

***The Asian American, Native  
Hawaiian, and Pacific  
Islanders in Alameda County:  
Literature Review on  
Challenges and Opportunities  
in Mental Health Services***

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According to the 2015 Census, the AANHPI (Asian American, Native Hawaiian, and Pacific Islander) populations are among the fastest growing racial groups in the United States. About 32.4% of the Asian population and 27.5% of the NHPI population in the U.S. reside in California, where the AANHPI communities represent 16.9 % of the state’s population. As the high prevalence rates of mental illness and the low utilization rates of mental health services in the AANHPI community have been well established in the literature (Center for Disease Control, 2007; Ta, Juon, Gielen, Steinwachs, & Duggan, 2008; Ivey et al., 2016), understanding and addressing barriers to care as well as developing culturally responsive programs become critical. This report is based on findings and literature review conducted through the California Reducing Disparities Project (CRDP) API project (2013) while incorporating available researches and reports targeting the AANHPI communities in Alameda County and the Bay Area. The aims of this report are to understand various aspects of the mental health disparities experienced by the AANHPI population, examine ethnic-specific barriers to mental health services, and offer recommendations on reducing their mental health disparities in Alameda County.

## ***DEMOGRAPHICS***

Who are the AANHPI? According to the U.S. Census Bureau (2017), “Asian” is defined as “a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.” “Native Hawaiian and other Pacific Islander (NHPI)” is defined as “a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.” Individuals who reported only one race category were referred to as the “race alone” population. In addition to the “Asian alone” and “Native Hawaiian and other Pacific Islanders alone” categories, Asians and Native Hawaiian/Pacific Islanders are also captured in the “Asian in combination” and “NHPI in combination” categories when a person is self-identified as multi-racial (Humes, Jones, & Ramirez, 2011).

### **DATA ON AANHPI POPULATIONS IN UNITED STATES**

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

According to the 2015 Census, out of the total U.S. population of 321.4 million, 16.23 million (5%) identified themselves as “Asian alone” (U.S. Census Bureau, 2015). In addition, another 2.93 million chose the “Asian in combination” category, bringing the total of “Asian alone” and “Asian in combination” populations to 19.16 million, amounting to 5.9% of the U.S. population. Although Asian populations still made up a relatively small proportion of the overall U.S. population, there had been a 38% increase (“Asians” and “Asians in combination” together) in the last decade, growing from 13.8 million in 2005 to 19.16 million in 2015. In terms of distribution of the total Asian populations at the state levels, 6.5 million resided in California while New York was the distant second with 1.89 million (U.S. Census Bureau, 2015). There were about 546,255 Native Hawaiians and Pacific Islanders (NHPI alone) residing in the U.S., and an additional 716,179 included in the “NHPI in combination” category, bringing the total NHPI population in the U.S. to 1.26 million, which accounted for 0.4% of the total U.S. population. This represented a significant 65% increase from the 764,255 NHPIs accounted for in the 2005 Census.

## **DATA ON AANHPI POPULATIONS IN CALIFORNIA**

According to the 2015 Census, out of the total population of 38.42 million in California, 6.2 million Californians who identified themselves as “Asian alone” or “Asian in combination,” which accounts for 16% of the state’s population, making California the state with the largest Asian population. There were 314,337 Californians identified as “NHPI” or “NHPI in combination,” which accounted for 0.8% of the state’s population. In total, the AANHPI communities represented 16.9% of the population in California in 2015 (U.S. Census Bureau, 2015). An argument could be made that the actual number of the AANHPI populations might be even higher, as not all AANHPI groups were captured in the census, and there might be reluctance in the AANHPI communities to participate in the census due to reasons such as immigration status and language barriers. Nevertheless, the 2015 Census results clearly speak to the significance of the AANHPI communities in California.

## **DATA ON AANHPI POPULATIONS IN ALAMEDA COUNTY**

The Alameda County is home to many AANHPI individuals and families, and the AANHPI population has grown significantly in the county over the years. According to the U.S. Census data, there was a 49% increase in the Asian population in Alameda County and a 51% increase in the NHPI population between 2000 and 2015 (not including AANHPI in combination). As of 2015, the total population in the Alameda County was 1,584,983, with 32% of the total population identifying themselves as Asian alone or in combination by selected groups, and approximately 1.5% identifying as NHPI alone or in combination by selected groups. Table I provides a list of AANHPI groups that were accounted for in the 2015 Census data in Alameda County. Please be reminded that this is not an exhaustive list of all the AANHPI communities in the county. For example, Afghani and Iranian were not on the list but based on other 2015 Census data, there were 8,958 people identified “Afghan” as their ethnic origin and 6,220 identified as “Iranian,” which were approximately 0.56 % and 0.4% of the county total population, respectively. The 2015 Census also indicated that AANHPI accounted for 58% of the foreign-born population in the county. In addition, 19% of the households in Alameda County speak API languages, and of those households, 29% are limited English speaking households. Country to stereotypic view, AANHPIs are not all doing well financially. Of the individuals who were below the poverty level in Alameda County, 9.4% of them identified as Asian alone and 11.9 % identified as NHPI alone in the 2015 Census.

