



NAMI

Asian American & Pacific Islander Outreach Resource Manual



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A Word from NAMI's Multicultural Action Center

It has been documented time and again that communities of color do not have equal access to mental health care, and when they do receive treatment the quality is often poor. Asian Americans and Pacific Islanders are no exception. Although Asian Americans and Pacific Islanders are comprised of many different ethnic groups speaking several languages, it holds true that while mental illness is not always recognized and treatment is not always sought among Asian Americans and Pacific Islanders, it is an alarming problem in these communities. For example, young Asian Americans have the highest suicide rate out of all racial and ethnic group in the country. Furthermore, many Asian Americans experienced severe trauma before emigrating to the U.S. or during the process of fleeing their homes, and social anxiety, depression, and trauma-related disorders are common.

One of the principles guiding NAMI's work is to improve access to treatment for individuals and families affected by mental illness. Therefore, it is only appropriate that NAMI develop strategies that will address the many barriers faced by Asian Americans and Pacific Islanders. The purpose of this manual is to provide valuable information about the current mental health status of Asian American and Pacific Islanders and resources for NAMI and other organizations who want to engage this community in a meaningful and culturally appropriate manner. Chapter 1 explores the specifics of mental illness in Asian American and Pacific Islander communities. Chapter 2 discusses cultural competence and describes model programs and best practices in the field that have proven to be successful. Chapter 3 details outreach steps and highlights NAMI affiliate efforts that can serve as examples to others looking to do similar work.

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Sincerely,

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Chapter 1

Asian Americans and Pacific Islanders & Mental Health

To date, little research has been done about mental health issues in Asian American and Pacific Islander populations. While the overall prevalence rate of diagnosable mental illness among Asian American and Pacific Islanders is similar to that of the Caucasian population, Asian Americans and Pacific Islanders have the lowest rates of utilization of mental health services among ethnic populations. In order to fully understand mental illness in the Asian American and Pacific Islander community, one must first examine the current mental health status of this group, as well as cultural norms and implications.

Asian Americans and Pacific Islanders

Exerts from *Diverse Communities. Diverse Experiences. The Status of Asian Americans & Pacific Islanders in the U.S.* By, The Asian & Pacific Islander American Health Forum. www.apiahf.org

Asian Americans and Pacific Islanders (AAPIs) are an extremely diverse group of peoples, originating from almost fifty different countries and representing over 100 languages and major dialects. Each group possesses a distinct culture, history, and immigration pattern that defies easy categorization or generalization. While some AAPI families have lived in the U.S. for many generations or have arrived as students or professionals, others have come during more recent waves of immigration and include refugees fleeing persecution or violence. Still others, such as Native Hawaiians, are indigenous populations to what is now the U.S.

Some highlights:

- ◆ Since 1990, the Asian American and Pacific Islander population has increased in size, diversity, and geographic distribution.
- ◆ The Census 2000 counted 11.9 million Asian Americans and almost 900,000 Native Hawaiians and other Pacific Islanders.
- ◆ In addition to overall increases, disaggregated data reveal that many of the smaller ethnic groups, such as Bangladeshis, Pakistanis, and Tongans, are growing at faster rates than the larger ethnic groups, leading to greater diversity in the composition of the AAPI population.
- ◆ Data on geographic distribution, furthermore, indicate that the highest growth rates are often in states that have historically not had large Asian American or NHOPI populations.
- ◆ These demographic changes obviously pose new challenges to health agencies and other service providers that have not previously served these populations in significant numbers.

- ◆ The wide spectrum of variation between and within AAPI groups results in significant differences that impact health.

Who are “Asian Americans”?

The U.S. Census Bureau’s definition of “Asian” refers to those people in the U.S. who have their “origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam).”

Who are “Native Hawaiians and Other Pacific Islanders”?

The U.S. Census Bureau’s definition of “Native Hawaiian and Other Pacific Islander” refers to people having “origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.” The Census Bureau further identified three distinct NHOPI cultural groups — Polynesian, Micronesian, and Melanesian. Data on NHOPIs in this report refers to those living in the 50 states, and does not include those residing in the U.S. affiliated territories of Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands.

Population

Using inclusive numbers, the Asian American population in the U.S. grew 72% between 1990 and 2000, far exceeding the growth rate of general population (13%), Whites* (5%), Black or African Americans (21%), and Hispanic or Latinos (58%).

Asian Americans:

In 2000, the Asian American population grew to 4.2% of the nation’s population (11.9 million), an increase from 1990 when Asian Americans and NHOPIs, taken together, comprised 2.9% of all Americans.

