Asian-American and Pacific Islander Mental Health

Report from a NAMI Listening Session

By
Jei Africa, Psy.D.
Majose Carrasco, M.P.A.

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Executive Summary

Asian American and Pacific Islanders (AAPIs) are one of the fastest growing ethnic communities in the United States. Often referred to as the "model minority," AAPIs in the U.S. number approximately 15 million and represent more than 100 languages and dialects. Nearly two-thirds of AAPIs were foreign born, while 38 percent of Asian Americans (AAs) do not speak English fluently. Most AAPIs live and reside in metropolitan areas and tend to be highly urbanized, with California, New York, Hawaii, Texas and New Jersey having the largest concentration of AAPIs in the U.S.

AAPIs tend to be healthier than whites and other ethnic groups, but further studies reveal a large disparity in health status among subgroups. Research suggests that AAPIs face many barriers when seeking health and mental health services in their communities, including lack of access to care, language challenges and lack of culturally and linguistically responsive providers. Cultural beliefs and values play an important role in how AAPIs experience their mental health issues. The cultural adherence to avoidance of shame and stigma also remains a powerful influence on how AAPIs deal with mental illness—many individuals and families remain in denial or silence about their situation.

Recognizing the unique needs of the AAPI community, the National Alliance on Mental Illness (NAMI) Multicultural Action Center hosted an Asian American/Pacific Islander Mental Health Listening Session on Nov. 4-5 in Los Angeles. Twenty mental health leaders—people living with mental illness, family members, service providers, advocates, researchers and academics—from AAPI communities gathered to discuss current issues in AAPI mental health.

This proceedings report documents the diverse experiences of AAPIs around mental health, including the many barriers and gaps AAPI individuals and families face when accessing services. It also shares some recommendations on how mental health systems can address these barriers, highlighted below.

- Address the high levels of stigma associated with mental illness through culturally congruent outreach and education.
- Understand the role AAPI cultural values such as strong, tight-knit family connections and avoidance of shame and stigma play in seeking and adhering to treatment.
- Increase and encourage AAPIs to join the health and mental health workforce.
- Encourage and support opportunities for AAPIs living with mental illness and their families to be leaders and advocates in their communities.

- Disaggregate, or "unpack," the broad term AAPIs and conducting more research on AAPIs especially among subgroups.

- Foster primary care and behavioral health integration to make care more easily accessible to AAPIs living with mental illness.

- Partner and collaborate with local, national and federal institutions to build, sustain and strengthen efforts to address the gaps and barriers AAPIs face when seeking mental health services.

In addition, participants focused their discussion on NAMI's role in supporting efforts to improve mental health access and services to the AAPI community in the U.S, highlighted below.

- Help to educate AAPI communities about mental health, wellness and recovery.

- Train service providers to be more culturally and linguistically responsive to the unique experiences of AAPIs.

- Act as a leader in advocating for AAPIs' voices and rights.

Introduction

Asian American and Pacific Islanders (AAPIs) are the fastest growing ethnic minority in the United States. Yet, despite a longstanding historical and cultural presence, many AAPIs remain marginalized and continue to face numerous challenges when seeking mental health services.

Recognizing the unique needs of the AAPI community, the National Alliance on Mental Illness (NAMI) Multicultural Action Center, hosted an Asian American/Pacific Islander Mental Health Listening Session on Nov. 4-5 in Los Angeles. Twenty mental health leaders—people living with mental illness, family members, service providers, advocates, researchers and academics—from AAPI communities gathered to discuss current issues in AAPI mental health.

This proceedings report documents the dialogue that took place during this meeting and is intended to be utilized as a tool for others to initiate conversations with a variety of stakeholders, community groups, local leaders, funders, policy makers, etc. about the experiences and needs of the AAPI communities. It also can serve as a framework for program development for those who are involved in creating support service infrastructure at both the local and national levels.

After an initial overview of the AAPI community and the mental health issues it faces, the report provides a comprehensive account of the themes and recommendations that emerged throughout the meeting. Recommendations are given in broad categories in order to help local, state and federal agencies identify actionable steps for change. Many of the recommendations provided here are drafted for the mental health system as a whole. These considerations can greatly aid the mental health community in addressing disparities in mental health access and quality for AAPI individuals living with mental illness. The report closes with specific recommendations for NAMI that can be easily applied to other organizations and agencies.

This proceedings document is divided into two main sections: 1) Introduction and Background and 2) Critical Issues and Focused Recommendations. Each of these sections is subdivided into information, discussions and recommendations that have been identified as cohesive themes by the facilitator and the participants. Recommendations on how to address AAPI issues on a broader level (*e.g.,* the mental health system as a whole, government, provider organizations, advocacy organizations, etc.) begin on page 13, while recommendations aimed specifically at NAMI begin on page 23.

Listening Session

The objectives of this listening session were to bring together AAPI leaders and stakeholders to engage in an open dialogue with NAMI to:

- Identify priority needs and issues within their local communities;
- Elicit feedback and recommendations on how NAMI can successfully engage and help in addressing the identified needs; and
- Identify and share available resources and opportunities that participants can use in their work as advocates, researchers, providers or policymakers.

At the beginning of the day, many of the attendees shared their enthusiasm about being gathered with others "who looked like them…and shared their similar experiences and struggles." Many were appreciative of "being seen, heard and recognized."

Prior to the event, participants were expected to review a white paper describing the diversity within the AAPI community, its mental health status, barriers to seeking and receiving mental health services as well as initial recommendations to address these identified issues. This overview is provided below to serve as the context for the dialogue highlights and recommendations that follow.

Brief Overview of the Asian American and Pacific Islander (AAPI) Population

Asian American and Pacific Islanders represent one of the fastest growing and most diverse populations in the United States.[1] AAPIs refer to a diverse and heterogeneous group of people whose roots span from China to Papua New Guinea and from Pakistan to Hawaii.[2] Often lumped together as a unit, AAPIs are described as the "model minority" that generally fairs better among all other ethnic communities in terms of health and economic status. This practice of "lumping together" often hides the richness, diversity and complexity of experiences of this population, as well as the many barriers and challenges they face.[3]

Demographics

According to the U.S. Census Bureau, AAPIs are the fastest growing racial group in the nation. AAPIs in the U.S. number approximately 15 million, reflecting a dramatic increase from 2.1 percent in 1960 to 4 percent in 2010. Nearly two-thirds of AAPIs are foreign born and arrived in the U.S. since 1965. California has the largest and most diverse AAPI population in the country, where the California Department of Finance projects the rapid and continuous growth of AAPIs to 13.8 percent in 2050. Among AAPI subpopulations in the U.S., the Chinese (25.4 percent), Filipino (19.3 percent), Asian Indian (17.6 percent) and Vietnamese (11.7 percent) communities remain the largest.[3] A majority of Asian Americans are foreign born but Native Hawaiian and Pacific Islanders (NHPIs) are predominantly born in the U.S.[2,3,4]

Most AAPIs live and reside in metropolitan areas and tend to be highly urbanized. California, New York, Hawaii, Texas and New Jersey have the largest concentration of AAPIs in the U.S. The largest number of Asians and Pacific Islanders are in Los Angeles County (13.8 percent and .4 percent, respectively), while San Francisco County and Yuba County have the largest percentage of Asians (33.5 percent) and Pacific Islanders (1.6 percent).[3]

Little information is available about sexual orientation and same sex couples among AAPIs.

Language

AAPIs speak more than 100 languages and dialects. Many AA subgroups have a higher percentage of people with limited English proficiency (LEP) compared with other groups. About 38 percent of AAs do not speak English fluently.[3] U.S. Census data reflects that approximately 66 percent of AAPIs speak an Asian or PI language at home and about 35 percent of AAPIs remain linguistically isolated.[4] The percentage of persons five years or older who do not speak English at home varies among Asian American groups: 62 percent of Vietnamese, 50 percent of Chinese, 24 percent of Filipinos and 23 percent of

Asian Indians are not fluent in English.[5] Vietnamese, Tagalog and Chinese are the three most commonly spoken AAPI languages in the U.S.[2] In addition, a very large proportion of APIs over 65 years of age do not speak English fluently.

