California Reducing Disparities Projects

Asian Pacific Islander (API)

POPULATION REPORT

In Our Own Words

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Kalusugan

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CALIFORNIA REDUCING DISPARITIES PROJECT

ASIAN PACIFIC ISLANDER

STRATEGIC PLANNING WORKGROUP

THE ASIAN PACIFIC ISLANDER POPULATION REPORT:

In Our Own Words

Prepared For:

OFFICE OF HEALTH EQUITY

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

By:

Pacific Clinics on behalf of the API-SPW

JANUARY 2013

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LETTER FROM PROJECT DIRECTOR

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 strengthen-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

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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]).*

Mental Health Services Oversight and Accountability Commission:

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

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EXECUTIVE SUMMARY

BACKGROUND OF THE MHSA AND CRDP

THE MENTAL HEALTH SERVICES ACT

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

At that time, California's public mental health funding was insufficient to meet the demand for services and was frequently portrayed as a "fail-first" model. However, with the inception of MHSA, there was the alternative "help-first" model that promised to transform exiting 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

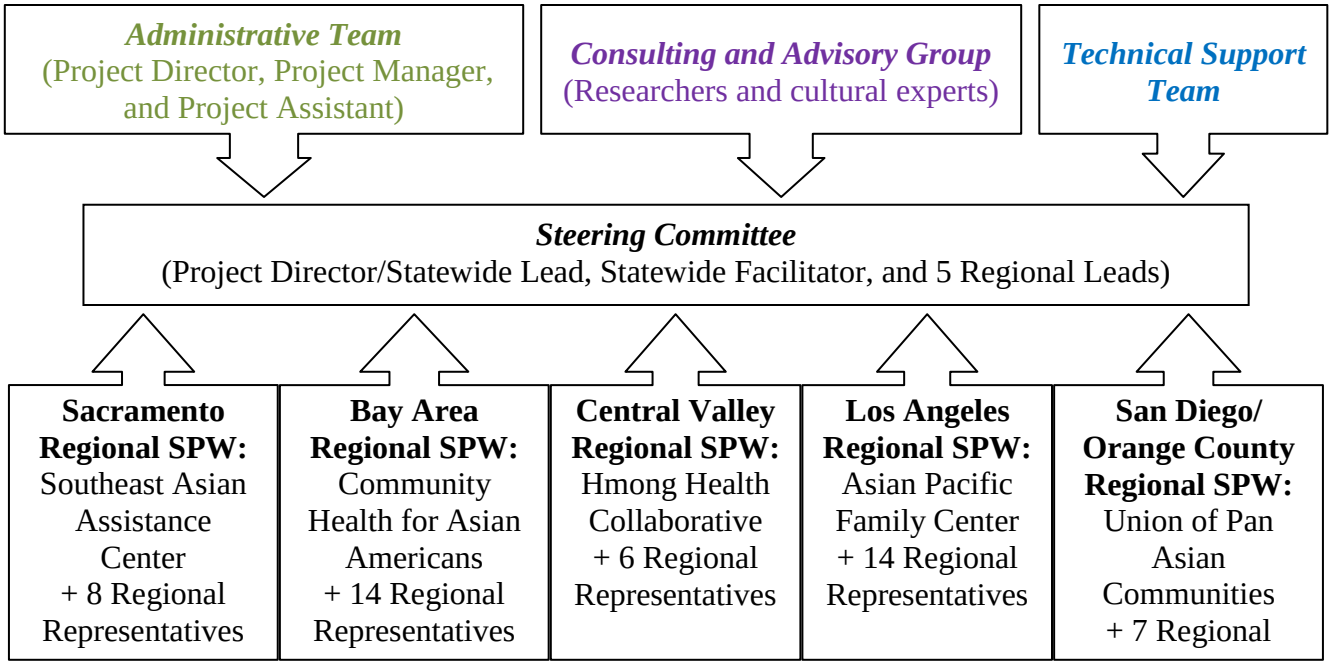
In response to the call for national action to reduce mental health disparities and seek solutions for historically underserved communities in California, the Department of Mental Health (DMH), in partnership with Mental Health Services Oversight and Accountability Commission (MHSOAC) called for a key 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 (strategic plans) 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 II-1: ***Asian Pacific Islander (API) Strategic Planning Workgroup (SPW) - Leadership & Organizational Structure***



SUMMARY 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 II-1: ***Focus Group Participants – Gender and Age***

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

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

Definition of "Wellness"

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

Factors Affecting "Wellness"

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

Manifestation of Metal Health Issues

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

Available Resources

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

Barriers to Seeking Help

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

Strategies to Address Unmet Needs

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

COMMUNITY-DEFINED STRATEGIES

CORE COMPETENCIES

While it may have been a widely accepted notion that cultural competence is required when working with the AANHPI communities, the definition of "cultural competence" may still need to be further clarified. The definition of "cultural competence" may also vary from culture to culture and from ethnicity to ethnicity. As the API-SPW set out to define core components of cultural competence, the workgroup agreed on common elements and developed a list of core competencies, which was divided into eight categories with each category further divided into three levels, as shown in Table II-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 Section VI of the report.

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

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

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

SELECTION CRITERIA FOR PROMISING PROGRAMS AND STRATEGIES

One of the major tasks given to the API-SPW was to identify community-defined promising programs and strategies to reduce existing disparities in the AANHPI community. Over the years, despite limited resources, programs and strategies were developed to respond to the unmet needs in the community. 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 II-3: ***Selection Criteria for Promising Programs and Strategies***

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

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

NOMINATION/SUBMISSION/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 II-4.

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, LGBTQ, school-based, gender-based, problem gambling, community gardening, training, suicide prevention, parenting, Alcohol and Other Drugs prevention, integrated care, faith-based, family, senior, violence prevention, youth, consultation, 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.

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

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

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 SERVICE

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

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

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

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

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

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

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

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

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

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

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

- Support for promotion of mental health careers through outreach to AANHPI youth and their parents.
- Support for mandating or at least including cultural competency as part of mental health career training 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 serving the AANHPI community, both in mental health and other fields.

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

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

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

- Support for existing culturally competent programs to continue serving the API community.
- Support for the 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, including technical assistance and training.
- 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 contribute to building the alternative to mainstream mental health models for the AANHPI community.
- Support for 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.
- Support for 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 AANHPI-relevant measures to ensure the efficacy of these measures.
- Support for validation of existing culturally competent programs, including technical support. The CRDP Phase II funding will be important in providing resources and opportunities for validation of community-defined programs.
- Support for culturally appropriate services in AANHPI communities to become either promising or best-practice PEI programs.

CAPACITY BUILDING

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

There are always more needs in the community than what available resources can possibly support. Thus, it makes sense for the systems to develop 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.
- Support for community capacity building such as technical assistance to develop, refine, and validate promising programs.

- Support for 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.
- Support for establishing or maintaining community infrastructures so resources can be shared and leveraged.
- Provision of resources and support for maintaining a statewide infrastructure where agencies can share resources and provide peer training.
- Support for computer technology, such as social networks, podcast, and web-based blogging, to be used for outreach to AANHPI youth.

GLOSSARY

AANHPI	Asian American, Native Hawaiian, and Pacific Islander
ACA	Affordable Care Act
Acculturation	The process of adopting the cultural traits or social patterns of another group
Administrative Team	Consists of the Project Director, Project Manager, and Project Assistant
API-SPW	Asian Pacific Islander Strategic Planning Workgroup
Asian	Defined by the 2010 Census as a person having origins in peoples of the Far East, Southeast Asia, or the Indian subcontinent
CBOs	Community-Based Organizations
CDC	Center for Disease Control
CHIS	California Health Interview Survey
Consulting and Advisory Group	Consists of researchers, cultural experts, and county Ethnic Service Managers that provide inputs to CRDP API-SPW
CRDP	California Reducing Disparities Project
Disaggregated data	Instead of using API as a whole group, look at granular data by smaller subgroups (e.g., Southeast Asian) or even by ethnic groups (e.g., Samoan).
Disparity	Inequality or differential service (quality) received not due to differences in needs or preferences but due to one's demographic, geographic, or other background factors. It often can be examined through five dimensions: availability, accessibility, affordability, appropriateness, and acceptability.
DMH	California Department of Mental Health
DSM	Diagnostic and Statistical Manual of Mental Disorders, a manual used to give guidelines for diagnosing mental disorders
ESL	English as a Second Language
Gradient of Agreement	A system used to express disagreement while allowing for dialogue to continue
H.E.C.T.E.R.R.	Developed by the CRDP API-SPW Project Director as a membership

Principles	participation guideline to ensure a sense of safety and fairness for all API-SPW members so that they would be at ease to share their experience and knowledge on AANHPI mental health concerns and to propose creative and effective local solutions.
LEP	Limited English proficiency
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LGBTQQI	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and Intersex
MHSA	Mental Health Services Act
MHSA OAC	Mental Health Services Act Oversight and Accountability Commission
Model Minority	A ethnic minority group that succeeds economically, socially, and educationally
Monolingual	Non English-speaking individuals
Native Hawaiian and other Pacific Islander	Defined by the 2010 Census as a person having origins in peoples of Hawaii, Guam, Samoa, or other Pacific Islands
NHPI	Native Hawaiian and Pacific Islander
OAC	Oversight and Accountability Commission
OMS	Office of Multi-cultural Services
PEI	Prevention and Early Intervention
PTSD	Post-Traumatic Stress Disorder
Regional SPWs	CRDP API-SPW consists of 54 member agencies, organizations, and individuals organized by 5 geographic regions: Sacramento (9 members), Bay Area (15 members), Central Valley (7 members), Los Angeles (15 members), and San Diego/Orange County (8 members)
SAMHSA	Substance Abuse and Mental Health Services Administration
Steering Committee	API-SPW's Steering Committee consists of the Project Director/Statewide Lead, Statewide Facilitator, and 5 Regional Leads

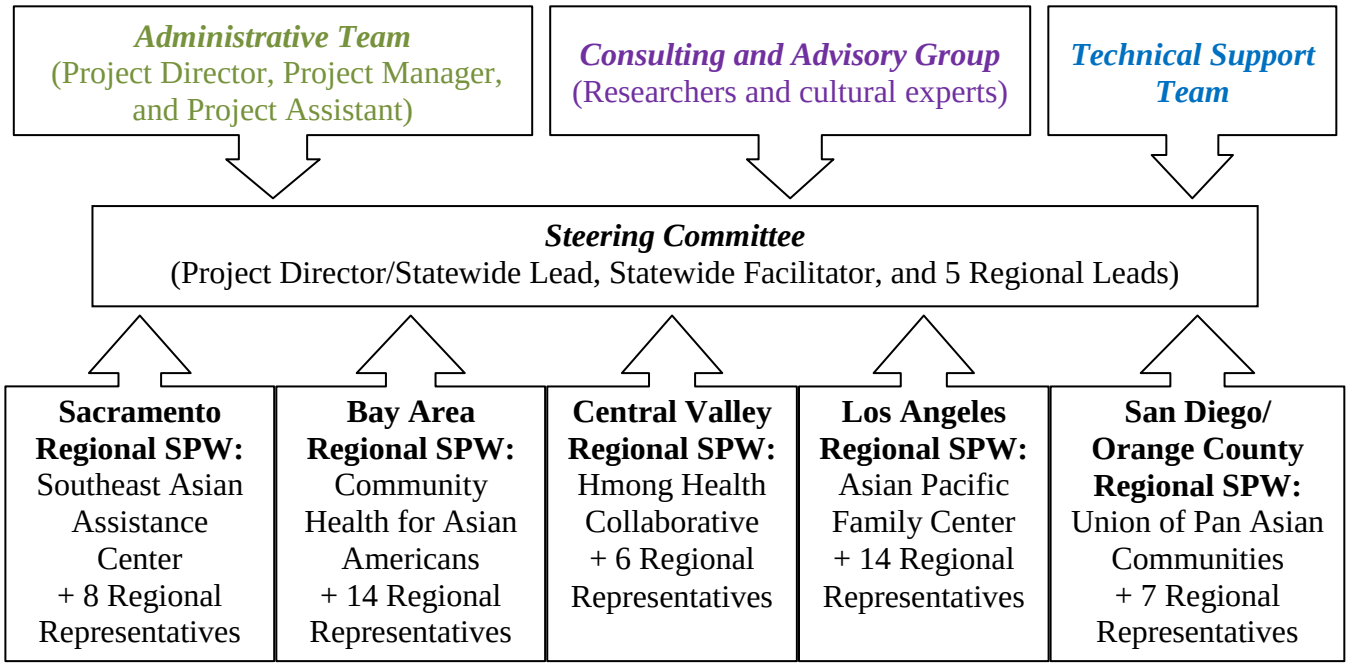
SUMMARY OF THE CRDP API-SPW

PROJECT STRUCTURE

LEADERSHIP AND ORGANIZATIONAL STRUCTURE

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

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



The Steering Committee

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

The Steering Committee provided leadership, oversight, and progress monitoring for the project. It was comprised of the Project Director/Statewide Lead (Dr. C. Rocco Cheng from Pacific Clinics), Project Consultant and Statewide Facilitator (Dr. D.J. Ida from National Asian American and Pacific Islander Mental Health Association), and five Regional Leads (Laura Leonelli from Southeast Asian Assistance Center, Beatrice Lee from Community Health for Asian Americans, Susan Vang from Hmong Health Collaborative, Dr. Terry S. Gock from Asian Pacific Family Center, and Dr. Dixie Galapon from Union of Pan Asian Communities). The Statewide Facilitator was invited to be on the Steering Committee for her decades of experience and advocacy work on mental health issues in the AANHPI communities across the country. The Regional Leads were invited because of their long-standing professional reputation, community credibility, and expertise in AANHPI mental health issues in their local and regional communities.

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

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

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

Regional Strategic Planning Workgroups (Regional SPWs)

Including the five Regional Lead agencies and the Statewide Lead agency, there were a total of fifty-five member agencies, organizations, and individuals forming five Regional SPWs in California: Sacramento Area (9 members), Bay Area (15 members), Central Valley Area (7 members), Los Angeles Area (15 members), and San Diego/Orange County Area (8 members). Each of these Regional SPW was coordinated and convened by the Regional Lead Agency in the region, as described above. Together, these five regional SPWs formed the Statewide CRDP API-SPW.

By using the small Regional Workgroup structure (with 7 to 15 members depending on the region) as the foundation to identify community-driven mental health concerns and to generate creative and effective local solutions, it was expected that there would be

more time for the Regional SPW members to ask questions, engage in deeper discussions, and come up with effective solutions for complicated mental health service issues in their local AANHPI communities. To help the Workgroup members familiarize themselves with the issues to be discussed, meeting agenda and previous meeting summaries were sent in advance so members could be prepared for meaningful discussions.

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

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

Supporting Teams to the Steering Committee and the API-SPW

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

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

***Consulting and Advising Group*:** Composed of the mental health experts from public and private sectors including researchers, community experts, and representatives from public entities (e.g.: County Ethnic Service Managers – hereafter referred to as County ESMs. The Consultant and Advisory Group provided relevant in-service training to Workgroup members at meetings to support their work and to facilitate better understanding of pertinent issues related to mental health disparities in the AANHPI communities. County ESMs were also invited to regional and statewide meetings to receive updates on the project.

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

PROCESS OF FORMING REGIONAL AND STATEWIDE NETWORKS

GUIDING PRINCIPLES FOR MEMBER SELECTION

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

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

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

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

MEMBERSHIP ASSESSMENT

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

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

MEMBER INFORMATION – *Please circle all that applies and specify if "other" is checked*	
Agency:	
Agency representative: **Gender**: M F	
Alternate (if applicable): **Gender**: M F	
Region represented: Sacramento Bay Area Central Valley Los Angeles San Diego/Orange County	
Type: Public Private for profit Private non-profit Foundation Consumer/Comm. Other(Specify):	
Level of Focus: National State County Local Other (Specify):	
Geographical community served: Urban Rural Suburban	
Number of years serving the AANHPI community:	
Number of employees: 1-20 21-40 41-60 61-80 81-100 101+	
Member of coalition(s) – Specify:	
Participated in the County's MHSA (Prop 63) planning: Yes No	
Currently sitting on the local county MHSA oversight body: Yes No	
Conducted needs assessment studies on APIs: Yes No	
Populations Served/Represented (please check all that applies):	
▪ Early Childhood (0-5)	
▪ Children/Youth (6-12)	
▪ Adolescent (13-17)	
▪ Transitional Age Youth (18-25)	
▪ Adults (25-55)	
▪ Older Adults (55+)	
Sectors Represented (please check all that applies):	
▪ Consumer/Family member	
▪ Faith-based organization	
▪ Ethnic-specific provider	
▪ Health care provider	
▪ Mental health provider	
▪ Traditional healing provider	
▪ Social service provider	
▪ Community development organization	
▪ Law enforcement	

▪ Educator	
▪ Ethnic media	
▪ Other (please specify):	
Primary Areas of Focus (please check all that applies):	
▪ Early childhood/Early intervention	
▪ Prevention program	
▪ Youth development program	
▪ Program development	
▪ Education/Special education	
▪ Training	
▪ Faith-based programs	
▪ Family advocacy/involvement	
▪ Youth advocacy	
▪ Health care services	
▪ Mental health services (treatment)	
▪ Mental health promotion	
▪ Interagency collaboration	
▪ Substance abuse (Specify: Prevention Treatment Recovery)	
▪ Crisis intervention	
▪ Outreach	
▪ Evaluation/Oversight	
▪ Research	
▪ Technical assistance	
▪ Case management	
▪ Support group	
▪ Other (please specify):	
Ethnic/Cultural Groups Served/represented (please check all that applies):	
▪ Asian American	
▪ Southeast Asian	
▪ South Asian	
▪ Chinese	
▪ Japanese	

▪ Korean	
▪ Vietnamese	
▪ Cambodian	
▪ Hmong	
▪ Pilipino	
▪ Lao	
▪ Iu-Mien	
▪ Indian	
▪ Pakistani	
▪ Sri Lankan	
▪ Tongan	
▪ Samoan	
▪ Guamanian	
▪ Hawaiian	
▪ LGBTQQI	
▪ Other (please specify):	

FORMING OF THE CRDP API-SPW

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

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

After the initial membership list was established, the Steering Committee continued to examine the membership composition based on the principles of diversity and balance during subsequent meetings as the membership continued to evolve throughout the course of the first year. A few challenges surfaced in the

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

MEMBERSHIP PARTICIPATION GUIDELINES

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

1. **Members will uphold the H.E.C.T.E.R.R. principles throughout the project:**
   - ***Honor traditional value and life style***: Different cultural traditions and life styles will be honored.
   - ***Everyone has a voice***: Regardless of the size of the agency and the ethnic/cultural group, every workgroup member will have a voice in the project.
   - ***Collaborative***: Different regions and agency representatives will work collaboratively to address the mental health disparity issues in AANHPI communities.
   - ***Transparency***: The decision making process will be transparent to all Workgroup members.
   - ***Empowerment***: Each Workgroup member will be empowered to advocate for the group he or she is representing.
   - ***Respect differences and proper boundaries***: Differences in opinion and perspective will be respected. Professional boundaries will be observed so small groups or agencies will not be concerned of being overwhelmed or dominated by large groups/agencies.
   - ***Recognize existing strengths***: The existing strength of each workgroup member and the cultural/sector he or she represents will be respected.

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

principles would serve as the overarching guidelines for the decision-making process throughout the project.

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

   Regional API-SPW Meetings

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

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

   Even though the overall direction and priorities for the project were to be set by the Steering Committee, it was duly acknowledged that the unique needs and circumstances of each region were to be respected and accommodated as much as possible. Therefore, it was understood that regional membership may choose to focus their priorities somewhat differently from other regions when making decisions at the regional level, while keeping in mind that a statewide perspective was expected for the final API-population report. One example would be the selection of focus group members where each regional SPW set their priorities and reached their initial decisions on the target populations based on their regional needs. The initial selections were shared among the API-SPW members for consideration while the regional SPWs attempted to balance their regional needs with the overall statewide representations to be reflected in the process. With a cooperative mindset, the API-SPW was able to include small, emerging, and hard to

reach populations such as Hmong, Mien, Mongolian, Punjabi, LGBTQ, and new refugee communities in the focus group selections.

Statewide API-SPW Meetings

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

Focus Groups

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

3. **Whenever the primary representative is not available to participate in a meeting, an alternate may be sent in his or her place to allow maximum inclusion of representations from the entire API-SPW. Both representatives will keep each other updated on the progress of the project.**

4. **Should voting be required, each member has an equal number of votes. In setting priorities for focus group selection for their region, each member was given same votes and they indicated what priority they saw as more important. In**

determining promising program selection criteria, a straw vote approach was used after thorough discussion.

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

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

Table III-3: ***Gradient of Agreement System***

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

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

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

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

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

BUILDING NETWORKS BEYOND THE API-SPW MEMEBRSHIP

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

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

In addition, the Project Director and Regional Leads participated in County Ethnic Service Manager meetings several times. They also presented the progress of the project at venues, such as: the Northern California Cultural Competency and Mental Health Summit, the SAMHSA Policy Summit, and the Southern California Cultural Competency and Mental Health Summit. The Project Director also attended meetings in California and Washington, DC to discuss and present on topics such as mental health service needs in the AANHPI communities, integrated healthcare, and the potential impact of the Healthcare Reform and the Affordable Care

Act. Moreover, the API-SPW conducted outreach efforts to policy makers, such as: state legislators and Mental Health Service Act Oversight and Accountability Commission (MHSA OAC) by inviting them to the statewide meetings for project updates. Regular communications were (and continue to be) maintained with other CRDP grantees as well. The Project Director attended (and continues to attend) OAC meetings and OAC Committee meetings, which provided opportunities to communicate with the Department of Mental Health (DMH) and OAC staff regarding the project. The Project Director kept federal agencies involved by regular communications with SAMHSA Senior Advisor, Dr. Larke Huang and the National Network in Eliminating Disparities in Behavioral Health (www.nned.net). The Chair for the President's Advisory Commission on Asian Americans and Pacific Islander, Daphne Kwok, attended the second statewide meeting in Oakland where the focus group findings were presented to reflect the mental health service needs of the AANHPI community in California (http://www.whitehouse.gov/aapi). To raise awareness of the project, the Project Director also engaged in multiple interviews at a local ethnic television station to share initial findings of the project.

MILESTONES

While the project officially started in March 1, 2010, the API-SPW actually initiated its work in December 2009 as the Steering Committee gathered to discuss and plan for the tasks ahead. The following is a summary of all the contributions and accomplishments by the API-SPW prior to and throughout the life of the project:

Table III-4: *CRDP API-SPW Milestones*

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

Time/Event	Goals/Accomplishments
7th Steering Committee Meeting 04/11/11	• Discussion: SAMHSA policy summit on 05/10, Northern region cultural competency summit on 06/27 • Discussion: Agenda for the 4th statewide meeting
SAMHSA Policy Summit May 2011	• Project Director presented CRDP at the SAMHSA Policy Summit in San Diego
4th Statewide Meeting 05/19/11, Pasadena	• Presentation: Healthcare reform and its relevance to CRDP, presented by Wendy Wang • Presentations: Logic Model and examples of promising programs, presented by Dr. Terry S. Gock, Simon Wai, Dr. Dixie Galapon • Discussion and approval of core competencies and selection criteria • Presentation: proposed process for nomination/submission/review of promising programs/strategies
Cultural Competency & Mental Health Summit June 2011	• Project Director and Bay Area Regional Lead Beatrice Lee presented CRDP at the Northern California Cultural Competency and Mental Health Summit in San Jose
8th Steering Committee Meeting 06/08/11	• Debrief: 4th statewide meeting • Discussion: Process for program selection, submission, review, and revision.
9th Steering Committee Meeting 06/21/11	• Discussion: Finalize the process for program nomination, submission, review, and revision.
5th Regional Meetings July to September, 2011	• Overview and discussion of the process of nomination, submission, review, and revision of regional promising programs and strategies
Promising Program & Strategy Submission/Review September – November 2011	• Members submitted and reviewed community-defined promising programs and strategies. • A total of 56 submissions were received and reviewed by 26 peer reviewers.
10th Steering Committee Meeting 10/21/11	• Update and debrief on program submissions • Discussion: Agenda for the 5th statewide & 6th regional meetings • Discussion: Agenda for the project conference
Cultural Competency & Mental Health Summit November 2011	• Project Director and San Diego/Orange County Regional Lead Dr. Dixie Galapon presented CRDP at the Southern California Cultural Competency and Mental Health Summit in Ontario
5th Statewide Meeting 11/15/11, Sacramento	• Presentation: "Challenges in providing culturally informed care in evidenced psychological practices," presented by Dr. Nolan Zane • Presentation: List of promising programs and strategies • Special guests: Dr. David Pating, Marina Augusto
6th Regional Meetings December, 2011	• Discussion: regional, statewide, system, and public policy issues • Debrief: participation in CRDP
11th Steering Committee Meeting 12/15/11	• Debrief: 6th regional meetings • Discussion: Agenda and preparations for the project conference
Project Conference 02/01/12, Los Angeles	• Sharing and celebrating the accomplishment of the API-SPW • Presentation: "Addressing behavioral health disparities," presented by Dr. Larke Huang • Special guest: Rachel Guerrero

OVERVIEW OF THE ISSUES

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

DEMOGRAPHICS

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

NATIONAL DATA ON ASIAN AMERCANS, NATIVE HAWAIIANS, & PACIFIC ISLANDERS (AANHPI)

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

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

While all major race groups have increased in size between 2000 and 2010, the fastest growing ethnic group was the "Asian alone" population, which increased by 43.3% from 10.24 million to 14.67 million. This increase was due in part to immigration. In terms of share of the total population, the "Asian alone" group increased from 3.6% to 4.8%. Even though the "Native Hawaiians and Pacific Islanders alone" group was the smallest racial

group, it had also seen an increase of 35.4% from 398,000 to 540,000 in the last decade, which doubled its share of the total population from 0.1% to 0.2% (Hume, Jones, & Ramirez, 2011).

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

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

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

Cities with the Largest Number of Asians	
New York, NY	1,134,919
Los Angeles, CA	**483,585**
San Jose, CA	**326,627**
San Francisco, CA	**288,529**
San Diego, CA	**241,293**
Urban Honolulu CDP, HI	230,071
Chicago, IL	166,770
Houston, TX	139,960
Fremont, CA	**116,755**
Philadelphia, PA	106,720

Table IV-2: ***2010 Census – Cities with the Highest Proportion of Asians in the U.S. (Asian Alone or Asian In Combination)***

Cities with the Highest Proportion of Asians	
Urban Honolulu CDP, HI	68.2%
Daly City, CA	**58.4%**
Fremont, CA	**54.5%**
Sunnyvale, CA	**43.7%**
Irvine, CA	**43.3%**
Santa Clara, CA	**40.8%**
Garden Grove, CA	**38.6%**
Torrance, CA	**38.2%**
San Francisco, CA	**35.8%**
San Jose, CA	**34.5%**

In terms of the NHPI population distribution, 23% of the total NHPI population in the U.S. resided in California, which was second to Hawaii's 29%. Four California counties ranked among the top 10 counties with the largest number of NHPI's as indicated in Table IV-3 (Jones, 2011):

Table IV-3: ***2010 Census – Counties with the Largest Number of NHPIs in the U.S. (NHPI Alone and NHPI In Combination)***

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

DATA ON AANHPI POPULATIONS IN CALIFORNIA

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

The AANHPI communities in California consist of many ethnic groups. Table IV-4 and Table IV-5 provide a snapshot of the various AANHPI groups accounted for in the 2010 Census. However, please keep in mind that this is not an exhaustive list of all the AANHPI communities in the state.

Table IV-4: ***2010 Census – Asian Populations in California***

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

Table IV-5: ***2010 Census – NHPI Populations in California***

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

In terms of distribution of Asian populations in California, Table IV-6 provides a list of the top 15 counties with the highest percentage and number of individuals of the Asian population in the county's total population, while Table IV-7 captures the percentage and number of individuals represented by the NHPIs in the counties listed.

Table IV-6: ***2010 Census – Top 15 California Counties with the Highest Proportion of Asians and Number of Asian Individuals***

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

Table IV-7: ***2010 Census – Top 14 California Counties with the Highest Proportion of NHPIs and Number of NHPI Individuals***

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

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

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

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

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

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

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

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

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

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

OVERVIEW OF DISPARITY ISSUES IN THE LITERATURE

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

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

PREVELANCE RATE AND UTILIZATION RATE

Asian Americans are often considered the "Model Minority" in the United States: hard-working, high-achieving academically, and successful. With such stereotypes, some may expect low prevalence rates of mental illness and low utilization rates of mental health services among Asians. According to the National Institute of Mental Health in 2008, Asian adults had the lowest prevalence rate for serious mental illness than any other race in the United States (National Institute of Mental Health, 2008). However, these rates may not accurately reflect the reality of the state of mental health needs in the Asian community, as they are influenced by cultural factors specific to the Asian community, such as cultural beliefs and stigma towards mental illness, acculturation, immigration history, immigration status, language barrier, and unfamiliarity with the mental health service system. In fact, Asian Americans with suicidal ideation or attempts were found to have perceived less need for help and would be less likely to seek help compared to Latinos (Chu, Hsieh, and Tokars, 2011). All these cultural factors similarly influence the attitudes and consequently help-seeking behaviors in the NHPI community. In examining the data released by the California Department of Mental Health based on the 2000 Census, it was estimated that Asian youths in California might in fact have a **similar prevalence rate** of 7.18% for serious emotional disturbance as compared to the rate of 7.51% for the total population. The Pacific Islander youths were estimated to have a prevalence rate of 7.67%. For adults with serious mental illness, Asians and Pacific Islanders were estimated to have a prevalence rate of 5.6% and 7%, respectively, compared to 6.25% for the total population in California (California Department of Mental Health, 2000).

> ***It is worth noting that despite the stigma against mental illness, Pacific Islanders were consistently estimated to have a higher than average prevalence rate, which coincides with the national data.***

As reported by the Asian & Pacific Islander American Health Forum, based on the data in 2008 by the Center for Disease Control (CDC), NHPI adults had the highest rate of depressive disorders at 20% among all racial groups, and the second highest rate of anxiety disorders at 15.7%.

In particular, the prevalence rates for both depressive and anxiety disorders among NHPIs were much higher in men than women – 32% of NHPI men were diagnosed with depressive disorders as compared to 5.8% of NHPI women, while 19.9% of NHPI men were diagnosed with anxiety disorders compared to 10.7% of NHPI women. Moreover, based on the 2009 CDC data, NHPI high school students ranked the highest at 33.4% to have felt sad and hopeless every day for two or more weeks in a row (Asian & Pacific Islander American Health Forum, 2010).

Contrary to the perception that Asians have lower prevalence rates of mental illness, in reviewing the data from the national Early Childhood Longitudinal Study-Birth Cohort (ECLS-B) from 2001 to 2002, it was found that Asian mothers in general had a similar prevalence rate of depressive symptoms as compared to the general population. However, foreign-born Asian mothers had a higher prevalence rate of depressive symptoms than U.S.-born Asian mothers.

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

(Huang, Wong, Ronzio, & Yu, 2006)

Interviews conducted with 1,503 Chinese Americans in Los Angeles indicated that 20.5% of respondents reported having experienced an episode of at least one of psychiatric disorders such as affective disorders, anxiety disorders, and substance abuse or dependence (Spencer & Chen, 2004).

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

Despite prevalence rates of mental health challenges being comparable to other ethnic groups, the utilization rate of mental health services remains low for AANHPIs. One way to understand the low utilization rate for AANHPIs is to look at the data regarding emergency services. Looking at children receiving mental health care from California's county systems from 1998 to 2001, it was found that AANHPI children were more likely than White children to use hospital-based crisis stabilization services, which suggested

that AANHPI caretakers might tend to postpone treatment until it reaches a crisis level. Delayed help-seeking may be due to stigma, mistrust of the system, and/or language barrier (Snowden, Masland, Libby, Wallace, & Fawley, 2008).

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

A study in Hawaii, a state with a large AANHPI population, on mothers with depressive symptoms revealed that AANHPIs were significantly less likely to receive services despite the presentation of symptoms (Ta, Juon, Gielen, Steinwachs, & Duggan, 2008). Furthermore, the tendency to group AANHPIs as one might have masked the reality as well. For example, from interviewing 339 Cambodian immigrants in Long Beach who were diagnosed with PTSD, major depression disorder, or alcohol use disorder, Marshall et al. found that, during the previous 12 months, 70% of interviewees had sought help with emotional or psychological problems from Western medical care providers, while only 46% turned to mental health providers for services (Marshall, Berthold, Schell, Elliot, Chun, & Hambarsoomians, 2006). The need for mental health services is apparent, yet those in need are not gaining access or receiving proper care.

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

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

BARRIERS TO CARE

Given that the evidence shows that AANHPIs do not have lower prevalence rates for mental illness, yet they consistently have low utilization rates of mental health services, it is critical to understand and address barriers that deter AANHPIs from accessing and receiving mental health services.

The following section outlines barriers to care identified in various studies:

Stigma

Stigma has been cited over and over again as one of the major barriers to seeking mental health services in the AANHPI communities. A 2005-2006 study focusing on older Korean Americans in Florida illustrated how stigma played a significant role in deterring those in need from seeking needed help. Out of the 472 foreign-born Korean Americans ages 60 and over, 34% had been assessed for probable depression and 8.5% reported suicidal ideation. However, only 6.5% had contacted mental health professionals, which might have been a reflection of their attitudes towards mental illness, as 71% considered depression as a sign of personal weakness and 14% stated mental illness would bring shame to the family. Moreover, the higher the levels of depressive symptoms, the more negative attitudes one would have towards mental health services (Jang, Kim, Hansen, & Chiriboga, 2007). Even for young Asian Americans, stigma towards mental illness is still a major factor affecting help-seeking behaviors. Compared to Caucasians, first- and second-generation South Asian college students reported more negative attitudes towards mental illness and consequently greater reluctance to seeking help. These South Asian students were also found to be more likely to distance themselves socially from those with mental illnesses. Thus, stigma was significant both at a personal and social level (Loya, Reddy, & Hinshaw, 2010).

Even when an individual could overcome stigma and seek help, mental health professionals often were not the first ones AANPPIs would turn to. Family, friends, community leaders, or spiritual leaders were among those AANPPIs would typically reach out to. Additionally, rather than seeking help for emotional difficulties, AANHPIs would tend to present their mental health problems as physical symptoms to their primary care providers (Zhang, Snowden, & Sue, 1998). However, primary care providers are typically not specialized in working with people who have mental health issues. They may not be properly equipped to diagnose or treat mental illnesses, which may leave some patients inaccurately diagnosed and/or therefore improperly treated for their mental illness.

Chung et Al. (2003) found that being Asian, or having low acculturation levels might make it less likely for primary care physicians to detect psychiatric distress in Asian patients compared to Latino patients (Chung, Guarnaccia, Meyers, Holmes, Bobrowitz, Eimicke, & Ferran, 2003). Such strong reluctance towards help-seeking consequently could result in situations where mental health services were sought only when problems become severe (Chow, Jaffee, & Snowden, 2003), which subsequently could lead to higher health care costs, as in some cases when patients receive their mental health treatment in the emergency room. In a 2001 study analyzing 10,623 AANHPI adults admitted to emergency departments, only 35% of all those who eventually received a psychiatric diagnosis came in with complaints of emotional distress. In addition, even after arriving in the emergency department, AANHPIs may still not receive the needed help. AANHPIs with psychiatric diagnoses were found more likely to be discharged against medical advice compared to AANHPIs with physical diagnoses only and AANHPIs with both physical and psychiatric diagnoses, which suggested that stigma or lack of culturally competent care might have resulted in refusal of treatment even in an emergency (Chen, 2005). Thus, the argument can be made that stigma may have led to underestimates of the prevalence rate and utilization rate among the AANHPI's (Zhang, Snowden, & Sue, 1998).

Language Barrier

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

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

As highlighted in the Ponce et al. report, the majority of Asians were foreign-born and many were recent immigrants. As a result, a significant portion (36%) of the Asian populations had limited English proficiency (Ponce, Tseng, Ong, Shek, Ortiz, & Gatchell, 2009). Consequently, language becomes a significant barrier as these Asian populations seek mental health services. For the service providers and policy makers, language barrier has serious implications to education, outreach, and service delivery. The issue of language barrier is even more relevant when older adults are concerned. In analyzing surveys responded by almost 17,000 adult

Californians ages 55 and older that included 1,215 Asians, it was found that Asians were more likely to report mental distress but less likely to use mental health services than their White counterparts. Moreover, among the Asians surveyed, 81% were foreign-born and 39% had limited English proficiency (Sorkin, Pham, & Ngo-Metzger, 2009).

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

In a study by Spencer and Chen, language barrier may have also contributed to reluctance in seeking needed care, where 13% of the 1,507 respondents reported that they were treated badly or unfairly because of language issues.

Given that culturally competent workforce shortage remains an issue, interpreters are sometimes utilized when the patients have limited English proficiency. Simply stated, the level of competence of the interpreter matters. In surveying 2,715 Asians with limited English proficiency (LEP) across the U.S. at 11 community-based health centers serving large Asian populations, it was revealed that perceived quality of the interpreter was strongly associated with the quality of care perceived by the patients, where interpretation by family members and untrained staff was associated with lower satisfaction. Even though the overall ratings on quality of care were similar between the group served by bilingual clinicians and the group served through interpreters, certain aspects of communications may have been compromised. For example, in comparison with clients treated by bilingual clinicians, clients assisted by interpreters tended to have more questions they did not ask the clinician. The difference may have been due to the time pressure and less rapport with the clinician.

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

Another important policy implication was that more time should be allotted when using interpreters, as the patient's ratings of interpreters were also highly correlated with feeling that there was sufficient time to explain the reason for their visit and to understand the clinician's explanation of their problems (Green, Ngo-Metzger, Legedza, Massagli, Phillips, & Lezzoni, 2005)

<u>Lack of Insurance</u>

Considering the diversity in the AANHPI communities, it is almost a given that there are differences in access to health care among different ethnic groups even just in terms of insurance coverage. Based on an analysis of data from the 2003 and 2005 California Health Interview Survey, as compared to non-Hispanic White children, Korean children in California were 4 times more likely to lack health insurance (2.8% vs. 12.5%). Filipino children were twice as likely not to have had

recent contact with a doctor (7.6% vs.13.1%) as they were 25% more likely not to have insurance (2.8% vs. 3.5%). Lack of insurance consequently resulted in less access to care and lower utilization of services (Yu, Huang, & Singh, 2010). Furthermore, a 2009 report by the University of California AAPI Policy Research Program revealed that 33% of adult Koreans in California were uninsured, the highest rate among all ethnic groups and more than two times higher than the state average of 15%. Moreover, even though Vietnamese and NHPIs have been found to experience mental distress more frequently than other AANHPI groups, 34% of Vietnamese who were insured did not have mental health coverage. While 88% of Chinese had health insurance, 28% did not have mental health coverage (Ponce, Tseng, Ong, Shek, Ortiz, & Gatchell, 2009). Given that primary care is often the first contact for mental health issues for AANHPIs, the lack of insurance coverage presents another major challenge for AANHPIs to receive proper care.

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

Lower Satisfaction with Quality of Care

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

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

– Focus group participant

Lack of Disaggregated Data and Research

In reviewing available literature and data with regards to the Asian American, Native Hawaiian, and Pacific Islander populations, it became abundantly clear that we have a long way to go in order to adequately identifying, assessing, and addressing the needs of various AANHPI communities in California. AANHPIs have often been grouped together, if included at all, in most studies. Even in

studies that attempted to collect subgroup data, only a few major Asian groups were counted, such as Chinese, Japanese, and Korean. Even when researchers sought for disaggregated data beyond these groups, only a few additional groups were included. The reality is, as described in many of the studies cited in this section, the AANHPI communities can be rather different. The study by Huang et al. in 2006 and the report by Ponce et al. 2009 are two examples crystallizing the great variations among various AANHPI subgroups. However, the heterogeneity of the Asian populations has not been sufficiently recognized and reflected in data collection and research. The scarcity of data collection and research on Native Hawaiians and Pacific Islanders is even more troubling, as they appear to be practically non-existent.

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

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

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

STRATEGIES TO REDUCE DISPARITIES

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

What were some of the proven strategies that studies showed to have effectively reduced mental health service disparities? From interviewing 59 county ethnic services coordinators and analyzing data on penetration rates in California, it was concluded that having bilingual and bicultural staff significantly increased penetration rates for Asian population in California. However, merely having a bilingual/bicultural first point of contact (e.g., receptionist) resulted in lower penetration rates (Snowden, Masland, Ma & Ciemens, 2006). Unfortunately, the study did not provide possible explanations as to what made having a bicultural and bilingual staff more effective than a bilingual/bicultural first point of contact. However, it may be reasonably speculated that the former would most likely possess a higher level of cultural competency than the latter. This finding is in agreement with the experience of the API-SPW members. As outlined in the section on "Core Competencies" in the latter part of this report, reducing mental health service disparities in the AANHPI communities requires much more than just overcoming the language barrier.

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

This underlines the importance of making cultural competent services available once the individuals in need have been successfully engaged by the first point of contact.

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

EXISTING ISSUES AND CHALLENGES

NATURE OF DISPARITIES

PROCESS OF IDENTIFYING DISPARITIES BY THE API-SPW

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

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

Lack of Access to Care and Support for Access to Care

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

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

one told by a community member in the Central Valley, where AANHPIs with mental illnesses have been turning to Cambodian and Laotian temples, even though these temples and clergies are not equipped to deal with mental health issues.

Lack of Availability of Culturally Appropriate Services

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

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

Lack of Quality of Care

Even if a consumer can successfully access a program targeting their culture, this does not always mean that the quality of care offered by the program is adequate.

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

Some mainstream programs may have one AANHPI staff with the expectation that this employee can serve the needs of all AANHPI consumers, regardless of language or culture. To provide good quality of care to the AANHPI community, a program would need to meet many of the core competencies as identified in the "Community-Defined Strategies" section of this report. In short,

cultural factors as determined by the community should be a critical part of the definition of quality of care.

Language Barriers

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

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

Lack of Disaggregated Data and Culturally Appropriate Outcome Evaluation

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

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

Stigma and Lack of Awareness and Education on Mental Health Issues

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

The issue of stigma remains significant and often deters many AANHPIs from seeking needed services. In many AANHPI languages, there is no proper translation for "mental health" without some kind of negative connotation. Therefore, the AANHPI communities tend to associate the phrase "mental illness" with the term "crazy," since it often is the literal translation. Lack of awareness and education on mental health

issues further perpetuates the stigma. In some AANHPI cultures, illness is regarded as a physical and not a mental issue, and there is a lack of understanding that mental health is as important as physical health. More culturally appropriate strategies would help reduce stigma and raise awareness. However, few resources are available to do so. Integrating community partners such as primary care, spiritual leaders, and schools into awareness-raising efforts could be a possible solution to reduce stigma, but the challenge would be to educate these potential partners on mental health issues, however there may be limited or no resources to support such efforts.

Workforce Shortage

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

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

MANIFESTATIONS OF DISPARITY IN THE AANHPI COMMUNITIES

PROCESS OF COLLECTING DIRECT INPUT FROM THE AANHPI COMMUNITIES

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

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

Selection of Focus Groups

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

Focus Group Questions

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

Table V-1: ***Questions for Focus Group Discussion***

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

Q#8	Are there services that you would like to have but are not available now?
Follow-up	• What do you think would be helpful for you, your family, and/or your community if you could design your own "wellness" program? • Please share any support services that you would like to have to maintain wellness or to get well, but are not available now.
Q#9	Please add a question specific to your particular focus group – youth, domestic violence survivors, elderly, women's or men's group.
Follow-up	• For those who experienced mental health problems: What was helpful on your road to recovery? What was not helpful? • For family members: What helped your family member to feel better? What helped you care for that family member? What made it harder in your efforts to help him/her?

Focus Group Facilitation

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

Focus Group Reports

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

FOCUS GROUP PARTICIPANTS

From July 2010 to January 2011, a total of twenty-three focus groups were held. In addition to the original twenty-one groups planned, the Sacramento region and the Central Valley region each held an additional focus

group. A total of 198 community members participated in these 23 focus group discussions. The following are breakdowns of all the focus groups conducted by the API-SPW:

Table V-2: ***Focus Groups Participants – Gender and Age***

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

Table V-3: ***Focus Groups – Sacramento Region***

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

Table V-4: ***Focus Groups – Bay Area Region***

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

Table V-5: ***Focus Groups – Central Valley Region***

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

Table V-6: ***Focus Groups – Los Angeles Region***

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

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

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

DEFINITION OF MENTAL HEALTH BY THE AANHPI COMMUNITIES

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

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

Definition of "Wellness"

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

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

Factors Affecting "Wellness"

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

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

Manifestations of Mental Health Issues

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

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

GAPS, UNMET NEEDS, AND SUGGESTIONS

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

Available Resources

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

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

Barriers to Seeking Help

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

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

Attitude towards Mental Health Issues

Participants shared their understanding of mental health services:

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

Strategies to Address Unmet Needs

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

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

QUALITY ISSUES

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

CORE COMPETENCIES IN WORKING WITH AANHPI COMMUNITIES

DEVELOPMENTAL PROCESS OF CORE COMPETENCIES

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

CORE COMPETENCIES AS DEFINED BY THE API-SPW

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

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

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

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

More detailed descriptions of each category are as follows:

Professional Skills

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

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

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

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

At the agency level, a culturally competent agency should employ, train, and support staff

that possess the necessary professional skills as indicated above.

> ***The mere hiring of a bilingual employee is not sufficient, as cultural competence goes far beyond language. It is also insufficient to merely hire one or two bicultural, bilingual staff to work with an AANHPI population.***

As much as possible, it is essential to have a critical mass to support the bicultural, bilingual staff to avoid burn-out and to facilitate the effective impact of the team. In addition, the agency should also have the capacity to work with other agencies to provide appropriate linkage services. At the systems level, it is critical for the systems to recognize the importance of cultural competence and to provide resource support for the development and retention of a culturally competent workforce. For instance, the systems can demonstrate its cultural competence by providing additional resources to encourage future workforce to enter the field and to retain the workforce with consistent funding, such as a bilingual bonus.

Linguistic Capacity

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

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

For agencies, employing bilingual staff is only part of the picture in providing culturally competent and effective services. Ongoing training and support of such staff are also vital to maintaining a culturally competent workforce. Moreover, written materials should

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

Culture-Specific Considerations

Cultural competence involves more than linguistic capacity and extends to include a clear and respectful understanding of the consumer's culture, history, values, beliefs, traditions, spirituality, worldview, sexual orientation, gender identity, gender, acculturation level, life span developmental issues, and immigration experiences, just to name a few.

Needless to say, all these factors should be taken into consideration when working with the AANHPI community. Moreover, AANHPIs tend to be much more family-oriented and the AANHPI communities tend to be close-knit. Therefore, unlike conventional services based on individualism prevalent in Western culture, family and community should also be taken into consideration when determining service plans appropriate for AANHPIs.

On an organizational level, it is important that board members reflect the composition of the community the organization aims to serve. Culture-specific or population-specific factors should be incorporated in the program design. For example, as voiced by the LGBT focus group, given the stigma against HIV/AIDS, a promising program should include components to address the issue of stigma, such as materials and intervention aiming to enhance communication skills among parents, family, peers, and social networks to discuss these topics. In addition to ongoing training and supervision on culture-specific issues, the agency itself should have policies that reflect and respect the cultural values and needs of the community. Spirituality may need to be considered or incorporated in service delivery to respect cultural practices. For certain cultures, it may be necessary to separate services based on gender. The physical location of the agency should be easily accessible to the community it serves. The hours of operation should be based on the convenience of the consumers.

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

Furthermore, the system should encourage and support culturally competent services by providing resources for programs that are designed with culture-specific considerations. For example, many ethnic community-based organizations (CBOs) have the expertise, staffing, and programs to effective reach the community. Therefore, these CBOs can be key partners for the systems to engage the community and to provide culturally appropriate services.

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

Community Relations and Advocacy

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

Stigma remains a big challenge for outreach as mental health issues are often considered a taboo subject in the AANHPI community. In many AANHPI cultures, mental illness is something unmentionable and often associated with shame and discrimination. Pacific Islanders, for example, believe that mental illness is a "curse" to the family, which leads to discrimination against not just the consumer but also their family. In many AANHPI languages, there is no proper translation for "mental health" without some kind of negative connotation attributed to it, which is one of the reasons the API-SPW decided to use "wellness" instead of "mental health" when conducting the focus groups. On the other hand, AANHPI cultures are family and community-oriented, which means that the ability on the part of the individual providers and agencies to effectively engage, educate, and collaborate with families and community leaders is critical in ensuring effective outreach and services. As AANHPI cultures often place great emphasis on relationship-building, it is also essential for the individual providers and agencies to earn and establish their credibility in the community by not just engaging and serving the community, but also by advocating for the needs of the community in areas that affect the overall wellness of the community. For example, lack of adequate insurance is a major barrier to receiving proper mental health services for many AANHPIs, and overcoming such a barrier may require education and advocacy in the areas of healthcare reform or immigration policy. Of course, all these efforts in forming relationships require resources and support, which is where the systems could be of great help.

Flexibility in Program Design and Service Delivery

As previously mentioned, the AANHPI community places great emphasis on relationship-building, so consequently more time is required to establish rapport and trust. For example, for Southeast Asians, story-telling is often the preferred mode of communication

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

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

Capacity Building

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

Lastly, support for a central resource center will be a cost efficient way to take advantage of technology for outreach and linkage.

Use of Media

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

– Focus group participant

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

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

Data Collection and Research

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

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

TYPES OF COMMUNITY-DEFINED STRATEGIES

SELECTION CRITERIA FOR PROMISING PROGRAMS AND STRATEGIES

One of the major tasks given to the API-SPW was to identify community-defined promising programs and strategies to reduce existing disparities in the AANHPI community. Over the years, despite limited resources and many other barriers, programs and strategies had been developed in the attempt to respond to the unmet needs in various AANHPI communities. However, not every program or strategy was necessarily effective or culturally appropriate. The challenge remains as to how to adequately assess the effectiveness of a culturally competent program or strategy. Therefore, based on the core competencies defined by the API-SPW, the focus group findings, and decades of experience serving the AANHPI community, the API-SPW set out to establish criteria to be used as parameters for selecting culturally competent promising programs and strategies to serve the AANHPI populations. The API-SPW aimed to create a list as comprehensive as possible, while recognizing that this list may be somewhat ambitious given the limited resources available. This list served as a guideline by the API-SPW in identifying and collecting community-defined promising programs and strategies. It was also hoped that this list would be used in the future by practitioners and policy makers to determine whether a program or a strategy is culturally appropriate for the intended population. Additionally, although the list of selection criteria was created for prevention and early intervention programs, many of the same criteria could be used to examine promising practices for treatment programs for AANHPIs. Table VI-2 is a summary of the criteria with more detailed discussions to follow:

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

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

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

PROGRAM DESIGN

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

Goals/Objectives

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

PEI-Specific

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

Focus on Addressing Community-Defined Needs

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

Addressing Culture/Population-Specific Issues

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

The promising programs and strategies collected should address and incorporate culture-specific issues. For example, for programs aiming to serve Southeast Asian communities, sensitivity and understanding of the history and experience of war and the resulting trauma should be reflected in the program design. For the Hmong community, traditional healers and clan leaders have a

significant role in their way of life. Therefore, efforts should be made to outreach to them and traditional practices should be integrated into program design. The Shamans program in Central Valley serves as a good example where shamans were incorporated as part of the treatment procedure for Hmong patients. For the immigrant population, the program or strategy should consider immigration and acculturation issues. Given that the AANHPI community is very family-oriented, it would be important to consider this factor and address how and when family should be part of the service plan.

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

For example, for certain Southeast Asian communities, it may be appropriate to have separate groups for men and women on certain issues, as women may not feel completely free to speak their mind in the presence of men given the gender roles dictated by their culture.

Community Outreach and Engagement

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

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

– Korean "sandwiched generation" focus group

Model

A culturally competent program or strategy should include components that were based on a reasonable logic model that could articulate the problem it aimed to address, the goals it aimed to achieve, the protective factors it aimed to reinforce, the risk factors it aimed to decrease, and the components it intended to utilize to reach the stated goals. Moreover, cultural considerations should be embedded in

the design of the program or strategy to maximize its effectiveness.

There may be many viable programs or strategies to address a problem. However, an effective program or strategy should ultimately strengthen and empower the consumers and the community.

Replicability

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

Advocacy

The design of the API-SPW reflected its belief that the community must be an integral part of the efforts to address disparity issues. Thus, an effective program or strategy should be able to empower the community to advocate for their needs and to help generate action within the community to achieve wellness. In addition, as community-based organizations often are the links between the community and the systems, they possess the knowledge and expertise to help the community promote necessary systems change in response to the needs of the community. Such capacity and commitment should be reflected in an effective program or strategy.

Capacity-Building

Community capacity building is critical in addressing disparities, since the needs are too many and the available resources are too few. This is particularly true of the emerging AANHPI communities. The wellness of the AANHPI community is to be achieved through wellness in many areas of life, as good mental health comes from an overall sense of wellness in one's life. Since mental health cannot be isolated from other aspects of life, it then becomes crucial for an effective program to develop and form community-wide collaborations with other community members and organizations, such as healthcare providers, social services, schools, spiritual leaders, traditional healers, faith-based organizations, and law enforcement. Such collaborations can help build capacity through supporting strong community leadership and ownership, which activates native capacity to participate in their own health and wellness. Community capacity building can be seen as creating the scaffolding needed to help put healthy communications in

place so that communities can move forward in a manner that supports wellness efforts, using tools such as Community-Based Participatory Research to engage community members and leadership in ways that reveal their expertise and to partner with them in identifying root causes and potential, doable actions.

Sustainability

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

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

Accessibility

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

As voiced by an API-SPW member, "We do not work from nine to five because the community needs us 24/7." Access to care has been named over and over again as one of the major barriers to receiving proper care in the AANHPI community. CBOs are often one of the few places community members can turn to for help. Therefore, accessibility is a key component in identifying an effective program. After all, a program is only as good as the services consumers can receive from it.

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

services more feasible? If so, does the program have the capacity to offer field-based services? In terms of language, does the program have the sufficient number of bilingual and bicultural support and professional staff?

PROGRAM EVALUATION/OUTCOME

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

AGENCY CAPACITY

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

Staffing

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

Lastly, the board and the management of the agency offering the program should reflect the community they serve.

Staff Training and Development

On any job, it is important for staff to have ongoing training to sharpen their skills, so it is no surprise that the API-SPW also deems this important in considering the cultural competency of a program. Examples of trainings may include: training for interpreters, training for staff on how to work with interpreters, and also ethical and professional boundaries in working with community members and clients. Staff training should include both professional training and cultural competency training, and it should not be limited to just staff who serve the AANHPI populations if the agency also serves other populations. Furthermore, it is also essential for an agency to provide and maintain a support system for its staff, as many of those who serve the AANHPI community often feel overwhelmed by the needs of the community, given the ongoing workforce shortage. The support system can even utilize external sources, such as linking the AANHPI-serving staff with their counterparts in other organizations.

Organizational Capacity

The AANHPI cultures place great emphasis on relationship building. Therefore, whether an agency has established trust and credibility

with the community can impact the effectiveness of the program. The ability of the organization to establish trust and credibility also serves the organization well as it helps increase its capacity through collaborative relationships formed with peer organizations and community networks. Collaborative relationships allow organizations to leverage resources and expertise so that the needs can be addressed accordingly.

NOMINATION, SUBMISSION, & REVIEW OF COMMUNITY-DEFINED STRATEGIES

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

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

2) Submission of Existing Programs that have been evaluated
   This category is for programs that:
   - have met most of the criteria of core competencies as defined by the API-SPW
   - have met most of the promising program selection criteria as defined by the API-SPW
   - can be articulated based on the Logic Model
   - have been formally evaluated and can articulate its evaluation component/process

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

4) Already Recognized Programs

This category is for programs that:

- have been formally evaluated and deemed effective by credible entities such as SAMHSA, local counties, research groups, or professional associations.
- have met most of the criteria of core competencies as defined by the API-SPW
- have met most of the promising program selection criteria as defined by the API-SPW

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

Members were also enlisted to be peer reviewers to lend more credibility to the process. A total of twenty-three members agreed to be peer reviewers, in addition to the 3 administrative team reviewers. After all submissions were collected, the administrative team conducted initial reviews, and then carefully assigned each submission to one to three peer reviewers based on the following considerations:

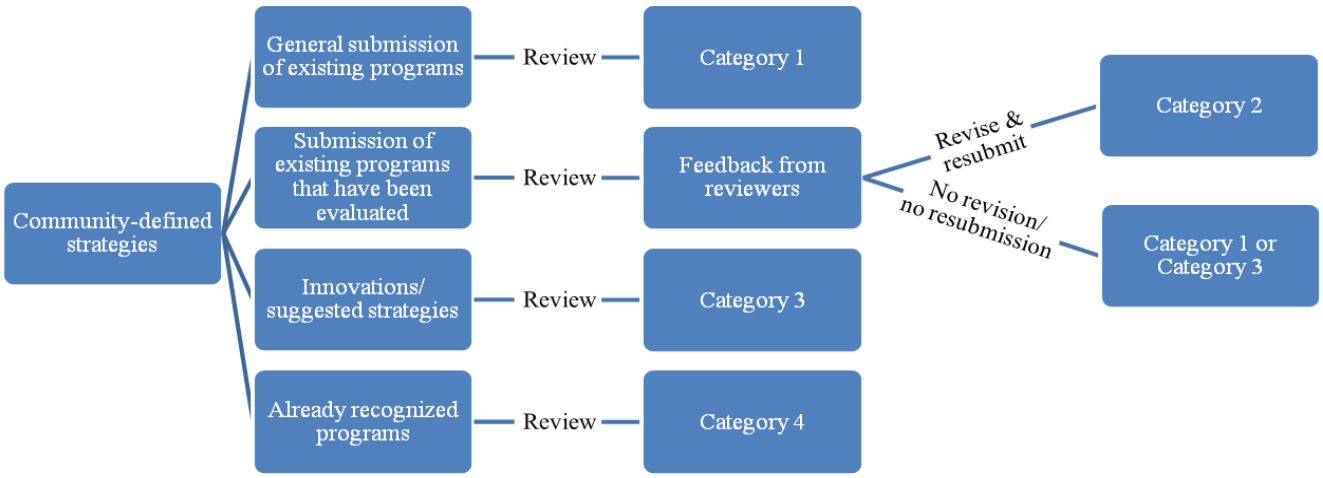
- Type of program or innovation: For example, parenting programs were reviewed by those who have run parenting programs. Community gardening programs were reviewed by those who are familiar with similar programs.
- The target population in terms of ethnicity, culture, age, and gender: For example, programs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

Moreover, geographic factors were also taken into account in reviewer's assignments. Each submission was reviewed by peers within the same region and outside the region. This was done with the hope that more diverse perspectives could be provided in the feedback from those who are knowledgeable about the region and those who may have similar or different experiences. Whenever possible, the administrative team also made the effort to match the region the peer reviewers represent and the location of the program. For example, for small regions such as Sacramento, Central Valley, and San Diego/Orange County, priorities were given to reviewers from regions of similar size, as regional issues in these regions may be more similar. Overall, each

submission was reviewed by three to six reviewers. The majority of submissions were reviewed by at least five reviewers.

Each reviewer was provided with a template for review (please see Appendix 2). Reviewer feedback was forwarded to the agency that submitted the program or innovation for revision. The purpose of the reviewer feedback was to offer constructive feedback on how the agency could better articulate its program or innovation for others to learn from. The design of the submission and review process was meant to create a mutually meaningful learning experience for all involved, in addition to the project's goal of collecting community-defined strategies. Many API-SPW members reflected upon the process and shared that they have benefited from the experience as reviewers or as those who completed the submissions. The review process was also very challenging given the constraints of time and resources. Some members had to decrease productivity time so their staff could work on the submissions while other members reported that their staff volunteered their own time to do so. While many of these programs submitted for review have been in existence for years, some reported that this was a useful experience for them to articulate their programs in such a specific format. Some also expressed their regrets that they could not complete the submissions due to limited resources. Therefore, what is presented is not an exhaustive list, rather an initial sampling. The API-SPW certainly recognizes that this process of identifying community-defined promising programs and innovative strategies is only the beginning of such an effort, and hopes there will be additional resources in the future to continue this process. A quick summary of the process of nomination, submission, and review of community-defined promising programs and innovative strategies is provided as follows:

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



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

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

Table VI-3: ***Submissions: Region and Category***

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

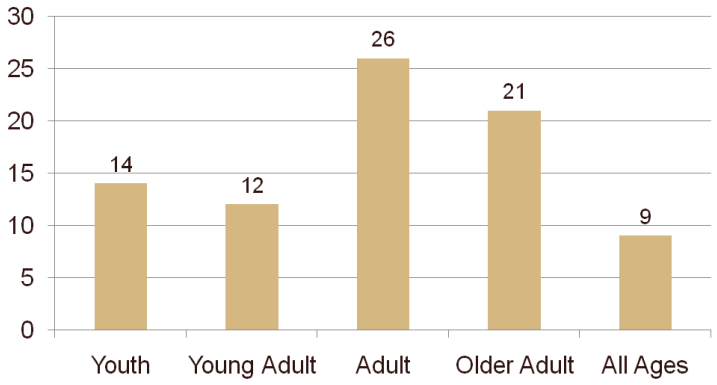
Given the diversity in the AANHPI community, it was not logistically possible to collect programs serving all AANHPI populations given the resources of this project. However, the 56 submissions collected covered 24 distinctive ethnic groups: Afghani, Bhutanese, Burmese, Cambodian, Chamorro, Chinese, Filipino, Hmong, Indian, Iranian, Iraqi, Iu-Mien, Japanese, Korean, Lao, Mongolian, Native Hawaiian, Nepali, Punjabi, Samoan, Thai, Tibetan, Tongan, and Vietnamese.

Table VI-4: *Ethnicities Served*

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

The target populations in the submissions included all age groups from infants to older adults. Given that many older adults are monolingual or with limited English proficiency, it makes sense that there are more older adult programs available in the AANHPI community. The following is a summary:

Graph VI-1: *Age Groups Served*



The types of promising programs and strategies collected were of a wide variety, including suicide prevention, recreation, LGBTQ, problem gambling, gender-based, community gardening, training, school-based, parenting, Alcohol and Other Drugs prevention, integrated care, faith-based, family, senior, violence prevention, youth, consultation, and support/social services. It is important to note that there were more consultation and support services in this collection. The higher number of consultation services may reflect workforce shortage issues and the need for collaboration. Even when community organizations, such as the school districts, recognize the need to engage the AANHPI community using culturally competent staff, there may not be a sufficient number of these staff in the workforce. Thus, consultation services allow the opportunity to leverage existing resources and extend knowledge and expertise of API providers through training and collaboration with community organizations. It is important to recognize that the point of entry to mental health may include other programs and strategies that provide basic social services. As the community is struggling with meeting basic needs, these types of services often provide a viable door of entry to the mental health system, making support services critical in outreach to AANHPIs. Summaries of these submissions can be found below. Details of these programs can be found in Appendices 4-7.