Native Hawaiians and Other Pacific Islanders:

Census 2000 counted 874,414 people in the U.S. who identified themselves as NHOPI, constituting 0.3% of the total population. This count reflects 398,835 people reporting as NHOPI alone and an additional 475,579 reporting as NHOPI and one or more other races (multi-racial).

Geographic Concentration

Asian Americans:

Although a high proportion of Asian Americans continue to reside in California, Hawaii, and New

York, they were an increasing presence in other geographic areas across the country. The table below shows the top ten states with the highest numbers of Asian American residents:

Top 10 States with Highest Number of Asian Americans

State Population (Inclusive)

California	4,155,685
New York	1,169,200
Hawaii	703,232
Texas	644,193
New Jersey	524,356
Illinois	473,649
Washington	395,741
Florida	333,013
Virginia	304,559
Massachusetts	264,814

- ◆ While 75% of Asian Americans resided in these ten states, approximately half (51%) resided in the three states of California, New York, and Hawaii.
- ◆ By region, 49% of Asian Americans lived in the West, 20% in the Northeast, 19% in the South, and 12% in the Midwest.

Native Hawaiians and Other Pacific Islanders:

The table below lists the ten states with the highest numbers of NHOPIs. An estimated 80% of NHOPIs resided in the following states:

Top 10 States with Highest Number of NHOPIs

State Census 2000 Inclusive Counts

State Population (Inclusive)

Hawaii	282,667
California	221,458
Washington	42,761
Texas	29,094
New York	28,612
Florida	23,998
Utah	21,367
Nevada	16,234
Oregon	16,019
Arizona	13,415

- ◆ By region, approximately 73% of NHOPIs lived in the West, 14% in the South, 7% in the Northeast, and 6% in the Midwest. A majority of NHOPIs (58%) lived in Hawaii and California.

- ◆ Hawaii was home to 282,667 NHOPIs (23% of the state’s population) while California was home to 221,458 NHOPIs (0.7 % of the state’s population).

Geographic Growth

Asian Americans:

- ◆ Interestingly, the highest growth states for Asian Americans were not the highest population states, pointing to the emergence of new settlement and migratory patterns.
- ◆ Nevada (219%), North Carolina (173%), Georgia (171%), Arizona (130%), and Nebraska (124%) exhibited some of the highest Asian American growth rates since 1990.

Native Hawaiians and Other Pacific Islanders:

- ◆ The states with the highest growth rates for NHOPIs included both the traditionally high population states as well as some newer emerging areas.
- ◆ California, with the second largest NHOPI population in the nation, showed one of the lowest rates of growth for NHOPIs while states like Nevada showed astounding growth.
- ◆ The NHOPI population there increased 461% while the state population grew by 66%.

Language Data

According to Census 2000, there were over 4.0 million AAPIs in the U.S. who have limited English proficiency (LEP). Limited English proficiency (LEP) is defined in as individuals who do not speak English “very well.”

Speaks A Language Other Than English At Home

Asian Americans:

- ◆ Census 2000 revealed that 73% of Asian Americans spoke a language other than English in their homes. This represents a rate that is four times higher than the national average (18%) and more than twelve times the rate for Whites (6%).
- ◆ When disaggregated by sub-group, the results show that many sub-groups had rates that were significantly higher.
- ◆ In seven subgroups, over 90% spoke a non-English language at home.

Native Hawaiians and Other Pacific Islanders:

- ◆ Overall, 35% of NHOPIs spoke a language other than English in their homes. This rate is almost twice the national average (18%) and almost six times that of Whites (6%).
- ◆ Among NHOPIs, Fijians were the most likely to speak a non-English language at home (82%), followed by Tongans (75%), Samoans (53%), Guamanians/Chamorros (37%), and Native Hawaiians (13%).

Limited English Proficiency**Asian Americans:**

- ◆ According to Census 2000, there were 3,962,270 LEP Asian Americans in the U.S.
- ◆ The five largest LEP sub-groups by total number were: Chinese (1,127,008), Vietnamese (674,939), Korean (525,338), Filipino (451,166), and Asian Indian (391,833).
- ◆ Asian Americans were over four times more likely to be LEP than the general population (36% vs. 8%) and more than eighteen times more likely than Whites (2%).
- ◆ Unsurprisingly, many of the same sub-groups with high rates of speaking non-English languages at home also had high rates of LEP.
- ◆ Over half of all Vietnamese, Hmong, Cambodians, Bangladeshis, Laotians, and Taiwanese living in the U.S. were LEP.