Given the diversity of the AANHPI populations, it is to be expected that there would be many differences across various subgroups. These differences could be observed in terms of language, culture, history, immigration patterns, religion, spirituality, traditions, acculturation, and socioeconomic status, just to name a few. The heterogeneity among AANHPIs was also reflected in the levels of English proficiency (LEP) and educational attainment. While only 14% of NHPIs reported limited English proficiency, the proportion of Asians with LEP ranged widely from around 22-24% for Japanese and Filipinos, around 41-46% for Chinese, Cambodians, Hmong, Laotians, and Koreans, to 53% for Vietnamese (Ramakrishnan & Ahmad, 2014). With regards to educational attainment, about 70% of Indians adults who are 25 years and older have a college degree, while the following AANHPI ethnic groups fall below the state average of 31% of adults to hold a college degree or higher: Vietnamese (29%), Cambodian (16%), Hmong (13%), NHPI (15%), Laotian (10%), and Guamanian or Chamorro and Samoan (12%) (The Campaign for College Opportunity, 2015). Subgroup differences can also be observed in terms of poverty rate in children. Specifically, while poverty rates for many Southeast Asians are higher than the state average of 23%, such as Hmong (42%), Cambodian (33%), Laotian (31%), and Burmese (23%), other AANHPI subgroups have significant lower rates of poverty than the state average; for example, 6% of Indian, 6% of Taiwanese, and 7% of Japanese (The Campaign for College Opportunity, 2015).

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

<b>Asian Population</b>				
<b>Subject</b>	<b>Alone</b>	<b>% of the total population in Alameda County</b>	<b>Alone or in combination with one or more other categories of same race</b>	<b>% of the total population in Alameda County</b>
Total:	439,055	27.7%	507,029	31.99%
Chinese, except Taiwanese	149,683	9.44%	170,413	10.75%
Filipino	88,349	5.57%	107,919	6.81%
Asian Indian	93,212	5.88%	98,131	6.19%
Vietnamese	33,949	2.14%	39,183	2.47%
Japanese	13,100	0.82%	22,906	1.45%
Korean	18,428	1.16%	21,615	1.36%
Afghani *	8,958	*0.56%		
Iranian*	6,220	*0.39%		
Taiwanese	5,088	0.32%	5,407	0.34%
Cambodian	4,210	0.26%	5,176	0.33%
Pakistani	4,751	0.29%	5,102	0.32%
Laotian	3,960	0.25%	4,492	0.28%
Burmese	2,249	0.14%	2,962	0.19%
Thai	2,180	0.14%	2,815	0.18%
Indonesian	1,298	0.08%	2,336	0.15%
Nepalese	1,699	0.1%	1,763	0.11%
Mongolian	1,109	0.07%	1,343	0.08%
Sri Lankan	796	0.05%	928	0.06%
Hmong	708	0.04%	737	0.05%
Bangladeshi	467	0.03%	539	0.03%
Malaysian	314	0.02%	518	0.03%
Bhutanese	103	0.006%	332	0.02%
Okinawan	0	0	96	0.006%
Other Asian, specified	131	0.008%	157	0.01%
Other Asian, not specified	1,507	0.09%	12,159	0.77%
<b>NHPI Populations</b>				
Total:	13,760	0.87%	24,698	1.56%
Native Hawaiian	2,326	0.15%	6,199	0.39%
Fijian	3,245	0.2%	4,374	0.28%
Samoan	2,846	0.18%	4,012	0.25%
Guamanian or Chamorro	1,500	0.09%	3,053	0.19%
Tongan	2,176	0.14%	2,811	0.18%
Marshallese	141	0.009%	141	0.009%
Other Polynesian	126	0.008%	177	0.01%
Other Micronesian	125	0.008%	154	0.01%
Other Melanesian	18	0.001%	18	0.001%
Other PIs, not specified	1,030	0.06%	3,759	0.24%

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

## ***OVERVIEW OF DISPARITY ISSUES IN LITERATURE***

The Surgeon General Report (U.S. Department of Health and Human Services, 2001) clearly concluded that disparities exist in the access to and utilization of mental health services for ethnic populations. Such disparities have left ethnic populations underserved, un-served, or with unmet needs. Even when ethnic populations are served, the quality of care they experience is often poorer than that received by Whites. Many of the barriers in behavioral health needs are similar across the different groups of AANHPI. Moreover, these barriers are often interrelated, as one barrier could lead to or be the cause of another barrier.

### **PREVALENCE RATE AND UTILIZATION RATE**

Asian Americans are often considered the “Model Minority” in the United States: hard-working, high-achieving academically, and successful. With such stereotypes, some may expect low prevalence rates of mental illness and low utilization rates of mental health services among Asians. However, data gathered from the 2000 Census and released by the California Department of Mental Health showed that prevalence rates for Asian Americans were similar to the general population. For example, 7.18% of Asian youths and 7.67% of Pacific Islander youths were estimated to have a serious emotional disturbance compared to 7.51% of the total youth population in California. Moreover, 5.6% of Asian adults and 7% of Pacific Islanders adults were estimated to suffer from serious mental illness, compared to 6.25% of the total adult population in California (California Department of Mental Health, 2000). Additionally, the Center for Disease Control data showed that API women ages 65 and over consistently had the highest suicide rate at 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%) compared to all other racial groups. 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). In particular, suicide is alarmingly common among NHPI youths. 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).

Despite prevalence rates of mental illness being comparable to or higher than other ethnic groups, the utilization rate of mental health services remains low for AANHPIs. A study conducted in 2011 found that Asian Americans with suicidal attempts were less likely to seek and perceive a need for help than Latinos (Chu, Hsieh, & Tokars, 2011). The authors of the study suggested that Asian Americans with suicide ideations may underestimate the severity of their condition or may have different ways of understanding or coping with suicidal ideations. The impacts of help-seeking behaviors on mental health services utilization can also be observed by looking at the emergency services data. Among children receiving mental health care from California’s county systems between 1998 and 2001, AANHPI children were more likely than White children to use hospital-based crisis stabilization services, which suggest that AANHPI caretakers tended to postpone treatment until it reached a critical level and became a crisis. The delayed help-seeking may be due to stigma, mistrust of the system, and/or language barrier (Snowden, Masland, Libby, Wallace, & Fawley, 2008). Another study focusing on Cambodian immigrants also revealed the low rates of services utilization. From interviewing 339 Cambodian immigrants in Long Beach who were diagnosed with PTSD, major

depression disorder, or alcohol use disorder, Marshall et al. (2006) 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. The need for mental health services is apparent, yet those in need are not gaining access or receiving proper care.