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

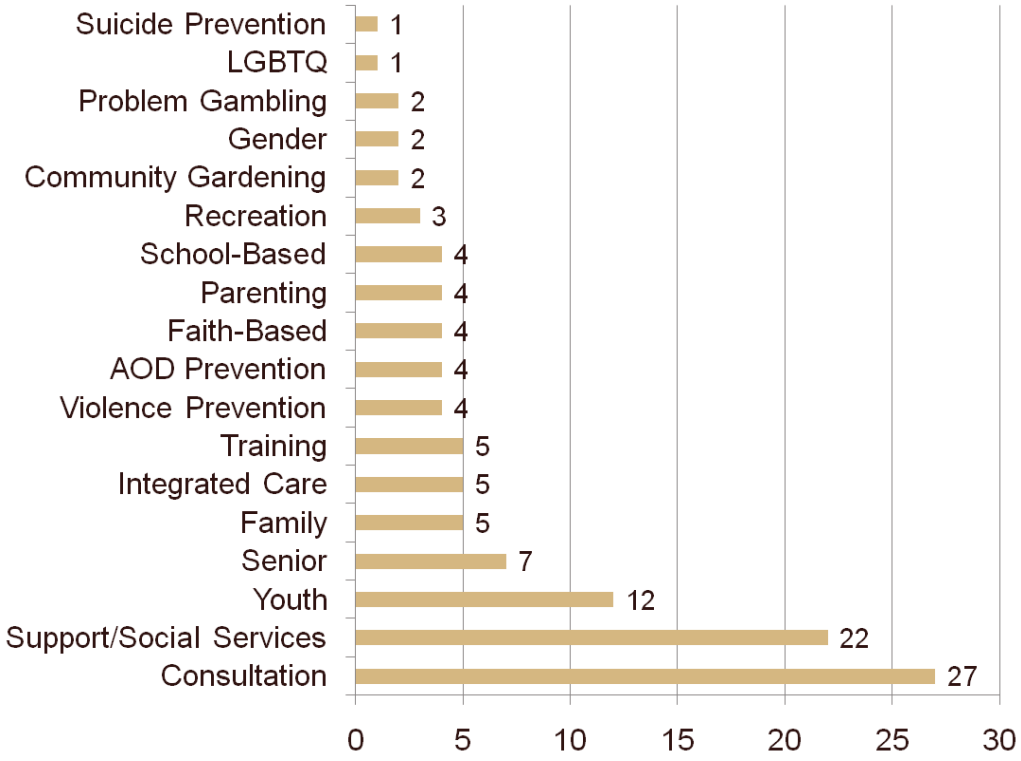


Table VI-5: *Summary of Promising Program and Strategy Submissions*

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Sacramento	Parenting Education	APCC	API and all other cultural groups	Cantonese, English, Hmong, Japanese, Mien, Tongan, Vietnamese	Parents of children 0-teenager	Both	Parenting	Focuses on reducing and coping with stress in parents due to parent-child conflicts and reinforce alternative ways to discipline children by strengthening existing positive parenting skills. Program promotes understanding the child's perspective and taking control of one's emotions and stress that is caused by parenting.	4-89
Sacramento	Youth AOD Prevention	APCC	API	English	Youth (K-12)	Both	AOD Prevention, Youth	Aims to help low-income, urban youth, who are at risk, make positive and healthy decisions when alcohol and other drugs are introduced. The Second Step (EBP) curriculum is used in classrooms with elementary to middle school youth and the Life Skills curriculum (EBP) is used at school or agency with middle to high school youth.	4-101
Sacra-mento	Hmong Talk-Line	HCCBC	Hmong	Hmong, Spanish	All	Both	Consultation	Confidential, over-the-phone support system, aiming to provide support for individuals going through the process of recovery from mental illness.	6-15
Sacra-mento	Promotores	HCCBC	Hmong, Latino	English, Hmong, Spanish	All	Both	Support Services	Provides support for individuals and family in linkage to community resources on mental health illness and isolation.	6-38
Sacra-mento	Zoosiab	HCCBC	Hmong	Hmong	Older Adult (50+)	Both	Consultation, Recreation	Focuses on Hmong survivors of trauma living in Butte County, offering consultation services and recreational activities.	6-47
Sacramento	Family Development Project	MAS-SSF	API and all other cultural groups	English (Arabic, Dari, Farsi, Hindi-Urdu, Pasho, and/or Punjabi may be added in the future)	All	Both	Faith-Based, Information and Referral, Family, Peer Counseling, Social Services	With the intention of increasing the number of emotionally and spiritually healthy Muslim families and individuals, this program helps prevent domestic violence, divorce, alienation of youth from family and faith community, developmental trauma, abuse of and addiction to alcohol, illegal and prescription drugs, and addiction to gambling.	4-52

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Sacramento	Iu-Mien Senior Social Group	UIMC	Iu-Mien	Mien	Older Adult (60+)	Both	Senior, Support Services	Aims to support the physical and mental well-being through activities and provision of information and resources.	4-73
Bay Area	Center for Addiction Recovery and Empowerment (CARE)	AACI	API and all other cultural groups	Cantonese, English, Hindi, Mandarin, Punjabi, Spanish, Tagalog, Taiwanese, Toishanese, Vietnamese	All	Both	Problem Gambling	Addresses problem gambling (PG) from multiple perspectives. Program attempts to outreach and educate the community at large about the signs and symptoms of PG and the available treatments, while also providing support services available for individuals and significant others affected by PG. Also, program will educate and train gaming establishment workers, law enforcement and behavioral health clinicians and/or clinicians in training about PG.	4-12
Bay Area	Center for Healthy Independence (CHI)	AACI	AAPI	Cambodian, Cantonese, English, Mandarin, Tagalog, Vietnamese	Adult, Older Adult	Both	Support Services	Focuses on populations who are Severely Mentally Ill (SMI) and presently receiving Specialty Mental Health Services from Santa Clara County Mental Health Department.	4-21
Bay Area	Center for Survivors of Torture - New Refugee Services	AACI	Afghan, Bosnian, Burmese, Cambodian, Eritrean, Ethiopian, Iranian, Iraqi, Vietnamese	Afghani, Bosnian, Cambodian, Eritrean, Ethiopian, Iranian, Iraqi, Vietnamese	Adult, Older Adult	Both	Consultation, Social Services	Aims to reduce the cultural stigma accompanying mental illness in recently arrived ethnic refugee groups and address the range of physical and mental health problems often exacerbated by legal, economic, and acculturation challenges.	4-29
Bay Area	Club IMPACT	Steve and Sela Teu (Submitted by AARS)	Pacific Islander	Chamorro, English, Fijian, Guamanian, Native Hawaiian, Samoan, Tongan	Youth, Young Adult (9-24)	Both	AOD Prevention, Consultation, Youth	Serves PI youth and young adults in the San Mateo County and aims to prevent and reduce the high school dropout rates and substance use/abuse.	4-40

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Bay Area	Em-Power	AARS	AAPI	English	Youth (11-13)	F	School-Based, Youth	Designed to serve girls ages 11-13, who are attending Morrill Middle School in Santa Clara County. Program addresses the specific needs of AAPI girls who experience acute intergenerational conflict due to differential acculturation between their parents and themselves.	5-1
Bay Area	Filipino Mental Health Initiative	SMCHS (Submitted by AARS)	Filipino	English, Tagalog	All	Both	Training	Three main components of FMHI specifically target behavioral health clinicians who work with Filipino clients, parents of middle school students who attend a high Filipino-populated school, and attendees at a widely attended annual Filipino festival. Activities include provider trainings, family nights, and community outreach.	4-54
Bay Area	Asian Primary Care Integration	ACMHS	API and all other cultural groups	Chinese, Korean	Adults, Older Adults	Both	Integrated Care	Aims to improve the overall wellness and physical health status of the SMI Asian and Pacific Islander population in Alameda County by making available coordinated primary care services.	6-1
Bay Area	Lotus Bloom	ACMHS	Asian, Latino/ Hispanic, White, African American	Cambodian, Chinese, English, Spanish	Youth	Both	Family, Support Services	Provides parent-child playgroup programs six days per week, Monday through Saturday, for low-income and immigrant families at four locations: two in San Antonio neighborhoods and two in East Oakland neighborhoods.	4-79
Bay Area	Qi-Gong	ACMHS	Asian	Cantonese, Mandarin	Older Adult (65+)	Both	Senior	The activities for this project include holding three series of eight two-hour workshops, co-led by Qi-Gong monks and the ACMHS' mental health consultants. Each workshop concentrates on Qi-Gong practice integrated with psycho-education on mental health symptoms and issues, followed by a group support and discussion.	6-42

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Bay Area	Incredible Years - BASIC Preschool Program	CCDC	Chinese	Cantonese	Adult	Both	Parenting	Focuses on helping parents attain skills known to promote children's social competence and reduce behavioral problems, as well as teaches parenting strategies for managing problem behaviors. Cultural and linguistic adaptations of Incredible Years have been made to serve the specific target population.	4-69
Bay Area	API Connections	CHAA	Bhutanese, Burmese, Chin, Kachin, Karen, Karenni, Mon, Mongolian, Nepali, Pacific Islander, Rakhaing, Shan, Thai, Tibetan	Burmese, English, Mongolian, Nepali, Rakhaing, Thai, Tibetan, Tongan	All	Both	Consultation	Aims to promote wellness in API communities living in Alameda County and help overcome stigma through culture-based outreach and consultation.	4-1
Bay Area	Mental Health Consultation School Based Program	Hume	API and all other cultural groups	Bengali, Cantonese, Dari, English, Farsi, Hindi, Mandarin, Punjabi, Singhalese, Spanish, Tamil, Urdu, Vietnamese	Adult	Both	Consultation, School-Based	Intended to serve first responders to mental health related challenges of the youth/student, which promotes psychological understand of common student difficulties.	6-26
Bay Area	PEI for the South Asian Community	Hume	South Asian	Bengali, Cantonese, Dari, English, Farsi, Hindi, Mandarin, Punjabi, Singhalese, Spanish, Tamil, Urdu, Vietnamese	All	Both	Consultation, Social Services	Aims to increase access to services by decreasing stigmatization of mental health through addressing individual issues and needs.	4-91

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Bay Area	Asian Youth Prevention Services	JCYC	API and all other cultural groups	Cantonese, English, Mandarin, Samoan, Tagalog, Vietnamese	Youth (12-16)	Both	AOD Prevention, Support Services, Youth	Aims to prevent, delay, and reduce the use and abuse of alcohol, tobacco and other drugs among Asian youth in San Francisco.	4-9
Bay Area	Asian Youth Prevention Services - Strengthening Chinese Families Program	CYC (Submitted by JCYC)	Chinese	Cantonese	Youth, Young Adult	Both	AOD Prevention, Consultation, Violence Prevention, Youth	Provides school-based support groups for at-risk youth in middle and high schools to prevent, delay, and reduce the use and abuse of alcohol, tobacco and other drugs (ATOD) among Asian youth in San Francisco.	4-43
Bay Area	Asian Youth Prevention Services - Strengthening Families Program	SCDC (Submitted by JCYC)	Samoan	English, Samoan	Youth, Adult	Both	Youth, Family, Consultation	Targets youth who are identified as being more at risk of being involved or are involved with the juvenile justice system, on the verge of dropping out of school, involved in unlawful activities and those at high risk, and have family issues. The site facilitates group meetings with parents, group meetings with youth, and a convening with both youth and their parents.	4-94
Bay Area	Fu Yau Project	RAMS	API and other cultural groups (African American, Latino)	Chinese, Spanish	Youth, Adult	Both	Consultation, Family, Support Services, Youth	"Fu Yau," which is translated to "to support and promote the well-being of young children," provides mental health services and consultation to the childcare community for children ages 0-5, targeting child care centers and family resource centers that serve children and families of color or otherwise marginalized communities.	4-61
Bay Area	Wellness Centers	RAMS	API and all other cultural groups	Cantonese, English, Gujerti, Hakka, Hindi, Mandarin, Spanish, Taiwanese	Youth	Both	Consultation, Family, School-Based, Youth	Focuses on students with behavioral health concerns who may benefit from intensive case management and behavioral health services, who may be dealing with trauma/grief & loss, or families with limited resources.	5-27

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Central Valley	Living Well	FCNA	Southeast Asian	Cambodian, English, Hmong, Lao	All Adults (18+)	Both	Consultation, Support Services, Training	Provides workforce development for mental health clinicians, cross-cultural training workshops for health providers, increase accessibility to mental health services for the Southeast Asian population, and help decrease stigma on mental health.	5-7
Central Valley	Horticultural Therapeutic Community Centers	FIRM	Hmong, Lao, Southeast Asian	Hmong, Lao	Older Adult	Both	Community Gardening	Aims to enhance existing community gardens as a platform for peer support, mental health delivery and engagement on matters that relate to mental well being and mental health services.	6-17
Central Valley	Elders Health Project	HH	Hmong, Punjabi	Hmong, Punjabi	Older Adult (55+)	Both	Faith-Based, Integrated Care, Senior, Support Services	Assists Hmong and Punjabi elders identify, understand, and seek resources for mental health issues, including access to shamans/priests, but also educating on physical basis for conditions, medications, etc. Home visits are provided.	6-11
Central Valley	In-Home Mental Health Support Training	HH	Latino, South Asian, Southeast Asian	Hmong, Punjabi, Spanish	All	Both	Support Services, Training	In-home training providing information regarding the physical basis of mental illness, in essence, redefining it as an illness rather than just a condition indicating spiritual discord.	6-19
Central Valley	Partners In Healing	HH	Hmong	English, Hmong	All	Both	Faith-Based, Integrated Care, Training	This “Partners In Healing” project is an orientation class for Hmong shaman to integrate them into the Western medicine system. It is also intended to give Western providers some cultural competency regarding Hmong spiritual and physical healing processes.	6-35
Central Valley	Southeast Asian Support Group	HH	Hmong, Lao, Mien	Hmong, Lao, Mien	All Adults (18-65)	Both	Recreation, Support Services	Provides an opportunity for participants to learn about mental wellbeing, serves as a place to let go of depression and ease stress, and offers recreational activities.	4-98

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Central Valley	Integrated Primary Care	MLFC	Hmong, Lao, Mien	Hmong, Lao, Mien, Thai	Adult (18+), Older Adult	Both	Consultation, Integrated Care, Support Services	Augment services available at existing primary care centers to help ensure that they are more able to provide early intervention for mental health issues, such as depression, anxiety, and suicide ideation in older adults.	4-71
Central Valley	Southeast Asian Consumer Advocacy Program (SEACAP)	MLFC	Hmong, Lao, Mien	Hmong, Lao, Mien	TAY, Adult, Older Adult	Both	Consultation, Support Services	Incorporates cultural understanding and individualization to ensure the effective treatment of the unique mental health issues of the SEA community. Consumer issues include PTSD due to their war and refugee experience, and stress and depression from poor adjustment and coping skills.	4-96
Los Angeles	Chieh Mei Ching Yi (Sisterhood)	APAIT	Chinese	Cantonese, Mandarin	Adult	F	Consultation, Gender-Based	Intended for women working in settings where they are at risk of HIV exposure, wage theft, and violence through sex work, namely massage parlors, acupuncture and aromatherapy businesses, and chiropractic clinics.	6-8
Los Angeles	Mind, Body, Spirit, Wellness	APAIT	API	English, but can be made available in other languages (e.g. Cambodian, Chinese, Filipino, Thai, Vietnamese)	Adult	M	Consultation, Gender-Based, LGBTQ	Designed to provide a sense of emotional well-being to HIV positive individuals with the knowledge that the mind, body, and spirit are all connected in each person. The program deals with issues such as sexual identity, teach them skills to disclose HIV status to loved ones, increase support system, and help them adhere to medications.	4-83
Los Angeles	Asian American Family Enrichment Network (AAFEN) Program	APFC	Asian	Korean, Mandarin, Vietnamese	Adult	Both	Parenting	Achievements made through participation in this program include increasing the emotional and behavioral self-efficacy of the Asian immigrant parents and/or primary caregivers as well as enhancing the safety and healthy development of Asian immigrant youths.	7-1

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Los Angeles	Asian Mentoring and Advocacy Support to Enhance Resiliency in Youth (MASTERY) Program	APFC	Asian	Chinese, Vietnamese	Youth	Both	Consultation, Youth	Targets youth who have engaged in some violent or delinquent act, experienced truancy and failure at school, and/or been living by themselves in this country with very little or no adult supervision after school.	7-5
Los Angeles	Inspire and Mobilize People to Achieve Change Together (IMPACT!) Program	APFC	Asian	Chinese, Korean	Youth	Both	School-Based, Youth	Assists youths in their development of such functional skills such as goal setting, effective communication and problem solving. It also addresses such issues as substance use and HIV to facilitate peer refusal skills development, and explores such topics as peers, family, and culture to enhance pro-social life choices.	7-9
Los Angeles	Resilience and Effectiveness of Asian Adolescents in Countering Hostility (REAACH) Program	APFC	Asian	Chinese, Korean	Youth	Both	Consultation, Violence Prevention, Youth	Targets youth who are often themselves the victims of peer violence (such as bullying) and hostility because of their racial/ethnic background, inadequate English-speaking capability, and limited access to responsive and supportive services at home, at school, and in the community.	7-12
Los Angeles	School, Community, and Law Enforcement (SCALE) Program	APFC	Asian	Chinese, English, Korean,	Youth	Both	Consultation, Youth	Addresses behavioral problems including, but are not limited to, school truancy, academic failure, association with gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers).	7-15
Los Angeles	Strengthening Intergenerational/ Inter-cultural Ties in Immigrant Families (SITIF)	Yu-Wen Ying (Submitted by APFC)	Chinese, Korean, Spanish, Vietnamese	Chinese, English, Korean, Spanish, Vietnamese	Adult	Both	Parenting	Aims to improve the intergenerational relationship of the target families by increasing the target parents' sense of self-efficacy and effective parenting of their children.	5-23

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Los Angeles	Keeping Cool	KAFSC	Korean	Korean	Adult (30-55)	Both	Consultation, Violence Prevention	Increases ability of Korean immigrant adults to manage stress and anger, and communicate more positively, thereby reducing incidents of household violence, depression/suicide, and increasing daily functioning.	4-75
Los Angeles	From Killing Fields to Growing Gardens	LTSC	Cambodian	Cambodian	Older Adult (55+)	Both	Community Gardening, Senior	Aims to improve the mental and physical health of Cambodian seniors through an integrated approach that taps into their existing skills (an improved sense of well-being as they feel productive and useful) and encourages them to talk about their experiences.	4-58
Los Angeles	Nikkei Tomodachi (Friendly Visitors)	LTSC	Japanese	Japanese	Older Adult (60+)	Both	Senior, Support Services	Provides companionship to seniors at their home with goals of increasing socialization, supporting independent living and delaying nursing home care via weekly home-visit or telephone calls by trained Japanese speaking senior volunteers. In return, the volunteers gain enriched retired lives by providing needed services to peers.	4-86
Los Angeles	Chinese Community Problem Gambling Project (CCPGP)	NICOS (Submitted by NAPAFASA)	Chinese	Cantonese, English, Mandarin	Adult	Both	Consultation, Problem Gambling	Seeks to address problem gambling in the Chinese community by building awareness of problem gambling and of resources available to address problem gambling and providing prevention education and intervention through individual, group and phone-based counseling.	4-37
Los Angeles	Saving Earth and Healing Hearts	TCF	API and all other cultural groups	Mandarin, Taiwanese	Adults (21-65)	Both	Faith-Based, Support Services	This recycling project is a humanistic approach targeting those who have symptoms of social isolation or depressed mood. The strategies are to engage the targeted population to perform simple task activities to collect recyclable materials and sorting the recyclables in a protective, caring, welcoming and spiritual environment.	6-40

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
Los Angeles	Maeta (Mercy Health)	UCC	Cambodian	Cambodian	Adults (40-75)	Both	Consultation, Support Services	Focuses on survivors of the Killing Fields in Cambodia by helping to sustain emotional and mental wellness of the refugees.	6-24
San Diego	Health Navigation	KCS	Korean	Korean	Adult	Both	Consultation, Support Services	Aims to educate individuals about federal health assistance programs such as Medi-Cal, Medicaid, MSI and others, and provide assistance to those seeking to apply to such programs, serving those who have difficulty navigating through the federal health assistance programs due to language barriers.	6-13
San Diego	Integrated Care Center	KCS	Korean	English, Korean	All Adults (18+)	Both	Integrated Care	Consumers in this program will be able to receive a combination of medical care and mental health services. Mental health assessments will be made for those individuals at-risk of suffering from mental health issues, in order to identify potential diagnoses early on.	6-22
San Diego	Mental Health Worker Training Program	KCS	Korean	Korean	Adult	Both	Training	Aims to educate the consumers and family members with information about mental health issues, as well as to empower those individuals to give back to the community once they are able to self-maintain.	6-30
San Diego	Suicide Prevention	KCS	Korean	Korean	All	Both	Consultation, Suicide Prevention	Intended for Koreans at risk of suicide and/or lost their family members to suicide, and includes support groups as well as individual counseling sessions.	6-45
San Diego	Outreach Groups	UCI	API and all other cultural groups	English	Young Adult	Both	Consultation, Support Services	Aims to reach vulnerable populations based on ethnicity, culture, gender, sexual orientation, and academic status by providing support, consultation, and helping the individual get a sense of their community. Groups may center on mentorship, skills, food, music, dance, art, and spoken word.	6-32

Region	Program Name	Agency	Ethnicity Served	Languages available	Age Group Served	Gender Served	Program Type	Brief Description of Program	Page Listing in Appendix
San Diego	Elder Multicultural Access and Support Services Program (EMASS)	UPAC	African American, Filipino, Latino, Somali	English, Tagalog, Somali, Spanish	Older Adult (60+)	Both	Senior, Support Services	Utilizes a promotoras or "community health workers" as health care liaisons to assists seniors who have limited access to physical and mental health care due to cultural/linguistic barriers, financial and transportation barriers.	4-46
San Diego	Helping to Empower Authentic Relationship for Teens (HEART)	UPAC	API and all other cultural groups	English	Youth, Young Adult (13-24)	Both	Consultation, Violence Prevention	Focuses and works with a multicultural population of youth who are exposed to dating violence, or are at risk of dating violence.	4-66
San Diego	Positive Solutions	UPAC	API and all other cultural groups	Chinese, English, Korean, Spanish, Vietnamese	Older Adult (60+)	Both	Senior, Support Services	Created to prevent depression with older adults who are homebound due to illness and/or disability. These seniors are unable to leave their home for activities of daily living without assistance from another caregiver or professional.	5-15
San Diego	Bridge-Culture Generation	VFSD	Vietnamese	Vietnamese	Adult	Both	Recreation	Strategy intended to target Vietnamese immigrants by providing programs and activities that cater to their specific needs and by promoting the concept of living independently in their own home for as long as they can, with the support of our programs to maintain a well balanced mental and physical wellness as an alternative to the typical retirement environment.	6-6

SYSTEMS ISSUES AND IMPLICATIONS ON PUBLIC POLICY

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

HOW TO REDUCE EXISITING DISPARITIES IN THE AA-NHPI COMMUNITY

ACCESS, AFFORDABILITY, AVAILABILITY, AND QUALITY OF SERVICES

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

Before any services can be provided, consumers will have to be engaged in order to become aware of mental health issues and resources available to them to deal with these issues. However, many mental health concepts are based on Western cultures and thus are not necessarily common knowledge in many AANHPI cultures. Thus, efforts are needed for education on mental health issues. Furthermore, in many AANHPI languages, the literal translation of mental health is often associated with negative connotations such as “crazy,” which results in stigma and discrimination. Therefore, for outreach and engagement to be effective, such cultural factors will need to be taken into consideration. While the lack of a culturally competent workforce remains an issue, one viable option is to take advantage of existing relationships community-based organizations have already established within the community. These CBOs can leverage existing relationships and resources to work with the community. Existing community programs can also be utilized as culturally appropriate venues for outreach given that AANHPIs may not readily acknowledge mental health issues. Whenever appropriate, input from the

community should be solicited and encouraged in outreach efforts, such as through community-based participatory methods. It also important to integrate existing community resources into outreach and engagement efforts to maximize effectiveness and efficiency, including collaboration with community gatekeepers and organizations, such as: schools, healthcare providers, faith-based organizations, law enforcement, businesses, and ethnic media.

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

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

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

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

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

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

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

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

A culturally competent program can only be effective if those providing services are culturally competent. As described in previous sections, linguistic capacity is only one of the qualities required of a culturally competent workforce. The providers need to possess professional competency, have a keen understanding of the culture and history of the community, demonstrate the ability to leverage and collaborate with other community resources, and empower and advocate for the needs of the community. It also requires support and commitment to developing and retaining a culturally competent workforce at the organizational level and the systems level, as careers in mental health services are not as well recognized or pursued in the AANHPI community. Moreover, the existing training model for future workforce often does not require or even include training in cultural competency. While community helpers are often utilized as a resource to cover for workforce shortages, it is important to provide them with adequate support as they are often the first point of contact and have to deal with highly stressful situations. Ongoing training and peer support structure are two useful modalities of support. Lastly, cultural competence training should not be limited to mental health providers and should also include those who serve the AANHPI community, such as healthcare providers, school, and law enforcement.

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

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

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

Availability of culturally competent services remains a major barrier to quality care. In many areas, there are very few culturally appropriate services available despite the vast needs in the community. Even when

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

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

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

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

OUTCOME AND DATA COLLECTION

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

One of the greatest challenges the API community faces is the lack of disaggregated data. Even though there are many similarities among the various AANHPI communities in California, there are also many significant differences in

terms of culture, language, religion, history, and available resources. Thus, treating all AANHPI communities as one is overlooking the unique and possibly drastically different needs of each community. Despite the fact that the communities have responded to their needs by developing successful promising programs, as collected in this report, very few of them have been evaluated at all, let alone been evaluated properly using culturally appropriate measures.

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

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

CAPACITY BUILDING

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

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

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

- …community capacity building such as leadership development so the community can be empowered to respond to its needs.
- …community capacity building such as technical assistance to develop, refine, and validate promising programs.
- …inclusion of community participation in the decision-making process as the

community understands its own needs and such inclusion can also empower the community to find its own solutions.

- …establishing or maintaining community infrastructures so resources can be shared and leveraged.
- … and provision of resources for maintaining a statewide infrastructure where agencies can share resources and provide peer training.
- …computer technology, such as social networks, podcast, and web-based blogging, to be used for outreach to AANHPI youth.

LIMITATIONS

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

Determination of Threshold Languages

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

Connection with the Affordable Care Act

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

Unique Experiences and Special Needs for Ethnic/Population Groups

Given the diversity in the API community, it is difficult for this report to include all possible culture-specific factors that need to be considered. For example, when serving the Southeast Asian communities, war trauma and Post-Traumatic Stress Disorder (PTSD) must be taken into consideration. The same is true for the newest wave of Asian refugees from war-torn areas such as Iraq and Afghanistan, who also face the unique challenge of being Muslim. Other examples include unique needs of those who were born in America as well as multiracial

AANHPIs and AANHPI LGBTQs who face additional challenges, potential stigma, and discrimination due to their ethnic identity, gender identity, and sexual orientation. Homeless AANHPIs are another population that deserves more attention.

Regional and Ethnic Differences

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

Immigration Policy

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

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APPENDIX 1: API-SPW MEMBERSHIP ROSTER

ASIAN & PACIFIC ISLANDER WELLNESS CENTER

730 Polk St.
San Francisco, CA 94109
Tel: (415) 292-3400
Fax: (415) 292-3404
http://www.apiwellness.org/home.html

Asian Americans for Community Involvement
2400 Moorpark Ave., Suite #300
San Jose, CA 95128
Tel: (408) 975-2730
Fax: (408) 975-2745
http://aaci.org/

APIsCAN

Asian & Pacific Islanders California Action Network
P.O. Box 2081
Gardena, CA 90247
Tel: (310) 532-6111
Fax: (310) 532-6166
http://www.apiscan.org/

ACMHS
asian community mental health services

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

ASIAN AMERICAN RECOVERY SERVICES, INC.

Central Office and Administration:
1115 Mission Rd.
South San Francisco, CA 94080
Tel: (650) 243-4888
Fax: (650) 243-4889
http://www.aars.org/

ASIAN HEALTH SERVICES

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

Asian Pacific AIDS Intervention Team Health Center
1730 W. Olympic Blvd., #300
Los Angeles, CA 90015
Tel: (213) 553-1830
Fax: (213) 553-1833
http://www.apaitonline.org/

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

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

華埠兒童培育中心
Chinatown Child Development Center
720 Sacramento St.
San Francisco, CA 94108
Tel: (415) 392-4453
Fax: (415) 433-0953

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

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

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

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

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

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

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

Hmong Cultural Center of Butte County

P.O. Box 2134
1940 Feather River Blvd., Suite H
Oroville, CA 95965
Tel: (530) 534-7474
Fax: (530) 534-7477
http://www.hmongccbc.net/

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

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

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

3727 W. 6th St., Suite 320
Los Angeles, CA 90020
Tel: (213) 389-6755
Fax: (213) 389-5172
http://www.kafscla.org/

Hume Center
Fremont location:
39420 Liberty St., # 140
Fremont, CA 94538
Tel: (510) 745-9151
Fax: (510) 745-9152
http://www.humecenter.org/

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

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

231 E. 3rd St., Suite G-106
Los Angeles, CA 90013
Tel: (213) 473-3030
Fax: (213) 473-3031
http://www.ltsc.org/

Tel: (562) 972-0969
http://www.kutturanchamoru.org/

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

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

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

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

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

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

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

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

Samoan Community Council
404 Euclid Ave., Suite 301-2
San Diego, CA 92114
Tel: (619) 888-1037
E-mail: samoancommunitycouncil@yahoo.com
http://www.samoancommunitycouncil.org/

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

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

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

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

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

To'utupu'o e Otu Felenite Association
2730 Florin Rd.
Sacramento, CA 95822
Tel: (916) 681-4635
http://tofainc.org/

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

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

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

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

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

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

Vietnamese Federation of San Diego
7833 Linda Vista Rd.
San Diego, CA 92111
http://www.vietfederationsd.org/Eindex.htm

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

APPENDIX 2: PROMISING PROGRAM REVIEW TEMPLATES

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

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

1. NAME OF PROGRAM:		
2. TYPE OF PROGRAM: Please mark the appropriate type of program the program should be submitted under.		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		
No need to assess this item. Please skip.		
4. TARGET POPULATION		

Target population must be API-specific and submission should include the following information:

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

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

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Submission should include the following information:

- *What are the specific problems this program aims to prevent or address?*
- *What are the protective factors this program aims to enhance?*
- *What are the risk factors this program aims to reduce?*
- *What are the specific goals this program aims to achieve?* (Do the goals make sense given the problem?)

WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**

REVIEWER'S COMMENTS:

6. CULTURAL RELEVANCE

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

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

WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**

REVIEWER'S COMMENTS:

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

REVIEWER'S COMMENTS:

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

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

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
2. TYPE OF PROGRAM:		Universal prevention
Please mark the appropriate type of program the program should be submitted under.		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		
No need to assess this item. Please skip.		
4. TARGET POPULATION		
Target population must be API-specific and submission should include the following information: • *What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.)* • *In what language(s) is the program provided?* • *Is the program intended for people with specific needs or risks?* • *Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)*		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		

5. WHAT ARE THE GOALS OF THIS PROGRAM?		
Submission should include the following information*:* • *What are the specific problems this program aims to prevent or address?* • *What are the protective factors (factors shown to reduce the likelihood of risky behaviors) this program aims to enhance?* • *What are the risk factors (factors shown to increase the likelihood of risky behaviors) this program aims to reduce?* • *What are the specific goals this program aims to achieve?* (Do the goals make sense given the problem?)		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		

6. CORE COMPONENTS		
Do the program components match the stated goals? Are there enough details about the program for the reader to get a good sense of the program? How well does the program articulate the following? • *What are the essential elements of this program? (e.g.: group size, accessibility, address issues on multi-levels, promote system change, etc.)* • *Why are these essential elements important?* (Do these elements make sense given the goals?) • *Have these essential elements been formulated (e.g.: manual, curriculum, specific skill set, etc.)? Is there a curriculum so that training and development can be offered to others? Please attach documents when applicable.* (Are the materials linguistically/culturally/age/gender appropriate?) • *When applicable, describe the model in terms of number of sessions required, frequency/ duration of sessions, number of consumers served, etc.* • *How well does the program demonstrate how it can be replicated?*		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		

7. CULTURAL RELEVANCE
How well does the program address cultural relevancy in its components? How are cultural elements considered and incorporated in the program components/design? What makes this program an API-focused program and culturally relevant/appropriate beyond bi-lingual/bi-cultural? • *What strategies does this program use to outreach to the target population?* • *How does the program incorporate the target population's traditions, beliefs, and customs?* • *How does the program incorporate cultural elements regarding mental health and well-being?* • *How does the program demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)?* • *Please describe the history of the development of this program. Has the program had input from the community in the design and/or evaluation of the program?*

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

8. STAFFING

Does the staffing plan make sense given the program design?

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

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

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

Did the submission state what type of setting is needed?

10. INDICATIONS OF EFFECTIVENESS

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

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

WAS THE INFORMATION PROVIDED ADEQUATE?	Yes ☐	No ☐

REVIEWER'S COMMENTS:
11. AGENCY INFORMATION
Please include the following information and be as specific as possible: • *Please provide name/contact information.* • *How do the board, management, and staff of the agency reflect the community the program intends to serve?* (Are members of the target population/community represented at these levels?) • *How does the agency provide ongoing support and training for its staff?* • *Please describe your history working with the target population or the community.* (Was there any documented history of positive involvements with the target community/population?)

WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**

REVIEWER'S COMMENTS:
12. ADDITIONAL COMMENTS - Please comment on the overall strengths and weaknesses of the program.
REVIEWER'S COMMENTS:

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

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

1. NAME OF INNOVATION/STRATEGY:		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
Please mark the appropriate type of proposed strategy the strategy should be submitted under.		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information		
No need to assess this item. Please skip.		
4. TARGET POPULATION		
Target population must be API-specific and submission should include the following information: • *What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.)* • *In what language(s) is the program provided?* • *Is the program intended for people with specific needs or risks?* • *Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)*		
WAS THE INFORMATION PROVIDED ADEQUATE?	**Yes ☐**	**No ☐**
REVIEWER'S COMMENTS:		
5. WHAT ARE THE GOALS OF THIS STRATEGY?		
Submission should include the following information*:* • *What are the specific problems will this proposed strategy aim to prevent or address?* • *What are the protective factors will this proposed strategy aim to enhance?* • *What are the risk factors will this proposed strategy aim to reduce?* • *What specific goals will this proposed strategy aim to achieve?* (Do the goals make sense given the problem?)		

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

6. CORE COMPONENTS/CULTURAL RELEVANCE

Do the core components match the stated goals? Are there enough details about the strategy for the reader to get a good sense of the strategy? How well does the strategy articulate the following?

- *What will be the essential components of this proposed strategy? (e.g.: group size, accessibility, address issues on multi-levels, promote system change, etc.)*
- *Why are these essential elements important?* (Do these elements make sense given the goals?)
- *When applicable, describe the proposed strategy in terms of number of sessions required, frequency/ duration of sessions, number of consumers served, etc.*

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

- *How will the proposed strategy outreach to the target population?*
- *How will the proposed strategy incorporate the target population's traditions, beliefs, and customs?*
- *How will the proposed strategy demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)?*
- *How will the proposed strategy incorporate cultural elements regarding mental health and well-being?*

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

7. ADDITIONAL COMMENTS - Please comment on the overall strengths and weaknesses of the strategy.

REVIEWER'S COMMENTS:

APPENDIX 3: PROMISING PROGRAM SUBMISSION TEMPLATES

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

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

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

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		
4. TARGET POPULATION		
Please include the following information and be as specific as possible: • *What specific population is this program intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.)* • *In what language(s) is the program provided?* • *Is the program intended for people with specific needs or risks?* • *Is the program intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)*		
5. WHAT ARE THE GOALS OF THIS PROGRAM?		
Please describe the goals the program aims to achieve and include the following information: • *What are the specific problems this program aims to prevent or address?* • *What are the protective factors this program aims to enhance?* • *What are the risk factors this program aims to reduce?* • *What are the specific goals this program aims to achieve?*		
6. CORE COMPONENTS		
Please describe core features of the program that are essential to its implementation and include the following information: • *What are the essential elements of this program? (e.g.: group size, accessibility, address issues on multi-levels, promote system change, etc.)* • *Why are these essential elements important?* • *Have these essential elements been formulated (e.g.: manual, curriculum, specific skill set, etc.)? Is there a curriculum so that training and development can be offered to others? Please attach documents when applicable.* • *When applicable, describe the model in terms of number of sessions required, frequency/ duration of sessions, number of consumers served, etc.* • *How well does the program demonstrate how it can be replicated?*		

7. CULTURAL RELEVANCE

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

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

8. STAFFING

Please describe staffing needed and include the following information:

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

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

10. INDICATIONS OF EFFECTIVENESS

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

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

11. AGENCY INFORMATION

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

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

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

1. NAME OF INNOVATION/STRATEGY:		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information		
4. TARGET POPULATION		
Please include the following information and be as specific as possible: • *What specific population is this proposed strategy intended to serve/work with? (e.g.: ethnicity, culture, age, gender, organizations, workforce, community, etc.)* • *In what language(s) will the proposed strategy be provided?* • *Is the proposed strategy intended for people with specific needs or risks?* • *Is the proposed strategy intended for people in a particular setting? Which setting? (e.g.: school, home, community center, rural area, etc.)*		
5. WHAT ARE THE GOALS OF THIS STRATEGY?		
Please describe the goals the proposed strategy aims to achieve and include the following information: • *What specific problems will this proposed strategy aim to prevent or address?* • *What protective factors will this proposed strategy aim to enhance?* • *What risk factors will this proposed strategy aim to reduce?* • *What specific goals will this proposed strategy aim to achieve?*		
6. CORE COMPONENTS/CULTURAL RELEVANCE		
Please describe the core features and cultural relevance of the proposed strategy and include the following: • *What will be the essential components of this proposed strategy? (e.g.: group size, accessibility, address issues on multi-levels, promote system change, etc.)* • *Why are these essential elements important?* • *When applicable, describe the proposed strategy in terms of the number of sessions required, frequency/duration of sessions, number of consumers served, etc.* • *How will the proposed strategy outreach to the target population?* • *How will the proposed strategy incorporate the target population's traditions, beliefs, and customs?* • *How will the proposed strategy demonstrate sensitivity to historical issues (e.g.: immigration, war trauma)?* • *How will the proposed strategy incorporate cultural elements regarding mental health and well-being?*		

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

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

4. TARGET POPULATION

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

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

5. WHAT ARE THE GOALS OF THIS PROGRAM?

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

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

6. CORE COMPONENTS

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

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

7. CULTURAL RELEVANCE

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

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

8. STAFFING

Please describe staffing needed and include the following information:

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

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

10. INDICATIONS OF EFFECTIVENESS

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

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

11. AGENCY INFORMATION

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

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

APPENDIX 4: CATEGORY 1 FULL SUBMISSIONS

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

1. NAME OF PROGRAM:		
Community Health for Asian Americans' API Connections Program		
2. TYPE OF PROGRAM:	X	Universal prevention
	X	Selective prevention
	X	Early intervention
	X	Other (please specify): Advocacy and Organizing; Workforce Development; Capacity Building

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

API Connections was developed as part of Alameda County Behavioral Health Care Services' MHSA Prevention & Early Intervention strategies planning for Underserved Ethnic and Linguistic Populations (UELP). UELP projects were designated for five un- and underserved communities, including Afghan, South Asian, Native American, Latino/Hispanic and Asian/Pacific Islanders (API). The program design was based on feedback from community focus groups and surveys conducted in 2005 and 2007 with consumers, family members, other community members, and providers by ACMHS and CHAA, who identified underlying causes for APIs being underserved and suggested strategies for addressing this complex issue, and through input from a task force that met across several months to refine the approach. Community Health for Asian Americans (CHAA) and Asian Community Mental Health Services (ACMHS) submitted a joint proposal to serve API communities, with ACMHS serving designated "underserved" communities and CHAA serving designated "unserved" communities. API Connections has been on the ground since July 2010.

Program developers at CHAA:

Sean Kirkpatrick, Associate Director
sean.kirkpatrick@chaaweb.org

Beatrice Lee, Executive Director
beatrice.lee@chaaweb.org

Ann Rojas-Cheatham, Research and Training Director
ann.rojascheatham@chaaweb.org

4. TARGET POPULATION

Populations served:

CHAA's API Connections work has targeted Burma refugees (Karen, Karenni, Chin, Kachin, Rakhaing, Burmese, Mon, Shan, etc.), Bhutanese refugees, Tibetan refugees and asylees, Nepali immigrants and asylees, Mongolians, Pacific Islanders, and Thai. Also, workforce, organizations and community.

Languages in which services are provided:
Burmese, Thai, Nepali, Tongan, Tibetan, Mongolian and English

Program scope:
Prevention and early intervention for targeted communities, individuals, families, children and youth

Program settings:
Services are provided largely at CHAA's Oakland office, in community settings, in homes, and at schools.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

General Project Overview:

The Asian and Pacific Islander Connections program (API Connections) is designed to help remedy a long-standing problem in Alameda County of the under-serving of API populations in Alameda County with respect to mental health services. According to the California Department of Mental Health Services data, APIs in Alameda County are 3 times less likely to utilize the County Mental Health system than the general population, with a penetration rate of 4.9% compared to 15.6% for Whites. And according to data provided by the Alameda County Behavioral Health Care Services, while 39% of the total population with SED/SMI is unserved, 65% of the API population is unserved. Based on community focus groups and surveys conducted in 2005 and 2007 with consumers, family members and other community members by ACMHS and CHAA, the underlying causes for APIs being underserved are cultural - the shame, stigma, and discrimination associated with mental health, and systemic – such as lack of cultural and linguistic services, lack of insurance coverage, and inappropriate services. These factors limit individuals and families to seek assistance from only the most trusted and familiar sources within their respective communities. Yet, the most trusted sources are often not trained to identify, let alone assess and handle the mental health and emotional disturbances of their constituents. Existing mental health programs have not adequately served these communities, and are not appropriately skilled or resourced to address their needs in a culturally competent way. Many of those in need believe that they will be misunderstood by service providers and judged wrongfully for cultural practices different than mainstream practices. Research and experience of API mental health providers support the need to intervene sooner as the majority of API consumers seeking help have struggled with their illness for years before getting treated. Persons with mental health issues need to be identified before they can be helped, and the proposed strategy is key to early identification.

The four-pronged components of the API PEI strategy – *Culture-Based Outreach*, *Culture-Based Mental Health Consultation*, *Cultural Wellness Practices*, and *Early Intervention* – are designed to address these barriers as identified by consumers and family members and other community leaders. By overcoming barriers to access for APIs, and because this is an integrated API strategy that links un/underserved community members with mental health services when available and appropriate, it also more effectively provide for early identification of PEI identified needs such as Impact of Trauma, Suicide Risk and First Onset. The strategy is to create bridges between API communities and mental health services by locating PEI services at trusted community sites routinely frequented by API communities and integrating PEI services into community services and activities. Community organizations receive consultation as partners in the continuum of outreach, referral, screening and assessment; in addition to receiving staff resources for education, development, support and counseling for youth and parents. Bilingual and bicultural mental health professionals and paraprofessionals, working with trusted community partners, ensure culturally competent services and strengthen linkages between community settings and mental health services.

Problems Addressed by API Connections

The API strategy increases the likelihood of successfully linking individuals identified through Outreach, Consultation, and Wellness Practices to mental health treatment in a number of ways. First, the strategies are embedded in viewing mental health in a holistic manner as body, mind, and spirit together as a system, which is in line with how API cultures see health. Stigma is reduced when treating and viewing mental illness in this manner. Second, co-locating mental health professionals and peer facilitators and integrating them in API community programs and activities promote trust and bonding with the community in a non-mental health setting. Individual participants who are perceived to need assessment and extended treatment for mental illness or emotional disturbance can receive mental health services in those co-locations, without having to go to a mental health agency.

Protective Factors API Connections Aims to Enhance

- Culture as a reservoir of positive and protective practices supporting individual, family and community wellness
- Healthy integration and strengthening bicultural identities
- Healthy intergenerational connections, reducing the harmful effects of growing gaps between youth and adults
- Greater sense of self-efficacy in knowledge of systems, services, and issues impacting health, mental health and wellness
- Stronger community institutions, including faith and community leadership, organizations, and greater collaboration and support

Risk Factors API Connections Aims to Reduce

- Stigma attached to mental health issues and services
- Cultural, generational and experiential gaps between young people and adults
- Disunity and division within communities
- Social, cultural and linguistic isolation
- Relatively weak and small community organizations
- Lack of trained, culturally competent workforce

Specific Goals of API Connections

Individual goals include:

- Reduced stigma attached to mental health services. Decreased feelings of shame.
- Increased knowledge and awareness of existing resources.
- Increased number of individuals receiving screenings for mental health disorders.
- Increased access to formal assessment and treatment at early onset of mental illness symptoms.
- Reduce family stress/discord.

Program goals include:

- Increased utilization with earlier assessment and intervention using traditional wellness practices, and reduction in the number of APIs who turn up as "severally mentally ill".
- Increase in the number of consumers, family members, community leaders and elders who are trained.
- Increase in referrals to culturally competent integrated services through collaborating agencies.
- Community organizations will have a formal process for identifying individuals, families with social, emotional, and behavioral issues.

Systems goals include:

- Increased ability to appropriately identify, refer, and/or serve API communities.
- The API community will have improved mental health status as they increase in knowledge of risk and resilience/protective factors, of social, emotional and behavioral issues, and mental health resources.
- Increase social supports for unserved APIs with MH needs.
- Increase in trained and supported workforce from target communities, with a shortened time for developing this workforce.
- Community-driven strategies for addressing health, mental health and wellness.

6. CULTURAL RELEVANCE

API Connections Strategies to Ensure Cultural Relevance and Responsiveness:

The **Culture-Based Outreach** component promotes wellness in the API communities and helps overcome stigma through outreach at community events and festivals; and by co-locating mental health professional Peer Facilitators and Community Wellness Advocates in community settings like health clinics, and community and faith-based organizations. Workshops led by program staff at these community settings empower individuals and families to contribute to their own wellness on a long-term basis. API Connections deploys Peer Facilitators (ACMHS) and Community Wellness Advocates (CHAA) to trusted community organizations and sites to: 1) conduct educational workshops on mental health issues and related topics to explain common responses to life stressors as conditions that can be helped through mental health services; 2) conduct group psycho-social educational talks where staff will visit existing community grown gatherings to organize group talks, mutual-support circles, and educational and mutual-interest groups; 3) produce Asian language educational materials to be used at the above meetings, at community events and with ethnic media such as newspapers, radio, television and for some communities, websites. Workshop and educational materials topics have included: 1) general information about mental health issues and symptoms; 2) educating parents to support their children's development; 3) the importance of seeking care early, rather than waiting for crisis; 4) removing the stigma of mental health; 5) how to access mental health and other services; mental health issues that impact older adults; 6) and helping families understand and bridge the cultural/generation gap. Workshops have also been conducted on historical and sociocultural topics, including trauma, immigration challenges and identity.

Cultural Wellness Practices. Peer facilitators and Community Wellness Advocates are deployed to trusted API community organizations and sites to work with individuals and families identified through the consultation process to create culturally appropriate personalized wellness plans that include accepted traditional healing practices and follow-up with the goal of supporting well-being in major life domains and to prevent escalations in mental health crises. Examples of community wellness practices in the API communities include youth gatherings enhancing cultural protective factors; psycho-educational model integrated with culturally-based activities (e.g. quilt project, gardening, cultural events and festivals, Polynesian dance, Tai Chi, etc.); and faith-based events, ceremonies with cultural themes, chanting, singing, poetry/spoken word, drumming, dancing, traditional arts and crafts, and so forth. These wellness-based alternatives include, where appropriate, access to community wellness practices conducted by community-based providers, institutions, and faith healers (shamans, priests, pastors, etc.). These practices address the needs of individual and families as a whole, and build their relationship to the community's resources and services, thereby using the community's own assets and social wealth.

Culture-Based Mental Health Consultation extends the pool of mental health human resources to include staff and volunteers at community social service providers and in the community. Group trainings and individualized consultation enable these staff and volunteers to become partners in helping identify, assess and refer individuals and families who need mental health services, while at the same time allowing for developing culturally-informed

counseling strategies. The community empowerment process also includes a resource and referral guide that is made available online; and coordination and connection with other County-run and County-sponsored initiatives. Consultation links mental health professionals with trusted leaders, elders and staff at trusted organizations to identify at-risk individuals before they reach an acute phase, support them in crisis resolution, and increase their mental health and improve functioning. As staff can only reach and identify a small number of at-risk individuals in each community, a resource guide is being developed and made available to the members of the community with relevant information to specific API populations. On-line consultation to providers will also be available including making available materials and resources as reference material for Consultants and for quick access for giving workshops and presentations, creating handouts and articles, etc. Also, screening tools for mental health issues are readily available.

Early Intervention services include short-term counseling based on individualized wellness plans, and are available to individuals showing signs of onset of mental health issues, those going through crises, and individuals and families who need ongoing support in one or more life domains. Program staff can also provide linkages to the County mental health system of care if available and other community resources for individuals and families with more complicated issues and needs. Multi-dimensional models for early interventions include family interventions, peer support, afterschool programs, parenting classes and support groups, and short-term counseling and therapy by culturally competent providers and practitioners that fit the culture and structure of families in the respective communities, and referrals and linkages to established mental health system programs and agencies.

The program adopts a strength-based approach that identifies and promotes the unique strengths of cultures, individuals, families and communities. Workshops and consultations reinforce the communities', consumer's and family members' strengths, resources and coping skills. In addition, the use of cultural wellness practices is grounded in the beliefs, values and traditions of the diverse API populations in Alameda County and promotes prevention and overall wellbeing.

Concrete benefits of the program include: 1) increased level of prevention and early intervention services for API individuals and families; 2) increased knowledge of API community of wellness practices and awareness of existing resources, and decreased stigma attached to mental health services; 3) increased capacity of API community to meet mental health needs, including more knowledgeable service provider staff, better coordination of community providers, and availability of culturally grounded educational materials (including online materials); and ultimately 4) increased access to mental health services by APIs in Alameda County to impact the core issue of Asian and Pacific Islanders being underserved.

Special Features of CHAA's API Connections Model

Community-Based Processes. CHAA engages the targeted communities through a combination of Community-Based Participatory Research (CBPR) and Popular Education in analysis of root causes (upstream analysis) for issues impacting individual, family and community wellness, and to engage in co-design of actions and strategies to address these issues in partnership with the communities themselves, while identifying solutions that focus on policy and structural change. CBPR has been recommended as an effective approach for reaching, strengthening and empowering marginalized immigrant and refugee communities, and other communities with significant health needs. CHAA has developed a palette of CBPR methods, popular and empowerment education modules designed to address issues related to social justice and health disparities, and to move dialogue within and between communities to deeper levels of understanding, helping communities analyze issues with attention to finding root causes while moving actions to proactive and preventive strategies. If needed, communities are supported in leading community research that gathers the information needed to move action toward addressing root causes. The approach is empowering and moves communities to deeper levels of understanding and change at policy and systems levels.

CBPR allows for the development of interventions from the ground up and in full partnership with community

members. Through participation in needs assessment and popular education, community members bring their life experiences to the process to more accurately identify the unique texture of issues in their community and root causes of those issues, increasing the likelihood that interventions will affect structural changes that benefit the community's overall health and wellness. Involvement of community members establishes the critical link between research and action or practice because community members buy in to a process that involves them from the beginning and they are in a better position to apply findings to actual practice and disseminate those findings. In addition to CBPR, CHAA also will utilize popular education to engage community members more fully in the process of understanding community-identified issues and implementing interventions to address them, and to help communities develop a collective analysis based on the life experiences of those involved in the program. Popular education is a form of political education that uses a framework of action and reflection to lead toward collective social changes that are empowering to the community. Based on the principles and philosophy of Paulo Freire and liberation struggles of marginalized and excluded peoples, it is typically used to develop a collective analysis based on the life experiences of those involved in a project, and promotes participation, interaction, social action, and critical thinking skills of analysis. Popular education provides the methods, tools, and theory needed to help groups of people understand their experiences within a social and political context, and move from blaming themselves to having a perspective on the environmental and structural causes of problems they face, allowing for the development of approaches that address these root causes as well as enhancing community members' confidence and abilities to affect positive change on their own behalf.

We feel that the approach to community-led needs assessment using CBPR and Popular Education 1) matches the communities' levels of readiness to address pressing issues, and; 2) helps create knowledge through CBPR with communities for which there is little, if any, available data due to their small size, newness to Alameda County, and relative invisibility to most systems and services they encounter. CHAA has experience trying to adapt existing best and promising practices for use with API communities, and based on this experience recognizes that they often require changes that ultimately undermine program fidelity. Moreover, there are very few existing best and promising practices that have been validated for use with any API communities, much less for communities new to the US. Mainstream approaches do not account for differences in language, culture, education, health practices and world views that will be critical to successful, healthy integration and effective programs that address issues faced by this community.

Environmental Strategies. We dedicated the first year of the project to community-based processes and alternative programming and activities, with the intent of beginning environmental strategies moving forward. Year one has laid the foundation for communities to formulate actions that can be translated into environmental strategies, as well as bring communities with challenges in common and with experiences of effective community-level change together to share, learn from each other, and build partnerships. Engaging communities in changing environmental factors impacting their health and wellbeing is a long-term strategy of empowerment, increasing community critical skills, and improving their sense of efficacy in addressing issues important to them. We feel that empowerment is a long-term protective factor.

Alternative programs and activities. API Connections develops and supports alternative programs and activities for youth and families in targeted communities. Settings such as community gardens, women's arts and crafts groups, and youth tutoring and activity groups are some examples. Inter-generational activities and groups are also preventive in the communities targeted for this project, and may include, for example, cooking and eating, storytelling, and language learning settings. We also support planning community events and conduct outreach and needs assessment through these events. Examples of these events include community New Years, cultural celebrations, health and wellness fairs, and community meetings.

CBO/Community Leadership Development, Conflict Resolution and Capacity Building. In CHAA's API Connections program we have invested resources directly in providing leadership development, conflict resolution and

capacity building support for small partner agencies from target communities. Partners include: Bhutanese American Community Center; Bhutanese Community in California; Burma Refugee Family Network; Karen Culture and Tradition Committee; Burmese Youth Association; Tibetan Association of Northern California; One Love Oceania; Ger Youth Center; and Mongolian Student Non-Profit Organization in America. Additionally, we make project resources available to the Sri Lankan refugee community, which has no agency presence currently, and is resettled primarily in Alameda County. API Connections has also been deeply engaged in the work of the East Bay Refugee Forum.

Community Helper Training and Consultation. Many of the communities engaged by API Connections have limited workforce, with a large amount of service navigation and case management being done by volunteers from their respective communities. This volunteer community helper workforce has little support, putting them at risk for burnout, boundary issues, vicarious trauma, and access to quality information and approaches to working in their communities. Individuals who are placed at area organizations find that they become inundated with requests for assistance, often beyond the scope of their assignments at their organizations. Additionally, very few people from the target communities consider careers in mental health, meaning that communities may not have a workforce for this work for many years. CHAA's community helper training series addresses these needs, providing training in best practices, support, consultation on how to do the work more effectively and minimizing negative impacts, while preparing people to pursue working in mental health and wellness fields.

History of the development of this program, and input from the community in the design and/or evaluation of the program

API Connections was developed as part of Alameda County Behavioral Health Care Services' MHSA Prevention & Early Intervention strategies planning for Underserved Ethnic and Linguistic Populations (UELP). UELP projects were designated for five un- and underserved communities, including Afghan, South Asian, Native American, Latino/Hispanic and Asian/Pacific Islanders (API). Community Health for Asian Americans (CHAA) and Asian Community Mental Health Services (ACMHS) submitted a joint proposal to serve API communities, with ACMHS serving designated "underserved" communities and CHAA serving designated "unserved" communities. The program design was based on feedback from community focus groups and surveys conducted in 2005 and 2007 with consumers, family members, other community members, and providers by ACMHS and CHAA, who identified underlying causes for APIs being underserved and suggested strategies for addressing this complex issue, and through input from a task force that met across several months to refine the approach. CHAA also engages the targeted communities through a combination of Community-Based Participatory Research (CBPR) and Popular Education in analysis of root causes (upstream analysis) for issues impacting individual, family and community wellness. The action-reflection cycle is ongoing in our program design, with co-design of actions, approaches and strategies to address these issues in partnership with the communities themselves being at the heart of the model.

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

1. NAME OF PROGRAM:		
Asian Youth Prevention Services (AYPS) Program		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Japanese Community Youth Council
Contact: Ramon Calubaquib, Program Director
2012 Pine Street
San Francisco, Ca 94115
Phone #: (415) 202-7941
Fax #: (415) 921-1841
Email: rcalubaquib@jcyc.org

4. TARGET POPULATION

The Asian Youth Prevention Services (AYPS) program target API youth who are experiencing significant transitional periods in their lives including transitioning from elementary school to middle school and transition from childhood to adolescences. In addition, youth who have experienced the transition of immigration are a priority population for the program. The program utilizes recognized ATOD prevention strategies to deliver prevention activities. The program has the language capacity to serve immigrant youth with the following languages: Mandarin and Cantonese, Tagalog, Vietnamese, and Samoan. The program's primary target population is middle school age youth, young men and women ages 12 to 16 year of age as well as youth whose sexual identification is LGBTQ.

AYPS serves San Francisco API youth citywide, but also target neighborhoods and schools with large populations of API. Current middle schools served by AYPS and the percentage of API youth includes Bessie Carmichael (56%), Francisco (64%), Hoover (42%), James Denman (42%), Presidio (46%), Roosevelt (65%), and Visitacion Valley (39%). Current high schools served by AYPS and the percentage of API youth include Washington (59%), Newcomer (57%), Galileo (67%), and Balboa (54%). Services are provided at school sites as well as the program sites of the AYPS consortium members. These neighborhoods are located in the following neighborhoods: Chinatown (94109), Tenderloin (94102), South of Market (94103), Western Addition (94115), Outer Mission (94112), Visitacion Valley (94134), Sunset (94122) and Richmond (94118 & 94122).

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Through a collaboration of six (6) community-based agencies that provide an array of culturally competent primary prevention services, the goal of the Asian Youth Prevention Services (AYPS) program focuses on preventing, delaying and/or reducing the use and abuse of alcohol and other drugs (AOD) among Asian youth in safe and welcoming environment.

The program utilizes a curriculum based approach that support family communication, encourage positive peer relationships, discourage engaging in risky behaviors, organize healthy activities and support cultural traditions and values. The program also enhances and reinforces positive cultural norms and organizes community service activities that support the diverse API community of San Francisco.

The program aim to reduce unhealthy behavior that may lead to family conflicts, delinquency, gang involvement, truancy, dropping out of school, and isolation from friends and family. The program aims to increase the skills of participant to enable them to live a healthy lifestyle and be productive members of their family and community.

Each partner agency is well established in their respective community and is well connected to their respective target population and schools. Services are provided at each of the respective agency site and at targeted school. Partner agencies also have established a long working relationship with targeted school enabling them to provide services at school site and have been welcomed each school year. Youth are recruited through referral from teachers and the school's counseling staff. Youth participating at agency sites are recruited from the community and referred by programs. Depending on the partner agency's target population, bilingual/bicultural services are provided unless the agency's target is recent immigrants and are provided in specific languages. For the current program, Asian American Recovery Services (AARS) provide services to a multi-ethnic population, while Community Youth Center (CYC) provides services in Cantonese for recent immigrant youth. The Filipino Community Center (FCC) provides bilingual/bicultural services along with the Samoan Community Center (SCDC) and the Vietnamese Community Development Center (VYDC). Each agency target schools where there is a large population of their respective target group. Example is CYC provide services at Marina Middle School with a large immigrant Chinese population as well as on-site at their agency while SCDC target Martin Luther King Middle School with a large Samoan student population.

6. CULTURAL RELEVANCE

The program subcontracts services to each members of the AYPS partnership. Each of the partners is well established in their respective API community and has long history of serving their respective population. They have demonstrated effective outreach and recruitment to the target population and have the cultural and language capacity to engage youth and families needing services. Each agency has the capacity incorporate language, traditions customs and beliefs in implementing the program curriculum to make it relevant to the program participants as well as engage youth in identifying potential conflicts with American norms and values.

The program has been in existence since 1997 and has been supported by the San Francisco Community Behavioral Health Services. Each of the partner agency's executive staff is a member of the AYPS Consortium that acts as the advisory body of the program. Staff of the program meets on a regular basis to review, plan and evaluate the program. Youth participants evaluate program activities and provide recommendations to program services.
Part of the curriculum identifies cultural norms that reinforce positive norms. Youth are engage to participate in identifying positive norms specific to their cultural and its importance to them and their culture. Youth also participate in alternative activities that celebrate cultural festivities. An example is the celebration of Tet and Chinese new Year and what it means to the community. Agencies also engage youth to participate in community events such as the Chinese Dragon Boat Race and Moon Festival, Tet Festival, the Pistahan, and Samoan Flag Day. JCYC has established Funfest which celebrates a weekend of AOD free activities and entertainment for the whole family. Agencies also incorporate ethnic dances into the program as part of their alternative activities and are also able to

perform in the program's annual cultural day celebration and other organized multi-agency events such as the annual API Youth Summit in San Francisco.

The program incorporates historical context to reinforce cultural norms and values as well as provide an understanding of the multi-cultural diversity of San Francisco and American.

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

1. NAME OF PROGRAM:		
CARE: Center for Addiction Recovery and Empowerment		
2. TYPE OF PROGRAM:	X	Universal prevention
	X	Selective prevention
	X	Early intervention
	X	Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Asian Americans for Community Involvement (AACI)
400 Moorpark Ave., Suite #300
San Jose, CA 95128
Tel: 408-975-2730

4. TARGET POPULATION

- All individuals and significant others of all ages affected by Problem Gambling (PG). All individuals and significant other in the greater San Jose area affected by PG are eligible to receive services under CARE.
- At present staff capabilities for service provision include Cantonese, English, Hindi, Mandarin, Punjabi, Spanish, Tagalog, Taiwanese, Toishanese and Vietnamese.
- Individuals directly affected by PG are highest need target population. Significant others of these affected individuals are also eligible as family conflicts, couple conflicts, and an entire host of behavioral health issues are affected by one PG member.
- Individuals living within the City of San Jose are most affected but also all residents in Santa Clara County who frequent the two cardrooms in San Jose.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- Problem Gambling (PG) is an invisible epidemic which encompasses various domains of healthcare, social services and the legal system. CARE addresses PG from multiple perspectives. It attempts to outreach and educate the community at large about the signs and symptoms of PG, avail treatment and support services available for individuals and significant others affected by PG, educate and train gaming establishment workers, law enforcement and behavioral health clinicians and/or clinicians in training about PG. CARE also has CA Office of Problem Gambling approved licensed, multilingual, multicultural and multidiscipline behavioral health clinicians ready to provide brief Cognitive Behavioral Treatment to individuals directly affected by PG and their significant others. In the area of Youth Prevention Services, CARE is collaborating with CA Friday Night Live to develop outreach, educational and prevention materials targeted at youths on the effects PG can have on them and their families. Youth oriented projects include developing a youth led video and public service announcements.

- Some of the protective factors this program aims to address include maintaining family harmony, unity and support, education and support to significant others in identifying signs and symptoms of PG and available treatment and support resources available to their family members affected by PG. Family members and significant others can also receive treatment themselves to address the indirect effects of PG by the loved one in their family.

- Some of the risk factors this program aims to reduce include the on-going addictive and impulsive behaviors of the PG individual, the dire financial consequences on the family and significant others; homelessness, co-occurring disorders of physical, mental and substance abuse etiology, most importantly suicide. Some studies have found PG to have a higher rate of death as a result of suicide as compared to the general population.

- Through working in a consortium and building on cardrooms' existing problem gambling programs, our agencies will accomplish the overall goal of reducing the negative consequences of problem gambling and promoting responsible gaming among greater San Jose adults and seniors. Our consortium includes Asian Americans for Community Involvement (AACI) as the lead agency, in collaboration with Asian American Recovery Services (AARS), Breathe California of the Bay Area, and UCLA's Gambling Studies Program (UGSP). Together, we seek to provide a comprehensive strategy that addresses all three service areas of capacity building, education and awareness, and intervention. In the area of *capacity building*, we will continue working to increase the number of certified problem gambling counselors through the state Office of Problem Gambling and the number of trainings held locally for interested qualified service professionals. We will also increase the number of support services that are offered to problem gamblers and concerned significant others (CSO). In the area of *education/awareness*, we will implement an array of grassroots, multi-media, and research-based strategies to increase awareness of problem gambling and services available to greater San Jose residents. In the area of *intervention*, we will recruit problem gamblers and CSO for treatment in order to reduce negative gambling-related impacts, and also refer clients in need to additional support services such as financial counseling, mental health counseling, substance abuse treatment, tobacco cessation, and domestic violence services. As noted in the Cardroom Charitable Contributions Allocation Plan, we recognize that Asians comprise a large percentage of the San Jose cardroom clientele and have higher rates of gambling disorders than the general population. Our consortium specializes in providing linguistically and culturally appropriate services for Asians, and also for Hispanic/Latinos and other groups at risk for problem gambling.

