016

Community Health for Asian Americans, "OAA HIV Prevention & Testing Annual Progress Report FY 2012-2013," July 2013.

Community Health for Asian Americans, "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," April 2015.

Community Health for Asian Americans, "Reflections on Working with API Immigrant and Refugee Youth: Well-Established vs. Newcomer Young People - CRDP Presentation."

Community Health for Asian Americans, "Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015."

East Oakland Building Healthy Communities, "Discussion Group Notes - API Stakeholders Group at LIMCA," April 11, 2010.

East Oakland Building Healthy Communities, "Discussion Group Notes - API Stakeholders Group at Lao Family Community Development, Inc.," April 10, 2010.

Fadiman, A., "The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures," Farrer, Straus and Giroux, New York, 1997.

Fraser, M. W. and Anderson, B.G., "Psychological Adaptation Among Indochinese Refugees," *The Journal of Applied Social Sciences*, 10,1:20-39, 1985(a).

Fraser, M. W. and Anderson, B.G., "The Social Support Networks of Indochinese Refugees," *Journal of Sociology and Social Welfare*, 12,4: 817-849, 1985(b)

Healthy Richmond API Work Group, "API Listening Sessions 2015 Findings Report," March 2016.

Hume Center, "FY 2013-2014 Annual Report," UELP PEI Programs.

Hume Center, "FY 2015-2016 Annual Report," UELP PEI Programs.

International Rescue Committee Center for Wellbeing, "Program Design: Refugee Wellness Navigators," October 2015

Korean Community Center of the East Bay/ Health Research for Action, "Korean Needs Assessment of the Bay Area (KoNA Bay Area)," January 2016.

Korean Community Center of the East Bay/ Health Research for Action, "Korean Needs Assessment of the Bay Area (KoNA Bay Area) Policy Brief Reducing Mental Health Disparity by Increased Efficacy in Culturally Relevant Community Engagement," January 2016.

Le, G., Liao, M., and Woo, K., "Problem Gambling in the Asian American Community, PowerPoint Presentation," September 22, 2011.

Mollica, J., "Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations," February 2014.

National Council on Crime and Delinquency, "Asian/Pacific Islander Communities: An Agenda for Positive Action," November 2001.

National Council on Crime and Delinquency, Center on Culture, Immigration and Youth Violence Prevention, "A Profile of Pacific Islanders in Oakland, CA," September 2007.

Personal Communication, Patricia Rojas-Zambrano, "Mental Health Interpreter Training and Wellness in Action Training," January 25, 2017.

San Francisco State University Asian American Studies and Community Health for Asian Americans, "2014 Mongolian Health Survey: San Francisco Bay Area and Sacramento," October 21, 2014.

San Francisco State University Asian American Studies and Community Health for Asian Americans, "Community Wellness Survey: Himalayan Women in the San Francisco Bay Area," July 31, 2014.

Southeast Asian Youth and Family Alliance (SAYFA) and Asian Pacific Psychological Services, "Asian and Pacific Islander Youth Homelessness in West Contra Costa County - A Needs Assessment prepared for West Contra Costa County Unified School District Homeless Programs," March 16 2007.

Smith, V. J., "The Information Needs of Female Afghan Refugees, Recommendations for Service Providers," 2009, 2012.

State of California Commission on Asian and Pacific Islander American Affairs, "Annual Report 2005 - Rising to the Task: Facing New Challenges in California's APIA Communities," 2005.

Tseng, Winston, et al., "Ethnic Health Assessment for Asian Americans, Native Hawaiians, and Pacific Islanders in California," August 2010.

Um, K., "A Dream Denied: Educational Experiences of Southeast Asian American Youth Issues and Recommendations," SEARAC, 2003.

Yang, L and PEERS, "Final Report of Social Inclusion Campaign-Chinese Americans (Year 1 Accomplishments)," June 24, 2015.

Yang, L and PEERS, "Powerpoint of Internalized Stigma Group Year 2 Results," January 14, 2017.

ENDNOTES

- ¹ The portion of the U.S. population that self-identifies as Asian grew 46 percent from 2000 to 2010. (“Reading Between the Data: The Incomplete Story of Asian Americans, Native Hawaiians, and Pacific Islanders,” Farah Z. Ahmed and Christian E. Weller, Center for American Progress, March 2014, p. 2)
- ² Latinos in Alameda County represent 22.6% of the total population (US Census 2015 estimates).
- ⁴ “Reading Between the Data: The Incomplete Story of Asian Americans, Native Hawaiians, and Pacific Islanders,” Farah Z. Ahmed and Christian E. Weller, Center for American Progress, March 2014, p. 2
- ⁵ Indeed, concerns with low levels of service utilization by Asians and Pacific Islanders and reflections on major challenges and recommendations for strategies to address these interconnected issues appear to be shared beyond Alameda County with other Counties in the Bay Area and Statewide, and the issue has been of concern for several decades. The concern with APIs being not served, poorly served or underserved with mental health services has been a local concern for over 40 years in Alameda County. Asian Community Mental Health Services was founded in 1974, initially to address LEP API needs. With the expansion of children’s MediCal, Asian Pacific Psychological Services (Community Health for Asian Americans since 2009) was founded in 1996 to address the limited mental health services available for API children and youth. A report solicited by Asian Pacific Fund and submitted to ACBHCS in December 2007 was researched and prepared by three local API-serving organizations - Asian Community Mental Health Services (ACMHS), Asian Pacific Psychological Services (APPS, which changed its name to Community Health for Asian Americans in 2009)), and Culture-to-Culture Foundation. Then, as now, APIs were recognized as “severely underserved” by Alameda County’s mental health system, and this report was written in order to provide community guidance on mental health service and access issues impacting API communities and to shape MHSA planning. The report found that “While 39% percent of the total population with SED/SMI is unserved, 65% of the API population or (3,918 people) with SED/SMI is unserved.” (p. 4-5) “The Asian community of Alameda County is severely underserved by the county mental health system. An estimated two of every three Asian individuals with severe mental illness or serious emotional disturbance are not being served. For children, youth and older adults three out of every four individuals is unserved. The implications of this lack of service is staggering. In addition to placing greater strain and suffering on individuals and families, it threatens the futures of children and youth, limits that chances of successful transition to adulthood, leaves women to suffer in silence from domestic violence and keeps older adults isolated and unsupported.” (p. 20) (“Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007)
- ⁶ “Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007
- ⁷ California Reducing Disparities Project API Strategic Planning Work Group, 2013, citing Sorkin, Pham, & Ngo-Metzger, 2009
- ⁸ “Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 20-21
- ⁹ Alameda County’s current official threshold languages include English, Chinese, Vietnamese, Cambodian, Farsi, and Tagalog.
- ¹⁰ “Reading Between the Data: The Incomplete Story of Asian Americans, Native Hawaiians, and Pacific Islanders,” Farah Z. Ahmed and Christian E. Weller, Center for American Progress, March 2014, p. 10
- ¹¹ “API communities living in Alameda County that are most impacted by inadequate services and supports include refugees and new immigrants. These include, but are not limited to: refugees and asylees from Bhutan (who speak Nepali); refugees and asylees from Burma (Karen, Karenni, Chin, and others); immigrants and refugees from Mongolia; immigrants and asylees from Nepal; Pacific Islanders (Tongan, Samoan, and others); refugees and asylees from Sri Lanka; immigrants from Thailand; immigrants, refugees and asylees from Tibet. Additionally, the Cambodian community, while having some resources, still faces levels of need that indicate additional support needs above what is currently available.” “API Adult Mental Health Needs and Potential Solutions,” Community Health for Asian Americans, 2013
- ¹² “Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County,” Community Health for Asian Americans, 2015, p. 10
- ¹⁴ “In Our Own Words: California Reducing Disparities Project API Population Report,” California Reducing Disparities Project API Strategic Planning Work Group, March 2013.
- ¹⁵ Fadiman, Anne, “The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures,” Farrer, Straus and Giroux, New York, 1997, p. 28. Fadiman’s well-known book was researched in the Hmong communities of Merced and Fresno, CA.
- ¹⁶ “Focus Group Summary Mongolian,” California Reducing Disparities Project API Strategic Planning Workgroup, September 26, 2010, p.4

-
- 17 "Asian Pacific Fund MHA Planning Focus Group - Youth Leaders Summary," Asian Pacific Psychological Services, November 18, 2005.
- 18 "Asian Pacific Fund MHA planning Focus Group - Senior Advocates Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, December 9, 2005, p. 1
- 19 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 15
- 20 "Focus Group Summary Pacific Islander", California Reducing Disparities Project API Strategic Planning Workgroup, September 17, 2010.
- 21 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 15
- 22 "Final Report of Social Inclusion Campaign-Chinese Americans (Year 1 Accomplishments)," Yang, L and PEERS. June 24, 2015.
- 23 "In Our Own Words: California Reducing Disparities Project API Population Report," California Reducing Disparities Project API Strategic Planning Work Group, March 2013.
- 24 "Korean Needs Assessment of the Bay Area (KoNA Bay Area) Policy Brief Reducing Mental Health Disparity by Increased Efficacy in Culturally Relevant Community Engagement," Korean Community Center of the East Bay/ Health Research for Action, January 2016.
- 25 "Focus Group Summary Thai," California Reducing Disparities Project API Strategic Planning Workgroup, September 25, 2010, p.3.
- 26 "Focus Group Summary Thai," California Reducing Disparities Project API Strategic Planning Workgroup, September 25, 2010, p.3-4
- 27 Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015," Community Health for Asian Americans," 2015, p. 9.
- 28 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 8
- 29 ASNAP Focus Group Note, July, 2010.
- 30 "Asian Pacific Fund MHA planning Focus Group - Senior Advocates Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, December 9, 2005, p. 2-3
- 31 "Report to MHA Santa Clara County Mental Health Department," Asian Pacific Islander American Health Forum, September 1, 2005.
- 32 ASNAP Focus Group Note, July, 2010.
- 33 "Final Report of Social Inclusion Campaign-Chinese Americans (Year 1 Accomplishments)," Yang, L and PEERS. June 24, 2015.
- 34 Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015," Community Health for Asian Americans," 2015, p. 9.
- 35 "Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015," Community Health for Asian Americans, 2015, p.13
- 36 "In Our Own Words: California Reducing Disparities Project API Population Report," California Reducing Disparities Project API Strategic Planning Work Group, March 2013.
- 37 Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), "Mental Health Services in San Francisco's Asian American and Pacific Islander communities," July 2005, p.2
- 38 2014 Mongolian Health Survey: San Francisco Bay Area and Sacramento," San Francisco State University Asian American Studies and Community Health for Asian Americans, "October 21, 2014, p.12.
- 39 "Community Wellness Survey: Himalayan Women in the San Francisco Bay Area," San Francisco State University Asian American Studies and Community Health for Asian Americans, July 31, 2014, p.36.
- 40 "Focus Group Summary Mongolian," California Reducing Disparities Project API Strategic Planning Workgroup, September 26, 2010, p.4
- 41 See "Epidemiological Study on Prevalence of Alcohol Consumption, Alcohol Drinking Patterns and Alcohol Related Harms in Mongolia." Funded by the World Health Organization and jointly published by the Ministry of Health of Mongolia, WHO, and Center of Mental Health and Narcology, Mongolia.
<http://moh.mn/moh%20db/HealthReports.nsf/32fe9f3e7452a6f3c8256d1b0013e24e/1380506cf1d8d8e1c825718c0012c0ed?OpenDocument> in "Alameda County Mongolian Community Profile and Health Needs Assessment," Asian Health Services, June 2009, p.16
- 42 "Alameda County Mongolian Community Profile and Health Needs Assessment," Asian Health Services, June 2009, p. 21
- 43 "Korean Needs Assessment of the Bay Area (KoNA Bay Area)," Korean Community Center of the East Bay/ Health Research for Action, January 2016, p. 22

44 "Problem Gambling in the Asian American Community, PowerPoint Presentation," Le, G., Liao, M., and Woo, K., September 22, 2011.