There are only a few studies and reports available examining the prevalence rates of mental illness and mental health service utilization among AANHPIs in Alameda County. Based on the 2000 Census, it was estimated that 6.1% of the total population in Alameda County were experiencing serious emotional disturbance or serious mental illness. Specifically, 6.95% of Asian youths and 7.53% of Pacific Islander youths were estimated to have serious emotional disturbance compared to 7.13% of the total youth population in Alameda County. Additionally, 5.39% of Asian adults and 6.79% of Pacific Islanders adults were estimated to suffer from serious mental illness compared to 5.76% of the total adult population in the county (California Department of Health Care Services, 2000). In a more recent study conducted by the Korean Community Center of the East Bay (KCCEB) and the Health Research for Action (HRA) center at UC Berkeley, they examined the health and social needs of the Korean communities in the five counties of the Bay Area including Alameda County (Ivey et al., 2016). The results revealed that 13% of their survey participants reported serious psychological distress (SPD) and 28 % were at a high risk of developing SPD. The results also indicated that many of their participants reported that their emotional distress had severely or moderately interfered with their work, daily, and social functioning. Nevertheless, of those who reported functional impairment due to SPD, only 9% felt that they might need help and only one respondent actually sought help from healthcare professional (Ivey et al., 2016). Other Alameda County-based reports have also raised the issue of mental health disparities in local underserved communities, such as refugees and recent immigrants as well as older Asian adults with serious mental illness (Afghan Coalition, 2007; Community Health for Asian Americans, 2015). Clearly, the need for mental health services has been and continues to be pressing for AANHPIs nationwide including those who reside in Alameda County. With 33.5% AANHPIs in the County and less than 3% of the consumers in the public mental health system are from the AANHPI communities, it is important to examine barriers that prevent AANHPIs from utilizing mental health services.

## **BARRIERS TO CARE**

Given the evidence for typical prevalence rates of mental illness and consistently low utilization rates of mental health services in AANHPIs, it is critical to understand and address barriers that deter AANHPIs from accessing and receiving mental health services. The following section outlines barriers to care identified in various studies:

### **Stigma**

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

South Asian college students reported more negative attitudes towards mental illness, and consequently, greater reluctance to seek help. These South Asian students were also found to be more likely to distance themselves socially from those with mental illnesses. Thus, stigma was significant both at a personal and social level (Loya, Reddy, & Hinshaw, 2010).

Even when an individual could overcome stigma and seek help, mental health professionals are often not the first to be approached by AANPPIs. Family, friends, community leaders, or spiritual leaders were among those AANPPIs would often reach out to. Additionally, rather than seeking help for emotional difficulties, AANHPIs would tend to present their mental health problems as physical symptoms to their primary care providers (Zhang, Snowden, & Sue, 1998). However, primary care providers are typically not specialized in working with people who have mental health issues and may lack proper tools and training to diagnose or treat mental illnesses. Such strong reluctance towards help-seeking could, in turn, result in situations where mental health services were sought only when problems become severe (Chow, Jaffee, & Snowden, 2003). Seeking help when problems have escalated can lead to higher health care costs, as it prolongs treatment, decreases the probability of a good prognosis, and increases the chances that patients would need to visit the emergency room to receive their mental health treatment (e.g., suicide attempts).

### **Language Barrier**

In an analysis of the 2001 California Health Interview Survey (CHIS), which included 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 indicated a need for mental health care and received mental health services, while 56% of English-speaking only AANHPIs received needed services (Sentell, Shumway, & Snowden, 2007). As highlighted in the Ponce et al. (2009) report, the majority of Asians were foreign-born and many were recent immigrants. As a result, a significant portion (36%) of the Asian populations had limited English proficiency (LEP), making it difficult for them to seek mental health services. The issue of the language barrier is even more relevant when older adults are concerned. Surveys that included almost 17,000 adult Californians ages 55 and older, of which 1,215 were Asians, showed that Asians were more likely to report mental distress but less likely to use mental health services compared to their White counterparts. Moreover, among the Asians surveyed, 81% were foreign-born and 39% had LEP (Sorkin, Pham, & Ngo-Metzger, 2009). As suggested by the authors of the Sorkin et al. (2009) study, language barriers might have increased an individual's sense of isolation, decreased the amount of social support available, and resulted in less access to care.

Theoretically, the challenge of LEP can be addressed with a multilingual workforce that provides culturally competent mental health services. However, the mental health field continues to suffer from a shortage of workers who are well-versed in the diverse languages, cultures, and the unique skill sets required to navigate the wide range of challenges posed by a heterogeneous Asian population. For example, training programs for mental health professionals typically do not teach in languages other than English nor do they provide additional resources for students who may wish to work with an Asian population. Given the shortage in culturally competent mental health professionals, interpreters are sometimes utilized to overcome the barrier of limited English proficiency in patients. Simply stated, the competency level of the interpreter matters. In surveying 2,715 LEP Asians at 11 community-based health centers serving large Asian populations across the U.S., it was revealed that the perceived quality of the interpreter was strongly associated with the quality of care perceived by the patients, and that interpretation by family members and untrained staff was associated with lower satisfaction (Green et

al., 2005). The findings clearly support the importance of providing rigorous training for interpreters and for clinicians to work with interpreters. Another important policy implication was that more time should be allotted when using interpreters, as research shows a high correlation between the patient's ratings of interpreters and the feeling that there was sufficient time to explain the reason for their visit and to understand the clinician's explanation of their problems (Green et al., 2005).