6. CULTURAL RELEVANCE

- To date outreach strategies include participating in existing community health fairs and cultural celebrations, community educational forums and/or other opportunities, ethnic media (radio, TV, newspaper), mainstream media (cable TV), professional education and outreach opportunities, graduate clinical training program outreach and educational opportunities, outreach and education to law enforcement, judiciary, and gaming industry personnel. Materials used to outreach to specific cultural populations have been translated produced and translated by the Office of Problem Gambling (e.g. Chinese, Vietnamese, Tagalog, Spanish, Korean). Materials aimed at specific populations for which translated materials are not available, CARE staff will translate (i.e. Japanese).

- Outreach materials and engagement approaches have taken much cultural sensitivity, respect and approaches to engage without offending or shocking the target cultural group focused on at the time of the outreach, education and/or treatment. Materials used to outreach to specific cultural populations have been translated produced and translated by the Office of Problem Gambling (e.g. Chinese, Vietnamese, Tagalog, Spanish, Korean). Materials

aimed at specific populations for which translated materials are not available, CARE staff will translate (i.e. Japanese). Given that the treatment community is overall small, consultation with statewide, national and international PG service providers have led to encouragement and allowances for CARE to utilize shared effective and proven strategies, outreach materials, marketing themes and engagement protocols used by statewide, national and international PG service provider partners.

- Cultural elements regarding mental health and well-being are incorporated via culturally sensitive and respectful approaches to engage target populations without offending or shocking them during outreach, education and/or treatment. Terminology, culturally appropriate metaphors, and communication styles are highly salient factors considered by the culturally and linguistically specific CARE staff member providing outreach, education and treatment services to the identified PG individual, significant other and community member. CARE has 13 licensed bilingual and bicultural clinical staff who have been approved by the Office of Problem Gambling to engage and treat individuals who may primarily speak Cantonese, Japanese, Mandarin, Hindi, Punjabi, Spanish, Tagalog, Taiwanese, Toishanese and Vietnamese. These licensed clinicians have been practicing in their respective communities for many years and are trusted cultural brokers. Given that the treatment community is overall small, consultation with statewide, national and international PG service providers have led to encouragement and allowances for CARE to utilize shared effective and proven strategies, outreach materials, marketing themes and engagement protocols used by statewide, national and international PG service provider partners.

- Given that the treatment community is not overall small, consultation with statewide, national and international PG service providers have led to encouragement and allowances for CARE to utilize shared effective and proven strategies, outreach materials, marketing themes and engagement protocols used by statewide, national and international PG service provider partners.

- On-going consultation with collaborative partners, statewide coalition, and AACI wide Behavioral Health Department's culturally competent staff, provide for CARE staff with much consultation opportunities to ensure sensitivity to cultural and historical factors affecting each of the PG service recipients. CARE staff also has been carefully selected to culturally and linguistically match the target populations being served.

- Prior to the formal Request For Proposal (RFP) process, the City of San Jose settled with the two existing cardrooms to set aside funding for a non-profit service organization to address the needs of individuals and significant others affected by PG. In this light, the City of San Jose representatives, organized a series of community forums in consultation with NICOS, an organized collaborative of mental health and social services providers in San Francisco providing PG services to the Chinese population for well over a decade. As several of these community forums ensued, different constituents shared their concerns and needs regarding the services to be developed and RFP to address PG issues. After almost a year of planning and community forums, the RFP came out and the collaborative lead by AACI was awarded the contract.

- The consortium led by AACI has experience in providing capacity building services specific to problem gambling. UGSP is currently conducting four statewide trainings with the state Office of Problem Gambling to train licensed clinicians through the California Gambling Treatment Services Program. The first training session was completed in November 2009 in San Francisco. AACI has partnered with UGSP to provide continuing education units to licensed psychologists who complete any of the four certification trainings through the California Gambling

Treatment Services Program.

- In April 2009, AACI helped sponsor the 2009 Northern California Problem Gambling Regional Summit in Oakland, CA, attended by close to 60 participants. In June 2009, AACI worked with NICOS Chinese Health Coalition to co-host the first ever South Bay problem gambling training workshop, which trained over 20 South Bay service providers. Most of the training participants reported increased awareness about problem gambling.

- The consortium is also currently working with NICOS and the statewide Problem Gambling Technical Assistance and Training Project (funded by the state Office of Problem Gambling) to plan a Problem Gambling Summit in San Jose for up to 100 local participants in late January 2010. The purpose of the summit was to promote greater awareness and interest about problem gambling among service providers, and to increase subject matter expertise in the greater San Jose area. The summit was also an opportunity to announce the launch of problem gambling services in greater San Jose.

- AACI, AARS, and Breathe CA participated in the cardroom allocation plan workgroup in 2009, demonstrating our strong commitment to building the capacity of the local community to address problem gambling. AACI has also been approached by Santa Clara Valley Health and Hospital System's Mental Health Department (MHD) and Department of Alcohol and Drug Services (DADS) Learning Institute to develop and provide training on problem gambling to the professional staff of both departments.

- AACI's CEO is approved as a Problem Gambling Technical Assistance and Training consultant by the state and has conducted outreach at one September 2009 community health fair in San Jose. This health fair attracted over 200 community members, and AACI distributed multilingual problem gambling educational materials developed by the state Office of Problem Gambling.

- The consortium has experience in providing services for the treatment of problem gambling. Dr. Timothy Fong, Co-Director of UGSP, also directs the UCLA Impulse Control Disorders Clinic. This outpatient clinic provides treatment for pathological gamblers and their families. Services included consultations, diagnostic assessments, pharmacological management, individual psychotherapy, and family therapy. To date, UGSP is the only such recognized treatment and research facility by the state's Office of Problem Gambling. UGSP also has experience evaluating treatment programs, as evidenced through its long list of publications (www.uclagamblingprogram.org/publications.html) and will bring expertise in evaluating patient outcomes, counselor performance, and longitudinal treatment effectiveness to greater San Jose.

- AACI and AARS have over 50 counselors who serve clients for mental health, substance abuse, and domestic violence issues, and many of these same clients also experience problem gambling issues in their family. Having a more formalized and systematic evidence-based, ongoing training program for effective treatment of problem gambling will improve the effectiveness of our work in greater San Jose.

7. ADDITIONAL INFORMATION

Activities conducted in the areas of capacity building, education/awareness and intervention include:

A. Capacity Building. The collaborative consortium will work with local and state entities to complement existing efforts and to build local capacity to address PG. Needs assessment is accomplished by researching the extent of PG in

greater San Jose by reaching out to the community, collecting data, and analyzing community needs including prevalence, identify communities at risk, and raise awareness about problem gambling. The number of licensed gambling treatment professionals will be increased. The consortium will develop and conduct ongoing training for local health and social service providers and community lay health workers, focusing on methods for prevention, identification, and treatment of gambling addiction.

B. Education and Awareness. Using information gathered in the community-based research to develop effective, targeted education and awareness strategies, the consortium will educate the greater San Jose community about problem gambling and the existence of new services, with a strong emphasis on education and awareness activities in year one of the grant. Education and awareness campaigns for the general public and target populations will address signs and symptoms of problem gambling, disruptions in everyday family communication and family harmony, negative financial and employment consequences, availability of service providers and referral processes, overall health and well-being consequences of problem gambling, strategies for responsible gaming, and other topics of interest based on the community focus groups. Specific education and awareness strategies will include: *1) A lay health worker project.* Consortium members will build upon their successful lay health worker projects in the San Jose Asian, Hispanic/Latino, and African American communities to recruit well-respected local individuals for training about problem gambling and local services available to help. These "lay health workers" will then train their friends and neighbors about what they have learned. *2) Local media outreach.* Through long-established ethnic media partnerships and using existing multilingual public service announcements, the consortium will reach more than 100,000 people, relying heavily on the culturally preferred mediums of radio and newspapers. Consortium partners will produce weekly radio shows and at least two problem gambling awareness segments on their existing weekly cable TV show. *3) Promotion of problem gambling helplines and the cardrooms' existing responsible gaming programs.* The consortium will promote utilization of 1-800-GAMBLER and the NICOS' 1-888-968-7888 Chinese problem gambling helpline, with a goal to increase the number of (408) area code participants. The consortium will work with hotline providers to encourage referral of greater San Jose callers to San Jose treatment providers, and it will launch a local 408 area code hotline if needed. The consortium will also educate the community about the cardrooms' existing responsible gaming initiatives, such as self-exclusion.
4) Information clearinghouse. AACI will house a library of information related to problem gambling, including treatment providers, training materials, policy papers, program evaluations, and research articles with a goal of serving up to 200 individuals in person, over the phone, or online. This clearinghouse will be open to other service providers funded by the cardrooms, as well as to the public. *5) Forums, theater, and outreach events.* The consortium will conduct problem gambling outreach in multiple languages at local health fairs, community centers, cultural events, and college campuses and use multilingual brochures developed by the California Office of Problem Gambling. Consortium members will incorporate problem gambling education and outreach into their many established community activities such as parenting workshops, support group meetings, and innovative nail salon worker outreach sessions.

C. Intervention. The licensed clinicians in the consortium who have been approved through the California Gambling Treatment Services Program will play a lead role in implementing intervention services. The consortium will also utilize non-licensed, master's level paraprofessionals (supervised by licensed clinicians) as additional clinical support to treat problem gamblers and their significant others. Community lay health workers will also identify, motivate, and recruit problem gamblers and their CSO to seek treatment and support services.

- All these elements are important because PG services have never been provided in the greater San Jose area and if

affects multiple domains of the individuals and their significant others' live domain (physical health, mental health, substance and addictive disorders, financial, employment, social, and legal).

- No such curriculum has been manualized to date that we are aware of. The core components of this program (needs assessment, outreach, education and treatment) have been modeled separately and in some combination in other existing programs but not to the degree of inclusiveness as the CARE and the collaborative alliance model.

- As each individual case is different in terms of their level and type of service needs, once engaged, and a full intake assessment is completed, the individualized and collaboratively developed treatment plan will indicate the type and intensity of services needed (e.g.: clinical, employment, financial, case management, education and support, etc.). Each staff fulfills a particular service role within the continuum of care provided in the program ranging from outreach and education, direct clinical services, case management, advocacy and support. Frequency and length of engagement, treatment sessions and case management encounters is highly dependent on the level of acculturation and understanding, motivational level, and commitment each individual has toward engaging the services provided. Best determination for the number of cases per staff is currently unknown as it is a new service being availed to the community. Unlike traditional mental health and/or substance abuse treatment caseloads, PG afflicted individuals are much more challenging identify as PG is invisible, stigmatizing, and in many ways socially accepted and tolerated to near pathological stages.

- For example, in the cases where referrals come from the PG trusted family member, ensuring confidentiality and assistance from the referring family member is key. On the one hand, the individual's right to privacy needs to be respected while simultaneously engaging the supporting family members in a systemic treatment approach is instrumental to the successful treatment outcome of the affected individual. The clinician's cultural understanding of expectations, face value and shame factors can also help to incorporate culturally specific narrative strategies to exemplify the behavioral changes and treatment concepts introduced in treatment. This is cultural competence process is a key foundation to the success of PG treatment with this particular AAPI population.

- This program can be well replicated with sufficient funding and the availability of a wide range of professional expertise including behavioral healthcare, multilingual and multicultural capacities, , outreach and community education, collaboration with graduate clinical training institution, administrative support from local government, and dedicated staff members (professional, peers, family members and volunteers).

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gambling will improve the effectiveness of our work in greater San Jose.

- CARE has 13 licensed professionals (LCSW, LMFT and Licensed Psychologists) approved by the California Office of Problem Gambling who are able to speak Cantonese, English, Hindi, Mandarin, Punjabi, Spanish, Tagalog, Taiwanese, Toishanese and Vietnamese. Currently 2.5 FTE Community Liaison are responsible for coordinating outreach, education and support activities for the program. One .5FTE Research Coordinator, 1 FTE Program Manager overseeing the program and coordinating the other collaborative partners' activities, reporting functions and service deliverables. Collaborative partner agencies maintain their own internal operating structure. Caseloads are dependent on each collaborative agency partner's outreach efforts to their targeted populations.

- Outpatient community multiservices provider is the best suited setting for this type of model. Integrated primary and behavioral healthcare, case management, education and advocacy, community outreach and education, and collaboration between ethnic specific and refugee focused community partners is also a key to stigma reduction.

- The program is currently in its 2nd of a 3 Yr grant and the evaluative component rests with UCLA's UGSP. An initial community needs assessment developed by UGSP was utilized in a multilingual community focus group process to determine the level of knowledge diverse language and cultural communities (Chinese, Vietnamese, Spanish, Tagalog, mixed English) had about PG signs and symptoms, prevalence and available resources. Participants in this pilot process were 100. Data analyses showed that overall community members had little knowledge of PG symptoms, prevalence and community resources. Most focus group participants knew of someone and/or someplace in their community where gambling was done but most reports were anecdotal. Currently a 2nd community needs assessment is being developed to be conducted about one year post initial needs assessment; comparisons will show effectiveness of YR1 of project. Goal for YR2 community assessment is 1,000 participants. Data analyzed will be shared with local, statewide, national and international collaborative PG partners.

- *Contact information:*

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- AACI's Board, management and agency wide staff accurately reflects the culturally diverse AAPI population served across its wide array of health and human service lines. AACI is the largest community-based organization

dedicated to serving Asians in Santa Clara County. AACI works with more than 12,000 individuals every year, predominantly low-income Asian immigrants and refugees. AACI has an active board of diverse community leaders.

- Asian Americans for Community Involvement (AACI) is Santa Clara County's largest community-based organization focused on the Asian community. Our mission is to improve the health, mental health and well-being of individuals, families and the Asian community by (1) providing an array of high quality health and human services, (2) sharing expertise about the Asian community's needs and best service delivery practices, and (3) providing Asian leadership in advocating on key health and human services issues.

- Asian Americans for Community Involvement has long been recognized for the excellence in services we provide to the community, but now AACI is also recognized as one of the top places to work. Bay Area News Group has chosen Asian Americans for Community Involvement as one of the Top Workplaces of 2011. Based on a survey with 109 participating companies, in which 16,249 employees rated their respective companies, AACI was ranked 17th in small companies in the Bay Area. This prestigious honor was bestowed upon AACI after careful deliberation of the ratings that AACI staff gave for its management, mission, and general satisfaction with work conditions. AACI scored consistently high in these sectors. The results of the survey were based solely on the input of employees. The "small companies" category consisted of companies with fewer than 150 employees. Of the companies that were considered for this recognition, AACI was one of only two non-profit organizations honored with this award. Other companies that were honored included The Container Store, Ask.com, Tivo Inc., and Hitachi. AACI is honored to be recognized by Bay Area News Group for its commitment towards fostering staff development and nurturing careers. (*June 28, 2011, see agency website at www.aaci.org)*

- Staff in the Behavioral Health Department receive on-going internal professional training pertaining linguistic and culturally diverse the clinical population we serve. The Santa Clara Valley Health and Hospital System's Learning Institute avails on-going professional trainings for the MHD and Department of Alcohol and Drug Services (DADS) which all staff are encouraged and welcome to participate. In addition, all professional track staff, interns and trainees are constantly encouraged to pursue professional development opportunities related to their particular job functions and budget permitting. Staff and interns are encouraged to participate in all agency wide activities and functions.

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- In 1973, a group of citizens of Santa Clara County gathered to express discontent and share common concerns about their experiences as Asian Americans. These community leaders founded an organization committed to the belief that diverse members of the euphemistically labeled "Quiet Minority" could unite, that their individual experiences and strengths could combine to advocate for the betterment of all Asians.

- It's not uncommon for Asians and other minorities to feel uncomfortable seeking and receiving services due to language and cultural barriers. The team of multicultural and multilingual professionals at AACI works to bridge these gaps through an array of services and programs in health, recovery, advocacy, shelter and community. The AACI team includes the following specialists: physicians, psychiatrists, psychologists, social workers, marriage and family therapists, teachers, health educators, and domestic violence prevention specialists.

- Please refer to our website at www.aaci.org for additional information and history.

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

1. NAME OF PROGRAM:		
Center for Healthy Independence (CHI)		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Asian Americans for Community Involvement (AACI)
2400 Moorpark Ave., Suite #300
San Jose, CA 95128
Tel: 408-975-2730

4. TARGET POPULATION

- CHI focuses on the co-ed adult and older adult populations of Asian Americans Pacific Islanders (AAPI) who are Severely Mentally Ill (SMI) and presently receiving Specialty Mental Health Services (MHS) from AACI's mental health contract through Santa Clara County Mental Health Department (MHD). Primary ethnic and cultural groups include Cambodian, Chinese (Cantonese and Mandarin), Tagalog, Vietnamese.
- Languages provided: English, Cantonese, Mandarin, Tagalog, Vietnamese and Cambodian.
- CHI is intended for current AAPI SMI populations who are stable in outpatient MHS who are socially and culturally isolated as a result of the SMI.
- Program is intended for people in outpatient, urban, community mental health setting.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- Program aims to prevent or address cultural and social isolation of AAPI SMI co-ed adult and older adult populations.
- AAPI cultural similarities in practices and beliefs are utilized to bring a diverse group of AAPI SMI adults and older adults together and collaborate on positive, creative, and enjoyable social activities.
- Risk factors this program aims to reduce are social and cultural isolation, mental illness stigma, dependence on care taker(s), low physical activity and mobility, and lack of interpersonal interaction opportunities.
- Specific goals this program aims to achieve are:
  1. Reduction of culturally enhanced mental illness stigma among peers and MHS provider(s).
  2. Normalize and incorporate the acceptance of stable and functioning SMIs with working professionals (licensed mental health staff, support staff, other departmental staff and interns) through cultural inclusive activities (teaching cooking and tasting of food, shared jewelry making, cultural celebrations). Bringing agency staff and consumers to celebrate shared cultural celebrations often helps reduce existing stigma and social interaction barriers.
  3. Increase opportunities to socialize with peers and similar minded AAPI peers.
  4. Decrease social and physical isolation for AAPI SMI adults.

5. Learn useful life skill while increasing meaningful daily activities.
6. Generalized meaningful and useful life skill and activities with immediate family and friends.
7. Peer led and planned activities such as cooking, crochet, jewelry making, learning to use the public transportation system, shopping at ethnic supermarkets and cultural celebrations with history and education components—to name a few, allow consumers to utilize their time effectively while also being assessed on their functional skills by staff.

6. CULTURAL RELEVANCE

- Outreach strategies have included the use of flyers translated in various languages. Much time was initially spent educating and informing clinical staff and/or case managing staff as to the relevance of these CHI activities in the continuum of care provided within the MHS. Having the CHI coordinator outreach personally to staff and ethnic groups has been vital to convince of the relevance and positive impact of CHI on their consumers' recovery process. As efforts mounted to meet the initial resistance of the staff, the support and directives from the department top management was necessary to elicit staff participation and enlisting of qualifying clients. As time passed and consumers were observed to benefit, learn and improve on their socialization skills and interpersonal relationships, professional staff members have been more willing to participate and join activities more frequently when their clients are participating in CHI activities.

- Peer planned and led activities are often culturally and traditionally specific per ethnic and linguistic AAPI group. As participating staff and consumers see and/or hear of similarities, invitations to join groups have been made, especially when bilingual and bicultural staff members are available. During larger cultural celebrations, all CHI participants from different ethnic groups are included. Participating mental health staff members assist in the translations and encouragement of cross ethnic group interactions. During special interest groups where an activity specific is being performed, groups have been smaller and/or mixed depending on individual interest and ability to communicate and understand instructions from the group activity leader(s).

- All MH concepts on recovery and well being are related to culturally specific and acceptable beliefs of health and wellness. All AAPI participants in CHI share the cultural beliefs that a mentally healthy individual need also to be physically healthy, eating healthy and having a healthy support network. All concepts held by members of the AAPI participants in CHI are very much aligned with the Wellness and Recovery philosophy and concepts. Therefore Wellness & Recovery is excellently suited and matched for CHI.

- All AAPI members of CHI share multiple parallels in their immigration process to the U.S. Many share war trauma, social and cultural isolation, limited English proficiency, racial discrimination from mainstream culture, poverty and layers of cultural stigma for being MI and of particular cultures where often times the belief in karma presents as a barrier to accessing MHS. Clinical staff and/or case management staff, as well as, CHI staff are all bilingual and bicultural and many are in training for professional clinical degrees and licensure. Supervision of CHI staff is also performed by bilingual and culturally competent supervisor(s).

- The development of the CHI program came about as the result of MHD System Transformation through MHSA. Mainstream consumer and provider groups touted The Village Model, Wellness and Recovery philosophy, and strong MHD administrative pressure to develop ethnic specific self-help centers. Centers developed at County MHD sites did not feel welcoming to many AAPI consumers who were less acculturated and linguistically limited. Attempts had been made by the MHD to include AAPI and/or have designated times within the existing self-help

centers for AAPI but consumers did not show increased enthusiasm or participation. CHI was developed after much discussion and planning to utilize available MHSA funding. Directives from top management and the careful hiring of staff who were bilingual, bicultural and experienced exposure to the Wellness and Recovery philosophy and activities gave rise to the development of CHI. Securing space, soliciting buy in and collaboration from clinical staff was also challenging until directives from management were issued to support CHI. All input, design and execution of CHI emanates from within the agency's Behavioral Health Department with a high level of input and participation from the consumers on direct CHI activities. Careful evaluation of the Wellness and Recovery philosophy and principles lead the clinical and management realize that AAPI health beliefs were much in-line with the prevention and normalization principles of MHSA and thus CHI was created.

- Success of the program has not been formally evaluated but the consistent participation of consumers and the transitioning out of leading CHI members over time has suggested the effective generalization of CHI activities and life skills strategies toward each graduating member to lower level of care facilities such as the MHD operated Federally Qualified Health Centers (FQHC). CHI's initially successful transitioning consumers are currently Peer Mentors in CHI. They not only serve as co-facilitators of CHI activities but also as cultural ambassadors and models to current CHI participants.

7. ADDITIONAL INFORMATION

- Small group activity of 6-10 participants focused on a useful and meaningful task and/or life skill. A coordinating staff member who assist in the execution of a planned activity derived though a group process led by the participating SMI consumer(s). Staff member(s) need(s) be bilingual and bicultural to ethnic and cultural group at hand to be able to communicate effectively. When different group members speak different languages, treating case manager and/or clinician should accompany consumer during group to ensure participation and level of comfort within group. During activities, consumer can interact with the group members as appropriate to learn and interact collaboratively to accomplish the activity at hand. Participation of case manager(s) and/or clinician(s) in the activity, allows for on-going clinical assessment of consumer's physical, social, and cognitive functions in a less structured setting like the interview room.

- These elements are essential as the participation allows for clinician and/or staff member to observe SMI consumer(s) interacting with peers and learning useful life skills consumers need to survive their daily lives. In observing the consumer's participation and attendance to groups, on-going assessment of their insight, symptom stabilization, and potential side effects of medications can also be observed. In the long run, as each consumer demonstrate their own ability to socially interact, learn essential life skills and practice them generally outside of the group and report back to the group; it allows for the consideration of moving the consumer to a lower level of care as evidenced through their stabilization and ability to related and function within peers.

- Documentation of planned activities and calendar of activities have been constructed and recorded to date. Cooking recipes have been collected in the hopes of compiling a simple multicultural cooking book with simple instructions for quick and tasty meals. Arts and craft projects have been recorded through photographs. Individual group activities with goals, observation and results are documented in each participating member's clinical record as group participation in rehabilitative MH activities. Cultural events and celebrations are enhanced by the increase participation of peers and staff members to help celebrate an event planned and collaboratively organized by peers and program staff.

- No curriculum has been written down since the inception of the CHI Program but staff is planning to manualize this culturally responsive and respectful engagement and participatory program. A multi-AAPI cookbook is in the planning process and a potential video cooking series will feature each consumer 'chef' instructing viewers on how to make each dish and giving some cultural history and background to the dish.

- One particular project which took 1.5 years to complete was the development of a DVD featuring staff, CHI members and family members talking about mental illness, MHS, personal and lived experience with MH, and encouraging viewers to seek MHS, while address the stigma MH has across AAPI cultures. This DVD is titled, 'Overcoming Adversity: Stories of Hope and Courage.' It has been utilized in various setting to introduce the idea of AAPI individuals living and recovering from mental illness and utilizing effective MHS to improve their quality of life. Discussion has occurred at clinical graduate programs, professional conferences, County MH Board meetings, consumer and family support and advocacy groups. This DVD has been distributed to CRDP AAPI and several federal health and human services offices. This DVD has recently been translated/voiced over into Cantonese, Mandarin and Vietnamese. We hope to translate/voice over into Tagalog and Cambodian to round off all current languages spoken at CHI.

- CHI uses the Wellness and Recovery philosophy at the core of its program. It programmatic function serves dual purposes. First it allows for a culturally welcoming and familiar self-help center model where not only consumers can attend but also include their clinical services and/or case manager to participate in all activities. Secondly, the self-help center model allows for the dissemination and education and discussion of MHD policy changes and/or directives affecting client care, program services, and client flow processes. Because CHI serves diverse AAPI linguistic and cultural groups, at times it allows for the combination of certain ethnocultural groups and their language specific clinical services and case managers to discuss impacts of MHD changes and directives. Staff has observed shared agreements and disagreements whenever groups are combined and/or news discussed is no well received by either ethnic groups.

- No set number of sessions is predetermined. It is an open group, participation and membership determines the activities to be performed. Frequency of group meetings can range from weekly to monthly depending on the availability of language specific participants and/or shared common interest in the activities on the calendar schedule. Length of activities range from 2 – 4 hrs depending on the number of shared interest individuals participating, significance of event, time suggested to execute activity and/or type of activity interest (e.g.: jewelry making, crochet and cooking can be 2hr; while Lunar New Year and Cambodian New Year's Celebrations can take up to 4 hrs with invited guests from the MHD).

- Size of groups have ranged from as small as 4 to 65 depending on activity type and cultural importance of activity and/or celebration.

- The CHI program is easily replicated as long available staff managing the program is able to communicate and relate effectively and respectfully with participating consumers. Consumers need be stable and able to follow multistep directions for activities. CHI focuses on consumers who are currently receiving specialty mental health services at AACI and not from other programs. The advantage of having CHI and the on-going support of the mental health clinician offer a more consistent and reliable support system to the recovering consumer, active communication between CHI staff and mental health clinician, and offer the consumer an expanded treatment team which aids in their socialization process.

- Depending on the size of the program, frequency of activities, dedicate vs. shared space in an outpatient clinic setting and/or other type of setting. Due to budget limitations CHI currently is staffed by a dedicated .5FTE who is supervised by the Adult and Older Adult Program Supervisor. Regular supervision is set according to available schedule and/or as needed. Staffing needs depend on the type of activities. If the activity is focused on a skill, then the .5FTE and the activity leader are main facilitators. If it is a cultural celebration, the CHI staff is main coordinator but assistance from additional departmental staff is required to ensure a successful event. Depending on the language needs of the group, primary language speakers are required. If the CHI staff speaks that language, then s/he can be the key staff coordinator, otherwise staff assistance with linguistic competence is required.

- CHI staff is always responsible of logistics and availing supplies. Linguistic needs as needed and matched with additional staff assistance. Depending on level of functioning of participating consumer(s) clinical and/or case management staff (usually same one due to language and cultural needs) accompanies consumer(s) and participates in the activity.

- Best staff person for CHI is one who is emotionally mature, creative, energetic, patient, clinically trained at graduate level, experienced with residential treatment and care, experienced with outpatient treatment, versed in psychopharmacology and possible neuropsychology to best assess functional capacities and deficits. Bilingual and bicultural is best, as well as, multidisciplinary team focused. CHI staff often serves as the on-site continued assessment of functioning behavioral health staff who will communicate and often coordinate with each consumer's designated clinical staff.

- Each staff need to be bi-lingual and/or bi-cultural preferably in at least one of the languages and cultures of CHI group members. Due to CHI members speaking multiple languages, either simple English becomes the common language of activities or the participation of multiple additional bilingual and bicultural staff members is necessary. Presently the CHI staff is a native Tagalog speaker, has a Masters degree, enrolled in a Clinical Psychology PhD program, with emphases on neuropsychology and community mental health.

- There is no ratio of staff to caseload as CHI operates on an activity schedule and language needs of participating group members. CHI staff is always the key logistics personnel.

- Space designed to be welcoming and culturally appealing within an outpatient MH center. Most effective facility would include a large enough group meeting/activities area and a full functioning kitchen and sink area. A comfortably furnished drop-in area with multimedia capabilities will also be very beneficial to the overall ambiance of the center.

- The CHI program is not currently under any structured evaluation process from the MHD specifically for CHI services. All CHI participants are concurrently open and active cases in the traditional MHS of the MHD and subject to all MediCal mandates. Anecdotally, CHI's highest functioning and stable consumers have been transferred out from our designated culturally specific Specialty Mental Health Services to MHD's FQHC's and our initial transferred consumers who continue to be stable and functioning are Consumer Interns in our Mental Health Department of our Behavioral Health Services and key co-facilitators of CHI activities. Anecdotal self reports from participating CHI members have expressed great satisfaction with the program, feeling comfortable and welcomed during their participations, and continue to participate regularly whenever transportation is

available either from family and/or staff if they live further away from the center and public transportation is not as convenient. Some other participants are able and willing to utilized public transportation over 2hrs to attend CHI activities. Indirect satisfaction measure of CHI activities, particularly cooking activities, is evidenced by the number of current Mental Health Department staff and graduate interns/trainees who welcome joining CHI toward the end of the activities to savor the delicious and simple food products produced by CHI members.

- At present, funding limitations and staff availability have proven to be barriers to design an effective evaluative process across all different CHI linguistic and cultural groups. Another existing barrier is the number of different languages CHI participants speak, posing a challenge of designing, translating and back translating assessment tools, and eliciting the assistance of language specific staff who if consumer is assessed to be ready to be transferred out to FQHC's new cases referred by the County MHD may and/or may not be of similar cultural backgrounds. In the most recent two fiscal years, most ethnic specific MHS providers transferring ethnic specific clients to County operated FQHCs have in turned be referred mainstream English speaking consumers to work with. It is the case that staff whose primary language is not English are forced to work with newly assigned culturally different consumers. Given this phenomenon, truly measuring the success of CHI will be challenging.

- **Contact information:**
  Agency: Asian Americans for Community Involvement (AACI)
  Contact: Laurie Leung, Ph. D., Adult/Older Adult Program Supervisor
  (408) 975-2730 x168; Laurie.leung@aaci.org

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- In 1973, a group of citizens of Santa Clara County gathered to express discontent and share common concerns about their experiences as Asian Americans. These community leaders founded an organization committed to the belief that diverse members of the euphemistically labeled "Quiet Minority" could unite, that their individual experiences and strengths could combine to advocate for the betterment of all Asians.

- It's not uncommon for Asians and other minorities to feel uncomfortable seeking and receiving services due to language and cultural barriers. The team of multicultural and multilingual professionals at AACI works to bridge these gaps through an array of services and programs in health, recovery, advocacy, shelter and community. The AACI team includes the following specialists: physicians, psychiatrists, psychologists, social workers, marriage and family therapists, teachers, health educators, and domestic violence prevention specialists.

- Please refer to our website at www.aaci.org for additional information and history.

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

1. NAME OF PROGRAM:		
AACI-Center for Survivors of Torture (CST)-New Refugee Services (NRS)		
2. TYPE OF PROGRAM:	X	Universal prevention
	X	Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Asian Americans for Community Involvement
2400 Moorpark Ave., Suite 300
San Jose, CA 95128

4. TARGET POPULATION

- NRS focuses on adults and older adults from the nine most recently arrived ethnic refugee groups into Santa Clara County (SCC). These refugee groups include Iraqi, Iranian, Afghan, Bosnian, Cambodian, Vietnamese, Burmese, Eritrean and Ethiopian who primarily reside in the urban areas within SCC where each of these refugee groups form ethnic enclaves.

- Services are provided in the primary languages these refugee group members speak. Refugees served in this project come from Afghanistan, Bosnia, Cambodia, Eritrea, Ethiopia, Iran, Iraq and Vietnam. The use of culturally and linguistically competent interpreters trained and supervised to work with mental health professionals will be crucial and utilized whenever no qualified clinician or staff is able to speak that individual's primary language.

- Initial focus groups with these specific populations found these refugee communities have persistent stigma about mental illness. Most participants were unaware of mental health services available in SCC. Health promotion, outreach, education, and training are integral to the service delivery model that NRS will to use to serve these populations.

- Refugee populations in SCC are fairly concentrated in the Central urban region of the county where the largest population density exists. Smaller enclaves are found scattered throughout SCC but not toward the rural and/or incorporated areas of the county. Services to these populations can be at their homes, communities, and our offices as deemed most appropriate to reduce access barriers to the clients.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- Newly arrived refugees to SCC experience a multitude of challenges including the complex intertwining trauma and often untreated mental health conditions ranging from mild to chronic and severe. Cultural stigma around mental illness, mental health services, the lack of understanding of available healthcare services in this new country, lack of understanding of confidentiality and the helpful role of government sponsored service agencies,

language and access to service barriers all lead to increased rates of mental health conditions, social isolations and often self limiting behaviors. This NRS program is aimed at addressing this range of physical and mental health problems often exacerbated by legal, economic and acculturation challenges.

- Protective factors this NRS aims to enhance include the increase in self sufficiency and efficacy each refugee and their family are able to mobilize to empower themselves within this process of acculturation and enculturation to SCC. By being able to communicate in their primary language with service providers they are better able to express their challenges, needs, and strengths throughout this process. Recognizing the value of each refugee's traditional healing practices while learning and incorporating new healthcare prevention and treatment models allows each participant to better accept the idea of mental health treatment as a component of an integrated healthcare model and services available in their new SCC home. It will therefore reduce the cultural stigma accompanying mental illness and it will enable them to mobilize their individual and community resources, and become a healthier consumer, productive and contributing member of our SCC community.

- New refugee communities have persistent stigma about mental illness. Most are unaware of mental health services available in SCC. Health promotion, outreach, education, and training are integral to the service delivery model that NRS will to use to serve these populations.

- Many experience a multitude of complex trauma and untreated mental health conditions ranging from mild to chronic and severe. Stigma about mental illness impedes accessing effective treatment in their primary language. The lack of understanding of the existing healthcare system and services becomes a barrier to access of care. Misunderstanding and mistrust of the role of government in funding community service organizations and access to services lead to the increased unreported rates of persistent and often chronic mental health conditions, social and cultural isolation. The NRS program aims at addressing this wide range of risk factors affecting the newly arrived refugees from these nine identified ethnic groups.

- The goals of this program are both targeted at prevention and early intervention including:
  1. Researching available literature and compiling resource materials, including existing videos about subject cultures. These efforts are primarily emphasized for those ethnic groups which are most recently arrived and do not have a history of services in our community and/or country.
  2. Identifying and calling on organizations working to improve mental health with ethnic groups, including refugee resettlement agencies throughout the county to develop an ongoing support network for newer arrived refugees.
  3. Studying, researching and understanding each ethnic culture and its beliefs around mental health, mental health manifestation, traditional healing practices and how to provide linkages to mental health services. Increased efforts are placed on newer arrived refugees from cultures not having a history of treatment within the existing mental healthcare system.
  4. Consulting with community leaders of each ethnic group to incorporate these cultural best practices.
  5. Organizing interviews and focus groups as necessary, as many of these groups may require cultural specific prevention and intervention strategies not currently or previously developed within our system of care, as refugee resettlement agencies within SCC continuously bring in new cultural groups into the area.
  6. Producing culturally specific films intended to increase awareness of mental health issues, improve mental literacy and reduce stigma associated with mental illness among refugee populations.
  7. Reinforce cultural protective factors that will address early onset of mental health symptoms related to

resettlement and trauma experienced in the native country.

8. Increase access to mental health services by reducing stigma associated with mental illness and mental health treatment,
9. Provide brief treatment interventions to reduce situational stressors that are characteristic of resettling refugee populations and to mitigate the need to seek services in the specialty mental health system,
10. Improve coping skills of refugees and their families during the stressful period of acculturation into the predominant cultural norms of SCC. Also develop well matched, timed and respectful enculturation

6. CULTURAL RELEVANCE

Asian Americans for Community Involvement (AACI) started in 1973 in large part because our founders saw the incoming wave of Southeast Asian refugees arriving in Santa Clara County and wanted to ensure support and services for this new population. Since then, AACI has served thousands of refugees in Santa Clara County (SCC) from 61 countries. AACI received Comprehensive Employment Training Assistance (CETA) funds for community services in 1974 and county mental health funds in 1976. Today, AACI's award winning multi-lingual, multi-ethnic staff of 160+ provides an array of health and human services to over 12,000 low income immigrant and refugee clients a year. AACI's services include comprehensive outpatient mental health services, primary health care for individuals and families, psychiatry, substance abuse prevention and treatment, HIV/AIDS education and testing, health education, ESL, citizenship and parenting classes, a senior center, a domestic violence program and shelter, youth programs and the Center for Survivors of Torture (CST). CST alone serves 200 clients annually, the vast majority of whom are refugees. This New Refugee Services (NRS) program is funded through MHSA and is modeled after CST through the Mental Health Department of Santa Clara County (SCC) as best practices in SCC to serve the nine newly arrived refugee groups to Santa Clara County.

AACI is the only service provider in SCC with three decades of expertise providing comprehensive culturally competent mental health services to refugees and funded federally to provide services to refugees who are torture survivors. All three resettlement agencies in SCC, i.e., Catholic Charities, Jewish Family Services and International Rescue Committee direct refugees to CST for comprehensive and culturally responsive mental health services to address their complex trauma and psychiatric presentations. Using a multi-disciplinary team of community workers, mental health clinicians and primary care providers, we assist our clients to develop individualized wellness plans that support their healing and recovery while their overall functioning improves. Our staff connects refugee clients to a full range of treatment, outreach, legal and social support services. AACI is part of SCCMHD's System of Care for children and families, adults, and older adults experiencing the full range of mental disorders, from mild to severe, acute and chronic. AACI's CST serves refugees and asylum seekers with an encompassing full range of treatment, outreach, legal and social support services. AACI conducts mental health promotion and trainings involving outreach and education to professionals and community members locally, statewide and nationally on culturally competent outreach strategies and interventions to address diverse and traumatized refugee mental health needs. In the last year, AACI staff conducted 130 presentations and multicultural trainings, and trained 518 providers on refugee and torture survivor issues. AACI has one of only two certified Mental Health First Aid (MHFA) trainers in SCC who provides trainings on stigma reduction, identification of mental health issues and community linkages for services and treatment of mental health conditions. One of AACI's Program Directors also serves on the Consumer and Family Leadership Committee (CFLC) of the California Mental Health Services Oversight and Accountability Commission (MHSOAC) providing leadership and guidance to ensure statewide services are culturally and linguistically competent to the diverse ethnic communities served in the State.

AACI has a long history of cross-departmental collaborations internally and externally with other community based organizations, in particular with the SCC Refugee Clinic, which has historically always referred refugees for

mental health services to AACI's CST. In 2008, we formalized this collaboration through a contract, whereby AACI provides a licensed clinician to conduct on-site assessments to newly arrived refugees at the primary care site. This integrated approach reduces mental health stigma and introduces comprehensive health wellness to the refugee populations. AACI's CST collaborates with SCC Social Services Agency (SSA) to provide ongoing trainings to eligibility and caseworkers on cultural considerations and trauma awareness in working with refugee populations. We have also trained the San Jose Police Department and their Crisis Intervention Team (CIT) on refugee and trauma issues. AACI is a consulting partner to national refugee serving organizations such as Boat People SOS and an executive member of the National Consortium of Torture Treatment Programs. AACI is an active member of the International Rehabilitation Council for Torture Victims, the Refugee and Immigrant Forum of SCC and the California Consortium of Torture Treatment Centers. Internally, refugee clients benefit from AACI's multiple programs, particularly the primary care clinic and substance abuse treatment programs.

For the last 38 years, AACI has successfully implemented programs and services that are responsive to new and existing refugee populations in SCC. For the last decade, AACI's CST has provided culturally competent services to torture survivor refugees and their families from 61 different countries. Our full range of rehabilitative services to refugees include mental health, psychiatry, case management, psycho-education, legal support and civic engagement activities for social and community involvement. Our collaborative relations with multiple refugee groups and community organizations allow us to provide a network of services tailored to new refugees. As new refugee data becomes available from the Refugee Programs Bureau, AACI NRS will recruit and contract with members of said refugee groups to assess and develop linguistic and culturally respectful services to meet the mental health needs of these emerging groups in the county. Using contractors allows for flexibility and adaptability to meet new refugee groups needs.

We believe that to truly provide culturally and linguistically competent service, our staff, management and Board must reflect the diversity of the community and consumers served. AACI is such an organization and strives to hire bilingual and bicultural staff from representative communities with "lived experience." Our staff represents over 60 cultures and languages/dialects. To ensure that clients receive quality services in their primary languages, we have a full complement of linguistically and culturally competent trained mental health providers, including rehabilitation staff, professionally licensed staff and consumer and family staff who reflect the refugee communities we serve. Many of our staff who themselves came as refugees to the U.S. are fully cognizant of ethnic and cultural values and specific issues pertinent and sensitive to refugees. For clients who speak languages not available at AACI, we train and supervise interpreters who collaborate with the existing service providers and often develop long lasting working relationships with our programs.

AACI CST conducted nine ethnic refugee focus groups (Iraqi, Iranian, Afghan, Bosnian, Cambodian, Vietnamese, Burmese, Eritrean and Ethiopian) and found that refugee communities have persistent stigma about mental illness. These efforts were cornerstones to the development of NRS. Findings suggested that most participants were unaware of mental health services available in SCC. Promotion, outreach, education, and training are integral to the service delivery model that AACI's CST will continue to use to serve these populations. AACI will continue to work with resettlement agencies and other already established refugee serving organizations (MOUs and Letters of Support attached) and fellow members of the Refugee and Immigrant Forum to outreach to and educate community members using the culturally adaptable MH First Aid curriculum with each targeted ethnic group within NRS. AACI has engaged and developed appropriate prevention strategies, based on different groups' perceptions of mental health and their traditional healing methods. NRS conduct workshops and focus groups in different languages, using existing DVDs featuring CST's refugee clients, focusing on stigma reduction and education about refugee specific mental health issues. Presentations and discussions are done in community settings,

refugee orientations, and resettlement agency sites using CST, NRS staff and members of that specific ethnic community. Prevention activities are conducted in culturally sensitive modalities at faith-based gatherings, cultural events and the annual Refugee Day celebrations, using art, cooking and other culturally amenable interventions. AACI's CST and NRS organize multicultural client and family gatherings during the year (Thanksgiving, Back to School, Summer Picnic, a Winter Holiday Party) and weekly Wellness and Recovery activities through our CHI (Center for Healthy Independence) program where peer mentors, family members and staff provide a welcoming, empowering and culturally respectful and supportive recovery environment. Through using AACI research oriented staff to do literature reviews, subject matter expertise and the ability to provide consultation and assistance to the video production company, NRS plans to successfully assist in the production of DVDs about mental health, stigma, available services and the relationship to immigrant/refugee communities to ensure a better adjustment to their new culture and communities. AACI CST's existing collaboration with the Refugee Clinic provides an immediate access to all newly arrived refugees in the county since the refugee health assessment is mandatory. CST and NRS staff's lived experience as refugees is the perfect example of the most effective delivery of mental health prevention activities to newly arrived refugees.

Services are aimed at early identification of mental health symptoms and short term culturally competent and respectful interventions to prevent the development of more severe mental health conditions. NRS will continue to use AACI and CST's existing "strength based model" of intervention and treatment with a comprehensive and integrated wellness and recovery focus. Our practice is "client centered", and clinicians and case managers build on clients' innate strengths and adapt their respectful interventions according to the culture of the specific refugee group. We will also avail a culturally and linguistically matched peer who benefited from mental health services to share and support the individuals in their recovery and provide lived experience about the benefits of mental health services for improved functioning in daily life. Peer testimonials will also take place at community centers and refugee gatherings and will help to demystify mental health, reduce stigma and increase psychological mindedness.

Barriers, including cultural beliefs, stigma, social, economic, and medical issues will be identified and reduced in the context of desired outcomes stated by the individual. Treatment interventions will naturally occur fluidly in the office and community settings. The "treatment team" will include a combination of the client, family members, psychiatrist, case manager, and clinician as culturally and clinically indicated. The team will work with additional providers for housing and employment services with current sub-contractors such as Catholic Charities. Newly arrived refugees tend to focus on securing basic needs such as housing and employment. Mental health services are viewed with suspicion and/or accompanied by fear of stigmatization. Being sensitive to this fact, we will continue to have a therapist on site at the Refugee Clinic 2-3 times a week to do screenings and assessments, psycho-education, referrals, and case management. Refugees assessed as needing mental health services will be provided more information and brief treatment in the culturally appropriate and respectful manner. Treatment will match the individual's level of readiness to change and involve individual, family, group treatments and/or social recovery activities as determined and agreed upon by the clinician and client.

7. ADDITIONAL INFORMATION

Promotion, outreach, education, and training are integral to the service delivery model that AACI's NRS will use to serve these populations. Close collaboration with resettlement agencies and other already established refugee serving organizations is crucial. Educating community members using the culturally adaptable MH First Aid curriculum with each targeted ethnic group is an important prevention and education element of this program. Conducting workshops, interviews and focus groups in different languages, using existing DVDs featuring refugee clients, focusing on stigma reduction and education about refugee specific mental health issues is also important. Short term treatment is also

valuable as an effective introduction to mental health services and their effectiveness to treat situational and early onset conditions and reduce stigma. Community visibility and presence is a key engagement strategy for cultural acceptance and legitimacy of services if providers also speak the community's primary language. Collaboration with primary healthcare services providers at SCC Refugee Clinic is also important to establish trust and acceptance of mental health as a continuum of existing healthcare services. Services provided in each of the refugee's primary language or having reliable and well trained translators is also key to developing trust and effectiveness within the community. Involving peers and similar cultural outreach and educators is also important to develop trust among new community members.

All these components are important as described above to not only identify, engage, educate and treat members of diverse refugee groups but to also increase cultural acceptance, understanding of available healthcare services in the new host country and overall decrease the stigma associated with mental illness.

No such curriculum has been manualized to date. The core components of this program have been modeled from another successful program at AACI—Center for Survivor of Torture which has operated under this model since 2001 and funded through the Office of Refugee Resettlement and the United Nations grants.

As each individual case is different in terms of their level and type of service needs, once engaged, and a full intake assessment is completed, the individualized and collaboratively developed treatment plan will indicate the type and intensity of services needed (e.g.: clinical, legal, case management, education and support, etc.). Each staff fulfills a particular service role within the continuum of care provided in the program ranging form outreach and education, direct clinical services, case management, advocacy and support. Frequency and length of engagement, treatment sessions and case management encounters is highly dependent on the level of acculturation and understanding, motivational level, and commitment each individual has toward engaging the services provided. Number of cases per staff is also dependent on the intensity of services and service types needed per case. Physical, psychological and emotional toll are high when working with potentially highly traumatized refugee populations and monitoring of staff degree of resiliency is also key to determining types and number of cases assigned to each program staff. Secondary trauma is often the case with staff working with this population and it is essential to have a system in place as a barometer for such invisible stressful reactions from staff.

This program can be well replicated with sufficient funding and the availability of a wide range of professional expertise including integrated behavioral health and primary care, multilingual and multicultural intensive case management, outreach and community education, collaboration with graduate clinical training institution, administrative support from local government, and dedicated staff members (professional, peer, family members and volunteers). NRS as an extension of AACI CST can provide technical assistant to any other ethnic communities interested in establishing similar service programs for their specific populations. AACI has historically served as an incubator for other community agencies in the past.

Due to the diverse languages and cultural backgrounds of clients served, it can be a significant challenge to find linguistically and culturally competent professional providers who are well trained clinically and willing to work with these populations; staff who are able to understand and navigate the existing social, educational, legal and healthcare system to provide effective case management and coordination. Collaborative and trusting inter-organizational relationships is key to serve these target populations, as often one organization by itself does not have sufficient resources to completely meet the overall needs of each individual. Cross agency cooperation and trust are key components to leverage each organizations' strength and resources as needed and/or clinically indicated.

In addition to community members from various refugee groups, NRS staff reflecting the population serve will best compliment the services provided to the targeted refugee groups.

- The Director of Mental Health Programs, is an immigrant from India, 10 years experience with refugees/immigrants, MFT, and fluent in Hindi and Punjabi.
- The Program Manager is a refugee from Bosnia; 15 years experience in the field, fluent in Bosnian, Croatian, Serbian.
- The Clinical Services Manager has 25 years experience treating traumatized populations as a licensed psychologist.
- The Clinical Supervisor, is a MFT, has 9 years experience treating refugees, conducting focus groups and clinical research, fluent in French.
- The Community Engagement Specialist/Case Manager is a recent refugee from Iran, fluent in Farsi and Arabic, and has over 3 years working with refugees. Another Community Engagement and Outreach Specialist is a recent refugee from Iraq, fluent in Arabic and has worked as an Arab/English interpreter in Iraq.
- The Project Lead, is experienced with detained refugees and asylum seekers in Thailand, fluent in Mien, Uzbek, Spanish, and has 4 years experience with refugees in U.S., and is experienced with focus groups and research.
- A Psychology Intern is a refugee from Iran; fluent in Farsi and experienced in literature review and research. Another Psychology Intern is Palestinian, fluent in Arabic literature review and research.
- A Peer Consumer Mentor, a refugee from Cameroon, fluent in French and two African languages.
- A Certified Mental Health First Aid trainer, licensed psychologist and recipient of the American Psychological Association Minority Fellowship.
- A Research and Outcome Evaluator, Postdoctoral Fellow, fluent in Japanese.
- A Quality Improvement, Compliance and Training Manager, licensed psychologist and Certified Healthcare Compliance Officer.
- A Director of Behavioral Health Services, licensed psychologist, a family member on the Consumer and Family Leadership Committee of the Mental Health Services Oversight and Accountability Commission with over 20 years in the mental health field in varied multilingual and multicultural settings. Fluent in Spanish, Cantonese, and Toishanese.

Outpatient community based multiservice provider in an urban setting is the best suited setting for this type of model. Integrated primary and behavioral healthcare, case management, education and advocacy, community outreach and education, and collaboration between ethnic specific and refugee focused community partners is also a key to stigma reduction.

The NRS program has not been formally evaluated as it is a PEI model expansion of an existing, yet smaller CST program AACI that has been in operation since 2001. SCC Mental Health Department has approved NRS as its PEI Refugee population focused program. The NRS program utilizes validated and widely accepted clinical assessment tools in their service delivery including, a comprehensive assessment of client's mental health symptoms using the Hopkins Symptom Checklist (HSCL-25) and the Harvard Trauma Questionnaire (HTQ), which we currently use in AACI's CST. The HTQ and HSCL-25 were developed to assist clinicians in assessing the mental health of refugee patients in specialized refugee mental health services and in primary care settings. These instruments provide core information about the client's trauma history, PTSD symptoms, depression, anxiety, and functional ability. The

primary advantages of these instruments are that they are non-stigmatizing and can be readily adapted linguistically and culturally to different refugee populations. They are widely accepted internationally as a "gold standard" in the assessment of traumatized populations.

CST and NRS also conduct a comprehensive functional assessment using the CAFI-XC (Current Adaptive Functioning Index - Cross-Cultural Version) a rating tool developed for assessing the functional needs and progress of cultural and language minority clients in seven key areas—Basic Resources, External Risks, Mental Health, Family Relations, Social Connections, Language Barriers and Cultural Navigation Barriers.

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

1. NAME OF PROGRAM:		
Chinese Community Problem Gambling Project (CCPGP)		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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(NICOS Chinese Health Coalition is permitting NAPAFASA to submit this paper on its behalf.)

4. TARGET POPULATION

Target population: Chinese community, particularly Non-English Proficient (NEP)/Limited-English Proficient (LEP) immigrant adults.

Services are provided in English and several dialects of Chinese, including Cantonese and Mandarin
Given studies that indicate a higher than average rate of problem gambling, and a needs assessment that indicates a community concern for problem gambling, the program is intended for Chinese-American problem gamblers and affected individuals (e.g., their family members and/or friends). Counseling services are provided at different neighborhood-based community mental health and social services agencies.

Although the program was originally created to serve San Francisco's Chinese community, components of it, such as a 24/7 bilingual helpline, have been expanded to serve Chinese communities statewide. Other components, such as general problem gambling education, have been expanded/ adapted to serve all California residents.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The CCPGP seeks to address problem gambling in the Chinese community.

The CCPGP seeks to enhance the protective factors of family and social support. Family has been used as a protective as well as motivating factor for gamblers/ their relatives to seek help. For example, an early awareness ad campaign

used the slogan, "When one person is addicted to gambling, the whole family suffers." Because of the importance of family and responsibility towards the family unit in Chinese culture, behavior modification techniques have included kin-centered strategies such as asking gamblers to carry a photo of the spouse and children in their wallets as a reminder of the impact their actions have on their loved ones when they reach for gambling money. The CCPGP has also successfully utilized weekly facilitated support groups for problem gamblers and groups for spouses of problem gamblers in Asian community-based settings as an alternative to Gamblers Anonymous/ Gam Anon, a model that has not always worked well with the population.

The CCPGP seeks to reduce risk factors associated with: stress/ trauma from the immigration experience; isolation due to limited opportunities to participate in the larger society; and stigma from accessing mental health services.

The overarching goal of the CCPGP is to prevent or reduce problem gambling in the Chinese community. Objectives include: building awareness of problem gambling; building awareness of resources available to address problem gambling; providing prevention education; providing intervention through individual, group and phone-based counseling.

6. CULTURAL RELEVANCE

The CCPGP uses community leaders, recovering problem gamblers/affected family members and the Chinese media to reach the target population. Staff creates ads and regularly purchase time/space on Chinese television, radio and newspapers. To supplement this, staff also host press conferences during National Problem Gambling Awareness Week as well as other times of the year to maintain a media presence, often with a recovering gambler as a featured speaker. Moreover, staff participates in outreach events such as community fairs and conferences, and regularly conduct educational workshops highlighting resources available. More recently, the agency is building relationships with industry partners to promote the helpline at the places where Chinese problem gamblers most often congregate – at casinos and card rooms.

Because gambling is a widely-accepted aspect of many Asian cultures, interventions require increased sophistication. For example, the typical group setting of Gamblers Anonymous does not address the Asian preference for guidance/ facilitation from a professional over a peer. Furthermore, the typical focus on the individual in American culture does not work nearly as well as interventions that focus on the harm to the family by the problem gambler's behavior. In addition, most intervention programs are provided in English, while many problem gamblers are fluent in a non-English language.

The program incorporates cultural elements regarding mental health and well-being. For example, due to the community's strong stigma toward mental illness, staff heavily stress confidentiality of services in their outreach efforts. Moreover, due to the community's low rates of utilization, program services have been offered at multiple locations, increasing accessibility by allowing individuals to conveniently seek service in their own or a nearby community – or outside it if anonymity is a greater concern. Phone-based counseling is now available as well, providing even greater anonymity and accessibility.

The program demonstrates sensitivity to historical issues such as immigration. Staff understand that Chinese immigrants may be at greater risk for problem/ pathological gambling due to: social isolation caused by language limitations, which may make gambling more attractive as it is an activity that largely requires no understanding of English; employment in industries that pay in cash rather than checks (restaurants, construction, taxi), which

immediately puts potential betting money into one's hands; and a cultural acceptance of gambling.

The CCPGP began as part of the response to a 1996 NICOS Chinese Health Coalition telephone survey involving 1,808 Chinese American adults in San Francisco. Survey results showed gambling to be a top social concern. The initial program was collaboratively developed by many different community stakeholders, from neighborhood leaders and professionals to students to recovering problem gamblers and those affected by them. Members of this "Problem Gambling Task Force" planned and developed the program components. They secured a week-long training for more than 30 mostly bilingual/ bicultural community counselors, making them eligible to become CA Certified Problem Gambling Counselors. They coined the initial media outreach message, and created bilingual educational materials such as brochures and print ads. And, they created an educational, prevention-oriented curriculum describing odds and harm reduction methods (setting time and money limits, leaving credit cards at home, etc.). Two graduate students in the Task Force devoted their Masters project to a prevalence study to support the need for a program.

The community continues to help guide the design of CCPGP, now largely through client satisfaction surveys and post-workshop/ training evaluations. Support group clients are often called upon to provide their feedback on outreach materials. CCPGP serves as a model for organizations nationwide interested in addressing problem gambling in Chinese/ Asian-American communities.

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

1. NAME OF PROGRAM:		
Club IMPACT		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		
Steve and Sela Teu – Both Steve and Sela Teu have given permission for this submission. Phone: (650) 922-0126 Email: s4steu@gmail.com and s8steu@gmail.com		
4. TARGET POPULATION		

The population Club IMPACT serves is Pacific Islander (PI) community in San Mateo County, specifically in East Palo Alto, specifically the population of focus are young people ages 9 through 24 and their families. The children and families we serve are immigrants or descendants of immigrants from Pacific Islanders, which include Native Hawaiians, Samoans, Guamanian or Chamorro, Tongans, and Fijians. As with many other different ethnic groups, cultural similarities and differences exist among the various PI populations and Club IMPACT is able to incorporate these in a way that is inclusive and embracing of overall PI culture.

The program is delivered primarily in English and incorporates a bilingual and bicultural approach therefore, participants as well as the facilitators and community presenters are encouraged to speak PI languages as well.

The San Francisco Bay Area is home to one of the largest concentrations of Pacific Islanders outside of Hawaii, yet their total numbers are small: the U.S. Census 2000 counted 9,043 in San Mateo County, just 1.3% of the county's total population ten years ago. They are spread out along a 40-mile corridor from Daly City and Brisbane in the northern part of the county to East Palo Alto in the south. The wide geographic dispersal is largely a result of economic necessity. The Bay Area is one of the nation's most expensive places in which to live, and neighborhoods that are affordable for immigrants are quite literally "few and far between." The small size of the community, intensified by its ethnic diversity, and its wide geographic dispersal, has made it difficult for its members to organize and advocate for public services. The small size of the community makes it difficult for Pacific Islanders to "get on the radar screen" of even well intentioned public service providers. For reasons of scale and lack of community advocacy, resources tailored to the Pacific Islander community are few and those that exist are chronically under-funded. The situation is exacerbated by a common trait among the Pacific Islander people themselves, which is to be socially quiet and non-complaining. Worrisomely low levels of civic participation and accessing of essential public services have occasionally resulted in serious misunderstandings between community members and public safety officers. Although dangerously isolated, Pacific Islanders have been able to fall back on many cultural assets. Pacific Islander children are the community's hope for the future. The Pacific Islander culture has historically promoted youth development as a process for the assumption of adult roles in the collective identity. Formal education and acquisition of vocational skills are highly valued. Pacific Islander parents frequently cite the ability for their children to get a better education as

the most important reason for immigrating to the United States. Too often, however, this is a disappointed hope. According to Kidsdata.org, the dropout rate for Pacific Islander children, who are just 2.9% of the student body in San Mateo County, is 26%. Not surprisingly, the college enrollment rate is also substantially lower than for other groups. Pacific Islander children who drop out tend to follow the similar footsteps as their U.S. educated parents, thus continuing a generational cycle of low educational achievement and economic insufficiency. This impedes the development of strong new leaders from the young generation. Substance abuse is a serious problem. Data collected by a Club IMPACT substance abuse prevention program last year offers quite specific insights into the demographics and challenges faced by these youth. Out of a total of 105 youth (ages 13-24) interviewed year, 13% of youth reported that they have used alcohol while 10% reported using marijuana or hashish. More than half of the youth (56%) also reported that they lacked family members and/or friends who are supportive of their recovery and 11% stated that when they found themselves in trouble, they had no one to turn to for assistance.

Club IMPACT is intended to work in both, community and in schools settings.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- **Specific Problems:**
  Club IMPACT aims to prevent and reduce the high school dropout rates and substance use/abuse for Pacific Islanders in San Mateo County.
- **Protective Factors:**
  The environmental resilience assets are caring family and community relationships, cultural pride, a propensity for cooperation, and community connectedness. We will seek to enhance all these assets as well as promote additional resilience assets including: self-reliance, creative problem solving, and a sense of positive future.
- **Risk Factors:**
  Low parental expectations, generational conflicts related to bicultural identity, and pessimistic outlook on the future related to low socio-economic status, few connections to the mainstream community and services, and small community size and dispersion.
- **Goals and Objectives:**
  Club IMPACT has an overall goal of promoting healthy community development for Pacific Islanders in San Mateo County. In support of the project goal, we have selected the following objectives:
  OBJECTIVE 1: Implementation of a culturally specific youth development program that utilizes best practices with culturally adapted activities for Pacific Islander youth and families.
  OBJECTIVE 2: Increasing mainstream understanding of Pacific Islander traditions and needs, and increase Pacific Islanders' access to the larger community for public resources and opportunities.

6. CULTURAL RELEVANCE

Club IMPACT was developed several years ago as a response to the high incidence of violence and drug use in the community by Steve and Sela Teu and other dedicated adult volunteers in the Urban Islanders' Club in East Palo Alto. Steve and Sela are bilingual and bicultural as they were born in Tonga, grew up in the U.S. and have spent their adult lives in both the U.S. and Tonga. They have generously volunteered for youth activities for over 16 years, having co-facilitated several successful youth-oriented programs in East Palo Alto. Steve and Sela are respected members of the Pacific Islander community and proud parents of six children whose ages range from 2 to 28 years old. Recognizing the local Pacific Islander community as being particularly vulnerable and poorly served, AARS has lent crucial support to Club IMPACT, including obtaining short-term public funding that made it possible its volunteers to serve on a full-time, paid basis.

Club IMPACT utilizes outreach strategies that are culturally appropriate. The PI community is relatively small and concentrated with a high emphasis on family; the program staff are active members of this community and are already establish as the "to go people" when issues related to youth and families come up. Local schools have also recognized a need of better understanding and supporting PI students and Steve and Sela Teu's work with the Polynesian Clubs in some of the high schools.

Club IMPACT incorporates PI traditions, beliefs, and customs in every aspect of programming. For example, parents are highly involved in the youth program as they attend these sessions and learn alongside their children the challenges of being bicultural in the US. When sex education is incorporated into the sessions, PI customs are observed by holding gender-specific groups and without the presence of the parents, as this is still considered a taboo subject in PI culture.

Since the program promotes a bicultural identity for youth, the approach calls for the knowledge of historical issues such as colonization, religion, immigration, and war. These subjects are not always easy to deal with and the program facilitators as well as the community presenters often rely on their personal experiences to share the knowledge with the participants. This allows for a more intimate representation of historical issues that can sometimes be presented in a cold and insensitive manner.

PIs have very specific mental health needs that Club IMPACT seeks to address. PI cultures have different beliefs from the mainstream community regarding the origin of emotional or psychiatric suffering, functional impairment, and the appropriate level of family acculturation. Some PI cultures lack synonymous words for some mental health symptoms and diagnosis. In response to these needs, culturally appropriate approaches and well-being are incorporated in the program in dialogue with mainstream values.

A key to the success of this strategy is being continually sensitive to the experiences, desires and aspirations of the community and responding appropriately in the ongoing delivery of the program. Youth and parents, for example, offer suggestions for activities and topics for discussion that are routinely incorporated in the program, keeping it relevant, timely, and responsive to current events.

Despite the PI community's dispersal throughout the county, East Palo Alto still serves as a kind of locus for community pride and institutions. Club IMPACT has started there for this reason but we believe it is geographically appropriate and needed in other locations where members of the PI community reside. Currently, many PIs residing elsewhere make the effort to travel to East Palo Alto to participate in Club IMPACT. Club IMPACT also holds promise for replicability for other small geographically dispersed communities with appropriate culturally specific content.

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

1. NAME OF PROGRAM:		
AYPS Program **Community Youth Center (CYC)-Strengthening Chinese Families Program**		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Community Youth Center
AYPS Strengthening Families Program at CYC
Contact: Sarah Wan, Executive Director
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Fax #: (415) 775-1345
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Original Author: Karol Kumpfer, Strengthening Families Program

Permission has been obtained from Karol Kumpfer, SFP Author and Sarah Wan, Community Youth Center Executive Director to submit this program to the CRDP for review and consideration.