45 "Asian Pacific Fund MHSA planning Focus Group - Senior Advocates Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, December 9, 2005, p.6

46 "Asian Pacific Fund MHSA planning Focus Group - Community Leaders-Respondent A Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, November 30, 2005, p. 10

47 "Annual Report 2005 - Rising to the Task: Facing New Challenges in California's APIA Communities, 2005," State of California Commission on Asian and Pacific Islander American Affairs, p. 15-19

48 "Asian Pacific Fund MHSA planning Focus Group - Senior Advocates Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, December 9, 2005, p. 2

49 "Are We Caring for Our Elderly?: Health and the Aging Laotian," Asian American Coalition, June 2001.

50 "Asian Pacific Fund MHSA planning Focus Group - Community Leaders-Respondent A Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, November 30, 2005, p. 10

51 "Asian Pacific Fund MHSA Planning Focus Group - Youth Mental Health Services Consumers Summary," Asian Pacific Psychological Services, December 2, 2005, p. 6

52 "Ethnic Health Assessment for Asian Americans, Native Hawaiians, and Pacific Islanders in California," Tseng, W., et al., August 2010.

53 Reports agree that there are sparse resources for API seniors in almost every community. Alameda County BHCS itself dedicated MHSA Innovations Round 3 to projects designed to reach Isolated and Older Adults with Severe Mental Illness in 2013-15, and funded several projects designed to reach specific API communities, including a project to reach Chinese and Korean elders (ACMHS), and a collaborative of projects reaching Cambodian (Center for Empowering Refugees and Immigrants), Filipino (Filipino Advocates for Justice) and Korean (Korean Community Center of the East Bay) through Community Health for Asian Americans. Center for Empowering Refugees and Immigrants largely serves Cambodian adult and older adult survivors of the Khmer Rouge genocide.

54 "Asian Pacific Fund MHSA planning Focus Group - Senior Advocates Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, December 9, 2005, p. 3-4

55 "Asian Pacific Fund MHSA planning Focus Group - Senior Advocates Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, December 9, 2005, p. 1-2

56 "Asian Pacific Fund MHSA Planning Focus Group - Youth Mental Health Services Consumers Summary," Asian Pacific Psychological Services, December 2, 2005, p. 2

57 "From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma," Burma Refugee Family Network, 2011, p.22

58 "While no group members mentioned specific mental health problems, issues of sadness came up in the focus groups. Research has shown that distressed refugees from Southeast Asia express symptoms that are more consistent with Asian classification of mental disorders than with Western clinical categories (Chung and Kagawa-Singer, 1995). These symptoms often resemble the construct for neurasthenia, which includes both physical and psychological manifestations of distress. Major symptoms of neurasthenia include a feeling of weakness or fatigue, which may be accompanied by chest pain, rapid irregular heartbeat, dizziness, and physical discomfort." "Are We Caring for Our Elderly?: Health and the Aging Laotian," Asian American Coalition, June 2001, p. 5-6

59 "From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma," Burma Refugee Family Network, 2011, p.22

60 "Are We Caring for Our Elderly?: Health and the Aging Laotian," Asian American Coalition, June 2001, p. 5

61 "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." "In Our Own Words: California Reducing Disparities Project API Population Report," California Reducing Disparities Project API Strategic Planning Work Group, March 2013.

62 "Among the respondents who had experienced these acts of IPV, only 29% reported having discussed this violence with others (third parties). When asked who might be good to talk with when violence happens in an intimate partnership, the respondents answered a health care provider of some type (62%), clergy (46%), friend (40%), family member (37%), other professional (20%), and community organization (13%) (multiple answers were permitted)." "Korean Needs Assessment of the Bay Area (KoNA Bay Area)," Korean Community Center of the East Bay/ Health Research for Action, January 2016.

63 "In Our Own Words: California Reducing Disparities Project API Population Report," California Reducing Disparities Project API Strategic Planning Work Group, March 2013.

64 "Korean Needs Assessment of the Bay Area (KoNA Bay Area)," Korean Community Center of the East Bay/ Health Research for Action, January 2016.

65 "Korean Needs Assessment of the Bay Area (KoNA Bay Area) Policy Brief Reducing Mental Health Disparity by Increased Efficacy in Culturally Relevant Community Engagement," Korean Community Center of the East Bay/ Health Research for Action, January 2016.

66 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006.

67 "FY 2012-2013 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

68 "Focus Group Summary Thai", California Reducing Disparities Project API Strategic Planning Workgroup, September 25, 2010, p.1.

69 "Korean Needs Assessment of the Bay Area (KoNA Bay Area) Policy Brief Reducing Mental Health Disparity by Increased Efficacy in Culturally Relevant Community Engagement," Korean Community Center of the East Bay/ Health Research for Action, January 2016.

70 "Asian Pacific Fund MHSA Planning Focus Group - Youth Mental Health Services Consumers Summary," Asian Pacific Psychological Services, December 2, 2005, p. 9

71 "Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015," Community Health for Asian Americans, 2015, p.13

72 "Focus Group Summary Thai," California Reducing Disparities Project API Strategic Planning Workgroup, September 25, 2010, p.2

73 "Focus Group Summary Mongolian", California Reducing Disparities Project API Strategic Planning Workgroup, September 26, 2010, p.3

74 "Focus Group Summary Thai," California Reducing Disparities Project API Strategic Planning Workgroup, September 25, 2010, p.3

75 "Focus Group Summary Mongolian", California Reducing Disparities Project API Strategic Planning Workgroup, September 26, 2010, p.3

76 California Reducing Disparities Project API Strategic Planning Workgroup Pacific Islander Focus Group Summary, 2010. For more on Pacific Islanders and faith communities, see also, Alameda County Behavioral Health Care Services, October, 2007: "Problems are shared with pastors"; ASNAP Focus Group Note, July, 2010: "Since the community is so church based, it's important to reach out to them. All Samoa churches have sister American churches"; National Council on Crime and Delinquency, September 2007, noted that in Oakland there are "six Samoan and Tongan-specific related places of worship."

77 "Tongan Focus Group," Alameda County Behavioral Health Care Services, October 11, 2007.

78 "The Information Needs of Female Afghan Refugees, Recommendations for Service Providers", Smith, V. J.,2009, 2012, p.18.

80 "Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015," Community Health for Asian Americans, 2015, p. 9

81 "Under the Microscope: Asian and Pacific Islander Youth in Oakland," API Youth Violence Prevention Center: National Council on Crime and Delinquency, November, 2003, p.53-54

82 "Asian/Pacific Islander Communities: An Agenda for Positive Action," National Council on Crime and Delinquency, November 2001, p. 9

83 "Under the Microscope: Asian and Pacific Islander Youth in Oakland," API Youth Violence Prevention Center: National Council on Crime and Delinquency, November, 2003.

84 "Asian Pacific Fund MHSA Planning Focus Group - Youth Mental Health Services Consumers Summary, Asian Pacific Psychological Services, December 2, 2005.

85 "In 1990, 55% of Hmong, 41% of Cambodian, and 34% of Lao immigrants had not completed the equivalent of the 5th grade (President's Advisory Commission on Asian Americans and Pacific Islanders, 2001), and only 6% of Cambodian, 3% of Hmong, 7% of Non-Hmong Laotian, and 17% of Vietnamese Americans have managed to complete a college education compared to the national average of 21% (Sok, 2001)," see "Asian/Pacific Islander Communities: An Agenda for Positive Action," National Council on Crime and Delinquency, November 2001.

86 "Asian/Pacific Islander Communities: An Agenda for Positive Action," National Council on Crime and Delinquency, November 2001, p. 13

87 "Reflections on Working with API Immigrant and Refugee Youth: Well-Established vs. Newcomer Young People - CRDP Presentation" Community Health for Asian Americans

88 "Asian and Pacific Islander Youth Homelessness in West Contra Costa County - A Needs Assessment prepared for West Contra Costa County Unified School District Homeless Programs, "Southeast Asian Youth and Family Alliance (SAYFA) and Asian Pacific Psychological Services, March 16 2007.

89 "Asian/Pacific Islander Communities: An Agenda for Positive Action," National Council on Crime and Delinquency, November 2001, p. 15

90 "Community Wellness Survey: Himalayan Women in the San Francisco Bay Area," San Francisco State University Asian American Studies and Community Health for Asian Americans, July 31, 2014, p 54, 56, 58, 61, 62

-
- 91 Korean Needs Assessment of the Bay Area (KoNA Bay Area), Korean Community Center of the East Bay/Health Research for Action, January 2016
- 92 "Asian/Pacific Islander Communities: An Agenda for Positive Action," National Council on Crime and Delinquency, November 2001, p. 16
- 93 "Asian Pacific Fund MHS Planning Focus Group - Youth Leaders Summary," Asian Pacific Psychological Services, November 18, 2005
- 94 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 15-16
- 95 "Asian Pacific Fund MHS Planning Focus Group - Youth Leaders Summary," Asian Pacific Psychological Services, November 18, 2005
- 96 "A Dream Denied: Educational Experiences of Southeast Asian American Youth Issues and Recommendations," Um, K. SEARAC, 2003.
- 97 "A Dream Denied: Educational Experiences of Southeast Asian American Youth Issues and Recommendations," Um, K. SEARAC, 2003.
- 98 "Asian Pacific Fund MHS Planning Focus Group - Youth Leaders Summary," Asian Pacific Psychological Services, November 18, 2005.
- 99 "Tongan Focus Group," Alameda County Behavioral Health Care Services, October 11, 2007.
- 100 "Focus Group for Community Needs-Burmese Community," Asian Pacific Psychological Services, December 4, 2007
- 101 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 11
- 102 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 13
- 103 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 13
- 104 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 15
- 105 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix E
- 106 "Report to MHS Santa Clara County Mental Health Department," Asian Pacific Islander American Health Forum, September 1, 2005, p. 5
- 107 "Focus Group Summary Pacific Islander," California Reducing Disparities Project API Strategic Planning Workgroup, September 17, 2010.
- 108 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 15
- 109 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 13
- 110 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 16-20
- 111 "Asian Pacific Fund MHS Planning Focus Group - Youth Mental Health Services Consumers Summary," Asian Pacific Psychological Services, December 2, 2005.
- 112 "Asian Pacific Fund MHS Planning Focus Group - Youth Mental Health Services Consumers Summary," Asian Pacific Psychological Services, December 2, 2005.
- 113 "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 10
- 114 "The Information Needs of Female Afghan Refugees, Recommendations for Service Providers," Smith, V. J., 2009, 2012, p.5, 7.
- 115 "Bhutanese refugees responding to this survey report language barriers (53%), lack of employment (47%), and difficulties with adjustment to the American culture and system (45%) to be the top problems facing their community... These top reported community issues match up well with the top services that the survey respondents reported needing for themselves: English classes (60%), followed closely by job training (59%), health care (55%),

and affordable housing (49%).” “Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California,” Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, June 2012, p. 19-20

116 “New immigrants and refugees we work with, express their urgent needs as accessing health care insurance and coverage, financial security, and personal and family safety.” “Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015,” Community Health for Asian Americans, 2015, p. 10

117 “Discussion Group Notes - API Stakeholders Group at Lao Family Community Development, Inc.,” East Oakland Building Healthy Communities, April 10, 2010.