Native Hawaiians and Other Pacific Islanders:

- ◆ NHOPIs were six times more likely to be LEP than Whites (12% vs. 2%) and one-and-a-half times more likely than the general population (8%).
- ◆ Data indicate that 29% of Tongans, 26% of Fijians, 16% of Samoans, 13% of Guamanians/Chamorros, and 3% of Hawaiians were LEP.

AAPI Mental Health

Exerts from *Cultural Diversity Series: Meeting the Mental Health Needs of Asian and Pacific Islander Americans*. Prepared by Evelyn Lee, L.C.S.W., Ed.D. National Technical Assistance Center for State Mental Health Planning (NTAC), February 2002.

Cultural Characteristics Relevant to Mental Health Needs and Utilization Partners

Conceptualizations of Mental Illness

Culture plays an important role in shaping health beliefs, coping strategies, help-seeking behavior, and conceptualizations of emotional difficulties and mental illness. Although many highly acculturated Asian Americans endorse more Western-oriented health beliefs and practices, many foreign-born immigrants and refugees in Asian American communities are guided by traditional religious and health beliefs. Additionally, it is commonly assumed that all people have the same basic mental processes, but recent findings in neurobiology indicate that this is not true (Castillo, 1997). Dispelling the assumption that all peoples' brains function in the same basic ways, despite differences in learning, memory, and cognition across cultures, has significant implications for understanding mental illness. First, it encourages an expanded cross-cultural understanding of illness, and second, it permits varying interpretations of people's subjective experiences of illness. It may be helpful to public mental health planners and providers to understand the belief systems and experiences that inform the way some API persons understand and respond to mental health concerns. Asian cultural explanations of some mental illnesses, such as schizophrenia and somatization, are discussed below.

Schizophrenia

Generally speaking, there are seven popular API cultural explanations of factors that may contribute to the development of schizophrenia (Lee, 1997):

- ◆ *Imbalance of “yin” and “yang,” and disharmony in the flow of “qi.”* In traditional Chinese medicine, humankind is viewed as a microcosm within a macrocosm. The energy (“qi”) within each human being is interrelated with the energy of the universe. The presence of emotional problems is thought to result from an imbalance of “yin” and “yang” (bipolar life forces), or from an excessive accumulation of “qi” (life force energy).
- ◆ *Supernatural intervention.* Psychotic symptoms such as hallucinations and delusions are often seen as a form of spiritual unrest meted out to the individual through the agency of a “ghost” or vengeful spirit. From this standpoint, symptoms are a sign of punishment, most likely due to the transgression of family rituals in ancestor worship (Lin & Lin, 1980).

- ◆ *Religious beliefs.* Mental illness may be viewed as “karma” caused by deeds from past lives, or as punishment from God.
- ◆ *Genetic vulnerability or hereditary defects.*
- ◆ *Physical and emotional strain and exhaustion.* This can be caused by external stresses such as a business failure, ending of a love affair, or death of a family member.
- ◆ *Organic disorders.* Mental illness is conceptualized as a manifestation of physical disease, especially brain disorders, liver diseases, or hormonal imbalances.
- ◆ *Character weakness.* Mental health is achieved through self-discipline, exercise of will power, and the avoidance of morbid thoughts. It may be assumed that a person who is vulnerable to emotional problems, having been unable to develop this discipline, was born with a weak character.

Somatization

Somatization, the expression of mental distress as symptoms of physical illness when no organic cause for illness can be found, is common among Asian Americans.

- ◆ There is a strong belief in the unity of body and mind among Asian Americans, and this somatic process may grow out of a holistic view of the body and mind. Various organs are associated with different emotions. Joy, for example, emanates from the heart. Sorrow is associated with the lungs, anger with the liver, and fear with the kidneys.
- ◆ Emotional problems are frequently explained in traditional Chinese medicine as caused by weak kidneys or heart. Or, conversely, excessive emotions are thought to weaken the function of the associated organs. Thus consumers may believe that physical symptoms are an expression of emotional distress and/or may present for mental health services with physical complaints.
- ◆ Mental health providers must be cautious in their interpretation of somatic complaints. Asian Americans who present physical symptoms may be suffering from genuine organic problems rather than a somatic expression of psychological stress.
- ◆ Using the Hamilton Rating Scale for depression, Cheung, Lau, and Waldemann (1981) studied symptoms of depression expressed by Chinese patients at a primary care clinic. Among those who were depressed, the most frequently endorsed symptoms were “feeling tired and fatigued,” “pains and aches,” and gastrointestinal or cardiovascular symptoms. Tension, nervousness, agitation, and restlessness also were endorsed by a majority of the depressed group. None of the depressed patients came to the clinic with initial complaints of sadness, unhappiness, or depressed mood.
- ◆ From the traditional Chinese patients’ perspective, their chief problem is not depression but “neurasthenia.” Neurasthenia—a syndrome of exhaustion, weakness, and diffused bodily complaints believed to be caused by inadequate physical energy in the central nervous system

(Kleinman, 1998)—is an official diagnosis in China and one widely used by traditional herbalists in Chinatowns in the United States.