4. TARGET POPULATION

The Asian Youth Prevention Services (AYPS) program-Strengthening Chinese Families Program (SCFP) targets immigrant Chinese youth and their families who are experiencing a significantly difficult period in their life. These youth are identified at being very high risk of being involved with the juvenile justice system because of unlawful activities and being on the verge of dropping out of school. The CYC-SCFP program is a Chinese cultural adaptation of the evidence-based Strengthening Families Program (SFP) that has been found to be highly effective in reducing risk for drug abuse and delinquency. Hence, it has been translated and tested in 26 countries but not for Chinese families. SPF was initially translated into both old and new Chinese characters by the program developer's (Kumpfer) Chinese doctoral student (Xie) and preliminary cultural adaptations are being made by the AYPS staff and consultant Francis Christian Chan based on the steps to cultural adaptation of evidence-based family skills training program as recommended by the UNODC (2009) and specifically for SFP Kumpfer, Pinyucheon, de Melo, & Whiteside, (2008). The Strengthening Chinese Families Program is conducted by culturally competent Chinese group leaders in Cantonese at CYC's program office that facilitates group meetings with parents for three hours weekly for 14 weeks. Following the SFP delivery model, there are one hour group meetings with the parents and youth separately and then one hour of a family skills training practice session by convening both youth and their parents together. The cultural adaptation of the SFP program is that it is conducted in Chinese (Cantonese) for both the parent session and the youth

session. SFP is a national model program accepted by all federal agencies and international evidence-based program according to the UN, WHO and Oxford University Cochrane Reviews in Medicine and Public Health. These reviews conclude the SFP is the most effective substance abuse prevention program and recently was found as one of the first child maltreatment programs to prove it is effective because of access to state case records. However, the SFP had never been tested for effectiveness with Chinese families. This cultural adaptation of SFP is specifically for Chinese immigrant and in Cantonese. Result of the evaluation is promising but not yet conclusive because of a small sample size; however, more data is being collected for the next two cohorts to determine success of the program.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- The program aims to increase the following for the parents: parenting efficacy, increased parenting skills, increased parenting involvement, increased positive parenting, increased marital communication, Decreased stress, decreased depression, decreased alcohol & drug use.
- For the youth participants, the program aim to decreased depression, decreased conduct disorders, decreased aggression, decreased tobacco, alcohol, drug use, increased cooperation, increased number of pro-social friends, increased social competencies, and increased school grades.
- For the family the program aim to decreased family conflict, increased family bonding, increase positive communication, increased family organization—family meetings, chores done, improved parent/child relationship, and increased family strengths and resilience.
- The program is conducted in 15 sessions with a pre and post-test. A minimum 10 families are engaged with participation from both the parent/s and youth. Each session is conducted once a week with assignments given for both the parents and child/ren. Parent meet separately and youth separately. Both parent and youth meet toward the end of the session. Each group is facilitated by a group leader. The leaders facilitate the family discussion.

6. CULTURAL RELEVANCE

The CYC-SFP program is a cultural adaption of SFP and is a new program. The lesson plan has been translated into Cantonese but has gone through several revisions to meet the different target audience whose education level, regional background and length in the US. are diverse. The program is strictly done in Cantonese and incorporates many of the cultural traditions, beliefs and customs of the audience. The program is sensitive in incorporating Chinese traditional health and well-being as well as incorporating American concepts in health and well-being. An example is the concept of family meeting. Convening a family meeting is not something that would work for many recent immigrant families. As mentioned, the program is new and it's a cultural adaption of a well establish evidence-based model that has been proven to work for many diverse populations but has not been implemented for recent Chinese immigrant population. The program has an evaluation process in place and will be implemented in this fiscal year. Participants complete both a pre and post test as well as a retro evaluation. The results of the SCFP are compared in a quasi-experimental design to those of other agencies in San Francisco implementing SFP with ethnic families as well as to the SFP norms collected from similar agencies across the USA implementing SFP. Once more data are collected from future groups a publication will be prepared for submission on the effectiveness of this Chinese version of SFP. Other Chinese immigrant services agencies are interested in replicating the new SCFP in the USA and also in Australia. In addition, the UN Office of Drugs and Crime is interested also in replicating the program with additional Chinese mainland cultural adaptations and with an evaluation by the University of Beijing School of Public Health and the University of Shanghai Medical School. These Chinese universities are now conducting the needs assessment using the SFP pre-test of family risk and protective factors to inform the cultural adaptation.

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

1. NAME OF PROGRAM:		
UPAC Elder Multicultural Access and Support Services Program		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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Program is funded by the County of San Diego, Behavioral Health Services, with funding from MHSA PEI.

4. TARGET POPULATION

The UPAC EMASS Program utilizes a promotoras or "community health workers" as health care liaisons for the Filipino, Latino, African American and Somali community. This target population was identified per our contract with the County of San Diego. In San Diego, Filipinos have the highest number of Asian elders, which is the reason why it is the target population in the EMASS program.

The program provides services in the following languages: English, Tagalog, Spanish and Somali.

The program is intended for seniors (ages 60+) from the Filipino, Latino, African American and Somali community, particularly those who have limited access to physical and mental health care due to cultural/linguistic barriers, financial and transportation barriers.

UPAC EMASS provides center-based services at the Escondido location, as well as a satellite location in Central San Diego. Mobile and field-based services are also conducted at senior centers, senior apartment buildings, senior residences, churches, Assisted living facilities, Adult Day Health Care programs, and other facilities where seniors gather. While most of the services are provided in urban and sub-urban parts of San Diego, we have also provided outreach to seniors residing in rural parts of San Diego.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Problems: lack of awareness about mental health issues, and how to access mental health issues. Cultural stigma,

linguistic and cultural barriers also prevent older adults from seeking mental health services and achieving overall wellness. For Filipinos in particular, they lack awareness about available mental health preventative mental health services in the community. They also have limited access to those services. While many Filipino seniors may understand English and communicate in English, not all of them can easily engage in the treatment process.

Protective factors – strong cultural identity/pride with traditional beliefs, support from family, connection to spirituality. Additionally, EMASS has two Filipino staff who are culturally competent in Filipino culture, aging issues and mental health challenges. Filipinos tend to have a collectivist identity and favor communal activities; therefore the EMASS center provides the venue to gather and practice group-oriented activities.

Risk factors – immigrant/refugee/ethnic minority status, limited English proficiency, history of abuse or trauma, complicated medical issues, stigma about receiving mental health services, communication barriers, and limited access to transportation and/or health care. For Filipinos, further risk factors include lack of mental health providers who are culturally competent in working with Filipino elders.

Goals:

1. increase timely access to care
2. Reduce disparities in care
3. increase and maintain individual self-sufficiency
4. Increase knowledge about healthcare system
5. Reduce isolation / increase socialization
6. Reduce utilization of specialty and emergency room services
7. Reduce institutionalization

6. CULTURAL RELEVANCE

The program uses community health workers to conduct the outreach. They have linkages to ethnic organizations, churches, adult day health care programs, and other facilities where older adults tend to live and gather. EMASS is different from Senior Centers and Adult Day Health Care programs because whereas Senior Centers provide center-based activities, the EMASS program provides center-based activities, in addition to mobile/field based activities. Additionally, whereas ADHC programs provide supervised/restricted social recreational activities, the EMASS program provides guided social and recreational activities with less restriction.

Regarding outreach to Filipinos, the outreach was conducted in Tagalog which is the national language and common means of communicating amongst most Filipinos. (Pending available future funding, EMASS would also like to employ other Filipino staff who speak Ilocano and other dialects.) The Filipinos who attend the EMASS center are varied in their professional and vocational experiences. Some have had limited education, while others were previously professionals and/or involved in the U.S. military. Some are living at home with their adult children, while others are living in senior housing.

The program also was creative in outreach by implementing County-funded senior congregate meals at the Escondido location twice per week. The meals served typically consist of a Filipino menu or Latino menu. The congregate meal setting allows for participants who naturally gather around meal time to develop relationships with peers and community health workers, and also to receive education at the same time. The congregate meal setting is a culturally appropriate way of gathering people because Filipinos enjoy eating and chatting in groups. Most of these older adults

miss their family and they complain that their children have not time for them. As a result, they often eat alone at home most of the time. That is why the congregate meal setting at the EMASS center allows for groups to gather, and also to receive education. The EMASS Center also provides a venue for senior participants to vent their feelings in a safe environment and use peer support and counseling to enable them to function effectively and address their overall health concerns.

Regarding traditional beliefs and customs, the program usually celebrate every month the traditional holidays for Filipinos, African Americans and Latinos; and what they do during those holidays and incorporate them in our program of activities. December is usually a Christmas celebration for Latinos, African Americans and Filipinos we share our memorable holidays and why it is memorable to him/her. Then, the seniors sing Christmas songs; and dance with Christmas songs. The program facilities discussion to talk about religious beliefs during Lenten Season for Christians; Mother's day and Father's day. The program also talks about celebrating Mexican Independence Day. The program also had many multi-lingual videos/music which play at the center which reflect the cultural traditions of the participants. Filipinos often use social activities such as dancing and singing to lift their spirits. The EMASS Center hosts such activities for Filipinos and other participants on a frequent basis. As far as religion and spirituality, Filipinos are very religious and have a strong faith in God. They typically resort to prayers to lift up their burden to God. The Community Health Workers have been trained in encouraging seniors to utilize their own spiritual/religious beliefs as a source of strength.

Regarding cultural elements, the program staff use the world "emotional problems" instead of mental health issues. The program staff also use the word "stressful situation" instead of mental health breakdown. The program practice coping skills such as: problem-solving; prayers and meditation; breathing exercise; music therapy; dancing; talk to someone they trust (talk therapy). Filipinos tend to be wellness oriented in general. Using this approach as a way to engaged them in the EMASS program will be the starting point to talk about their emotional health, mental health and coping skills. Filipinos tend to be more responsive to prevention intervention rather than going to treatment for mental health.

Regarding sensitivity to historical issues (e.g.: immigration, war trauma), the program includes in discussion when they come the first time in the US; what problems they encountered; how they cope with these problems; who helped them; then acknowledged their strengths and provide them inputs on the process of acculturation and assimilation. Promotoras/Community Health Workers will explore how EMASS can help them. Some participants have shared problems with immigration, and the Community Health Worker staff help to address those issues.

This program was developed as a response to a Request for Proposals from the County of San Diego. Prior to the development of the RFP, there was considerable input from the Filipino, African American, Latino and African refugee community. After the program was implemented, we continue to receive input from community leaders in the respective communities. The program was developed through a partnership of four non-profit organizations who represent the following communities (1) Filipino, (2) Latino, (3) African American and (4) Somali.

7. ADDITIONAL INFORMATION

The program provides community outreach strategies through the Promotoras model. The Promotoras model uses Community Health workers who apply a social intervention model, based on the development of partnerships between providers of health care services and community members. They serve as the bridge between the providers of health care services and the targeted ethnic communities.

The program utilizes individual interventions (1) Interpretation/Translation, (2) Advocacy, (3) Peer Education and Support, (4) Referrals to basic social services, (4) Depression Screening, and (5) Transportation Assistance. In addition to individual interventions, the following Group Interventions are used: 91) Healthier Living Self Management Workshop, (2) Good Mental Health is Ageless, (3) other older adult health/wellness curriculum, (4) Weekly social and recreational activities; (5) Ethnic support groups.

The program hosts educational activities including "Healthier Living" Self-management curriculum, as well as "Good Mental Health is ageless" curriculum. The "Healthier Living curriculum" is an evidence based practice developed by Stanford University. It emphasizes chronic disease self management. Although the Healthier Living curriculum is identified as an evidence based practice, it has not been specifically identified as an evidence-based practice for the API community. The Healthier living curriculum requires about 2.5 hours per session, with 6 sessions for the series.

The "Good mental health is ageless" was created by County of San Diego, Aging and Independence Services. It focuses on tips for staying well, and for older adult participants to be able to recognize early warning signs of depression. The Good mental health is ageless workshop can be done in 1 session, and typically takes about 1.5 hours – 2hours to conduct.

All programs can be replicated, but translation is required in different languages. All activities can be done on a one-on-one basis, or can be done in a large group classroom format.

In addition to the "signature" programming listed above, the UPAC EMASS program promotes peer counseling, as well as social/recreational activities such as "Laughter Yoga", computer class, and congregate meals for seniors. Transportation education is also provided through the assistance of a Mobility Lead staff in order to promote self-sufficiency.

Activities are provided weekly at the EMASS Center in Escondido, and also at mobile locations around San Diego County. Mobile locations include senior apartments, other senior congregate meal centers, Adult Day Health Care programs, cultural centers, and other facilities where seniors tend to gather. If activities are provided at the EMASS Center, they are often provided on the same day as our senior congregate meals which are provided at the center twice per week.

We currently have the following staffing:

For Filipino participants, we have:
1.0 FTE bilingual Filipino Program Manager
.65 FTE Filipino bilingual Community Health Worker

Additionally, the Program Manager for the Congregate Meals is bilingual Filipino, and is present for meal service twice per week. Furthermore, there are several part-time Filipino volunteers who assist with co-facilitating the Healthier Living workshops, and who also assist with meal service during congregate meal days.

For other participants, we have the following direct staff:
1.0 FTE bilingual Somali Community Health Worker (CHW)

1.3 FTE bilingual Latino Community Health Worker
1.0 FTE African American Community Health Worker

Lastly, we have 1.0 FTE bilingual Mobility Lead/Admin Assistant (Spanish speaking) who assists all participants.

Community Health Workers receive training as Promotoras, and shall be experienced and have knowledge about community health outreach and education with their respective communities. CHWs shall be community leaders, age 55 or over, from each of the target communities. They will be responsible for providing outreach, education, peer mentoring and facilitating access to other services and support.

The Mobility Lead staff will be experienced and knowledgeable about community-wide transportation service network.

Most staff are required to be bilingual in the following: Tagalog, Somali, Spanish and English.

The average ratio of staff to participants on a given day is approximately 1 staff to 25 participants.

A facility is required for some of the center-based activities. Outreach activities are also conducted in the senior apartments/community/health fairs/ recreational buildings/social service programs for older adults.

The program is being evaluated thru satisfaction surveys and also focus groups. This program is also working with contractor evaluator from UCSD Health Research Center to look at outcomes. The UCSD Health Research Center has been able to find favorable outcomes with this program. However, the outcomes are only available for one year only because this program was just implemented in October 2009.

The biggest barrier with the data collection process is that not all participants have the same literacy and reading ability in their own native language. Also, the surveys had to be translated into each respective language. The focus groups also required the use of an interpreter. Currently, the basis of effectiveness I mostly the rate of participation. Regular participants invite their friends, neighbors and relatives to join the program. Most of the time, testimonials are captured and published in the EMASS newsletter. In FY 10-11, there were 304 Filipinos served out the targeted 800 older adults (Filipino, Latino, African American and Somali) for this project. There were 304 Filipinos served out of the 906 total served, which 34% of total population served. Other cumulative statistics include the following: Goal 1 – Increase timely access to care: 404 duplicated clients; Goal 2 – Reduce disparities in care: 483 duplicated clients; Goal 3 – Increase and maintain individual self-sufficiency: 775 duplicated clients; Goal 4 – Increase knowledge of healthcare system: 1023 duplicated clients; and Goal 5 – Reduce utilization of specialty and emergency room services – 813 duplicated clients.

The board, management and staff consists of primarily Asian/Pacific Islander representatives. However, there is a growing contingent of African American, Latino and other refugee/immigrant communities within UPAC staff. Among the 117 UPAC staff, 74 are Asian/Pacific Islander.

The agency provides cultural competence training in-house, and also recommends staff to attend cultural competence training in the community. The same applies for clinical trainings. UPAC does not have a dedicated training department.

UPAC's mission is to provide for the social service needs of San Diego County's Asian/Pacific Islander and other ethnic communities of San Diego. It was established in 1974, with mental health services being the largest component of its services. UPAC has been providing mental health services to youth, young adults, adults and older adults from the API community for over 25 years.

Particularly in working with older adults, UPAC works closely with local Aging and Independence Services (AIS), senior centers, and other older adult providers to serve unserved and underserved seniors. The EMASS Program Manager also sits on the County of San Diego Behavioral Health Services Older Adult Council as a representative of Asian/Pacific Islander communities. The role of the Older Adult Council is to provide an advisory role to the Mental Health Director for San Diego County.

EMASS also has a strong partnership with the UPAC Positive Solutions program, which is funded by County of San Diego for prevention and early intervention. Services are provided to older adults, including API adults.

EMASS has also developed some initial collaboration with CEMHAC, California Elder Mental Health Aging Coalition.

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

1. NAME OF PROGRAM:		
Family Development Project (FDP)		
2. TYPE OF PROGRAM:	x	Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Muslim American Society-Social Services Foundation
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masssfsac@yahoo .com
or
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Sacramento, CA 95821
(916) 486-8626

4. TARGET POPULATION

Target population: Muslim, including of course Asian Pacific Islander Muslims.

Language of delivery: English currently. Delivery in Arabic, Urdu, Punjabi, one Afghan language, and Bosnian is desirable and will become possible in the future as capacity permits

The FDP is intended for any Muslim. Refugees and immigrants may have specific needs and risks. Indigenous Muslims such as US born African-Americans and Anglo and Latino converts may also have specific but different needs and risks.

The FDP is not restricted to or intended for people in a particular setting. Most people who attend are from the Sacramento area.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The FDP is intended to increase the number of emotionally and spiritually healthy Muslim families and individuals.
The FDP is intended to address the following serious problems in the Sacramento Muslim community:

Emotionally and spiritually unhealthy families leading to domestic violence, high divorce rate, youth who are alienated from family and faith community, developmental trauma, abuse of and addiction to alcohol, illegal and prescription drugs, and addiction to gambling.
Mental illness triggered by living in an unhealthy family environment may be reduced. Resilience against religious bigotry and racism in the social and political environment may be strengthened.

6. CULTURAL RELEVANCE

A needs assessment was conducted. Muslims were most concerned to see the organization provide counseling for marital and parenting problems. After that was organized the FDP was set up to provide prevention and early intervention.

The major outreach strategy is creation and delivery of culturally and spiritually appropriate psycho-educational workshops. They cover the lifespan: Marriage Preparation, Communication in Marriage, Prenatal Childbirth Education for Couples*, Breastfeeding, Parenting Young Children 0-5, Parenting Children from 6-12, Parenting Teens, Conflict Resolution in Family Relationships, Stress and Anger Management*, Preparing for Retirement*, and Caring for Aging Parents.*(Starred workshops are in preparation.)

A more recent strategy is teaming with SALAM mosque for intense months devoted to a particular topic. In April, 2012 a month of events focusing on bringing mercy and compassion back into marriage was successful. The imam presented Friday four congregational sermons on the topic. MAS-SSF presented two three-hour mini-workshops to showcase the structured pre-marital counseling 12 hour 6 session sequence and the full-length communication in marriage workshop. In a culminating event the imam had a three-hour question and answer session in the prayer hall with community members. Future month-long projects are being planned.

Cultural traditions, beliefs, and customs that support healthy family life are encouraged. They may co-exist harmoniously with congruent spiritual traditions in Islam. Presenters are Muslim community members who have knowledge of historical issues of fellow Muslims. In some cases they share the same or similar experiences.

The curricula incorporate cultural elements as well as material from spiritual traditions of Islam that support mental health and wellness. Discussion of cultural elements that are not supportive of mental health and wellness is encouraged. For example, stigma and discrimination against people with a mental illness are cultural traditions that do not support health and wellness. Keeping family and individual problems secret and avoiding treatment or information about solutions are cultural traditions that do not support health and well-being. The spiritual traditions of Islam discourage stigma and encourage seeking help and knowledge.

At this time attendance at a public parenting or marital workshop is still a very unusual action for most Muslims. However since 2007, average number of attendees at any particular workshop or class increased from five to over fifty in the last two workshops. With time community members will become even more comfortable with sharing questions, concerns, and problems with SSF staff in workshops and in counseling if they seek it. Seeking help and knowledge to solve problems before they lead to trauma and crises will be normal for the next generation.

Evaluations are collected at the end of workshops.

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

1. NAME OF PROGRAM:		
Filipino Mental Health Initiative (FMHI)		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
	x	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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*Permission has been given to Asian American Recovery Services (AARS) to submit the program to CRDP.

4. TARGET POPULATION

The Filipino Mental Health Initiative (FMHI) intends to serve Filipinos in San Mateo County. There are over 70,000 Filipinos in this county (9.8% of the population) and over 50,000 live in the city of Daly City (the most per-capita US city population of Filipinos outside of Manila) and in surrounding areas. Three main components of FMHI specifically target behavioral health clinicians who work with Filipino clients, parents of middle school students who attend a high Filipino-populated school, and attendees at a widely attended annual Filipino festival.

FMHI's activities include provider trainings, family nights, and community outreach and are conducted predominantly in English with opportunities in Tagalog to better articulate and explain cultural aspects of health. Because of the large American influence in the Philippines, a majority of Filipinos have a general understanding of the English language. FMHI updated a 136-page county resource guide with Tagalog translation as a way for Filipinos to identify with a community resource directory and to access critical services otherwise not sought. Updated mental health resources, media contacts, Philippine Consulate, Social Security, US passport services, and Department of Motor Vehicles were

added to the directory.

FMHI reaches out to the broader Filipino population with an emphasis on the immigrant population since their assimilation to a new country can pose a potentially chronic and problematic adjustment period. Problems such as substance use, lack of knowledge related to acceptable forms of disciplining children, domestic violence, under or unemployment, gambling, and isolation, to name a few, are indicators that gravely affect one's mental health in deleterious ways if not addressed. Focus groups conducted by FMHI during its inception determined that mental health is a heavily stigmatized topic that is often ignored and highly misunderstood.

To maximize benefit and impact, FMHI targeted behavioral health personnel including psychiatrists, psychologists, community mental health nurses, case managers, therapists, counselors and student interns who work with Filipino clients. Direct service personnel not familiar with the Filipino culture, beliefs, and behaviors were invited to learn about the history and people of the Philippines as well as learn pragmatic solutions to improve professional effectiveness. Another targeted group in a specific setting were parents of middle school students. Two middle schools in Daly City, which both consisted of high percentage of a Filipino student body, hosted family nights which discreetly addressed mental health by presenting topics about communication, effective parenting, substance use and asset building. The third setting targeted was at a widely attended annual Filipino festival in Daly City. FMHI strategically placed a booth near the main stage for visibility and hopes to attract the busy foot traffic.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

FMHI aims to decrease stigma associated with mental health, to increase outreach to the Filipino community about mental health, and to increase access to mental health services and other related services needed to increase the well-being of the Filipino community.

The notion and concept of mental health in the Filipino community is heavily stigmatized. Blatant denial, lack of knowledge and lack of acceptance poses problems which not only affect the individual but transmits throughout the extended family unit. The complex dynamics of stigma affects and often impairs decisions related to self-care, self-worth, and health-seeking behaviors and can have lifelong implications. Family members often misunderstand the root causes of mental health issues making them reluctant to acknowledge problems. For the providers who aim to assist Filipino clients, many can seem unsympathetic, judgmental or aloof if they do not understand the full value of the stigma that which the client lives in. The client can internalize these as negative experiences with service providers and result in not seeking further services.

FMHI uses culturally appropriate strategies to maximize and benefit the community. Because mental health is not a term readily understood and accepted as part of the health spectrum, FMHI aims to craft activities that are reframed and better recognized in the natural cultural context such as having colorful and translated brochures, and utilizing more positive phrases such as "getting ready for high school" versus "how to help your child avoid drugs". In addition, using culturally appropriate context helps to appreciate the complexity of the Filipino experience. Acknowledging how Filipinos perceive health can help the community's ability to identify mental health issues, recognize that sensitive culturally-competent help is available, and be comfortable seeking needed services.

The complexities of comorbidities with other illness processes, substance use, lack of accessing needed services, are just a few of the challenges ahead for FMHI. The stigma within those problems in combination with mental health disorders is deeply and widely felt in the community. Denial of health issues, specifically mental health related, will

not be easy to overcome. FMHI hopes to educate and increase awareness about various factors which promote the well-being and importance of seeking effective information and help.

6. CULTURAL RELEVANCE

Because of its highly stigmatized association, strategies to outreach include reframing discussions about mental health to other verbiage that the lay Filipino can relate to. At the festival, basic questions were asked of visitors at the booth "True or false: only poor people get depressed." Aside from the high likelihood of answering correctly, this entry point of engagement was a critical window to begin even a brief dialogue about the mental health topic. Also, experience has taught FMHI that the desire for privacy regarding mental health issues makes many reluctant to come forward to learn more, much less seek help, in a public venue, and so it was important to conduct public outreach and promote visibility in venues under our control and where we had support. FMHI conducted outreach efforts at an annual festival popular and widely attended by Filipinos. Another outreach strategy specifically for the parents of students who attended heavily Filipino-populated middle schools needed the support of the school principals. From the collaboration, FMHI-sponsored family nights were strategically advertised during talent show intermissions, notified with report cards and calendared during the school year. In addition, dinners, childcare and raffle prizes were offered as incentives to attend. For the provider trainings, continuing educational units (CEUs) were offered not only for professional credits but also confirmation of the importance of this culturally-specific educational opportunity.

FMHI considers the Filipino experience in all its activities. During the 6hr provider trainings where Filipino food is served, the credible and highly sought out speakers (who are Filipinos) present from both lens: as a provider and as a member of the community sharing personal insights. Cultural values from an ethnocentric perspective and in terms of Filipino world, view and milieu are intertwined to enhance the learning objectives of the attendees. FMHI's presence at public events including the festival and school settings are carefully set up so the outreach effort is welcoming and festive (a primary trait of the Filipino culture): the colorful banner “Mindful of Our Community's Health" (rare mention of mental health due to the stigma), FMHI staff speak the native dialects to immediately engage the connection, balloons are present, and the customary smiles are part of the interactions.

The first 3 hours of the 6 hour provider trainings provide a lively historical and anthropological presentation which is helpful in understanding the early stories of the Filipino people, their existence and interrelation with other cultures. The trainings attempt to bridge the existing gaps of understanding between the provider perspective with western approaches with how Filipino communities live and conceptualize health. The trainings give special attention to the impact of the immigration experience from the perspective of Filipino-Americans. Attention is also given to post-immigration acculturation and how the experiences vary between Filipinos born abroad as adults and those who were born in the US or immigrated to the US at a very young age.

In provider trainings, clinical vignettes of Filipino clients are presented and group- discussed to deepen empathy, validate and possibly correct professional insights. In addition, Filipino consumers of mental health services are present to share their perspective and their cultural lens regarding their state of health. Presentations at the middle school incorporate cultural aspects of parenting children in the US, the differing experiences of students in modern school environments and the effect of how parents address esteem and disciplinary opportunities. FMHI aims to increase awareness with cultural elements into consideration so that aspects of mental health are not as a source of shame but as one of the very common perils of life in our stressful modern times.

FMHI has formally been in existence since 2006. Prior to the birth and to current, FMHI has consistently received

input from the community. A series of outreach and planning discussions facilitated by the San Mateo County Department of Health during a Prop 63 process began in 2004 with an informal group of service providers known as KAPAG (which stands for Kapwa Advocacy Group) and then broadened out to include community members, providers, business owners, consumers, leaders, line staff, clinicians, politicians, attorneys, agency directors, law enforcement, and individuals who had an wholehearted interest in serving the Filipino community. The discussions entailed input of needs, barriers and solutions to addressing mental health.

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

1. NAME OF PROGRAM:		
From Killing Fields to Growing Gardens		
2. TYPE OF PROGRAM:		Universal prevention
	x	Selective prevention
	x	Early intervention
		Other (please specify)
3. NAME OF PROGRAM DEVELOPER – Please include all contact information		
Amy Phillips for the Cambodian Seniors Nutrition Program c/o Little Tokyo Service Center • 231 E 3rd St, G106 • Los Angeles, CA • 90013; 213.473.3035; aphillips@ltsc.org		
4. TARGET POPULATION		

From Killing Fields to Growing Gardens serves Khmer-speaking older adults aged 55 and up. Survivors of the infamous Killing Fields and brutal Khmer Rouge regime in Cambodia experience a variety of mental health issues related to their experience. Common diagnoses include Post-Traumatic Stress Disorder, anxiety, and depression. As in many Southeast Asian refugee communities, Cambodians tend not to utilize professional mental health services due to language barriers, cultural stigma, and a belief in supernatural causes for mental health phenomena. Low levels of literacy and acculturation, particularly among older adults, as well as a general distrust of authority due to abuses by the government under the Khmer Rouge, make it particularly difficult for outsiders and professionals to penetrate this population though the needs are great.

In order to address these needs, service providers can make use of the natural assets of the target population. Since Cambodia is largely an agrarian society, many older Cambodians retain memories and skills to grow plants and crops from their younger days in rural areas. Research indicates that working in a garden can be immensely therapeutic for people in general. However, many Cambodian seniors live in apartments or other settings where there is not enough land for a garden. A community garden can provide the space for seniors to be active and interact.

Bringing together Cambodian older adults under the guise of gardening allows trained staff to engage consumers and establish a rapport with them outside of a clinical setting. Establishing this trust makes it easier to educate and refer consumers to mental health resources as necessary. Growing a garden necessitates daily or almost daily work. This simple fact draws older adults to the garden so that staff can engage them regularly, either in a rotation of "volunteers" or daily. The level of care is adjusted to the size of the Cambodian population. As the number of participants expands, the garden can be expanded as well.

Note: This program could be adapted for other immigrant senior populations with agrarian backgrounds by modifying the language, outreach methods, types of plants and growing methods to the specific ethnic population.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The primary goals of the program are to improve the mental and physical health of Cambodian seniors through an integrated approach that taps into their existing skills (an improved sense of well-being as they feel productive and useful) and encourages them to talk about their experiences. This is important because many Cambodian seniors self-report or exhibit signs of depression or anxiety. Their mental state often has an adverse effect on their physical health as well since they tend to experience their symptoms somatically.

The mental and physical distress experienced by older generations can have a negative spiraling effect on entire families and communities. As spouses, family members, and friends feel stressed about their loved ones, they have less energy to help each other cope. Therefore, a secondary goal of this program is to improve natural support systems as caregivers and family members of participants also experience a reduction of stress and develop a better understanding of the seniors' experiences.

The protective factors the program aims to enhance include: participation in pro-social activities, good physical health, a sense of identity and purpose, strong family or community support, access to timely referrals and additional services, and connections with other living things. The primary risk factors reduced include: social isolation and inactivity.

6. CULTURAL RELEVANCE

Historically, Cambodia is an agrarian society and many older Cambodians grew up in rural areas. By growing vegetables and herbs that are native to Cambodia, Khmer older adults can feel a sense of connection to their home country and culture, as well as a kinship with the earth. This, and interacting with Khmer-speaking peers, reduces social isolation. Family members are also invited to participate alongside the older adults for an intergenerational interaction and to encourage sharing of stories and culture from Cambodia.

Past experiences such as witnessing the brutality of the Khmer Rouge and life in refugee camps, or immigrating to the United States are difficult for many people to talk about. Additionally, Cambodian seniors often feel out of place, useless or dependent in the U.S. due to language barriers, cultural differences, and the lack of education and skills to participate in the economy. Gardening not only taps into their cultural heritage, but also helps participants feel productive.

The gardening project for Cambodian seniors began as a result of the Cambodian Seniors Nutrition Project's desire to improve health. The participants themselves cited a desire for the herbs and vegetable from their native palate. They reported the difficulty they experienced in finding fresh items at an affordable price. One of the seniors among the group is an expert gardener. Community members and organizations worked to identify a piece of land large enough to use as a communal gardening space.

Under the direction of the senior gardener, the garden flourished. Staff began noticing that not only were the vegetables and herbs flourishing, but also the men and women actively participate in the gardening. The staff used this opportunity to engage participants in conversations and sharing.

Outreach methods for this program are primarily through word of mouth due to the varying literacy levels in the target population. Program staff go to temples and grocery stores, or tap into informal networks of friends. Initial assessments are conducted at the consumer's home or at a local community-based organization. All other activities are conducted at a community gardening space, or en route to or from the garden.

Informal interviews appear to be the best way to gather data from consumers about the effectiveness of this program due to the lower literacy rates and a general distrust of governmental and other "official" authorities. They report an increased sense of pride in their work, and while they do not usually explicitly use terms such as reduced "depression" or "anxiety," staff observed more lively conversation, laughter, etc. as indications of improved mood. As providers earn the trust of program participants, participants may grow increasingly likely to participate in more formal forms of evaluation.

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

1. NAME OF PROGRAM:		
Richmond Area Multi-Services, Inc. (RAMS), Fu Yau Project		
2. TYPE OF PROGRAM:	X	Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

The Fu Yau Project (translation "*to support & promote the well-being of young children*) represents a collaboration of RAMS and SF Department of Public Health – Chinatown Child Development Center (CCDC). In operation since 1999, the program is funded by a grant from the SF Human Services Agency's CalWORKs Program, SF Department of Children, Youth & Their Families, San Francisco Families and Children Commission, and Preschool for All through the SF Department of Public Health Community Behavioral Health Services - Child, Youth and Family - System of Care, Quality Child Care Mental Health Consultation Initiative.

RAMS, Inc.
3626 Balboa Street, San Francisco, CA 94121
Tel: (415) 668-5955; Fax: (415) 668-0246

4. TARGET POPULATION

The Fu Yau Project (herein referred to as "Fu Yau") provides prevention and early intervention mental health services and consultation to the childcare community for children, ages 0–5. The target population are childcare centers/sites and family resource center's that serve children & families of color or otherwise marginalized communities, living in high crime or unsafe environments and neighborhoods, who are immigrants, or refugees. They are often monolingual in a language other than English, or have limited capacity to speak and/or understand English..

The Fu Yau Project currently provides services at more than 44 childcare centers, 8 family childcare providers, four family resource centers (FRC), and one after school site, which are located in over nine San Francisco neighborhoods. The program's current client demographics include the following: 99% are low-income families with limited resources; over 80% of the families are of Asian & Pacific Islander ethnicity, many of whom are from China and have limited or no English-speaking skills; 12% are Latin Americans; 6% are African American.

The sites' staff reflect the ethnic and linguistic diversity as the families in the programs; majority of staff speak a Chinese dialect or Spanish as their first language. Childcare centers range in size from 24 to 120 children, family childcare sites with four to 14 infants, toddlers, preschoolers. Some of these providers also care for school-age children. Fu Yau also serves two home-based programs with 22 families. FRC programs range from 60 to over 100 families and some outreach to more than 500 families. The majority of the childcare centers has a mixture of federally funded (Head Start), state funded, and Preschool for All slots. A significantly smaller number of center-based programs accept tuition or other subsidies. The family childcare providers have children of mixed income families,

with some designed slots for subsidized agencies.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Program outcomes are to enhance the psychological well-being of children & families participating at their childcare center/site and/or family resource center sites as well as build capacity amongst sites and their staff to support young children and their families' needs and overall wellness.

Fu Yau services include: On-Site Program and Child Observation; Clinical Case Consultation with childcare/FRC staff and families; On-Site Intervention with individual and groups of children; Parenting Classes and Support Groups; and In-Service Training for the childcare/FRC staff related to child development and mental health related issues.

Families turn to their childcare center and/or family resource center for support when family issues arise (e.g. child-rearing, acculturation stress, legal system). Oftentimes, center staff/FRC find themselves stretching beyond their own knowledge base to meet the multiple needs of families; staff want to learn more about mental health and young children, in order to help parents engage prevention services when they are needed. Many childcare and/or family resource center staff are paraprofessionals, so they are able to utilize Fu Yau Mental Health Consultants to learn about children's basic mental health needs and socio-emotional development. Mental Health Consultants can facilitate skills-building to address some of the families' interpersonal needs: skills such as active listening, conveying empathy, and maintaining confidentiality. When site center staff collaborate with Mental Health Consultants, the families and children also benefit in many ways. Most importantly, the families are able to receive support in a setting that feels safe and familiar to them, from staff who possess a skill-set that is culturally and linguistically sensitive and grounded in a desire to strengthen family bonds.

Program specific goals include:

1. Understanding of Emotional and Developmental Needs: As a result of individual and group consultation, formal & informal trainings, coaching, and modeling, 75% of staff will report increased understanding of children's emotional & developmental needs, how to respond to those needs, and how to administer developmental screenings.
2. Communication with Parents: As a result of consultation services, 75% of staff will report increased learning to effectively communicate with parents about child's behavior.
3. Response to Children's Behavior: As a result of group and individual consultation, modeling, trainings, workshops, and written materials provided by consultants, 75% of staff will report in increased ability to respond to and communicate with children.
4. Overall Satisfaction: 75% of staff who received consultation services will report satisfaction with the quality of service received from their consultant.
5. Responsiveness to the Needs of Children: 75% of parents who receive direct services for themselves or children will report that consultant attended & responded conscientiously to needs.
6. Linkage to Resources: 75% of parents will report that consultant researched resources for their specific needs; consultant will assist parents in linkage to needed resources.
7. Understanding of Child's Behavior: 75% of parents will report that consultant helped them understand typical child development, the developmental stage of their own child(ren) and identify behaviors and needs via psycho-education, observation, and intervention.
8. Improvement of Child's Behavior: 75% of parents whose children received direct services will report that the consultant supported the child's social-emotional development and improved her/his behaviors. The direct

intervention improved their understanding of their child, their communication skills, and attachment, thus a result in measurable behavioral improvements.

The target population are childcare sites and family resource centers (administrators and staff), as well as the children and families served by the agency. Families and childcare/FRC staff possess the following protective factors:

- Oftentimes, the children are of families that are multi-generational (e.g. grandparents, aunts, uncle, etc.) who are actively involved in the children's immediate family. As such, there are additional resources available to support the parents (e.g. grandparents can assist with caretaking while the parents are working). This can increase the family's support systems to help sustain financial means.
- Parents tend to be very dedicated to preparing their children for school and academic success. As such, they are very motivated and open to taking suggestions/recommendations from the childcare site/FRC staff and Fu Yau Project Consultants (as well as coordinating with other referral systems) to support their child's success in school.
- Childcare staff are also very motivated and invested in the children's "success" and preparing them for school. As such, they can be receptive to Fu Yau Consultants.

Risk Factors include:

- As many of the children are of first generation, immigrant families, the parents tend to have more limited options for employment. The employment options tend to have low wages, without healthcare benefits, etc.
- Parents with limited employment options, in a down economy with diminishing jobs, have additional stressors on their existing already-limited financial resources (e.g. one parent may become unemployed; parent that maintains employment may have additional stressors at job).
- Because of financial stressors, the family may immigrate at different times, which is disruptive to the family unit and reduces the resources of all family members (e.g. one parent and one child may immigrate first while the other parent and children move years later).
- Childcare/FRC staff face similar stressors due to financial limitations, as pay scales tend to be low in the field. They are experience stress at home and, at the same time, while working with families with similar challenges.

6. CULTURAL RELEVANCE

The Fu Yau consultation services model includes: program consultation; individual and group staff consultation; classroom observation; child observation; and skills development activities (e.g. staff training, parent workshops). Direct services to children and families include: playgroup-socialization or -therapeutic; individual play therapy; individual parent sessions; crisis and short-term therapy for families or children; and facilitation of referrals for families and children to outside resources. Other strategies will involve assessing the site's needs on an on-going basis through regular meetings and surveys.

Fu Yau regards each childcare program as a "client." While this approach is not traditionally "clinical," it is, at the core, very relational. Consultants utilize any point of entry of an organization to establish rapport, trust, and "buy-in" for service implementation. This effective approach allows the organization and its staff to decide when and how to accept the offering of services. For example, some agencies' staff are initially mistrustful of outsiders (Fu Yau) or may minimize the social and emotional health of young children. In this case, the consultant focuses on providing "curb-side" consultation, which involves speaking with individual teachers in the spaces and times that are comfortable and safe for them. In Fu Yau's experience, consultants gain staff's trust, as the consultants value them and their needs, and adjust to formal group meetings. Per FY 2008-09 Provider Survey, 92% indicated high satisfaction with consultation

services (also, indicated increase understanding of children's emotional needs & development and to more appropriately respond to children's behavior and communicate with parents).

Fu Yau partners with childcare providers who serve underserved, low income families. The majority of the sites' families are Asian & Pacific Islander (75% Chinese), with the remaining families of Latino, African-American, and Caucasian ethnicities. The bilingual & bicultural site staff reflects the families' demographics (ethnically & economically), as childcare compensation is generally around minimum wage and some staff have limited English-speaking ability. Fu Yau supports children, families & staff by retaining bicultural staff with demonstrated experience working with immigrant & low income communities; 100% of consultants are bi- or multi-lingual.

Fu Yau matches the consultant's cultural & linguistic abilities and clinical expertise to the site in order to effectively serve the staff, children, and families. Consultation and direct services skills are further enhanced by RAMS and CCDC's effective supervision & training structure which includes the cross section of working with diverse communities (e.g. race/ethnicity, economically diverse, immigration generation, language, age, sexuality, gender, etc.) and the continuum of children & family issues and complex trauma. Fu Yau coordinates weekly in-service trainings and RAMS coordinates regular agency-wide trainings, including an annual mandatory culturally competency session.

Furthermore, consultants have demonstrated experience & understanding of the socio-historical experience of ethnic & linguistic minorities and economically diverse communities. For example, as many caregivers are extended family members; consultants facilitate workshops on intergenerational communication about discipline practices. Through community referrals, consultants offer additional family support in meeting basic needs (e.g. housing, food, and clothing) and provide direct psycho-education and outreach to families at risk for mental health issues. Consultants also support sites in managing the challenges of caring for children of mixed socio-economic groups.

In order to tailor services to the needs of each site, the Consultant, Program Director, and center staff have an initial meeting before service begins to do a Needs Assessment. In that meeting, everyone has an opportunity to create a clear picture of how they envision the work progressing, from beginning to end. A discussion also takes place about parameters, or scope of services, as well as expectations for the work logistics (e.g. frequency of visits, role definitions of all involved). The Site Agreement is reviewed, and goals for the year's work are established. Following these initial meetings, the Consultant follows-up with individual visits with each of the staff at the site, who are working with him/her. Subsequent meetings with the entire group of center staff occur to work out the finer details of the consultation activities, such as which topics for staff trainings or how parents are to be engaged in group activities (e.g. workshops or support groups). Weekly meetings with the staff take place to review the activities after they have occurred and plan for any necessary changes or further development of new activities. Furthermore, Fu Yau has actively engaged parents in various capacities including forming a parent advisory group with representatives from each childcare site. This group has significantly contributed towards shaping Fu Yau's priorities in service provision. The consultants also routinely meet with parents to discuss site-specific issues, establish their positions as partners with parents during program parent orientations and introduce Fu Yau services. During these meetings, parents may be surveyed about their support and resource needs and desired workshop topics. The program provides parenting classes, parent support groups, case consultations, and various cultural & family activities.

Examples of how cultural considerations are incorporated and demonstrated in the program design:

- Tailored staff recruitment efforts such that Fu Yau staff reflects the diversity of the target population (culture, ethnicity, preferred language for services)

- Tailored modality such that the program focuses heavily on working in groups. The target population tends to learn best in groups – members feel "safer" because individuals can blend in the larger unit
- Tailored groups types, depending on site – educationally-based with curriculum vs. support groups.
- Parent Advisory Committee, comprised of parents from the childcare center/site, who specifically provide feedback to the program about how to tailor the services, models, and outreach
- Tailored outreach strategies such that Consultants approach parents and foster relationships (instead of waiting for parents to come to Consultants)
- Tailored language in which services are provided (multi-lingual groups)
- Tailored approach with childcare/FRC staff in acknowledging strengths and working on increasing knowledge about adult-child communication styles, particularly since there may be differences between practices/protocols in the U.S. vs. home country
- Tailored program materials (including Fu Yau Site Agreements, information to children & families) are available in target population languages

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

1. NAME OF PROGRAM:		
UPAC HEART Program (Helping to Empower Authentic Relationships for Teens)		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Dixie Galapon
Mental Health Director
UPAC
5348 University Avenue, Suite 101
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4. TARGET POPULATION

The HEART program works with a multicultural population of Asian/Pacific Islander, Latino and African American youth exposed to dating violence, or are at risk of dating violence. The youth/young adults live in San Diego County, and are ages 18-24. Services are provided primarily in English, but interpretation services are available. We currently have a Spanish-speaking young adult in our group; and we utilize an interpreter for her.

This outreach/education component of the program can be done in multiple settings – typically community center where youth groups congregate. Individual mentoring and safety planning can be done at mobile locations, and/or program office. The G-TREM "Love and Life" groups are provided at any facility that can host a group. Individual counseling and family counseling are typically done in the program office, but can be provided off-site as needed.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Problems: lack of knowledge about dating violence; lack of awareness regarding community resources; lack of skills on how to do safety planning.

This program aims to prevent future incidences of dating violence to those youth/young adults who have experienced dating violence from Asian/Pacific Islander, African American and Latino communities. It also aims to prevent dating violence for those youth/young adults who may be at risk for dating violence.

Protective factors – strong cultural identity/pride, strong cultural identity as youth/young adults

Risk factors – immigrant/refugee/ethnic minority status, limited English proficiency, history of abuse or trauma, some

cultural "acceptance" of abuse or trauma; lack of recognition of problems with dating violence.

Process Goals include:

(1) Level 1 Services – 300 victims of dating violence will receive education on the cycle of dating violence
(2) Level 2 Services – 150 victims of dating violence will receive safety planning, mentoring, peer support, and linkages to community resources
(3) Level 3 Services – 75 victims of dating violence will participate in G-TREM group counseling

Goals – (1) increase self esteem of youth; (2) decrease trauma and depressive symptoms in youth; (3) increase knowledge about dating violence among youth and young adults. These specific outcomes are measured via pre/post surveys, and are given to youth during their participation with Level 2 and Level 3 services.

6. CULTURAL RELEVANCE

We use youth mentors who have same cultural/ethnic match as the communities they serve, i.e. Asian/Pacific Islander youth mentor, African American youth mentor, and Latino youth mentor. The program incorporates' the target population's traditions, beliefs by using mentors from the community to speak about their experiences with dating violence (i.e. African American, API) in educational outreach video. The outreach video created for the HEART program reflects true-life experiences of African American and API victims of dating violence as they share their personal stories of struggle and survival. Cultural outreach is also done thru use of technology (Facebook, Twitter, etc.) to capture youth/young adults with similar concerns, as well as using creative art projects to capture youths' attention. Outreach is done in middle and high schools, colleges, and other venues which have a large number of the target population. Outreach is also done to individuals who have been in juvenile hall, as well as gang-involved youth.

The education (Level 1) services educate youth/young adults by "quizzing" participants on signs of dating violence in present-day society. This is done by bringing in examples of Top 40 music and by asking the audience to identify if there any abusive themes in the lyrics. This appears to be culturally consistent with the youth as many of them are engaged with Top 40 music on a regular basis. A similar exercise is done by looking at examples of dating violence in the media.

The mentoring/safety planning (Level 2) services are tailored to the individuals' needs and strengths, including their cultural needs. For example, if the youth has not been involved in counseling before, that youth may have some hesitation to receive services because of cultural stigma and other reasons. The role of the youth mentor is to provide some education on the benefits of counseling, as well as provide tools for maintaining safety if the victim is in an active abusive relationship.

In terms of (Level 3) G-TREM Services, there are not specific cultural elements incorporated into the Love and Life curriculum, but facilitators will elicit discussion about cultural norms and cultural views on trauma, wellness and healing during the group process. For example, many API youth have been told by their parents, that they are not allowed to "date." The group normalizes that fact by mentioning this as a common experience among API youth. The program also demonstrates sensitivity to historical issues of immigration and war trauma by recognizing that their parents may have very different notions of dating and dating violence, depending on their own cultural upbringing. There are not specific cultural elements built into the curriculum, but staff will elicit some of these elements in discussion. Furthermore, while the G-TREM group is focused towards female victims, there has been more research suggesting that there are young male victims of dating violence. As a result, this piece of information is also brought

into the discussion during the G-TREM groups.

Given that the target population aims for youth/young adults, ages 13-24, we recognize that we have to separate the younger group participants (ages 13-17 approximately) from older participants (ages 17-24 approximately) because of differences in maturity, experiences with dating, etc.

This program was developed through a collaborative partnership with representatives in San Diego County who represent domestic violence, youth organizations, and refugee/immigrant communities, including African American, Latino and Asian/pacific Islander communities. The program was developed through a successful grant proposal submitted to the Office on Violence against Women, awarded in October 2010 for a three-year duration. Of the 15 youth-serving awardees for this grant nation-wide, UPAC's HEART program was the only awardee that specifically targeted a specific multicultural population.

We also recognize that dating violence impacts many young men, and young men have been taught to remain silent on this issue. We have actively recruited for male mentors (paid or volunteer) to assist with outreach to male victims.

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

1. NAME OF PROGRAM:		
Incredible Years (IY) BASIC Preschool Program		
2. TYPE OF PROGRAM:		Universal prevention
	xx	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

The original developer of Incredible Years (IY) is Dr. Carolyn Webster-Stratton who is Professor and Director of the Parenting Clinic at the University of Washington. However, in order for CCDC to implement IY at our clinic, our clinicians have had to make both cultural and linguistic adaptations. The names of the primary staff involved include Jenny Chan, Irving Mok, Grace Fung, and Joe Lai. They are all licensed clinicians at the Chinatown Child Development Center (CCDC), San Francisco Dept. of Public Health, 720 Sacramento Street, San Francisco, CA 94108. Telephone number: 415-392-4453. Program Director is Nancy Lim-Yee, LCSW.

4. TARGET POPULATION

- The program that our clinicians adapted intends to serve Chinese-speaking parents of young children ages two to 10 years of age.
- The program is provided in Chinese, currently in the Cantonese dialect.
- The program is not necessarily intended for people with specific needs or risks. The program is intended for parents with young children, ages 2 to 10 years of age. The program teaches parents strategies for managing problem behaviors, effective limit setting, and effective praise and incentives, as well as skills to help children learn at school and to play effectively with peers.
- The program is conducted in a group format and can be conducted in a community setting or a school setting.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- The program focuses on helping parents attain skills known to promote children's social competence and reduce behavior problems. The program teaches parents strategies for managing problem behaviors, effective limit setting, and effective praise and incentives, as well as skills to help children learn at school and to play effectively with peers.
- The protective factors this program aims to enhance are nurturing and attachment (building a close bond between parents and child); knowledge of parenting and of child development; parent resilience; and social connections (support system for parents).
- The main risk factors this program aims to reduce are harsh and/or ineffective parenting skills and a lack of parental monitoring and nurturing relationship with children.
- IY has two long-range goals. The first goal is to provide cost-effective, early prevention programs that all families of young children can use to promote social, emotional, and academic competence and to prevent children from developing conduct problems. The second goal is to provide comprehensive interventions for parents that are targeted at treating and reducing the early onset of conduct problems in young children.

6. CULTURAL RELEVANCE

- Because the primary target population are the parents of the children who are receiving mental health services at CCDC, our main outreach strategy has been to have the primary therapist working with a particular child talk with the respective child's parent about the IY program and to encourage that parent's participation in the program. Usually, because the parent already has an established relationship with the therapist, outreach and engagement have been achieved much more easily. When attempting to outreach to parents outside of CCDC, we have developed informational flyers about the IY program in Chinese to pass out at community-based organizations serving Chinese children and families.
- The program uses culturally relevant images, metaphors, and stories and incorporates these into the vignettes that are used throughout the curriculum presented to the parents. Similarly, traditions, beliefs, and customs are also taken into consideration when implementing the program.
- Interventions must sometimes be tailored to meet the individual needs of the parents in order to be sensitive to historical issues such as immigration and war traumas; the variability that exists within groups must be appreciated. Staff make use of methods that are acceptable and appropriate given the cultural values of the parents in the group.
- The staff who implement IY use Chinese terms that parents do not find "stigmatizing". The term "mental health" is considered quite stigmatizing and staff have found other terminology in Chinese to talk about mental health in ways that are more acceptable. For example, staff have found that parents are very willing to talk about their family stress, their long work hours, and financial struggles. Although, a few of these parents may have depression as a result of these challenges, it is easier for them to discuss the stress and financial difficulties rather than their "depression".
- Since 2007, Chinatown Child Development Center (CCDC) has been involved in a system-wide roll-out of the IY BASIC Preschool program. Thus far, five clinicians at CCDC have been trained in the IY program and five 12-week groups have served approximately 52 Cantonese-speaking families. Pre-post outcomes of the IY program at CCDC have been impressive. For children rated at baseline as being above the clinical cutoff on the Eyberg Child Behavior Inventory (ECBI), the average score dropped from being two standard deviations above average to being less than one standard deviation above average (and under the clinical cutoff) on both the Problem and Intensity scales. CCDC continues to conduct one to two IY groups on an annual basis depending on staff resources.
- Input into the design and/or evaluation of the program comes directly from the staff at CCDC who are implementing the program. We have also invited feedback from parent participants to improve the IY curriculum for subsequent groups that we will be running.

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

1. NAME OF PROGRAM:		
Integrated Primary Care & Mental Health Services/Cultural Brokers for Mental Health Services		
2. TYPE OF PROGRAM:	X	Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Merced Lao Family Community, Inc. **(MLFC)**
855 W. 15th Street
Merced, CA 95340
209-384-7384
mlfc@laofamilymerced.com

4. TARGET POPULATION

- Specifically target the Hmong, Mien, and Lao adults and older adults in Merced County (18+).
- Program is intended for the specific cultural and linguistic needs of the Hmong, Mien, and Lao population in Merced County (Men, women, and families)
- Languages available: Hmong, Lao, Mien, Thai
- The program is intended for individuals who are not utilizing or know about the mental health system and those that have chronic health problems, which may trigger mental health problems.
- Services are provided in client's homes and in their primary care physician's office

5. WHAT ARE THE GOALS OF THIS PROGRAM?

This program seeks to augment services available at existing primary care centers to help ensure that they are more able to provide early intervention for mental health issues, such as depression, anxiety, and suicide ideation in older adults. A clinical care manager is placed in a primary care clinic to provide short term problem solving therapies, to teach coping skills, and link participants to existing services. The Care Manager provides mental health depression screenings using the PHQ-9 (Patient Health Questionnaire), care coordination, and early interventions.

The project was developed to address some of the largest disparities in access related to income, geography, language or cultural background, and age. The provision of the Care Manager at the primary care physician's office has proven early intervention mental health services for poor and underserved SEA residents who would otherwise forego treatment due to costs.

The Care Manager provides direct mental health prevention and early intervention services in community clinics and work with patients to help identify resources and supports to eliminate or reduce stressors in their lives. Additionally the Care Manager works closely with the Cultural Broker to help culturally and linguistically isolated individuals identify the services and supports needed to stabilize their mental health being. Care Managers also help transition

clients to more extensive mental health services available throughout the county.

Major protective factors that the Care Manager and Cultural Broker aim to enhance include support from extended family members, and community leaders, and support availability at primary care setting,

Additionally, our Cultural Broker works closely with the Care Manager under this project. The Cultural Broker conducts community outreach, provides culturally and linguistically appropriate information about wellness, mental health and mental health services. This component ensures that linguistically and culturally isolated SEA community members are more aware of and more comfortable with accessing services.

In addition, this program is able to provide clinician trainings to non-mental health care providers. This training allows for the treatment of mild mental health issues within the primary care setting.

6. CULTURAL RELEVANCE

MLFC utilizes its strong base of SEA community leaders as cultural brokers in this program. We have trained approximately 20 Leaders on mental health signs, recognition, and referrals, and they have been outreaching to the SEA community. They provide that first outreach. Once they have contacted a family who they feel may need services, our staff makes a follow up visit to discuss any issues the client or family may have and offer services, resources, and information.

The custom of the Hmong family is to place high regard for the man of the house. Our Cultural Broker ensures that both the man and woman of the household are home prior to discussing any issues with the family. The Hmong still have very strong beliefs in their shamanistic practices as it relates to their physical and mental well being. This is taken into consideration. The Cultural Broker assists clients with accessing their leaders, local resources, or shamans and spiritual healer if needed.

The development of this PEI program was through planning and community conversation with community members. For many of these community members, physical and mental health go hand in hand. If one health is deteriorating so is the other. SEA community members indicated that rather than seeing a mental health clinician, they go to their primary care doctor for issues such as chronic diseases, aches and pain, etc. but also have symptoms such as stress, despair, and depression because of their physical ailments. However, they do not seek clinicians for their mental health issues. Thus, this program was created under the County's PEI plan with a goal to reduce disparities in access to mental health care and the provision of short term mental health services to address the psycho-social impact of trauma. The program is able to augment the services available at existing primary care centers to help ensure that they are more able to provide early intervention for mental health issues such as depression and anxiety.

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

1. NAME OF PROGRAM:		
Iu-Mien Senior Social Group		
2. TYPE OF PROGRAM:	x	Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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Web: www.unitediumien.org

4. TARGET POPULATION

- The specific program is intended to serve the Iu Mien senior citizens ages from 60 and up in the Sacramento and surrounding areas, but other age groups and ethnic individuals are welcomed. There are approximately 60-70 senior men and women attend weekly.
- This program is provided in Mien language.
- Individuals do not have to have any specific needs or be in any specific risks in order to qualify for this program.
- This program is located at Mutual Housing at Lemon Hill's community center (space is donated, and UIMC office is also located there).

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Many of the Iu-Mien senior citizens that were born and raised in Thailand and Laos are having hard time, both mentally and physically adjusting to the American culture. This program is to support the physical and mental well-being through activities and provision of information and resources.

The protective factor that this program is aiming to enhance is to allow people with the related background or experiences to share with one another. This is a great way for them to relief stresses from home.

The risk factors this program aim to reduce are stresses and depressions many Iu-Mien seniors are facing at home. Seniors also tend to go to casinos for recreation, and that is not always healthy. This is a safe alternative activity.

Currently there is no specific goal this program trying to achieve, except for preventive mental health.

6. CULTURAL RELEVANCE

The outreach strategies United Iu-Mien Community uses are word to mouth, Iu-Mien new year events, and Mien radio

(used to have one).

This program is culturally sensitive. It respects individual traditional, cultural beliefs. Staff and volunteers are bilingual/bicultural Iu-Mien, and the program celebrates cultural holidays such as New Year.

The program incorporates culturally valued activities such as socializing, exercise, and learning about new topics of interest from outside health and mental health professionals. The program links seniors to other services that they need, which reduces anxiety about income, citizenship, family problems, etc. The program is a lifeline to seniors who would be otherwise isolated.

This program was formed right after United Iu-Mien Community office open its door in February 2003 and since then the program has been running strong. This program is solely based on fundraising; no grant money is currently supporting it. The program has developed through ideas from the participants, and has included collaborative support from other agencies that provide transportation and exercise class.

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

1. NAME OF PROGRAM:		
"Keeping Cool": Korean Adult Anger Management Workshop		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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4. TARGET POPULATION

- This program is intended to serve and work with 30-55 year-old Korean speaking immigrant adults in greater Los Angeles area (LA County and surrounding counties).
- This program is provided in Korean.
- This is a prevention program intended for less acculturated Korean immigrants who are at higher risk of mental illness and/or family violence. Korean community has disproportionately high rates of domestic violence and some mental illnesses, including depression, suicide and alcohol abuse.
- This program is intended for Korean immigrant adults, particularly those who are culturally and linguistically isolated, undergoing acculturation stresses, and, as a result, lacking in accessibility to appropriate anger management program and other prevention programs.
- This program is intended in a community center setting or office setting, but could also be incorporated in other cultural community settings, such as a church.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- The program aims to prevent and/or address family dysfunction, domestic violence, child abuse, elder abuse, and trauma.
- The program also intends to prevent or provide early intervention for mental health issues, such as depression, anxiety disorder, and ADHD, which are often correlated with anger management issues.
- Protective factors this program aims to enhance:
  - Strengthening family unit/Family cohesion
  - Effective parenting including positive reinforcement
  - Involvement and support of Korean churches and other faith-based/spiritual institutions
  - Increased social support by Korean community groups
  - Accessibility to culturally and linguistically appropriate social, legal, and mental health resources
  - Encourage open communications and adopting an egalitarian communication pattern

- Increased awareness and understanding of mental illness and family violence.

- Risk factors this program aims to reduce:
  - Disproportionately high rates of suicide, depression, alcoholism, and debilitating psychological distress within the Korean American community, which is higher within the immigrant community.
  - General life stresses including occupational and economic stresses
  - Higher rates of family violence (domestic violence and child abuse) in the Korean community
  - Chronic family conflict
  - Cultural and social isolation, which results in greater acculturation stresses and higher risk of mental health issues/family violence. Isolation also results in lack of seeking intervention services such that symptoms become more severe.
  - Lack of knowledge of American legal system as it relates to violence and corporal punishment
  - Cultural stigma against mental illness
  - Hierarchical and patriarchal communication patterns in family and community
- Specific goals this program aims to achieve:
  - Heightened awareness of anger and stress patterns by 100% of attendees.
  - Increases ability to manage anger constructively and increase daily functioning by 80% of attendees, based on self-reporting.
  - Improve effective stress coping skills by 80% of attendees, based on self-reporting.
  - Increase ability to communicate more positively and effectively by 80% of attendees, based on self-reporting.
  - Improve understanding of American law and judicial process as it relates to violence and child/elder abuse by 90% of attendees, based on self-reporting.
  - Reduced incidents of domestic violence in household by 60% of attendees.
  - Reduce incidents of child abuse in household by 60% amongst attendees.

6. CULTURAL RELEVANCE

- Program uses strong media outreach through Korean newspapers, radio, and TV in order to promote the program as well as raise the public's of mental health, behavioral issues, family violence, and the need for prevention/early intervention services. We also collaborate closely with Korean-language faith/community leaders and service providers in order to increase our referral/support base and maximize the reach of our programs. This program is part of our community outreach strategy to educate the community on priority mental health issues to reduce stigma and increase access. We employ culturally-embedded outreach to dispel shame associated with mental health and train Korean churches and service providers on detection and intervention to expand access to competent care.
- This program has been developed and refined by 1st generation, Korean American, bilingual/bicultural, masters-level counselors. The program developers have over 10 years' combined experience providing mental health and family violence clinical counseling and group pscyho-education to more than 200 Korean immigrants in Los Angeles. In developing the program, KAFSC has considered the problems most prevalent amongst Korean immigrant adults, including high rates of, and correlations between, family violence, alcohol abuse, depression, anxiety, acculturation stress, and PTSD. This program also takes into account the complex set of social, cultural, and environmental factors, including recent immigration history, high linguistic isolation (47%), low assimilation, patriarchal values, and lack of safety net and adequate support system that exacerbate the level of psychological distress for community members, many of whom live with depressive symptoms and anxiety. These issues are compounded by the lack of health care coverage, inability to pay for services, scarcity of

culturally-competent mental health care providers, and deeply-ingrained stigma towards mental health, especially among the less acculturated. This prevention program aims to address mental and emotional health problems before they develop into serious illnesses requiring extended treatment or lead to family violence or suicide. KAFSC's "Keeping Cool" program seeks to address these complex issues through outcome-based, culturally-responsive practices and education to improve access to care and mental health outcomes for the uninsured immigrant population in Los Angeles. We use the name "Keeping Cool" and describe it as an "anger management" seminar because anger management courses have become a more popular trend that is culturally acceptable. It is less stigmatizing in the Korean immigrant community than referring to this as a mental health or family violence prevention program.

