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

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

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

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

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

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

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

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

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

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

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

The Mental Health Services Act

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

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

The California Reducing Disparities Project

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

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

CRDP is divided into seven components. Five of these components covered the five major populations in California: African American, Asian/Pacific Islanders (API), Latinos, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ), and Native Americans. Each of these five populations formed a Strategic Planning Workgroup (SPW) in developing population-specific reports that will form the basis of a statewide comprehensive strategic plan to identify new approaches toward the reducing of disparities. In addition to these five SPWs, there is the California MHSA.
Multicultural Coalition (CMMC) to inform the integration of cultural and linguistic competence in the public mental health system. The final component of the CRDP is the Strategic Plan writer/facilitator to integrate the five population reports into a single strategic plan to illustrate community-identified strategies and interventions that will address relevant and meaningful culturally and linguistically competent services and programs.

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

OVERVIEW OF THE CRDP
API-SPW Leadership and Organizational Structure

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

The Steering Committee and Regional Strategic Planning Workgroups

The Steering Committee provided leadership, oversight, and progress monitoring for the project. The responsibilities of the Steering Committee were to refine and integrate regional community-driven concerns and solutions before presenting them at the statewide API-SPW meetings for further review, discussion, and decision-making. Including the five regional lead agencies and the statewide lead agency, there were a total of fifty-five member agencies, organizations, and individuals forming five Regional Strategic Planning Workgroups in
California. Each of the five regions was led by an agency with established involvement in local communities. These regional workgroups met regularly to discuss disparity issues and to identify community-driven responses to these disparities. A total of thirty-six meetings were held, including five statewide meetings, thirty regional meetings, and one statewide project conference.

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

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

Lack of Access to Care and Support for Access to Care
- Logistical challenges such as transportation, hours of operation, and location.
- “Medical necessity” may not take cultural specific conditions and symptoms into consideration.
- Lack of proper insurance and affordable services.

Lack of Availability of Culturally Appropriate Services
- Challenges in finding culturally appropriate services.
- Long waiting period to receive culturally appropriate services.
- Current billing guidelines do not allow sufficient time to establish rapport and trust needed for culturally competent care.
- Culturally appropriate service components, such as interpretation and integration of spirituality, are often not “billable.”
Lack of Quality of Care
- Linguistic and cultural match is important, yet often unavailable.
- Even with cultural and/or linguistic match, quality of care may still be inadequate as availability of bicultural and bilingual staff does not automatically make a program culturally appropriate.
- Cultural factors as determined by the community often are not included in the definition of quality of care.

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

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

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

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

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

Table 1: Focus Group Participants – Gender and Age

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
<th>&lt; 18</th>
<th>19-25</th>
<th>26-59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>118</td>
<td>80</td>
<td>13</td>
<td>27</td>
<td>118</td>
<td>40</td>
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Due to stigma towards mental illness and given the cultural preference for a holistic view of “health,” the API-SPW deliberately chose the term “wellness” for the focus group discussions. The following are summaries of the responses from the focus group participants:

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

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

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

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

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

Strategies to Address Unmet Needs
The participants were asked to name services that would meet some of their needs if they could be made available: (1) programs for a specific culture, issue, topic, or age group, (2) social/recreational activities, (3) services in primary language, (4) availability and affordability, (5) more outreach effort to
counteract stigma, (6) inclusion of family, and (7) culturally sensitive/competent staff.