Educational Attainment

Education is highly valued in the AAPI community, yet educational attainment varies among the subgroups. In general, Asian Americans have the highest proportion of college graduates of any racial or ethnic group (44.1 percent of AAs have a bachelor's degree, compared with 24.4 percent of the total population.).[6] However, further analysis reveal disparities among subgroups—Southeast Asians have less than a high school diploma while a higher number of Indians (65 percent), Koreans (56 percent) and Chinese (51 percent) have at least a bachelor's degree.[2, 3]

Socioeconomic and Occupational Status

In 1993, the U.S. Census reported that AAPI families and non-Hispanic whites had comparable median incomes—$44,460 and $41,110 respectively. In 2000, the median household income for AAPIs jumped to $55,521 compared to $45,904 for whites, while the per capita income was $22,352 for AAPIs and $25,278 for whites. The degree of difference in income varied within the subgroups. Southeast Asians have a higher percentage of individuals living below the poverty line. Cambodians (47 percent), Hmong (63 percent), Laotians (51 percent) and Vietnamese have a higher rate of people who rely on public assistance and food stamps. By contrast, Asian Indians, Japanese and Chinese Americans tend to fare relatively better.[3, 7]

In 2000, AAPIs made up 15 percent of the nation's physicians and 9 percent of nurses. Fifteen percent were in service occupations (11 percent in skilled, semi-skilled and laboring occupations). Still, many immigrants remain in underpaid jobs with poor working conditions and are often uninsured.[2, 7]

Health

The average life expectancy for AAPIs is 80.3 years compared to whites at 75.1. Many studies note that overall health among AAPIs as a group tends to be better than that of whites and other ethnic groups. However, wide variations exist within subgroups. For example, Vietnamese Americans reported fair or poor health more often than either Chinese or Korean Americans. Further examination also reveals numerous areas where AAPIs have higher risks of illness: cancer, diabetes, heart disease, stroke and unintentional death (accidents).[8]

AAPI Mental Health

The U.S. Surgeon General's Report on Mental Health, Culture, Race and Ethnicity, published in 2001, provided a strong voice in acknowledging the strong influence of culture on the mental health beliefs and practices of ethnic minorities. The report also provided a framework for understanding the disparities in need, access, utilization and availability of mental health services among AAPIs, highlighted below. Highlights include:

- Low utilization of mental health services due to a number of cultural values such as avoidance of shame and stigma among AAPI subgroups and the lack of bicultural and bilingual providers;

- High rates of distress caused by trauma associated with political and economic turmoil (*e.g.,* Vietnamese, Cambodian, Laotian and Hmong refugees); and

- Diversity in presentation and expression of psychological and psychiatric distress among AAPIs (*e.g.*, somatization of symptoms).[9]

A more recent report stated that mental health among AAPIs is often difficult to assess due to the overlap of a number of factors such as the model minority myth, underrepresentation of AAPIs in epidemiological studies, mind-body conceptualization and role of racial discrimination, to name a few.[3] However, among all ethnicities, AAPIs tend to be the least likely to seek mental health services because of a variety of factors such as stigma, cultural impact of shame, language barriers, etc. Many studies suggest, however, that AAPIs have comparable rates of psychological distress to the general population.

Little is also known about the mental health needs of AAPI youth but studies suggest that there are higher rates of depression, anxiety and suicide among this group. Generational differences and conflict regarding family values and beliefs often cause additional strain, stress and anxiety problems for AAPI youth.[10]

A 2009 Center for Disease Control (CDC) report noted that 2.3 percent of AA adults aged 18 years and over experienced serious psychological distress,[11] with those who were below the poverty level reporting a higher rate of distress at 4.9 percent.[12] In addition, Vietnamese and Native Hawaiian and Pacific Islanders (NHPI) experience frequent mental distress at higher rates than other AANHPI groups. Korean, Filipino and Japanese rates of frequent mental distress are also high while rates for Chinese, South Asians and other Asians are lower.[3] Data from the Kessler 6-Scale, a measurement of psychological distress in the past 30 days, indicate that in California, Korean adults reported higher

rates of distress—similar to those of Latinos and African Americans—among Asian Americans as a whole, while South Asians and Japanese reported the lowest rates.[13]

One study suggests that older Asian American women have the highest suicide rate of all women aged 65 and older, with elderly Chinese American women exhibiting rates 10 times higher than those of white elderly women.[10]

The Office of Minority Health website is a source for facts about mental health issues in the AAPI community (below).

- Suicide was the fifth leading cause of death among AAs, compared to the ninth cause of death for white Americans.

- Older Asian American women have the highest suicide rate of all women over age 65 in the U.S. In 2005, the suicide rate for that group was 1.6 times greater than it was in the white population.

- Southeast Asian refugees are at risk for Posttraumatic Stress Disorder (PTSD) associated with their experiences before and after immigration to the U.S.[14]

Additional data from the National Asian Women's Health Organization (NAWHO) reiterates the salience of mental health issues in the AAPI community (below).[15]

- As a largely immigrant and refugee population, Asian Americans face economic and language barriers that prevent them from accessing health care and make them more vulnerable to advanced depression and other mental health disorders. Stress related to immigration and acculturation may also be a factor in developing depression. For example, suicide rates are higher for foreign-born Asian Americans than for those who are American-born.

- Seventy-one percent of Southeast Asians meet the criteria for a major affective disorder (which includes depression), with Hmong (85 percent) and Cambodians (81 percent) showing the highest rates. Moreover, 70 percent of Southeast Asian refugees are found to have PTSD.

- Three decades of research on mental health show that Asian Americans exhibit high numbers of depressive symptoms as well as confounding factors such as war experiences, abuse and stress.

- Among women ages 15–24, Asian American girls have the highest suicide mortality rates across all racial/ethnic groups.

- Asian American adolescent girls have the highest rates of depressive symptoms of all racial/ethnic and gender groups.

- Asian American college students report higher levels of depressive symptoms than white students.

- Asian American adolescent boys are twice as likely as whites to have been physically abused and three times as likely to report sexual abuse.

- Asian Americans have the lowest utilization for mental health services and are more likely to have psychotic diagnoses in inpatient and outpatient settings. Studies further show that Asian Americans have greater disturbance levels than do non-Asian clients.

Other studies suggest that many AAPIs are at risk for PTSD because of the trauma suffered before immigration caused by war, combat, torture, relocation or other repeated exposure to catastrophic events.[10]

Addiction Disorders (Gambling, Substance and Alcohol Use)
Compared to the general population, AAPIs show higher rates of gambling disorders. Twenty percent of Chinese Americans are said to be problem gamblers while Southeast Asian Americans have the highest lifetime prevalence of pathological gambling.[10]

Numerous studies suggest that alcohol and substance use is increasing significantly among AAPIs. However, patterns of substance and alcohol use among AAPIs subgroup vary tremendously. Among AAPIs, Japanese Americans seem to have the highest lifetime prevalence for alcohol abuse and Vietnamese Americans appear to be at high risk for heavy drinking. According to the National Asian Pacific American Families Against Substance Abuse, immigrants from Japan (62.1 percent) and Korea (53.2 percent) had a higher prevalence of past-month alcohol use than those from the Philippines (24.1 percent), China (28.4 percent), Vietnam (26.4 percent) and India (26.6 percent). In one study, data revealed that Filipino men were at a greater risk than Chinese men for a lifetime substance abuse disorder. Generational status was also associated with depressive and substance abuse disorders. Compared to first-generation women, the odds for substance use increased for second- and third-generation women.[16]

Among adolescents, AAPIs generally have lower rates of alcohol consumption and appear to be at lower risk for alcohol abuse compared to other ethnic communities. Despite this low rate, heavy drinking rose among AAPI youth from 0.5 percent to 0.9 percent in 2000.