- The program addresses the differences between Korean and US legal systems and their approaches to family violence, cultural differences towards childrearing and corporal punishment, the high rate of alcohol abuse, depression, and other mental health issues in the community, acculturation and adjustment stressors on immigrants, and promotion of mental wellness to dispel the stigma associated with these topics. The program discusses the hierarchical and patriarchal cultural history, and how this affects relationships, family dynamics, and communications.
- The program discusses the role that social support systems such as extended family, social/community groups, and friends can play, particularly the Korean churches that 70-80% of Koreans attend.
- In Korean tradition, it is generally believed that it is culturally appropriate to suppress anger rather than to manage it. This belief frequently leads to either somatization or extreme expression of unmanaged anger. Also, Koreans are less likely to seek professional help, such as counseling, because of stigma and the high value placed on privacy in the home. KAFSC's anger management program seeks to increase participants' awareness of and appreciation for professional services, such as psychotherapy.
- Participants are encouraged to engage actively with the instructor and other classmates in order to speak freely on current topics or events in our community, such as internet/gaming addictions, economic stresses, suicide prevention, etc. The program also raises common "hot button" issues amongst Korean families in order to help open the discussion onto family violence, such as children's education, in-laws, and the roles of husband/wife. The open dialogue format promotes Korean immigrants to express their emotions and discuss their problems openly as a way to relieve stress and develop a support system within the group.
- The program is intended for a group that is entirely first generation Korean immigrants. Koreans in LA County are one of the most linguistically and culturally isolated ethnic groups amongst Asian Pacific Islanders (see 2008 report by Asian Pacific American Legal Center), so they are much more likely to participate in the program and be engaged if it is targeted exclusively for Korean immigrants. As such, this program is also facilitated by 1st generation Korean speaking staff who fully understand the language and culture of Korean immigrants. All written resources and powerpoint presentations are written in Korean in order to enhance the participants' comprehension.
- The program is specifically targeted for Korean American immigrants who face acculturation stresses and/or family dysfunction. The program works with Korean immigrants who face many language, cultural, legal, and practical barriers to receiving mental health or social services. It takes into account the high number of uninsured individuals (one in three) with no access to services. Also, the high rate of undocumented immigrants in our community (15-20%) who are especially vulnerable and isolated from resources and information. This program does not use individual's names to protect people's privacy, particularly due to the stigma associated with seeking professional services. The program does not require specialized screening or qualifications such as medi-cal, which would discourage or prevent many members from participating.
- This program promotes emotional wellness, safety and healthy relationships by teaching participants how to

make healthy life choices and engage in health behaviors. The program recognizes the community's pluralistic approach to well-being that integrates physical with mental wellness. Korean immigrants with mental health issues such as depression often exhibit somatic symptoms, such as headaches, insomnia, and abdominal pains. As such, this program takes a culturally-responsive approach to "wellness" or "well-being" that includes addressing both mind and body to improve mental health outcomes and life functioning. The program also takes into account that individual wellness is often closely tied to familial or collective wellbeing in Korean culture. Therefore, this program places heavy influence on the role of family, social support structures (such as church), and group dynamics in determining well-being.

- This program was developed in 2010 and has been run twice. It was created to assist general members of the Korean community who were struggling with elevated stress levels and impaired functioning in order to improve their functioning and reduce mental health and behavioral symptoms. With 17 years' experience, KAFSC has the largest and long-running anger management classes and domestic violence batterers' treatment programs for court-mandated/-referred clients in the Korean community of Los Angeles. In 2009, we found that 24% of our counseling clients (100 out of 416) were referred or mandated by the courts due to anger-related issues. In recognizing the severity of anger management problems in our community, KAFSC's Korean clinical counselors developed this program for the general Korean American public with input from our supervisors: a board-certified psychiatrist and licensed MFT supervisor with over 40 years' combined experience. This program is open to all Korean Americans for a sliding scale fee ($15-$30) without regard insurance, immigration status, etc. Our accelerated curriculum covers the major points of our regular anger management course (12 sessions x 1-hour each) within 3 evening classes that are 2 hours each. This accelerated evening program accommodates working individuals and parents. Despite the stigma often associated with seeking mental/behavioral services at KAFSC, KAFSC had a strong turnout with 32 participants in 2010. The participant evaluations and high retention rate every week showed that participants were extremely satisfied with the workshop and found it effective. Based on participant feedback, we have modified the design and content of the program to make it more interactive, include more role-playing, include more time for open dialogue amongst the attendees and reduce the number of sessions while increasing the time of each session.

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

1. NAME OF PROGRAM:		
Lotus Bloom with Asian Community Mental Health Services		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Angela Louie Howard, Director
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Katherine Chun, Chief Operations Officer
Asian Community Mental Health Services
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4. TARGET POPULATION

Lotus Bloom is a multicultural organization that develops and provides innovative programs for inner-city children, youth and families. Each week, Lotus Bloom, along with Asian Community Mental Health Services, and Early Head Start provides parent-child playgroup programs six days per week, Monday thru Saturday, for low-income and immigrant families at four locations (two in San Antonio, and two in East Oakland neighborhoods). Each group serves 25 families, providing a safe, structured, stimulating environment for them to learn and grow. The programs are offered in Chinese, Cambodian, Spanish and English. The largest population that Lotus Bloom serves is immigrant families in the neighborhood who need additional support to achieve family stability and economic independence. More than 70% of our participants are immigrants who are non-English speakers. Our participants are 52% Asian American, 14% African American, 18% Latino, and 16% White.

Lotus Bloom is located in the San Antonio neighborhood. The area has a strong need for free, low cost, accessible and culturally-competent family support services. According to the US Census 2000, children under 5 make up 9.5% (2,990). Our neighborhood is one of the most diverse neighborhoods in the city with a population that includes Asian (35.7%) Latino/ Hispanic (35.2%), Whites (19.8%), and African Americans (18.9%). The San Antonio neighborhood is also one of the poorest neighborhoods in the City of Oakland, 52.8% of the residents are living below 200% of the federal poverty level and 52% have less than a high school diploma.

Since our inception in October 2006, Lotus Bloom has served more than 600 families in Alameda County (57 in 2007, 123 in 2008, 210 in 2009, and 220 in 2010). The largest population that Lotus Bloom serves is immigrant families in

the neighborhood who need additional support to achieve family stability and economic independence. 32% of our participants come from single parent households.

Lotus Bloom programs are in the community and held at neighborhood centers, recreation centers, and nonprofit centers that are conveniently located along commercial corridors and bus lines. The center offers program offers programs that serve 0-3, 3-5, special needs families, mental health services, social support, screening and assessment using ASQ's and DRDP and aligns with State Standards and Developmental needs of young children. Each program has a parenting component, development of resources, and social support, which are integral protective factors to support families. The programs use attachment models, child-abuse prevention protective factors, best practices in the 0-5 field to cultivate an academically-rich program feeding into elementary school, so that children enter school ready to learn.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Lotus Bloom follows the Federal Child Welfare Protective Factors for Strengthening Families:

Nurturing and Attachment. A child's early experience of being nurtured and developing a bond with a caring adult affects all aspects of behavior and development. When parents and children have strong, warm feelings for one another, children develop trust that their parents will provide what they need to thrive, including love, acceptance, positive guidance, and protection.

Knowledge of Parenting and of Child and Youth Development. Discipline is both more effective and more nurturing when parents know how to set and enforce limits and encourage appropriate behaviors based on the child's age and level of development. Parents who understand how children grow and develop can provide an environment where children can live up to their potential. Child abuse and neglect are often associated with a lack of understanding of basic child development or an inability to put that knowledge into action. Timely mentoring, coaching, advice, and practice may be more useful to parents than information alone.

Parental Resilience. Resilience is the ability to handle everyday stressors and recover from occasional crises. Parents who are emotionally resilient have a positive attitude, creatively solve problems, effectively address challenges, and are less likely to direct anger and frustration at their children. In addition, these parents are aware of their own challenges—for example, those arising from inappropriate parenting they received as children—and accept help and/or counseling when needed.

Social Connections. Evidence links social isolation and perceived lack of support to child maltreatment. Trusted and caring family and friends provide emotional support to parents by offering encouragement and assistance in facing the daily challenges of raising a family. Supportive adults in the family and the community can model alternative parenting styles and can serve as resources for parents when they need help.

Concrete Supports for Parents. Many factors beyond the parent-child relationship affect a family's ability to care for their children. Parents need basic resources such as food, clothing, housing, transportation, and access to essential services that address family-specific needs (such as child care and health care) to ensure the health and well-being of their children. Some families may also need support connecting to social services such as alcohol and drug treatment, domestic violence counseling, or public benefits. Providing or connecting families to the concrete supports that families need is critical. These combined efforts help families cope with stress and prevent situations where

maltreatment could occur.

Lotus Bloom seeks to improve family literacy and school readiness in Oakland, especially in the San Antonio/East Lake neighborhood. In 2006, the California Department of Education indicated that 86% of 3rd graders scored "Far Below Basic to Basic" on the English Language Arts Test in the San Antonio neighborhood at Garfield, Bella Vista, and Franklin Elementary Schools. Oakland Unified School District reports that children entering kindergarten are unprepared due to the lack of preschool or structured care activities prior to entering school. Research shows that children from low-income ethnic minority backgrounds benefit most from high-quality developmentally appropriate preschool programs (Fuller, Kagan, Caspary, Gauthier, 2002). Despite these findings, low-income ethnic students are often the least likely to receive such care before entering kindergarten (Magnuson, Meyers, Ruhm, Waldfogel, 2004; Pianta, 2007). This is true in the San Antonio neighborhood where we have a large population of working class families who do not make enough to pay for private preschool and make too much to qualify for Head Start and/or Child Development Centers. Many of the participants that come to Lotus Bloom tell us that we are the perfect alternative to preschool because of the quality and affordability of the playgroup programs where participants are requested to donate $1 per day.

In June 2010, Child Trends published a research article that shows a significant achievement gap already exists between low-income children and their more affluent peers at kindergarten entry. They said, "In order to improve long-term academic outcomes, increased attention is being given to supporting and assessing school readiness and identifying successful, evidence-based programs in early childhood that can ensure a more even start at school entry" (Sarah Daily, Mary Burkhauser, and Tamara Halle, 2010). If children in the San Antonio neighborhood do not have access to Community Based Early Childhood services, they will continue to miss out on key academic and socialization experiences, and will enter Kindergarten unprepared, and the achievement gap will continue to widen.

6. CULTURAL RELEVANCE

Lotus Bloom uses several outreach strategies to reach participants. We provide grassroots on foot outreach where we flyer around neighborhood, bus stops, Laundromats, parks, etc. We have several partnerships with community groups (business associations, libraries, park & recreation facilities, Bananas, 4c's, Alameda County Social Services, Regional Center, Oakland Unified School District, crime prevention groups, County Clinics, Children' Hospital, etc.) that help spread the word and refer participants to our programs. Lastly, we use Ethnic Media to help us reach monolingual and bilingual participants. We have formed relationships with KTSF Channel 26, AM 1400, Chinese Times, Sing Tao News, Bay View, Sun Newspaper, San Antonio Unity, Univision, NuestroNinos, Childhood Matters Radio Show, etc.

Lotus Bloom incorporates diverse participants in leadership positions in all areas of activities. In practice this translates to 4 bilingual active parents in our programs that serve on the Board of Directors, programs offered in 5 languages, and incorporating cultural traditions into our programs. For example, we use traditional African Drumming and Storytelling to be part of Circle Time, we celebrate specific cultural traditions that our families celebrate (Moon Festival, Lunar New Year, Cinco De Mayo, etc.) and using Oral History in our literacy program. Additionally, all the staff members are bilingual or bicultural in two or more cultures and languages.

We have a strong belief that, "programs affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society" – Family Support Principle. In practice, this means that we do our circle time in two or more languages, and encourage participants to share in their home languages, and to learn words from other languages. We also act as a bridge between cultures, bringing together families from Asia, Latin

America, the United States, and Africa in our Multicultural Playgroups. Our groups provide a space for participants to make friends and build community across the cultural, racial and ethnic lines that often keep us isolated and insulated in our own communities.

The organization's original design developed from the result of a July 2006 survey of 60 families residing in the San Antonio district of Oakland, indicating a need for school readiness, parenting support, and literacy programs. Since then, Lotus Bloom has always integrated language (providing programs in multiple languages) and culture (history, shared experiences, etc.) to guide our work and respond to the community's need. Our philosophy is that "our programs are for the community, by the community, and of the community." To this end, Lotus Bloom employs locally; 100 % of our staff lives nearby and 50% of staff are former participants in our programs. Therefore, we gain a plethora of knowledge from staff and parent leaders on how to do outreach, integrate history and culture into our programs, and further develop programs.

One of our core beliefs at Lotus Bloom is that staff and families should work together in relationships based on equality and respect. Our staff uses interactive materials to promote a love of learning that starts with the child and parent dyad. The parents then feel connected to their children, knowing that they are preparing them for future school settings. Children in turn feel close and cared for, as well as receive the crucial building blocks of school success. Together, families feel connected to the larger community creating opportunities for mutual support and decreased isolation.

One of the parents, Jie May shared, "My son and I have made so many new friends at Lotus Bloom. It reminds me of when I lived in a village. The other day, one of the grandmas bought me some beans from China so I can make a soup to help with my child's digestive system. She heard me talking about his stomach problems last week and brought me some beans my parents use to give me in my home country."

Until the creation of Lotus Bloom, there were no other family resource centers in the San Antonio neighborhood. Now, residents in the San Antonio and community at large have a place where they can come together to access services, gain educational skills, receive knowledge around childrearing, and develop stronger community networks. Participants know that when they come into our center, they will find the referrals and the help they need. Whether it's an issue of domestic violence, pre-school enrollment, or a job search, our knowledgeable staff engages with participants appropriately to meet their needs.

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

1. NAME OF PROGRAM:		
Mind, Body, Spirit, Wellness		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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Bryan Choi, PhD
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4. TARGET POPULATION

- This program is intended to serve/work with Asian and Pacific Islander Men Who Have Sex with Men (MSM) and who are HIV positive.
- Program is provided in English, but can be done in various languages.
- This program is for Men Who Have Sex with Men living with HIV. It is also a program that has been used with persons who are co-infected with Hepatitis C.
- However, persons who are "affected by HIV" are also clients. The "Affected" are individuals, couples and families who are not HIV infected but living with or know someone who is.
- The program is conducted in group/individual settings in private, community or clinical settings. It has been done in specific ethnic settings (Thai, Filipino, Vietnamese, Chinese, and Khmer).

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- This program is designed to assist clients effectively identify and cope with symptoms and problems that may be contributing to their distress in order to improve overall quality of life. It incorporates: A) A weekly social lunch and educational lunch; B) individual counseling where clients learn techniques to feel less stressed and

become more empowered; and C) specialized support groups for various Asian languages.

- The programs aims to reduce isolation; decrease depression; tease out more severe mental health diagnoses; investigate substance use issues; tackle paranoia; and other cognitive disorders. It also incorporates other health messages (drug regimen, co-infection).

- There are many protective factors associated with this program. "Pride" or self-confidence in areas concerning identity. The positive reinforcement of their cultural (ethnic) heritage, positive reinforcement of their sexual orientation (removing stigma about being gay), and acceptance of their HIV/AIDS status.

- All of this is aimed to decrease shame and low self-esteem; encourage both individual and group pride; and improve self-acceptance and self-empowerment.

- Risk factors this program aims to reduce include: Limited English Proficiency, being an immigrant and dealing immigration status, lack of support system, economic status.

- This program is designed to provide a sense of emotional well-being to HIV positive individuals with the knowledge that the mind, body, and spirit are all connected in each person. The main focus is on the client, or client centered. The program deals with a whole gamut of issues such as sexual identity, teach them skills to disclose HIV status to loved ones, increase support system, and help them adhere to medications. The goal of this program is to help clients feel good about themselves. This program works in three ways—through emotional support, interactive mind-body-spirit workshops, and counseling (individuals, couples, or family). It focuses on the whole person with multi-faceted activities.

- With APAIT becoming a clinic, clients can now have their physical aspects (STDs, HIV, and other care issues) addressed.

6. CULTURAL RELEVANCE

- This program has its own Client Advisory Board (CAB) consisting of an active/diverse clientele. Feedback is solicited on Best Practices.

- This program works with agency's education/prevention programs outreaching at cultural fairs and festivals (LA Gay and Lesbian Pride, Lotus Festival, Nissei Festival, Lunar New Year); Mental Health Professional Gatherings (Coping with Hope Conference, HIV Mental Health Taskforce); agency functions ("Day Room"); clinical settings (LA Rand Schrader).

- Program incorporates outings ethnic specific neighborhoods (Chinatown, Little Tokyo, etc.); go to specific spiritual settings (Hsi Lai Temple, Hindu Gardens); serve ethnic Asian food; set aside certain times to meditate and pray.

- A trauma symptom management group was started in order to both provide emotional support to trauma survivors as well as teach skills appropriate for coping with symptoms specific to posttraumatic stress disorder. Trauma is considered to be an event in which a person experienced, witness, or confronted an event or events

that involved actual or threatened death or threat of oneself. These events result in responses such as intense fear, helplessness, or horror, subsequently leading to impairment in a person's daily functioning, e.g., ability to work, ability to develop and maintain relationships, due to chronic symptoms such as intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. Case managers are made available to deal with a host of other issues (immigrations, housing, legal, transportation).

- This program highlights various cultural customs and celebrations quarterly (Filipino Independence Day, Chinese New Year, Thai New Year); language specific groups are enacted; and ethnic food is made available at educational workshops; service providers and selected group attendees would enhance activities by wearing traditional Asian clothing.

- The program chose to remove "mental health" from its services because of the stigma. When the program changed its name to Mind, Body, Spirit Wellness, there was an increase in client participation.

- The program maintains its own CAB, administers a Client Satisfaction Survey, and an annual program review is conducted by funder.

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

1. NAME OF PROGRAM:		
Nikkei Tomodachi (Friendly Visitors) Program		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information
LTSC Community Development Corporation Yasuko Sakamoto: ysakamoto@ltsc.org 231 E. Third Street, Suite G-106, Los Angeles, CA 90013 213-473-3035

4. TARGET POPULATION
Nikkei Tomodachi Program provides emotional supportive services to socially isolated low-income seniors (60 and older) living in Los Angeles, especially those who are primarily Japanese speaking and in need of companionship. This is one of Little Tokyo Service Center's (LTSC) programs that supplement our case management services. The program provides companionship to seniors at their home with goals of increasing socialization, supporting independent living and delaying nursing home care via weekly home-visit or telephone calls by trained Japanese speaking senior volunteers. In return the volunteers gain enriched retired lives by providing needed services to peers.

5. WHAT ARE THE GOALS OF THIS PROGRAM?
This program prevents social isolation and early institutionalization of seniors into nursing homes. It also reduces the number of urgent telephone calls to case managers for emotional or psychosomatic needs from seniors. Enhanced protective factors include: community awareness, trained older adults who are able to identify risk factors among peers, culturally and linguistically appropriate social support, early detection and timely referrals to additional services as necessary, and cognitive stimulation for both Tomodachi volunteers and seniors. The primary risk factors reduced include: cultural values such as feeling shame about seeking mental health services (stigma) and social isolation. The goal of the program is to improve isolated seniors' sense of well-being and decrease feelings of depression or anxiety. Also, the program strives to reduce caregivers' and family members' stress. Tomodachi volunteers increase their knowledge and have an elevated sense of satisfaction because they are using skills to serve community members.

6. CULTURAL RELEVANCE
Despite Little Tokyo Service Center's best efforts to provide a comprehensive social service program there is still a significant population that falls between the cracks of existing services. This population is composed primarily of

homebound or "shut-in" seniors who suffer silently due to cultural and/or language barriers. In general, it is hard for anyone to ask for help from non-family members. It is especially hard for Japanese and other Asian people because traditionally they are taught they should solve their own problems within their family. They are also expected to have perseverance. These factors and the concept of shame, thinking it is better not to burden others or embarrass oneself prevent them from consulting with others about their problems, which in turn delays their seeking of help, often resulting in more serious problems. Due to these traditional values, language barriers and lack of familiarity with social service systems, there are many senior citizens at risk in the Japanese American community and they suffer silently. Even if they seek help many of our senior clients are monolingual and unable to access needed services because most existing programs do not provide linguistically and culturally competent services in their language. The Tomodachi program provides culturally sensitive and linguistically appropriate emotional support to these seniors who are isolated and/or nearly homebound, so they may improve the quality of their lives while staying at home.

Some research indicates that they feel more comfortable with informal resources, such as friends, family and peers, who understand their language, culture and generational issues (Narikiyo and Kameoka, 1992). Additionally, the Kame Study, an 11 year study of Japanese American seniors in the Seattle area, found that those associated with Japanese language, cultural and social activities had a slower rate of cognitive decline (Borenstein Graves, at al., 1999). Among Japanese American older adults, concerns about health, fear of dependency on family members, and lack of emotional support are associated with depression (Shibusawa & Mui, 2001). Older adults, particularly those who primarily speak Japanese and/or adhere to more traditional Japanese values, are in need of "tomodachi," or friends, to alleviate stressors and to facilitate access to further services when necessary.

To identify seniors who are in need of home visitors, LTSC utilizes referrals from the agency's own case managers. In addition, LTSC uses the Asian ethnic media that seniors in the Japanese American community are familiar with to conduct outreach. LTSC distributes bilingual Japanese/English brochures at markets, churches, event sites, nutrition programs, cultural and community centers in Los Angeles to reach isolated seniors. Once seniors are identified case managers conduct initial assessment and refer to the Tomodachi Program if appropriate.

Bilingual Tomodachi volunteers are also recruited through similar methods and given training to become effective advocates for homebound isolated seniors.

In summary, the main components of the program are:

a. Recruitment of volunteers through mass media and distribution of outreach flyers.

b. 4 trainings (3 hours/session) for the newly recruited volunteers with the following topics: purpose of the program and its systems, understanding the senior population being served including culture and values, effective listening, depression among seniors and how to administer the depression scale, how to handle emergency situations and an emergency protocol, stress management, available resources for seniors, confidentiality, how to document each visit/telephone contact, what to expect on a home visit, discussion of volunteers' cultural norms and values, behaviors and related issues and how to acknowledge and respect others, the volunteers' own cultural values toward mental health, and role play.

c. Individual meetings with case managers.

d. Trained volunteers are matched to a senior in need of companionship.

e. Volunteers attend monthly support group meetings run by a Licensed Clinical Social Worker to share and discuss concerns and problems with specific clients, make assessments and develop a future plan for each client.

f. Long-time volunteers convene monthly support group meeting for the volunteers.

g. On-going training to become effective advocates by professionals from various fields.

h. Case managers closely work with volunteers and also periodically monitor progress of seniors.

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

1. NAME OF PROGRAM:		
Asian Pacific Community Counseling **Parenting Education (Curriculum: Make Parenting a Pleasure)**		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information
Asian Pacific Community Counseling (916-383-6783)

4. TARGET POPULATION
• Parents of children 0 – teenager. Targeted cultural groups will be Asian and Pacific Islanders; however, all cultural groups can be included. • Parents may be referred by: CPS, probation, children's school, community, or self • Available language: Hmong, Mien, Vietnamese, Cantonese, Tongan, Japanese, English. Services will be provided with cultural and linguistic competence by facilitators who are bi-lingual and bi-cultural. • Class size from 2 to 10 • Groups can focus on prevention, early intervention, or treatment. Curriculum will be enhanced when members have increased risk factors. • Groups will be provided at the most convenient location for the group members. This could include schools, community centers, faith based organizations, or the agency's main facility.

5. WHAT ARE THE GOALS OF THIS PROGRAM?
• Groups can include parents who want to strengthen skills, as well as those parents who have previously exhibited inappropriate parenting skills. • Risk factors of parents include all or some of the following: monolingual non-English, recent immigrant, low income, isolation, less acculturated that their children. • Protective factors include the modification of the program to match the cultural norms of the group (modifications have been made after consultation with the model developer), service delivered in natural community settings, involvement of extended family encouraged. • Goals include: • Reduction of stress in parents due to conflicts between parents and children • Remind parents of taking care of their stresses by finding ways to cope • Reinforce alternative ways to discipline children • Give positive recognition for parents for their efforts to help children succeed, and provide tools to support parents to increase children's ability to function effectively at home, school, and in the community.

6. CULTURAL RELEVANCE
• Outreach to schools, CPS, local events, and informal community gatherings to offer information in multiple languages. Outreach efforts will be completed by trained individuals who are members of the targeted community. • Trained facilitators modify the tools (example: DVD in English will be modified to be a role play by facilitators) and include cultural differences in beliefs in parenting. Customs and traditions are integrated into the curriculum. Facilitators are bi-lingual and bi-cultural, and members of the same community as group participants. • Modifications were made to the presentation methods to increase sensitivity to risk factors including immigration, acculturation, trauma, low income, and others. • Program will promote "taking care of own anger, emotions, stress in positive ways" and "understanding children's prospective", instead of talking about "mental health". • The original model was developed in a community based setting and has been modified for use throughout the world. The agency brought the original model developer to our site to train facilitators and discuss concerns the community had regarding the cultural competency of some of the presentation methods. Modifications and enhancements were made after consultation with the model developer and after ensuring that the core competencies of the training would not be impacted.

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

1. NAME OF PROGRAM:		
Prevention and Early Intervention for the South Asian Community		
2. TYPE OF PROGRAM:	*	Universal prevention
	*	Selective prevention
	*	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

The Portia Bell Hume Behavioral Health and Training Center
Attention: Fawada Mojaddidi, Administrative Manager
39420 Liberty Street Suite 140
Fremont, CA 994538
(510) 745-9151

4. TARGET POPULATION

Specific Population:

- 75 percent of the consumers served are from the South Asian population (persons from Afghanistan, Bangladesh, Bhutan, Burma, India, Iran, Nepal, Sri Lanka) with other populations accounting for the balance
- This program serves individuals of all ages
- This program serves individuals and families from all geographic regions of Alameda County
- Majority of the services are directed to children or youth up to 25 years old

Languages:

- English, Hindi, Punjabi, Dari, Farsi, Cantonese, Mandarin, Vietnamese, Singhalese, Bengali, Tamil, Urdu, and Spanish

Specific needs or risks: Yes

- South Asian individuals and families who lack access to behavioral health care because of their language needs
- Unaddressed mental health problems stress family members who are unprepared to address these issues by themselves or to seek professional help
- Individuals with unaddressed mental health problems are liable to become isolated, unable to function in the community, or even at risk of regressing into long-term mental illnesses

Particular setting:

- The program is unusually flexible with regard to the setting of the delivery of services. It could be an agency clinic, religious center, community center, home, school, or any other appropriate setting.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Specific problems:

- This community has severe shortage of professional resources to address mental health needs
- This shortage is even more acute for culturally and linguistically competent South Asian professionals

Protective factors:

- Individual motivation with strong personal values
- Resilient, caring family systems

Risk factors:

- Stigmatization of mental health problems and need to access services

Specific goals:

- To increase access through outreach and early intervention services for the underserved and un-served members of the South Asian community
- Increase availability of culturally grounded educational materials about mental health in culture specific language
- Increase capacity of the South Asian community to meet its own mental health needs
- Increase knowledge in South Asian community of wellness behaviors and awareness of existing community and public resources
- Prove Mental Health Consultation to other organizations who work with this population

6. CULTURAL RELEVANCE

Outreach:

- Community Events
- Home Visits
- Psycho-educational workshops
- Support groups
- Workshops for the community

How does the program incorporate target population's traditions, beliefs, and customs:

- By holding outreach events at various religious sites and cultural celebrations.

How does the program demonstrate sensitivity to historical issues:

- By offering services in multiple languages to those populations who are in a need
- By developing groups for those have experienced war or other forms of trauma or with the immigration process.
- By offering a presentation on the impact of immigration.
- The facilitator has had continuous training in working with survivors of trauma, torture and vicarious trauma. The facilitator receives training from Iranian Refugee Mental Health Services and ARMAN.

How does the program incorporate cultural elements regarding mental health and well-being:

- By developing community information fliers in all appropriate South Asian languages, stating the services offered that are distributed to stakeholders and community based organizations.
- By offering a presentation on the challenges people face in life without stigmatization.

- Members who attend these groups are refugees, trauma survivors, or those who have experienced vicarious trauma. It is important to create a safe environment for these people. Most groups are offered in a language other than English. In order to create a safe environment it is important not to refer to the groups as trauma groups. The facilitator listens to the group members' story and builds upon their strengths and resiliency. The purpose is not to completely focus on the trauma but to build on the positives and to focus on the themes that the group members discuss. The facilitator performs a needs assessment to cover a variety of topics. Topics can include pain management, meditation, processing the trauma, coping skills, and psych-education.

History of the Development of the Program:

- The program began with a needs assessment in which the community played a crucial part. This assessment looked at individual protective factors as well as common risk factors. It sought to identify existing mental health resources in the community to promote leveraging and avoid duplication of services.
- The program has developed tremendously over the past year by strengthening the existing resources, increasing access to services, and developing ongoing support groups.
- We strengthened existing resources through Community Mental Health Consultation. We offered this service through our *Helping the Helpers* program. This is based on the recognition that in every helping role the "helpers" (both professional and non-professional) confront certain predictably difficult behaviors. We helped the helpers to understand the psychological significance of their clients' or supervisees' behavior and respond in ways that the negative impacts are minimized and work effectiveness increases. The program helps the helper to develop useful knowledge and skills that can also be transferred to work with other clients who present similar behaviors. In this way the "helped" become the "helpers," multiplying the effectiveness the original intervention many times over for a long time to come (Singh, 1971).
- Increasing Access to Services: Through our network of developing relationships we were able to provide services to the persons who would have otherwise never approached the mental health clinics for services. We are providing Early Intervention Services on site at a culture specific center. Our consultant developed a Behavioral Health Screening Instrument that is being used at the agency the consultant was providing services. With this behavioral health screening the caseworkers are able to identify and refer their clients for appropriate services.
- We have developed and facilitated a Peer Consultation Support Groups for the various high-risk groups. Through this process we normalize experiences which otherwise would have been processed at risk in isolation. Additionally group participants were able to share useful approaches to dealing with their own problems which other group members found valuable and helpful.

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

1. NAME OF PROGRAM:		
AYPS Program **Samoan Community Development Center-Strengthening Families Program**		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Samoan Community Development Center
AYPS Strengthening Families Program SCDC
Contact: Patsy Tito, Executive Director
2055 Sunnydale Ave, Room 100
San Francisco, Ca 94134
Phone #: (415) 841-1086
Fax #: (415) 333-1658
Email: scdc@pacbell.net

Permission has been obtained from SCDC, Patsy Tito to submit this program to the CRDP for review and consideration.

4. TARGET POPULATION

The Asian Youth Prevention Services (AYPS) program-Strengthening Families Program (SFP) targets Samoan youth and their families who are experiencing significant a difficult period in their life. These youth are identified at being more at risk of being involved or are involved with the juvenile justice system, on the verge of dropping out of school, involving in unlawful activities and those at high risk, have family issues. The SCDC-SFP program is conducted in bilingual Samoan and English at SCDC's program office. The site facilitates group meetings with parents; group meetings with youth and a convening with both youth and their parents.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The specific issues to be addressed by the program are to enhance family communications, increase parenting skills, reduce high risk behaviors of youth and reduce the involvement of youth ATOD. The program aim to enhance parent and child communication, increase parenting skills and youth skills to negotiate and compromise, increase the family's help seeking skills, and reduce youth involvement the juvenile justice system, gangs and prevention high risk behaviors.

6. CULTURAL RELEVANCE

The SCDC-SFP program is a cultural adaption of SFP and is a new program. The lesson plan is in English but implemented in both Samoan and English The program incorporates many of the cultural traditions, beliefs and

customs of the audience as well as incorporates the youth cultural that the Samoan youth relates to. The program is sensitive in incorporating Samoan traditional health and well-being as well as incorporating American concepts in health and well-being. As mentioned, the program is new and a cultural adaption of a well establish model that has been proven to work for a diverse population but has not been implemented to the recent Chinese immigrant population. The program has an evaluation process in place and will be implemented in this fiscal year. Participants provide a pre and post test as well as a retro evaluation.

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

1. NAME OF PROGRAM:		
Southeast Asian Consumer Advocacy Program (SEACAP)		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
		Early intervention
	X	Other (please specify) ***General Systems Development (Community Services & Support [CSS] program of MHSA)***

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Merced Lao Family Community, Inc. **(MLFC)**
855 W. 15th Street
Merced, CA 95340
209-384-7384
mlfc@laofamilymerced.com

4. TARGET POPULATION

- Specifically target the Hmong, Mien, and Lao transitional aged youth (TAY) adults, and older adults
- Languages: Hmong, Mien, Lao
- Program is intended for the specific cultural and linguistic needs of the Hmong, Mien, and Lao population in Merced County (Men, women, and families with children that have severe mental illness, post traumatic stress disorders, and/or depression)
- The SEACAP program provides services in a trusted, community-based setting. Services are also provided in clients' homes when necessary.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Merced County lacks culturally and linguistically competent mental health services for the Southeast Asian (SEA) community. The County contracted with MLFC to implement the SEACAP Program providing mental health outpatient services. SEACAP was developed to incorporate cultural understanding and individualization to ensure the effective treatment of the unique mental health issues of the SEA community. SEACAP consumer issues include PTSD due to their war and refugee experience, and stress and depression from poor adjustment and coping skills.

The SEACAP program aims to reduce risk factors of alienation, and family problems stemming from mental health and adjustment stressors. The SEACAP program provides services through a client-directed care plan. This gives the clients the power to identify their own unique issues in their lives that are keeping them from obtaining full integration. The program provides individual and group services, cultural practices (shamans, natural healing practices, and ceremonies), skills-building instruction to promote wellness, parenting education, and family intervention. This all encompassing program aims to improve client's knowledge of their symptoms and how to cope with them in an effective manner incorporating both their culture and the American culture.

Successful recovery towards hope and resiliency is the goal of the SEACAP program. Consultation and collaboration with shamans and spiritual healers regarding clients' treatment creates a holistic wellness focus that brings together Western and Eastern healing practices.

6. CULTURAL RELEVANCE

SEACAP staff utilizes it unique network of Community Leaders to outreach to SEA community members. Leaders are aware of services at SEACAP so they in turn inform their Hmong families about services. Outreach is done by our Case Manager through direct one-on-one outreach, Hmong TV PSAs on MLFC's local Hmong TV program, presentations during community meetings, and outreach through community events.

Cultural competence is at the heart of this program. It provides clients with the opportunity to be seen in a community setting that they are comfortable with and to be given services by providers who share the experiences, culture, norms, and customs. Allowing shamans and spiritual healers to be a part of the treatment team and to use them in groups and/or individual interventions adds a unique piece of cultural competence that is not available within the county system.

The SEACAP Program offers traditional cultural practices using traditional practitioners, natural healing practices, and ceremonies recognized by the SEA community in addition to mainstream services. SEACAP was created to provide traditional mental health services in collaboration with the SEA client's designated Shaman or spiritual healer as requested. Many SEACAP consumers come to the center to seek for help on how to deal with and cope with the aftermath of the war experience and their inability to adjust to this society.

Through community input, MLFC was able to collaborate with the Merced County Department of Mental Health to develop the SEACAP program. Prior to the SEACAP program, the County had never contracted out services to community based providers in the County. Although the County does have SEA staff members, it has not had a program solely devoted to the SEA population. Additionally, until the SEACAP program, SEA clients in the County system were served under the Medi-Cal medical model and not the recovery model. Through community input, the integration of natural and spiritual healing practices was integrated with Western treatment models.

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

1. NAME OF PROGRAM:		
Southeast Asian Support Group		
2. TYPE OF PROGRAM:	✓	Universal prevention
		Selective prevention
	✓	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Healthy House Within A MATCH Coalition
1729 Canal Street
Merced California 95340
Tel. (209) 724-0102
Fax (209)724-0153

4. TARGET POPULATION

This Southeast Asian Support group was established in 2001. There are typically 16-17 Hmong, Mien, and Lao adults with differing culture and beliefs who participate. (The vast majority is Hmong but all services are also available for Mien and Lao participants as needed.) They are between 18-65 years of age. Typically, 80% are females and 20% are males. Healthy House provides a Language & Cultural Specialist for facilitating and interpreting discussions, aimed at addressing mental health stressors, every Friday from 1-3pm at a local Mental Health facility.

The support group meeting serves several different roles in the lives of the participants. For some individuals, the support group means an opportunity to learn about the American healthcare system, including Mental Healthcare, and a chance to go to a special "school". One of the Hmong Interpreters commented that the group enjoys her 'animal-color' lesson, a strategy for relieving the emotional and mental stress which refugees routinely experience. She reported that the group was very excited because they had never engaged in a coloring activity before in their lives. Happy giggling and whispers went through the room as they asked each other for opinions of what color should be used for the cow's tail.

Some individuals come to mingle and socialize, something new that the Hmong people are learning from Western culture. Socializing and meeting people was not used in the Hmong culture to alleviate stress. The support group meeting has shown that talking with friends can make a big difference in their lives. Some feel comforted by listening to other people who have similar problems. Some participants feel that they have more freedom to express how they feel at the Support Group because it is less structured or focused on counseling techniques. Instead, it focuses on social and creative group activities.

Some people come to the support group to relax their minds and bodies. Games like Bingo are played. Some say these group activities help them to forget about their problems at home. Hmong traditional songs are sung and videos are shown as well. This informal approach helps the facilitator address mental health issues more effectively as participants are able to concentrate and understand more than when they are home, where crowded living conditions

present many distractions.

Meeting on a weekly basis helps the participants to stay in close touch with the group as well as develop their interests. Many of the participants suffer from severe depression, as a result of the cultural displacement experienced by new refugees, and it is necessary for them to receive consistent and frequent support.

Approximately 75 Hmong refugees who are over the age of 40 were part of the newest group of refugees to relocate in Merced County, and they are suffering from severe cultural shock. The SEA Support Group provides a great and non-threatening educational experience where they can come and access community support, resources, and help. A Language & Cultural Specialist is available to address any questions/concerns they might have, including those relating to all aspects of mental, emotional, physical and spiritual health. Moreover, the Specialist also offers mental and physical health education (e.g. Diabetes education and Mental Health First Aid) as needed. Health aids and community nurses are occasionally brought in to serve specific needs or present specific programs. Individual case management is utilized if deemed necessary.

The cost to maintain the SEA Support Group meeting is roughly $40.00 per week. Mercy Hospital supported the SEA Support Group from 2003-2009, providing monies to supply tea, coffee, ice water, some snacks, and most importantly, the location. When Mercy Hospital moved to the new Hospital on the other side of town in April, the Mental Health Department began providing a meeting room.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The mission of Healthy House is to promote the well being and health of all people in our community through the provision of education, services and advocacy which are founded in respect for language, culture and health equity. Health House staff provides educational presentations to the group on varied topics, including relationship building, drugs and alcohol, gambling addiction, hygiene, mental health and physical health. This support group primarily aims to alleviate depression and suicidal thoughts in refugee populations who are suffering from culture shock, as well as addressing the physical manifestations resulting from such mental conditions.

- To provide interpreting services for participants who have mental health issues and/or suffer from chronic diseases. Support services include help with accessing services, understanding medication regimens and scheduling follow up healthcare appointments.
- Brainstorming possible solutions to everyday problems, significant contributors to depression, is a major focus of the class. The group shares information and strategies to help them learn/remember how to cope with seemingly simple situations which can be major dilemmas for people new to mainstream culture. Some subjects discussed include: 1) how to use the western healthcare system; 2) police involvement in child/spousal abuse cases; 3) where to find legal help; and 3) where to get help for suicidal individuals.
- To provide interpreting for individuals who need help with their citizenship applications and other civic responsibilities.
- To create community support for and provide valuable information on any relevant topic identified in the SEA Support Group.

6. CULTURAL RELEVANCE

- At least 30% of the participants are patients who have been referred by the Family Care Clinic or Golden Valley Health Center and others come by word of mouth from the community. Almost all are suffering undue stress as a result of culture shock, displacement from war torn countries, and long term internment in refugee camps.

- These refugees also routinely suffer from Post Traumatic Stress Disorder (PTSD) and other chronic diseases such as diabetes, hypertension and depression associated with culture shock. Trans-adaptation of educational materials is used to help facilitate culturally appropriate understanding of these conditions (many of which are new to the respective cultural groups).
- This program was originally designed in 2000 to provide culturally competent healthcare interpreting and cultural mediation for SEA refugees suffering from chronic disease and depression. Healthy House provided two cultural brokers to Family Care Clinic and Golden Valley Health Center. This pilot project was called the "Culture Clinic." Southeast Asian patients with long term and/or multiple mental or physical health issues were scheduled to see a resident physician with assistance from a culture broker in order to assess each patient's mental and physical health. Home visits were made if necessary. The formation of a support group was eventually instituted to provide a more efficient, supportive and ongoing process.

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

1. NAME OF PROGRAM:		
Youth Alcohol and Other Drug Prevention Program		
2. TYPE OF PROGRAM:	X	Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Lynn Thull, Ph.D.
Asian Pacific Community Counseling
7273 14th Avenue, Suite 120B
Sacramento, CA 95820
lthull@apccounseling.org
(916)383-6783

4. TARGET POPULATION

- Low income urban children and youth, focusing on Asian Pacific Islander (API) Children/Youth (K-12)
- Language: English (multiple API and other languages as primary in the home setting)
- Second Step (EBP) curriculum is used to elementary to middle school in classrooms
- Life Skills curriculum (EBP) is used afterschool with middle school and high school-age students at school or at the provider agency's office
- Youth will learn about negative effects of AOD, help youth to develop skills to say "no" to peer pressure, and leadership skills to be a role model in positive life skills
- Alternative afterschool activities to provide youth safe environment to keep them from boredom and engaging in unhealthy activities

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- Program aims to help youth make positive/healthy decisions when alcohol/other drugs are introduced
- Small group afterschool activities will help program staff to develop individualized positive relationship and trust with each youth
- Program provides skills to strengthen family systems in low income areas of Sacramento County, focusing on Asian Pacific Islander Youth.
- Participants often experience challenges in cultural differences between them and their parents, and program staff address positive communication, understanding their heritage and how they could embrace differences in various forms
- The long term goal if this program is to develop youth to the point that they become happy and healthy community members. Youth will contribute to their community.
- The program will like to other community resources; seeking input as well as educating other regarding the protective and risk factors associated with API youth.

6. CULTURAL RELEVANCE
• For this program, participants come in through word of mouth and through outreach to school leaders. Youth recruitment often works best by having current participants identify their peers to participate and recruit on their own • Participants may have experienced challenges in cultural differences between the youth, their parents, and the mainstream community. Program staff focuses on positive communication, understanding their heritage, and how they could embrace/understand differences between the youth, their family members and the larger community. • Children and youth are encouraged to practice appropriate traditional beliefs related to mental health and well-being. The children/youth are also encouraged to educate other group members (peers) about their unique traditions and beliefs. • Although the target population is API youth, the groups also include other cultural/ethnic populations. Participants all respect individual's differences and are encouraged to share/celebrate their heritage and background when opportunities are presented

APPENDIX 5: CATEGORY 2 FULL SUBMISSIONS

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

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
***Em*-Power**: *Em* (Vietnamese for *sister*)—Power		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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4. TARGET POPULATION

Em-Power is designed to serve Asian American and Pacific Islander (AAPI) girls ages 11 to 13 residents of Santa Clara County who are attending Morrill Middle School in the Berryessa School District in San José. The program curriculum and activities are provided in English. Em-Power is intended to address the specific needs of AAPI girls who experience acute intergenerational conflict due to differential acculturation between their parents and themselves. The program is intended for a school setting and has been delivered as an after-school enrichment activity and as a class elective during the course of the academic year.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Overall Goal. To improve the emotional and behavioral health of AAPI girls ages 11 to 13 in Morrill Middle School by creating opportunities for activities and discussions in order to raise self-esteem and self-efficacy, improve family and peer relationships, and foster positive cultural identity.

6. CORE COMPONENTS

Em-Power provides workshops (Girl Talk) designed to build and support developmental resilience through gender-specific, culturally relevant activities and discussions. Themes are topics relevant to AAPI girls, including female identity and empowerment, anger management and conflict resolution, communication skills, cultural identity, self-esteem, sexual health, social skills, career goals, substance abuse prevention, and gang prevention. Modes employed to support these themes include dramatic presentations, radio interviews, media literacy projects, and community participation activities. An average of 10 girls per group attend the workshops, which are held in their middle school site during after-school hours thus providing a familiar and safe space as well as convenient access to the program.

We have drawn on data obtained from evaluation forms collected from participants in AARS' Sister-to-Sister Conference to identify the issues AAPI girls face these days and the problems they would like to talk about in a

confidential, safe, and supportive environment. This data has been key to helping us identify the need for a program like *Em*-Power. An influential meta-analysis of cultural competence in youth programs found that although identity development is basic to adolescence, minority youth face unique challenges in doing so because they must "operate in at least two distinct cultures," which requires a more complex and protracted process. There is, moreover, a tendency for characteristics of minority youth to be defined as deficiencies or oddities rather than assets. A culturally-appropriate developmental assets approach is now widely understood to be basic to successful prevention programs. Local AAPI girls need and *Em*-Power has been designed to provide support for acquiring or strengthening both external assets, such as establishment of relationships with and connections to others in the school and community, and internal assets, such as building self-efficacy and self-awareness.

Girls Talk provides a consistent support base in which participants can share, listen, and voice their experiences, concerns, and successes. The curriculum draws on insights from Dr. Stephanie Covington, recognized for her pioneering work on females, which encourages girls to find their voices and share their diverse life experiences with each other. Girls Talk allows a chance for participants to problem-solve together as they go through such challenges. Each girl takes part in a major group project at the end of the school year that will give them an opportunity to learn confidence-building skills like creative design or large-event planning and experience the benefits of team work, group accountability, and team spirit. Some girls help design, plan and organize the Sister-to-Sister Conference, a yearly flagship AARS event, for 300 middle school and high school girls, an energizing day of inspirational speakers, informative workshops, and fun activities. Other girls choose to produce Em-Powering Voices, a cultural performance at the conference illustrating the most influential experiences from Girls Talk. The curriculum for both the Girl Talk workshops and *Em*-Power Leadership development sessions are included as attachments. Training and staff development can be available to other programs and staff who are interested in implementing *Em*-Power in their area.

Girls Talk groups of ten students each meet for 1 ½ hours twice a week during the school year (following the academic calendar) for discussions relevant to bicultural girls in this age group, including self-esteem, body image, cultural identity, interpersonal skills, and establishing positive family and peer relationships. To date, total of 78 girls have participated in the program. The program demonstrates a strong level of replicability and is currently being considered by AARS for adoption in San Mateo and San Francisco counties pending availability of funding.

7. CULTURAL RELEVANCE

Em-Power is designed to serve AAPI girls in the sixth and seventh grades in Morrill Middle School. These girls constitute the selected population for prevention activities as defined in Institute of Medicine (IOM) prevention categories. Within this population, a girl's personal risk is not specifically assessed or identified but there is a presumption of likely need, given her membership in the at-risk subgroup of AAPI girls. There is a smaller but significant indicated IOM population, girls who show early danger signs, such as falling grades and problematic behaviors such as conduct disorders and alienation from their parents, school, and positive peer groups. For girls in the indicated IOM population who display some type of emotional, academic, attendance or behavior issues we will rely primarily on teachers and counselors at the school for referrals. For girls in the larger selected population, outreach is more difficult but nonetheless very important. For cultural reasons, AAPI youth are compliant and not acting out in school yet are withdrawn and struggling with many internal anxieties. AAPI girls are sometimes raised to be so conforming and obedient that they do not know they are depressed and end up, years later, imploding and at risk of self-mutilation, suicide or other forms of harm and violence to family members or themselves. They are hard to reach with conventional outreach measures. But in our pilot program we have found that when girls already participating in Girls Talk feel safe, comfortable and supported, they are the best source of referrals for peers whom they know to be suffering in silence.

Research has shown that interventions like Em-Power help strengthen the social support and acculturation of students, thus improving their overall mental health. Mental health services have been shown to be more effective when they are provided "within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served." On the other hand, a locally-based study found that "The failure to adapt service delivery to the socio-cultural perspectives of people of color has relegated large segments of the U.S. population to inappropriate treatment, inadequate levels of service, or lack of any service." AARS was one of the organizations analyzed in this review and cited for "bridging intergenerational cultural gaps, focus on the family, and systematic cultural competence. Taking this research into account, we have adopted the culturally-appropriate developmental assets approach for Girls Talk described above in section 6 Core Components.

Before its implementation at Morrill Middle School, AARS piloted a Girls Talk program on a volunteer basis at Independence High School in San Jose from 2003 to 2004. While there was no formal evaluation and data analysis, we conducted surveys for the Santa Clara Department of Alcohol and Drugs that included indicators like self-reported relationship qualities and alcohol and drug use. Considered along with program and school data, these showed improved grades, better parent-daughter relationships, reduced drug and alcohol use, and high retention rates.

Planning for Em-Power has drawn on a wide variety of community-based informants including: participants in our annual Sister to Sister conferences; AAPI girls in our current youth programs; parents in our Vietnamese Parents' Workshops; and listeners to our previously funded radio program on behavioral health issues who call in to respond to topics they have heard discussed. Girls assist in the program implementation by selecting the topics for Girls Talk, playing an active role in organizing the Sister-to-Sister Conference, and determining the theme and type of performance for Em-powering Voices. Participant satisfaction surveys are a crucial element in understanding the successful elements of the program, along with findings from focus groups and interviews with selected girls.

8. STAFFING

Successful implementation of Em-Power requires one (1) program manager, two (2) youth development specialists and one (1) youth development intern.

The Program Manager is responsible for supervision of staff, program design and support direct service staff and interns for special student needs. The Program Manager requires a BA or MA in social work or counseling or psychology and at least 5 years experience in designing, implementing and supervising programs to marginalized youth and communities of color.

Youth Development Specialists (YDS) are responsible for building referral networks, recruiting participants, assess and refer to appropriate services, implementation of Girl Talk groups, gather and enter evaluation data and facilitate organization of Sister-to-Sister Conference. YDS require a BA or MA in social work or counseling or psychology and at least 2 years experience working with disenfranchised youth and communities of color.

Youth Development Intern co-lead group activities, and assist in gathering and entering evaluation data. Interns must be Bachelor or Master-level students working in social work, counseling or psychology.

Successful implementation of Em-Power requires a bicultural and bilingual staff representative of the AAPI communities. Staff members who have delivered Em-Power have been Filipina and Vietnamese and spoke English,

Ilocano and Vietnamese. Staff-to-student ratio is 1:10.

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

Em-Power has been delivered in a school setting, both as an after-school enrichment activity and as a course elective with the eligibility to earn school credits. A consistent space that is available for Girl Talk groups is needed with large space for interactive activities. Ideally, this space can be physically represented with appropriate decor that promotes AAPI cultural pride. For replication purposes, it is possible for *Em*-Power to be implemented in a community setting as long as this space is conveniently located, easily accessible, and safe for girls.

10. INDICATIONS OF EFFECTIVENESS

Em-Power has been evaluated and produced outcome data. This data showed (1) level of participation in the program was positively related with social skill and self-esteem (Pearson product-momentcorrelationcoefficient $r = .21$, $p=0.5$ and $r = .31$, $p<.05$, respectively) and negatively related with risk behaviors ($r = -.37$, $p<.05$); (2) Student's self-esteem has a positive relationship with their relationship with parents ($r =.51$, $p<.05$); (3) The more a student being resilient, she experienced less conflict with family ($r =-.55$, $p<.01$) and greater relationship with parents, especially with mother($r =.62$, $p<.01$); and (4) The better students' peer relationship is, the better the relationship with parents ($r =.57$, $p<.01$).

The methods for program evaluation utilized a sort of pre-experimental study design using a longitudinal data collection method based on the curriculum of the Girl Talk component. Girl Talk curriculum consists of three sub-curriculums, corresponding to the proposed objectives: (1) self-esteem and cultural identity, (2) peer and family relationship, and (3) healthy behaviors. Three sets of individual Pre-Post test were implemented to evaluate the effectiveness of each sub-curriculum: the pre-test survey was administered at the beginning of each curriculum and the post-test survey was administered at the ending of the each curriculum.

An independent, contract evaluator conducted the evaluation. Dr. Meekyung Han, Professor of Social Work at San Jose State University, and expert on the impact of acculturation on immigrant health, conducted a process evaluation to capture learning for future program replication. She also examined *Em*-Power's short-term results.
Standardized instruments were used to assess the effectiveness of Em-Power and to evaluate each objective proposed. Emotional well being, more specifically, self-esteem, was measured by the Rosenberg Self-Esteem Scale (RSE, Rosenberg, 1979), a widely used measure of self-esteem. Participant's resiliency was measured by a sense of coherence (SOC). The 13-item SOC (Antonovsky, 1987) that examined individual's comprehensibility, manageability, and meaningfulness. To supplement the data obtained from these standardized instruments, two additional instruments developed for use with congruent target populations were employed. These were the Asian American Family Conflict (AAFC) and the Intergenerational Congruence of Immigrant Families-Child Scale (ICIF-CS) that were used to measure improvements in families. AAFC (Lee, et al., 2000) was developed to assess intergenerational conflict in immigrant Asian American families while ICIF-CS (Ying, 2004) was constructed to assess the degree of parent-child agreement in values and behaviors across varying life domains. All of the ICIF-CS items were deliberately chosen to be sufficiently general in content, such that they may be used with migrant families from different ethnic groups.

The 15-item Social Skills Assessment (McCarthy, et al., 2004) was developed to measure the school-age students' social competence, interpersonal skills, and self-management skills.

The quality of peer relationships was operationalized as the perceived acceptance by peers and attachment to peers,

measured by Inventory of Parent and Peer Attachment – Peer part (IPPA-Peer) developed by Armsden and Greenburg (1984). This measurement has been widely used with adolescents across the ethnic groups to measure the perceived acceptance by peers and attachment to peers.

General Ethnicity Questionnaire (GEQ)-Ethnic and American versions (Tsai et al., 2000) were used to assess cultural orientation and embracement of Ethnic and American culture. GEQ consists of several constructs including cultural identity (used for objective 5a) and behavioral patterns of acculturation (used for objective 5b). The original General Ethnicity Questionnaire -Asian and American versions (GEQ-Ethnic and GEQ-A, respectively) consisted of 37 identical items that assessed degree of affiliation – identity and behavioral patterns of acculturation- with the two cultures (Asian and American). For this study, we used the shorten-version of GEQ after consulting with the authors. The short GEQ contained 20 items. Among them, 9 items assessed cultural identity with two items measuring overall ethnic and American orientations. Other 11 items assessed behavioral patterns of ethnic affiliation. No significant barriers where encountered in the process of data collection.

11. AGENCY INFORMATION

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AARS, as a multi-ethnic organization, highly values diversity in the workplace. This is reflected though the staff's approach, innovation and creativity in delivering culturally specific services to AAPI communities, as well as a growing demographic of Latino and African Americans, in the San Francisco Bay Area.
AARS board of directors and staff is comprised of both bicultural and bilingual representatives of the various AAPI communities as well as members of other communities we serve. Staff is able to utilize their personal and professional experiences in assessing the cultural and linguistic needs of our clients. AARS consistently draws upon cultural values that support the recovery process.

Em-power staff and interns receive training opportunities in adolescent development, working with parents and teachers, behavior modification skills, expectations and boundaries, and conflict resolution. To promote workforce development, AARS utilizes and trains interns from San Jose State University each year.

AARS was founded in 1985 by the community-wide efforts of the Asian American Substance Abuse Task Force in response to rising substance abuse rates among San Francisco's Asian and Pacific Islander (API) population. The purpose of AARS is to reduce the impact of substance abuse in the API and other affected communities of the San Francisco Bay Area. Specifically, we offer services in Santa Clara, San Mateo, and San Francisco counties. We accomplish our mission and goals by providing outreach, prevention, intervention and treatment services, as well as, engaging in education, research and advocacy.

AARS is one of the nation's largest community-based organizations to specialize in behavioral health care of API communities. It operates 20 programs in a three-county region in the San Francisco Bay Area. Widely recognized for its development of culturally competent behavioral health services, AARS provides treatment services to more than 3,000 youth and adults annually, and outreach, education and prevention services to more than 20,000 individuals yearly.

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

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
Fresno Center for New Americans—Living Well Program (FCNA-LWP)		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
	X	Early intervention
		Other (please specify) Culturally Competent Mental Health Program

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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4. TARGET POPULATION

- The FCNA-LWP is intended to serve members of the Southeast Asian (SEA) populations (e.g., Hmong, Lao, Cambodian, & Vietnamese) whose ages are 18 years and older.
- The program provides mental health services in Hmong, Khmer (Cambodian), Lao, and English.
- The program is intended to provide early prevention and intervention mental health services in a culturally and linguistically manner to the underserved and un-served members of the SEA populations who have mild to moderate depression and anxiety. Additionally, we also serve SEA clients who had experienced trauma, chronic depression, acculturation and relational problems, and other mental health related issues.
- The program is intended to serve all SEA adults in a community-based setting in Fresno County. The setting and location of the program is geographically and culturally appropriate, and it is conveniently assessed by members of the SEA community. The setting is located in a centralized area where a vast majority of the SEA resides, accesses for social services, and shops. Also, the program is a project of FCNA which is a community-based organization that collaborates with other local social services and agencies, non-profit organizations, and educational institutions in providing services to the SEA community.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

- The specific problems this program aims to prevent or address are:
  - *Workforce Development*. Shortage of bicultural and bilingual mental health clinicians in the County is one of the many problems. Currently, there is a shortage of bicultural and bilingual mental health clinicians serving the needs of the diverse population in Fresno County. In the SEA community, the need is significant as there are only about five licensed mental health clinicians for an estimated population of 30,000 plus SEA members. LWP also received workforce funding to increase the number of licensed bilingual and bicultural clinicians by serving as a training program.

- *Cross-cultural training.* Conducts workshops and training to other health and mental health providers about working with SEA clients. The purposes of the training are to help mental health providers to be more knowledgeable, to have better understanding of the SEA's cultural values and beliefs, and to acquire the necessary skills to work efficiently and effectively with the SEA clients. Likewise, outreached activities and health educational training are available to the SEA families, spiritual leaders, clan leaders to be more aware of the various mental health problems and services.

- *Accessibility.* Increasing mental health services to the underserved and un-served community of the SEA populations. In Fresno County, not only that is there a lack of licensed SEA mental health clinicians, but also there is a lack of a culturally competent mental health program that addresses prevention and early intervention. Besides the County's API mental health program, which many people are not aware of how to access its services, there are no other mental health services in the community for them, except for the LWP. LWP is currently the only community-based mental health program that is contracted to serve the SEA populations in Fresno County.

- *Decreasing Mental Health Stigma.* Mental health stigma is an ongoing problem in the SEA community. This is due to a lack of culturally competent mental health outreach and education program that addresses prevention and early intervention. Therefore, the program aims to educate the targeted population about mental health problems and resources in the community; to de-stigmatize mental health issues and to encourage people to seek help when needs dictate; to send a message to the community that mental health problems are similar to other chronic and spiritual health problems, and that it is culturally appropriate to seek help.

- Protective factors include strong social/spiritual support of traditional healers, leaders, religious professionals (e.g., pastors); reliable reciprocal support system, high value of education & self-determination, family/community-oriented value, fostering the spirit of interdependence and support.

- The risk factors the program aims to reduce are mental health stigma, reluctance to seek help, being passive, a belief that one's destiny is pre-determined, prevalence of chronic health problems, acculturation problems, and a sense of hopelessness and powerlessness**.**

- Specific goals: To de-stigmatize mental health problems and increase utilization of mental health services; to increase the ability to cope with mental health problems more effectively; to be more aware of how mental health problems affect daily role function and role expectations; to serve as a training site to increase the limited number of licensed bilingual clinicians; to enhance health professionals' knowledge and skills in serving the SEA community through cross-cultural training.

6. CORE COMPONENTS

The Living Well Program is one of many programs at Fresno Center for New Americans, and its success is how the program provides mental health services to meet the needs of members of the SEA community who are currently adjusting to a new environment. On average, LWP serves approximately over 100 adult consumers on a monthly basis. LWP clinicians also provide cross-cultural training to health professionals and graduate students who major in health-related fields. LWP staff members also provide information related to mental health issues and resources through radio

programs, cultural gathering activities, and mental health educational workshops.

Unlike traditional Western therapy, the program incorporates and adapts many of the Western therapeutic techniques and treatment interventions in providing culturally and linguistically appropriate mental health services to the targeted populations. The core components are as follows:

- *Bilingual and Bicultural Staff.* All of the LWP staff members are bilingual and bicultural; therefore, the program is able to provide mental health and rehabilitation services, as well as outreach and education services in Hmong, Lao, Cambodian, and English.
- *Accessibility. Transportation is provided.* LWP recognizes that transportation is a barrier that prevents SEA clients from seeking mental health services. To address this issue, LWP has leveraged its resources and provides transportation to the meet the needs of the consumers.
- *Therapy, Rehabilitation and Supportive Services.* LWP provides culturally and linguistically appropriate group and individual therapy to clients. A typical therapeutic group setting consists of 8-10 people with similar mental health problems. In group sessions, members have the opportunity to share with each other about their successes and challenges and learn to support each other. Members learned about coping and problem solving skills, as many of the problems they present are associated with their own cultural values and beliefs. For example, in therapy by focusing and exploring cultural roles and responsibilities, many women in the group were able to accept and cope with their relational problems with their spouses and children. In other situations, clients are taught to understand the power of thinking, and how this can affect their overall health. This is one of the main differences between mental illness and mental well-being. Furthermore, in the rehabilitation activities not only do clients learn to create cultural arts and crafts, but they also learn about other cultural arts and crafts. LWP program also created a Hmong Community Garden Village that is accessible to all clients. Lastly, the program provides supportive services to help clients minimize their daily stressors. Some of the services include providing immigration supportive services to help clients and their families gain their permanent or naturalization status and helping them to apply for social security benefits and/or other social service benefits, such as Medi-cal, Medicare, general relief fund, and housing assistance.
- *Therapeutic Environment.* The site and location of the program is geared toward helping clients to feel like "at-home." The location is located just across from the Asian Village Shopping Center, known as "Ban Vinai Village," which has a variety of social and business services catering to the SEA community and also it is very accessible through public transportation. The offices are arranged and designed to welcome clients in a culturally and linguistically manner. LWP is currently working with doctoral students from the California School of Professional Psychology of the Alliant International University-Fresno Campus. The collaborative work is to conduct a study on what constitutes a culturally appropriate therapeutic office/setting in consideration of the SEA's spiritual and cultural values.
- *Cultural/Spiritual Referrals.* In group and in individual therapy settings, clients tend bring up cultural and spiritual issues that would warrant consulting and/or seeking services of a traditional healer, like a shaman. When this occurs, the bilingual clinician would first explore options and beliefs and process feelings and concerns with the clients. Non-judgmental analysis of the pros and cons of the presenting problems and the meanings behind such issues are also discussed and explored thoroughly with them. As culturally and therapeutically appropriate and agreed by clients, cultural and spiritual referrals will be made.

As referenced above, there is a shortage of bilingual and bicultural mental health clinicians and the lack of culturally and linguistically appropriate mental health services in Fresno County, the services provided by the Living Well

program are essential. Through these services, the LWP becomes like a "one-stop" mental health services program to help SEA clients with overcoming their barriers, fears, misunderstanding, and lack of support systems and resources. These services are critical in helping the SEA clients to gain new insight, have the ability to reframe and think more positively, and understand more about their mental health problems, and thus can have a healthier and happier life in America. These services are likely to equip them to access resources, to be able to think more logically and rationally, to enhance their skills in solving problems and to manage mental health problems more effectively.

This multi-cultural approach to psychotherapy, prevention and early intervention approach is a pilot effort to introduce Western psychotherapy to the Southeast Asian populations, and it is also a way to help de-stigmatize mental illnesses in the community. The program is contracted with Fresno County to provide culturally and linguistically mental health services to members of the Southeast Asian populations with mild to moderate mental health disorders.

The program has a manual that is approved by the County for its services. It has procedures and protocols for how services are obtained and delivered. For example, when a consumer is referred to the LWP, he/she will be scheduled to meet with a LWP's Case Counselor to complete the intake process (e.g., to learn about LWP's mental health services, limited confidentiality issues & privacy practices; to sign consent for treatment, to obtain information about therapeutic roles and expectations). Then the consumer will be assessed by a bilingual/bicultural clinician to determine medical necessity and to formulate a mutually agreed-upon Plan of Care. After this process, based upon a consumer's clinical needs, on a weekly basis, he/she can attend an one-hour session of individual and/or group therapy, rehab therapy, and collateral therapy; while at the same time, he/she can also be provided clinical case management services as needed. The timeframe/duration for LWP's services can be one or two years, depending on medical necessity and/or the severity and complexity of a consumer's mental issues. Ultimately, when a consumer has achieved his/her treatment goals, or when he/she can manage the problem(s) more effectively, he/she will be terminated in treatment, and/or will be engaged in horticultural and rehab activities, as needs dictate.

The LWP also works collaboratively with spiritual healers and clan leaders to reinforce people who have mental health issues to seek services as needed. Spiritual healers (e.g., shamans, herbalists and ritual practitioners) have traditionally played a vital role in the process of resolving social, medical, and mental health issues. In fact, traditional Hmong individuals tend to seek mainstream professionals' help as the last resort. They would first seek help from a spiritual leader/clan leader prior to asking for help from other local health professionals. Two of the LWP clinicians are certified Mental Health First Aid Trainers, who have provided workshops to spiritual healers, clan leaders and other local professionals to help them be more aware of mental health issues and resources in the community.