### **Affordability of Medical Care**

Considering the diversity in the AANHPI communities, it is almost a given that there are differences in accessing health care (e.g., insurance coverage) across different ethnic groups. Based on an analysis of data from the 2003 and 2005 CHIS, Korean children in California were 4 times more likely than non-Hispanic White children to lack health insurance (12.5% vs. 2.8%). Filipino children were twice as likely as non-Hispanic White children to not have had recent contact with a doctor (13.1% vs. 7.6%) as they were 25% more likely than non-Hispanic White children to not have insurance (3.5% vs. 2.8%). Lack of insurance consequently resulted in less access to care and lower utilization of services (Yu, Huang, & Singh, 2010). Furthermore, a 2009 report by the University of California AAPI Policy Research Program revealed that 33% of adult Koreans in California were uninsured, the highest rate among all ethnic groups and more than two times higher than the state average of 15%. Moreover, despite experiencing mental distress more frequently than other AANHPI groups, 34% of Vietnamese with health insurance did not have mental health coverage. Similarly, while 88% of Chinese had health insurance, 28% did not have mental health coverage (Ponce et al., 2009). Given that primary care is often the first contact setting for mental health issues in AANHPIs, the lack of insurance coverage presents another major barrier for AANHPIs to receive proper care. In addition, even for those with health insurance, a significant portion did not have mental health coverage. While the issue of insurance coverage has improved significantly under the Affordable Care Act (ACA), the affordability of the insurance premiums and co-pays remains a challenge for some Asian individuals to fully utilize health care.

### **Lower Satisfaction with Quality of Care**

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

### **Lack of Disaggregated Data and Research**

In reviewing available literature and data with regards to the AANHPI populations, it became clear that we have a long way to go to adequately identify, assess, and address the needs of various AANHPI communities in California. AANHPIs have often been grouped together, if included at all, in most studies. Even in studies that attempted to collect subgroup data, only a few major Asian groups

were counted, such as Chinese, Japanese, and Korean. When researchers sought for disaggregated data beyond these groups, only a few additional groups were included. The reality is, as described in many of the studies cited in this section, the AANHPI communities can be rather different. The study by Huang, Wong, Ronzio, and Yu (2006) and the report by Ponce et al. (2009) are two examples crystallizing the great variations across AANHPI subgroups. However, the heterogeneity of the Asian populations has not been sufficiently recognized and reflected in data collection and research. The scarcity of data collection and research on Native Hawaiians and Pacific Islanders is even more troubling, as they appear to be practically non-existent. The lack of disaggregated data continues to marginalize AANHPI populations and worsen the issues of disparity in mental health services. In addition to ethnicity, factors such as immigration history, acculturation level, socioeconomic status, and educational attainment should also be critical considerations in data collection and public policy.

Funding is always a challenge as it is more costly to provide more ethnic and linguistically specific outcome measures and staffing required administering these measures. Another possible reason contributing to the lack of disaggregated data for AANHPIs may be the lack of infrastructure to develop programs and support researchers who may be interested in collecting data on AANHPIs. In analyzing lessons learned at the University of Hawaii at Manoa, which largely serves AANHPI populations, several barriers to research were identified. For example, limited physical and human resources, as well as a lack of mentors and role models, made it rather challenging to attract junior researchers to conduct research that could better capture the mental health needs in the AANHPI communities (Yanagihara, Chang, & Ernst, 2009).

## ***WHAT IT TAKES TO WORK EFFECTIVELY WITH AANHPIs***

While it may have been a widely accepted notion that cultural competency is required when working with the diverse communities, there continues to be a need to further clarify the definition of “cultural competence.” In 2013, the Asian Pacific Islander Strategic Planning Workgroup (API-SPW) identified the essential components of cultural competence as “*Core Competence*” in the CRDP report that hopefully serves as a guideline in considering what constitutes cultural competence. Please see Attachment I for a summary of core competencies. More detailed descriptions of each category are as follows:

### **Professional Skills**

It is a given that any individual provider should possess the professional skills necessary for the services provided, including a clear understanding of prevention and early intervention strategies and relevant clinical issues. The term “professional skills” is not limited to those with credentials, licensure, or degrees. It is broadly defined here to include skills that meet both established professional standards and cultural appropriateness. It is also a given that individual providers should have continuous training on relevant prevention, early intervention, clinical, and related cultural topics to provide culturally appropriate services. Moreover, as individual providers often serve as the point of contact and the link between individuals seeking help (i.e., the consumer) and other resources, a culturally competent provider should also possess the ability to engage with the community, to work with other agencies, and to provide proper linkage to available resources.

At the agency level, a culturally competent agency should employ, train, and support staff that possess the necessary professional skills as indicated above. The mere hiring of a bilingual employee is not sufficient, as cultural competence goes far beyond language. It is also insufficient to merely hire one or two bicultural, bilingual staff to work with an AANHPI population. As much as possible, it is essential to have a critical mass to support the bicultural, bilingual staff to avoid burn-out and to facilitate the effective impact of the team. In addition, the agency should also have the capacity to work with other agencies and communities to provide appropriate linkage services. At the systems level, it is critical for the systems to recognize the importance of cultural competence and to provide resources and support for the development and retention of a culturally competent workforce. For example, ways to develop culturally competent workforce can be to provide regular workshops at high schools to outreach to AANHPI students and their guardians about mental health related careers or to develop mentorship programs to link AANHPI high students who show interest in the field of mental health with more seasoned mental health professionals in order to help guide through their career development.

### **Linguistic Capacity**

Many in the AANHPI community prefer to receive services from providers who can speak their native language even if the consumers have some proficiency in English. In particular, language is a crucial engagement tool for the elderly and the immigrant communities, as many individuals in these communities are LEP or monolingual. Linguistic capacity is more than the ability to speak the consumer's preferred language. It is also the ability to understand the cultural context of the language. However, given the diversity in the AANHPI community, it may be challenging financially and logistically for any agency to maintain enough staff to speak all of the languages preferred by consumers. Therefore, interpreters may be used to augment service delivery, which makes the provider's ability to work with an interpreter an essential skill when rendering culturally competent services. Additionally, interpreters need to have adequate training in mental health issues to know how to properly translate mental health terms and concepts in culturally acceptable language to the consumers. Training interpreters to effectively manage secondary trauma for the challenging issues and traumatic experiences they are exposed to while performing interpretation is also important.