Regarding tobacco use, one estimate lists that from 15,000 to 20,000 AAPIs will die every year due to tobacco-related illnesses. Currently, illicit drug use among Native Hawaiian/Pacific Islanders (9.1 percent) is higher than other racial/ethnic groups and stimulant-related hospital admissions for AAPIs are nearly four times higher than total hospital admissions.[17]

Culture-bound Syndromes

In addition to psychiatric disorders commonly accepted in the West, culture-bound syndromes also exist among Asian Pacific Islanders. For many AAPI, mental illness is so stigmatized that emotional and psychological distress is often expressed as more acceptable physical aches and pains. Understanding these syndromes (*e.g.*, cause, presentation of symptoms, prescribed treatment, etc.) can help pinpoint specific cultural nuances within the AAPI subgroups. For example, *hwa-byung*, or fire illness, is a Korean culture-bound somatization disorder that often develops in response to an emotional disturbance. *Amok* (from Indonesia and Philippines) is described as a dissociative disorder involving violent, aggressive or homicidal behaviors towards people or objects. *Shenjing shuairuo* is described as Chinese neurasthenia or "nerve weakness."[18]

Age of Immigration

An important factor when examining the onset of a mental disorder among AAPI individuals is its link to immigration. Earlier studies posit that a higher risk of mental health issues came with the challenges of moving to another county, and that once immigrants adjusted to their new home the risks decreased. However, recent data collected from more than 2,095 Asian Americans for the National Latino and Asian American Study extends past findings to include other factors such as age of immigration. Researchers found that compared to their U.S. counterparts, Asian immigrants who arrived at age 12 or younger were at greater risk for psychiatric disorders and substance abuse, while those who arrived before age 41 also had greater risk for mood disorders. Those who came after age 41 were likely to have experienced symptom onset before immigrating to the U.S. The complexities of immigration and the experiences of adjustment, acculturation and assimilation cannot be underestimated when looking at the AAPI community.[19]

Model Minority Myth

The popular conception of AAPIs as being more successful—academically, economically and socially—than any other ethnic minority in the U.S. is false. This stereotype dismisses the heterogeneity of AAPIs in terms of experience and culture. It also hides the actual experiences of racism and prejudice that many AAPIs experienced—and are still experiencing—in their communities (*e.g.*, work environment, neighborhoods, etc.). A 2000 report noted AAPIs earn less than their white counterparts even with the same qualifications and educational experience—AAPI men earn 10-20 percent less and AAPI women 40-50 percent less.[20] The model minority myth also perpetuates the stigma of seeking mental health services among AAPIs by masking the existence of psychological distress in their families and communities.[3, 20]

Barriers to Seeking Mental Health Treatments and Supports

Access to Health Care
Data from the NLAAS indicate Asian Americans do not seek quality care for their mental health problems. For example, among Asian Americans with a depressive disorder, 69 percent did not receive mental health treatment during the past year. Furthermore, while 33 percent of non-Latino whites with depression received quality depression treatment, only 14 percent of Asian Americans received such treatment.[21]

AAPIs contend with numerous factors that may threaten and/or worsen their mental health, including infrequent medical visits, language and cultural barriers, high levels of stigma associated with mental illness and the lack of health insurance.

Lack of health insurance coverage remains a barrier to many AAPIs. Many AAPIs work in small businesses or service industries that do not provide health insurance. In 1998, 21.1 percent AAPIs were uninsured compared to 11.9 percent of non-Hispanic whites. Thirty-two percent of AAPIs were classified as uninsured poor in contrast to 28.5 percent of non-Hispanic whites and 28.8 percent of blacks. Uninsured rates didn't change dramatically in 2009—17.2 percent of AAs, 15.8 percent of non-Hispanic whites, 21 percent of blacks and 32.4 percent of Hispanics were uninsured.[22] Insurance coverage among AAPIs also varies among the subgroups, but nationally about 21 percent of AAPIs lack health insurance. For example, a California report suggested that 33 percent of Korean Americans, 15 percent of NHPIs and 17 percent of both Vietnamese and other Asian groups were without insurance.[13] In addition to lack of coverage, many insurance providers do not cover alternative, traditional or culturally based medicine (*e.g.*, acupuncture or herbalists).[2]

Immigration status, especially for those who are undocumented, deters many individuals from accessing care. Eligibility and benefits are often determined by one's residency status, in many cases marginalizing those who are not able to provide documentation of their status. In reference to AAPI countries, the Department of Homeland Security Office of Immigration Statistics noted in 2009 that the largest number of undocumented individuals in the U.S. come from the Philippines (2 percent), India (2 percent), Korea (2 percent) and China (1 percent).[23]

Lack of Linguistically and Culturally Responsive Providers
Providers' general lack of knowledge and sensitivity to specific cultural nuances when working with AAPIs creates additional barriers to care. According to the U.S. Surgeon General's Report, there are approximately 70 Asian providers for every 100,000 AAPIs.[9] Because of the diversity of Asian languages and dialects, there aren't enough providers who can speak the languages of AAPI communities. Interpretation and translation of materials are not necessarily available for every single AAPI language and dialect.

This disparity between the need and availability of bicultural and bilingual service providers remains a significant gap in effective service delivery.[9] Linguistic and cultural competency are necessary for establishing a trusting relationship with people living with mental illness and family members. A 2009 report examined the perceived unequal treatment experienced by AAPIs when receiving medical care. The results showed that 4-11 percent of all AAPIs and Native Hawaiians perceived that they were targets of race-based discrimination.[3] Poorly trained and culturally incompetent providers not only lead to misdiagnosis and negative health outcomes but also add to the cultural mistrust that might exist among members from the AAPI community towards others.

Health Beliefs

Religious and spiritual philosophies have a strong influence on AAPI health beliefs and practices. Conceptions of health—and mental health—among AAPIs differ from their white counterparts along numerous variables: ethnic heritage; level of acculturation; religious beliefs; age and rural, urban or regional origin, to name a few. Many AAPI subgroups share common views closely tied to religious beliefs, while others have a more naturalistic theory of balance (*e.g.*, body and mind, hot and cold states, environment, etc.) Pacific Islanders also significantly differ from Asian Americans. For example, Samoans believe that physical ailments can be caused by interpersonal conflicts, failure to carry out social roles or disobedience from God. Native Hawaiians take on a more holistic view; believing that there is no separation between the body and the mind and that illnesses are caused by an imbalance in these two forces.[7, 20, 24]

Similar to the influence of religion and spirituality on health, beliefs about causes of mental illness differ within different AAPI subgroups. For some, mental disorders are caused by one's own wrongdoings in the past, the will of dead ancestors, a weakness of spirit, God's punishment and/or the loss of one's soul. For others, it is a result of an imbalance of the mind, body and spirit or disharmony in the vital humors in the body (*e.g.*, bile, phlegm and breath) representing elements in the universe.[25]

Help-seeking Behavior

Help-seeking behavior is deeply influenced by health beliefs among AAPIs. Traditional medicine is the most accepted form of intervention, especially for somatic complaints, but most AAPIs believe that personal and family affairs should not be discussed with a stranger. The belief that seeking help, from public benefit programs for example, might be frowned upon by others is common in the AAPI community. Many studies reported that AAPIs in the U.S. tend to present with acute levels of distress or severe symptoms because they did not seek help in a timely manner for problems that could have been easily addressed and treated.[21] Dr. Stanley Sue reported in 2002 that many AAPIs tend to avoid health or mental health agencies or welfare agencies because it means a public admission of familial difficulties. In terms of emotional difficulties, seeking outside help is the last resort for many AAPI families.[21]

Lack of awareness and knowledge about mental illness can also be a factor in the low mental health utilization rates of AAPIs. Western concepts and descriptions of mental

disorders are not as familiar among AAPI communities, who are used to their own cultural understanding of their symptoms. Increasing awareness about Western concepts of mental health should be balanced with knowledge about each community's indigenous explanation of the situation.

Avoiding Shame and Stigma

The concept of shame and loss of face in the community is a critical factor in understanding low utilization of services among AAPIs. Many consider stigma as being the major obstacle preventing AAPIs from seeking help. Shame, known as *hiya* among Filipinos, *mentz* among the Chinese, *haji* among the Japanese and *chaemyun* among Koreans, is a concern about saving face that motivates individuals and families in the AAPI community.[19,21] The protection of the family's reputation often takes precedence over all help-seeking behaviors. Many individuals with mental health disorders often deny or conceal their symptoms for fear they will be rejected by their families or communities. Avoiding shame and saving face are both very difficult to address because they are intimately tied to AAPI values.