Therefore, by creating a multi-cultural approach, we have the capacity to provide not only culturally competent mental health services, but we also have the ability to shape the SEA community's misperception of mental health treatment and prevention. Shaping the community's misperception of mental problems and seeking services is done through community campaign e.g., hosting community conferences and workshops, utilizing local SEA media, such as TV and radio programs to convey the message to the community in a culturally sensitive manner. LWP staff can invite community leaders, culturally competent health professionals, clan leaders, and public officials and administrators to get involved in the educational process to reinforce prevention and intervention.

FCNA-LWP provides direct mental health services to any Southeast-Asian referrals from the community and/or other local agencies ages 18 and older. On average, LWP serves approximately over 100 adult clients on a monthly basis. The program has 5 fulltime clinicians, with only one fully licensed and the other 4 are in the process of attaining their

licensures, 1 case manager/case counselor, and a program associate who primary provides interpretation for the clinicians and clients, transportation for clients, and other supportive needs of the program. There are two sessions of group therapy from Monday thru Thursday with about 8-10 people in the each group, and individual therapy sessions beginning after 10 am to 3 pm. The duration of group and individual therapy sessions is approximately 60 minutes each.

Replicating the program is certainly doable, however identifying and hiring competent bilingual and bi-cultural staffing is often the challenge in trying to duplicate such program.

7. CULTURAL RELEVANCE

The program utilized these strategies: media outreach via Hmong radio programs, school outreach to talk to teachers and parents; establishing an advisory board, which consisted of Hmong healers, pastors, and health professionals to provide feedback and recommendations related to culturally relevant practices, outreach and early intervention.

The LWP incorporates the target population's traditions, beliefs, and customs by exploring the elements of culturally acceptable ritual practices, by facilitating the different options in seeking the help of a shaman or herbalist, by inviting culturally competent health professionals to educate the target population about the pros and cons of Western & Eastern treatment prevention and intervention. LWP will recruit SEA healers, shamans, and herbalists who are willing to provide spiritual support for any consumers who are in need of spiritual intervention or prevention. Then, a list of reliable resources, such as Hmong healers, shamans, herbalists, and other religious pastors will be compiled and available to the community; so that people can seek help as spiritual needs dictate. LWP staff will help to coordinate such services.

Hmong cultural and spiritual beliefs and practices play a key role in the perception of good health and illnesses. Hmong believe in animism, which means that all living and nonliving things have spirits and that they interact with each other. It is believed that a Hmong person may have as many as 32 spirits, which are in existence with the body, and 3 immortal souls which are reincarnated again and again into another living form. Thus in life, a traditional Hmong believes in the importance of being in harmony with the self (making sure that all of the spirits and souls are one whole with the body) and the environment. Therefore, this cultural aspect plays an important role in the person's mental health and overall well-being. For example, many times illnesses are not only being perceived as something physically wrong with the body, but are being viewed as something wrong with the person's spiritual well-being, in relationship to idea of losing one's souls. It is believed that because of the departure of these spirits or souls that causes the physical body to be ill. Another example is that when someone has episodes of depression or anxiety, it is believed that they are not only psychological, but have a spiritual root causes in association with the loss of souls. In ensuring that there is a balance or spiritual unity with the physical body, traditional healers (e.g., a shaman) would employ ritual ceremonies and practices to help restore that balance. As result, when working with Hmong clients who are still traditional, we often explore with them on their perspectives and understanding of their illnesses. Through working mutually and collaboratively with consumers, we are able to come with various goals about seeking services from traditional healers.

All of the staff and clinicians at the LWP are knowledgeable and trained about cultural competency and sensitivity in various settings and groups. They attended professional workshops, conferences, and training to gain the necessary clinical skills to in working with various populations. Additionally, the staff and clinicians are also members of the SEA community who all have gone thru similar experiences as their clients, which helps them to build better empathy

and rapport. Finally, after years of experience working SEA clients, the clinicians have been providing workshops training and presentations about effective ways of working with the SEA populations to the mainstream American providers.

LWP was initially established in 2004 to respond to the complex mental health needs of the targeted populations. Originally, the program was intended to respond to a shocking pattern of eight Hmong teens who committed suicide in Fresno during the late 1990s and early 2000s. Also, it was created to provide direct mental health services to the targeted populations because during the 2000s, there had been incidents of Hmong American foreign-born couples who committed murdered-suicides in the Central Valley and elsewhere. Inputs from community leaders, spiritual healers and pastors, and community health professionals during the initial establishment through community meetings, focus groups, and media outreach activities were made, and initial funds from private foundations like The California Endowment and The James Irvine Foundation ware given to start up the program. In regard to program evaluation, consumer satisfaction surveys have been conducted. On-going feedback from the community and consumers have been conducted on an annual basis.

8. STAFFING

FCNA-LWP consists of ten staff members: One LCSW-Clinical Director; one Registered Psychologist; two Associate Clinical Social Workers (ASWs); two MSW-Student Interns; one MS-MFT-Trainee; two Case Counselors (B.A and M.S levels); one Cambodian Interpreter/Assistant Case Manager.

FCNA-LWP has experienced bilingual/bicultural clinicians and supportive staff members to provide culturally sensitive outreach and education to the SEA community by focusing on prevention and early intervention. The LWP has six bi-lingual staff members and three MSW Student Interns to provide the services. Mr. Ger Thao, LCSW, is current the Clinical Director who provides clinical supervision and directs culturally relevant mental health therapeutic services and outreach and education activities.

Dr. Ghia Xiong, Registered Psychologist, is bi-culturally knowledgeable of both Hmong ritual beliefs/ practices and Western approaches of providing psychotherapy and education. He has conducted research studies of Hmong culture and Hmong utilization and perception of western psychotherapy. He has been providing cross-cultural training for many health professionals. He is currently working as a clinician/Registered Psychologist for the LWP. He also coordinates LWP's Horticultural Therapeutic Community Center.

Ms. Yer Yang, MSW/ASW, is a bilingual mental health clinician at the LWP. She provides culturally appropriate mental health services, as well as outreach and education related to mental health stigma in the SEA community.

Ms. Mor Chang, MSW/ASW, is also a bilingual mental health clinician at the LWP. She also provides culturally appropriate mental health services, as well as outreach and education related to mental health stigma in the SEA community.

Mr. Jeff Xiong, MS, Rehab Counselor, is a bilingual mental health counselor at the LWP. He provides rehab activities and services related to mental health stigma and resources in the community via radio programs and workshops.

Ms. Koua Yang, BS, Counselor/Case Manager, provides clinical case management and rehab activities.

Other LWP members include: Ms. Choeun Vonn, MSW Student Intern--a Cambodian bilingual clinician in training; Ms. Phaivan Maneesai, Khmu/Lao MFT Trainee; Ms. La Hang, a Hmong MSW Student Intern. These students assist in providing culturally appropriate mental health services and other prevention and early intervention activities; and Mary In, Assistant Case Manager/Cambodian Interpreter.

The Clinical Director oversees the overall clinical program and culturally competent treatment interventions, supervises clinical staff members and student interns, and provides limited mental health services. Clinicians are responsible for conducting mental health assessment, providing direct clinical services (e.g., individual, group, collateral therapy). Student interns are assigned to provide clinical services to fulfill their academic, professional and clinical skill development requirements. Case Counselors are responsible for conducting intakes and providing case management services and other clinical rehab activities.

All bilingual clinicians are required to have a Doctorate Degree in Psychology, MSW, MA, or they are in progress in working toward such degrees. Bilingual/bicultural clinicians who have experiences in working with the target population are preferable. For clinical case counselors or case managers, a BA level of education and at least four years of experiences in working with a social system are acceptable. Prior to hiring any culturally competent mental health staff, FCNA's Board Members and the Executive Director had an extensive cross-reference check to ensure that they meet the training, education, criteria and qualifications set forth by FCNA's administration.

Each staff have to speak Hmong, Lao, Thai, or Cambodian, and they have to be culturally sensitive and competent, as determined by the guidelines set forth by FCNA.

The ratio in terms of staff to caseload is approximately 25 consumers per 1 bilingual clinician.

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

Out-patient community-based setting/program.

10. INDICATIONS OF EFFECTIVENESS

- LWP utilizes consumer satisfaction surveys to get feedback from consumers and the community, consumer-based participatory research, and focus groups have been conducted.

- Evaluation was done internally by staff. Externally the County audits clinical charts randomly on an annual basis to ensure that LWP meets Managed Care's standard of care.

- LWP uses the Hmong Adaptation of the Beck Depression Inventory to assess consumers' progress in treatment as pre-post tests. In 2010, Dr. Ghia Xiong, LWP's Registered Psychologist conducted a qualitative and quantitative research study on the effectiveness of using adapted CBT techniques to work with the SEA individuals.

- Trust and illiteracy have been the biggest barriers in the data collection process. These factors seem to be associated with war trauma experiences, chronic health issues and complex acculturation distress**.**

11. AGENCY INFORMATION

Fresno Center for New Americans-Living Well Program. Contact information: Mr. Lue Yang, Executive Director; 559/255.8395; luenyang@fresnocenter.com; Ger Thao, LCSW, Clinical Director,

gthao@fresnocenter.com.

It is the policy of FCNA that the majority of the Board of Directors are of SEA descents. The Board members are culturally and professionally diverse, so are the management team and FCNA's staff members. In other words, we have had Hmong, Lao, and Cambodian board and staff members.

FCNA provides some financial support for unlicensed staff members to attend professional trainings or workshops to help them pass the licensure exams. Staff members are encouraged to attend educational conferences and participate in advocacy work to enhance their professional growths/skills and to be competent in impacting policy changes.

Mr. Lue N. Yang, Executive Director has been working with the target community since the early 1980s in various non-profit organizations. He is a well-respected Hmong leader and a culturally competent administrator in promoting new Americans to fulfill their dreams and potentials. He is knowledgeable in program development especially related to health, education, employment, advocacy work, and culturally appropriate conflict resolution. He has been working for FCNA since its establishment in 1991**.**

Mr. Ger Thao, LCSW, Clinical Director, has been working for the LWP as a mental health clinician since 2004, and as the Clinical Director since 2010. He is the first bilingual/bicultural clinician at FCNA to pass the LCSW licensure exams of the CA Board of Behavioral Sciences. He presents with commitments and cultural competency in working effectively with the SEA community. Other than English, he is capable of communicating Hmong, Lao, and Thai.

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

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
UPAC Positive Solutions Program		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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Program is funded by the County of San Diego, Behavioral Health Services, with funding from MHSA PEI.

4. TARGET POPULATION

The UPAC Positive Solutions Program works with homebound older adults, ages 60+ who have minor depression or mild anxiety. Services are provided in English, Spanish, Vietnamese, Korean, and Chinese. Other languages are provided as needed through the assistance of an interpreter. Services are provided to a multicultural population including Asian/Pacific Islander, Latino, African American, Caucasian and other ethnic groups.

The program was created to prevent depression with older adults who are homebound due to illness and/or disability. These seniors are unable to leave their home for activities of daily living without assistance from another caregiver or professional.

All services are provided in the seniors' home or residence.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Homebound older adults face problems such as social isolation, lack of social support, limited access to healthcare, increased risk for depression, high suicide rate, complex medical issues which may be correlated with depression or anxiety, and stigma in seeking gout mental health services.

The goals of the program are to reduce isolation for seniors, increase social support, reduce depressive symptoms, increase individual self-sufficiency, reduce suicidal attempts, and reduce or eliminate stigma of mental health issues and service utilization, which is to address issues of social isolation, lack of social support, high depression rate, lack of

individual self-sufficiency, high suicide rate, and high stigma related to mental health issues and service utilization among homebound seniors.

Protective factors – strong cultural identity/pride with traditional beliefs, support from family and friends, connection to spirituality, positive life experiences, individual strengths

Risk factors – immigrant/refugee/ethnic minority status, limited English proficiency, history of abuse or trauma, complicated medical issues, social isolation, limited resources

Goals –

a. Reduce and/or resolve depressive symptoms to achieve outcomes that are similar to those achieved in the evidence-based PEARLS program (e.g. reduced depression, increased remission, and reduced hospitalization) As indicated in the original PEARLS Study, 43% of the participants have at least a 50% reduction in Depressive Symptoms versus 15% for other interventions; 36% achieve complete remission from Depression versus 12% for other interventions.
b. Increase social support
c. Reduce feelings of isolation
d. Increase and maintain individual self-sufficiency
e. Increase knowledge of appropriate resources in the community
f. Reduce or eliminate stigma of mental health issues and services utilization.

6. CORE COMPONENTS

This program was developed as a collaborative partnership primarily with meal delivery programs, such as "Meals on Wheels" and other related entities. The meal delivery drivers and intake personnel serve as gatekeepers to identify homebound seniors who may be needing mental health services.

In addition to PEARLS model, Gatekeeper model is used as a method to help to outreach and enroll underserved and unserved seniors to participate in PEARLS intervention. The primary set of gatekeepers we work with include meal delivery drivers. A secondary set of gatekeepers include firefighters, police officers including retired police officers, pharmacists and also ethnic community leaders who work with the Vietnamese, Chinese and Korean older adult communities. Meal delivery programs and other community partners are trained to identify homebound seniors who are at risk or have symptoms of depression.

Once a senior is identified, the PEARLS model (evidence-based model) is utilized. The PEARLS (Program to Encourage Active and Rewarding Lives for Seniors) encompasses (1) problem solving treatment, (2)social and physical activation, and (3) pleasant activity scheduling. The PEARLS program is intended for seniors with minor depression, and dysthymia. There are 8 individual sessions total, which spread out over the course of 19 weeks (Session 1-3: weekly session; Session 4-5: biweekly session; session 6-8: monthly session). Each session last for about 60 minutes with three emphasis listed above.

Positive Solutions Program (PSP) has its first full year outcome in Fiscal Year 10-11 (07/01/10-06/30/11). Through this whole year, PSP has served 814 unduplicated seniors in both San Diego Central Region and North County. Moreover, 86.19% of seniors who received brief intervention services have shown risk and symptoms reduction, and 46.15% of those who participated in PEARLS intervention have at least a 50% of symptoms reduction compared to

43% for the original PEARLS (Program to Encourage Active and Rewarding Lives for Seniors) study.

Problem solving treatment is relevant because the approach is participant-driven. This participant-focused approach in selecting the problem and solution creates a sense of empowerment for the participant.

Regarding social and physical activation, research has shown that increased activity leads to decreased depression. During each session, the counselor works with participants to increase engagement in social and physical activities.

Regarding pleasant activity scheduling, the counselor encourages participants to select an activity they would enjoy, which has been found to reduce depressive symptoms.

There is a curriculum available for PEARLS, which can be downloaded from PEARLS official website at http://www.pearlsprogram.org. PEARLS was created by the Health Promotion Research Center (HPRC) at the University of Washington, in close collaboration with local community partners. This evidence-based program has been included in the National Registry of Evidence-based and Promising practices of SAMSHA, and has been recommended by many health and aging services experts. Although the PEARLS model is listed as an evidence-based practice, it has not yet been identified as an evidence-based practice specifically for API communities. However, the creators of the PEARLS model have already been implementing use of the PEARLS model with Filipino and Chinese older adults, in addition to other ethnic seniors, in Seattle, Washington.

The program can be replicated with some modifications. There are several documents, including screening tools, PHQ9 (Patient Health Questionnaire – 9), Baseline/Final Questionnaire, and problem solving worksheet which have been translated. Also, if some seniors have had limited schooling, the concept of homework and written assignments may be challenging for them. Incorporating the assistance of a caregiver, a family member, or a care manager in executing the action plan developed during the session could be an option. In addition, due to the stigma for mental illness and/or limited knowledge about mental health, providing psychoeducation prior to starting PEARLS session would be beneficial.

7. CULTURAL RELEVANCE

The program uses gatekeepers in the community to outreach to the homebound seniors. The primary set of gatekeepers we work with are meal delivery drivers and intake personnel who deliver meals to seniors who are disabled. We have expanded our outreach to other gatekeepers who have a lot of interaction with seniors including (1) firefighters, (2) librarians, (3) pharmacists, (4) home health agencies, (5) senior residence service coordinators, and (6) retired police who still volunteer in the community. We also have developed a partnership with several non-profit organizations which host senior community activities, as well as the Vietnamese Federation of San Diego and other loosely-organized Chinese and Korean groups in San Diego. Additionally, we have conducted outreach to Vietnamese pharmacists and Vietnamese primary care doctors who provide healthcare services to primarily Asian/Pacific Islander patients.

According to Sue & Sue (2003), "Asian American clients expect concrete goals and strategies focused on solutions.....Cognitive-behavioral and other solution-focused strategies are useful in working with Asian Americans." The basis of PEARLS stem from Cognitive Behavioral Therapy, which requires the participant to think about their problems, identify goals, generate solutions, and create action plans. Although Asian Americans consist of many subgroups, one of the similarities is that most of them would benefit from Cognitive-behavioral and other solution-

focused strategies. The differences between the subgroups and each participant are addressed through out of the course of the treatment, such as how religious belief affects one's problem solving approach.

The program emphasizes on the participants' strengths, and incorporating their traditional beliefs/customs in problem solving treatment to create an action plan for the participant to achieve his/her goal during each session. Based on each participant's strength, s/he is encouraged to identify several alternative solutions, which often related to his/her cultural beliefs/customs. For example, many Chinese seniors serve as caregivers throughout of their adult lives. They developed many surviving skills, such as being able to manage living with limited income. These skills often become their strengths and can be helpful in Problem Solving Treatment.

The API community in San Diego consists of about 11% Asian/Pacific Islander. Of that group, some of the highest groups include: Chinese, Vietnamese and Korean. We have also targeted these particular ethnic groups because they reside in the geographic targets of our contract which includes Central San Diego (including Downtown San Diego) which tends to be more urban, and North County San Diego (including Oceanside, Vista and San Marcos) which has a mixture of both urban and suburban. Of the API subgroups that are served, we have worked with Chinese immigrants from Hong Kong, Mainland China and Taiwan. We are able to provide services in both Cantonese and Mandarin. These Chinese immigrants are split into two groups (1) new arrivals and (2) have immigrated to U.S. many years ago. In either case, most of them tend to have taken on the role of "babysitter" for the grandparents, yet have limited ability to speak English, and have limited interaction with adults from their community. The Vietnamese we serve tend to be refugees who arrived in the U.S. in the past thirty years. Some of them are also newer arrivals. Many of them served in the military when they were in Vietnam. The Vietnamese have limited English proficiency. Many of the Korean older adults we serve immigrated to the U.S. for their children to get better education. They are isolated from the main society and have limited English proficiency. For the Chinese, Vietnamese and Korean older adults we serve, most of them are unfamiliar with the public mental health system and have limited knowledge on available community resources due to their limited English proficiency, stigma about utilizing mental health and other social services, and isolation from the main society. These are underserved and unserved populations of San Diego County.

The program aims to address the participants' needs in culturally appropriate manner. Alternative healing practices/beliefs, religious, spiritual, and cultural related issues are assessed during the assessment session prior to starting PEARLS. This information is used to incorporate in the problem solving treatment to improve the participants' mental health condition and well-being. For example, a huge percentage of Korean seniors in San Diego have strong Christian belief and church becomes their main social support. Many of them would incorporate prayers and church activities as part of their activity planning. Often times, church members can also be included in their action plan for the goal they identify during the PEARLS session.

Immigration history and other traumatic issues were often discussed during the assessment session. We recognize that the immigration process may have been traumatic for many of our seniors. We also recognize that many of them have witnessed war trauma in their native country. In addition, we assess for any family violence (past and present.) How these issues affect the participants' problem solving skills are reviewed throughout the PEARLS intervention. Many of our clients have experienced immigration process. Clinicians often discuss with the participants on identifying their strengths through the immigration process and utilize these strengths when doing PEARLS. For example, many Vietnamese seniors had some traumatic experiences during their immigration process, such as surviving through one refugee camp to another refugee camp, finally make it to the United States, and started a family with very little or no supports. The problem solving skills they developed under these circumstances with limited resources become one of

their strengths during the PEARLS intervention.

Asian American seniors, in general, need more assistance in identifying available resources and social support groups. Modifications that have been made beyond translation to accommodate cultural needs of the API population include but not limited to: (1) Addressing case management issues prior to starting PEARLS intervention in order to build rapports and trust with the participants. (2) Establishing rapports through Community Outreach Workers' (usually is someone who has the same cultural background as the participant) prior to starting PEARLS. (3) Addressing physical health issues first instead of depression. (4) When working with illiterate participants, using pictures instead of written words to complete the PEARLS worksheet. (5) Start with psychoeducation to increase the participant's mental health awareness before starting PEARLS. (6) Incorporate the family member and/or caregiver in the action plan to achieve the participant's goal.

Prior to the development of this program, the County of San Diego conducted an inclusive community planning process for the development of this program. Several venues and opportunities were offered to community stakeholders to participate in the planning process, include: (1) Qualitative Assessment of Need for Mental Health Services Among Older Adults in San Diego County – February 2006; (2) Aging and Mental Health Summit Recommendations – June 2006; (3) Older Adult PEI Stakeholder Forum – November 2007; (4) Special Populations Community Focus Groups – December 2007 through February 2008; and (5) Older Adult Mental Council Prevention Early Intervention Planning Workgroup. Through this process, Home-based Prevention and Early Intervention Program for Older Adults is identified to be significantly needed in the San Diego County. That is how the basis of this program was initially formed.

We collect inputs from our participants as well as our partners by distributing Satisfaction Survey to our participants and conducting monthly progress meeting with our partners. Based on these inputs, the program manager has discussed with the County of San Diego (funding source) on modifying the program to address the cultural needs of the population we serve. This program is continuing to be developed and shaped into a better program.

8. STAFFING

We currently have 1.0 FTE Chinese-speaking Program Manager/Therapist. We also have 1.0 FTE Korean-speaking therapist, and 1.0 FTE Spanish-speaking therapist. We also have .50 FTE Vietnamese speaking senior community worker and .25 FTE Spanish speaking senior community worker. We have other clinical, admin and intern staff as well. This program needs a minimum of 2.0 FTE bilingual staff, along with .75 FTE bilingual senior community worker. We serve a multicultural population of Asian/Pacific Islander, Latino, African American, Caucasian and other older adults.

The therapists are responsible for conducting screenings, assessments and doing the PEARLS model. The senior community workers are responsible for conducting outreach in the community- especially Vietnamese community. He also conducts initial screenings, and does interpretation in Vietnamese.

Therapists are Master's level clinicians (or higher). However, the PEARLS model allows individuals with less than master's level degree to conduct the PEARLS model. All clinicians have been trained in the PEARLS model. The Senior community workers have been trained in using the PHQ-9 which is an evaluation tool for depression.

We require staff to be bilingual/bicultural at least in Vietnamese, Chinese (Mandarin, Taiwanese, and Cantonese) and

Spanish because those are the majority senior populations whom we have identified in San Diego County. We also have a Korean-speaking clinician, but there are only smaller numbers of Korean seniors in San Diego.

The ratio of staff to clients is 1 full-time clinician for 25 clients.

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

An office setting is the minimum requirement with space for admin/paperwork activities. However, all clinical activities are conducted in the seniors' home. Outreach activities are conducted in the senior apartments/community/health fairs/ recreational buildings/social service programs for older adults.

10. INDICATIONS OF EFFECTIVENESS

Several methods are used to evaluate the effectiveness of the program, including use of the PHQ-9, baseline/final PEARLS questionnaires, Satisfaction Survey, and individual testimonies. Each participant is assessed with PHQ9 to monitor his/her depression level during every visit. Prior to start PEARLS intervention, each participant is also assessed with a baseline PEARLS questionnaire. When s/he completes the PEARLS intervention, a final PEARLS questionnaire is assessed to monitor the participant's improvement. By the end of the PEARLS intervention, each participant will also receive a Satisfaction Survey to rate his/her own condition compare to before s/he starts receiving PEARLS intervention. In addition, the program participants are invited to share their testimonies in our program quarterly newsletter.

The PHQ-9 is a nine item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. The primary care clinician and/or office staff should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff.

There are two components of the PHQ-9:

- Assessing symptoms and functional impairment to make a tentative depression diagnosis, and
- Deriving a severity score to help select and monitor treatment

The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). PHQ9, baseline/final PEARLS questionnaires are conducted by the staff members, and Satisfaction Survey and individual testimonies are completed by the participants on their own or with caregiver or staff's assistance.

Both quantitative and qualitative data are collected and entered to HOMS (County of San Diego database system). Measurements include: PHQ9, baseline/final PEARLS questionnaires, Satisfaction Survey, and individual testimonies.

Barriers for collecting data includes: (1) Staff's learning curve in utilizing County of San Diego HOMS database system; (2) HOMS database system's limitations; (3) participants' stigma for answering PHQ9

Our Outcome for Fiscal Year 10-11 (07/01/10-06/30/11) is listed below:

We have served 814 unduplicated seniors in both San Diego Central Region and North County. Out of 814 seniors, 138 of them received PEARLS intervention. Moreover, 86.19% of seniors who received brief intervention services have shown risk and symptoms reduction, and 46.15% of those who participated in PEARLS intervention have at least a 50% of symptoms reduction compared to 43% for the original PEARLS (Program to Encourage Active and Rewarding Lives for Seniors) study.
Satisfaction Survey:
Increase & maintain self-sufficiency: 100%
Reduce self-isolation: 83.12%
Increase social support: 83.33%
Feeling more comfortable to seek for help: 92.94%
Increase knowledge about available resources: 94.25%
Overall Satisfaction: 94.25%

11. AGENCY INFORMATION

Dixie Galapon, Ph.D., Director Mental Health Services
Union of Pan Asian Communities
Contact info is listed above (#3).

The board, management and staff consists of primarily Asian/Pacific Islander representatives. However, there is a growing contingent of African American, Latino and other refugee/immigrant communities within UPAC staff. Among the 117 UPAC staffs, 74 are API.

The agency provides cultural competence training in-house, and also recommends staff to attend cultural competence training in the community. The same applies for clinical trainings. UPAC does not have a dedicated training department.

UPAC's mission is to provide for the social service needs of San Diego County's Asian/Pacific Islander and other ethnic communities of San Diego. It was established in 1974, with mental health services being the largest component of its services. UPAC has been providing mental health services to youth, young adults, adults and older adults from the API community for over 25 years.

Particularly in working with older adults, UPAC works closely with local Aging and Independence Services (AIS), senior centers, and other older adult providers to serve unserved and underserved seniors. Examples of these services include:

a. Positive Solutions Program: The short-term prevention and intervention mental health services are provided to homebound seniors, including API, and other seniors. Using the evidence-based Program to Encourage Active and Rewarding Lives for Seniors (PEARLS), seniors are assisted in addressing feelings of isolation, decreasing risk and symptoms for depression and suicide, and improving access to mental health care and support.
b. EMASS (Elder Multicultural Access and Support Services): Services are designed to address mental health issues, provide prevention activities, and increase access to mental health care for over 800 Filipino, Latino, African-American and African refugee communities.
c. Senior Nutrition Program: Funded by the County of San Diego, Aging & Independence Services, the program provides ethnically appropriate, nutritious meals and nutrition education to Pan Asian seniors at five congregate meal sites throughout San Diego County, including North County. The program enhances good nutrition, reduces

social and emotional isolation, enhances positive socialization through cultural activities and engages seniors in the planning, preparation and serving of the meals. The program also provides education on available community resources.

d. Chinese Outreach Project: In partnership with a local senior center, a Chinese-speaking case manager provides education to monolingual Chinese seniors at the senior center on Medicare and other public programs, facilitates English as a second language and computer classes, provides translation and interpretation, and attends interdisciplinary team meetings to facilitate integration of mental health, social work and nursing services.
e. Changes Pilot Program: In partnership with the Self-Help for the Elderly, the project provides a) outreach, b) consumer education workshops on energy consumption, energy conservation, consumer rights, consumer protection and assistance with utility programs such as CARE, FERA and medical Baseline to limited English-proficient (LEP) and persons with disabilities.
f. Telecommunication Education and Assistance: In partnership with the Self-Help for the Elderly in a statewide coalition, the project conducts a) outreach, b) consumer education workshops on telecommunication choices, consumer rights and consumer protections, and c) complaint resolution services to limited-English proficient (LEP) communities with telecommunication complaints/inquiries.

UPAC also has initiated some collaboration with CEMHAC – California Elder Mental Health and Aging Coalition.

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

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF): A Curriculum for Immigrant Parents		
2. TYPE OF PROGRAM:		Universal prevention
	XX	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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4. TARGET POPULATION

The target populations of the SITIF Program are immigrant parents and/or primary caregivers with inadequate parenting skills to effectively discipline and nurture their children. The curriculum has been applied to immigrant parents of various ethnic origins. The curriculum has various language versions (including English, Spanish, Chinese, Korean, and Vietnamese). The Chinese and the Korean version of the SITIF Program have been implemented in Los Angeles (at the Asian Pacific Family Center of Pacific Clinics). Due to cultural and linguistic barriers as well as acculturation stress, many of the target parents of the SITIF Program often feel overwhelmed and have conflictual relationship with their children youth that created unnecessary stress in their families. Unfamiliar with the cultural and legal norms in the U.S., many of these immigrant parents may be accused of improper discipline (e.g., corporal punishment) and referred to Department of Children and Family Services (DCFS). As a result, their children may be at risk of being removed from home. In addition, many of these parents often feel helpless and hopeless in terms of their parenting ability while their children often feel "trapped" between two cultures and perceive their parents as unnecessarily strict, unfair, or not understanding of their struggles. Hence, the family ties and parent-child relationship are often greatly strained and/or impaired. Furthermore, these children are at high risk of behavioral and emotional problems. Without timely and culturally competent support and intervention, these youth may develop such behavioral problems as "Oppositional Defiant Disorder" and/or other delinquent behaviors.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The overall goal of the SITIF Program is to improve the intergenerational relationship of the target families by increasing the target parents' sense of self-efficacy and effective parenting of their children.

6. CORE COMPONENTS

The three core components of the SITIF Program are as follows:

(1) Community Education/ Outreach Workshops: These are one-time workshops (about two hours each) on effective bicultural parenting and family management for education and outreach. This is an important program component in demystifying the stigma associated with the parenting class series offered by the SITIF Program (see [2] below). It can also provide some objective and helpful tips for workshop participants to enhance their daily interaction with their children. In addition, these community education/outreach workshops are also effective recruitment strategy for the parenting class series offered by the SITIF Program (see [2] below).

(2) Bicultural Parenting Class Series: This is a 10-week, culturally competent, skill-based, interactive, and manualized parenting and family management curriculum offered in Chinese and Korean (in addition to English, Spanish and Vietnamese) to the target parents and/or primary caregivers. These once-a-week class sessions last for 2 to 3 hours per week in a group format. Topics include parenting skills to help promote the bicultural identity of immigrant children, enhance parent-child understanding, and effectively utilize reinforcement, rule, and consequences in this country. Stress management for parents is also included in this curriculum.

(3) Family Support Service Linkage: When parents and/or primary caregivers indicate that they would need additional assistance to access mental health and/or other social services to address the biopsychosocial needs of their families, case management linkage to linguistically and culturally competent community service entities is offered as part of the SITIF Program.

7. CULTURAL RELEVANCE

To help outreach to the target Asian immigrant parents and primary caregivers, all the staff of the SITIF Program (especially the Parent/Family Specialists and Community Organizers) are hired from the bilingual and bicultural members of the target Asian immigrant communities to the extent possible. In addition, respected community leaders and members (including leaders of the local Asian ethnic Parents Association) are enlisted to support the outreach and engagement efforts of this Program (e.g. inviting program staff to offer the "Community Education/Outreach Workshops" as part of the meeting of their organizations).

Each of the three essential elements and primary strategies of the SITIF Program that target Asian (i.e. Chinese, Korean, and Vietnamese) immigrant parents has incorporated Asian cultural and parenting values and approaches. The SITIF Program is specifically designed for Asian immigrant parents with an emphasis on enhancing their effectiveness in implementing bicultural parenting and family management in the contemporary social context of this country. This Program has been piloted with, and refined with input from¸ the parents and primary caregivers of the respective target Asian immigrant communities (i.e. Chinese, Korean and Vietnamese) before full-scale implementation began.

8. STAFFING

To implement ten to 15 "Community Education/Outreach Workshops" and conduct four "Bicultural parenting Class Series" per year with each target Asian immigrant parent group (i.e. Chinese, Korean, or Vietnamese), the following staffing is required:

(a) 0.5 FTE **Parent/Family Specialist**: Bachelor's degree in psychology or related field (Master's training preferred, but not a requirement). Each Parent /Family Specialist should be bilingual in the same language as target immigrant parents (i.e., Chinese, Korean, or Vietnamese). Effective communication skill with public speaking experience is

preferred.

(b) 0.50 FTE **Community Organizer**: Bachelor degree in psychology or related field. They should have a good understanding of local community experiences and familiar with community resources for the target families. Because this person serves as the liaison between the program and the community; s/he should have the ability to network with community stakeholders and members, and recruit them to support and/or participate in the program.

(c) 0.25 FTE **Project Director**: Master's degree in psychology or related field preferred for staff supervision and program management.

(d) 0.25 **Clerical Aide**: This staff person will provide administrative and office support to the Program.

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

The activities of the SITIF Program are delivered at locations that are "natural congregation" places for the target Asian immigrant parents and/or primary caregivers. Examples include school sites or other community human service delivery locations. In addition, community-based and culturally competent behavioral healthcare settings are also appropriate service delivery sites.

10. INDICATIONS OF EFFECTIVENESS

Through UC Berkeley School of Social Work, the SITIF Program has been evaluated utilizing a quasi-experimental design with culturally valid pre-post measures. The program evaluation has included data from the implementation of the SITIF Program at the Asian Pacific Family Center of Pacific Clinics in Chinese (Mandarin) and Korean. The results of the program evaluation indicate that many of the pre-post measures reach statistical significant. More specifically, the results indicate that the target parents have made meaningful changes in the positive direction in several areas, including an enhanced sense of self-efficacy in parenting their children in the U.S., and an increase in the effective management and discipline of their children. In addition, the target parents have reported an improvement in their relationship with their children and a reduction of parent-child conflict after program participation. The effectiveness of the program has been published in several professional journals by Dr. Ying.

11. AGENCY INFORMATION

As noted above, the Chinese and Korean version of the SITIF Program has been implemented at the Asian Pacific Family Center (APFC) in Los Angeles County. As a division of Pacific Clinics (a private, nonprofit mental health and behavioral healthcare agency established in 1926), APFC has been offering a wide spectrum of mental health services, as well as behavioral health prevention and intervention services, to the Asian immigrant communities in the San Gabriel Valley area of Los Angeles County for 25 years. The program services at APFC are offered by a multilingual and multidisciplinary team off nearly 100 highly trained professionals, including psychiatrists, psychologists, social workers, counselors, nurses, parent, youth and family specialists, and community workers. In addition, the APFC Community Advisory Board (comprising of clients and parents, school and law enforcement officials, civic leaders and businesspersons, and other community stakeholders from both the local Asian immigrant and mainstream communities) provides input and support to ensure that the programs developed and offered by APFC are culturally and linguistically responsive to the local Asian immigrant families we serve. Moreover, asides from regular in-service training and support, all staff members are provided at least 5 days of continued education leave a year to attend training courses offered by the Pacific Clinics Training Institute (free of charge to staff) or by other training facilities of their choice. One requirement is that all staff members are expected to attend training courses each year that are

designed to enhance their cultural competence.

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

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
Richmond Area Multi-Services, Inc. (RAMS), Wellness Centers Program		
2. TYPE OF PROGRAM:	X	Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

The behavioral health services program has been collaboratively developed by Richmond Area Multi-Services, Inc. (RAMS). The Wellness Centers is a collaboration with leadership from the SF Department of Children, Youth and Their Families (DCYF), SF Department of Public Health (DPH), San Francisco Unified School District (SFUSD), and RAMS.

RAMS, Inc.
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Tel: (415) 668-5955; Fax: (415) 668-0246

4. TARGET POPULATION

The target population includes all San Francisco Unified School District (SFUSD) high schools (e.g. students & families; administrators & teachers), focusing on students with behavioral health concerns who may benefit from intensive case management and behavioral health services, who may be dealing with trauma/grief & loss, or families with limited resources. Furthermore, clients present with a wide scope of issues (e.g. mental health, substance use/abuse, diverse ages, ethnicity, sexuality, socio-economic status). Many are referred for concerns relating to mood, behavior, and other adverse circumstances.

Specifically, this includes an ethnically diverse high school youth community, economically diverse families, multi-lingual communities, varying immigration generations, and underserved families. Over 50% of RAMS Wellness Centers Program staff are bi- or multi-lingual, with languages including but not limited to: Cantonese, Mandarin, Hakka, Taiwanese, Gujerti, Hindi, and Spanish.

SFUSD High School Demographics:

- Total Enrollment: 19,051
- Ethnicity: Latino (21%); Other White (8.7%); African American (12.3%); Chinese (35.9%)
- English Language Learners: 8.6%
- Special Education: 10%
- Free or Reduced Lunch (based on income eligibility): 43.2%

RAMS Wellness Centers Program Participant Demographics:

a. Annually, over 1,600 youth served
b. Gender: Female (58%), Male (42%)
c. Ethnicity: Latino (27%), Chinese (24%), African American (19%), Other Non-White (15%), Filipino (6%), Other White (7%), Non-Stated (2%)

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Participant outcomes are improved psychological well-being, positive engagement in school & community, awareness & utilization of resources, improved individual & school capacity to support student wellness, and decrease in retaliatory incidents in the community. The program works to enhance protective factors and reduce the impact of risk factors.

Protective factors include:

- Some youth have positive support systems including friends/peers, family, and community connectedness
- Some youth are of families that are multi-generational (e.g. grandparents, aunts, uncle, etc.) who are actively involved in the youth's immediate family. As such, there may be additional resources to support the parents. This can increase the family's support systems to help sustain financial means.
- Some parents are highly involved in their child/youth's lives and dedicated to supporting them for academic success. As such, they are very motivated and open to taking recommendations.
- Community resources are very accessible, on-site at schools

Risk Factors include:

- Prevalence of substance use & abuse and mental health concerns among the target population
- Poor coping mechanisms and resiliency in youth
- Increasing rates of community violence and complex trauma (family dysfunction, abuse, neglect, poverty and oppression, and the cumulative experience of living in environmentally, socially and emotionally traumatized communities)
- Stigmatization of seeking support services
- Poor knowledge of and linkage to community resources
- Low socio economic status in the family; thus, causing additional stressors at home
- Academic performance may be low
- First generation families and youth may be isolated
- First generation parents may have limited options for employment. The employment options tend to have low wages, without healthcare benefits, etc.; thus, increased stressors at home.
- Furthermore, families with limited employment options, in a down economy with diminishing jobs, have additional stressors on their existing already-limited financial resources (e.g. one parent may become unemployed; parent that maintains employment may have additional stressors at job).

For Behavioral Health Services, more specific goals include:

- At least 80% of students receiving behavioral health services will report feeling better about themselves (e.g. self-esteem, improved quality of life), as measured by an anonymous evaluation survey
- At least 75% of students receiving behavioral health services will report improved handling daily life (e.g. coping and independence skills), as measured by an anonymous evaluation survey
- At least 80% of students receiving behavioral health services will express overall satisfaction with services, as measured by an anonymous evaluation survey

For Trauma/Grief & Loss Group Counselor, Clinical Case Manager more specific goals include:

- At least 75% of students receiving services and engaged in groups will report increased coping skills and effective utilization of resources in dealing with issues of grief & loss/trauma, as evidenced by pre- & post-tests
- 75% of students will report decreased severity in Post-Traumatic Stress Disorder symptomology
- At least 70% of students receiving services and enrolled in groups will complete the group counseling cycle, as evidenced by attendance records

- Of the 85% of students receiving services and referred to community resources, 85% will be successfully linked to said services, as evidenced by Case Management Log

6. CORE COMPONENTS

The Wellness Centers is a collaboration with leadership from the SF Department of Children, Youth and Their Families (primary funder), SF Department of Public Health (provides oversight of health services), San Francisco Unified School District (supporting three of the four roles), and RAMS (provider of behavioral health services). Confidential student services are provided on-site at 15 Wellness Centers located in SFUSD high schools. Each Wellness Center staff includes four core staff members: wellness coordinator, school nurse, behavioral health counselor (RAMS), and a health outreach worker. The Wellness team members address immediate student health needs and equip students with skills and knowledge to be able to make healthy choices throughout their lives.

RAMS counselors specifically provide the integrated behavioral health services component (mental health & substance abuse). This includes confidential on-site mental health and substance abuse assessments, individual and group counseling, crisis intervention/consultation, grief & loss/trauma counseling, conduct youth development strategies, and other prevention and early intervention services. Referrals to community resources, and Consultation to school staff and community. The Wellness Centers provide resources to a vast community of youth from a wide range of cultural and socioeconomic backgrounds, many of who may not otherwise access services.

The RAMS' model of Wellness prevention & early intervention services as well as treatment modalities & strategies include: behavioral health (mental health & substance abuse) assessment and individual & group intervention (short, medium, & long-term counseling, collateral); crisis intervention; substance use/abuse services; clinical case management, service coordination & liaison; consultation (school personnel); outreach & educational activities for students, families, and teachers on various behavioral health issues (e.g. presentations at school meetings, participating in parent meetings, Back to School Nights, and PTSA meetings); and collaborating with Wellness staff in outreaching to students including general population as well as specific/targeted, hard to reach communities (e.g. LGBTQ, Chinese, gang-involved) by conducting various activities such as presentations (student orientation, classrooms, assemblies, and health fairs), contributing articles to the school newsletter, participating in student clubs & associations (culture/interest-based and student government), and other methods (e.g. drop-in hours). Moreover, group counseling may be offered by RAMS Counselors for students needing to enhance social and communication skills, discuss & explore substance use/abuse issues, or addressing stress. RAMS is well experienced in facilitating various groups, offering flexibility in topics, culturally-based (e.g. Latino, African American) and language access (e.g. Spanish, Chinese).

Furthermore, there are the positions of Trauma/Grief & Loss Group Counselor and Clinical Case Manager. The Trauma/Grief & Loss Group Counselor greatly strengthens the capacity of schools and the community to intervene, respond, and support students. Outreach, engagement, and retention strategies & services include: crisis intervention; mediation & de-escalation; individual & group counseling (ongoing & immediate response); case management & liaison; consultation & workshops for teachers & parents; outreach & prevention (e.g. school assemblies, health fairs, parent groups); and consultation on school climate activities.

The Clinical Case Manager provides more intensive, individualized follow-up & coordination. Outreach, engagement, and retention strategies & services include case management with persistent follow-up; outreach & liaison; consultation & workshops for students, teachers & parents (e.g. behavioral health issues, resources); and prevention activities (e.g. organizing health fairs, school parent meetings). Linkage strategies include: meetings with parents, student follow-up meetings, jointly making referral connection, accompanying student to community agency (if appropriate), etc.

RAMS program models and treatment modalities are participant-centered, youth-focused, strength-based model with an inter-relational approach. The agency understands the nature of complex issues from clinical & cultural perspectives, and the importance of building therapeutic relationships and providing flexible services that meet the needs of participants, facilitates and sustains positive change. As students present with a wide scope of issues (e.g. mental health, substance use/abuse, diverse ages, ethnicity, sexuality, socio-economic status), service provision must be comprehensive to assess and respond, while de-stigmatizing therapy and establishing trust. In doing so, RAMS incorporates various culturally relevant evidence-based practices for working with adolescents: Motivational Interviewing (focused, goal oriented), Stages of Change (substance use/abuse, co-occurring), Brief Intervention Sessions (substance use in schools), Beyond Zero Tolerance (reality-based drug education), and Seeking Safety (trauma, substance use/abuse). These models are applied in individual & group counseling (e.g. facilitating MI curriculum) and case management. It also informs practitioners on assessment and appropriate treatment planning (e.g. Stages of Change). RAMS is committed to continued training and consultation on these models to ensure fidelity and quality of care. Additional youth-focused practice models: Attachment, Self-regulation & Competency (adaptable intervention for trauma; Interpersonal Therapy (evidence-based; short-term therapy for depression and major life changes); Cognitive Behavioral Therapy (evidence-based; active, problem-focused & goal-directed); Mindfulness-Based Treatment (intervention for those suffering from trauma, depression, anxiety, pain and chronic illness).

During each stage of engagement, RAMS assesses students for appropriateness of services modality, frequency, and accessibility (language, location, schedule). RAMS provides services on-site at the Wellness Centers as well as off-site by other community program providers. The type, frequency, and location (on- or off-site) of services are tailored to the participant's acuity & risk, functional impairments, and clinical needs as well as accessibility to community resources (e.g. family support, insurance coverage, ability to pay if needed). The Counselor determines such need during the assessment, weighing risk factors that can prompt more immediate on-site services with short term counseling (one to five sessions), medium length (six to 11 sessions), or long term counseling (12 or more sessions, requires DSM IV diagnosis and potential decompensation). The RAMS model focuses on short-term behavioral health counseling and case management services, with longer durations to be assessed in consultation with RAMS Clinical Supervisors and referral may be made to other community clinics. About 75% of RAMS Wellness students/participants received one to six sessions. On-site services are generally provided to those exhibiting high level of need and whose school attendance is conducive to regular sessions. Treatment frequency is reported & reviewed monthly for medium length cases by clinical supervisors and long-term cases are reviewed by clinical supervisor and RAMS Director, at least quarterly.

RAMS strongly values the integral role of case management services and continually dedicates efforts towards problem solving and seeking methods to facilitate the linkage between students/families and community services. As such, RAMS tracks the referrals made by Counselors to community resources and generates, distributes, and evaluates monthly reports for staff to follow up with students, as appropriate. RAMS has a Clinical Case Manager solely focuses on building relationships with community resources (e.g. HMO providers, public clinics, etc.) and linking students and families. This results in enhanced care coordination, competence, and capacity/resource building, leading to prevention & early intervention of the impact of risk factors.

The RAMS Wellness Centers Program has a funding mix of Mental Health Services Act – Prevention & Early Intervention as well as the San Francisco Department of Public Health and other local entities.

7. CULTURAL RELEVANCE

In ensuring that services continue to be culturally relevant and appropriate for the school-based setting, the agency and staff draws from its expertise, a deep contextual understanding of the target population's cultural/social/political history & trends and its clinical implications as well as evidence- and practice-based treatment practices, recruits

staffing that reflects the diverse SF population and who have demonstrated experience in working with youth in a school setting, regularly consults with Wellness Center staff and SF Wellness Initiative, and maintains a high level of consumer involvement in various capacities.

Effective activities at school-based programs that inform service delivery include: focus groups & meetings with students, families, and school administrators & teachers to identify & address the school's needs and best practices; anonymous surveys; coordinate a Student Advisory Committee; and engage & foster relationships with consumer community at convenient & easily-accessible venues/platforms (e.g. staff development trainings, PTSA meetings, "free periods," hosted lunch hour events). All meeting outcomes, evaluations, and reviews are reported to RAMS executive management along with any action plans (e.g. adjustment of service strategies in consideration of cultural relevancy and school-based setting).

Furthermore, when providing services to participants, the agency considers all cultural components of the individual including her/his immigration generation, level of acculturation, accessibility of resources & support, and other factors (e.g. age, race/ethnicity, sexuality, socio-economic status, academic needs, neighborhood/defined community, etc). As such, service delivery is strengths-based, adaptable & flexible, individual and group counseling are provided in the student(s)'s primary/preferred language(s), and involves family participation (as appropriate).

Specific examples of how the program incorporates cultural elements:

- The approach to working with those of Asian & Pacific Islander ethnicity is adapted such that it focuses more on skills building and development and may be directive, as there is emphasis on de-stigmatization of seeking help and other support services. There are also facilitated discussion/exploration of cultural adjustments, generational differences, and communication styles.
- Various groups incorporating cultural elements (cultural adjustments, language) and effective engagement strategies (skills development) as wells using youth-friendly verbiage (not using "loaded" words), such as *Acculturation* (in Chinese); *Desi Girls* (with South Asian Girls); *Chillin' the Body* (Stress Reduction Group), *Understanding Addiction*; *Anger Management*; and *Healthy Relationships.*
- RAMS engages with schools with a higher concentration of Asian & Pacific Islander student population by specifically providing focused trainings and consultation on raising awareness on signs/symptoms of possible mental health and/or substance use concerns (many teachers and school administrators may still hold the "model minority" perception of A&PI youth).
- Specific outreach strategies to the Asian American youth (i.e. Chinese teens, both American and foreign-born) including, but not limited to: classroom presentations in Chinese about Wellness services, confidentiality issues, health topics, and self-care strategies; assist to establish culture-specific clubs; suicide prevention workshops; and facilitate group discussions on Asian specific issues.
- In outreaching to A&PI parents, activities include, but are not limited to: providing bilingual information about services; assisting Wellness in translating materials; engaging parents in discussing their service needs; psychoeducation co-presented with Wellness staff; focus groups about service de-stigmatization strategies; and writing articles about culturally-specific signs of behavioral health issues.

8. STAFFING

To serve the SFUSD students and families (direct services) and school personnel and Wellness staff (consultation services), the RAMS service model includes over 23 FTE (24 staff and 5 Interns/Volunteers). The integrated behavioral health services (mental & substance abuse) are delivered by the RAMS Behavioral Health Counselors (17.0 FTE), Clinical Interns (2.7 FTE), and a Volunteer Counselor (0.4 FTE) while medication evaluation & support services are provided by Child & Adolescent Psychiatrists (0.05 FTE). Additional prevention and early intervention services are delivered by a Trauma/Grief & Loss Counselor (1.0 FTE) and Clinical Case Manager (1.0 FTE). The staff

structure also includes 1.75 FTE supervisors (program director, clinical supervisors). RAMS is able to increase the number of students served due to its effective leveraging of resources and structured internship program (master's level students, studying counseling). Annually, well over 1,600 unduplicated youth are served; each full-time counselor serves about 100 unduplicated youth.

During staff & intern recruitment and placement, RAMS prioritizes demonstrated work experience and bilingual & bicultural capacity. All staff have at least Masters Degree or higher in Psychology, Social Work, Counseling, or other related disciplines along with demonstrated experience and significant expertise in working with diverse cultural youth populations and families reflecting the participant demographics (e.g. race/ethnicity, economically diverse, immigration generation, language, age, sexuality, gender, etc.) as well as the continuum of adolescent issues and complex trauma. Furthermore, the Interns are enrolled in graduate studies in the field of mental health. Over 50% of direct services staff are bi- or multi-lingual, with languages including but not limited to: Cantonese, Mandarin, Hakka, Taiwanese, Gujerti, Hindi, and Spanish.

Staff Descriptions:

a. Behavioral Health Counselors and Interns: Primarily responsible for delivering integrated behavioral health services and the aforementioned outreach, engagement, and retention strategies & services.
b. Clinical Case Manager: Provides intensive, clinical case management with individualized follow-up & coordination; outreach & liaison; consultation for students, teachers & parents; and prevention activities
c. Trauma/Grief and Loss Group Counselor: Primarily responsible to respond to situations of community violence and trauma impacting the youth; providing crisis intervention; mediation & de-escalation; individual & group counseling; case management & liaison; consultation for teachers & parents; and outreach & prevention
d. Child & Adolescent Psychiatrists: The psychiatrist assumes medical responsibility for cases and prescribes medications, as necessary; works with youth, families, and the multidisciplinary care providers regarding psychiatric services as well as treatment planning, assessing progress, and reviewing/approving disposition of cases.
e. Clinical Supervisors: Provides clinical supervision of direct services staff, ensuring compliance to clinical care standards, documentation & record keeping standards, and high quality of service delivery
f. Program Director/Director of Behavioral Health Services: Provides oversight for and accountability of the RAMS Wellness Centers Program, overseeing the behavioral health services provided

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

The Wellness Centers Program is based on-site at the high schools, which provides a more accessible location for youth to engage in services. Furthermore, the Wellness Centers serve as a resource for consultation for school administrators and faculty. The physical space includes private meeting spaces as well as larger rooms to facilitate groups.

10. INDICATIONS OF EFFECTIVENESS

RAMS has been the behavioral health services provider for the high school-based Wellness Centers, since its inception in 2000. RAMS has consistently been able to meet participant's behavioral health outcomes, as evidenced by various survey conducted by ETR Associates (independent evaluator) to assess satisfaction with services and behavioral health outcomes. Furthermore, there are evaluations completed by school personnel. These are anonymous surveys that are distributed, collected, and analyzed by ETR Associates.

Evaluation surveys have indicated that, as a result of meeting with a RAMS Counselor, students had improved psychological well-being & skills around managing school & home life. Other results include:

- 90% Planned to take steps to improve health & well-being; 77% have taken those taken steps
- 80% Learned about community organizations/clinics; 52% were successfully linked
- 71% Increased understanding of own cultural identity/background
- 80% Feel better about themselves
- 82% Learned ways to solve problems on their own
- 78% Improved handling daily life
- 65% Got along better with family
- 69% Are doing better in school

Other evaluation surveys has indicated the following, as a result of RAMS services: 77% Improved handling daily life; 78% Learned new ways to reduce stress in their life; 69% Increased school attendance; 69.5% Attempted to reduce use of tobacco, alcohol, or other drugs; 88% Plan to take steps to improve their own health and well-being; 80.6% Learned ways to reduce stress in their lives; and 70% Doing better in school.

In addition, ETR Associates evaluated how successful linkage to on-site behavioral health services impacted suicidal risk factors. The data indicated a reduction in all risk factor areas for suicide as well as gives evidence to support the clinical success of the RAMS approach with students in the Wellness Program making a positive impact on their mood, coping skills, relationships, behavior, and academic performance.

In addition to evaluating direct services to students/participants, consultation services to teachers were also reviewed, with surveys yielding positive feedback. Survey results indicated:

- 92% Supported having mental health & substance abuse services on campus
- 82% Satisfied with the quality of services available
- 72% Indicated that they have a place to go to discuss students who are experiencing health, mental health, and substance abuse issues
- 66% Observed changes in student behavior due to Wellness

For Trauma/Grief & Loss Group Counselor and Clinical Case Manager services, goals and outcomes included:

- At least 75% of students receiving services and engaged in groups will report increased coping skills and effective utilization of resources in dealing with issues of grief & loss/trauma, as evidenced by pre- & post-tests

OUTCOME: Aggregated data reports that 81% of students, at intake, received a score identifying them at being above clinical PTSD range. At post-test, only 52% rated as continuing to score above PTSD range suggesting significant impact of groups on trauma symptomology. Furthermore, 92% of students, after participating in groups, reported that they could identify an adult who they could ask for help when they felt overwhelmed or stressed. This is compared to 77% at pre-test.

There was difficulty matching pre- and post-surveys due to students either refusing to complete, dropping out of group, or joining the group post-survey administration. Because of this, the pre- and post-tests are currently be distributed on an individual basis. Therefore measurement of impact of groups on individual symptomology is challenging.

- At least 70% of students receiving services and enrolled in groups will complete the group counseling cycle, as evidenced by attendance records.

OUTCOME: Of the total 57 students attending groups, 38 (67%) completed post-tests. Furthermore, there are students who refused to complete the post-test due to being triggered by questions.

- Of the 85% of students receiving services and referred to community resources, 85% will be successfully

linked to said services, as evidenced by Case Management Log.

OUTCOME: There were 32 ongoing students receiving services (85% of 32 students = 27 students); furthermore, a total of 27 students were successfully linked. Therefore, the program achieved 100% of the target of successfully "linkage" to said services.

11. AGENCY INFORMATION

Agency Contact Information:

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It is the mission of RAMS to advocate for and provide community based, culturally-competent, and consumer-guided comprehensive services. Founded in San Francisco's Richmond District in 1974, the agency offers comprehensive services that aim to meet the behavioral health, social, vocational, and educational needs of the diverse community of the San Francisco Area with special focus on the Asian & Pacific Islander American and Russian-speaking populations.

RAMS was originally founded by the Richmond Asian Caucus under the name Richmond Maxi-Center in response to the overwhelming need for culturally inclusive, competent, and appropriate mental health services that were accessible to the residents of San Francisco's Richmond district. Today, RAMS has expanded to offer over 30 programs, which are integrated in 11 core programs in over 75 sites citywide to meet the diverse needs of our client population. The agency believes in serving clients in their primary or preferred language(s) of treatment, supporting consumer choice & empowerment, and advocating for the accessibility to services. Annually, the agency serves and outreaches to well over 15,000 adults, children, youth, and families, and provide services in over 30 languages, including Asian dialects – Cambodian, Chinese (Cantonese, Mandarin, Toishanese, Taiwanese), Hindi, Japanese, Korean, Punjabi, Tagalog, Thai, and Vietnamese – Russian and Spanish. Services are prioritizes to those with limited resources such that our client population tends to be of extremely low socioeconomic status, receiving public health benefits or uninsured, and be mono-lingual, non-English speaking .

Historically and currently, the demographic makeup of RAMS Board of Directors is representative of the populations served by the organization. RAMS' Board members include professionals, consumer advocates, leaders, and members of different Asian and Russian communities as well as have experience working in the SF mental/public health field and/or the ethnic/cultural communities served by RAMS. As the agency maintains policies and practices to recruit, retain, and promote at all levels diverse service providers and leadership that reflect the multi-cultural, multi-lingual community, the RAMS staff and management appropriately represent various cultures and ethnicities. Many staff are immigrants and/or refugees and have expertise and training in specific areas such that they are aware of the unique needs of the communities, its levels of complexities, and changing dimensions.

As part of RAMS' efforts to support and further enhance the professional development of its staff, RAMS consistently coordinates for various trainings which are agency-wide as well as program-specific. Prominent local clinical experts as well as nationally and internationally renowned therapists, researchers, and authors regularly present at RAMS on various clinical and cultural topics pertinent to the day-to-day work and further professional growth of our clinical staff, trainees, and interns. Furthermore, RAMS retains several consultants who have widely recognized expertise in working with community clients and provide regular consultation, training and/or supervision to RAMS staff, interns, and supervisors. In addition, the agency maintains a continuing education leave policy that supports staff participating in other professional development activities. On an ongoing basis, RAMS offers the following in-house activities to

foster professional development and staffing capacity: school-based program-specific trainings (for interns; staff may participate depending in schedule), weekly didactic trainings on culturally specific issues, monthly children & youth case conferences, and weekly case conferences.

APPENDIX 6: CATEGORY 3 FULL SUBMISSIONS

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

1. NAME OF INNOVATION/STRATEGY:		
ACMHS' Asian Primary Care Integration Project		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
	x	Selective prevention
	x	Early intervention
	x	Other (please specify): Psycho-education

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Asian Community Mental Health Services (ACMHS) in partnership with Asian Health Services (AHS) through a Primary and Behavioral Health Care Integration grant administered by the Substance Abuse and Mental Health Services Administration (SAMHSA).

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4. TARGET POPULATION

The population of focus for ACMHS' Asian Primary Care Integration project (Asian PCI) is the annual 400 active seriously mentally ill clients receiving acute behavioral health services at ACMHS. Although ACMHS does not refuse services to anyone based on race or ethnicity, the population is primarily Asian and Pacific Islander (API). The Asian PCI project is focusing on the API population because studies have shown over the past 15 years that in both behavioral and primary health care, ethnic-specific centers are better able to meet the needs of the Asian immigrant and refugee population.

In behavioral health, compared to those receiving services at mainstream centers, Asian Americans seeking services at ethnic-specific centers are more likely to keep their initial appointment have increased utilization, longer

treatment, better consumer satisfaction, and more positive therapeutic outcomes and receive more cost-effective care. In primary health, when patients were matched with an ethnically similar clinician who was also proficient in their preferred language, they had fewer emergency service visits than did clients who were unmatched on the basis of ethnicity and language. Even more significant than ethnicity or language matching was the proportion of minority clients the center served. Clients in programs serving a relatively large proportion of minority clients had fewer emergency service visits than those in programs serving a smaller proportion of minority clients. The implication is that quality care for immigrant populations is more than hiring bilingual and bicultural provider staff in mainstream organizations; it is having organizational design and structure that are culturally competent.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

The Nature of the Problem

As part of our ongoing consumer empowerment initiative, ACMHS conducts regular focus groups with our consumers to give them voice in improving and redesigning services. In the last two years, a series of focus groups with a total of 37 participants have centered on access to quality primary health care. The inter-related problems identified in the focus groups are almost identical to ones identified in a national survey conducted by researchers.

Poor understanding of their illness. The most commonly cited problem, and the most time spent in the focus groups was regarding how doctors and nurses did not spend enough time explaining their illness and what the client needed to do to improve the situation and prevent it in the future. This is supported by a survey conducted by the Commonwealth Fund in 2001, which showed that 69% of the general adult population felt that their doctor spent enough time with them, while only 52% of English-speaking Asians and 19% of non-English-speaking Asians felt that way. ACMHS consumers in our focus groups identified that they would like to participate in education classes to learn about prevention and intervention of diseases through diet, exercise, and nutrition, and to learn what causes diseases. They said their main current source of knowledge is word-of-mouth from friends and family.

Lack of attentive services. Our focus group consumers said that the main reason why they either continue or stop primary care services depends on how they are treated by the provider. Many complained about nurses and doctors who were rude or made judgments because of the way they looked, or with providers showing exasperation because of language barriers. When they are treated this way, they just stop going rather than asking for another provider. When the subject changed to positive experiences, the most commonly remembered by far was when they received attention from "good doctors." In the Commonwealth Fund survey, 60% of English-speaking Asians and 53% of non-English-speaking Asians felt they had been treated with respect by their doctor, compared with 76% for the general population; and 58% of English-speaking Asians and 31% of non-English-speaking Asians felt they had been involved in decisions about health care, compared with 75% of the general population. This lack of attention is compounded by the unfamiliarity and distrust of Western medicine described above, and for Asians with serious mental illness.

Lack of linguistically and culturally competent services. The absence or limited supply of interpreters and bilingual providers at hospitals is well documented. Waiting for an available interpreter lengthens already long wait times. The multiple languages and dialects among different Asian ethnic groups make finding the right match difficult. One of the most cited solutions for improving quality of care in our focus groups was for more interpreters at hospitals. However, even when interpreters were present, focus group members often mentioned that they would be told different things at different visits depending on who the interpreter was, to the point of the patient being told a different diagnosis from the actual illness.

Lack of culturally competent outreach. Language and cultural barriers prevent many immigrant Asians not only from utilizing mainstream health and human service systems, but also from even being aware of them. In a community access survey of 467 East Bay Asians conducted by ACMHS in 2002, the most cited reasons that Asians do not use services were because the respondents didn't know about them (50%) and that they didnt know how to enroll (33%).

The least cited reasons were lack of need and lack of time (3% for both).

Most mainstream institutional providers lack the linguistically appropriate and culturally sensitive services that low income, monolingual immigrant API consumers require. Data show that immigrants, particularly those from developing countries, are most likely to seek care at ethnic specific agencies and health centers instead of hospital-based clinics. This is largely due to the fact that community centers provide culturally and linguistically appropriate services and offer services free or on a sliding scale.

Lack of transportation. Problems include not having a driver's license, not having access to a car, no public transportation near their home, too many bus transfers that take too long, and not being able to afford public transportation.

Not following through on referrals. Currently about 40% of ACMHS' SMI consumers are patients at Asian Health Services. We often hear anecdotal information that when we help our clients make an appointment with AHS, the clients often no-show, although we have no data on how often this happens. From 2004-2005, Dr. Philip Akutsu of the University of Michigan did a series of studies on our client data to research help seeking behaviors among Asian immigrants. In one study, Dr. Akutsu found that ACMHS had about 20% attrition each time a consumer was handed off from one staff person to another (for example from intake person to therapist). (Akutsu, Tsuru & Chu, 2004). This occurred even though the referral or transfer was internal to our organization. We expect referrals outside ACMHS, for example to a primary health clinic, to have an even lower completion rate. The lesson is to make the hand-off as "soft" as possible.

Purpose and Goals of Project

The purpose of the Asian Primary Care Integration project is to improve the overall wellness and physical health status of the SMI Asian and Pacific Islander population in Alameda County by making available coordinated primary care services at Asian Community Mental Health Services. ACMHS provides about 95% of public mental health services for monolingual APIs with serious mental illness in the County.

Goal 1. Increase the quantity and improve the quality of primary health services for SMI, API population in Alameda County.

Goal 2. Improve coordination and communication between the main primary health care provider (AHS) and the main behavioral health care provider (ACMHS) serving the API population in Alameda County.

Overall, the increased availability of primary care services, the easier convenience and accessibility of services, the increased satisfaction with services that will lead to higher retention, the increased knowledge of clients and family members to self-monitor the patient's health, and the better coordination and communication between AHS and ACMHS staff will improve wellness and health status of ACMHS consumers with serious mental illnesses.