118 “Top sources of stress are work (36%); school (30%); finances (30%); and unemployment (20%); Top needs for help include getting a job (35%); educational funding (33%); affordable housing (18%); health care (16%); and English improvement (16%)” “Community Wellness Survey: Himalayan Women in the San Francisco Bay Area,” San Francisco State University Asian American Studies and Community Health for Asian Americans, July 31, 2014, p. 23, 39, 41

119 “Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California,” Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, June 2012, p. 12

120 “From Crisis to Community Development: Needs and Assets of Oakland’s Refugees from Burma,” Burma Refugee Family Network, 2011, p.22

121 “From Crisis to Community Development: Needs and Assets of Oakland’s Refugees from Burma,” Burma Refugee Family Network, 2011, p.21

122 “Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California,” Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, June 2012, p. 17

123 “Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California,” Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, June 2012, p.12, 17

124 “Suicide and Suicidal Ideation Among Bhutanese Refugees — United States, 2009–2012,” *Morbidity and Mortality Weekly Report (MMWR)*, July 5, 2013, 62:533-536, <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6226a2.htm>

125 Estimated data from 2010-2014 indicated Alameda County’s undocumented population to be 105,000. An estimated 30,000 are from Asia. Numbers from Oceania have been combined with those from Europe and Canada for a total of 3,000. Largest undocumented Asian communities in Alameda County include from China (9,000-8%), India (8,000-7%), Philippines (5,000 - 5%), Korea (2,000-2%), and Vietnam (2,000-2%). Community reports also indicate undocumented communities from Cambodia, Mongolia, Nepal, Thailand and Tonga. See <http://www.migrationpolicy.org/data/authorized-immigrant-population/county/6001> and <http://www.migrationpolicy.org/programs/data-hub/charts/authorized-immigrant-populations-country-and-region-top-state-and-county>.

126 “Alameda County Mongolian Community Profile and Health Needs Assessment,” Asian Health Services, June 2009, p.20-21

127 “Discussion Group Notes - API Stakeholders Group at LIMCA,” East Oakland Building Healthy Communities, April 11, 2010, p.2

128 “Dr. Wallin at SLHP estimates that 30% of the Mongolian patients are depressed, stressed, and experience other mental health problems (such as anxiety, insomnia, panic disorders, alcohol and drug abuse, poor memory, post-traumatic stress disorder, and anger management).” “Alameda County Mongolian Community Profile and Health Needs Assessment,” Asian Health Services, June 2009, p.20-21

129 “Focus Group Summary Mongolian,” California Reducing Disparities Project API Strategic Planning Workgroup, September 26, 2010, p.1, 5

130 “A Dream Denied: Educational Experiences of Southeast Asian American Youth Issues and Recommendations,” Um, K. SEARAC, 2003.

131 “A Dream Denied: Educational Experiences of Southeast Asian American Youth Issues and Recommendations,” Um, K. SEARAC, 2003.

132 “Discussion Group Notes - API Stakeholders Group at LIMCA,” East Oakland Building Healthy Communities, April 11, 2010, p.1

133 “Discussion Group Notes - API Stakeholders Group at Lao Family Community Development, Inc.,” East Oakland Building Healthy Communities, April 10, 2010, p.1

134 “Discussion Group Notes - API Stakeholders Group at LIMCA,” East Oakland Building Healthy Communities, April 11, 2010, p.2

135 “Discussion Group Notes - API Stakeholders Group at Lao Family Community Development, Inc.,” East Oakland Building Healthy Communities, April 10, 2010, p.2-3.

136 East Oakland Building Healthy Communities, Discussion Group Notes - API Stakeholders Group at Lao Family Community Development, Inc., April 10, 2010, p.4

137 “Asian Pacific Fund MHS Planning Focus Group - Youth Mental Health Services Consumers Summary,” Asian Pacific Psychological Services, December 2, 2005.

138 “Discussion Group Notes - API Stakeholders Group at Lao Family Community Development, Inc.,” East Oakland Building Healthy Communities, April 10, 2010, p.1, 4

-
- 139 "Asian and Pacific Islander Youth Homelessness in West Contra Costa County - A Needs Assessment prepared for West Contra Costa County Unified School District Homeless Programs, Southeast Asian Youth and Family Alliance (SAYFA) and Asian Pacific Psychological Services, March 16 2007.
- 140 "Discussion Group Notes - API Stakeholders Group at Lao Family Community Development, Inc.," East Oakland Building Healthy Communities, April 10, 2010, p.3.
- 141 "Asian and Pacific Islander Youth Homelessness in West Contra Costa County - A Needs Assessment prepared for West Contra Costa County Unified School District Homeless Programs, Southeast Asian Youth and Family Alliance (SAYFA) and Asian Pacific Psychological Services, March 16 2007.
- 142 "From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma," Burma Refugee Family Network, 2011, p.23-24
- 143 "Mental Health Services in San Francisco's Asian American and Pacific Islander communities," Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), July 2005, p.3
- 144 "API Listening Sessions 2015 Findings Report," Healthy Richmond API Work Group, March 2016, p. 3
- 145 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 10-11
- 146 The authors also note fear of Child Protective Services encountered through mental health services when cultural disciplinary styles clash with legal and ethical standards upheld by mandated reporters. This is another barrier to accessing mental health services, as communities have stories of families that have lost custody of their children or entanglement with CPS resulting from having accessed services. Paraprofessionals are also often reluctant to report concerns due to fears of community backlash, and require dedicated support in understanding and complying with mandated reporting requirements.
- 147 'As long as doctors and parents continue to negotiate, even if they disagree, the conflict is confined to differences in belief systems. "Once the police are called and court orders are obtained, however, the difficulties escalate to another level," wrote Culhane-Pera. "The differences are no longer about beliefs. The differences are about power. Doctors have power to call the police and to access state power which Hmong parents do not have." Because the Hmong have historically been so resistant to authority, they are especially confused and enraged when they are stripped of their power in a country to which they have fled because of its reputation for freedom.' (Anne Fadiman, "The Spirit Catches You and You Fall Down," p. 84)
- 148 "Korean Needs Assessment of the Bay Area (KoNA Bay Area)," Korean Community Center of the East Bay/ Health Research for Action, January 2016.
- 149 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 14
- 150 "Korean Needs Assessment of the Bay Area (KoNA Bay Area)," Korean Community Center of the East Bay/ Health Research for Action, January 2016.
- 151 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 10
- 152 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix
- 153 "Korean Needs Assessment of the Bay Area (KoNA Bay Area) Policy Brief Reducing Mental Health Disparity by Increased Efficacy in Culturally Relevant Community Engagement," Korean Community Center of the East Bay/ Health Research for Action, January 2016.
- 154 "Focus Group for Community Needs-Burmese Community," Asian Pacific Psychological Services, December 4, 2007.
- 155 "Report to MHSA Santa Clara County Mental Health Department," Asian Pacific Islander American Health Forum, September 1, 2005.
- 156 "Under the Microscope: Asian and Pacific Islander Youth in Oakland," API Youth Violence Prevention Center: National Council on Crime and Delinquency, November, 2003.
- 157 Statistic from Ponce, Tseng, Ong, Shek, Ortiz, & Gatchell, 2009 as cited in "In Our Own Words: California Reducing Disparities Project API Population Report," California Reducing Disparities Project API Strategic Planning Work Group, March 2013.
- 158 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 10
- 159 "Tongan Focus Group," Alameda County Behavioral Health Care Services, October 11, 2007.
- 160 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006.

161 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 10

162 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 11

163 "From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma," Burma Refugee Family Network and San Francisco State University, 2011

164 California Reducing Disparities Project API Strategic Planning Work Group, 2013

165 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 14

166 "Reading Between the Data: The Incomplete Story of Asian Americans, Native Hawaiians, and Pacific Islanders," Farah Z. Ahmed and Christian E. Weller, Center for American Progress, March 2014, p. 9

167 "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 9

168 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 10-11

169 "Many state that they accompany their parents from place to place to provide confidence and serve as translators. Increasingly it appears among the Southeast Asian community that this language disparity affects the way both the relationship between parent and child, but also the reliability in which they access services. Parents often do not have a signature and can only print their name, asking youth instead to help their parents write out their own signatures. Parents tend to rely on their children to translate difficult adult issues like housing, finances, and health, instead of asking other adults for help. Illustrating this trend, one youth stated how he often does not understand the advanced vocabulary, does not know how to find the equivalent translation, leading to misunderstandings and mistranslations." "Asian and Pacific Islander Youth Homelessness in West Contra Costa County - A Needs Assessment prepared for West Contra Costa County Unified School District Homeless Programs," Southeast Asian Youth and Family Alliance and Asian Pacific Psychological Services, March 2007

174 "In addition to stigma and lack of familiarity or comfort with mainstream mental health services, language needs are among the most significant barriers to access for mental health and other services for APIs, especially those from new, emerging and small communities. API clients frequently report a lack of adequate language support, including well trained and supported interpretation, case management and service navigation. Cultural competency is also an issue, as well as client understandings of health issues, complex systems, and access issues related to insurance and immigration status that exacerbate language appropriate service gaps." "API Adult Mental Health Needs and Potential Solutions," Community Health for Asian Americans, 2013, pp. 2-3

175 Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California," Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, June 2012, p.28

177 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 7

178 Hume Center, FY 2015-2016 Annual Report, UELP PEI Programs, p. 3

179 "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 9

181 For example, one report examining refugee and asylee health and behavioral health services in Alameda County noted that "Within behavioral health systems, a lack of referral mechanisms and specially-trained interpreters creates barriers to care access." ("Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations," Jennie Mollica, February 2014, p. 6)

182 "For behavioral health care, there are virtually no professionally trained mental health clinicians in any locations who speak the languages of Alameda County newcomer immigrant and refugee communities, and the current MediCal mental health service models do not include those where the inclusion of interpreters is part of the service model. Organizations wishing to provide such models are discouraged by the system from doing so, and are often insufficiently resourced to support the needs of interpreters on par with the supports given professional mental health providers (e.g., weekly individual and group supervision provided by a licensed mental health clinical supervisor). MHPA PEI-funded providers from new and emerging communities are, hence, taxed with providing service support, often without their own good support and outside of their individual and program scopes of work." "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 15

183 Language access challenges for APIs appears to be an issue not only an issue in Alameda County, but in neighboring Bay Area Counties as well as statewide and nationally. Healthy Richmond (one of the 14 community sites for The California Endowment's 10-year "Building Healthy Communities" initiative) convened an API Work

Group to identify issues and priorities for the initiative and to conduct Listening Sessions with API community members in 2014. The work group reported that “API residents [in Contra Costa County] pointed to language and culture as barriers to their integration and acceptance in the community. These were barriers to information, resources, and services, as well as their interaction with other residents and city/county agencies.” The report also highlighted the need for interpretation and translation, transportation, and language/cultural assistance with navigating systems, particularly for senior residents” (API Listening Sessions 2015 Findings Report, Healthy Richmond API Work Group, March 2016, p. 3). The California Reducing Disparities Project API Strategic Planning Work Group, for example, noted that “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)” (California Reducing Disparities Project API Strategic Planning Work Group, 2013). In Alameda County (2007), “Seventy-two percent (72%) of respondents to the Consumer and Caregiver survey [used for preparing recommendations to ACBHCS on MHSA planning for API needs] indicated that they had difficulty finding appropriate mental health providers due to language barriers” (“Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 14).