Conceptualizations of Mental Illness in Pacific Islander Cultures

For many cultures of the Pacific, there is no direct translation for mental illness because emotional and psychological problems are often integrated holistically with biological, cognitive, and spiritual functions.

- ◆ In Native Hawaiian culture, “Hawaiians do not use the phrase ‘mental illness’ but instead state that *pilikia* (trouble) occurs” (Ginny Kinney, personal communication, February 1, 1996).
- ◆ Emotional and psychological concerns are viewed in a broader context as an imbalance that may be occurring in key relationships between the individual, family, natural, and spiritual realms (Andrade, 1989; Mokuau, Lukela, Obra, & Voeller, 1997).
- ◆ Similarly, in Micronesian culture, depressive emotions are understood to be connected to the loss of important relationships. The emotion *lalomweiu* (loneliness or sadness from the loss of a loved one) appears to be the closest thing to the Western idea of major depression (Castillo, 1997).
- ◆ Expanded notions of mental illness and wellness also encourage varying interpretations of people’s subjective experiences. For example, the subjective experience of talking with deceased family members should not necessarily lead to a diagnosis of schizophrenia if providers understand that having visions of the dead is recognized as a part of grieving in Native Hawaiian culture (Pukui, Haertig, & Lee, 1972).

Values and Acculturation Levels

Members of the many different Asian and Pacific Islander American groups arrived in, or became part of, the United States at different times and for different reasons. Thus they exhibit varying degrees of acculturation, from the very traditional to very “Americanized.” More traditional individuals or families identify with Eastern or Pacific native cultural values, while more acculturated ones identify with Western cultural values.

Some broad generalizations can be made about Eastern and Western values that may help readers to recognize differences in world view and behavioral expectations. Table 1 describes some of these differences (Lee, 1997). Note that these differences are intended to be generalizations that clearly do not apply to all individuals in each culture; rather, most people fall somewhere within this East-West continuum. Within any given Asian American family, in fact, it is likely that various family members may identify with different elements of each cultural perspective, depending especially on their ages and acculturation rates. Although these generalizations contrast Eastern and Western values, those delineated for the Eastern perspective have broad applicability for Pacific Islanders.

Eastern (agricultural) systems: Traditional society values	Western (industrialized) system: Modern society values
Family/group oriented	Individual oriented
Extended family	Nuclear/blended family
Multiple parenting	Couple parenting
Primary relationship: parent-child bond	Primary relationship:marital bond
Emphasis on interpersonal relationship and harmony	Emphasis on self-fulfillment and self-development
Status and relationships determined by age and role in family	Status achieved by individual's efforts
Well-defined family members' roles	Flexible family members' roles
Favoritism toward males	Increasing opportunities for females
Authoritarian orientation	Democratic orientation
Suppression of emotions	Expression of emotions
Fatalism/karma	Personal control over the environment
Harmony with nature	Mastery over nature
Cooperative orientation	Competitive orientation
Spiritualism	Materialism, consumerism
Past, present, and future orientation	Present, future orientation

Within this continuum, there are numerous variations. A model has been proposed that describes five acculturation styles among Asian American families (Lee, 1997). These five family types are hypothetical constructs offered to help increase understanding of the complexity of Asian American families.

The Traditional Family

- ◆ Traditional families usually consist entirely of family members who were born and raised in Asian

countries and who continue to hold strong beliefs in the types of traditional Eastern values described above.

- ◆ They usually speak in their native languages and dialects at home and typically reside in ethnic Asian communities such as Chinatown, Koreatown, Japantown, or Little Saigon in major cities.
- ◆ Historically, an agricultural economy and society and the teachings of Confucianism and Buddhism have had a profound influence on Eastern philosophical approaches to life and family interactions. In traditional Asian families, the family unit—rather than the individual—is highly valued.
- ◆ A person’s actions reflect not only on that individual but also on his or her extended family and ancestors (Shon & Ja, 1982).
- ◆ An individual is expected to function in his or her clearly defined roles and positions in the family hierarchy, based on age, gender, and social class.
- ◆ Obligations and shame are the mechanisms that traditionally help to reinforce societal expectations and proper behavior.
- ◆ There is an emphasis on harmonious interpersonal relationships, interdependence, and mutual obligations or loyalty for achieving a state of psychological homeostasis or peaceful coexistence with family or other fellow beings (Hsu, 1971).