6. CORE COMPONENTS/CULTURAL RELEVANCE

Asian Community Mental Health Services (ACMHS) has been providing culturally and linguistically competent mental health services to the underserved Asian and Pacific Islander (API) population in Alameda and Contra Costa Counties since 1974. ACMHS has pioneered mental health approaches and that are consumer driven and community based to fill the void in behavioral health care of the API community (for more info: www.acmhs.org).

Cultural Characteristics Relating to Health Care

Asian and Pacific Islanders in the San Francisco East Bay speak over 30 different languages, and each ethnic group comes from a distinct culture and sociopolitical environment. Trying to generalize cultural characteristics of the

diverse API population is always a dangerous endeavor. However, certain common themes are shared among the different cultures as they relate to health care and health seeking behaviors.

Etiology of Illness: Illness may be attributed to organic or physical problems, an imbalance of yin and yang, an obstruction of chi (or life energy), a failure to be in harmony with nature, punishment for immoral behavior (in this or past lives), or a curse placed by an offended spirit. Many Asians believe in organic or supernatural causes of illness.

Distrust of Western Medicine: Many seek western health care only after more traditional methods fail. Also, many know people who have used western care and died anyway. Rural people have had less exposure to western medicine and distrust it more than those who were urban dwellers prior to arriving in the US. Many think physicians should be able to diagnose a problem in the first visit by looking at the patient and feeling their pulse. They do not understand the concept of using further techniques for diagnosis. They may think procedures are meant to cure or alleviate pain, and feel frustrated when, for example, they still cough after the X-ray. If they feel the procedure is ineffective, they may not seek further care or return for follow up.

Resistance to invasive procedures: Many believe that surgery upsets the soul or can actually cause one's spirit to leave the body. Some think injections may hurt the spirit, and therefore be hesitant to receive immunizations. Resistance to venapuncture is common for fear of upsetting the hot/cold balance. Many less educated people do not realize that the body can make more blood, and believe any blood drawn will weaken them.

Beliefs about Asian physiology: Western medicines are thought of as "hot" and too potent for Asian physiology. Therefore, western drugs, doses, and interventions may not be seen as appropriate for Asian bodies. Thus, patients may not take medicines as prescribed, may shorten the duration or decrease the dosage. If symptoms resolve or no effect is seen, patients may discontinue medication.

Poor physician-patient communication: Asian cultures value politeness, respect for authority, and avoidance of shame. Because of this, many will not ask questions, will not voice disagreement or concern, and will not reveal intentions or actions that seem in contrast to the physician's wishes. If patients disagree or do not understand, they may simply listen and answer yes in respect, then not return for further care or comply with recommendations.

<u>Cultural Characteristics of Key Staff</u>

All staff, both project leadership and direct service providers, reflect the language and cultural background of the constituents served. Project staff are not only bilingual, but also *bicultural*, meaning that they grew up in the culture of the patients they will be working with. The difference is that staff will have the ability to identify with and understand what consumers are trying to say, even when the youth and parents have trouble articulating it in any language. Our staff have lived the cultural characteristics relating to health care described in Section A, as opposed to reading it in a book or pamphlet, or taking a workshop on it.

Even with four full-time bilingual positions, the project staff will not be able to cover the 8-10 languages that we expect to serve in the Asian PCI. Our plan to overcome this is to have ACMHS MH providers play a more active role 1) in participating in the primary care services by providing not only language support but also emotional support, and 2) in helping with many of the case management duties that the nurse care manager did in the EBPs.

ACMHS has the capacity to provide written translation for all informational notices and evaluation surveys in 8 Asian languages, including all the languages represented in the target population. However, even this is not enough as many of members of the target population are not literate in their native language. Therefore, the project will ensure that all information and feedback can be delivered orally as well as in writing.

- Interpreters available as needed for our monolingual clients.
- Case managers accompany clients to first primary care appt to provide translation services and coordinate care
- Wellness is comprised of activities that are culturally sensitive such as qi-gong, acupuncture, acupressure, yoga, use of herbs, tai chi and others as deemed appropriate for our specific API population
- Resources are gathered from the local the Chinatown community to address wellness needs
- Outreach efforts will be done by holding health fairs to existing SMI clients as well as organizations in the community
- Core program components consist of primary care treatment to all SMI clients currently being served in our clinic as well as a comprehensive, culturally sensitive wellness program.

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

1. NAME OF INNOVATION/STRATEGY:		
The Bridge-Culture Generation		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Vietnamese Federation of San Diego
Lan Le (619) 808-6934

4. TARGET POPULATION

- This program is to promote and provide social, economic and physical support for the targeted audience: those who came to the USA after the fall of Vietnam in or after 1975 and now are either reaching retirement age with limited retirement funds or are disabled.
- This targeted audience is called the cross-culture golden age group: they are the children of the first generation of Vietnamese refugee immigrants who, after immigrating to the U.S.A., spent a big part of their life adjusting in the USA. This audience, the children, is well adjusted to the society. They speak some or fluent English as a second language, have embraced the Western culture while still maintaining deep roots in their own culture, and have contributed to the workforce and understood the main stream social system.
- This group of targeted audience usually adapt to in a multi-generation living arrangement: they are the primary care providers for their elderly parents and are raising their own children under the same household as well.
- They have a cultural mindset that prevents them from placing their elders in a traditional retirement home because that is seen as an honorable duty to their parents in their original culture. This leads to the expectation that their children will provide and support them in the same way when they reach old age.
- As they are reaching retirement age, this group is finding themselves without options. Their Vietnamese-American children do not plan to have to care for their parents and they are unable to adapt in American retirement homes. They are the cross-culture golden age group who has specific needs that cannot be met.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

Depression, anxiety, resentment and stress are quite common emotional turmoil in this group due to culture clash and generational differences in expectation. The program intends to help address social and wellness needs of this target group

- By providing programs activities that cater to the social and wellness needs of the target group.
- By promoting the concept of living independently in their own home for as long as they can,

6. CORE COMPONENTS/CULTURAL RELEVANCE

There are three main program activities which will be offered on a rotation basis to promote physical and mental well-being:

1) The Mental Wellness Program:
   - Teach how to play card game that are familiar to the culture (such as Mah-Jong) to promote mental alertness, memory retention and maintain active socially; organize card games tournaments to motivate learning

- Provide group counseling session to help promote a well balanced life.
- Coach on how to nurture a healthy relationship between this target group and their adult children.

2) The Physical Fitness Program:
   - Provide cross-cultural exercise sessions such as Tai Chi, Yoga, and Ballroom Dance.
   - Learn to eat healthy by westernizing the Vietnamese foods with new modern twists to monitor the glucose intake and to prevent illnesses associated with aging.

3) The "Find a New Hobby" Program:
   - Help the target group develop new hobbies and interests as an antidote for depression and mental illness.
   - Offer Vietnamese karaoke singing group activities to promote socializing and relaxation.
   - Organize trips to places of interest to bring people with common interests together and to build friendship.

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

1. NAME OF INNOVATION/STRATEGY:		
Chieh Mei Ching Yi/Sisterhood		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
	x	Selective prevention
	x	Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

APAIT Health Center
1730 W. Olympic Blvd. Ste. 300
Los Angeles, CA 90015

4. TARGET POPULATION

Chieh Mei Ching Yi (CMCY)/Sisterhood serves monolingual Chinese immigrant women employed as masseuses in Los Angeles County. These women are limited in their employment options because of their linguistic isolation, and generally, the husbands and families of these women are unaware that they are working as masseuses. The women face severe mental stress because of their isolation and the stigma associated with this industry, especially the assumption that masseuses are sex workers. The program is provided primarily in Mandarin, but is available in Cantonese if needed. CMCY/Sisterhood is intended for women working in settings where they are at risk of HIV exposure, wage theft, and violence through sex work, namely massage parlors (where masseuses are required to have licenses by California law, but many do not and are arrested for not having licenses), acupuncture and aromatherapy businesses, and chiropractic clinics (in the latter three business types, these women are not required to have masseuse licensing). These women are at high risk due to their involvement in sex work and limited ability to practice safe sex or access preventive services.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

CMCY/Sisterhood seeks to prevent HIV infection through improving self-esteem, self-efficacy, and negotiating skills in a low English proficient high-risk immigrant female population. This problem is not widely recognized, but the prevalence of HIV/AIDS among Asians and Pacific Islanders (APIs) has grown substantially, and API women have had the highest rate of increase in new HIV/AIDS infections in the nation. HIV/AIDS cases among APIs are also likely to be underestimated as APIs are less likely than any other racial/ethnic group to test for HIV. API women who work as masseuses are at particularly high risk of HIV infection and mental distress due to a combination of factors. Such factors include multiple sex partners, verbal and physical abuse from customers, economic vulnerability (as women are often offered substantial financial incentives to not use condoms), and sexual coercion. Although there are an estimated 600 massage parlors in Los Angeles County that employ Asian immigrant women, little attention is focused on HIV prevention in this population. Due to barriers such as limited English proficiency, low income, and documentation status, these women have very few resources for information and health care, and few economic opportunities enabling them to leave the massage parlor industry.

To address these needs and barriers through a culturally and linguistically competent prevention and early intervention strategy, APAIT Health Center is currently implementing and evaluating CMCY/Sisterhood through a grant from the University of California's California HIV Research Program (CHRP). The specific goals of CMCY/Sisterhood are to improve the following in monolingual Chinese immigrant women: (1) HIV knowledge, (2) self-esteem and gender/ethnic pride, (3) condom self-efficacy, and (4) sexual negotiation skills so that they can

negotiate condom use and safer sex with their sexual partners.

Components of CMCY/Sisterhood are designed to enhance several protective factors. Gender and ethnic pride are integrated into the intervention to aid women in understanding power differentials in relationships, and building communication skills that overcome barriers associated with gendered or culturally driven definitions of sexually appropriate behaviors and roles. Participants further develop communication skills through group discussions about individual and social level barriers to discussing sexual health with others. Another crucial protective factor is having HIV knowledge, which is provided through the intervention by engaging women in culturally tailored discussions about HIV transmission and prevention. Additional protective factors stem from increasing self-efficacy. Women are taught condom use and negotiation skills, as well as on how to foster assertive decision-making. Finally, CMCY/Sisterhood promotes skills around coping with stress, rejection, and negative responses, including reducing alcohol and substance use, and sex while under the influence.

The cultural and linguistic competence of CMCY/Sisterhood reduces a number of risk factors. Limited English proficiency, low income, lack of culturally specific HIV prevention services, and work environment (e.g., expectations of massage parlor managers) prevent these women from accessing necessary health information and services, as well as alternative economic opportunities. CMCY/Sisterhood addresses these barriers by providing free workshops conducted in Chinese at a convenient community venue (not associated with HIV or sexual health to minimize stigma). The strategy provides culturally specific HIV information, addressing common myths about HIV and HIV transmission in the Chinese community. Preliminary data have indicated that the intervention significantly increases knowledge and awareness in a high-risk but underserved population. Additionally, program components are culturally tailored, which ensures that the women will learn to minimize their HIV risk in ways that are acceptable to them, and that do not stigmatize them. Because condom use and negotiation are central components of the strategy, addressing these skills in a culturally appropriate way will enable women to protect themselves from HIV infection in the high-risk environment of sex work. The focus on coping and negotiation also provides culturally appropriate means for these women to develop strategies in a group setting that enables them to share their stories and devise alternative ways to deal with stress, sexual coercion, and economic distress.

6. CORE COMPONENTS/CULTURAL RELEVANCE

CMCY/Sisterhood is adapted from the CDC's evidence-based intervention (EBI) SISTA, or Sisters Informing Sisters about Topics on AIDS. SISTA was developed for African American women and applied the Social Cognitive Theory and the Theory of Gender and Power. APAIT Health Center adapted SISTA by preserving a few elements but substantially changing or deleting others. Several key components from the original SISTA intervention are preserved, including gender and ethnic pride, HIV knowledge, condom use and negotiation, assertiveness skills training, and coping. However, CMCY/Sisterhood alters these core elements to be culturally appropriate. For example, to address cultural differences in communication, the strategy integrates discussion about passive-aggressive communication prevalent in API households, communication skills-building that includes Chinese verbal and non-verbal communication styles, and exercises to practice overcoming cultural norms against discussing sexual behavior or reproductive health with family members or friends. Another example is the strategy's emphasis on the HIV information core element, where a majority of Chinese women have the misconception that HIV is transmitted via mosquitoes. Some infrastructural elements are also substantially changed. CMCY/Sisterhood is shorter than SISTA (from an original set of five 2-hour weekly workshops to two 4-hour workshops conducted one day apart) to accommodate the multiple challenges faced by program participants, including scheduling conflicts due to mandated court appearances after being arrested for suspicion of prostitution, work schedules that include 14-16 hour workdays, child care, and other household responsibilities. All of these elements ensure that CMCY/Sisterhood is applicable to the realities faced by monolingual Chinese women who work in massage parlors.

The CMCY/Sisterhood intervention consists mainly of group activities, including interactive exercises and role playing, as well as some individual activities, such as homework. The workshops are delivered in a group setting at a community venue by a female Chinese immigrant facilitator, with a total of two workshops that lasts four hours each and are conducted one day apart. The first workshop focuses on self-affirmation, HIV knowledge, and condom use.

The second workshop covers self-assertiveness, negotiation, coping, and gender and ethnic pride. In addition to pre- and post-workshop questionnaires, follow-up questionnaires are administered three months after the last workshop to assess changes in knowledge, condom self-efficacy, intention to use condoms, and sexual negotiation skills. Approximately two to seven (2-7) women attend each workshop, and a total of 62 women have been served thus far.

CMCY/Sisterhood outreaches to potential participants primarily by advertising in Chinese language newspapers. APAIT Health Center designs the ads to mimic employment ads for massage parlors, and negotiates with a Chinese language daily newspaper to have these ads strategically placed in the employment section near the massage parlor employment ads. The ads advertise social services and legal referrals for massage parlor workers and indicate that the services are free of charge. CMCY/Sisterhood also uses word-of-mouth referrals by participants as well as outreach to law offices to access women who are required by court to attend HIV education workshops after being arrested on suspicion of prostitution. Furthermore, APAIT Health Center recruits directly at massage parlors and massage schools.

Chinese cultural norms and practices against discussing sexual behavior and sex work, and the severe stigma associated with this industry, are incorporated into the strategy to collect information from participants. For example, CMCY/Sisterhood uses Chinese euphemisms regarding sexual behavior to reduce discomfort and refer to sex work in the third person in order to avoid the need for participant self-disclosure. Questions are phrased in a manner to avoid incriminating participants whose responses can possibly attract stigma, and instead give a positive perspective to the responses. For example, instead of "Have you performed sexual services?" participants are asked "Have you ever had to walk out of the room because the customer was requesting sexual services?" The strategy also addresses Chinese beliefs on medicine, discussing with participants their health beliefs and emphasizing misconceptions and myths regarding the effectiveness of Chinese medicine on treating HIV. Nonetheless, the stigma and fear associated with this industry remain. Even with these strategies, participants have largely reported engaging in no paid or remunerated sex work, either in the U.S. or China, despite having informal conversations with the facilitator during the workshops that indicated otherwise.

Moreover, CMCY/Sisterhood incorporates several scenarios sensitive to the experiences of monolingual Chinese immigrant women. Issues addressed include participant feelings of isolation from being away from their families and friends in China. The intervention not only involves scenarios in which the women must identify and find solutions to their feelings of isolation, but also ways for participants to connect with each other after workshops. In addition, CMCY/Sisterhood addresses barriers to being foreign-born, such as having to negotiate with a sexual partner who does not speak Chinese, and promotes alternatives to the perception that massage parlor work is the best and/or only option in times of financial hardship. Lastly, participant mental health is highlighted in an exercise that empowers participants through fostering feelings of pride about their own gender and culture. Participants are encouraged to think about and remember the strong Chinese women they know and respect; at the end of the workshops, they are asked to list these women, and then to add their own names.

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

1. NAME OF INNOVATION/STRATEGY:		
Elders Health Project		
2. TYPE OF PROPOSED STRATEGY:	✓	Universal prevention
	✓	Selective prevention
	✓	Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Health House Within A MATCH Coalition
1729 Canal Street
Merced Ca. 95340
Tel. (209) 724-0102
Fax (209) 724-0153

4. TARGET POPULATION

- This program serves Hmong and Punjabi elders in Merced County. The majority of Hmong elders served hold traditional spiritual beliefs ("shamanism"), and the majority of the Punjabi elders are Sikh. The two groups speak only Hmong and Punjabi, respectively, and they are 55 years or older and include both men and women.
- The Hmong and Punjabi elders who came to the United States are still struggling to access and utilize available senior services. Many elders live with extended family members, yet feel less connected to them and more isolated. The adult children typically work every day and the grand children are in school and have assimilated to a point where the grandparents feel alienated from them. Moreover, no one is home to support grandma and grandpa when they are sick.
- Our program serves ethnic seniors who have lived in Merced County for years as well as new arrivals to the area. Our Language & Cultural Specialist/Community Nurse teams help them to achieve improved health and well being. They make home visits to help the elders manage their health, troubleshoot obstacles to good health outcomes, facilitate connection to and support within the family and community, and provide linkages with healthcare providers, healthcare insurance and other senior resources.
- The Language & Cultural Specialist/Community Nurse teams visit elders with chronic disease, or when necessary, at home in order to assist in all the activities described above.
- HH teams do most of the visits with Hmong elders at their residents in both town and rural areas, while the Punjabi elders are visited mostly on Sundays at local Sikh temple.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

- Develop a multidisciplinary integrated service delivery model for elder Hmong and Punjabi.
  - Research best outreach, education and case management practice (include Native American)
  - Conduct a focus group of Hmong and Punjabi elders
  - Develop written plan
- Provide holistic case management services to 20 Hmong and 20 Punjabi seniors.
  - Coordinate efforts of a CSU, Stanislaus Social Worker intern, a community nurse, and an interpreter/cultural mediator from each language group.
  - Home assessment and case management services provided by HH staff and Social Worker intern.
  - Community nurse provides information and referrals to appropriate health services, linkage with primary care

providers, referrals to public and social services agencies, information on transportation needs and access, referrals to health insurance application assistance, and basic orientation and education on the local healthcare delivery system and rationale for confidentiality, informed consent and advance directives.
    - Community nurse provides mental health screening and support for patients at risk or suffering from diabetes, hypertension and stroke.
- Provide case management services that support the spiritual, mental and physical health of Hmong and Punjabi elders.
    - Involve Hmong shaman as 'spiritual' health resource.
    - Provide referral to existing Hmong support groups in the community.
    - Referrals to shamans if there is a need.
- Foster intergenerational relations within the family as well as preservation of the culture overall.
- Assist in helping Hmong and Punjabi elders identify, understand and seek resources for mental health issues, including access to shamans/priests, but also educating on physical basis for conditions, medications, etc.

6. CORE COMPONENTS/CULTURAL RELEVANCE

- Provides cultural and acculturation groups which offer intergenerational interaction opportunities for seniors with youth in order to ensure better intergenerational relations as well as cultural understanding and preservation.
- Build support groups of 15-20 seniors with activities such as painting, knitting, cooking, games, etc. and provides health education (e.g. Mental health, diabetes, nutrition education, hypertension, hepatitis B, TB, heart attack, stroke, etc). These mental and physical health education, health advocacy and social activities are essential to keep elders from the depression and isolation which contribute to poor mental health.
- Provide transportation to elders as needed. Community bus tickets are provided as needed, but may not be suitable for elders with health issues. Healthy House staff has provided transportation when called for. In town facilities are available for Hmong groups, but Punjabi elder groups prefer to meet at the temple. Healthy House also provides snacks and drinks for these meetings as well.
- To enhance Hmong elders' health and well being as well as to reduce language barriers, PTSD, and cultural clash, and multiple resulting mental health issues.
- Spiritual healing is also integrated into discussions on mental and physical health issues.
- The social determinants of health, including limited access to healthcare, language and cultural barriers, loss of and threats to communal family structure, assimilation issues, and lack of support/interaction with adult children are addressed in order to help with the depression that results from these realities.
- Much of the discussion is trans-adapted to Hmong culture in order to address mental and physical health issues that may not have existed or had specific vocabulary in the Hmong culture.
- Mental health issues are discussed in terms of physical health without discounting the spiritual element attributed to these conditions.
- In home mental health services are preferable for Eastern, communal cultures due to stigmas regarding disclosure of such issues, necessity to educate and work with entire family and trust established by the team working with the individual suffering from mental illness. In 'high context' cultures, access to the home environment is also a source of critical information to help the team address the social determinants of mental and physical health.

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

1. NAME OF PROGRAM:		
Health Navigation/Outreach & Engagement		
2. TYPE OF PROGRAM:	X	Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Korean Community Services
7212 Orangethorpe Ave., Suite 9A
Buena Park, CA 90621
(714) 449-1125

4. TARGET POPULATION

The Health Navigation/Outreach & Engagement Program aims to educate individuals about federal health assistance programs such as Medi-Cal, Medicaid, MSI and others, and provide assistance to those seeking to apply to such programs. The program mainly serves the monolingual Korean American population in Orange and Los Angeles counties, who have difficulty navigating through the federal health assistance programs due to language barriers.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

Koreans are one of the largest and most rapidly growing ethnic groups in Orange County, but have the highest rate of uninsured among all racial/ ethnic groups due to lack of information and language barriers. This program aims to educate Koreans about eligibility requirements for federal health assistance programs through outreach efforts and various seminars, and also provides individual consultations for those who have specific questions or need assistance in completing applications. The ultimate goal of the program is to reduce risk factors such as homelessness, falling into severe poverty, and isolation from the community by helping individuals achieve overall well-being in all areas of life including physical health, financial stability and inclusion into the community.

6. CULTURAL RELEVANCE

This program was developed in response to the growing number of inquiries that flooded KCS in regards to federal health assistance programs. Since its beginning in February of 2009, outreach has been done in the community through seminars, media, as well as individual consultations. In general, the Korean immigrant community tends to hesitate seeking assistance from others, and coupled with a strong stigma towards poverty, mental health issues and other societal issues, a great percentage of the Korean population ends up being unserved. Therefore, this program aims to act as a bridge that links the Koreans to American health assistance programs. By using bicultural and bilingual staff who knows the community well, staff are more likely to gain the trust of the individuals in the community. As staff helps individuals navigate through the healthcare system, they can also address mental health issues and demystify any misconception and stigma individuals have toward mental health issues and struggles.

Health Navigator utilizes material with detailed information regarding updated health and social benefits, while the outreach staff relies on a manual with instructions on how to do effective outreach.

One of the essential elements of this program is the utilization of various resources such as brochures, media, and

others, to disseminate information in the language familiar to the community and outreach to as many individuals as possible. Although there is no set curriculum due to the nature of the program, there is an outreach manual illustrates various ways to conduct effective and culturally appropriate outreach.

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

1. NAME OF INNOVATION/STRATEGY:		
Hmong Talk-Line		
2. TYPE OF PROPOSED STRATEGY:	X	Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER/AGENCY/ORGANIZATION– Please include all contact information

Hmong Cultural Center of Butte County (HCCBC)
1940 Feather River Blvd., Suite H
Oroville, CA 959565
Phone: (530) 534-7474 Fax: (530) 534-7477

Northern Valley Catholic Social Services (NVCSS)
10 Independence Circle
Chico, CA 95973
Phone: (530) 345-1600 (800) 339-8336
Fax: (530) 345-1685

4. TARGET POPULATION

- Hmong Talk-Line is intended to serve the Hmong population in Butte County, and it also support in both Hmong and English speaking.
- Strategy is intended for people who are in the recovery process from mental illness; additional support to people who requests community resources to cope with recovery and supp in prevention from mental illness.
- Strategy is intended for all people in Butte County, which included home, community, schools and rural area.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

- This strategy is to provide support for individuals who come into problems/road blocks in their recovery process from mental illness; also it will prevent individuals from entering state of mental illness.
- Strategy will enhance individual's own self esteem and thus better the recovery process and will reduce the risk of an individual going back to his or her old negative behaviors in the state of mental illness.
- The goal of this strategy is to provide support for individuals going through the process of recovery from mental illness, making his or her recovery process as smooth as possible.

6. CORE COMPONENTS/CULTURAL REVEANCE

- The essential components of this strategy will be at a one on one support basis. Support is provided via the phone or in person; both phone and person support are confidential. Support completely via the phone may also be anonymous.
- Essential elements are important because individuals going through the recovery process may not want other to know that they have mental illness. Also, confidentiality will make sure unnecessary information about their recovery process or mental illness leaks out although all providers are mandate reporters.
- There is no specific amount of times an individual is required to call for support to be effective. The support

Hmong Talk-Line provides is meant to be there when the support is needed. An individual going through the process of recovery may just use the support to Hmong Talk-Line once during their whole process, and another individual may use the support multiples times (17 times) there are no amounts of session require for this strategy.

- Outreach is done though the use of community radio, advertisement in the community local businesses, community events and word of mouth.
- The target population's traditions, beliefs, customs are critical elements that the strategy takes into consideration of culturally appreciate. The strategy is to incorporate both tradition belief and western approach. Together, the strategy hopes to provide effective support for the target population.
- The strategy demonstrates sensitivity to historical issues such as immigration and war traumas in the sense that the client and the providers of the strategy were also a victim and/or family members of victims of immigration and war traumas. This allows for the providers to understand and be more sensitive to the client's historical issues.
- The strategy takes into consideration cultural elements regarding mental health and well-being. When conversing, both providers and clients will come up with the strategy that best for the clients, whether it is from a cultural perspective or western perspective, to cope with the issue of the client. The understanding of the provider about the cultural elements regarding mental health and well-being will be beneficial for this process because we do belief that both of practices are beneficial as well.

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

1. NAME OF INNOVATION/STRATEGY:		
Horticultural Therapeutic Community Centers (HTCC)		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Rev. Dr. Sharon Stanley
Fresno Interdenominational Refugee Ministries
1940 N. Fresno Street
Fresno, CA. 93703
559-487-1500, 559-487-1550 (FAX), sharons@firminc.org.

Project also in partnership with Fresno Center for New Americans, Dr. Ghia Xiong, Fresno, CA.

4. TARGET POPULATION

New Americans and immigrants, especially low income Southeast Asian Hmong and Lao refugees struggling with symptoms of depression, isolation, PTSD, anxiety or other mental health challenges. Southeast Asian language and cultural competencies available on staff. Some Slavic refugees, Hispanics, and African Americans also served through project partnerships. Gardeners are primarily elders, with some preschoolers and teens.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

HTCC aims to enhance the development of Horticultural Therapeutic Community Centers or to enhance existing community gardens as a platform for peer support, mental health delivery and engagement on matters that relate to mental well being and mental health services. The project also seeks to deliver mental health PEI activities in traditionally and culturally relevant environments for traditionally un-served and underserved suburban and rural communities. By so doing, the project hopes to reduce problems of isolation and mental stressors and illnesses, connect generations to build relationships that promote sharing of cultural practices, and utilizes gardens as points of access for mental well being workshops and resources. Risk factors of suicide ideation, hopelessness, social disconnection, fear of community engagement in a new society, and lack of awareness of available mental health care will be replaced by improved well being, hopefulness, social supports, access to care and knowledge of care, and increased skills in problem solving, civic engagement, and help-seeking.

6. CORE COMPONENTS/CULTURAL RELEVANCE

- The project recognizes that most Hmong and Lao Southeast Asian refugees come from backgrounds that highly valued the land, and focused their lives before war upheavals on family centered and subsistence level farming. Once in the United States, however, agricultural skills are often given little value. Opportunities to continue to utilize agriculture to contribute economically and emotionally to family well being are often thwarted by limited access to land, high cost of land access, and lack of awareness about how to acquire growing areas for gardens. The HTCC supports the planning and development of new gardening sites, or expansion of existing sites, that are secure locations for community gatherings and gardening. Each site is provided with shelters as locations for culturally sensitive celebrations. Within each shelter are display areas where mental health resources are displayed

to enhance access to care. The project likewise promotes the consistent development of additional linguistically and culturally appropriate resources, and each site offers periodic (usually monthly) workshops in topics of mental health well being and horticultural practices, especially as requested by gardeners. Peer support groups for anxiety/depression and other care are encouraged.

- Currently, four sites exist for Hmong, Lao, and other Southeast Asian gardeners. Sites are located in various areas of South Fresno and nearby Sanger. In each case, gardens are within walking distance from large Southeast Asian apartment complexes and/or housing or private farm developments.

- Participants are recruited locally through relationships with participants in other programs of FIRM and FCNA, and some participants are sought through ethnic media (especially Hmong) radio or TV information segments. Lao and Hmong fluent staff provide supportive access to care, and promote the strength and good management of each garden site. As needed, gardeners are provided transportation support to community center sites. Gardeners are assigned numbers of rows (dependent on site acreage), and most garden sites serve between 12-25 gardeners (and their extended relatives, as desired.) Support groups have at times developed among various participants.

- HTCC began only in April, 2011, and thus is an early emerging model of culturally congruent care. Garden opening events stressed celebration of vegetable harvests and abilities of participants to produce them, allowed for cultural education and gift sharing among generations, and educated mainstream populations about Southeast Asian vegetables and farming practices. Short term program and system performance measurements will include to increase the number of prevention and early intervention activities that are directed at culture-specific communities who are un-served and underserved, and to increase the number of families and individuals who receive prevention and early intervention services within such communities. Long term community performance measurements will include to increase cultural competency and understanding that PEI models must be diverse and uniquely tailored for cultural relevance, to reduce stigmatizing attitudes towards mental health illness and suicide, and to strengthen earlier access to mental health treatment and services for un-served and underserved cultural, ethnic, racial, and linguistic communities.

- Early elements of cultural competence in services include engagement by participants in community celebrations that include Hmong "leaf instrument" playing, Lao and Hmong cultural dancing, food sharing of recipes utilizing grown crops, Hmong "hai ku tsia" (singing with storytelling), displays and descriptions of Southeast Asian specialty vegetables, decoration of shelters by Lao/Hmong cultural products, sharing of products through hospitality, locations of gardens in venues near to larger refugee populations and/or in areas that recall the feel and style of gardeners' homeland of Laos, and use of cultural blessing and clothing styles in project celebrations. Workshop topics are participant selected, and participants engage in community leadership experiences, such as helping recently with a meeting with Fresno's Mayor and City Council representatives.

- Community partners, in addition to funders from Fresno County Department of Behavioral Health/MHSA, have included Mental Health America, Fresno County Agricultural Extension office, Master Gardeners, Fresno Metro Ministry's Community Garden Program, the American Horticultural Therapy Association, and political support officials from Fresno County Department of Behavioral Health, the City Council of Fresno, and the Mental Health Advisory Board. Some participants have likewise been trained in community organizing through PICO (People Improving Communities through Organizing.)

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

1. NAME OF INNOVATION/STRATEGY:		
In Home Mental Health Support Training (Trans-adaptation of Mental Health First Aide Model)		
2. TYPE OF PROPOSED STRATEGY:	✓	Universal prevention
	✓	Selective prevention
	✓	Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Healthy House Within A MATCH Coalition
1729 Canal Street
Merced California, 95340
Tel. (209) 724-0102
Fax (209) 724-0153

4. TARGET POPULATION

- Health House intends to serve Latino, Southeast Asian, and South Asian immigrants and refugees in Merced County who are at various levels of acculturation and integration into the community. Meeting their mental health needs must take into consideration cultural and linguistic factors that include spirituality, family/social dynamics, attitudes toward medicine and doctors/clinicians, healing systems that may include shamans or other traditional healers, taboos regarding mental health behaviors, and lack of familiarity with the concept of mental health services as well as lack of language equivalency for mental health disorders. The training will be delivered in Hmong, Punjabi, and Spanish, respectively, to individual or family members of all ages and genders.

- Merced County, one of the ten most ethnically diverse counties in the entire country, has an agricultural-based economy and has suffered some of the highest rate of unemployment, foreclosures, population growth and poverty in the country as well. The fact that it is home to so many diverse ethnic communities provides additional challenges to addressing the afore-mentioned problems. The resulting mental health pressures on the individual members of these populations, who are disproportionately impacted by the socio-economic problems experienced, has increased both the need and the demand for an effective mental health support program. Moreover, the communal and/or shame-based nature of many of these ethnic cultures has dictated the need for an "in home" mental health training that can overcome the taboos and cultural beliefs that inhibit disclosure of mental health issues.

- Our experience working with Hmong and Spanish speaking communities on mental health issues has been extremely positive. In the end, we used the trans-adaptation approach in the refinement and delivery of Mental Health First Aid for Hmong, Spanish and Punjabi speakers. Messages were adapted in ways that reflected that these cultural groups receive information, respect cultural etiquette, incorporate symbolic language, and include real life immigrant and refugee stories as examples. The materials tried to incorporate the insights of community members in the local Hmong-speaking and Spanish –speaking communities who do not share the same basic understanding of psychological concepts as English-speaking individuals. The "In Home Support" training is to use the trans-adaptation of the Mental Health First Aid course based on the Australian curriculum to train 3 community families in their target languages (e.g. Hmong culture does not have terms for some of the mental and

physical illnesses being experienced due to lack of assimilation, isolation, etc. in Western culture. Descriptions, proverbs and other stories are utilized to help illustrate these conditions and their treatment.)

- This particular "In Home Support" training mostly will provide at clients' home with family members support. If there is a big family members involved in the training can be at a training site facility in town.

- In communal societies, it is essential to access the entire, even extended, family in order to adequately address and treat the mental health conditions of individuals.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

- This trans-adaptation program is aimed at reducing the cultural stigma and discrimination toward individuals with serious mental illnesses or serious emotional disturbances.

- The program is also dedicated to reducing disparities in access to mental health services for the multi-ethnic populations in Merced County, one of the most ethnically diverse counties in the entire country.

- An important goal or the program is to give information regarding the physical basis of mental illness, in essence, redefining it as an illness rather than just a condition indicating spiritual discord.

- Healthy House proposes a trans-adaptation approach in the refinement and delivery of both written and spoken outreach messages developed by the Merced County Department of Mental Health. Messages will be adapted in ways that reflect the ways that different cultural groups receive information (indirect/use of third person), respect cultural etiquette, incorporate symbolic language. Trans-adaptation involves a process of modifying English text to meet the literacy level and communication characteristics of the intended target audiences. Target groups include Spanish-speaking Latinos, Southeast Asian, Hmong -speakers, and South Asian, Punjabi-speaking Sikh from India.

- Prevention and early intervention with this training is essential due to the increased economic and familial pressures in this area which is disproportionately impacted by the economic and foreclosure crises. Affected individuals and communities need to be able to recognize the symptoms of mental illness as well as know where to go for help.

- Building collaborative partnerships between traditional healers (such as shamans, priests, and clergy) and mental health workers. These traditional healers are resources who need to work closely with the communities to gain trust and build confidence in and acceptance of psychologists and other clinicians as well as the medications and therapies being prescribed.

6. CORE COMPONENTS/CULTURAL RELEVANCE

- In Home Mental Health Support Training will be given in the home setting to the individuals as well as members of the extended family who are critical to constructively address individual mental health issues in communal cultures.

- Reducing Health Disparities by identifying culturally responsive prevention and early intervention strategies and trainings regarding mental health needs.

- Addressing the cultural taboos and beliefs that inhibit disclosure of mental health issues in the respective communities served.

- Addressing the geographic isolation and lack of transportation which severely limits access of these cultural communities to systems of care.

- Addressing the fear of deportation and/or being reported to immigration authorities if mental issues are disclosed and/or recognized.

- Acknowledging the un-served or underserved community members who feel alienated from established medical care and/or mistreated when they sought formal services; helping them to seek mental health care from informal service providers – trusted friends, family members, or clergy.

- Acknowledging that some community members felt threatened by mental health treatment they described as punitive – removal of children from their custody, involuntary hospitalization and physical restraint.

- Acknowledging that a major theme that emerged from the focus groups was the impact of oppressive social conditions on underserved and vulnerable communities (such as racism, discrimination, social exclusion and lack of power).

- Acknowledging that members of underserved communities felt isolated and perceived that they were regarded as unimportant by service providers and powerless to provide input and create change.

- Acknowledging that oppressive social conditions such as racism, criminalization, and social exclusion played a central role in limiting the ability of unserved, underserved and poorly served communities to improve their living conditions and, thus, led to mental health challenges for individuals in the community.

- Based on our work with multi-ethnic communities, we recommend utilizing a trans-adaptation model in the development of both written and spoken outreach messages. Trans-adaptation involves modifying existing text written in English to meet the literacy level and typical communication characteristics of the intended target multilingual audiences. Often the information must be simplified, summarized or re-written to better convey intended meaning. Often new text must be added to incorporate examples of community life experiences, cultural beliefs and practices, and these are essential elements important.

- Linguistically and culturally proficient key staff members involved in the trans-adaptation process will also provide public service announcements and the community outreach presentations in places such as migrant camps, migrant Head Start programs, and parenting groups. They will seek to change the perception of mental health within their specific cultural communities. Multimedia examples for dissemination include Radio Lobo, Arriba Valle Central television in Fresno, El Tiempo and Revista La Mejor for Spanish speakers and Merced Lao Family Community cable television channel, and Hmong Radio KBIF 900 AM in Fresno.

- The campaign will reduce stigma and discrimination by informing individuals of the prevalence of mental illness across cultures, nature of mental illness, and potential for resiliency, recovery and well-being.

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

1. NAME OF INNOVATION/STRATEGY:		
Integrated Care Center		
2. TYPE OF PROPOSED STRATEGY:	X	Universal prevention
		Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Korean Community Services
7212 Orangethorpe Ave. Suite 9A
Buena Park, CA 90621
(714) 449-1125

4. TARGET POPULATION

This project plans to serve the Korean American population of Orange County by integrating healthcare and mental health services. Through the Integrated Care Center, Korean American adults, ages 18 and up, who have Medi-Cal or MSI, will be able to receive a combination of medical care and mental health services. Those who struggle with mental health issues and have limited access to medical care due to inability to navigate medical systems, will be able to receive the necessary care and improve their overall well-being. Also, mental health assessments will be made for those individuals at-risk of suffering from mental health issues, in order to identify potential diagnoses early on. These services will be provided mainly in Korean to support the monolingual Korean American community, but will also be provided in English, based upon the language preference of the client /patient.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

The Integrated Care Center at KCS is an innovative program which aims to eradicate the disconnect between healthcare and mental health services by creating a single system that can be navigated by an individual needing both services. Currently, healthcare and mental health systems are separate from one another, and therefore, it is often difficult for individuals struggling with mental health issues to access healthcare, and also makes it difficult for a diagnosis to be identified early on in a medical setting. KCS is a non-profit organization with the mission to assist and empower Korean American individuals, families and the greater immigrant community. As the largest provider of Korean mental health services in Orange County, KCS currently has counseling programs and various mental health programs for children, adults and families. In addition, KCS runs a health clinic for low-income Koreans who do not have access to healthcare due to inability to pay for medical services and/or lack of insurance. While providing services to clients/patients through the different programs, it became apparent that most, if not all, individuals who struggle with mental health issues need medical care. In addition, many Koreans do not recognize mental health issues, and do not seek help even if they are aware of their struggle, due to existing stigma within the community. However, most are willing to share their mental health struggles with a medical care provider, and therefore, by integrating the two services, this project will allow those individuals to receive the mental health services needed in a non-threatening environment. Patients will also be referred to a mental health worker from the medical clinic, and receive an assessment for their mental health, and provide services to support their needs as necessary, such as counseling and medication.

6. CORE COMPONENTS/CULTURAL RELEVANCE

The essential component of this program/strategy is an organization with the experience and capacity to provide mental

health services and medical care, since the program is in integration of the two services. One important and unique quality of the program is that it plans to hire not only bilingual and bicultural staff to support the Korean American community of Orange County, but also aims to hire consumers and family members who have a desire to help others and give back to the community. Outreach for the program will be done in English and Korean through the press, flyers, web postings, and also by introducing the program to existing clients/patients.

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

1. NAME OF INNOVATION/STRATEGY:		
Maeta (Mercy)		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Sara Pol-Lim, Executive Director
United Cambodian Community
2201 E. Anaheim ST. #200
Long Beach, CA 90804
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E-Mail: spol98@aol.com

4. TARGET POPULATION

- This program intends to serve the Cambodian population. Our focus is on first generation between the ages of 40-75 years old. The first generation suffer severe depression because of the Killing Fields in Cambodia from 1975-1979.
- Program is intended for Cambodian refugees who have suffered from Post-Traumatic Stress Disorder (PTSD) and will be provided in Khmer.
- This program will be provided at the Community Center.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

- This program aims to reduce mental health struggles among Cambodian Americans.
- We aim to enhance wellness and to heal the emotional and mental pains that were built up among first generation Cambodian after experiencing the Killing Fields from 1975-1979. The strategy is to engage Cambodian Americans to talk about their past and to acknowledge struggles of depression, anger and pain as the first step to recovery.
- We hope to reduce the tendency of avoid talking about mental health issues and remove barriers and myth about mental health issues in the Cambodian community.
- The goal is to promote emotional and mental wellness among first generation Cambodian refugees. To enhance their longevity is by helping them gain meaning to their life experience by encouraging the discussion of war history in a supportive environment and by teaching the next generation about human kindness and leadership. By understanding the past history we are to appreciate our current freedom and to preserve and to protect and to honor it.

6. CORE COMPONENTS/CULTURAL RELEVANCE

- Essential elements include helping target group get in touch and reflect with new understanding of historical and cultural backgrounds and trauma.

- UCC will provide information about this program to those who come for general services. We will also partner with local CBOs to put the words out about "Maeta" program. We will utilize local media to promote what purpose and objective to the Maeta program.

- We incorporate traditions by having an event on honoring the deaths. Many Cambodians believe in "Karma" meaning we deserve what we get. They work to build on their next lives, but miss out on the present life. With open discussion about their beliefs and tie it with current issues on post traumatic stress disorder syndrome we can help them have a new and more positive ways of relating to themselves and their loved ones, to replace fear and anger with love and nurturance.

- UCC staff come with the same cultural experience, hence, they are understanding, sensitive, and supportive to those who went through the same traumatic experience. Staff who speak the same language and understand the historical hardship will help build positive connection in the community.

- The program incorporates linguistic and cultural elements in outreaching and delivering the service in the process of discussion on difficult life trauma and mental health recovery. The strategy focuses on physical and emotional wellness. The program will help them gain better understanding of their current struggles by connecting their cultural upbringing, life trauma experience, and eventually reduce stigma attached to their mental health struggles. The program should be a group setting. Coming together to talk about hardship from the genocide era in a supportive environment should reduce the fear of mental illness and encourage group support to reduce depression and substances abuse.

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

1. NAME OF INNOVATION/STRATEGY:		
Mental Health Consultation School Based Program		
2. TYPE OF PROPOSED STRATEGY:	*	Universal prevention
	*	Selective prevention
	*	Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

The Portia Bell Hume Behavioral Health and Training Center
Attention: Fawada Mojaddidi, Administrative Manager
39420 Liberty Street Suite 140
Fremont, CA 994538
(510) 745-9151

4. TARGET POPULATION

The proposed strategy is intended to serve first responders to students' mental health related challenges. These include principals, counselors, and teaching staff in school based settings. The goal is to promote the academic, social, and emotional success and development of students at any level of education. Beneficiaries of the strategies are students and their families (particularly Asian Pacific Islanders [API]) who are un-served or underserved, from any ethnicity, cultural background, gender, and age.

Services can be provided in the following languages: English, Hindi, Punjabi, Dari, Farsi, Cantonese, Mandarin, Vietnamese, Singhalese, Bengali, Tamil, Urdu, and Spanish.

Because the model is empowering it can be utilized with most people who have a desire to meet their work objectives. We help the first responders by promoting psychological understanding of common student difficulties in order to assure the earliest possible identification of students' presenting problems and to prevent further distress. We have the capacity to leverage long term treatment needs when appropriate within our agency.

The program is flexible with regard to the setting of the delivery of services. It could be in a classroom, principal quarter, district office, library, or other available and appropriate school locations. This strategy is capable of being deployed not only in traditional public schools but also in charter schools and private schools including emerging sectarian or religious-based schools. Recently these have included local schools specifically developed to serve API Islamic, Sikh, and Christian families.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

This strategy is to build and/or strengthen individuals' capacity to meet their work objectives, particularly related to students learning. It does this by building on their academic expertise by exploring the psychological processes of the individuals they work with in order to promote a safe environment that is conducive to learning.

Because the proposed strategy is delivered in the context of school communities, we focus upon supporting the improvement of school capacity to contribute to healthy child development in three categories. These categories align and are derived from the California Healthy Kids Survey, Department of Education. These include: (1) Caring and

Support – which the youth finds from administration, teachers and counselors within the school. (2) Administrators, Teachers and Counselors establish high expectations, i.e. students perceive that they are being told they are bright and capable and supported to achieve academic and school social success. (3) Youth Participation and Involvement i.e., that by bonding to school, youth perceive themselves to gain some power and control over direction of their life. The program's training is designed to facilitate educator (i.e., teacher, counselor, and administrator) growth in motivation and capacity to promote the protective factors by improving relationships with students, and youth participation through student and parent peer group activities.

We find that most educators have a desire to contribute to, or represent, the protective factors noted above, but a key solution is how to sustain the promotion of these factors. Educators have a desire to expand or contribute to the knowledge base of any individual student. This desire can be thwarted over the years due to the internal and external pressures experienced in working in an organization. Through working with the different individuals in a school setting, the Mental Health Consultant is able to help the individual maintain their drive and level of passion that initially brought them to the world of academia allowing them to continue experiencing their work as positive and rewarding. When they can maintain a position that allows them to feel satisfied within their roles they can be more successful in maintaining a flexible, solution-focused, and empathic view of their students.

Because of the variation in school communities, risk factors identified and addressed will vary by specific program. Common risk factors we have found include:

- Acculturation Issues
- Immigration Trauma
- Mental Health Stigma
- Drugs and Alcohol
- Dating/Relationship Issues (specifically Domestic Violence)
- Bullying (including Cyber-bullying)
- Depression
- Family Issues (including Parental Alcoholism and Financial Difficulties)
- Pregnancy
- Social Skills/Peer Relationships
- Self-Destructive Tendencies
- Suicide and Suicidality
- Emotional/Physical Abuse
- Low Self-Image
- Truancy
- Gang Affiliation
- Autism Spectrum Disorders
- Grief and Loss
- Eating Disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Sexual Identity

A component of our proposed strategy is the completion of a needs assessment among stakeholders of a school community (youth, parents, other providers, teachers, counselors, school administrators, school district representatives, and/or funding sources). We find that through conducting a thorough needs assessment, relevant risk factors are identified, and in addition, stakeholder buy-in is increased which encourages the community's response to the identified risk factors.

Goals this proposed strategy aims to achieve:

- Build and maintain a school systems' capacity to support administration, staff, and students.
- Reduce stigma of mental health by creating an approach that fosters empowerment to manage with mental health challenges
- Equip school staff with the knowledge and skills to work effectively with members of the API community (especially those of immigrant backgrounds) by drawing attention to unique cultural variables that need to be understood in a productive learning environment.
- Reduce crisis driven responses to problems that can be prevented when attention is paid to early signs of student challenges.
- Promote opportunities to provide or strengthen students' coping skills
- Identify any API child or youth who may exhibit exacerbated behavioral health distress, relying on early intervention and/or navigation to a treatment network provider.
- Provide outreach and education around mental health to API community members

6. CORE COMPONENTS/CULTURAL RELEVANCE

Essential components of this proposed strategy will include:

- Mental Health Consultation group forums will be implemented as part of the organizational structure. They will ensure accessibility and will be developed at multiple levels, including with the administrative and teaching staff as well as Special Education division personnel. We will also establish these forums for onsite school health providers. We will implement peer consultation for students and caregivers.
- Times and days of the forums are set to achieve the highest level of participant and stakeholder engagement to promote positive development of the student community.

Generally speaking, health care is scarce, absent, and/or expensive in school settings. Behavioral health care is even less likely to be adequately provided in these settings even though addressing mental health issues is critical for educational achievement. Behavioral health care professionals who are linguistically and culturally competent are scarce everywhere in the broader community and rarely found if ever in the school systems. These shortages exacerbate existing barriers to accessing services particularly for populations like API. New cost effective practical strategies like Mental Health Consultation are essential to bridge these gaps with cultural and linguistic competence, sensitivity to community needs, and new approach to extending the range of professional understanding in the school system.

Since the strategy is extremely flexible, delivered across a broad range of participant types, and particularly responsive to the needs of these participants, these traditional program metrics will vary considerably. Sometimes a single one hour session will serve one person or up to ten people in a group consultation forum. On the other hand, an outreach educational workshop intended for students' caregivers may last up to two hours and serve up to forty participants.

How the proposed strategy will outreach to the target population:

- When a relationship is established with a school, we begin by working with the decision makers who usually are the administrative leaders. These decision makers work with us to develop selection criteria to recruit the first responders and to determine appropriate times and venues for the intervention (i.e. staff orientation days, staff meetings). We are particularly interested in working with first responders who themselves are in close contact, on a daily basis, with API children and youth.
- When we are working with students and their families, we conduct outreach by attending existing student and parent forums (i.e. student assemblies, classrooms, and parent back-to-school nights, particularly those established for the benefit of English language learning communities). We also seek to identify student

leaders in the API community already recognized as natural peer leaders. By linking up with them we create additional productive engagement opportunities. We are careful to use only informational materials and media tools that are not threatening but are stigma-reducing and that are effective for engaging a student into preventive activities.

Everyone we work with, be they teachers and other professionals or students and their families has their own cultural beliefs and practices. Each person forms his/her own set of beliefs and way of living based upon upbringing, societal influences, economic opportunities which together form the individual's interpreted experience. Because the model works with this experience, each individual who engages in the service explores their traditions, beliefs, and customs in their unique contexts and how these correspond with the lived experiences of individuals from other cultural traditions. This works both ways, from a mainstream perspective understanding to a non mainstream perspective and vice-versa.

How the proposed strategy will demonstrate sensitivity to historical issues:

- By developing groups for those who have experienced war or other forms of trauma or with the immigration process to identify resilience factors or skills that now have become strengths.

- By offering a presentation on the impact of immigration, how to navigate educational, health care, legal, and public benefit systems, and how to raise their children in a multicultural environment.

The strategy recognizes the importance of understanding and incorporating traditional cultural practices and understandings regarding mental health and well being. To do this, the consultant will engage the family, often working with the family's identified leader, to ensure an effective intervention and positive role modeling in working with effected family members presenting issues. Also important is consulting to school officials to help them appreciate and understand common non-mainstream cultural practices (i.e. eastern approaches to mental health and well being) that are particular to certain API communities and are critical for successful interventions. Finally, we offer presentations on the unjustified stigma of mental health in the API community and how to raise awareness about mental health problems despite this stigma.

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

1. NAME OF PROGRAM:		
Mental Health Worker Training Program		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

The program has been developed by Pacific Clinics – the contact is Steven A. Bush/ 714-480-4682. It was implemented in Korean and the contact in Korean Community Services is– Sarah Jun/714-449-1125.

4. TARGET POPULATION

The Mental Health Worker Training Program was developed by Pacific Clinics to provide adult consumers, family members, and TAY (Transitional Aged Youth) interested in giving back to the community by working in the mental health field with the training and education necessary to serve others. Korean Community Services became the first provider of the training program in the Korean language, in an effort to reduce the cultural and language barriers that exist in the English program. Strong stigma towards mental health issues dominates the Korean culture, making it extremely difficult for consumers and family members to disclose their struggles and seek services. Therefore, many of those who go through the training program seek to gain more information about mental health in order to better understand and support their loved ones. The program is best provided in a community based organization, where consumers and family members feel the least threatened.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The main goals of the Program is to educate the consumers and family members with information about mental health issues, in order to prevent consumers' symptoms from getting worse due to lack of understanding and knowledge of mental health, as well as to empower those individuals to give back to the community once they are able to self-maintain. The program allows individuals to share their stories with one another, and as they support and encourage one another and share valuable information, they are no longer bound by stigma that prevented them from receiving the services they needed. As a result, more and more individuals begin to stand up against stigma and work together to raise awareness about mental health issues.

6. CULTURAL RELEVANCE

Many of the individuals on the board, management and staff team are bilingual and bicultural Koreans, and have experienced the difficulties that recent immigrants are often faced with. Ongoing support and training are provided through various training curriculum developed in-house, as well as from other organizations such as the OCHCA. They are very familiar with the challenges the target population experienced in dealing with stigma, navigating through the complicated healthcare system.

To outreach to the Korean community, KCS contacted the press, developed flyers, and introduced the program at seminars and resource fairs. Because of our awareness of the strong stigma dominating the Korean community, the staff members were able to approach consumers and family members in a non-threatening manner and allowing them to see the benefit of the program. The Korean community relies heavily on personal relationships, and so each participant is approached with a respect for the struggles they faced not only as consumers and family members, but

also as immigrants who spend their lives working hard to adapt to American life. While outreaching to the Korean community of Orange County for the past 4 years, it became evident that consumers and families desperately needed an educational program that worked as a support group as well. Therefore, in collaboration with Pacific Clinics, KCS provided the first ever Korean language Mental Health Worker Training program last year. This year, in our second year of the program, the number of participants nearly doubled, and along with the growth in number, came valuable feedback and evaluation of the program from both participants and instructors. Their feedback and suggestions will be considered and incorporated for next year's program.

7. ADDITIONAL INFORMATION

There is no limit for group size for this program, but it is most effective when the group is no more than twelve individuals, because a large group size makes it difficult for individuals to share with one another freely. Participants of the program should follow the privacy rule by keeping all conversations strictly confidential, and everyone is required to sign agreement forms when they register. These two elements will allow individuals to participate in the program more comfortably, and will therefore allow successful completions of the program. The curriculum was developed by Pacific Clinics and translated by Korean Community Services. Participants enroll in a 14 week course for a total of 128 hours of education, and at the end, are given an opportunity for an internship with a community-based organization if they are interested.

This program requires a minimum of one staff member acting as a coordinator who oversees the program. However, the coordinator will need a network of professionals in the mental health field who can provide different lessons according to their specialty. All staff involved must be bilingual and bicultural in order to provide culturally and linguistically competent services to the consumers and family members. Most importantly, the recruited staff must have enthusiasm, compassion and a passion to serve the mental health community. The program is best conducted in a classroom setting where lessons and discussions can be conducted.

KCS was established in 1977 as an immigrant relief organization to support the needs of the rapidly growing Korean community in Los Angeles. In the 1980s, KCS became the first provider of culturally and linguistically competent substance abuse services for the Korean American community, and eventually expanded the services into multiple languages. A decade later, KCS expanded the services to Orange County, and opened the K.C. Services division and began providing various court mandated outpatient counseling programs. By the new millennium, it became evident that the growing Korean population of Orange County was neglected as a result of being overshadowed by the larger population dwelling in the Los Angeles county. Therefore, KCS established Korean Community Services (Bokji Center) to provide culturally competent social services to the growing Korean American community of Orange County, and is now the largest provider of Korean services.

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

1. NAME OF INNOVATION/STRATEGY:		
Outreach Groups		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)
3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information		
UC Irvine Counseling Center		
4. TARGET POPULATION		

These outreach groups aim to reach vulnerable populations based on: ethnicity, culture, gender, sexual orientation, and graduate students. All groups are facilitated in English. Some outreach groups are offered outside the Counseling Center (e.g. Graduate Resource Center, International Coffee Hour) while the majority of groups are offered in the Counseling Center group rooms.

Specifically, the following groups were created for populations with specific needs or risks:

Estamos Unidas: A support group for Chicana/Latina female students who will have the opportunity to connect with other women who are seeking to create community with one another and address a host of concerns. Some areas of focus are cultural concerns in a university environment, transitional issues between family and university life, relationships, identity, ways to succeed academically and socially, and mentoring.

International Coffee Hour: A support group for international students who will have an opportunity to relax and enjoy lively conversation and refreshments.

What's Going On?: A support group for African Americans students interested in discussing issues that are important to the African American community.

My Black Is Beautiful: This group is for undergraduate African American female students. The goals of the group are to build community among Black women, promote empowerment, strengthen connectedness to the university, and to encourage social engagement that will promote a positive image of African-American students/people across campus. Women in the group will use food, music, dance, art, spoken word and their own unique talents.

Chai Time: This is a support group for Asian American female students to provide them a safe and supportive environment to explore social and cultural issues. Topics can include religious values, intergenerational conflict, gender roles, family concerns, academic/career concerns, dating, and sexuality.

Rainbow Anteater Connection: This is a weekly rap group where LGBTIQ students can explore and learn more about issues related to the LGBTIQ community. It is also a place to meet and network with other LGBTIQ students.

Peace of Mind: This is a semi-structured 6-week workshop designed to help male and female graduate students increase their ability to cope with difficult emotions through being mindful and accepting. Through the Peace of Mind

group we will explore ways to live more fully in the present moment, manage our negative emotions, and develop inner resources of strength.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

The outreach groups provide support, consultation, and a sense of community to target vulnerable groups and specific areas that are listed above in the group description. The specific goal is to extend services beyond the walls of the Counseling Center in order to build bridges to our underserved and isolated students and provide them with a space to connect with each other. In addition, outreach groups aim to enhance protective factors, such as social support, skills, mentoring, healthy coping, and academic achievement. The risk factors that are aimed to reduce include attrition, alcohol and substance abuse, isolation, depression and anxiety.

Risk factors specifically among API students and their families include: financial distress, immigration concerns (e.g. anti-immigration sentiment, pre-immigration trauma), role conflicts, value clashes, identity conflicts, limited social support and community, model minority, family pressures, language barriers, acculturative stress, mental health stigma, racism (e.g. micro-aggressions, discrimination), substance abuse, and domestic violence.

Vulnerable subgroups among APIs include API women and API LGBT individuals. According to Professor Eliza Noh, suicide is the second leading cause of death among Asian American women, ages 15-24. API women face sexism, gender role conflicts, in addition to general API risk factors. API LGBT individuals are also a vulnerable group considering their dual minority statuses (ethnicity/race and sexual orientation) and potential community splits that can lead to discrimination and mental health distress.

Protective factors for APIs can be: churches or temples, family network which can be immediate and extended family, respected elders, practitioners of indigenous healing methods, agencies or organizations serving APIs (e.g. alumni, business), positive racial/ethnic identity, academic and family oriented values.
Counseling Center's outreach groups provide cultural relevancy, sensitivity and competency that may not be found in individual counseling services. For example, Chai Time provides a safe space that identifies and addresses the needs of API women related to academic, interpersonal, health/substance, abuse, dating, bicultural and biracial issues, family difficulties, cultural differences, marginality, sexism, and racism experiences. The less formal nature of outreach groups can prevent family shame and increase comfort. Some of the groups are offered outside the Counseling Center where API students may feel more comfortable meeting, such as the Student Center or LGBT Resource Center.

6. CORE COMPONENTS/CULTURAL RELEVANCE

The essential components of this proposed strategy involves open accessibility where students can drop-in and join anytime; no pre-enrollment or screening required. In addition, a few groups are located outside the Counseling Center to improve access. There are is no group size limit and groups aim to create an inviting and welcoming atmosphere. Each group caters activities, format and topics based on population specific traditions, beliefs and customs. For example, groups may center on mentorship, skills, food, music, dance, art, and spoken word. These essential elements are important to combat stigma, eliminate isolation, and cater to population specific-needs. The outreach groups are marketed internally in the Counseling Center as well as throughout the UCI campus via list serves, newsletters, and campus departments, such as Cross Cultural Center, Dean of Students, Graduate Division, and International Center. The outreach groups include cultural elements regarding mental health and well-being by providing a place where students can discuss concerns without the traditional counseling format, and more community-oriented support.

The group leaders are Counseling Center staff members who are carefully recruited based on the Center's mission to provide culturally competent services. The Center is dedicated to providing cultural and population-specific competencies through ongoing trainings and weekly case consultation meetings. Also, certain group leaders have

partnerships with International Center, and teach as an adjunct professor for the Department of Asian American Studies. The group leaders usually identify with the particular cultural group's focus. For example, Chai Time group is usually run by Asian American women leaders. In addition, the group leaders have awareness, knowledge and skills to work specifically with the group they are facilitating. For example, leaders understand the importance of building on the protective factors of API students. Thus, group leaders may integrate a mentor, advocate and counselor role with a strength-based approach. In addition, group leaders may self-disclose appropriately or provide practical advice and suggestions. Group leaders also focus on enhancing members' sense of community and support with each other.

These are unique aspects of group that are distinguished from individual counseling treatment. As a result, the Counseling Center highlights groups with equal importance to individual treatment. This can be reflected on the support given to the space, funding and marketing of these groups.

UCI's Counseling Center is considering a survey that will include future evaluation of outreach groups.

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

1. NAME OF INNOVATION/STRATEGY:		
Partners In Healing		
2. TYPE OF PROPOSED STRATEGY:	✓	Universal prevention
		Selective prevention
	✓	Early intervention
	✓	Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Healthy House Within A MATCH Coalition
1729 Canal Street
Merced, Ca. 95340
Tel. (209)724-0102
Fax (209)724-0153

4. TARGET POPULATION

- Merced County is one of the most ethnically diverse counties in California with the largest per capita resettlement of refugees in the state. Eight major languages are spoken in the county, including Spanish, Hmong, Mien, Lao and others.
- Healthy House is known both nationally and internationally for its 'cutting edge' program, Partners in Healing.
- This "Partners In Healing" project is an orientation class for Hmong shaman to integrate them into the Western mental and physical healthcare system. It is also intended to give Western providers some cultural competency regarding Hmong spiritual and physical healing processes. (The spiritual healing ceremonies of the Shaman are intended to serve anyone who needs help in the Southeast Asian community. Individuals of all ages and both genders are 'called' to be shamans.)
- Most of the shamans and spiritual healers speak Hmong and only a few also speak English. However, Healthy House provides Language & Cultural Specialists for the trainings so both the Shamans and the Western providers can understand and be understood. The Specialists interpret, translate and trans-adapt materials used so that the training is culturally appropriate and responsive.
- The proposed strategy is intended for people living in Merced County (and other Valley counties such as Fresno, Stockton, and Sacramento) that have large Hmong populations. The cross-cultural understanding shared between Hmong Shamans and Western providers is essential to minimize health disparities and ensure good health outcomes for Hmong patients. Moreover, it reinforces the notion of "Culture Cures," an acknowledgement that most indigenous traditions and practices are based on good mental, physical and spiritual health principles.
- Merced County Hmong residents who experience barriers to adequate access to health care are the intended beneficiaries of this program. This includes both ethnic people who are unfamiliar with western medical care and who experience difficulty in negotiating the Western medical system as well as the traditional healers in Hmong culture. Shamans and spiritual healers are often the initial and preferred choice for Hmong patients, even when modern Western health care services are available.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

The goals of the program are:

- To address the mental and physical healthcare disparities caused by lack of cross-cultural awareness and cooperation as well as linguistic barriers experienced by Hmong patients;
- To address the preference for traditional medicine in Hmong culture which has led to further disparities and

poor mental and physical health outcomes due to mistrust and lack of cross-cultural understanding;

- To address the lack of programs that integrate traditional and Western medicine, and to utilize traditional healers as a valuable link, "gate keepers," between ethnic populations and Western practitioners;
- To empower the traditional healers with essential mental and physical healthcare information that encourages them to refer individuals to appropriate western health care services, and to ensure that Western providers understand and utilize the healing services of Hmong Shamans to ensure optimum mental and physical health outcomes for Hmong patients;
- To educate shamans and spiritual healers to western medicine and mental health care systems as well as introduce shaman ceremony activities to providers so both can enjoy the benefit of modern healthcare as well as traditional healing;
- To prevent conflict between mental and physical health care providers/administrators and the general lay Hmong community and Hmong Shamans which can lead to compromised outcomes for Hmong patients.
- To bridge the gap between Western health care providers and Hmong spiritual healers in order to allow them to work as a healthcare team to ensure optimum mental and physical health outcomes for Hmong community members;
- To offer ongoing continuing education for the shaman and spiritual healers through hospital tours, mental health trainings, and healthcare presentations on subjects varying from acute disease and chronic illness to new hospital technologies and mental health therapies and medications.