¹⁸⁴ “Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County,” Community Health for Asian Americans, 2015, p. 9

¹⁸⁵ It appears that one unintended consequence of creating UELP programs is that ACBHCS program funding through MHSA PEI is filling language access gaps for other systems (health, schools and social services, in particular) that have not invested in, or do not have the resources to invest in, providing language support for some API communities: “Some systems are also paying for meeting the language assistance needs for clients not met by shrinking resources in other systems. For example, organizations funded by ACBHCS for MHSA Prevention and Early Intervention work are often called upon to provide interpretation at schools, hospitals and social services due to inadequate language access and service navigation resources for LEP clients from many communities who do not meet threshold language numbers. For example, many immigrants and refugees report that Social Services Agency (SSA) lacks the linguistic capacity to communicate with people who speak language of lesser dispersion either in person or telephonically in many cases. According to the Alameda County Social Services Agency Language Access Plan (2015 draft), currently only 6% (120+ people) of the total ACSSA staff (2000+) are bi- or multi-lingual, and only a fraction of these are available to provide their languages in support of clients seeking access assistance due to language. The client’s inability to understand notices of action or re-determination requests leads them to require a third-party translator from the community.” “Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County,” Community Health for Asian Americans, 2015, p. 15

¹⁸⁶ Personal communication, Tracy Hazelton, MHSA Manager, Alameda County Behavioral Health Care Services, 02/03/17.

¹⁸⁷ For comparison, San Mateo County Behavioral Health and Recovery Services has invested in a training called “Working with Interpretation in Behavioral Health Settings” since 2010 for providers supplied by their language access vendor, which is required as part of their contract agreement, and for County therapy staff. SMCBHRS pays for the trained interpreters to provide interpretation services in mental health services provided by County staff through their interpretation vendor which is funded through County General Funds. Further, interpreters are available to provide support throughout the health system, not just in the behavioral health system. SMBHRS-funded CBOs have a separate budget line in their contracts for language access services that allows them to access interpreters from the approved language access vendor. Going rates for interpreters in SMBHRS’ system range \$60-100/hour, depending on how common the language is. Personal communication with Doris Estremera, MHSA Manager, San Mateo County Behavioral Health and Recovery Services, 01/17/17.

¹⁸⁸ For example, “ACCESS does not have the capacity to do the screening and referrals which makes it challenging for this population to connect to services.” (Hume Center, FY 2013-2014 Annual Report, UELP PEI Programs, p. 3)

¹⁸⁹ API Connections (UELPE) Annual report, Asian Community Mental Health Services, July 2011

¹⁹⁰ “Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County,” Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 14

¹⁹¹ “Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 10-11

¹⁹² “Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County,” Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix A

193 “Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 12

194 Participants in the behavioral health conversations included Tracy Hazelton and Gigi Crowder (ACBHCS) and representatives of Afghan Center, Alameda Health System, Asian Americans for Community Involvement, Asian Community Mental Health Services, Catholic Charities of the East Bay, Center for Empowering Refugees and Immigrants, Community Health for Asian Americans, East Bay Refugee Forum, Hume Center, International Rescue Committee, Oakland International High School, and Survivors International.

195 “Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Jennie Mollica, February 2014, p. 7

199 Community Health for Asian Americans, API Connections (UEL) Program

200 “From Crisis to Community Development: Needs and Assets of Oakland’s Refugees from Burma,” Burma Refugee Family Network, 2011, p.10

201 “Community representatives report many kinds of gaps related to in-language services for their communities, including: no professional provider from their community; no interpreter for their communities at key health and social service sites; concerns with professionalism, confidentiality and privacy in getting assistance with sensitive issues in a small community; inadequately trained telephonic interpreters, especially in areas involving domestic violence, legal assistance, and health/mental health topics.” “API Adult Mental Health Needs and Potential Solutions,” Community Health for Asian Americans, 2013, pp. 2-3

202 “From Crisis to Community Development: Needs and Assets of Oakland’s Refugees from Burma,” Burma Refugee Family Network, 2011, p.10-11

203 “From Crisis to Community Development: Needs and Assets of Oakland’s Refugees from Burma,” Burma Refugee Family Network, 2011, p.11

204 “Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California,” Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, June 2012, p. 25

207 “Increasing the number of bilingual/bicultural staff is the main concern that CBOs and mental health providers should address in the near future.” (“Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County,” Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 13)

208 “Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County,” Community Health for Asian Americans, 2015, p. 17

209 “Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 14

210 “API Adult Mental Health Needs and Potential Solutions,” Community Health for Asian Americans, 2013, p. 3

211 Workforce shortages for API communities are an issue throughout the Bay Area.

Contra Costa County: “In Contra Costa County, there is a serious shortage of bilingual and bicultural mental health professionals in private practice as well as in the county system that can provide culturally competent services to Chinese Americans, fewer still for Southeast Asian and Pacific Islander communities. Even though there is a large population of a high-risk group – Asian American older adults – utilization rates of mental health services are very low. This results in a huge and growing gap in mental health services for un-served and underserved Asian American populations.” “Adults, seniors, community leaders, advocates, and community-based providers voiced strongly that limited linguistic and cultural competency significantly affects access to services and the effectiveness of most mainstream mental health providers in working with Asian communities. Consumers who currently receive mental health services indicated that staff sharing the same language or native dialect and culture with their provider is highly preferred and contributes to increased levels of comfort and trust. In choosing a provider, language and culture are more important than other factors, including gender or race.” “A shortage of providers with ethnic-specific language capabilities limits not only access but impact of mental health services.” “Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County,” Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 13-14

San Francisco: “There are far too few providers trained at this level to treat these clients as well as speak their language. While it is difficult at times to even find providers that can speak “threshold” S.F. languages such as Cantonese, Tagalog, or Vietnamese, there are a host of other A&PI languages needed that further complicates service accessibility.” Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), July 2005, p. 2

212 “Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Jennie Mollica, February 2014, p. 7

213 Some Counties in the Bay Area, however, appear to view this differently, and interpret language access laws for health as inclusive of behavioral health care. San Mateo County Behavioral Health and Recovery Services is an

example. BHRS Cultural Competence Council minutes 04/02/10 indicate they see language interpreter training as a mandate at the State level.

214 "Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations," Jennie Mollica, February 2014, p. 7

215 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 16-20

216 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 3-4

217 RTR/ Project 4PLAY (4 County Prevention and Leadership for Asian and Pacific Islander Young Adults): Final Report, Asian American Recovery Services, a program of HealthRight 360 (AARS/HR360), December 2015, p. 12.

218 East Bay Refugee Forum has been discussing this with Refugee Health and Social Services Agency.

219 "API Adult Mental Health Needs and Potential Solutions," Community Health for Asian Americans, 2013, pp. 2-3
220 The Birthplace, Primary Language and Ethnicity/Race lists are created at the State level and required minimum collection items for California Counties.

222 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, pp. 16-20)

223 ACBHCS was planning on paying for interpreter services provided through the CHAA-CERI services for Level III Adults (no longer in operation) using MHSA funds as a way to address this issue. San Mateo County Health System uses resources from the County's General Fund for language access investments.

224 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 11

225 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 11

226 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 14

227 Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), July 2005, p. 2

228 Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), July 2005, p. 1

229 "A Call to Action: Aligning Public and Private Investments in Asian American, Native Hawaiian and Pacific Islander Communities," Asian Americans and Pacific Islanders in Philanthropy, 2013, p. 4

230 "Consistent and reliable services: Many community leaders see outside organizations who are non-Lao, provide services, and then leave once the funding runs out. Without SEASAC [Southeast Asian Senior Access Collaborative] program, there is no other program, and even right now it is having sustainability issues. If this model can be sustained and replicate in other communities, that will be good." ("Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix E) Incidentally, this program and the organizations that hosted parts of it (United Laotian Community Development, Inc., Lao Senior Association, and Cambodian Community Development, Inc.) all folded when this and other core programs lost their funding from The California Endowment, and when no public system in Alameda County or Contra Costa County stepped in with funding to sustain their services. Since then, there have been no services for Southeast Asian seniors in the East Bay.

231 "With continued economic recession, 3 CBO partners suffered setbacks and lost significant funding to the point of two ending their services (CCDI, FAJ youth south county), and one (OASES) has merged with a larger CBO partner, EBAYC. We were unable to do much in building the capacity of these smaller CBOs when their survival was at stake. However, by maintaining close communication with these CBO executive directors and staff, we were able to provide some support such as writing letters to their respective funders and governmental agencies to advocate for their agency and communities." (ACMHS UELP Report, July 2011)

232 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 11

233 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 10-11

234 See, for example: "Korean Needs Assessment of the Bay Area 2014-15," Korean Community Center of the East Bay, 2015, p. 13; "Are We Caring for Our Elderly?: Health and the Aging Laotian," Asian American Coalition, June 2001.

²³⁵ In the Bay area, there is one domestic violence shelter and one legal services provider for APIs <http://www.api-gbv.org/resources/programs-serving-apis.php>

²³⁶ “The Problem Gambling Program of the NICOS Chinese Health Coalition in San Francisco remains the only service in California specifically dedicated to treating APIA problem gamblers.” see “Annual Report 2005 - Rising to the Task: Facing New Challenges in California’s APIA Communities,” State of California Commission on Asian and Pacific Islander American Affairs, 2005, p.14

²³⁷ “Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Jennie Mollica, February 2014, p. 4

²³⁹ “Although improved County coordination, collaboration between service providers and sensitization of agency staff will further improve services, there remain important service gaps. For example, culturally competent mental health services for war and trauma victims are limited.” (“Refugee Services Plan Alameda County Input for annual Planning Process 2014 and Beyond: Executive summary to the Social Services Agency,” prepared by the East Bay Refugee Forum, p. 5)

²⁴⁰ “Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Jennie Mollica, February 2014, p. 4

²⁴¹ “Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Jennie Mollica, February 2014, p. 6

²⁴³ Refugee Health Service in Alameda County are funded through an annual grant of \$300,000 from the California Refugee Health Program (originating as a State grant from the federal Office of Refugee Resettlement). “Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Jennie Mollica, February 2014, p. 8

²⁴⁴ “Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Jennie Mollica, February 2014, p. 7

²⁴⁵ “IRC has taken significant steps over the past year to increase the organization’s capacity to screen newcomers and deliver culturally-appropriate clinical and community-based behavioral health treatment and prevention services. While not historically a strength of IRC’s resettlement process, mental health services are now considered an integral piece of the agency’s Center for Well-Being and are resourced through a MHSA Innovation Grant from Alameda County Behavioral Health Care Services. Services include an in-depth, on-site clinician screening; mental health counseling and case management; ethnic-based peer support groups; referrals to County and community-based mental health care; and ESL and employment services designed to reduce refugees’ isolation. The program will target refugees in the U.S. 6 months to 5 years and will be staffed by one supervising Clinical psychologist, one pro-bono psychiatrist, two UC Berkeley MSW interns and 2 clinician interns, in addition to IRC’s Center for Well-Being Coordinator and Case Manager.” (Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Jennie Mollica, February 2014, p. 7-8)

²⁴⁶ There is also the issue that newcomer communities do not always immediately identify with the larger category of “API” that frames how services and advocacy are shaped in the US, often identifying only or mostly with their own ethnic and language identities and communities. Hence, we shouldn’t assume that they will be aware of or drawn to API-identified organizations on their own. It is in the authors’ experience that newcomer API communities arrive through in-community connections with providers or through word-of-mouth in their communities. There may be some benefit to moving programming away from racial/ethnic-defined to shared experience-based models such as immigrant and refugee models that are not racially specific. For refugees, many are already receiving services in multi-cultural settings such as refugee resettlement organizations, social adjustment programs, and refugee health settings.