The “Cultural Conflict” Family

- ◆ In these families, members hold different cultural values.
- ◆ A typical family in cultural conflict may consist of grandparents and parents with strong traditional beliefs (usually foreign born) living with a more acculturated and Americanized younger generation (typically born in the United States).
- ◆ This type of family experiences a great deal of stress caused by intergenerational conflicts.
- ◆ Another type of “cultural conflict” family is one in which the spouses have differing levels of acculturation or differing beliefs about the desirability of increased acculturation.
- ◆ Cultural conflicts can be caused not only by the varying degrees of acculturation of family members but also by religious, philosophical, or political differences.

The Bicultural Family

- ◆ A majority of bicultural families are headed by highly acculturated parents who came to the United States many years ago for their education and are very familiar with American culture.

- ◆ Before arriving in the United States, they were likely to have lived in major Asian cities and to have been exposed to urbanization, industrialization, and Western culture.
- ◆ They may also have been born in the United States and raised in traditional families.
- ◆ The parents in bicultural families are typically middle and upper class and hold professional jobs.
- ◆ They are bilingual and bicultural and thus are familiar with both Eastern and Western values.

The “Americanized” Family

- ◆ Most of these families consist of parents and children who were born and raised in the United States.
- ◆ As generations pass, the roots of their traditional Asian cultures begin to disappear, and individual members tend not to maintain their ethnic identities.
- ◆ Family members communicate in English only and adopt a more individualistic and egalitarian orientation.

The Interracial Family

- ◆ The rate of marriages between Asian Americans and members of other racial groups is steadily increasing.
- ◆ Some interracial families are successful in integrating both cultures, but many struggle with their biracial or multiracial identity.
- ◆ Common areas of conflict in interracial marriages include values, religious beliefs, communication styles, racism, childbearing issues, and in-law problems.

Most Asian countries have changed rapidly in the past three decades due to modernization, urbanization, industrialization, and, in recent years, improved communication and business efficiency resulting from technological advances worldwide. These changes are obvious in Japan, China and the so-called “Four Tigers”—Taiwan, Korea, Hong Kong, and Singapore. India has also recently blossomed into a major center for software development for many high-tech companies in the United States as well as a source of thousands of programmers who come to the United States to work on temporary H1 visas.

It is important to remember that Asian countries, as they evolve under the influence of these recent socioeconomic forces, may take on dramatically different characteristics that affect their people and family systems. Providers should be prepared for a family of farmers from a mountaintop in Laos to be very different in terms of family values, Westernization, formal education, and outlook from an

urban family from Hong Kong or New Delhi in which the parents work for high-tech companies.

Strength, Resilience, and Community

It is also important to recognize the strengths and resilience of many API individuals, families, and communities. Although many immigrant and refugee families arrived in the United States under great socioeconomic and psychological stress, they also possessed personal, cultural, philosophical, and spiritual strengths. For instance:

- ◆ The Eastern philosophical approach to life teaches the importance of family obligations and loyalty, filial piety, and parental sacrifice for the future of the children.
- ◆ High parental expectations regarding educational achievement and a strong work ethic have resulted in many academic and business successes.
- ◆ The teaching of karma and compassion, and the strong focus on family harmony and interpersonal relationships, have provided much-needed support during personal and family crises.
- ◆ Native Hawaiian and other Pacific Islander families have increasingly drawn upon cultural values and practices to promote resiliency, specifically emphasizing strategies that involve the family and community, spiritual diversity, and native sovereignty to build personal and community strength (McCubbin, Thompson, Thompson, & Fromer, 1995).
- ◆ The divorce rate for API couples is roughly half that of non-Hispanic Whites (U.S. Census Bureau, 2000c).
- ◆ Various immigrant groups have sustained cohesion and cultural identity strongly enough to establish thriving centers of culture, commerce, and population, such as the Chinatowns, Koreatowns, Japantowns, and Little Saigons evident in many U.S. urban areas.
- ◆ Strong civic organizations in these API ethnic communities provide important opportunities for social support, networking, advocacy for community needs, and development of cultural pride.

Strong community ties may affect utilization of mainstream mental health services because of the availability of natural support systems within the community. These natural support systems are an important strength, especially if they are effectively linked with larger mental health systems when the need arises for referral. Partnerships with community-based organizations are thus an important part of culturally competent mental health services and help to cultivate provider awareness of assets within API communities.