Exclusion of Traditional or Indigenous Providers by the Western System

Many AAPIs continue to seek treatment from traditional or indigenous healers from their communities. However, Western health care systems have been slow to include these providers as part of their system and refuse to recognize these practitioners as equal and credible counterparts. Many who do not seek out traditional Western providers will visit local herbalists, priest, healers or shamans for treatment.[7]

Experience of Prejudice and Racism

AAPIs, like other ethnic communities, have experienced—and continue to experience—racism and prejudice in the U.S. Many AAPIs report experiencing racism and prejudice in different settings (*e.g.*, while at work or in social settings). For example, in California, more AAs and NHPIs reported experiencing discrimination "sometimes," "often" or "all of the time" compared to the state average.[26] These experiences can add more distress to an already challenging life situation (*e.g.*, the immigrant experience).

Many AAPIs also distrust public institutions such as government, health care and human services agencies because of a variety of factors: past negative experience, personal biases and institutional barriers.

Lack of Research

Few studies have focused on the AAPI community and even fewer studies have examined its subgroups, often creating a generalized and inaccurate picture of the experience and needs of AAPIs in the U.S. Their heterogeneity and relatively small representation in the U.S. population make it challenging to get adequate and representative samples from the AAPI community. Even when there are surveys and studies, the diversity of socio-cultural context—level of acculturation, language, country of origin—among AAPIs makes it difficult to develop generalizations.[21]

Listening Session Dialogue

An initial discussion on the above topics, including the barriers faced by many AAPI individuals, families and communities, set the groundwork for the day. Participants stressed that many AAPIs do not have equal access to health and mental health care and that the quality of the services, when received, has historically been inadequate. Participants highlighted the critical role that culture plays in how AAPIs define, experience and respond to emotional distress or illness, often influencing whether or not an individual or family even acknowledges that it exists.

In the larger group discussion, participants were asked to reflect on three general questions pertaining to:

1. The strategies for addressing the barriers AAPI communities face in seeking mental health services;

2. The role people living with mental illness and family members play in changing the negative perception of mental health; and

3. The role NAMI can play to address the indentified barriers.

Four major themes emerged from this dialogue: advocacy, engagement, meaningful inclusiveness and education and support. Participants then divided into working groups focused on each of these four themes in order to provide concrete recommendations to address the issues. Each small group presented a summary of their discussion for the consideration of the full group and additional recommendations were subsequently made.

The following section highlights the group's dialogue exploring the initial three questions as well as the recommendations made on the four identified themes.

Critical Issues and Focused Recommendations

1. How the Mental Health System Can Improve Access and Quality of Care for AAPI Communities

Participants discussed at length topics such as stigma, outreach and engagement, education, workforce development, research and data, the need for collaboration and most importantly, the influence and role of culture in relation to mental health. The following recommendations were drafted for the mental health system as a whole.

A. Recognize the Role Culture Plays in Mental Health

Throughout the dialogue, it was clear that culture plays a significant role in shaping and influencing an individual's as well as a community's response to life circumstances—particularly in relation to mental health and health behaviors. The AAPI community boasts distinct cultural traditions, beliefs and values that need to be clearly recognized, understood and incorporated in the mental health arena. Participants expressed the significance of being sensitive and responsive to culture and of embedding this awareness in every conversation and decision specifically affecting AAPIs. For example, having culturally sensitive and responsive media messages about mental illness (*e.g.*, news briefs, PSAs, billboards, ads) makes learning easier, especially for AAPI individuals who have very strong cultural beliefs and attitudes.

Additionally, there is a wide diversity of experiences within the AAPI community. Acknowledgment of this variety is critical for providing effective and efficient services responsive to particular needs and influential cultural factors.

Institutions should be aware of the important role culture plays in all aspects of mental health. They should also be more culturally and linguistically responsive and respectful to the individuals they serve. Participants commented that mistrust of these institutions persists for many reasons such as past negative experiences endured from the government, both personal and historical. In the past, AAPIs have been subjected to many discriminatory practices, including being placed in concentration or internment camps or subjected to exploitative labor practices—forced labor in the case of Chinese Americans—that have lingering impacts upon cultural groups today.

Participants acknowledged that due to the diversity of the AAPI community (in terms of language, country of origin, immigration, socioeconomic status, educational status, etc.), representing all the ethnic subgroups might be a challenge. They noted, however, that AAPIs experience stigma, generational issues, prejudice and discrimination within groups in different ways. For this reason, having what they called a "balanced approach" to representation of both communities and perspectives at different levels is key. The

group stressed the importance of having the AAPI voice in every dialogue and in every situation where decisions that impact their community are made.

Key recommendations:

- Understand the pivotal role and influence that cultural values such as strong, tight-knit family connections and the avoidance of shame and stigma play among AAPIs when seeking and adhering to treatment.

- Understand that AAPIs face unique challenges and stressors due to immigration, discrimination and other factors such as the need to assimilate and acculturate and the experience of having to learn English as a second language.

B. Address Racism and Discrimination at all Levels

Participants stressed the importance of acknowledging historical practices, racism and policies that have discriminated against AAPIs. Though, the need does not stop there. More importantly, there is a call to inspect current practices, whether personal or institutional, that continue to negatively impact the lives and overall health—particularly mental health—of AAPIs. Participants advocated for multilevel changes in public institutions, especially in the area of social services. The prevailing attitude needs to be moved away from "business as usual" and toward a reprioritizing of goals and programs that can be more responsive to their communities while nurturing and supporting a diverse representation of leadership.

Key recommendations:

- Acknowledge and address past and current policies and practices that are racist and discriminatory against AAPIs.

- Empower community leaders to be strong advocates to influence systems change.

C. Promote Cultural Strengths

Participants stressed the importance of recognizing the strengths and resilience of AAPIs—as individuals, families and communities. Many of these strengths, such as the importance of loyalty and family obligations, parental sacrifice, spirituality, compassion and a strong adherence to cultural values, help many AAPIs deal with difficult life events that they may experience—leaving their home country or living far from family, for example. These values play a crucial role in helping AAPIs overcome common challenges or barriers and succeed on a path of mental health recovery.

D. Address Stigma

Participants underscored the importance of addressing negative notions associated with mental health issues in the AAPI community, such as avoidance and shame due to stigma. Many agreed that addressing stigma requires framing mental health within other related issues such as physical health or wellness beliefs, help-seeking behaviors (including traditional or indigenous healers), educational success, work productivity, social and familial harmony and spirituality. Given the diversity within AAPIs, creating a message that resonates with many individuals, families or communities may be challenging, but it is possible. A primary recommendation for addressing this challenge is to focus on values and beliefs that many AAPIs share, holistic approaches and strong familial connections.

Key recommendations:

- Focus on AAPI cultural strengths as part of messaging directed to address health and mental health; create anti-stigma campaigns that feature positive images and role models of AAPIs living with mental illness, including the message that AAPIs belong to a strong and resilient community.

- Develop social marketing tools that are culturally congruent and commonly associated with AAPIs such as using red envelopes during Chinese New Year or employing familiar symbols (*e.g.*, yin and yang, the number 8, the Lokahi triangle).

- Reduce diagnostic labeling and reframe the effectiveness of prevention and treatment to include cultural beliefs and practices.

- Highlight success stories of recovery framed in AAPI cultural values (*e.g.*, educational success, work productivity and social and familial harmony).

E. Outreach and Engagement

Participants had many ideas about outreach, spanning from unconventional educational approaches and activities to the importance of understanding specific cultural nuances within AAPI subgroups. In terms of visibility, “being present in (our) community” garnered strong agreement from the attendees. “You have to be in our churches, in our grocery stores… and attend our community events,” one participant noted. Additionally, many agreed that social media, such as YouTube, Facebook and Twitter, could be an effective way to get the message across, especially when addressing age-appropriate issues and information. In addition, training AAPI community leaders to be mental health ambassadors (*e.g.,* health navigators or first responders) creates a strong message that partnerships are being built between different sectors of the community.