6. CORE COMPONENTS/CULTURAL RELEVANCE

- In Merced County, over 100 shamans were trained by Healthy House in the past 10 years and there are still shamans on the waiting list for future trainings.
- The Partners in Healing curriculum involves 40 hours of shaman training. An orientation class typically involves 5-10 shamans who tour the hospital, including the operating room, emergency department, labor and delivery room and laboratory and radiology departments. During the intensive training they learn about Western biomedical practices, germ theory, disease symptomatology and mental health topics, including mental health conditions, symptoms and services.
- Continuing education classes typically involve 10-15 shamans and are offered several times each year. They focus on developments in both mental and physical healthcare.
- The training introduces shamans to the aforementioned topics and/or developments in Western healthcare and then gives them opportunities to talk directly with Western providers concerning their respective healthcare practices.
- Mercy Hospital Merced has adopted a shaman policy since 2009 which recognized the shamans' role in the healing process. In addition, Mercy Hospital has been an active participant in our Partners in Healing program for many years. The orientation training, hospital tour, and continuing education classes are all essential to ensure the cross-cultural communication and understanding necessary to ensure good mental and physical health outcomes for Hmong patients.
- The development of a Shaman Policy for the hospital establishes the procedures to coordinate a shaman visit at the hospital and to conduct a Hmong shaman healing ceremony at the hospital. The Shaman Policy delineates which ceremonies are allowed and any accommodations available for non-approved ceremonies as well. Finally, it allows for adequate documentation of Hmong spiritual healing practices and ceremonies in the patient's records.
- Hmong is a high context culture which embraces a very holistic notion of health, a notion that is firmly rooted in longstanding spiritual practices. Mental health issues are typically viewed as having spiritual components as opposed to physical bases. Integration of Hmong and Western approaches to mental health is an important focus of the program.
- Outreach activities utilized to recruit shamans include Hmong T.V. from Sacramento, 900 KBIF radio from Fresno and the Merced Lao Family T.V talk show. The program also benefits by word of mouth and its reputation in the community. Previously trained shamans are also instrumental in promoting the program as they are able to more

effectively advise community members on all aspects of mental and physical health.

- Partners in Healing embraces the spiritual beliefs and practices of the Hmong community, facilitates an understanding of these important healthcare practices by Western mental and physical healthcare providers and allows a collaboration of both cultural healthcare practices to ensure optimum health outcomes for Hmong patients in the Great Central Valley of California.
- The majority of Hmong residents are (or are descended from) refugees with Post Traumatic Stress Disorder, a result of their involvement in the ravages of the Vietnam War, including fleeing a war torn country and internment in refugee camps. Moreover, a shaman is the only spiritual healing resource who the Hmong recognize to "bring the soul that was lost during the war back to the physical body." In other words, the shaman is essential to perform the ceremonies necessary for both mental and physical health for Hmong individuals.
- The most recent accomplishment of the program has been the development of Shaman Directories which have been placed in hospitals in Merced, Fresno and Sacramento to facilitate the calling of shamans, organized by specialties, by hospital staff when Hmong patients are admitted.

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

1. NAME OF INNOVATION/STRATEGY:		
Promotores		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
		Selective prevention
	X	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER/AGENCY/ORGANIZATION– Please include all contact information

Hmong Cultural Center of Butte County (HCCBC)
1940 Feather River Blvd., Suite H
Oroville, CA 959565
Phone: (530) 534-7474 Fax: (530) 534-7477

Northern Valley Catholic Social Services (NVCSS)
10 Independence Circle
Chico, CA 95973
Phone: (530) 345-1600 (800) 339-8336
Fax: (530) 345-1685

4. TARGET POPULATION

- The specific population of this proposed strategy intended to serve and work with the Hmong and Latino families in East of Eaton Apartments in Chico, California. There more than fifty unites and most of them are Hmong and Latino families.
- The languages that are proposed strategy to provide are English, Spanish and Hmong. These are the languages that to be used and communicated at these apartments units.
- This proposed strategy intended for the people with high risks of mental illness, language barrier, cultural difference, lacked of resources and facing difficulty accessing of mental health service.
- The proposed strategy intended in two settings of grouping and home visiting. Grouping activities in prevention of mental health relate nutrition and more... In home visit settings focused on family, individual goals and linkage to community resources.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

- This strategy will provide support for individuals and family in linkage to community resources of mental health illness, isolation and provide educational support for early mental health prevention in culturally competence.
- The proposed strategy aim to prevent isolation from under serve population and to outreach to mental health services access.
- This proposed aim to reduce the individuals and family isolation and hesitation in getting mental health services accessing with the mean stream society.
- The specific goals of this proposed strategy aim to linkage the Latino and Hmong individuals and families to mental health services resources to prevent them from early state in their own languages and culturally competence.

6. CORE COMPONENTS/CULTURAL REVEANCE
• The essential components of this proposed strategy are to provide support for families and individuals with their own cultural, tradition and western approach of mental health services by providing direct and indirect weekly activities. • These essential elements are important because the families and individuals are able to communicate and share their thought to heal their wounds in their own language, traditions and culturally competence. • The strategy outreach to these individuals and families are mouth to mouth, pass out flyers. • The strategy demonstrates sensitivity to historical issues such as immigration and war traumas in the sense that the client and the providers of the strategy were also a victim and/or family members of victims of immigration and war traumas. This allows for the providers to understand and be more sensitive to the client's historical issues. • The strategy takes into consideration cultural elements regarding mental health and well-being. When conversing, both providers and clients will come up with the strategy that best for the clients, whether it is from a cultural, tradition perspective or western perspective, to cope with the issue of the client. The understanding of the provider about the cultural elements regarding mental health and well-being will be beneficial for this process because we do belief that both of practices are beneficial as well.

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

1. NAME OF INNOVATION/STRATEGY:		
Saving Earth and Healing Hearts		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Calvin Hsi
Buddhist Tzu Chi Foundation
1100 S. Valley Center Ave., San Dimas, CA 91773
909-447-7931, calvin_hsi@us.tzuchi.org

4. TARGET POPULATION

The strategies are provided in Mandarin and Taiwanese in the community agency setting. It is designed for Chinese Transition age youth and adults aged 21-65 years with symptoms of social isolation or depressed mood, although it can also be utilized by the general population.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

- Prevention of social isolation that further exacerbates mental health issues.
- Protective factors: supportive and positive social environment that encourages involvement, enhance self- esteem and self-concept by getting the affirmation from other volunteer staff, peers, and the fact that they are contributing to saving the environment, and increase information and knowledge about mental health issues (through workshop).
- This strategy will help strategy participants reduce risk factors: social isolation, low self-esteem, stigma of struggling with mental health issues; lack of information about mental health issues.
- Goals: reduce social isolation, increase self-esteem, gain social support, gain mental health knowledge, gain spiritual support to help strategy participants accept their current situation and look for improvement of their own condition, reduce stigma and discrimination of strategy participants struggling with mental health issues (by working together and having more direct interaction with people struggling with mental health issues, other members become more receptive and supportive of people with mental health issues).

6. CORE COMPONENTS/CULTURAL RELEVANCE

- Saving Earth and Healing Hearts is a humanistic approach targeting Chinese Transition age youth and adults aged 21-65 years who are with symptoms of social isolation or depressed mood. It is delivered in the site of Buddhist Tzu Chi Foundation where there is a recycling station for Foundation's volunteers to involve in various environmental protection programs promoting recycling that aim to save the earth and reduce garbage turning trash into monetary donation which goes to the Foundation for the charity works to help more people in need. Saving earth and caring for the environment is part of traditional Chinese philosophy of people living in harmony with the nature/environment. In recent years, Taiwan has been become more conscientious about preserving the precious environment. The recycling project is very popular and well received in Taiwan.
- There are more than 4,500 recycling stations in Taiwan staffed by 70,000 volunteers. Currently Tzu Chi Foundation in Southern California has 3 recycling stations across Los Angeles County.

- The strategies are to engage the targeted population to perform simple task activities to collect recyclable materials and sorting the recyclables in a protective, caring, welcoming and spiritual environment where Tzu Chi volunteers speak the same languages and are extremely supportive to facilitate social interaction with others. In addition, strategy participants will be exposed to the TV program with Tzu Chi's Founder, Dharma Master Cheng Yen's teachings and Tzu Chi volunteers' personal stories and testimony during the 1-hour structured session. The use of Master's teaching is consistent with the spiritual belief of people who are prone to Buddhist thinking; who believe in doing good deed. It provides positive and supportive experiences for strategy participants and often they develop a new sense of purpose in life as they are contributing to the preservation of the environment. By involving in recycling, strategy participants are empowered to have the opportunity to be a helping person to turn trash to gold and gold to the loving hearts for the charity. In addition, family members are encouraged to join the recycling activities and 1-hour session so family is facilitated and engaged in a positive interaction with strategy participants and receiving emotional and spiritual support from the volunteers and Founder's teachings which enhance family relationship and support.
- The strategies are conducted by mental health workers and therapist who provide psycho-education to family members and provide orientation and trainings for Tzu Chi volunteers to learn about the depressive symptoms and how to engage strategy participants into recycling activities and interaction with others and provide them a positive and supportive environment. The recycling activities are open all year round to the general public and Tzu Chi volunteers 3 to 5 days a week in various sites according to their schedules. The duration of participation for strategy participants in recycling activities can be shortened or lengthened from 2 to 5 hours a day, once to twice a week depending on the needs and availability of the strategy participant and his or her rate of progress. The strategies are administered to groups of 6 to 10 strategy participants per day for up to 6 months. The strategy participant may continue to participate in the activities as the Tzu Chi volunteers if he or she chooses to do so after 6 months.
- During these up to 6 months, strategy participants typically participate in the recycling activities for at least 2 hours per week and one 1-hour session with 15 minutes of Master Cheng Yen's teachings and 45 minutes of discussion and sharing facilitated by volunteer staff to enhance strategy participant's spiritual practice. The success of these strategies will be self-reported and shared by strategy participants during this 1-hour session. These success stories can also be obtained by interviews of strategy participants, family members and Tzu Chi volunteers.
- The staffing of this approach consists of supervisor/therapist, staff/community or mental health workers and volunteer staff/Tzu Chi trained volunteers. The strategy participants are selected based on the severity of the mental health issues, age and language capacity. They are primarily recruited from the referral of Tzu Chi volunteers, community and faith-based organizations, and community mental health agencies. They are also recruited via Tzu Chi monthly newsletter, Tzu Chi Journal, and Tzu Chi TV and Radio Program in the Chinese communities.
- Buddhist Tzu Chi Foundation is an international, volunteer-led charitable organization providing humanitarian aid, spiritual care and medical services to families and communities locally and internationally. Tzu Chi means "serving with compassion". Founded in 1966, the Foundation has dedicated itself in the field of charitable services, medical services, education, environmental protection, as well as the promotion of humanistic values and community volunteerism. There are now more than 80 offices and facilities in the U.S. with over 100,000 volunteers and donors working to make a difference in their local communities.

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

1. NAME OF INNOVATION/STRATEGY:		
Innovation Project: Qi-Gong Workshops for Oakland Chinatown Seniors		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
	x	Selective prevention
	x	Early intervention
	x	Other (please specify): Psycho-education

3. NAME OF DEVELOPER/AGENCY/ORGANIZATION – Please include all contact information

Oakland Asian Cultural Center (OACC) and Asian Community Mental Health Services (ACMHS) on behalf of Alameda County Behavioral Health Care Services (Innovative Project Grant).

Contact Information:

Lily L. Stearns, Ph.D. Executive Director
c/o Asian Community Mental Health Services
310 8th St. Suite 201
Oakland, CA 94607
510.869.6020
lilys@acmhs.org

Mona Shah, Executive Director
c/o Oakland Asian Cultural Center
388 9th St. Suite 290
Oakland, CA 94607
510.637.0460
mshah@oacc.cc

4. TARGET POPULATION

Research has consistently shown that API's tend to delay seeking mental health services and as a result suffer from more severe mental health conditions and have longer hospitalizations than other ethnic groups. Many logistic and cultural obstacles have been cited for this underutilization, including lack of English proficiency, economic limitations, transportation difficulties, post-traumatic stress disorder, multiple inter-related health and mental health problems, lack of understanding of U.S. social systems, and a severe stigma related to seeking psychological support or treatment. Data from the California Department of Mental Health indicate that rates of psychopathology among API's have been underestimated, that API's underutilize services, that language, culture, and socioeconomic status are barriers to accessing care.

In May 2010, ACMHS and OACC held a community healing outreach event targeting low-income seniors from the Oakland Chinatown community to address the impact of the recent violence on the mental wellness of the community and the lack of mental health services provided for this population. Over 100 seniors attended the event and requested follow up activities to address their mental wellness.

This innovation project, funded by the Alameda County's Innovative Project Grant, targets low-income seniors (65 or

older), Asian immigrants living in the downtown Oakland Chinatown community. Seniors are a very vulnerable population as they are isolated from much of the Bay Area community due to language and cultural barriers. These factors paired with the stress of growing older put this population at risk for mental health issues, i.e, depression, anxiety, feelings of helplessness and hopelessness. Language barriers and stigma further contribute to lack of access to mental health services.

The languages used for this project are primarily Cantonese and Mandarin.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

The learning questions of this project are two-fold:

1. How will Qi-Gong, a practice well known to Asian Seniors in Oakland, impact their mental well-being when combined with mental health screening, psycho-education on mental health symptoms, and group process?

2. Would including more traditional group therapy and education on identifying early signs and symptoms of mental illness with traditionally accepted methods of mind-body care (Qi-Gong) reduce the stigma around accessing mental health services in Asian Seniors in Oakland's Chinatown?

Short-term goals:
1. Increased knowledge among the Seniors of Qigong and its benefits to mental health
2. Increased knowledge among the Seniors of identifying mental health symptoms and dealing with it effectively
3. Build community/support network from the support groups
4. Lower levels of depression evaluated through psychological assessments

Long-term goals:
1. Improved mental health status (reduction of stress, depression and anxiety) and well being among the Seniors at risk for mental health issues in the Oakland Chinatown community
2. Reduce the stigma of Mental Health
3. Provide access to mental health services

6. CORE COMPONENTS/CULTURAL RELEVANCE

Asian Community Mental Health Services (ACMHS) has been providing culturally and linguistically competent mental health services to the underserved Asian and Pacific Islander (API) population in Alameda and Contra Costa Counties since 1974. ACMHS has pioneered mental health approaches and that are consumer driven and community based to fill the void in behavioral health care of the API community. ACMHS has been a contractor with Alameda County Behavioral Health Care Services for over 30 years (for more info: www.acmhs.org).

Oakland Asian Cultural Center (OACC) was founded in 1984 by a coalition of volunteers who recognized the need for a strong artistic and cultural force in the Chinatown area. Since opening its own facility in 1996 in the heart of Oakland's Chinatown district, the OACC has presented countless high quality cultural programs. OACC believes that the arts can be a powerful vehicle for positive social change (for more info: www.oacc.cc).

Oakland Asian Cultural Center (OACC) has been providing Qi-Gong classes with the Shaolin Buddhist Temple and Education Foundation (SBTEF) for the past five years. SBTEF was founded in 2006 and provides Kung Fu and Qigong classes taught by Master Shaolin monks to students from all backgrounds to preserve the 1,500 year old tradition of Shaolin Buddhism for the SF Bay Area(for more info: www.shaolinlife.org).

This innovation project is both culturally and linguistically competent and targets a vulnerable and hard-to-reach population. Qi-Gong is recognized by this population to be a practice for better health – impacting body, mind, and spirit. Qi-Gong has been proven to reduce anxiety, depression and overall mood imbalance while improving one's health from a holistic approach.

The activities for this project include holding three series of eight two-hour workshops, co-led by Qi-Gong monks and the ACMHS' mental health consultants. Each workshop concentrates on Qi-Gong practice integrated with psycho-education on mental health symptoms and issues, followed by a group support and discussion. The project is held over a span of one-year and takes place at OACC. Limited to 12 clients, each series begins and ends with a mental health screening by a clinical psychologist from ACMHS.

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

1. NAME OF PROGRAM:		
Suicide Prevention Program for the Korean Population		
2. TYPE OF PROGRAM:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Didi Hirsch
2021 E. 4th St. Ste 204, Santa Ana, CA 92705
Phone: (714) 547-0885 Fax: (714) 547-8352

Korean Community Services - Helen Ahn
7212 Orangethorpe Ave. Suite 9A, Buena Park, CA 90621
Phone: (714) 449-1125 Fax: (714)562-8729

4. TARGET POPULATION

The Suicide Prevention Program at KCS is a program for Koreans at risk of suicide and/or lost their family members to suicide, and includes support groups as well as individual counseling sessions. The program is led by a bilingual & bicultural staff member in order to support the needs of first and second generation Koreans. Although the program does not need a particular setting to succeed, it is best to host the program at a safe location such as a community center where individuals will not feel threatened by participating in the program.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

The goal of this program is to reduce stigma towards suicide and mental health, thereby preventing suicide rates from increasing in the Korean community as more at risk individuals and family members become aware of suicide and mental health issues. Support groups and individual counseling sessions allow individuals to share their struggles in a safe environment as they encourage and support one another by sharing their lives, and ultimately create healthier family dynamics for those individuals. It is commonly known that those who have been exposed to suicide have a higher risk of suicide, and therefore, the program aims to reduce the risk by providing those individuals with the education and support they need to overcome their struggles.

6. CORE COMPONENTS/CULTURAL RELEVANCE

Didi Hirsch established the first 24-hour crisis line in the United States in 1958, and since then, several different suicide prevention services have been developed, such as support groups for those who have attempted suicide, a Suicide Response Team, as well as a support group who lost a loved one through suicide. However, KCS is the first to make this program available in the Korean language, who often cannot seek the help they need due to language and cultural barriers. In order to accommodate the cultural and linguistic needs of the Korean community, outreach for the program was done through various cultural media sources and introduced at different seminars and resource fairs with a large Korean community base. The program seeks to not only address the issue of stigma in a cultural context, but also to address the stress experienced by immigrants as they struggle to adjust to a new life full of uncertainties and financial difficulties. The program will address the impact of the recent financial crises in both the U.S. and Korea, which has put a great financial strain on many Korean families, as well as the rising suicide rate within Korea and the

increased exposure to suicide that continue to put more individuals at risk.

7. ADDITIONAL INFORMATION

The essential elements of this program are individual counseling sessions and support groups for those at risk of suicide and family members who lost a loved one to suicide. Individual counseling sessions last for 50 min each, are held once a week for 8 weeks. The support groups should have no more than eight individuals involved, and is also held once a week for a total of eight weeks, with each session lasting for an hour and a half. It is best to maintain the group size to no more than eight individuals, because that allows all participants to share their experiences openly and encourage one another as they share their struggles. These essential elements are significant in raising awareness and reducing stigma towards suicide and mental health within the Korean community. Currently, KCS is in the process of creating a guide book in Korean for those who lost a loved one through suicide.

The program requires one Program Coordinator and a couple other staff members who can assist with outreach, translations and help lead the support group. All staff must be bilingual in Korean/English & bicultural in order to support the needs of the Korean community. The coordinator must have experience serving individuals with mental health issues, preferably with a degree in counseling or social work. The assisting staff members are not required to have a degree or experience in the field, but must have an enthusiasm and compassion to help individuals who have struggled with suicide or lost their loved ones through it. For case management, the ratio should be one staff member for every three clients.

The program requires private rooms where individual counseling sessions can be held, as well as a medium sized room that holds approximately ten individuals for the support groups to be conducted.

KCS developed this program based on the original program established by Didi Hirsch, and therefore the program will be evaluated through surveys translated in Korean, as well as individual interviews. The evaluation will be conducted by staff members, who will also conduct qualitative case studies to collect data.

KCS was established in 1977 as an immigrant relief organization to support the needs of the rapidly growing Korean community in Los Angeles. In the 1980s, KCS became the first provider of culturally and linguistically competent substance abuse services for the Korean American community, and eventually expanded the services into multiple languages. A decade later, KCS expanded the services to Orange County, and opened the K.C. Services division and began providing various court mandated outpatient counseling programs. By the new millennium, it became evident that the growing Korean population of Orange County was neglected as a result of being overshadowed by the larger population dwelling in the Los Angeles county. Therefore, KCS established Korean Community Services (Bokji Center) to provide culturally competent social services to the growing Korean American community of Orange County, and is now the largest provider of Korean services.

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

1. NAME OF INNOVATION/STRATEGY:		
Zoosiab Program		
2. TYPE OF PROPOSED STRATEGY:		Universal prevention
	X	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER/AGENCY/ORGANIZATION– Please include all contact information

Hmong Cultural Center of Butte County (HCCBC)
1940 Feather River Blvd., Suite H.
Oroville, CA 95965
Phone: (530) 534-7474 Fax: (530) 534-7474

Northern Valley Catholic Social Services (NVCSS)
10 Independence Circle
Chico, CA 95973
Phone: (530) 345-1600 (800) 339-8336
Fax: (530) 345-1685

4. TARGET POPULATION

- Zoosiab is a program intended to serve the Hmong elders in Butte County ages 50 years and older. The program will target Hmong speaking clients. Staff of Hmong Cultural Center will mainly use the Hmong language to communicate with their clients in order for them to understand. The project's main focus is on Hmong trauma survivors living in Butte County. Most of its clients will have symptoms of unresolved trauma due to their exposure to many years of war and additional post-war trauma in refugee camps and in the U.S. as they tried to create new homes. In addition, the project will take place in a recreational room with a variety of indoor and outdoor social activities involved.

5. WHAT ARE THE GOALS OF THIS STRATEGY?

- The purpose of the project is to address the specific needs of Hmong elders who have experienced trauma. The Hmong population is often hidden and misunderstood outside of the Hmong community and also within the Hmong community's younger generations. The older Hmong participants will participate in the project by sharing their skills, stories, healing practices with others in a recreational room. They will give input as the program progresses to help understand the real impacts of the project. One of the challenges being addressed is the fact that the Hmong community is fractured within the family structure, with older people having a completely different cultural identity than younger people, due to the loss of homeland and the erosion of original cultural values.

- Zoosiab will adopt a practice based on evidence model developed by the Cree Tribe in Manitoba to treat historical trauma known as Paving the Red Road to Wellness, to be culturally relevant to older Hmong. Furthermore, this project will apply general Mental Health Services Act (MHSA) standards to enhance the project's goal. The MHSA standards include consumer and family driven program, community collaboration, cultural competence, wellness, recovery and resilience focus, integrated service experience. Zoosiab aim to achieve positive outcomes within its clients. Older Hmong trauma survivors will resolve unresolved trauma which they will demonstrate the

wellness and recovery factors. For instances, including established self-esteem, engage more in healthy activities outside their homes, regain their self-worth and personal value, experience the ability to go about their day with reduced symptoms of trauma related mental health symptom, laugh more, and feel more satisfied among family members of other generations.

6. CORE COMPONENTS/CULTURAL REVEANCE

- The essential components of the proposed strategy are its staffs providing services to the clients, and the clients' families and clients' back ground. The client's entire family will be included in the evaluation component by having family members participate in focus groups, and for young people this may include using electronic technology for input if better response will result. Having a history of the clients' background is essential to understand the cultural and psychological impact of trauma on the individuals. Plus, an understanding of the Hmong culture will be a necessity for everyone involved in the project. Hmong or non Hmong clinicians and Hmong Wellness staff members such as Hmong counselors, Hmong peer partners, or Hmong healers will be needed as Hmong language will be used to communicate with the Hmong elders effectively. The services will be provided to the extent possible in Hmong community settings including the Center, home and other.

- Zoosiab will include an outreach component including some accompanied transportation to services. This help breaks down cultural, linguistic and stigmatization as well as the fear of reaching out for services that many trauma survivors experience. The project will utilize the Trauma Recovery Empowerment Model as a Western service to provide group therapy to its targeted population. At the same time, the project will also incorporate spiritual practices such as healing ceremonies, practices led by shamans, drum ceremonies, singing ceremonies, soul calling ceremonies, story time and Qheng ceremony. A variety of Hmong cultural and recreational activities will be provided and will focus on building skills: community gardening, fishing, group exercise and sewing/embroidery. These activities will focus on the skills that they develop and how they address trauma. For instance, traditional Hmong sewing/embroidery tells a story and can help embroiderers and viewers of the artwork to become aware of the trauma and the path towards recovery.

APPENDIX 7: CATEGORY 4 FULL SUBMISSIONS

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
COMMUNITY-DEFINED PROMISING PROGRAM
RECOGNIZED BY: Los Angeles County Department of Mental Health Community-Defined Evidence (CDE) Program (reviewed by CiMH)

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
Asian American Family Enrichment Network (AAFEN) Program		
2. TYPE OF PROGRAM:		Universal prevention
	XX	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Terry S. Gock, PhD., M.P.A.
Asian Pacific Family Center, Pacific Clinics – 9353 East Valley Blvd., Rosemead, CA 91770-1934
Phone number: (626) 287-2988 **Email:** tgock@pacificclinics.org

4. TARGET POPULATION

The AAFEN Program is offered in Chinese (Mandarin), Korean, and Vietnamese. The target populations of the AAFEN Program are Asian immigrant parents and/or primary caregivers with inadequate parenting skills to effectively discipline and nurture their teenage children. Because of the cultural and linguistic barriers experienced by many of these immigrant parents, they often feel overwhelmed and incompetent in terms of effectively managing their family lives. Moreover, their teenage children experience reduced family attachment and social functioning, as well as increased family conflict. The children are thus at high risk for those emotional and behavioral problems that would qualify them for such diagnostic impressions as "Oppositional Defiant Disorder" and "Substance Abuse Disorders." Their immigrant parents and/or primary caregivers are also at high risk for such diagnostic impressions as "Dysthymic Disorder" and "Major Depression," among others. In addition, they are at serious risk for being reported to DCFS for monitoring as they resort to such measures as corporal punishment in an attempt to discipline their children.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The overall goals of, and outcomes achieved through, the AAFEN Program include increasing the emotional and behavioral self-efficacy of the Asian immigrant parents and/or primary caregivers as well as enhancing the safety and healthy development of Asian immigrant youths. In particular, the AAFEN Program is designed to promote such protective factors as the stability of the Asian immigrant families, the confidence and competence of the Asian immigrant parents and/or primary caregivers in carrying out responsive and effective bicultural parenting and family management skills, and the positive bonding and relationship between these parents and/or primary caregivers with their teenage children. It is also designed to reduce such risk factors as family conflict and adolescent psychosocial maladjustment.

6. CORE COMPONENTS

The essential elements and primary strategies of the four components of the AAFEN Program are as follows: **(1) Theme-Based Parenting Workshops** (These are one-time workshops on effective bicultural parenting and family management for education and outreach.); **(2) Bicultural Parenting Class Series** (This is a 12-week, culturally

competent, skill-based, interactive, and manualized parenting and family management curriculum offered in Chinese, Korean, or Vietnamese to the target parents and/or primary caregivers once a week for 2 to 3 hours per week in a group format. Topics include essential bicultural parenting skills, culturally effective family communication approaches, positive discipline methods, child and adolescent development knowledge, stress and anger management, and laws and expectations about child abuse and neglect.); **(3) Family Bonding Activities** (These are monthly structured group social activities for the AAFEN program participants and their children, and designed to facilitate positive family interaction.); and **(4) Parent Support Groups and Family Support Service Linkage** (These are biweekly support groups to help the program participants reinforce the principles learned in the Bicultural Parenting Class Series and obtain peer support for implementing these bicultural parenting and family management skills in their family settings. In addition, linkages to linguistically and culturally competent community service entities and providers are offered as needed, to help them address those biopsychosocial needs that impact on the effective functioning of their families.). This program, which was initially developed for the Chinese immigrant parents, has been replicated for Korean and Vietnamese immigrant parents respectively.

The level of care for the four components of the AAFEN Program are as follows: (1) Theme-Based Parenting Workshops (a series of one-time workshops for education and outreach); (2) Bicultural Parenting Class Series (a 12-week group in Chinese, Korean, or Vietnamese for 2 to 3 hours per week); (3) Family Bonding Activities (monthly structured social activities for the AAFEN program participants and their children); and (4) Parent Support Group and Family Support Service Linkage (biweekly peer support group with individualized family support linkage offered, as needed).

7. CULTURAL RELEVANCE

To help outreach to the target Asian immigrant parents and primary caregivers, all the staff of the AAFEN Program (especially the Family Specialists) are hired from the bilingual and bicultural members of the target Asian immigrant communities to the extent possible. In addition, respected community leaders and members (including leaders of the local Asian ethnic Parents Association) are enlisted to support the outreach and engagement efforts of this Program.

Each of the four essential elements and primary strategies of this bicultural parenting Program has incorporated Asian cultural and parenting values and approaches. All these essential elements and primary strategies are designed to help Asian immigrant parents in effectively implement bicultural parenting and family management in the contemporary social context of this country. In its initial development, a number of existing parenting programs in the mainstream and other racial/ethnic communities were reviewed by a representative group of Chinese immigrant parents from the target community. The one program that was considered by them to be most responsive to their parenting concerns and needs was then adapted by incorporating Asian cultural values and parenting approaches. In addition, this group of Chinese immigrant parents reviewed the AAFEN Program after it was developed to ensure its cultural responsiveness before it was piloted, refined, and subsequently implemented on a full scale basis.

8. STAFFING

The primary service delivery staff members of the AAFEN Program are bilingual and bicultural Family Specialists. Each full-time Family Specialist can be expected to carry out the AAFEN Program group activities with about 40 target families (with about ten families in each group) per week. It is most desirable that these Family Specialists are from the same target Asian immigrant communities, and have high familiarity and identification with these communities. Strong social and networking skills as well as curriculum delivery skills are also desirable. Their primary responsibilities include the implementation of the four components of the AAFEN Program. In addition, a Project Director (for staff supervision and program management) and adequate support staff (for clerical and other administrative support) are required for successful program implementation.

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

The activities of the AAFEN Program are delivered at locations that are "natural congregation" places for these Asian immigrant families. Examples of such places include school sites or other community service delivery settings. For Asian immigrant families, community-based and culturally competent behavioral healthcare settings are also appropriate service delivery sites.

10. INDICATIONS OF EFFECTIVENESS

As part of a SAMHSA demonstration grant, the AAFEN Program was evaluated using a quasi-experimental design with culturally valid pre-post measures. The program evaluation results indicate that the over 350 participating parents in the AAFEN Program reached statistically significant changes in the positive directions on many of the measures used. They include: family strengths, family cohesion, family attachment, parent self-efficacy, parent-child relations, and overall health. Moreover, there was a significant decrease in family conflict and the level of maladjustment on the part of their children.

Although the SAMHSA demonstration grant from which the AAFEN Program was created, refined, and evaluated has ended over five years ago, this culturally competent parenting education and family management program for Asian immigrant parents and/or primary caregivers is still being conducted through local funding support. As part of the current program implementation efforts, pre-post measures with diverse Asian immigrant parent groups have continued to be collected to further increase the evidence base for this Program. Most recent data analyses of 110 Chinese and Korean immigrant parents who have completed the AAFEN Program parenting class series from 2005 to 2010 reveal that they evince a statistically significant increase in their confidence and in their ability to be an effective parent, as well as significant improvement in their parent-child relationship. In addition, they have rated their program satisfaction to be very high in terms of both curriculum content and class presentation modalities.

11. AGENCY INFORMATION

As a division of Pacific Clinics (a private, nonprofit mental health and behavioral healthcare agency established in 1926), the Asian Pacific Family Center (APFC) has been offering a wide spectrum of mental health services, as well as behavioral health prevention and intervention services, to the Asian immigrant communities in the San Gabriel Valley area of Los Angeles County for 25 years. The program services at APFC are offered by a multilingual and multidisciplinary team off nearly 100 highly trained professionals, including psychiatrists, psychologists, social workers, counselors, nurses, parent, youth and family specialists, and community workers. In addition, the APFC Community Advisory Board (comprising of clients and parents, school and law enforcement officials, civic leaders and businesspersons, and other community stakeholders from both the local Asian immigrant and mainstream communities) provides input and support to ensure that the programs developed and offered by APFC are culturally and linguistically responsive to the local Asian immigrant families we serve. Moreover, asides from regular in-service training and support, all staff members are provided at least 5 days of continued education leave a year to attend training courses offered by the Pacific Clinics Training Institute (free of charge to staff) or by other training facilities of their choice. One requirement is that all staff members are expected to attend training courses each year that are designed to enhance their cultural competence.

Contact Information:

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CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
COMMUNITY-DEFINED PROMISING PROGRAM
RECOGNIZED BY: Los Angeles County Department of Mental Health Community-Defined Evidence (CDE) Program (reviewed by CiMH)

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:
Asian Mentoring & Advocacy Support To Enhance Resiliency in Youth (MASTERY): A Mentoring Program

2. TYPE OF PROGRAM:		
		Universal prevention
	XX	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information
Terry S. Gock, PhD., M.P.A. Asian Pacific Family Center, Pacific Clinics, 9353 East Valley Blvd., Rosemead, CA 91770-1934 **Phone number:** (626) 287-2988 **Email:** tgock@pacificclinics.org

4. TARGET POPULATION
The target population of the Asian MASTERY Program is middle school age Asian male and female immigrant youths (primarily Chinese and Vietnamese) from low income families with limited English proficiency who are at high risk for substance abuse and other delinquent behaviors. They include those who have engaged in some violent or delinquent act, experienced truancy and failure at school, and/or been living by themselves in this country with very little or no adult supervision after school (i.e., unaccompanied minors). In terms of background characteristics, some have recently moved to the United States (i.e. within four years) and are dealing with the stress of adapting to a new environment, culture, language, etc. Many of them report feelings of social isolation, a lack of family support, a lack of school connectedness, and language barriers. Others are from immigrant families, dealing with the stress of developing bicultural identity and negotiating between at least two different sets of cultural values and norms, and report a lack of family support. As mentioned above, all of them are at high risk for becoming entrenched in such delinquent behaviors as gang involvement, substance abuse, school truancy, and/or academic failure. In addition, the behavioral, emotional, and academic problems that these target youths exhibit are often the precursors to more severe psychiatric disturbances that would qualify them for such clinical diagnoses as "Oppositional Defiant Disorder," "Major Depression," and substance abuse disorders. Moreover, the severity of their behavioral and emotional problems is such that they would not qualify for the services of such traditional volunteer mentoring programs as Big Brothers and Big Sisters.

5. WHAT ARE THE GOALS OF THIS PROGRAM?
The overall goals of, outcomes achieved through, the Asian MASTERY Program include enhancing such protective factors as positive family bonding and community ties, strong family and community support for each other, bicultural life skills, and effective school and social functioning. It is also designed to reduce such risk factors as ineffective peer and authority conflict resolution, association with delinquent peers, poor cultural identity, self-esteem, and self-efficacy, and lack of knowledge and access to needed formal and informal community services and support.

6. CORE COMPONENTS
The Asian MASTERY program uses four coordinated program components to attain the program outcomes described above. These four core components or features include: **(1) Individualized Mentoring Needs Assessment** (This is a semi-structured, strengths-based and needs-driven assessment process to develop a flexible, creative, and individualized mentoring plan for each youth "mentee.") **(2) Intensive One-to-One Mentoring** (Based on the

interests, hobbies, strengths and concerns in the various life domains identified in the "Individualized Mentoring Needs Assessment" process described above, age and gender appropriate mentoring activities are tailored to fit the particular interests and needs of each youth "mentee." These activities use a non-threatening, positive role modeling, and "teachable moments" approach for the Youth Specialists [i.e., mentors] to provide prosocial guidance, insight, and/or perspectives to the "mentees" in the course of their weekly "hanging out" together.) **(3) Social and Life Skill Development Group Activities** (This is a culturally competent, age appropriate, and interactive life-skills curriculum that is 42 weeks in length designed to support the target youths in their development of such functional skills as goal setting, effective communication, anger management, problem solving, and conflict resolution. The curriculum also explores such topics as self-identity, peers, family, and bi-cultural competence to enhance prosocial life choices. These curriculum-based preventive intervention sessions are further enhanced by including such team and relationship building activities through afterschool tutoring and positive recreational activities. It also uses a structured weekend retreat during the program year to further address such issues as substance abuse, peer refusal skills development, and prosocial relationship building.) **(4) Youth and Family Service Advocacy** (These service advocacy efforts are designed to offer linkage and access to needed formal and informal community services and support besides those provided by the Asian MASTERY Program in order to help the target youth "mentees" and their family members address other functional and psychosocial needs in their lives.)

The level of care for the four components of the Asian MASTERY Program are as follows: **(1) Individualized Mentoring Needs Assessment** (one to two hour pre-service assessment with each potential youth "mentee"; **(2) Intensive One-to-One Mentoring** (two hours per week with each youth "mentee" in the Program for a 12-month duration); **(3) Social and Life Skill Development Group Activities** (about three to four hours per week for each group of 8 to 10 youth "mentees" in the Program for a 12-month duration); and **(4) Youth and Family Service Advocacy** (these services are offered to the youth "mentees" and their families on an as needed basis).

7. CULTURAL RELEVANCE

To help outreach to the target Asian immigrant youth and their families, all the staff of the Asian MASTERY Program (especially the Youth Specialists) are hired from the bilingual and bicultural members of the target Asian immigrant communities to the extent possible. In addition, respected community leaders and members (including school officials and teachers) are enlisted to support the outreach and engagement efforts of this Program.

As noted in Section (6) above, each of the four core components or essential elements of the Asian MASTERY Program has incorporated Asian cultural values and approaches in its design and content to ensure its appropriateness and relevance for the target Asian immigrant youth and their families. In addition to working with the target Asian immigrant youth "mentees," the Program works on securing the support and engagement of the parents or primary caregivers of these youth participants in as many of the program components and activities as possible. Besides demonstrating respect for the cultural emphasis on family hierarchy in decision making, the resulting collaborative "extended family" relationship with the family members of these youth participants helps the program staff as they offer support to these families as part of the "Youth and Family Service Advocacy" program component.

8. STAFFING

Each Youth Specialist can serve as a "professional mentor" for no more than 8 to 10 youth "mentees," and implement the four components of this Asian MASTERY Program. The desired qualifications of these "Youth Specialists" include their having at least a Bachelor's degree in Psychology, Sociology, Social Work, or related field, and their having previous experience working with youth. The key roles of mentors are to conduct individualized mentoring assessment, provide weekly individual mentoring, implement a weekly life-skills curriculum group, and provide youth and family advocacy services as needed. Other responsibilities include communicating and coordinating with the target schools and other referral sources, working with the parents of the program youths, and collaborating with

community agencies to provide linkage services. In addition, a Project Director (for staff supervision and program management) and adequate support staff (for clerical and other administrative support) are required for successful program implementation.

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

The individual mentoring activities of the Asian MASTERY program are delivered at various settings within the community, including recreational facilities like basketball courts, depending on the interests and needs of each individual youth "mentee." The Youth Specialists may also conduct home visits with the youth mentees and/or their family members. Program activities for the weekly skill-based curriculum groups can be delivered at school sites and/or community-based and culturally competent behavioral healthcare settings.

10. INDICATIONS OF EFFECTIVENESS

The Asian MASTERY program was developed and refined through a federal SAMHSA demonstration project grant. It was evaluated using a longitudinal experimental design that included random assignment of youths to an "intervention group" that received all the program activities described above and a "control group" that received monthly alternative social and recreational activities. The youths in both groups completed an assessment survey at the beginning of the program, at program completion (i.e. 12 months later), and at 8-month follow-up after program completion. In addition, the level of program participation (i.e. program dosage) was collected using duration measures (in minutes) in several pre-specified types of activities. Staff interviews and participant focus groups were also conducted for process evaluation purposes, with immediate feedback provided to program staff, and to determine key components of the program at the end of the project.

The evaluation outcomes support that the Asian MASTERY program is effective with the target population of middle school age Asian male and female immigrant youths (primarily Chinese and Vietnamese) from low income families with limited English proficiency who are at high risk for substance abuse and other delinquent behaviors. Trend effect analyses of pre-test and 8-month follow up assessment data reveal that those youths in the "intervention group" outperform their "control group" counterpart on a number of the culturally validated measures used. In specific, they evince a statistically significant: (1) reduction in drug use and in favorable attitudes toward drug use, (2) increase in positive school bonding and comfort, (3) improvement in academic performance and life management skills, and (4) enhancement in cultural pride and relationship with significant adults.

11. AGENCY INFORMATION

As a division of Pacific Clinics (a private, nonprofit mental health and behavioral healthcare agency established in 1926), the Asian Pacific Family Center (APFC) has been offering a wide spectrum of mental health services, as well as behavioral health prevention and intervention services, to the Asian immigrant communities in the San Gabriel Valley area of Los Angeles County for 25 years. The program services at APFC are offered by a multilingual and multidisciplinary team off nearly 100 highly trained professionals, including psychiatrists, psychologists, social workers, counselors, nurses, parent, youth and family specialists, and community workers. In addition, the APFC Community Advisory Board (comprising of clients and parents, school and law enforcement officials, civic leaders and businesspersons, and other community stakeholders from both the local Asian immigrant and mainstream communities) provides input and support to ensure that the programs developed and offered by APFC are culturally and linguistically responsive to the local Asian immigrant families we serve. Moreover, asides from regular in-service training and support, all staff members are provided at least 5 days of continued education leave a year to attend training courses offered by the Pacific Clinics Training Institute (free of charge to staff) or by other training facilities of their choice. One requirement is that all staff members are expected to attend training courses each year that are designed to enhance their cultural competence.

Contact Information:
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CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
COMMUNITY-DEFINED PROMISING PROGRAM
RECOGNIZED BY: Los Angeles County Department of Mental Health Community-Defined Evidence (CDE) Program (reviewed by CiMH)

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
IMPACT! (Inspire & Mobilize People to Achieve Change Together): A Youth Development and Leadership Program		
2. TYPE OF PROGRAM:		Universal prevention
	XX	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

Terry S. Gock, PhD., M.P.A.
Asian Pacific Family Center, Pacific Clinics, 9353 East Valley Blvd., Rosemead, CA 91770-1934
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4. TARGET POPULATION

The target population of the IMPACT! Program is high school age Asian immigrant youths who are at high risk for exhibiting behavioral problems. They have recently moved to the United States (i.e. within five years) and are often dealing with the stress of adapting to a new environment, culture, language, etc. Many of these youths report feelings of incompetence and social isolation, a lack of family support, a lack of school connectedness, and language barriers in addition to having to deal with the "normal" stress of adolescent development and the high academic expectations and pressures they experience from their families. The behavioral, emotional, and academic problems they exhibit are often the precursors to more severe psychiatric disturbances that would qualify them for such clinical diagnoses as "Oppositional Defiant Disorder," "Major Depression," and substance abuse disorders.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The overall goals of, and outcomes achieved through, the IMPACT! program include enhancing such protective factors, for this target population, as self-awareness and self-efficacy; healthy and positive peer interactions, strong family bonds, and school and community connectedness. They also include reducing such risk factors as substance abuse, risky sexual activities, and other delinquent behaviors.

6. CORE COMPONENTS

The IMPACT! Program uses a culturally competent, age appropriate, and interactive life-skills curriculum that is 26 weeks in length to support the target youths in their development of such functional skills such as goal setting, effective communication and problem solving. It also addresses such issues as substance use and HIV to facilitate peer refusal skills development, and explores such topics as peers, family, and culture to enhance prosocial life choices. These curriculum-based preventive intervention sessions are further enhanced by team and relationship building activities. In addition, they are bolstered by the required and structured group community service projects that empower the youth participants to experience that they can and do make a positive difference in their world.

The skill-based and manualized curriculum of the IMPACT! Program is offered to the youth participants once a week after school for 2 hours in a group format (approximately 8 months). In addition, these youths are also supported and monitored as they complete their group-chosen community service projects.

7. CULTURAL RELEVANCE

To help outreach to the target Asian immigrant youths and their families, all the staff of the IMPACT! Program (especially the Youth Specialists) are hired from the bilingual and bicultural members of the target Asian immigrant communities to the extent possible. In addition, respected community leaders and members (including school officials and teachers) are enlisted to support the outreach and engagement efforts of this Program.

Each of the curriculum-based life skills training sessions of the IMPACT! Program has incorporated Asian cultural values and approaches in its design and content to ensure its appropriateness and relevance for the target Asian immigrant youths and their families. The structured group community service projects are similarly designed to emphasize such Asian cultural values as group and community orientation. To ensure continuous input from the target population, a Youth Advisory Council (comprising of high school age Asian immigrant youths who are program participants or are graduates of the program) meets regularly to review and monitor program progress as well as offer feedback to ensure that the program is responsive and relevant to them and their peers in terms of addressing their interests and their issues in this area.

8. STAFFING

The IMPACT! Program is primarily a school-based program. For program implementation at three local high schools, at least two full-time Youth Specialists are needed to make up the core service provider team. The anticipated caseload is about 30 students per school (i.e., three groups of ten youths each per school). The desired qualifications of these Youth Specialists include their having at least a Bachelor's degree in Psychology, Sociology, Social Work, or related field, and their having previous experience working with youths in social group settings. The key roles of Youth Specialists are to implement the life-skills & leadership curriculum, facilitate the groups, and support the community projects that are taken up by the program youths as part of their program requirements. Other responsibilities include communicating and coordinating with the target schools, working with the parents of the program youths, collaborating with community agencies to set up the community projects to be implemented by the program youths, and supporting the youths in completing their chosen community projects. In addition, a Project Director (for staff supervision and program management) and adequate support staff (for clerical and other administrative support) are required for successful program implementation.

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

Most of the activities of the IMPACT! Program are delivered at the targeted school sites after school hours. Program activities are also implemented at such community settings as local parks, convalescent or retirement centers, and homeless agencies, where the youth-selected community service projects are carried out.

10. INDICATIONS OF EFFECTIVENESS

The IMPACT! Program was developed and refined through a federal SAMHSA demonstration project grant. It was evaluated using a longitudinal experimental design that included random assignment of youth to a weekly (intervention) group, and a monthly (control) group. The youths in both groups completed an assessment survey at the beginning of the program, at program exit, and at follow-up (approximately six months after program exit). In addition, the level of program participation (i.e. program dosage) was collected by duration (in minutes) in several pre-specified types of activities. Staff interviews and participant focus groups were also conducted with immediate feedback provided to program staff for continuous program refinement and to assess key process components of the program.

The evaluation outcomes support that the IMPACT! Program is effective with the target Asian immigrant youth population as planned in that those youths in the IMPACT! Program evinces a statistically significant increase in such prosocial attitudinal and behavioral indices as their risk perception of substance use, their harm perceptions related to sexual risk behaviors, and their HIV knowledge. These outcome data also show that the IMPACT! Program is

effective in maintaining the school bonding of these high risk Asian immigrant youths.

11. AGENCY INFORMATION

As a division of Pacific Clinics (a private, nonprofit mental health and behavioral healthcare agency established in 1926), the Asian Pacific Family Center (APFC) has been offering a wide spectrum of mental health services, as well as behavioral health prevention and intervention services, to the Asian immigrant communities in the San Gabriel Valley area of Los Angeles County for 25 years. The program services at APFC are offered by a multilingual and multidisciplinary team off nearly 100 highly trained professionals, including psychiatrists, psychologists, social workers, counselors, nurses, parent, youth and family specialists, and community workers. In addition, the APFC Community Advisory Board (comprising of clients and parents, school and law enforcement officials, civic leaders and businesspersons, and other community stakeholders from both the local Asian immigrant and mainstream communities) provides input and support to ensure that the programs developed and offered by APFC are culturally and linguistically responsive to the local Asian immigrant families we serve. Moreover, asides from regular in-service training and support, all staff members are provided at least 5 days of continued education leave a year to attend training courses offered by the Pacific Clinics Training Institute (free of charge to staff) or by other training facilities of their choice. One requirement is that all staff members are expected to attend training courses each year that are designed to enhance their cultural competence.

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CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
COMMUNITY-DEFINED PROMISING PROGRAM
RECOGNIZED BY: Los Angeles County Department of Mental Health Community-Defined Evidence (CDE) Program (reviewed by CiMH)

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
Resilience and Effectiveness of Asian Adolescents in Countering Hostility (REAACH) Program		
2. TYPE OF PROGRAM:		Universal prevention
	XX	Selective prevention
		Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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4. TARGET POPULATION

The target populations of the REAACH program are intermediate school age male and female Asian immigrant youths at high risk for exhibiting aggression and other behavioral problems. They are often themselves the victims of peer violence (such as bullying) and hostility because of their racial/ethnic background, inadequate English-speaking capability, and limited access to responsive and supportive services at home, at school, and in the community. Many of the target youths of the REAACH Program have recently moved to the United States (i.e. within five years), are "unaccompanied minors," and/or are experiencing such migration and minority stresses arising from their struggle to adapt to a new environment, culture, language, etc. In addition, they lack such supportive resources as family support and/or school connectedness to buffer them from hostile or violent peer victimization. As a result, these target youths are vulnerable to developing such psychoemotional and behavioral symptoms that would qualify them for such clinical diagnostic impressions as "Oppositional Defiant Disorder," 'Conduct Disorder," "Dysthymic Disorder," "Posttraumatic Stress Disorder," and "Major Depression."

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The overall goal or primary outcome achieved through the REAACH program is that of a reduction in violent or aggressive behaviors on the part of the target youths when dealing with peer conflicts. Such is attained by reducing such immigrant-specific stresses for the target Asian youths as devalued ethnicity, limited cultural models for effective peer conflict resolution, acculturation stress, and language difficulty, as well as by enhancing such protective factors for them as extended family support, school bonding, and bicultural competence.

6. CORE COMPONENTS

The primary strategies for the three core components of the REAACH Program are as follows: (**1) Theme-Based School and Community Anti-Bullying Education** (These are one-time and individually tailored presentations to schools and community groups to increase the support of these entities against peer aggression and violence, as well as help them identify Asian immigrant youths who are either the victims of such peer hostility or the perpetrators of such aggressive behaviors and who are appropriate for referral to the REAACH Program.); **(2) "Making Connections" Curriculum Groups** (This is a 14-week, culturally competent, age appropriate, manualized, and interactive conflict resolution curriculum offered in Chinese or Korean to the target youths for 1 hour per week in a group format. Rooted in the Asian cultural values of "collectivism" and "hierarchy" when it comes to interpersonal conflict resolution, this

curriculum supports the target youths in their development of such functional and bicultural conflict resolution skills as non-verbal anger management skills and the effective use of relational networks and supportive "intermediaries" in conflict resolution. These skills are further bolstered by curriculum activities [including an Asian "Rite of Passage" Ceremony] to enhance the cultural identity, bicultural competence, and self-efficacy of the program participants.) **(3) Youth and Family Support Service Linkage** (Linkage to culturally competent community service agencies and responsive school entities are offered, as needed, to the target youths and their families in the REAACH Program to help them address other biopsychosocial needs that impact the ability of the target youths to avoid using violence in their peer conflict resolution encounters.)

The level of care for the three core components of the REAACH Program are as follows: (**1) Theme-Based School and Community Anti-Bullying Education** (a series of one-time presentations to schools and community groups for education and outreach); **(2) "Making Connections" Curriculum Groups** (a 14-week skill-based and manualized curriculum offered to the target youth participants in a group format on a once a week basis for 1 hour per week); **(3) Youth and Family Support Service Linkage** (offered to the target youths, their parents, and/or their primary caregivers on an as needed basis)

7. CULTURAL RELEVANCE

To help outreach to the target Asian immigrant youth and their families, all the staff of the REAACH Program (especially the Youth Specialists) are hired from the bilingual and bicultural members of the target Asian immigrant communities to the extent possible. In addition, respected community leaders and members (including school officials and teachers) are enlisted to support the outreach and engagement efforts of this Program, including helping to link the REAACH Program with school and community entities with which they have connection to offer the "Theme-Based School and Community Anti-Bullying Education" presentations.

As noted in Section 6 above, each of the three core components or essential elements of the REAAACH Program has incorporated Asian cultural values and approaches in its design and content to ensure its appropriateness and relevance for the target Asian immigrant youth and their families. To ensure continuous input from the target population, a Youth Advisory Council (comprising of the target Asian immigrant youth members who are program participants or are graduates of the program) meets regularly to review and monitor program progress as well as offer feedback to ensure that the program is responsive and relevant to them and their peers in terms of addressing their issues in this area.

8. STAFFING

Each Youth Specialist can be expected to provide the core services of the REAACH Program to about 50 target youths (i.e., five groups with about 10 youths in each group). The desired qualifications of the Youth Specialists include their having at least a Bachelor's degree in Psychology, Sociology, Social Work, or related field, and their having previous experience working with youths in social group settings. The key roles of the Youth Specialist are to implement the core services of the REAACH Program (including its "Making Connections" curriculum). In addition, a Program Director (for staff supervision and program management) and adequate support staff (for clerical and other administrative support) are required for successful program implementation.

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

The services of the REAACH program are delivered primarily at the school sites, either during or after school hours. They can also be provided at community-based and culturally competent behavioral healthcare settings.

10. INDICATIONS OF EFFECTIVENESS

The REAACH Program was developed and refined through a SAMHSA-CMHS demonstration grant project. This REAACH Program (and the Asian LEADER Project, its predecessor) was evaluated using an experimental randomized

control trial design. The REAACH Program in general, and its "Making Connections" curriculum in particular, has been found to be effective in attaining the outcomes described in Section 5 above. For example, statistical data analyses reveal that, compared to their counterparts in the "control group," those Asian immigrant youths who have participated in the "Making Connections" curriculum groups engaged in significantly less "risky behaviors" (e.g. beating up others when angry, carrying weapons, threatening others with weapons, etc.) when dealing with peer conflicts.

11. AGENCY INFORMATION

As a division of Pacific Clinics (a private, nonprofit mental health and behavioral healthcare agency established in 1926), the Asian Pacific Family Center (APFC) has been offering a wide spectrum of mental health services, as well as behavioral health prevention and intervention services, to the Asian immigrant communities in the San Gabriel Valley area of Los Angeles County for 25 years. The program services at APFC are offered by a multilingual and multidisciplinary team off nearly 100 highly trained professionals, including psychiatrists, psychologists, social workers, counselors, nurses, parent, youth and family specialists, and community workers. In addition, the APFC Community Advisory Board (comprising of clients and parents, school and law enforcement officials, civic leaders and businesspersons, and other community stakeholders from both the local Asian immigrant and mainstream communities) provides input and support to ensure that the programs developed and offered by APFC are culturally and linguistically responsive to the local Asian immigrant families we serve. Moreover, asides from regular in-service training and support, all staff members are provided at least 5 days of continued education leave a year to attend training courses offered by the Pacific Clinics Training Institute (free of charge to staff) or by other training facilities of their choice. One requirement is that all staff members are expected to attend training courses each year that are designed to enhance their cultural competence.

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CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)
ASIAN PACIFIC ISLANDER STRATEGIC PLANNING WORKGROUP (API-SPW)
COMMUNITY-DEFINED PROMISING PROGRAM
RECOGNIZED BY: Los Angeles County Department of Mental Health Community-Defined Evidence (CDE) Program (reviewed by CiMH)

1. NAME OF COMMUNITY-DEFINED PROMISING PROGRAM:		
School, Community, and Law Enforcement (SCALE) Program		
2. TYPE OF PROGRAM:		Universal prevention
		Selective prevention
	XX	Early intervention
		Other (please specify)

3. NAME OF PROGRAM DEVELOPER – Please include all contact information

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4. TARGET POPULATION

The target population of the SCALE Program is intermediate school and high school age Asian male and female immigrant youths who are at high risk for, or are exhibiting the beginning signs of, delinquent behavioral problems. These behavioral problems include, but are not limited to, school truancy, academic failure, association with gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers). The background characteristics of these youths often include their having recently moved to the United States (e.g. within five years), and are having difficulty dealing effectively with the stress of adapting to a new environment, culture, language, etc. Many of these youths also report a lack of family support, prosocial peer network, and/or school connectedness. The behavioral, emotional, and academic problems that the target youth exhibit are often the precursors to more severe psychiatric disturbances that would qualify them for such clinical diagnoses as "Oppositional Defiant Disorder," "Conduct Disorder," "Major Depression," and substance abuse disorders.

5. WHAT ARE THE GOALS OF THIS PROGRAM?

The overall goal and outcome achieved through the SCALE Program is the improvement of the prosocial behaviors and lifestyles of the target Asian immigrant youths in order to effectively redirect their emerging life trajectory of delinquent behavior involvement. In specific, this strength-based Program focuses on helping the target youths foster such protective factors as bicultural identity development, effective intercultural conflict resolution, and prosocial decision making. It also is designed to address such dynamic delinquency risk factors as the low ability of the target youths to stay on task at school, poor family relationship, poor academic and/or vocational achievement, difficulty with anger or impulse control, antisocial attitudes, and association with antisocial peers. Along this line, emphasis of this Program is also on enhancing the structure and functioning of their families (through family case management with parents and primary caregivers), as well as the capacity of the school and law enforcement entities involved (through community education and consultation), to counteract some of the risk factors described above that lead to violence, gang involvement, and other antisocial behavior with these target youths.

6. CORE COMPONENTS

The SCALE Program uses four coordinated and integrated core components to attain the program outcomes described above. They include: **(1) Holistic Family Needs Assessment** . All the high-risk youths referred to the SCALE Program by school or law enforcement authorities or other community referral sources are assessed with respect to

their biopsychosocial needs in different life domains. This assessment process uses a semi-structured, strength-based, and culturally competent format to examine those life domains in which support to the target youth and family may be beneficial to enhance their family structure and prevent further delinquent and other behavioral problems. Based on this assessment and in collaboration with the appropriate school and law enforcement entities, a case management service plan is developed for implementation. **(2) Individualized Life Skills Mentoring and Counseling.** This is a time-limited [up to one year, but generally between 6 to 9 months] and individually tailored life skills "mentoring" and counseling process with the target youths. It is designed to address their unique constellation of delinquency risk factors and improve their prosocial attitudes and values. Depending on the needs of the particular youth as well as his/her identified protective factors and strengths, the specific "mentoring" and counseling activities may include those that help them with goal setting, effective problem solving, prosocial decision-making, positive bicultural identity development, and peer refusal skills. **(3) Family Case Management Service Linkage.** Based on the needs identified in the Holistic Family Needs Assessment process described above, appropriate and culturally competent service linkage is provided to the target youths and their families on an as-needed basis. Examples of these linkage services include assisting the parents and primary caregivers of the target youths negotiate through the school system and/or communicate with teachers regarding attendance problems or academic performance, helping the target youths and their families negotiate through the law enforcement system [e.g. probation], and connecting the appropriate parents with bicultural parenting education and family management classes. In addition, linkage with linguistically and culturally competent individual and family counseling or psychotherapy support in the community is also offered to target youths and families who may benefit from such services. **(4) Community Education and Consultation.** This community collaboration and capacity building program component is an integral part of the SCALE Program. It is designed to enhance the Program's responsiveness and effectiveness by strengthening the network of providers from different service systems (i.e. school, community service agency, and law enforcement) that must work closely together to support the prosocial behaviors and lifestyles of these target youths. It involves informational- and skill-based activities to enhance the collaboration between the Case Managers in the SCALE Program, the school authorities, and the law enforcement officials through cross-training and cross-consultation. Emphases of this program component include increasing each other's knowledge and skills in order to make appropriate early identification and referral of the target Asian immigrant youths to the SCALE Program, as well as enhancing community service capacity, coordination, and responsiveness.

7. CULTURAL RELEVANCE

To help outreach to the target Asian immigrant youth and their families, all the staff of the Asian MASTERY Program (especially the Case Managers/Family Specialists) are hired from the bilingual and bicultural members of the target Asian immigrant communities to the extent possible. In addition, respected community leaders and members (including school officials, teachers, probation officers, police officers, etc.) are enlisted to support the outreach and engagement efforts of this Program.

The SCALE Program was initially conceived and developed with input from local Asian community stakeholders and service providers, including, but not limited to, community leaders, school officials, probation officers, and police. It has been designed to specifically capitalize on those Asian cultural values and traditions associated with the "extended family" concept in its preventive intervention approaches. By re-creating through the cores services of this Program what is a culturally "natural" community practice, a stronger and more functional family system can be re-established for the high risk youth targeted by the SCALE Program. In specific, the SCALE Program has systematically incorporated features that are particularly responsive to those biopsychosocial needs and cultural issues of relevance to the target youth and their families. For example, when providing "Individualized Life Skills Mentoring and Counseling" services, the SCALE Program staff accommodate the diverse life experiences of the target youth by serving as the "cultural bridge" to them in their appropriate goal setting, effective problem solving, prosocial decision-making, peer-refusal skill learning, and acculturation and ethnic identity development. In addition, they serve as "cultural brokers" for the target youth and their families when offering "Family Case Management Service Linkage"

by functioning as mediators and facilitators with the various public service systems (e.g. school, health, law enforcement and social service). By serving this capacity, they help to constructively resolve those cultural issues that tend to complicate the behavioral and life problems of the target youth (such as the culturally sanctioned indirect communication style) can be constructively resolved.

8. STAFFING

For each caseload of 35 youths and families, a full-time Case Manager/Family Specialist is needed to provide the core services of the SCALE Program. The desired qualifications of these Case Managers include their having at least a Bachelor's degree in Psychology, Sociology, Social Work, or related field. In addition, their having bilingual and bicultural capabilities, as well previous experience working with Asian immigrant youths and families, would be preferable. The key roles of Case Managers/Family Specialists include completing a holistic family needs assessment, providing individualized life skills "mentoring," collaborating with school and law enforcement entities to implement a family case management service plan (e.g. coordinating community resource linkage to help the parents of the target youth negotiate through the school system, link them with appropriate bicultural parenting education, etc.), and facilitating cross-training and consultation services with school and law enforcement personnel (i.e., community capacity building). Moreover, to ensure successful program implementation, a Program Director, preferably with an advanced degree in Psychology, Sociology, Social Work, or related field, is preferred for staff supervision and program administration. Furthermore, adequate Support Staff is needed for clerical and other administrative support.

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

Services of the SCALE Program are offered primarily at school sites. The Case Managers/Family Specialists may also make home visits with the target youths and/or their family members as part of conducting the initial holistic family needs assessment and/or providing family case management services. Moreover, these needs assessment and case management services may at time be provided in community-based and culturally competent behavioral healthcare settings as appropriate.

10. INDICATIONS OF EFFECTIVENESS

As mentioned above, the SCALE Program was initially conceived and developed with input from local Asian community stakeholders and service providers. After initial funding through private donations to pilot this program, it has been funded by a Los Angeles County Probation Department Delinquency Prevention contract. It has been evaluated annually using a quasi-experimental (pre-post program participation) design with selected behavioral indices (e.g. school disciplinary action, school homework assignment submission, and probation involvement and violation) and the ratings from the "Youth Level of Service/Case Management Inventory (YLS/CMI)" developed by Hoge and Andrew (2003). These evaluation data have supported that there is a decrease in school disciplinary action and in missed homework assignment submission, as well as an improvement in school attendance leading to successful promotion to the next school grade level. In addition, YLS/CMI ratings by the Case Managers/Family Specialists, as well as the reports from the referring school and law enforcement authorities, also reveal positive changes on the part of the target Asian immigrant youths in the SCALE Program as indicated by a reduction in their level of risk for delinquent behaviors so that formal probation is avoided.

Data collection using some of the behavioral indices and ratings described above is still ongoing. Because of the lack of funding allocation for program evaluation in the Los Angeles County Probation Department contract, further efforts to increase the level of evidence to support the effectiveness of this Program cannot be carried out at this time. However, discussion is currently underway with local county government entities for funding to further analyze the data collected.

11. AGENCY INFORMATION

As a division of Pacific Clinics (a private, nonprofit mental health and behavioral healthcare agency established in

1926), the Asian Pacific Family Center (APFC) has been offering a wide spectrum of mental health services, as well as behavioral health prevention and intervention services, to the Asian immigrant communities in the San Gabriel Valley area of Los Angeles County for 25 years. The program services at APFC are offered by a multilingual and multidisciplinary team off nearly 100 highly trained professionals, including psychiatrists, psychologists, social workers, counselors, nurses, parent, youth and family specialists, and community workers. In addition, the APFC Community Advisory Board (comprising of clients and parents, school and law enforcement officials, civic leaders and businesspersons, and other community stakeholders from both the local Asian immigrant and mainstream communities) provides input and support to ensure that the programs developed and offered by APFC are culturally and linguistically responsive to the local Asian immigrant families we serve. Moreover, asides from regular in-service training and support, all staff members are provided at least 5 days of continued education leave a year to attend training courses offered by the Pacific Clinics Training Institute (free of charge to staff) or by other training facilities of their choice. One requirement is that all staff members are expected to attend training courses each year that are designed to enhance their cultural competence.

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