Barriers to Adequate Care and Concerns With Current Mental Health Service Systems

Major Barriers

Early studies in mental health settings demonstrated that Asian Americans were usually underrepresented as clients and had higher dropout rates and shorter stays than did Caucasian Americans (Sue & McKinney, 1975; Sue & Sue, 1974). More recently, according to *Mental Health: A Report of the Surgeon General* (1999), one national sample revealed that Asian Americans were only one-quarter as likely as Whites, and one-half as likely as African and Hispanic Americans, to have sought outpatient treatment for mental health concerns. Asian Americans are also less likely than Whites to be psychiatric inpatients. Yet several studies also found that Asian Americans exhibit more severe disturbances compared with non-Asians, suggesting that they are likely to endure psychiatric distress for a longer time before finally coming to the attention of the mental health system at the point of acute breakdown and crisis. Studies also show that Asian Americans are more likely to drop out after initial contact with mental health providers or to terminate prematurely (Uba, 1994).

There are a number of possible explanations for these low utilization and high dropout rates (See Panel on Mental Health Standards of Care for Asian and Pacific Islander Populations, 1998):

- ◆ Lack of services available in consumers' primary languages effectively prevents many individuals from seeking or receiving help.
- ◆ Existing services typically are not responsive to the needs of Asian Americans and Pacific Islanders. Western diagnostic criteria may overlook culturally specific symptom expression and culture-bound syndromes, for example.
- ◆ Services may be geographically inaccessible.
- ◆ Asian American and Pacific Islander clients may feel that their cultural viewpoints are not understood or valued and thus may be suspicious of non-Asian clinicians.
- ◆ There is a shortage of culturally competent personnel.
- ◆ Consumers lack awareness of the availability of local mental health services, or of the right to receive services.
- ◆ Consumers lack familiarity with U.S. community mental health systems, which are different from those of their countries of origin.
- ◆ Consumers lack financial resources. Many working-class Asian Americans do not have health insurance or other health benefits. Census data indicate, for example, that 21.1 percent of APIs are uninsured, compared with 11.9 percent of non-Hispanic Whites (U.S. Census Bureau, 1999).

- ◆ Consumers may have cultural inhibitions about seeking mental health services, including stigma, shame, and other cultural factors that influence symptom expression, concepts of illness, and help-seeking behaviors.
- ◆ Consumers may have different help-seeking patterns. Some traditional Asian Americans seek help from primary care physicians, community leaders, or indigenous or spiritual healers rather than mental health professionals.

It is essential that mental health administrators and planners address these barriers in order to make mental health services more accessible, available, and culturally appropriate for AAPI clients.

The Prevalence of Mental Health Problems Among Asian American Adolescents and Children: Symptoms and Treatment Issues

By Irene Chung, Ph.D. Assistant Professor at the Hunter College School of Social Work.

A Statistical Profile of Mental Health Issues among Asian American Children and Adolescents:

- ◆ 96% of Asian American children are immigrants or children of immigrants (1996 Housing and Vacancy Survey).
- ◆ 33% of Asian American students in public high schools drop out or do not graduate on time (Class of 1999 Four Year Longitudinal Report and Event Drop Out Rates, NYC Board of Education).
- ◆ The number of Asian American youths arrested for major felonies increased 38% between 1993 and 1996 (NYPD, Office of Management Analysis and Planning).
- ◆ Asian American children and adolescents are considered by mental health providers to be highly prone to depression (Fact Sheet April 2001, Coalition for Asian American Children and Families).
- ◆ In a national survey, 30% of Asian American girls in grades 5-12 reported suffering from depressive symptoms. Also, Asian American girls reported the highest rates of depressive symptoms compared to White, Black and Hispanic girls (The Commonwealth Fund Survey of the Health of Adolescent Girls. The Commonwealth Fund, 1998).
- ◆ Asian American teenage boys were more likely than their White, Black and Hispanic peers to report physical or sexual abuse (The Commonwealth Fund Survey of the Health of Adolescent Boys. The Commonwealth Fund, 1998).
- ◆ In 1997, suicide alarmingly ranked as the leading cause of death among South Asians ages 15-24 in the U.S. (Monthly Vital Statistics Report. Center for Disease Control and Prevention/National

Center for Health Statistics, Vol. 46, No. 1, Aug. 1997).

- ◆ Asian American women ages 15-24 have a higher rate of suicide than Whites, Blacks, and Hispanics in that age group (Monthly Vital Statistics Report. Center for Disease Control and Prevention/National Center for Health Statistics, Vol. 46, No. 1, Aug. 1997).
- ◆ In New York City in 1999, suicide was one of the ten leading causes of death for Asian Americans of all ages, but was not a leading cause of death for any other ethnic group (Summary of Vital Statistics 1999, The City of New York, Office of Vital Statistics, New York City Department of Health).
- ◆ Of all the children in New York City receiving licensed mental health services in 1995, only 1% was Asian Americans (New York State Office of Mental Health, 1995 Patient Characteristics Survey).