For agencies, employing bilingual staff is only part of the picture in providing culturally competent and effective services. Ongoing training and support of such staff are also vital to maintaining a culturally competent workforce. Moreover, written materials should also be made available in languages preferred by the consumers. Lastly, as part of the agency's ongoing efforts in providing culturally appropriate services, there should be regular training to foster effective working relationships between staff and interpreters. Support is therefore needed at the systems level to recruit and retain a bilingual workforce. For example, incentives should be provided to recruit and retain culturally competent workforce and resources and funding should be set aside for interpretation both in service delivery and printed materials.

### **Culture-Specific Considerations**

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

conventional services based on individualism prevalent in Western culture, family and community should also be taken into consideration when determining service plans appropriate for AANHPIs. Another important consideration is the role of faith and spirituality in prevention, healing, and recovery. Faith and spirituality is very important to AANHPIs, services without considering these factors will not be quite as effective.

On an organizational level, it is important that board members reflect the composition of the community the organization aims to serve. Culture-specific or population-specific factors should be incorporated in the program design. In addition to ongoing training and supervision on culture-specific issues, the agency itself should have policies that reflect and respect the cultural values and needs of the community. Spirituality may need to be considered or incorporated in service delivery to respect cultural practices. The name of the agency should refrain from using the term “mental health” given the issue of stigma. The setting of the agency should convey welcoming messages by incorporating decorations and displays familiar to the consumers, and culturally important elements such as food, tradition, art, music, and dance can be used as effective tools for engagement to decrease stigma. Furthermore, the system should encourage and support culturally competent services by providing resources to programs that are designed with culture-specific considerations. For example, many ethnic community-based organizations (CBOs) have the expertise, staffing, and programs to effectively reach the community. Therefore, these CBOs can be key partners for the systems to engage the community and to provide culturally appropriate services. It is important to note that these CBOs may not necessarily be mental health clinics, as they can be community centers, senior centers, local churches, and etcetera.

One research directed by CHAA, in partnership with KCCEB, Filipino Advocates for Justice (FAJ), and Center for Empowering Refugees and Immigrants (CERI), offers a broad framework and specific strategies on designing and implementing culturally responsive programs through a community driven process (Asian Elder Wellness Project, 2015). The proposed method involves a seven-step process with a framework to allow community members to drive the development of the programs that are intended to serve them. The seven steps are as follows: 1) Team and Trust Building; 2) Listening Survey; 3) Theme Development; 4) Building Group Analysis; 5) Research; 6) Action; and 7) Reflection. Through the seven-step process, community members at each of the partner agency developed a program aimed to decrease social isolation and improve quality of life among adults and older adults with serious mental illness (SMI). As the results indicated, KCCEB founded an 8-week social engagement program that was culturally relevant and appropriate (e.g., engage in traditional celebrations and activities to help the participants “feel like home”); FAJ implemented a cultural celebration that incorporated healing modalities (e.g., yoga, acupuncture, dance) to increase outreach and engagement to the individuals with SMI; and CERI implemented an innovative intervention through the form of a garden party to engage isolated SMI Cambodians. These projects were successful in reaching the target populations and received positive feedback from their communities (CHAA, 2015).

The effectiveness of culturally responsive mental health services in meeting the needs of AANHPI communities was also evident in a study conducted in 2016 by ACBHCS in collaboration with seven local Underserved Ethnic Language Population (UELPP) programs. Their results indicated that clients in prevention and early prevention programs were benefitting from culturally-sensitive and ethnic-specific mental health services. Specifically, program participants reported benefitting from UELPP programs that included all of the following five domains: 1) connecting individual and families with their culture, 2) forming and strengthening identity, 3) changing knowledge and perception of

mental health, 4) building community and wellness, and 5) improving access to services and resources. This study highlighted the advantages and the importance of providing culturally competent programs to the underserved communities in order to better meet their language, cultural, social needs, and mental wellness needs.

### **Community Relations and Advocacy**

AANHPI cultures are family and community-oriented, which means that the ability on the part of the individual providers and agencies to effectively engage, educate, and collaborate with families and community leaders is critical in ensuring successful outreach and services. As AANHPI cultures often place great emphasis on relationship-building, it is also essential for providers and agencies to earn and establish their credibility in the community by not just engaging and serving the community, but also by advocating for the needs of the community in areas that affect the overall wellness of the community. Of course, all these efforts in forming relationships require resources and support, which is where the systems play a pivotal role.

### **Flexibility in Program Design and Service Delivery**

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

The location and operation hours should also be as accessible to the consumers as possible. For example, many AANHPI consumers need transportation assistance to receive services or can only come for services during certain hours. In some cases, field services or home-based services could provide a more natural setting for consumers due to reasons such as stigma and/or other logistical challenges. For example, the Project Asian Reach (PAR) conducted by the Asian Community Mental Health Services (ACMHS) in 2015 demonstrates the effectiveness of providing home or community-based services to Korean and Chinese adults and older adults with mental illness. Specifically, their study results showed that the home-based services provided by bilingual and bicultural clinicians and peer mentors were effective in decreasing the participants' social isolation through relationship building. However, their place-based outreach (e.g., parks, libraries, coffee shops) was found to be quite ineffective in meeting their project goals, as the lack of privacy and resistance to talk to strangers in public settings had prevented people from participating in the services. As a result, the place-based outreach was modified by targeting senior housing facilities instead and offering an onsite 8-week Art and Wellness Group. This modification of the outreach strategy was successful, and participants reported feeling positive and experiencing increased self-esteem and social connection at the end of the 8-week group (ACMHS, 2015). Providing services at a place where the target population naturally gather, such as senior housing facilities for elderly populations, can be advantageous and effective in reaching the desired community due to its convenient location and safe setting; moreover, it provides consumers with a sense of community and social connection in their home environment.