²⁴⁷ California Reducing Disparities Project API Strategic Planning Work Group, 2013

²⁴⁸ “Ethnic Health Assessment for Asian Americans, Native Hawaiians, and Pacific Islanders in California,” Winston Tseng, et. al, August 2010, p. 32

²⁴⁹ API Youth Violence Prevention Center: National Council on Crime and Delinquency, 2003

²⁵⁰ “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.” (California Reducing Disparities Project API Strategic Planning Work Group, 2013)

²⁵¹ California Reducing Disparities Project API Strategic Planning Work Group, 2013, citing (Snowden, Masland, Libby, Wallace, & Fawley, 2008)

²⁵² “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.” (California Reducing Disparities Project API Strategic Planning Work Group, 2013)

²⁵³ California Reducing Disparities Project API Strategic Planning Work Group, 2013

²⁵⁴ “A Dream Denied,” Dr. Khatharya Um, 2003

²⁵⁵ “Unlike the more economically stable segments of the Asian American population, Southeast Asian American families and communities are largely economically vulnerable. According to the 1990 Census, the percentage of Hmong, Laotians, Cambodians, and Vietnamese living below the poverty line was 63.2 percent, 35.2 percent, 41.9 percent, and 26.9 percent respectively. Moreover, in California, single females headed 9.1 percent of Vietnamese American households, 17.13 percent of Cambodian, 11 percent of Laotian, and 7.25 percent of Hmong households. For the Cambodian community in Oregon and Washington State, the percentages increased to 20.87 percent and 25.21 percent respectively. Overall, these disconcerting statistics reveal an economically vulnerable population that seriously lacks the necessary resources, both at home and in the community, to provide sufficient support for its youth. The number of community-based organizations that exist to serve this highly diverse population varies according to the sub-groups. There are proportionately few local or national organizations, for instance, that address the particular concerns of Cambodian Americans and the highly pluralistic Laotian American communities, and even fewer still with quality educational programs. As a result, relatively few Southeast Asian students and their families have ready access to community-based support. Where support programs are available, be it in the schools or in the community, many Southeast Asian students are prevented by economic and cultural constraints from accessing them. Students may be unable to participate in after-school tutoring, or to capitalize upon educational opportunities because of the lack of transportation, and because of family responsibilities” (Um, 2003)

²⁵⁶ “The small amount of disaggregated data available for LEP Asian students demonstrates variance in success levels of different LEP API groups. LEP Asian and Pacific Islander students have low GPA and high truancy rates. These groups may not receive the attention they need because other API students are able to perform well on standardized tests, and the lower achievement of some groups is hidden.” (API Youth Violence Prevention Center: National Council on Crime and Delinquency, 2003)

²⁵⁷ “NHPI adults (8%) reported substantially higher rates of serious psychological distress than the state total (2 times) and White adults, and were similar to American Indians/Alaska Natives (9%).” (“Ethnic Health Assessment for Asian Americans, Native Hawaiians, and Pacific Islanders in California,” Winston Tseng, et. al, August 2010, p. 32). See also footnote 79.

²⁵⁸ See footnote 51 above on isolated and older adult APIs

²⁵⁹ “[API] Young people have to fail at everything in order to get services, even when they are truant. A young person can get caught with marijuana and be suspended several times before receiving a referral. There is insufficient buy-in on the part of school staff and incentives are lacking to motivate teachers to support counseling.” (“Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 11)

²⁶⁰ “Bay Area Koreans also have higher serious psychological distress (SPD) (18%) and functional impairment rates than California Koreans (5%) and other racial groups in California.” (“Ethnic Health Assessment for Asian Americans, Native Hawaiians, and Pacific Islanders in California,” Winston Tseng, et. al, August 2010.)

²⁶¹ “Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County,” Community Health for Asian Americans, 2015, p. 13

²⁶² “Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County,” Community Health for Asian Americans, 2015, p. 14-15

²⁶³ “According to the Alameda County Social Services Agency Language Access Plan (2015 draft), currently only 6% (120+ people) of the total ACSSA staff (2000+) are bi- or multi-lingual, and only a fraction of these are available to provide their languages in support of clients seeking access assistance due to language. The client’s inability to understand notices of action or re-determination requests leads them to require a third-party translator from the community. Though previously in place at SSA during the 1980’s, there is currently no window specifically geared toward limited English proficiency encounters at the agency. Clients report an inability to call a social worker and leave a message due to their insufficient English capacity. In some cases social workers cancel appointments, but notify the client in English causing them to come to the office only to be turned away and forced to make another appointment.” “Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County,” Community Health for Asian Americans, 2015, p. 15

264 "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 15

265 "Refugee Services Plan Alameda County Input for annual Planning Process 2014 and Beyond: Executive summary to the Social Services Agency," prepared by the East Bay Refugee Forum, p. 4

266 API mental health organizations have long advocated that case management as a billable service be allowed for LEP clients who required more support in navigating their needs as part of their treatment plans, and in 2015-16 when Adult Level III service model was being negotiated with ACBHCS were allowed 6 hours of case management per client. Prior to this, ACBHCS did not allow for case management as a billable service for Adult Level III clients.

267 "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 14

268 API refugees and asylees in recent years have included a new wave of Special Immigrant Visa-holders and refugees from Afghanistan, refugees from Bhutan (Nepali-speakers), diverse refugees from Burma (Chin, Karen, Karenni, Kachin, Mon, Rakhaing, Shan, Burman, and others), and asylees from Tibet and Mongolia.

269 "Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations," Jennie Mollica, February 2014

270 See the position paper written by then-lead organization, Community Health for Asian Americans, on this recommendation: "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015

271 Fraser and Pecora, 1985a and b.

272 Fraser and Pecora, 1985a, p. 23-24.

273 "Many are reluctant to send their loved ones to a psychiatric hospital, nursing home or a group home. Receiving help and support from extended families and natural support systems like temples and churches is oftentimes the first choice. Extended family and natural supports are strong coping mechanisms valued by many Asian communities. Seeing a psychiatrist or taking western medication is the last resort." ACMHS UELP Report, July 2011

274 California Reducing Disparities Project API Strategic Planning Work Group, 2013

275 San Francisco State University Asian American Studies and Community Health for Asian Americans, Community Wellness Survey: Himalayan Women in the San Francisco Bay Area, July 31, 2014, p. 37

276 San Francisco State University Asian American Studies and Community Health for Asian Americans, Community Wellness Survey: Himalayan Women in the San Francisco Bay Area, July 31, 2014, p.40

277 Korean Community Center of the East Bay/ Health Research for Action, Korean Needs Assessment of the Bay Area (KoNA Bay Area), January 2016

278 Alameda County Behavioral Health Care Services, October, 2007

279 "Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California," Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, June 2012, p. 28

280 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 17

281 "Young people in API communities find strength when given opportunities to connect to their cultures. This may include a range of activities from Polynesian dance classes to learning how to cook traditional dishes." (Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 17)

282 "Over there (Thailand) we can rely on our family. Here I have to learn to struggle. It is hard, but I am proud of myself. Instead of family, I form groups of supportive friends to help each other. Friends is very important here." California Reducing Disparities Project API Strategic Planning Workgroup, "Focus Group Summary Thai", September 25, 2010, p. 1

283 "In spite of the critical issues facing the refugee communities from Burma, Su Lay and her fellow refugees display a strong resilience and a persevering hope for their future. In addition to their individual abilities and their strong family connections, they have numerous community assets upon which they can build, including committed leaders, educated individuals, and social capital." (Burma Refugee Family Network, From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma, 2011, p. 26.)

284 "Those surveyed identified several skills that they have brought with them from Burma. The top three skills include cooking (71%), farming/growing plants (59%), and childcare (25%), skills that can be transferred to the labor market (See Chart 20, "Individuals' Skills"). These skills are also assets in contributing to community causes and co-ethnics in times of need." Burma Refugee Family Network, From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma, 2011, p. 26

285 "A significant number of survey participants indicated particular skills and interests that represent assets to their community. These include gardening/farming (30%), cooking (32%), and tutoring/educating children (16%). Some skills with traditional handcrafts, such as sewing, weaving (20%) or folk dancing (23%), child/eldercare (25%)." Bhutanese Community in California (BCC), Asian Health Services, and San Francisco State University, Barriers vs. Bridges: Needs and Aspirations of Bhutanese Refugees in Northern California, June 2012, p. 27

286 “One realized that such capacity building and coalition networking would facilitate community development and empowerment: According to my convictions and hope--I don't know whether this could be done or not-- I want to try to organize all the refugees from Burma to become united. As a first step, I want to support national and cultural unity—not political organizing. The next step is for all the refugees from Burma to be able to stay here in harmony and to work in collaboration.” (Burma Refugee Family Network, *From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma*, 2011, p.26.)

287 California Reducing Disparities Project API Strategic Planning Workgroup Pacific Islander Focus Group Summary, 2010

288 For more details on the role of faith leaders in API communities see “FY 2013-2014 Annual Report,” Community Health for Asian Americans, UELP PEI Programs and “FY 2014-2015 Annual Report,” Community Health for Asian Americans, UELP PEI Programs.

289 “Asian Pacific Fund MHS planning Focus Group - Senior Advocates Transcript,” Asian Pacific Fund and Asian Pacific Psychological Services, December 9, 2005, p. 4-5; “Asian Pacific Fund MHS planning Focus Group - Community Leaders-Respondent A Transcript,” Asian Pacific Fund and Asian Pacific Psychological Services, November 30, 2005, p.14

290 ACMHS, UELP Annual Report 2011-2012

291 California Reducing Disparities Project API Strategic Planning Workgroup Pacific Islander Focus Group Summary, 2010. AS NAP Focus Group Note, July, 2010: “Since the community is so church based, it's important to reach out to them. All Samoa churches have sister American churches”; National Council on Crime and Delinquency, September 2007, noted that in Oakland there are “six Samoan and Tongan-specific related places of worship.”

292 “When participants were asked about involvement with groups or organizations, almost half answered that they were **involved in a church (46%)**, followed by Korean school (9%), and dry cleaners associations (4%). The remaining 41% of the participants listed names of various Korean-related and non-Korean-related groups.” “Among the respondents who had experienced these acts of IPV, only 29% reported having discussed this violence with others (third parties). When asked who might be good to talk with when violence happens in an intimate partnership, the respondents answered a health care provider of some type (62%), **clergy (46%)**, friend (40%), family member (37%), other professional (20%), and community organization (13%) (multiple answers were permitted).” (Korean Community Center of the East Bay/ Health Research for Action, *Korean Needs Assessment of the Bay Area (KoNA Bay Area)*, January 2016).