Mental health stressors for Asian American children and adolescents:

As minority members and descendants of immigrant families, there are many psychological burdens created by:

- ◆ the prevalence of racism in society
- ◆ the lack of Asian mentors in the school system who could serve as advocates and role models
- ◆ cultural and generational conflicts with parents
- ◆ the lack of emotional nurturance from parents who are often overworked and experience difficulties in adjusting to a new country.

Some debilitating conditions:

- ◆ verbal and physical abuse by parents
- ◆ sexual abuse by parents or family members
- ◆ scapegoating in school or at home
- ◆ prolonged separation from parents/placement with different caretakers during infancy and childhood

Depressive Disorders:

- ◆ Major Depressive Episode (6 – 9 month duration)
- ◆ Dysthymic Disorder (2 – 4 year duration)

- ◆ Transient Depressive symptoms

Anxiety Disorder as a comorbid condition:

- ◆ Separation Anxiety
- ◆ Generalized Anxiety Disorder
- ◆ Social Phobia
- ◆ Specific Phobia
- ◆ Obsessive Compulsive Disorder

Depressive symptoms among children and adolescents are often different from those observed among adults.

Behavioral and attachment symptoms are frequently observed among infants and children of very young ages who are physically or emotionally separated from their primary caretaker.

Examples with infants: whining during initial separation period with caretaker; after prolonged separation, symptoms may include impaired social interaction; slow motor responsiveness; dazed and immobile facial expression; slowed or stunted growth; susceptibility to infection.

Examples with toddlers: irritable moods; delays in developmental milestones such as walking, language, and toilet training; nightmares; self-stimulating behaviors (rocking, head banging, masturbation); clinginess; excessive fears; oppositional behavior; decrease in play.

Examples with pre-schoolers: sadness, tiredness, anger, apathy, irritability, social withdrawal, weight loss, motor retardation.

Cognitive and emotional symptoms are more common with older children and adolescents.

Examples with older children: anxiety, phobias, somatic complaints, reluctance to leave the room or house, complaints of boredom, disruptive behavior at home and/or at school, decline in academic performance.

Examples with adolescents: volatile mood, rage, intense self-consciousness, low self-esteem, poor academic performance, truancy, delinquent behaviors, substance abuse, sexual acting-out, social withdrawal (anhedonia), eating and sleep disturbance.

Cultural values and norms that may contribute to depressive symptoms/syndrome:

- ◆ Family is the central unit of life and one's sense of self and identity revolves around meeting family expectations and needs
- ◆ Total obedience and compliance toward authority and parental figures.
- ◆ Communication patterns that sanction internalization of negative feelings and indirect expression of love.
- ◆ Academic achievement of children perceived as validation of parents as “good” parents, and the pathway to a successful life for the children

Suicidal Risk Factors:

- ◆ Poor problem-solving and coping skills in handling disappointments and losses in life
- ◆ Difficulties in managing or expressing anger
- ◆ Isolation in family and school
- ◆ Dysfunctional family environment
- ◆ Family history of suicide/ suicidal attempts/ suicidal threats
- ◆ Family history of loss of loved ones and views of death and dying

Suicidal Risk Symptoms:

- ◆ Accident-prone behavior (children)
- ◆ Preoccupation with death and morbid thoughts (children)
- ◆ Self-hate ideations
- ◆ Inability to recover from relationship breakups (adolescents)
- ◆ Fascination and identification with icons who embrace the idea of “death” (adolescents)

Recommended Treatment approach: Combination of individual and family therapy

Use of culturally sensitive interventions:

- ◆ Family-syntonic approaches versus blaming parents, i.e., reframing generational conflicts to project a sense of hope for the family; validating the hardships and aggravations of the parents.
- ◆ Role-modeling parenting techniques that are culturally meaningful, i.e., some discipline and goal-setting; a balanced focus on outcome.

- ◆ Cognitive and behavioral approaches in working with the individual child/adolescent to improve self-esteem and coping skills.
- ◆ Facilitating communication of positive feelings between parents and child.

Medication to alleviate/stabilize more severe symptoms

Treatment Issues:

- ◆ Parents' perception of problem: child is being "lazy", "defiant", etc;
- ◆ Parents' perception of solution: child needs to develop better will power, get closer supervision, spend more time at home, etc.
- ◆ Parents find it difficult to understand the concepts of "blanking out", "lack of motivation and concentration", "anger outbursts" as depressive and anxiety symptoms.
- ◆ The lack of commitment to seek mental health treatment because of the stigma associated with mental illness, and the lack of understanding of the goals and means of psychotherapy.