COMMUNITY-DEFINED STRATEGIES
Core Competencies
While it may have been a widely accepted notion that cultural competence is required when working with the AANHPI communities, the definition of “cultural competence” may still need to be further clarified. The definition of “cultural competence” may also vary from culture to culture and from ethnicity to ethnicity. As the API-SPW set out to define core components of cultural competence, the workgroup agreed on common elements and developed a list of core competencies, which was divided into eight categories with each category further divided into three levels, as shown in Table 2. The three levels were devised to highlight the importance to conceptualize cultural competence beyond the individual level, as it would take recognition and support from organizations and systems to make cultural competence possible and meaningful. While the API-SPW realized that some may view this list as too overreaching, it was hoped that this list would serve as a guideline when one considers what constitutes cultural competence. Details of each component can be found in Chapter IV: Community-Defined Strategies.
<table>
<thead>
<tr>
<th>Table 2: Summary of Core Competencies</th>
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<tbody>
<tr>
<td><strong>PROVIDER LEVEL</strong></td>
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<tr>
<td><strong>Professional Skills</strong></td>
</tr>
<tr>
<td>Must have training to provide culturally appropriate services and interventions.</td>
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<tr>
<td>Ability to effectively work with other agencies and engage with community.</td>
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<td>Clear understanding of PEI strategies and relevant clinical issues.</td>
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<td>Knowledge about community resources and ability to provide proper linkage.</td>
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<td><strong>Linguistic Capacity</strong></td>
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<tr>
<td>Proficiency in the language preferred by the consumer OR</td>
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<tr>
<td>Ability to work effectively with properly trained interpreter.</td>
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<tr>
<td><strong>Culture-Specific Considerations</strong></td>
</tr>
<tr>
<td>Respect for and clear understanding of cultural/historical factors including history, values, beliefs, traditions, spirituality, worldview, sexual orientation, gender identity, gender differences, cultural beliefs and practices, and acculturation level/experiences.</td>
</tr>
<tr>
<td>Recognize the importance of integrating family and community as part of services.</td>
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<tr>
<td><strong>Community Relations &amp; Advocacy</strong></td>
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<tr>
<td>Ability to effectively engage community leaders and members.</td>
</tr>
<tr>
<td>Ability to form effective partnerships with family.</td>
</tr>
<tr>
<td>Willingness and ability to advocate for needs of the consumers.</td>
</tr>
<tr>
<td>PROVIDER LEVEL</td>
</tr>
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</table>
| **Flexibility in Program Design & Service Delivery** | - Flexibility in service delivery in terms of method, hours, and location.  
- Understand and accommodate the need to take more time for AANHPIs to build rapport and trust. | - Capacity to allow flexibility in service delivery (e.g.: more time allowed for engagement and trust building for consumers/ family members; provide essential services to ensure access to services, such as transportation, available hours of operation, and convenient location).  
- Program design should consider community-based research, culture, and traditional values so it will make sense to the consumers.  
- Willingness to look for innovative venue for outreach, such as ESL (English as a Second Language) classes. | - Recognize the importance and support more time needed for engagement and trust building.  
- Recognize the importance and support essential ancillary services needed to ensure access to services.  
- Recognize the importance and support flexibility in service delivery.  
- Encourage and support programs that include community-based research and/or community-designed practices.  
- Flexibility in diagnostic criteria to accommodate cultural differences.  
- Provide support for innovative outreach. |
| **Capacity-Building** | - Ability to empower consumers, family members, and community.  
- Capacity to collaborate with other disciplines outside mental health. | - Capacity to educate the community on mental health issues.  
- Capacity to collaborate with other sectors outside mental health, such as primary care and schools.  
- Plan in place to groom the next generation leaders and staff for the future.  
- Capacity to provide cultural competence training to mental health professionals and professionals from other fields. | - Provide support for capacity-building within the agency and within the community.  
- Provide support for future workforce development.  
- Encourage and support outreaching and educating the community on mental health issues.  
- Provide support for cultural competency training.  
- More involvement of the community in the policy-making process.  
- Provide support for a central resource center. |
| **Use of Media** | - Capacity to utilize ethnic media and social media for outreach. | - Encourage and support the use of ethnic media and technology for outreach. |
| **Data Collection & Research** | - Collect disaggregated data.  
- Work with researchers and evaluators to assess effectiveness of programs and services. | - Provide support for disaggregated data collection.  
- Support ethnic/cultural specific program evaluation and research.  
- Support research to develop evidence-based programs (EBPs) for AANHPI communities. |
Selection Criteria for Promising Programs and Strategies

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

Table 3: Selection Criteria for Promising Programs and Strategies

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Number of Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General submission of existing programs</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>Submission of existing programs that have been evaluated</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Innovations/suggested strategies</td>
<td>19</td>
</tr>
<tr>
<td>4</td>
<td>Already recognized programs</td>
<td>5</td>
</tr>
</tbody>
</table>

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

SYSTEMS ISSUES AND IMPLICATIONS ON PUBLIC POLICY

Over the last two years, the API-SPW has actively listened to AANHPI community representatives, community members, and community experts regarding the current state of disparities in California. Therefore, the disparities in mental health services documented in this report were primarily based on personal experiences observed and shared by the AANHPI community. Despite limited resources, the AANHPI communities had
developed responses to many unmet needs, and the 56 community-defined promising programs and strategies collected through this project were good examples of such efforts. However, to effectively and timely reduce these disparities, support and leadership from policy makers at the local, county, and state level are essential. The following are recommendations for policy considerations on how to reduce existing disparities in the API community:

Access, Affordability, Availability, and Quality of Services

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Increase access by supporting culturally competent outreach, engagement, and education to reduce stigma against mental illness and to raise awareness of mental health issues.</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Increase availability and quality of care by supporting the development and retention of a culturally competent workforce.</td>
</tr>
</tbody>
</table>

A culturally competent program can only be effective if those providing services are culturally competent. Mental health careers are not as well recognized or pursued in the AANHPI communities. Culturally competent training has not been sufficiently emphasized in the current training model. Providers currently serving the AANHPI community can use more
ongoing training and peer support as the community relies heavily on them for services. Lastly, cultural competence training should also include those who serve AANHPIs such as healthcare providers, school, and law enforcement.

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

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

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Increase availability and quality of care by supporting services that meet the core competencies and program criteria as defined by the API-SPW.</td>
</tr>
</tbody>
</table>

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

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

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

**Outcome and Data Collection**

**Recommendation**

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

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

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

Capacity-Building

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tr>
<td>Empower the community by supporting community capacity-building through efforts such as leadership development, technical assistance, inclusion of community participation in the decision-making process, and establishment of infrastructures that can maximize resource leveraging.</td>
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</tbody>
</table>

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

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

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

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