Cultural competence requires flexibility at the systems level as well. For example, more time and sessions could be allowed when engaging and serving the AANHPI community. Similarly, the system should recognize that while some of these services are not traditionally "billable" under a typical program, they do not detract from the productivity, effectiveness, and the value of the program.

Resources should be allocated for ancillary services such as transportation to improve access to services and for innovative and culturally appropriate outreach efforts. Moreover, flexibility should be incorporated into the requirement of meeting medical necessity, since symptoms may be presented differently due to cultural differences and thus may not meet diagnostic criteria based on the Western model. For example, research has shown that mental health symptoms are often manifested through physical symptoms (e.g., headaches, nausea, vertigo) or other unexplained medical symptoms among AANHPIs (Kirasaki, Okazaki, & Sue, 2002; Kalibatseva & Leong, 2011), and these cultural-bound syndromes may not be captured in the Western based diagnostic criteria.

### **Capacity Building**

Many agencies in the AANHPI community are relatively small in size and capacity despite the amount of services they provide and their importance to the community. There are limited resources available to the AANHPI community despite the great need. In Alameda County, there are several AANHPI communities with less than 3,000 individuals with high needs. The task of supporting these smaller communities and the agencies that serve them is essential. Therefore, capacity building is a critical issue at all levels. Empowering the community and leveraging existing resources are important skills at the individual provider level. For agencies, several capacities are needed to demonstrate cultural competence: the ability to educate the community on mental health issues, to collaborate with other community organizations such as schools and primary care providers, to train professionals and paraprofessionals on cultural competence, and to develop future culturally competent workforce. With sufficient support from the systems, all these capacities can significantly contribute to the empowerment of the AANHPI community and the development of its capacity to meet its needs in the future. For example, it was documented that Cambodian temples housed the mentally ill in the Central Valley. Given that spirituality is an important cultural component reported by the community, the system could provide resources for the mental health service providers, the family members, and the temples to work together to take care of those in need. Furthermore, the system can also foster capacity-building by encouraging meaningful involvement by the community in the policy-making process to ensure that policies adequately and effectively address the needs of the AANHPI community. One effective way to do so would be to create and support infrastructures that leverage existing resources in the community. Lastly, support for a central resource center will be a cost efficient way to take advantage of technology for outreach and linkage.

### **Use of Media**

Ethnic media is often one of the best channels to reach the AANHPI community, especially to those who have LEP. Individual providers are natural front-liners who play the central role of gathering stories for ethnic media, developing culturally appropriate materials to be shared with the community, and/or influencing ethnic media to raise awareness on mental health issues. However, support from the agency is required because there is usually no funding for such activity. Therefore, it really falls on the agency to demonstrate its willingness and capacity to engage and utilize ethnic media and even social media for education and outreach. One of the major difficulties agencies encounter is the lack of resources because such efforts involve staff time and funding. By allocating resources for outreach work with the media, the systems can show their understanding of the importance of utilizing ethnic media to engage and outreach the community. In addition to ethnic media, social media and blogging can also be used to reach the younger generations and the general public. Web-based information sharing can also be an effective way for outreach and education.

## **Data Collection and Research**

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

When doing program evaluation, selecting approaches and measures that are culturally and linguistically appropriate can make a big difference in outcomes. Combining both quantitative and qualitative approaches in collecting data and outcomes is important, as case studies, in-depth interviews, or focus groups may provide additional data that are not observed or measured by self-report scales, which are often designed from or influenced by the Western point of view. Community-based participatory research (CBPR) is another viable approach to actively engage the community in designing and gathering more accurate data.

Furthermore, when considering funding diverse communities like the AANHPIs, funders will need to reconsider decreasing the emphasis on evidence-based programs (EBPs). Despite EBPs have been researched and deemed effective, most of them are not validated in the AANHPI communities. It is uncertain whether these EBPs are based on culturally and linguistically appropriate research paradigms and data collection strategies suitable for the AANHPIs. If EBP is the sole funding criterion, AANHPIs may be left with no “scientific” evidence intervention to choose from. Nevertheless, there has been community and clinically developed programs that have been implemented and deemed effective in the communities. Funders should really consider using a variety of criteria to determine awards.

## ***IMPLICATIONS ON PUBLIC POLICY AND RECOMMENDATIONS***

The recommendations offered in this section are derived from the CRDP API-SPW population Report (2013). Through reviewing the available data in Alameda County, similar patterns in mental health disparities among the AANHPI communities in Alameda County were found when compared to data statewide and nationwide, including having high prevalence rate of mental illness and low mental health service utilization rate due to the common barriers to care (e.g., stigma, language barrier, lack of insurance). Therefore, even though some of recommendations are based on data collected outside of Alameda County, their implications are still closely and clearly relevant to Alameda County in reducing mental health service disparities.

### **Increase Access**

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.

*To increase mental health awareness, we recommend:*

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

In addition, due to cultural differences, the manifestation of symptoms for AANHPIs with mental health issues may be different from those common in Western culture, which render eligibility requirements such as meeting medical necessity as defined by Western-derived syndromes inappropriate for the AANHPI populations.

Lack of adequate insurance coverage for available and affordable mental health services continue to be barriers to care for many AANHPIs. Moreover, a number of other barriers such as lack of transportation and interpretation make it critical for providers and policy makers to include ancillary services to promote access to care.