293 “There is social stigma attached to mental health issues. Most people don't think that they need mental health services. Some use to see a therapist but it was too expensive. The temple is where the service is...For Thai people, the temple is where we go to restore mental health. It is not necessary that discuss with monks. It is just being inside the chapel and worship.” (California Reducing Disparities Project API Strategic Planning Workgroup, “Focus Group Summary Thai”, September 25, 2010, p.3-4).

294 In a Vietnamese discussion group for East Oakland Building Healthy Communities in 2010, “temples and churches” were listed as “good things” in the community, along with community-based organizations and markets. (East Oakland Building Healthy Communities, Discussion Group Notes - API Stakeholders Group at LIMCA, April 11, 2010, p. 1).

295 ACMHS, UELP Annual Report 2011-2012

296 California Reducing Disparities Project API Strategic Planning Workgroup Pacific Islander Focus Group Summary, 2010

297 “For resources (e.g., emergency cash, translations, advice), half (50.0%) of survey respondents (N=82) would seek out family members and the rest would use religious avenues (ask God and church) and friends (43.9% and 6.1%, respectively).” (National Council on Crime and Delinquency, September 2007)

298 ACMHS UELP Report, July 2011

299 “From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma,” Burma Refugee Family Network, 2011, p. 26

300 California Reducing Disparities Project API Strategic Planning Workgroup, “Focus Group Summary Mongolian”, September 26, 2010, p.1

301 “Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 17-18

302 “People that do not have friends can be isolated here, because we rely on each other for counseling.” (California Reducing Disparities Project API Strategic Planning Workgroup, “Focus Group Summary Thai”, September 25, 2010, p.1-3)

303 “Informal social networks may provide vehicles for reaching communities, particularly when they lack formal organizations. Some of the unserved communities have informal social networks. One youth development program staff person mentioned that friendship networks among teenage girls provided pathways for involving youth in their program.” (“Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 16

304 For example, “For those PIs who do not have biological family support or support from PI church’s, they create new families with other PIs and non-PI allies who are not related to them biologically. An example of this is gay, queer and lesbian PIs who are not accepted by churches and don’t come out to their families. These PIs create support groups like OLO, One Love Oceania, a PI queer women’s group and UTOPIA, a predominantly PI gay men’s group. Another example is the participation of Pacific Islander youth in creative projects like Youth Speaks, an organization that encourages youth expression through poetry.” (California Reducing Disparities Project API Strategic Planning Workgroup Pacific Islander Focus Group Summary, 2010)

305 “Over there (Thailand) we can rely on our family. Here I have to learn to struggle. It is hard, but I am proud of myself. Instead of family, I form groups of supportive friends to help each other. Friends is very important here. For mental health or mental distress, a few people go to workshop at the temple for mental health restoration. The older members said they consult with the monks about life, challenges. But females in the group said they don’t prefer to disclose some life problems with monks. One has seen private practice therapists. The majority of group prefers friends and family members for psychological support.” (California Reducing Disparities Project API Strategic Planning Workgroup, “Focus Group Summary Thai”, September 25, 2010, p.3-4)

306 “The values of supporting communities and honoring elders is reflected in a strong tradition of volunteerism. For example, in the Burmese focus group, it was mentioned that there are volunteers who help the community and would be able to help the community more effectively if they received training on understanding the MH system (See Attachment 5).” (Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 17-18)

307 For example, “It is through the establishment of relationships with community leaders/center and Human Service Professionals and organizations that experienced the Hume Center’s South Asian Team as being useful that has been effective in connecting and helping the identified populations we are serving.” (Hume Center UELP Annual Report 2012)

308 Asian American Coalition, *Are We Caring for Our Elderly?: Health and the Aging Laotian*, June 2001, p. 14-15.

309 For example, “In terms of places where Koreans usually get most of their health information, responses indicated that the Internet was the number one source (51%), followed by friends or relatives (29%), family doctor or doctor’s office (27%), newspaper (26%), hospital (25%), television (22%), insurance company (5%), and public library (1%). When asked about preferred places to get health information, half of the survey participants ranked their family doctor or doctor’s office as their number one choice (51%), followed by the Internet (39%), hospital (35%), newspaper (20%), television (16%), friends or relatives (13%), insurance company (9%), and public library (3%). (Respondents could choose more than one option).” (Korean Community Center of the East Bay/ Health Research for Action, *Korean Needs Assessment of the Bay Area (KoNA Bay Area)*, January 2016).

310 “Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act,” Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 16

312 For example, “Now that the Sisterhood project is in its 3rd year, more and more women and men in the community are coming to CHAA with reports of various forms of discrimination, abuse, and trauma. CHAA is beginning to be seen as the ‘place to go’ for members in these communities who are suffering from various forms of stressors such as unemployment, wage theft, domestic violence, lack of health coverage, abuse in the work place, etc. Below are examples of a few cases that came to our attention involving various forms of domestic violence, impact of alcoholism, and a case of incest that got reported after the survivor turned into a teenage young girl.” (Community Health for Asian Americans, *Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015*, 2015, p. 11)

313 “Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County,” Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix F

314 “The Information Needs of Female Afghan Refugees, Recommendations for Service Providers”, Smith, V. J. (2009, 2012), p.8-10

315 “Korean Needs Assessment of the Bay Area (KoNA Bay Area) Policy Brief Reducing Mental Health Disparity by Increased Efficacy in Culturally Relevant Community Engagement,” Korean Community Center of the East Bay/ Health Research for Action, January 2016.

316 “Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County,” Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 16-20

317 “Focus Group Summary Pacific Islander,” California Reducing Disparities Project API Strategic Planning Workgroup, September 17, 2010.

318 “Focus Group Summary Pacific Islander,” California Reducing Disparities Project API Strategic Planning Workgroup, September 17, 2010.

319 Yang, L and PEERS. *Final Report of Social Inclusion Campaign-Chinese Americans (Year 1 Accomplishments)*, June 24, 2015.

320 Yang, L and PEERS. Final Report of Social Inclusion Campaign-Chinese Americans (Year 1 Accomplishments), June 24, 2015; Yang, L and PEERS. Powerpoint of Internalized Stigma Group Year 2 Results, January 14, 2017

321 Face loss has been shown to affect discrimination and rejection of those with mental health issues as well as delayed help-seeking and treatment non-adherence among those with mental health challenges. See Yang, L and PEERS. Final Report of Social Inclusion Campaign-Chinese Americans (Year 1 Accomplishments), June 24, 2015.

322 "FY 2011-2012 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

323 "FY 2011-2012 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

324 "FY 2011-2012 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

325 "FY 2012-2013 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

326 Partnership with these community groups: Afghan Cultural Society, Afghan Professionals Network, Danish Cultural Society, Lemar TV and Afghan Seniors Association of the Bay Area, in "FY 2015-2016 Annual Report" Afghan Coalition, UELP PEI Programs.

327 "FY 2012-2013 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

328 Automatic translation is still very inaccurate. Translated materials need to be produced with great attention by a professional bilingual translator.

329 "FY 2014-2015 Annual Report," Community Health for Asian Americans, UELP PEI Programs.

330 "FY 2012-2013 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

331 "FY 2012-2013 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

332 "From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma," Burma Refugee Family Network and San Francisco State University, 2011.

333 Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County, Community Health for Asian Americans, 2015, p. 10

334 Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County, Community Health for Asian Americans, 2015, p. 10

335 "The Information Needs of Female Afghan Refugees, Recommendations for Service Providers," Smith, V. J. (2009, 2012), p.3

336 "FY 2014-2015 Annual Report," Afghan Coalition, UELP PEI Programs.

337 Paraprofessional training should include: The role of paraprofessionals, social determinants of health and impacts on access to care and health outcomes, boundaries and self-care, active listening with client, role of advocacy, how do you build capacity in others, understanding service coordination, case management, navigating systems "Mental Health Interpreter Training and Wellness in Action Training," Personal Communication, Patricia Rojas-Zambrano, January 25, 2017.

338 Smith provides an outline for paraprofessional training curriculum topics, see "The Information Needs of Female Afghan Refugees, Recommendations for Service Providers," Smith, V. J. (2009, 2012), p.11-12

339 "The Information Needs of Female Afghan Refugees, Recommendations for Service Providers", Smith, V. J. (2009, 2012), p.11-12

340 "FY 2014-2015 Annual Report, Community Health for Asian Americans, UELP PEI Programs.

341 See "FY 2014-2015 Annual Report," Afghan Coalition, UELP PEI Programs and "FY 2014-2015 Annual Report," Community Health for Asian Americans, UELP PEI Programs

342 "Mental Health Interpreter Training and Wellness in Action Training," Personal Communication, Patricia Rojas-Zambrano, January 25, 2017.

343 Some of the languages we note are provided by doctoral-level interns, for example Tamil, Urdu, Pujabi. The availability of these languages change from year to year.

344 One of the challenges for interpreter training is that it is standard to train cohorts of trainees who speak a specific language, and that the training is provided by a trainer who is bilingual in that language, which is easier for some languages than others. In particular, it is very difficult to create trainings for each specific language due to lack of bilingual trainers. The model piloted described here addressed this challenge by training diverse paraprofessionals in English, and including therapists in the training.

345 The training was a project Community Health for Asian Americans as part of their Adult Level III MediCal expansion in partnership with Center for Empowering Refugees and Immigrants. It was led by Patricia Rojas-Zambrano, Program Director of Leadership for Community Wellness at CHAA, in collaboration with another trainer, Toc Soneoulay-Gillespie, Refugee Resettlement Program Manager at Catholic Charities of Oregon, who has offered a similar mental health interpreter training model in Portland, OR, Washington state, and Alaska. This investment was interrupted by issues at CHAA and CERI's withdrawal from the partnership at the end of 2016.

346 Mental health therapists rarely receive interpretation training as part of their formal education or internship experiences. Consequently, many express reservations about providing services with language assistance. The pilot hoped that engaging therapists in the training content would shift this reluctance, and that over time the training would reach more therapists and tap into them as a resource in the absence of the availability of a therapist who speaks a specific language needed by a client.

347 Languages included Amharic, Arabic (including different local dialects), Burmese, Dari, Farsi, French, Hindi, Khmer, Ladakhi, Malay, Mam, Mandarin, Mongolian, Nepali, Pashto, Portuguese, Rakhaing, Spanish, Thai, Tibetan, Tigrinya, Urdu, Vietnamese. See this [link](#) for more details.

348 The mental health speciality should include topics such as: How therapy works; Role of interpreters; Self-care; How to use clinical consultation and supervision; and Coping with vicarious trauma, from "Mental Health Interpreter Training and Wellness in Action Training," Personal Communication, Patricia Rojas-Zambrano, January 25, 2017.

349 "Program Design: Refugee Wellness Navigators," International Rescue Committee Center for Wellbeing, October 2015, p. 3-4

350 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix C

351 "From Crisis to Community Development: Needs and Assets of Oakland's Refugees from Burma," Burma Refugee Family Network and San Francisco State University, 2011.

352 "FY 2011-2012 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

353 "Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015," Community Health for Asian Americans, 2015.

354 "OAA HIV Prevention & Testing Annual Progress Report FY 2012-2013," Community Health for Asian Americans, July 2013.

355 "FY 2014-2015 Annual Report," Afghan Coalition, UELP PEI Programs.

356 "FY 2011-2012 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

357 "FY 2015-2016 Annual Report," Center for Empowering Refugees and Immigrants, UELP PEI Programs.

358 "FY 2013-2014 Annual Report," Community Health for Asian Americans, UELP PEI Programs.