Successfully reaching out to AAPI communities requires the building of trust. Often, outreach workers are tempted to jump into partnerships right away without understanding that relationships are built over time. Highlighting the importance of building trust and credibility with AAPI groups, participants found having a continued presence in the community to be crucial. For example, outreach workers should not only be seen during special events but should participate in everyday gatherings and activities in the community. Others suggested not only having brochures and handouts at events, but also taking time to talk to individuals and families about issues that, at first, may not seem related to mental health. Many noted that this type of outreach is a crucial first step to establishing a relationship and building rapport. Additionally, staff doing outreach should also be open to sharing personal experiences, as this can be very helpful in connecting with individuals. Participants agreed that shame and stigma prevent AAPIs, especially those who live with mental illness, from admitting their situation. When they talk to someone who shares their experience, the barriers start breaking down.

Attendees found a great significance in the distinction between engagement and outreach. Engagement tends to happen over a period of time, requires trust and is often the basis for a more a meaningful relationship than an outreach opportunity.

A grasp of complex cultural beliefs and practices is a necessary tool for reaching out. An ignorance of cultural factors such as religious or spiritual philosophies and the avoidance of shame and stigma can have detrimental effects on well-meaning efforts to engage with AAPIs. Help-seeking behavior is greatly influenced by health beliefs. For example, somatic symptoms are regarded as more acceptable than emotional or psychological complaints. Since seeking help also can be seen in a negative light, perhaps considered a sign of weakness, many AAPIs avoid discussing their difficulties outside the family.

One participant shared that along with understanding culture, “being creative helps in outreach.” For example, sponsoring an educational table at dragon boat races or creating clubs for dim sum or tea are ways to bring people together to talk about mental health related issues and can be very effective.

Key recommendations:

- Develop a national strategy to improve outreach to and engagement of the AAPI community by using strong cultural messages and community members as ambassadors.

- Use social media such as YouTube, Facebook and Twitter to reach a broader audience, especially for hard-to-reach communities.

- Focus on cultural strengths such as familial connectedness, interdependence and spirituality to connect with AAPIs.

- Create outreach and engagement initiatives that build community skill and capacity as a strategy to empower community members in their lives and their communities.

F. Education

Awareness and education were identified as a key factors in addressing barriers in the AAPI community. Many participants stressed the need to educate individuals, families and communities about the importance of health—incorporating mental health as part of overall health. AAPIs (providers included) should also be educated about wellness and recovery—that people with mental health and addiction issues can have meaningful lives and relationships and function successfully in their communities.

Because the avoidance of shame plays an important role among AAPIs, those who do live with mental illness remain in silence, thus perpetuating the notion that mental illness does not exist within their communities. For this reason, it is important to educate the community about mental illness—its signs, symptoms and treatments—utilizing first-person stories about recovery and hope. Sometimes knowing that one is not alone and that someone else is going through a similar situation can make a significant difference.

Participants felt that the goal was not to simply correct misconceptions and increase awareness but to promote a fundamental change in attitudes about mental health. “It’s about hope and recovery,” was a common sentiment. This change in attitude, one participant added, “can lead to less stigma which in turn can influence how one seeks and accepts help.”

Key recommendations:

- Educate AAPI communities about the importance of mental health as part of overall health.

- Develop and implement a national AAPI mental health education campaign based upon AAPI cultures.

- Develop culturally and linguistically appropriate marketing and education materials, paying particular attention to the language used (for example, using “squeeze ball” versus “stress ball” because of the negative connotation of having stress).

- Focus on inclusive, empowering and non-stigmatizing messages that AAPIs can relate to—wisdom and wellness, for example, or spiritual balance and emotional health.

- Train communities and providers about wellness, recovery and hope.

G. Workforce Development

A robust health care workforce is needed to address the diverse needs of the AAPI community. Developing creative strategies about how to encourage young AAPI adults to choose career paths in mental health is crucial in addressing the increasing needs of AAPIs in the U.S. Efforts to increase bilingual and bicultural mental health workforce and advocates, including peer educators and leaders—especially among AAPIs—should be an ongoing priority. Financial incentives (such a loan repayments) could help recruit AAPIs into pipeline programs.

In addition to increasing AAPI representation within mental health professions, it is imperative to improve the cultural competency of service providers and agencies. Building multicultural knowledge, improving cultural competence skills, changing attitudes and understanding one's own biases are critical components when working with the AAPI community. Providers and advocates need to be educated about specific cultural nuances within the AAPI community, especially mental health and health-related beliefs and behaviors. These areas include indigenous or traditional healing practices such as seeking out spiritual leaders and herbalists. Participants encouraged providers to be mindful and respectful of these "non-Western" perspectives.

Key recommendations:

- Develop a linguistically and culturally responsive workforce.
- Ensure the availability of professionally trained interpreters and translators for Limited English Proficient (LEP) speakers.
- Develop and implement a recruitment plan to encourage bilingual and bicultural AAPIs to join the mental health field.
- Increase the education and training about the cross-cultural understanding of illness within the AAPI community that is made available for providers and researchers—for example, some AAPIs believe that illness equals character weakness or may be a punishment or "karma" from past wrongdoings.
- Increase the number of bilingual and bicultural AAPI peer educators as well as the funding for employment opportunities for people living with mental illness.
- Improve cultural competence among providers by training about specific cultural nuances within the AAPI community, including the impact of historical experiences and cultural factors on help-seeking behavior among AAPIs.
- Train providers to promote trauma-informed care in response to the negative experiences that refugees and immigrants may face when leaving their home country.

H. Research and Data

Since AAPIs in the United States make up only about 4 percent of the population and are a very diverse and constantly changing group, it is difficult to get adequate samples for research studies. However, it is imperative to conduct more research and studies about AAPIs and their subpopulations in order to truly understand the needs and experience of this community. The lack of studies about the experiences of AAPIs living with mental illness in the U.S. creates the notion that, as one participant said, "We don't exist." To many participants, addressing this misconception remains a crucial priority, one that can help break down many of the barriers that AAPIs face.

More national, collaborative and longitudinal studies should be planned to develop a more complete and accurate view of the issues affecting AAPIs, especially those related to health and mental health. The compilation and analyses of these studies can be invaluable in addressing the complex needs of the AAPI community. Researchers argue that larger-scale and longitudinal studies are needed to investigate the mental health problems and needs of AAPIs, paying special attention to the sociocultural diversity—acculturation, geographic location—of this community.

Research findings suggest that the broad AAPI "race" categories commonly reported tend to paint a distorted—and often contradictory—picture of the mental health status of AAPIs in the U.S., especially among its subgroups. All the participants agreed that having only aggregated data about the many groups falling under the AAPI umbrella contributes to the negative and destructive notions of the model minority stereotype. "This stereotype really adds to the problems we face…We are not all the same…We have different needs," stated one participant. Disaggregation of data will help provide more accurate information and allow AAPIs to break free from their perception as a model minority.

Results of longitudinal and national studies should be shared among academics, researchers, service providers and the community. Often, a divergence persists between research and practice. Although there has been a noticeable increase in published works about AAPIs in recent years, a gap still exists between how the information is shared among all stakeholders in the discussion about AAPI needs. One participant saw practitioners as "needing to understand research and data…Likewise, researchers need to be informed by front-line service providers."

Participants shared that researchers often identify "evidence-based practices" based on their sample populations without adequately testing the validity of these practices in the AAPI community. Evidence-based practices should be guided and informed by community-based participation and involvement. Being intentional about these shared efforts will benefit communities and, in turn, can help individuals' decision-making, especially when their loved ones are in distress.

Additionally, data and research can be used as tools to de-stigmatize mental health in the AAPI community. One must be mindful of the information's presentation and audience, however, making sure it benefits both individuals and families.

Key recommendations:

- Develop a consistent appreciation for the richness and diversity of the AAPI community.
- Conduct more research on AAPIs to learn more about prevalence and risk factors of mental illness.
- Disaggregate the current AAPI grouping and modify data collection to include the smaller subpopulations.
- Evaluate the applicability of evidence-based practices in AAPI communities to ensure they are culturally competent and validated with community participation.
- Identify and describe AAPI community-driven programs as best practice models that increase access and quality of care.
- Create opportunities to share research, data and effective practices among providers, researchers, academics and communities through conferences, ethnic focused dialogues, etc.
- Provide information on cutting-edge practice and treatment options that is age-appropriate and suitable for people living with mental illness and their families utilizing venues such as AAPI newspapers, television, medical and psychological associations.