*To increase access, we recommend:*

- ❖ Support for more flexibility in establishing eligibility for services such as modifying the requirement to meet medical necessity.
- ❖ Support for inclusion of ancillary services as part of the service plan and make them reimbursable, such as interpretation and transportation.
- ❖ Support for more flexibility in providing home-based services or field services (e.g., senior housing facilities) to meet consumers' needs.
- ❖ Support for allotting more time when using interpreters.

### **Increase Availability and Quality of Care**

A culturally and linguistically responsive program can only be effective if those providing services are culturally competent; however, mental health careers are not well recognized and not often pursued in the AANHPI communities. Even if there are culturally and linguistically competent workforces, CBOs often face the challenge of losing trained staff to private or government agencies that can offer more competitive salary and benefits. Therefore, CBOs are constantly facing the challenge of recruiting, training, and retaining diverse and effective workforce.

Additionally, cultural competency training has not been sufficiently emphasized in the current training model. Mental health providers currently serving the AANHPI community can use more ongoing training and peer support. Moreover, culturally and linguistically responsive training should also include other professionals who serve AANHPIs, such as healthcare providers, school, and law enforcement in order to decrease mental health stigma, increase collaboration between disciplines, and improve client care.

*To increase cultural competent workforce, we recommend:*

- ❖ Support for promotion of mental health careers through outreach to AANHPI youth and their parents.

- ❖ Support for financial incentive to develop and retain culturally and linguistically competent workforce
- ❖ Support for mandating or at least including cultural competency as part of career training for mental health at various academic levels from certification to advanced degrees.
- ❖ Support for creating mentorship for future workforce.
- ❖ Support for ongoing training and technical assistance for providers who serve the AANHPI community, both in mental health and other fields.
- ❖ Support for providing rigorous training for interpreters and for clinicians to work with interpreters.
- ❖ Support for identifying and training paraprofessionals to serve as mental health liaison in the AANHPI communities.

In addition, availability of culturally and linguistically responsive services remains a major barrier to receiving good quality of care and access to care. The core competencies developed by the CRDP API-SPW (2013) can serve as a starting point in developing culturally responsive programs. The seven-step process developed by CHAA (2015) can serve as a template in designing and implementing culturally sensitive programs through a community driven process. Other successful culturally competent programs in Alameda County, such as the Underserved Ethnic Language Population (UELPP) programs (ACBHCS, 2016) and the Project Asian Reach (ACMHS, 2015) can also be used as examples when developing culturally responsive programs.

*To increase quality of care, we recommend:*

- ❖ Support and resources allocated for existing culturally and linguistically responsive programs to boost their ability to continue serving the API community (e.g., the UELPP programs).
- ❖ Support for development of new culturally competent programs to respond to unmet and emerging needs in the community.
- ❖ Support for replication of community-defined programs and strategies across agencies, including technical assistance and training to initiate these programs, to maintain good fidelity, and to adapt according to community needs.
- ❖ Support for a written review of evidence-based practices as it relates to AANHPIs by providing training and resources for agencies to do so.
- ❖ Support for culturally competent models that add to the ability to build alternatives to mainstream mental health models for the AANHPI community.

### **Increase Culturally Appropriate Outcome and Data Collection**

A major challenge the AANHPI community faces is the lack of disaggregated data despite the heterogeneity of the community and wide range of differences across ethnic subgroups. Without disaggregated data, we cannot adequately identify, assess, and address the needs of various AANHPI communities. This lack of meaningful information continues to be a contributing factor to disparities in access to care and quality of care experienced by the AANHPIs. Although the AANHPI communities have responded to their needs by developing successful promising programs, very few of them have been evaluated and even fewer have been evaluated properly using culturally appropriate measures.

*To increase disaggregated data collection and use of culturally appropriate outcome measurements, we recommend:*

- ❖ Support for mandating collection of disaggregated data to respect the diversity of AANHPI communities.

- ❖ Support for developing culturally appropriate outcome measurements to properly assess the effectiveness of programs aiming to serve the AANHPI community. Financial resources and technical assistance are needed to develop AANHPI-relevant measures and to ensure the efficacy of these measures.

### **Capacity Building**

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

*To support community capacity building, we recommend:*

- ❖ Support for community capacity building such as leadership development to empower the community to respond to its own needs.
- ❖ Support for community capacity building such as technical assistance to develop, refine, and validate promising programs with high cultural relevance and efficacy.
- ❖ Support for community participation in the decision-making process as the community best understands its own needs, and the inclusion of the voices of community members can also empower the community to find its own solutions.
- ❖ Support for establishing or maintaining community infrastructures so resources can be shared and leveraged.

## **CONCLUSION**

The richness of the AANHPI community lies in its diverse culture, with over 40 counties in the Asian Pacific Region and over 2000 spoken dialects and languages (Ethnologue Language of the World, 2017). This cultural richness is often lost in research and census data due to the lack of relevant researches and disaggregated data. As a result, it is challenging to accurately assess and attend to the needs of the diverse subgroups within the AANHPI community. Based on the literature reviewed and the landmark project, CRDP, we found similar patterns in mental health disparities among AANHPIs in Alameda County when compared to data collected in the nation and in California (e.g., Ivey et al., 2016; CHAA, 2015). Some common barriers to care for AANHPIs include mental health stigma, lack of affordable health insurance, lack of access to care (e.g., transportation & language issues), and lower satisfaction when receiving care. Moreover, as there is a large percentage of first generation AANHPI immigrants in Alameda County (U.S. Census Bureau, 2015), linguistic and cultural isolation are also significant barriers that prevent AANHPIs from seeking mental health services. Thus, to reduce mental health disparities, it is critical to develop culturally and community specific interventions and programs to meet the needs of the AANHPI community. It is also important to empower local CBOs, who often carry the burden of nurturing culturally and linguistically competent workforce, with more resources and infrastructural support so they can grow and retain appropriate workforce to respond to the needs of the community. There have been some local programs and studies demonstrated the process and the efficacy in designing and implementing culturally competent programs in outreaching to target populations (e.g., ACBHCS, 2016; ACMHS, 2015). Therefore, providing continuous support in refining and generalizing these existing programs' models and strategies, as well as allocating resources to develop new community-defined, culturally competent programs can be the next step in working towards decreasing mental health disparities for the AANHPI community in Alameda County.