359 "Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities Outcomes and Recommendations," Mollica, J., February 2014.

360 "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, p. 17-19

361 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 16-20

362 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix E

363 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix C

364 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006.

365 "Asian Pacific Fund MHSA planning Focus Group - Community Leaders-Respondent A Transcript," Asian Pacific Fund and Asian Pacific Psychological Services, November 30, 2005.

366 "FY 2014-2015 Annual Report," Community Health for Asian Americans, UELP PEI Programs.

367 "FY 2013-2014 Annual Report," Hume Center, UELP PEI Programs and "FY 2015-2016 Annual Report," Hume Center, UELP PEI Programs.

368 "FY 2014-2015 Annual Report," Center for Empowering Refugees and Immigrants, UELP PEI Programs.

369 "FY 2014-2015 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

370 "FY 2013-2014 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

371 "The Information Needs of Female Afghan Refugees Recommendations for Service Providers," Smith, V. J. (2009, 2012), p.18

372 "FY 2014-2015 Annual Report," Community Health for Asian Americans, UELP PEI Programs.

373 "FY 2014-2015 Annual Report," Center for Empowering Refugees and Immigrants, UELP PEI Programs.

374 "FY 2014-2015 Annual Report," Center for Empowering Refugees and Immigrants, UELP PEI Programs.

375 "FY 2015-2016 Annual Report," Center for Empowering Refugees and Immigrants, UELP PEI Programs.

376 "FY 2013-2014 Annual Report," Community Health for Asian Americans, UELP PEI Programs.

377 "Focus Group Summary Mongolian," California Reducing Disparities Project API Strategic Planning Workgroup, September 26, 2010, p.5. and "Alameda County Mongolian Community Profile and Health Needs Assessment," Asian Health Services, June 2009, p.25-26

378 Banteay Srei, a youth development, asset building organization, is an Oakland-based organization that works with young SEA women who are at risk of or engaged in sex work.

379 For more information about Banteay Srei, see <http://www.banteaysrei.org/programs/s-a-u-c-e/>

380 "FY 2011-2012 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

381 Organizers included Asian Community Mental Health Services, in collaboration with CHAA, CERI, EBAYC, and Cambodian Community Development Inc. (CCDI), see Asian Community Mental Health Services, FY 2011-2012 Annual Report, UELP PEI Programs.

382 Participating organizations included: Alameda County Behavioral Health Care Services, Asian Health Services, Community Health for Asian Americans, Filipino Advocates for Justice, Korean Community Center of the East Bay, Korean Pastors Association, Mindful Center, Oikos University and UC Berkeley School of Public Health, see “FY 2012-2013 Annual Report,” Asian Community Mental Health Services, UELP PEI Programs.

383 Other participating orgs included the Alameda County Department of Public Health, API Domestic Violence Research Institute, Korean Community Center of the East Bay, Tibetan Association of Northern California and UC Berkeley School of Public Health, see “FY 2012-2013 Annual Report,” Asian Community Mental Health Services, UELP PEI Programs.

384 For more details on the boat concept see “Creative California Communities Program Asian American Women Artists Association Application,” Asian American Women Artists Association, March 29, 2014.

385 “Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015,” Community Health for Asian Americans, 2015, p. 2

386 “FY 2014-2015 Annual Report,” Community Health for Asian Americans, UELP PEI Programs.

387 “Southeast Asian youth enjoy numerous healthy activities - from sports to video games, chatting online, listening to music, going to the mall, and hanging out with friends. However, many of these youth also mentioned taking part in at-risk activities, such as smoking marijuana and tobacco, drinking alcohol, shoplifting, and going to adult parties and clubs as well as friend’s houses.” (SAYFA and APPS, March 16, 2007)

388 KCCEB’s current older adult project focused on using Korean Drama as a medium for exploring mental health topics is an example, as are the many cultural activities CERI leverages in their work with Cambodian adult and older adult survivors of the Khmer Rouge genocide. CHAA has used youth interest in B-Boy dance with youth in Richmond.

389 An example is the API Women’s Summits and International Women’s Day events organized by CHAA, ACMHS and CERI in recent years and the Healing and Resiliency Summit organized by KCCEB, CHAA, CERI and others in response to the Oikos University mass shooting.

390 Gardens are increasingly common sites for mental health support in the Bay Area. For more details see the following section.

391 Cooking is used both in youth development settings and adult gatherings. Cooking is used for intergenerational connection, self-care, and spiritual offering. For more details see the section below.

392 Sharing stories is an important part of healing, whether it is in small peer groups (like Banteay Srei’s SAUCE program) or large inter-community settings (API Women’s Summit). See the section below for more details.

393 “FY 2014-2015 Annual Report,” Community Health for Asian Americans, UELP PEI Programs and “FY 2015-2016 Annual Report,” Center for Empowering Refugees and Immigrants, UELP PEI Programs.

394 “FY 2014-2015 Annual Report,” Center for Empowering Refugees and Immigrants, UELP PEI Programs.

395 “FY 2014-2015 Annual Report,” Asian Community Mental Health Services, UELP PEI Programs.

396 “FY 2014-2015 Annual Report,” Center for Empowering Refugees and Immigrants, UELP PEI Programs.

397 CHAA supported community garden development as part of a Cambodian Women’s Health Project with partners Prevention Research Center and CERI, and Cambodian Community Development, Inc. (2010-12), and CERI continued with community gardening as the site of its intervention for Round 3 Innovations project work. CHAA and International Rescue Committee of Northern California initiated and IRC supported establishing gardens for newcomer refugees and asylees located at Laney College in Oakland which brought refugee adults and youth from Oakland International High School together for intergenerational learning. CHAA also supported, until recently, a garden at Lakeside Gardens for interested participants from communities served through their UELP program.

398 “FY 2014-2015 Annual Report,” Community Health for Asian Americans, UELP PEI Programs.

399 “Sisterhood for Wellness Project Final Report: July 1, 2014 – June 30, 2015,” Community Health for Asian Americans, 2015, p.2

400 “FY 2011-2012 Annual Report, Asian Community Mental Health Services, UELP PEI Programs.

401 For more information about how the Burma, Thai, Tibetan, Mongolian, and Tongan communities engage in spiritual practices for personal healing, community conflict resolution, and cultural education, see “FY 2014-2015 Annual Report,” Community Health for Asian Americans, UELP PEI Programs.

402 For more information about how Cambodian communities engage in chanting and prayer with monks, see “FY 2011-2012 Annual Report,” Asian Community Mental Health Services, UELP PEI Programs.

403 “FY 2014-2015 Annual Report,” Community Health for Asian Americans, UELP PEI Programs.

404 “FY 2014-2015 Annual Report,” Community Health for Asian Americans, UELP PEI Programs.

405 “FY 2015-2016 Annual Report,” Afghan Coalition, UELP PEI Programs.

406 “FY 2014-2015 Annual Report,” Afghan Coalition, UELP PEI Programs.

407 San Mateo County’s Behavioral Health and REcovery Services and Office of Diversity and Equity’s “Storytelling Project” started in 2011 to lift up personal stories to reduce stigma and promote recovery, connection and understanding of mental health. Stories are shared through words, photos, drawings, objects and music, see <http://www.smchealth.org/bhrs/ode/stories>

408 For more information about Banteay Srei, see <http://www.banteaysrei.org/programs/h-o-l-g-a/>

409 Leadership for Community Wellness: Mid-term report, Community Health for Asian Americans, 2016

410 Participants were from the following ethnic communities: Bhutanese, Chilean, Chinese, Eritrean, Mongolian, Nepali, Rakhaing (from Burma), Thai, and Tibetan

411 "Mental Health Interpreter Training and Wellness in Action Training," Personal Communication, Patricia Rojas-Zambrano, January 25, 2017.

412 Participants are from the following communities: Bhutanese, Cambodian, Chinese, Eritrean, Nepali, and Vietnamese

413 "FY 2013-2014 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

414 Community Health for Asian Americans, MHSA Regulations Presentation, Spring 2016

415 ACMHS, for example, noted how it was "Creating better linkages between early intervention and treatment" through its UELP programming. "The outreach and early intervention program at ACMHS has been able to create strong linkages within their system to refer individuals who need treatment to other ACMHS services including therapy, case management and rehabilitation. These linkages are critical to ensuring that individuals who need higher levels of care can enter the system smoothly." see "FY 2011-2012 Annual Report," Asian Community Mental Health Services, UELP PEI Programs.

416 ACBHCS Cultural Competency Plan 2010, Table 9, p. 47

417 ACCMHA provider contract budget analysis, FY 2015/16

418 At the time of this data (FY 2014/15), ACBHCS was directly funding API-targeted mental health services through Asian Community Mental Health Services, Community Health for Asian Americans, Center for Empowering Refugees and Immigrants, Portia Bell Hume Center, and Afghan Coalition. A large portion of ACMHS' services have been moved to Asian Health Services. ACBHCS also funds Jewish Children and Family Services, which has a history of providing services for refugees including Asians, but it is unclear how much of their services end up serving APIs currently. ACBHCS has also funded ACMHS, CHAA, Korean Community Center of the East Bay, CERI, Filipino Advocates for Justice and International Rescue Committee of Northern California through MHSA Innovations projects that reached API communities, but these projects ended in 2015. ACBHCS will be funding API and refugee-focused projects in an upcoming round. However, Innovations projects are pilots not long-term durable investments. Notably, ACBHCS did create specific community-based EPSDT programs focused on Chinese and Vietnamese children and youth services - A-YA at CHAA in North Alameda County, and a similar program that no longer exists in Central County through ACMHS.

419 We see similar patterns of underfunding API-targeted services in Alameda County for other systems. While Asians and NHPI comprised approximately 8-10% of new HIV cases in Alameda County between 2009-11, funding for care and prevention services in the same period averaged less than 1-2% of Alameda County Office of AIDS Administration's (OAA) annual budget.

420 The majority of ACMHS' contracts have since moved to Asian Health Services, and a few of CHAA's programs have been defunded, including adolescent AOD treatment and a workforce development pilot project.

421 Contract amounts for Center for Empowering Refugees and Immigrants and Afghan Coalition were not included in the contract budgets provided by ACCMHA. However, their contracts from ACBHCS are small, so including them would not significantly alter this analysis.

422 "API seniors have been extremely underserved. Without senior programs, API seniors have to rely on their families for services that are nearly impossible to handle without putting added stress and expenses on the household... More funding needs to be targeted to support senior programs that are coordinated and supported by API community advocates and members. In addition, mental health and community-based organization providers are requesting to expand alternative therapeutic approaches, such as gardening or craft therapy, because they have found it to be a very effective and culturally compatible treatment for seniors. Providers want to work with cities to identify land and space that can be used for gardening, year-round group sessions and exercise equipment for seniors." "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, p. 16-20

423 "Most often the mental health concerns are related to domestic violence coupled with immigration issues. We refer to Asian Women's Shelter, API Legal Outreach and ACMHS to cover all bases, see "Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 33-34

424 ACBHCS Cultural Competency Plan 2010, Table 9, p. 46-47

425 BHCS has funded two language access programs through CSS: the Asian ACCESS Program operated by Asian Community Mental Health Services (ACMHS) and the Latino ACCESS Program operated by La Clinica (CASA del Sol). ACMHS was contracted to provide services in multiple languages including: Cantonese, Mandarin, Vietnamese, Japanese, Khmer, Korean, Tagalog and Mandarin (Alameda County Cultural Competency Plan 2010, p. 90). The Asian ACCESS Program has been moved to Asian Health Services as of 2016-17.