H. Collaboration and Integration of Services

Many attendees agreed that collaboration and partnerships would facilitate the success of the above recommendations. Participants suggested working with community leaders and local and grassroots organizations that have the pulse and trust of the community. AAPI-targeted media outlets were mentioned as a powerful ally and tool, especially in getting the message out to hard-to-reach populations and in helping to de-stigmatize mental health issues.

Others suggested working with educational institutions such as schools and universities to include health and mental health topics in the curriculum. In addition, teachers and school staff (such as administrative staff and activity monitors) could be trained about the signs and symptoms of distress so that they can know how to respond appropriately. Participants added that Parent-teacher Associations (PTAs) could be an important partner

in the schools, especially because of the high value that AAPI families place upon getting an education.

Participants also noted that developing and strengthening partnerships with primary care physicians and clinics could be helpful in addressing the stigma associated with mental health among AAPIs. Other attendees also stressed that primary care and behavioral health integration is an important step toward reducing disparities in care and increasing access for AAPI individuals. Locating primary care and behavioral health services in the same place makes it more logistically convenient and culturally acceptable for AAPI individuals and families to get the appropriate services. This "one-stop shop" model might improve access to mental health services.

Partnerships can create louder voices, especially in advocacy and influencing policy change, while helping to integrate inefficient and defragmented health care systems. Listening session participants emphasized the importance of building partnerships over time. Just like with outreach, consistent and meaningful efforts to collaborate should be tempered with patience, flexibility and respect—many AAPIs carry a deep-rooted sense of mistrust toward other communities or institutions (either public or private) that influences their behaviors and interactions.

The quality of the partnership was also significant to the attendees. Many underscored the importance of meaningful collaboration, which means creating and sharing leadership equally among all parties and creating a safe space to engage in honest dialogues. These are valuable ingredients for the sustainability and success of efforts and partnerships.

To address the broader issue of health and mental health disparities, it is crucial to establish strong partnerships with national, state and local government agencies. Despite current financial challenges, funding for programs that address the needs of vulnerable populations remains available in the form of transformation grants and culturally targeted grants. Thinking outside the box—in terms of effective programs and practices (*e.g.*, evidence-based versus practice-based)—is necessary when partnering with government agencies.

Advocacy groups can help institute changes in funding and budgeting for resources allocated to public benefits and health care. Participants suggested collaboration with agencies and institutions that focus on health, mental health and wellness such as the American Psychological Association, American Psychiatric Association, Asian Pacific Islander American Health Forum, Asian American Psychological Association, National Asian American Pacific Islander Mental Health Association, National Asian Pacific American Families Against Substance Abuse and California Pan-Ethnic Health Network, as well as non-health focused agencies such as the National Asian Pacific American Women's Forum and The Asia Foundation. Local ethnic associations can also be tapped as partners in ongoing efforts to educate and address mental health stigma.

Key recommendations:

- Partner with local grassroots AAPI organizations that have the pulse and trust in the community.
- Build and strengthen opportunities to network and collaborate, especially with faith-based communities (such as Buddhists and Christians), schools and community centers.
- Collaborate with teachers and school staff in educational institutions to create a shared learning environment for health and mental health issues.
- Foster primary care and behavioral health integration to make treatment more easily accessible to AAPIs living with mental illness.
- Link to and work with local Asian-focused media.
- Collaborate with agencies that focus and support the promotion of mental health and wellness in the AAPI community.
- Partner with national, state and local government agencies to allocate funds that support projects that address mental health disparities.

2. Role of AAPIs Living with Mental Illness and Family Members

The desire to be "part of the solution" was a strong sentiment from the group. Participants agreed that people living with mental illness and their family members play a vital role in all aspects of the mental health system and its transformation. In particular, the group agreed with the three statements below.

- People living with mental illness and their families are crucial to changing the negative perception of mental health in the AAPI community.
- People living with mental illness and their family members play an important role in outreach and education efforts.
- People living with mental illness and their family members are now—or can be—strong and successful political advocates.

Many participants found sharing personal mental health stories to be an effective way to give a face to issues that are often considered taboo. Many AAPIs who have mental health issues often remain isolated from their communities when they could be interacting with others who care about them and may be able to provide help and support.

However, the group warned that it is crucial to create a safe space for people to be able to share their stories. A participant from Hawaii shared a successful setting for allowing people living with mental illness to share their experiences—a project called "Talking Story" in which participants come together to tell their stories as part of their own healing process. Listeners come to understand that each individual's story is unique and that each journey is as important as any other.

There are others with lived experience—as people living with mental illness, family members or both—who are ready to take their advocacy a step further and become more involved in broader systems change. Participants agreed that those who decide to become mental health advocates must acquire certain skills. These include the ability to evaluate oneself, to speak in public and act as a peer mentor and counselor, to identify steps for reducing isolation and burnout as well as learning to encourage collaboration, to name a few. Many agreed that having role models and mentoring opportunities can help those who need the extra support to master these skills.

Supporting the leadership potential of those who have any variety of lived experience was also a strong sentiment among the participants. It is necessary to create better infrastructure to support AAPI peer leaders—as teachers, advocates and service providers. Teaching individuals to be advocates for themselves and others is a vital component of ensuring that issues are addressed in different areas of the mental health field.

Given the crucial roles people living with mental illness and family members play in the mental health system, opportunities such as mentoring programs and leadership academies should be made available to all who are currently working in the mental health field—including people living with mental illness and family members. Promotions and career pathways should be made available as well.

Key recommendations:

- Provide opportunities—paid or unpaid, short-term or long-term—for AAPIs living with mental illness and family members to be meaningfully involved in outreach and education, program monitoring and administration, advocacy, etc.

- Increase training and skill-building opportunities for AAPIs living with mental illness and family members.

- Develop mentoring programs and strong networks as a way to sustain the roles of AAPIs living with mental illness in the promotion of health and wellness.

- Create leadership opportunities for AAPIs living with mental illness in all dimensions of the mental health system.

3. Role of NAMI

After focusing on the mental health system as a whole, participants were challenged to think about NAMI's role in moving the agenda forward. They agreed that NAMI can play a key role in addressing the barriers many AAPI individuals, families and communities face when dealing with mental health issues. NAMI's voice and influence in the public education of mental health could help spread the message of wellness and recovery in the AAPI community if activated in a culturally competent manner. In terms of education and information, NAMI can be a clearinghouse of quality information for AAPI communities, promoting the accurate translation and adaptation of materials and providing direction to state organizations and affiliates as they take on these goals.

As a national leader, NAMI can build strong and sustainable partnerships, continue to facilitate dialogues and conversations on AAPI mental health and encourage the sharing of resources and networking opportunities. As the strongest grassroots mental health advocacy organization in the country, NAMI can also influence policy changes and funding decisions to improve AAPI mental health. NAMI's role can be categorized by the principles below.

A. Act as an Information Hub

There was consensus from the group about the vital role NAMI can play in addressing the barriers many AAPI individuals, families and communities face when seeking support regarding their mental health. Participants highlighted the wealth of resources NAMI provides through programs, trainings and conferences as well as its publications and brochures. They also shared that NAMI's website is an invaluable hub for resources providing a broad range of information including causes, signs and symptoms of mental illness, treatment options and other resources. However, they added that NAMI's offerings are seen as being tailored for "more for the mainstream community" rather than for racial, ethnic and cultural communities. "NAMI is not seen as much in the AAPI community," commented one attendee. It was also pointed out that there are very few NAMI materials available in Asian languages and that these materials may not be appropriately translated. This is particularly alarming since, as a participant pointed out, "translation without consideration to the cultural context can be very harmful and can add to the existing stigma." Participants agreed that NAMI's website can be improved to include translated information in different AAPI languages, historical and cultural content on AAPIs, links to local and national AAPI focused agencies and more.

Key recommendations:

- Add ethnic-specific AAPI information and resources to the NAMI website, including links to local organizations (such as the Filipino Mental Health Initiative in the San Francisco Bay Area and the New York Coalition on Asian

Mental Health) and national organizations (such as the Asian American Psychological Association and National Asian Women's Health Organization).

- Develop mental health materials and brochures that are culturally and linguistically competent for AAPIs.

- Add videos of stories from AAPI individuals and families who have been touched by mental illness to the NAMI website.