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*Attachment I: Summary of Core Competencies (CRDP API-SPW, 2013)*

	<b>PROVIDER LEVEL</b>	<b>AGENCY LEVEL</b>	<b>SYSTEMS LEVEL</b>
<b>Professional Skills</b>	<ul style="list-style-type: none"> <li>▪ Must have training to provide culturally appropriate services and interventions.</li> <li>▪ Ability to effectively work with other agencies and engage with community.</li> <li>▪ Clear understanding of PEI strategies and relevant clinical issues.</li> <li>▪ Knowledge about community resources and ability to provide proper linkage.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Employ, train, and support staff that possess the necessary professional skills.</li> <li>▪ Capacity to provide needed linkage to other agencies.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Recognize the importance and provide support for the development and retention of professionally qualified and culturally competent workforce.</li> <li>▪ Support the capacity to provide linkage.</li> </ul>
<b>Linguistic Capacity</b>	<ul style="list-style-type: none"> <li>▪ Proficiency in the language preferred by the consumer OR</li> <li>▪ Ability to work effectively with properly trained interpreter.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Employ, train, and support staff that possesses proficiency in the language preferred by the consumers.</li> <li>▪ Provide language appropriate materials.</li> <li>▪ Provide resources to train interpreters to work in mental health setting.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Recognize the importance and provide support for the development and retention of linguistically qualified workforce.</li> <li>▪ Provide resources to support bilingual staff and reimbursement for the service, including interpreters.</li> <li>▪ Provide resources for preparing and printing bilingual materials.</li> </ul>
<b>Culture-Specific Considerations</b>	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Recognize the importance of integrating family and community as part of services.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provide ongoing training and supervision on cultural and language issues.</li> <li>▪ Board members should reflect the composition of the community.</li> <li>▪ Culture-specific factors should be considered and incorporated into program design.</li> <li>▪ Support the integration of family and community as part of the service plan.</li> <li>▪ Develop policies that reflect cultural values and needs of the community including physical location, accessibility and hours.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Actively engage ethnically diverse communities.</li> <li>▪ Funding should allow culture-specific factors to be considered and incorporated into services appropriate for that cultural community.</li> </ul>
<b>Community Relations &amp; Advocacy</b>	<ul style="list-style-type: none"> <li>▪ Ability to effectively engage community leaders and members.</li> <li>▪ Ability to form effective partnerships with family.</li> <li>▪ Willingness and ability to advocate for needs of the consumers.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Capacity to effectively engage the community.</li> <li>▪ Credibility in the community.</li> <li>▪ Capacity and willingness to advocate for systems change aiming to better meet community needs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Encourage and support culturally appropriate efforts for community outreach and community relationship-building.</li> <li>▪ Recognize the importance and provide support for collaboration with community leaders.</li> <li>▪ Promote cultural competency.</li> </ul>

	PROVIDER LEVEL	AGENCY LEVEL	SYSTEMS LEVEL
<b>Flexibility in Program Design &amp; Service Delivery</b>	<ul style="list-style-type: none"> <li>Flexibility in service delivery in terms of method, hours, and location.</li> <li>Understand and accommodate the need to take more time for AANHPIs to build rapport and trust.</li> </ul>	<ul style="list-style-type: none"> <li>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).</li> <li>Program design should consider community-based research, culture, and traditional values so it will make sense to the consumers.</li> <li>Willingness to look for innovative venue for outreach, such as ESL (English as a Second Language) classes.</li> </ul>	<ul style="list-style-type: none"> <li>Recognize the importance and support more time needed for engagement and trust building.</li> <li>Recognize the importance and support essential ancillary services needed to ensure access to services.</li> <li>Recognize the importance and support flexibility in service delivery.</li> <li>Encourage and support programs that include community-based research and/or community-designed practices.</li> <li>Flexibility in diagnostic criteria to accommodate cultural differences.</li> <li>Provide support for innovative outreach.</li> </ul>
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>Ability to empower consumers, family members, and community.</li> <li>Capacity to collaborate with other disciplines outside mental health.</li> </ul>	<ul style="list-style-type: none"> <li>Capacity to educate the community on mental health issues.</li> <li>Capacity to collaborate with other sectors outside mental health, such as primary care and schools.</li> <li>Plan in place to groom the next generation leaders and staff for the future.</li> <li>Capacity to provide cultural competence training to mental health professionals and professionals from other fields.</li> </ul>	<ul style="list-style-type: none"> <li>Provide support for capacity building within the agency and within the community.</li> <li>Provide support for future workforce development.</li> <li>Encourage and support outreaching and educating the community on mental health issues.</li> <li>Provide support for cultural competency training.</li> <li>More involvement of the community in the policy-making process.</li> <li>Provide support for a central resource center.</li> </ul>
<b>Use of Media</b>		<ul style="list-style-type: none"> <li>Capacity to utilize ethnic media and social media for outreach.</li> </ul>	<ul style="list-style-type: none"> <li>Encourage and support the use of ethnic media and technology for outreach.</li> </ul>
<b>Data Collection &amp; Research</b>		<ul style="list-style-type: none"> <li>Collect disaggregated data.</li> <li>Work with researchers and evaluators to assess effectiveness of programs and services.</li> </ul>	<ul style="list-style-type: none"> <li>Provide support for disaggregated data collection.</li> <li>Support ethnic/cultural specific program evaluation and research.</li> <li>Support research to develop evidence-based programs (EBPs) for AANHPI communities.</li> </ul>