426 While we have not been able to review ACBHCS' most recent Cultural Competency Plan Updates, in 2010, ACBHCS invested in training and deploying interpreters in the public mental health system for threshold languages. This training partnered with the National Latino Behavioral Health Association to train 30 local providers who were identified as bilingual in English and at least one threshold language through a "train-the-trainer" model, with the goal of finding providers from each of the County's threshold languages. Trainees were to commit to providing four services annually for BHCS, providing interpretation with a peer interpreter while still a trainee. The strategy was seen as a compliment to ACBHCS' investments in local CBO providers serving LEP communities. The long term goal, as of the 2010 plan, was to have 10 trained mental health interpreters for each threshold language. (Alameda County Cultural Competency Plan 2010, p. 94) Also see referenced 2015 interpretation training program for immigrant, indigenous and refugee communities discussed in Sections 2 and 3.

427 See Alameda County Behavioral Health Care Services Cultural Competency Plan 2010, Table 13, p. 61

428 Include legal, ethical, professional boundaries, self-care, role clarity, anti-stigma, systems knowledge, and resources knowledge as part of the curriculum

429 San Mateo County Behavioral Health and Recovery Services' Office of Equity and Diversity offers Cultural Competence Stipends for internships working with their Health Equity Initiatives.

430 "The availability of free services to all ages, regardless of insurance and/or medical diagnosis is great news for those who do not qualify for other ACMHS programs which have specific eligibility requirement such as Medi-Cal and medical necessity. ACMHS no longer has to turn callers or inquirers away!" (ACMHS UELP July 2011 report)

431 "Full-service model (not only 'therapy' but also case management, social support, and daily survival skill building services)", see "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, Appendix I

432 "Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, pp. 16-20

433 Helpful resources should include: newcomer orientation seminars, translation and interpretation services, employment training centers, driving schools, faith centers, libraries, primary health care and mental health clinics, domestic violence support, substance abuse support and treatment, social support groups, and education program, see "The Information Needs of Female Afghan Refugees, Recommendations for Service Providers", Smith, V. J. (2009, 2012), p.7-8

434 "Create a website with a listing of low-cost mental health care providers in the area, including their language capabilities. A website, unlike a printed publication, allows for changes to be made (e.g. when an agency changes its services because of lack of funding)." (Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 33-34)

435 "Fund the development of a multilingual San Francisco Bay Area wide A&PI resource/referral/clearinghouse network for behavioral health and mental health services. This program needs to have a physical location as well as an online website." ("Mental Health Services in San Francisco's Asian American and Pacific Islander communities," Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), July 2005)

436 "Korean Needs Assessment of the Bay Area (KoNA Bay Area) Policy Brief Reducing Mental Health Disparity by Increased Efficacy in Culturally Relevant Community Engagement," Korean Community Center of the East Bay/ Health Research for Action, January 2016.

437 "Relationship/Coordination/Education among Agencies"

- Closer relationship between our agency and mental health agencies.

- I think there is a need for a more coordinated way of knowing where to refer, what languages are available. Also, where to go for a crisis.

- Outreach to more community base organizations where the general public interact with each other on a daily basis. Through the social/psychological model we can reach out to a broader audience.

- I would like to see Asian Health Services and Center for Elders independence work in a more collaborative realm in delivering health care services to the Asian community.

- Establishing formal programmatic partnerships with one or more mental health service providers.

- Coordinated services and case management. Mental health work group so that community-based organizations and service providers are aware of the services available in Alameda County" (Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 33-34)

438 "Fund linkages:

- Fund training and education efforts that will help mainstream employees to better identify A&PIs who need mental health services, to facilitate referrals. Interface with the criminal justice system, school districts, and churches towards this effort.

- Fund mental health services in “natural settings” such as in churches, and in youth and family community centers. Integrate health, mental health, and substance abuse psychoeducation into recreational, vocational, and artistic programs using trained mental health professionals with A&PI families.
- Return to a “single standard of care” policy to equally serve all members of the community without regard for severity of illness and/or insurance status.
- Support media and educational campaigns aimed directly at reducing the stigma of mental health issues in A&PI communities. (“Mental Health Services in San Francisco’s Asian American and Pacific Islander communities,” Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), July 2005)

⁴³⁹ “Word of mouth, community venues - A strong mental health outreach initiative that targets the API population needs to expand into more areas of API daily life, including churches, temples, community ceremonies, clan and family organizations, and schools because many respondents reported that resource awareness is best communicated by word of mouth within their communities.” (“Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County,” Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2006, pp. 16-20)

⁴⁴⁰ “Recommendation 2: Establish a system for universal refugee mental health screening and referrals. Alameda County has the opportunity to leverage the strengths of the Refugee Health Screening, IRC, the Human Rights Clinic at Highland Hospital and community-based providers to define a coordinated approach to universal mental health screening for every newcomer refugee and asylee. Improvements may include additional training on the utilization of screening tools, mental health-specific training for interpreter and navigator staff, and facilitation of clinician involvement in the assessment of patients with identified need. Beyond initial assessment, this system will support effective referrals throughout a network of mental health service providers. Although behavioral health needs may not always surface immediately upon resettlement, a universal and comprehensive screening and referral process is a vital element of our commitment to refugees’ and asylees’ well-being and will ultimately reduce later incidents of crisis and institutionalization.

The Task Forces recommend that Alameda County partners formalize a process of screening all newcomer refugees and asylees and referring individuals in need to culturally-competent care.” “Alameda County Refugee and Asylee Health Services Coordination: Report on Task Force and Research Activities, Outcomes and Recommendations,” Mollica, J. February 2014, p. 10

⁴⁴¹ Human Rights Clinic at Highland Hospital serves high need victims of trauma and torture needing forensic evaluations for asylum applications

⁴⁴² “Provide more funds to Asian Health Services in Oakland to reopen its satellite office in tri-city, and Chinese American Mental Health Network and John George Psychiatric Hospital to expand their services.” (Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 33-34)

⁴⁴³ Refugee Health conducts initial refugee screenings and has thirty-three in-house Alameda County health interpreters fluent in 26 languages, plus resources for phone and video interpretation; annual grant of \$300,000 from the California Refugee Health Program (ORR funds to the State)

⁴⁴⁴ “Fund non traditional mental health providers 2) diversifying investment to community- based organizations and other relevant entities beyond traditional mental health service providers; Hiring in-language staff and conducting traditional outreach is current approach by most service providers, that is a simple solution to a complex problem and insufficient strategy; Diversification and investment is likely to include: Increase efficacy of funding decision by: Community Based Organizations that have track record for successful community engagement with wide reach for different sectors, and in changing behaviors and attitude; Faith-based organizations (Korean Community Center of the East Bay/ Health Research for Action, Korean Needs Assessment of the Bay Area (KoNA Bay Area) Policy Brief Reducing Mental Health Disparity by Increased Efficacy in Culturally Relevant Community Engagement, January 2016)

⁴⁴⁵ In ACBHCS’ Cultural Competency Plan (2010), it was indicated that a Full Service Partnership program for Wraparound, funded with MHSA CSS resources, for API and Latino children and youth (FSP 8) was an intended investment. Authors also believe that there was discussion within ACBHCS to split the FSP into dedicated separately funded programs, one for Latino children and youth, and one for API children and youth. The RFP for this planned-for program was never issued. Given community report findings that API communities benefit from, and, culturally, respond positively to family-based or family inclusive interventions, as well as highly positive assessments from some API communities in neighboring counties who participated in Wraparound programs, we urge ACBHCS to consider investing in Wraparound for API communities using CSS funding as originally planned.

⁴⁴⁶ One report made the connection between disparities in funding and data disaggregation in a recommendation, as follows: “Invest in Data collection and monitoring:

- Department of Public Health to convene, fund, review, monitor, and adopt recommendations of an ongoing “expert” committee addressing the disparities of Asian American and Pacific Islander health and mental health.

- Support research and statistical record keeping efforts that disaggregate A&PI ethnic data to capture trends within specific groups. Separate out gender (Male, Female, & Transgender) and nativity status when possible. (Asian and Pacific Islander Proposition 63 Planning Group (San Francisco), "Mental Health Services in San Francisco's Asian American and Pacific Islander communities," July 2005)

447 'For example, current state-level forms allow immigrants and refugees from Africa to identify as "Black/African American" but do not allow them to specify their country of origin, as is possible with other racial/ethnic categories (i.e., Asian, Hispanic/Latino, Native American, and Native Hawaiian and Pacific Islander). For primary language preference, other state-level forms only offer threshold languages and an "other" box as options, but do not allow for other specified languages to be listed.' "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 16

448 "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 16

449 "Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County," Community Health for Asian Americans, 2015, p. 16

450 "Specific cultural knowledge

Recommendation 8) Raise awareness of needs of Southeast Asian and other API youth among current youth service providers.

- Re-evaluate current youth programs to determine their inclusion of Southeast Asian youth in programming and staffing, and what steps need to be taken so that Southeast Asian youth feel accepted and embraced in the larger community." (SAYFA and APPS, March 16, 2007)

451 "Recommendations to increase effectiveness of mental health supports for SEA youth:

- Outreach, education
- Going out to all community events, talk to schools, recruit them
- Identify different groups to target
- Build trust
- Train teachers about mental health, cultures
- Encourage parents to go to PTA meetings
- Encourage law enforcement to hire and work directly with mental health, not just send youth to jail
- Need money to implement these programs, staff
- Need professional development and training (APPS, November 18, 2005)

452 "Increase the cultural competency of the city departments that are involved in the juvenile justice system by increasing the bilingual and multicultural skills within the various departments. This can be done by making these skills an expressed value in recruitment and by joining forces with non-profit organizations, which may already provide translation, etc." (API Youth Violence Prevention Center: National Council on Crime and Delinquency, 2003)

453 "Require training providers in cultural competence, which includes understanding how different Asian groups conceptualize and express issues of mental illness. Learn ways of communicating about mental health that are understandable and less likely to alienate Asian communities." ("Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act," Asian Community Mental Health Services, Culture-to-Culture Foundation, and Asian Pacific Psychological Services, 2007, pp. 18-19)

454 "Refugee and immigrant needs for all systems: Mandate cultural competency trainings specifically addressing what is needed for meeting the needs of immigrant and refugee communities for all systems that make contact with and serve these communities. Cultural competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations"; in the term cultural competence implies that an individual or organization has the capacity to function effectively "within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities." (Position Paper: A Newcomer Immigrant and Refugee Welcome Center in Alameda County, Community Health for Asian Americans, 2015, p. 28)

456 "Furthermore, efforts need to be made to better align the primary health system with the mental health system such that primary care physicians are more aware of API mental health issues and how these present themselves in everyday clinical situations. If physical causes are not found, physicians need to consider somatization in their assessments. ("Mental Health Services Act: West Contra Costa County - Improving mental health services for Asian & Pacific Islander Americans in Contra Costa County," Asian Pacific Psychological Services, Asian Community Mental Health Services, Culture-to-Culture Foundation, and Prevention Research Center, December 2007)

457 "...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." (California Reducing Disparities Project API Strategic Planning Work Group, 2013).

⁴⁵⁸ ACHCSA began hosting trainings for its agency and partner organizations' staff as well as appointing Lori DeLay as the Trauma Informed Systems Coordinator in 2016.