B. Strengthen Advocacy Efforts

Participants defined advocacy as "representing or pushing forward the issues of those who cannot represent themselves." For these participants, discussion about power, privilege, inclusion and representation in different leadership areas was important. They agreed that supporting advocacy at different levels—local grassroots as well as national and global efforts—remains monumental in addressing the gaps in services among AAPIs.

Because of NAMI's longstanding history and credibility in the mental health advocacy arena, many participants suggested that focusing and strengthening NAMI's multicultural voice to influence political leadership should be a priority. "It's not just about having the voice," one participant stated, "it's also about influence." Developing political influence means having representatives who care about putting AAPI mental health issues on the agenda, as well as allocating resources to address these issues. Participants shared that many communities of color, AAPIs included, perceive NAMI's approach and values to be very mainstream and Westernized. This Eurocentric approach continues to make AAPI advocates feel unseen and unheard. NAMI should focus attention on issues specific to AAPI communities—such as disparities in care and quality of care—as part of its advocacy agenda and public policy platform.

Key recommendations:

- Encourage more studies and research on AAPIs, especially those focusing on the effects of immigration, acculturation and discrimination.

- Establish an AAPI advisory group representing multiple communities that can help offer guidance to NAMI's efforts.

- Develop toolkits, curricula and programs aimed at empowering AAPIs to become strong leaders and advocates.

- Ensure that programs, policies and practices take into consideration the historical experiences of AAPIs.

- Provide continued support and advocacy for the funding of health and mental health efforts, particularly those addressing treatment disparities for AAPIs and other multicultural communities (such as the Mental Health Services Act in California or universal health care reform).

- Advocate for AAPI inclusion and representation in all aspects of the mental health system.

- Advocate for the inclusion of AAPI-specific mental health programs as part of the implementation of the Health Care Accountability Act.

C. Promote Diversity at the NAMI Affiliate Level

While participants praised NAMI's grassroots strength, they pointed out the lack of diversity and inclusion at the local level. Attendees suggested that NAMI could recommend resources that local NAMI affiliates might provide in their communities while encouraging programs and practices that specifically address diverse cultural contexts and backgrounds. Participants also wondered how local NAMI affiliates choose and implement programs, pointing out that there doesn't seem to be a "consistent and standard" menu of services offered across the country. While there are a few affiliates that have AAPI-specific efforts and programs, most do not seem to have culturally and linguistically competent resources and supports for AAPI individuals and families.

Key recommendations:

- Increase visibility of NAMI among AAPI communities.

- Establish standardized protocols for the implementation of programs among local NAMI affiliates.

- Encourage local NAMI affiliates to develop culturally and linguistically competent AAPI programming and support (for example, by incorporating the importance of spiritual philosophies in the Provider Education program or using AAPI rituals in the Family-to-Family program).

D. Promote Cultural Competency

Many AAPIs continue to be guided by traditional and religious beliefs that shape not only how they define their distress and their illness but also how and when they choose to seek help. Encouraging providers and institutions to be culturally competent was another issue on which participants strongly urged NAMI to take a lead. They argued that advocating for cultural and linguistic responsiveness in the mental health field is a critical step to addressing the needs of AAPIs. "Including diversity and embedding the role of culture in what we do both help to create an environment that welcomes everyone," stated one

attendee. The tendency is for the most widely available approaches and practices to fit more the "mainstream" community—and experiences that many AAPIs cannot relate to.

Key recommendations:

- NAMI should become a culturally competent organization and increase efforts (such as outreach and policies) to address the needs of AAPI communities.

- NAMI should lead the efforts to promote cultural competency as a value for health and mental health organizations.

E. Foster and Sustain Innovative Collaborations

Participants suggested that NAMI can play a bigger role in building bridges in the AAPI community, especially by linking multicultural resources together (for example, having joint dialogues between Cambodian, Laotian and Vietnamese people who are living with mental illness around the country). Participants also suggested that collaborations should also be developed among organizations unrelated to health or mental health, such housing, employment and local businesses. NAMI can also act as a powerful resource in building and creating coalitions for AAPIs living with mental illness, especially in local communities.

Key recommendations:

- Expand the Listening Session model to focus on AAPIs, bringing together other stakeholders who have not been included in the discussion, such as traditional healers, faith-based organizations, artists and media, etc.

- Encourage local affiliates to sponsor dialogues and networking about AAPI health and mental health issues.

- Highlight AAPI-focused practices and programs during the NAMI convention and other events.

Moving Forward and Action Steps

This listening session was a first step in working to address the barriers many AAPI individuals and families face when confronted with mental illness. It was intended to bring together leaders with different perspectives from across the country to share stories, identify barriers, provide solutions and—most importantly—to network. Many of the participants felt rejuvenated, hopeful and encouraged after discovering that they are not alone and that there are others out there upon whom they can rely.

As mentioned at the beginning, this proceedings document should be utilized as a tool to initiate further conversations with a variety of stakeholders, community groups, local leaders, funders and policy makers about the experiences and needs of AAPI communities. Its purpose is to help NAMI and local, state and federal agencies develop AAPI-appropriate services and supports in order to equip the mental health system as a whole to meet this community's needs. Lastly, this proceedings document acts as a reminder to all advocates, particularly people living with mental illness and family members, of the many ongoing efforts and work being done at different levels to improve access and services to AAPIs individuals dealing with mental health challenges.

Since convening the listening session, NAMI's Multicultural Action Center has begun exploring the steps needed to address some of the issues identified by the participants. Throughout 2011, NAMI's Multicultural Action Center will continue to focus attention on the AAPI community, starting out with the initial steps listed below.

- Re-launch NAMI's AAPI Leaders Group. This group will act in an advisory role to NAMI on AAPI mental health issues, helping to monitor the implementation of the NAMI Standards of Excellence and providing a variety of leadership-building and networking opportunities throughout the year.

- Develop culturally competent materials on AAPI mental health, working with members of the AAPI Leaders Group to identify topics and help develop materials.

- Translate and adapt the newly developed materials into three of the most spoken Asian languages in the United States.

- Revamp the AAPI mental health section on the NAMI website.

- Host training webinars on becoming successful multicultural advocates. These trainings will focus on advocacy related to eliminating disparities in mental health for diverse communities. While the webinars will not target AAPIs only, NAMI

will certainly reach out to this community to encourage participation in the trainings.

- Host a national webinar on AAPI mental health issues in May in honor of Asian American Pacific Islander Heritage Month. This event will help NAMI call attention to this community, encourage cultural competence in service delivery and highlight best practices in AAPI mental health. NAMI will work in partnership with its AAPI Leaders Group to identify the topics and speakers for the webinar.

- Feature a workshop on AAPI mental health at the NAMI 2011 Convention, spotlighting this report and the efforts that have taken place to date. This workshop will also allow opportunities for networking and feedback.

NAMI is committed to working with the AAPI community in order to provide advocacy, education and support. As with any major effort, some of the above recommendations will be implemented in the short term (during the next 12 months) while others will require a longer time frame.

In addition to these efforts related to the AAPI community, important changes are taking place at NAMI that will have implications in the long-term future of the organization.

- In 2010, the NAMI Board of Directors approved Standards of Excellence for the entire organization, including standards on diversity and inclusion. These standards require that:

  "*NAMI at all levels shall actively recruit, engage and serve members from every race, culture, ethnicity, age, religion, socio-economic status, sexual orientation, gender and disability and shall not discriminate against any person or group in the requirements for membership, provision of service or support or in its policies or actions.*"

  During the next couple of years, NAMI will work closely with its state organizations and affiliates to help them implement this and other provisions of the Standards of Excellence. The AAPI community will be one of the communities receiving special attention throughout the process as states and affiliates become more diverse and inclusive.

- In 2010, recognizing the importance of incorporating issues that affect the AAPI and other multicultural communities, the NAMI Board of Directors approved new sections on cultural competence and disparities for the organization's public policy platform. Since this document guides the organization's advocacy efforts, it signals a greater focus on this important area of advocacy for AAPI communities.

This report will serve as a road map as NAMI moves forward to becoming more inclusive of AAPI communities. NAMI thanks the participants of the AAPI listening session for taking part in this important first step. NAMI looks forward to working with these individuals, other AAPI organizations and the wider mental health system in order to successfully address the mental health needs of AAPI communities.

Participants from this listening session agree that the barriers AAPIs face when seeking services—especially in health and mental health—are enormous. Further, major reform and overhaul are needed in many levels—individually, institutionally and socially—to provide quality early intervention, access and care for AAPIs living with mental illness. Participants also agreed that this document is not intended to be the definitive solution to the many problems AAPI face, but rather one of the many tools needed to move toward making these much-needed changes a reality.

Sources

1 U.S. Environmental Protection Agency. (2008). *Asian American and Pacific Islander Primer*. www.epa.gov/aapi/primer.htm.

2 Ro, M. (2001). *Overview of Asian and Pacific Islanders in the United States and California*. www.communityvoices.org/Uploads/om3gfk55hhzyvrn00n4nerbf_20020828090003.pdf.

3 Ponce, N., Tseng, W., Ong, P., Shek, Y.L., Ortiz, S. and Gatchell, M. (2009). *The State of Asian American, Native Hawaiian and Pacific Islander Health in California Report*. www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=329.

4 U.S. Census Bureau. (2010). *Asian/Pacific American Heritage Month: May 2010.* http://www.census.gov/newsroom/releases/pdf/cb10-ff07.pdf.

5 U.S. Census Bureau. (2003). *Language Use and English-Speaking Ability: 2000.* http://www.census.gov/prod/2003pubs/c2kbr-29.pdf.

6 U.S. Census Bureau. (2003). *Educational Attainment: 2000*. www.census.gov/prod/2003pubs/c2kbr-24.pdf.

7 Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department. (2003). *A Provider's Handbook on Culturally Competent Care: Asian and Pacific Islander Population, Second Edition.*

8 U.S. Office of Minority Health Resource Center. (2010). *Highlights in Minority Health and Health Disparities, Asian American and Pacific Islander Profile*. www.cdc.gov/omhd/highlights/2010/HMay10.html.

9 U.S. Department of Health and Human Services. (2001). Mental Health Care for Asian Americans and Pacific Islanders. In *Mental Health: Culture, Race and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. www.surgeongeneral.gov/library/mentalhealth/cre/.

10 American Psychiatric Association. (n.d.). *Healthy Minds, Healthy Lives: Asian American/Pacific Islanders.* www.healthyminds.org/More-Info-For/Asian-AmericanPacific-Islanders.aspx.

11 Center for Disease Control. (2009). Table 6.1. In *Health United States, 2008.* www.cdc.gov/nchs/fastats/asian_health.htm.

12 Center for Disease Control. (n.d.). *Health Data for All Ages*. http://205.207.175.93/HDI/TableViewer/tableView.aspx?ReportId=455.

13 Kuo, W.H. (1984). Prevalence of Depression among Asian-Americans. *Journal of Nervous and Mental Disease*, 172, 449-457.

14 Office of Minority Health. (n.d.). *Mental Health and Asians.* http://minorityhealth.hhs.gov/tempplates/content.aspx?lvl=3&lvlIID=9&ID=6476.

15 University of Hawaii. (n.d). *NAWHO Factsheet on Mental Health and Depression Among Asians.* www.hawaii.edu/hivandaids/Mental_Health_and_Depression_in_Asian_Americans.pdf.

15 California Health Information Survey. (2010). *2010 Survey*. www.chis.ucla.edu.

16 National Asian Pacific American Families Against Substance Abuse. (n.d.). *Fact Sheet*. www.napafasa.org/resources/factsheets.htm..

17 Cochran, S., May, V., Ortega, A., Alegria, M. and Takeuchi, D. (2007). Mental Health and Substance Use Disorders among Latinos and Asian American Lesbian, Gay, and Bisexual Adults. *Journal of Consulting and Clinical Psychology*, 75, No. 5, 785-794.

18 American Psychiatric Association. (2000). *Diagnostic and Statistical Manual Text Revision-IV*. Washington, D.C.: Author.

19 Takeuchi, D., Alegria, M., Jackson, J. and Williams, D. (2007). Immigration and Mental Health: Diverse Findings in Asian, Black, and Latino Populations. *American Journal of Public Health*, Vol. 97, No. 1.

20 Woo, D. (2000). *Glass Ceilings and Asian Americans.* Walnut Creek, Calif.: AltaMira Press.

21 Sue, S. (2002). "Asian American Health: What We Know and What We Don't Know". In Lonner, W.J., Dinnel, D.L., Hayes, S.A. and Sattler, D.N. (Eds.), *Online Readings in Psychology and Culture*. Bellingham, Wash.: Center for Cross Cultural Research, Western Washington University.

22 U.S. Census Bureau. (2010). *Income, Poverty and Health Insurance in the U.S., 2009.* http://www.census.gov/prod/2010pubs/p60-238.pdf.

23 U.S. Department of Homeland Security. (2009). *Estimates of Unauthorized Immigrant Population Residing in the U.S.: January 2009.* www.dhs.gov/xlibrary/assets/statistics/publications/ois_ill_pe_2009.pdf.

24 Du, N. (2006). Asian American Patients. In Lim, R. (Ed.), *Clinical Manual for Cultural Psychiatry*. (pp. 69-117). Arlington, Va.: American Psychiatric Publishing, Inc.

25 Dana, R., Gamst, G. and Der-Karabetian, A. (2008). *The California Brief MultiCultural Training Scale*. Thousand Oaks, Calif.: Sage Publications.

26 Asian and Pacific Islander American Health Forum. (n.d). *Ethnic Health Assessment for Asian Americans, Native Hawaiians and Pacific Islanders in California.* www.apiahf.org/images/stories/Documents/publications_database/policy_ca_ehap_aanhpi.pdf.

NAMI Asian American and Pacific Islander Mental Health Listening Session

Participant List

John Aldam
Can Empowerment Group
Western Mass.

Ellen Awai
Council for Native Hawaiian Advancement
Honolulu

Kavoos Bassiri
President and CEO
RAMS, Inc.
San Francisco

Edwin Chandrasekar
Executive Director
Asian Health Coalition
Chicago

Teddy Chen
Director
Mental Health Bridge Program
Charles B. Wang Community Health Center
New York

Rocco Cheng
Corporate Director of Prevention and Early Intervention Services
Pacific Clinics
Arcadia, Calif.

Dixie Galapon
Director, Mental Health Services
Union of Pan-Asian Communities
San Diego

Jonathan Griggs
Peers Envisioning and Engaging in Recovery Services
Oakland, Calif.

Arpana Inman
Associate Professor, Counseling Psychology
Lehigh University
Bethlehem, Pa.

Nancee Lee-Allen
Executive Director
NAMI Orange County
Santa Ana, Calif.

Russell Lim
Health Sciences Clinical Professor
U.C.-Davis School of Medicine
Department of Psychiatry and Behavioral Sciences
Davis, Calif.

Maggie Luo
Program Coordinator
Chinese American Mental Health Outreach Program in New Jersey
NAMI New Jersey
North Brunswick, N.J.

Tri Nguyen
Teacher
NAMI Family-to-Family
San Diego

Eliza Noh
Coordinator, Associate Professor
Asian American Studies Program
California State University
Fullerton, Calif.

Jeong Shin
Program Manager
NAMI San Francisco
San Francisco

Khang Tran
Family-to-Family Coordinator
NAMI Orange County
Santa Ana, Calif.

Can Truong
Center for Education Empowerment
National Asian American Pacific Mental Health Association
Moab, Utah

Amanda Wang
Producer and Founder
RethinkBPD
New York

Ming Wang
Project Director
Utah CAN/PASSAGE
Utah Division of Substance Abuse and Mental Health
Salt Lake City
.

Michael Zarate
Community Based Case Manager
Hawaii Certified Peer Specialist
Hana, Hawaii

Facilitator
Jei Africa
Health Equity Initiatives Manager
Behavioral Health and Recovery Services
San Mateo County Health Department
San Mateo, Calif.

NAMI Staff
Majose Carrasco
Director
NAMI Multicultural Action Center
Arlington, Va.

NAMI Staff
Marin Swesey
Coordinator
NAMI Multicultural Action Center
Arlington, Va