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Chapter 2

Cultural Competence and Model Programs

As evidenced in Chapter 1, Asian American and Pacific Islander communities have diverse experiences and perspectives when dealing with mental illness issues. Providers, family and consumer-supporters must consider cultural differences when dealing with AAPI communities in order to successfully interact with them.

Cultural Competence

Adapted with permission from the Report of a Cultural Competence Panel by Dr. Ernest Quimby, Dr. Albana M. Dassori, and Dr. Annette B. Primm. November, 2001

Cultural competence is a process of applying appropriate intervention strategies which consider the role and potential impact of values, norms, attitudes, norms, perceptions, communication and behavior of providers and consumers. It involves identifying and responding to consumers' perspectives, needs, experiences and interests.

Cultural competence implies:

1. Cultural self-awareness
2. Awareness of cultural context of 'the other'
3. Understanding the dynamics of the difference
4. Development of cultural knowledge
5. Ability to adapt and practice skills to fit the cultural context(s) of consumers

Cultural self-awareness

Understanding the assumptions and values upon which one's behavior and worldview rest. These values and assumptions are long ingrained in our worldview and affect how we perceive ourselves and our consumers. Whenever we come into an interaction, we bring our own pre-conceptions about 'the other' and these pre-conceptions can impact our behaviors and communication styles. As much as we want to think of ourselves as culturally sensitive, we all have biases.

Awareness of the cultural context of the 'other'

This encompasses a wide range of elements including ethnicity, race, country of origin, language, acculturation, gender, age, sexual orientation, religious and spiritual beliefs, socioeconomic class and education. Awareness of 'the other's' cultural context also implies awareness of the consumer's own explanations of the illness/problems, (i.e., perceived causes, idioms of distress, local illness categories, meaning and severity of symptoms in relation to cultural norms), as well as cultural interpretations of social stressors, social supports and levels of functioning.

Understanding the dynamics of the difference

Unfortunately, many times we assume that culture is not relevant. Some well-meaning people are concerned with the risks of stereotyping. Although, a valid concern, we cannot conclude that there is no need for having basic knowledge of common beliefs/norms/values held by members of the sociocultural groups we come most frequently in contact. A key to cultural competence is to be flexible and constantly check whether our basic knowledge on the cultural background of the individual fits his/her reality.

Development of cultural knowledge

To be culturally competent we must familiarize ourselves with the individual's culture and country of origin, history and pertinent psychosocial stresses, family life and intergenerational issues, culturally acceptable behaviors, role of religion, beliefs about causes and treatment of illness, etc. The changing demographic characteristics of the U.S. makes it very difficult to be knowledgeable about all the potential groups. Therefore, as a first step, we should attempt to become familiar with one or two of the groups that we most commonly encounter.

Ability to adapt and practice skills to fit the individual's cultural context

As an initial step, we need to assess the cultural context of the individual. We have to attend to nonverbal and verbal cues and interpret them within the appropriate cultural context. For example, rules for eye contact and other feedback behaviors (smiling, nodding, and leaning forward) may differ across cultural groups. Mainstream Anglo-Saxon listeners are taught to maintain eye contact with the speaker. In fact, avoidance of eye contact may be misperceived as a sign of dishonesty or psychopathology by certain non-minority providers and practitioners. However, some Asian and Hispanic/Latino consumers may show deference by not engaging in eye contact with the speaker. Personal space is another variable that can be defined differently. In mainstream U.S. culture, we tend to stand about three feet apart to have an ordinary conversation. In Hispanic/Latino cultures, people typically stand closer. This can be interpreted as threatening or intrusive, if the other person is not aware of the specific norms.

Assessing and sustaining cultural competence in evidence-based practices

Cultural competence involves developing new and different relationships with consumers,

families and their supports, providers, practitioners, and administrators, among others. Assessing and sustaining cultural competence in evidence-based practices requires structures which encourage and assist stakeholders to identify and articulate their needs, interests and solutions. Public and private agencies, organizations and community-based groups, must be the central agents of change to implement, monitor and sustain cultural competence in evidence-based practices. Culturally diverse and consumer-involved mental health training and research centers could play a major role.

Viewing consumers as diverse individuals

Consumers with severe mental illness do not constitute a group or a homogeneous population responsive to monolithic treatment strategies. Their heterogeneity requires complex and varied treatment approaches.

Characteristics of cultural competence

Cultural competence involves several characteristics. These are:

- Recognition of and respect for cultural differences
- Cultural introspection by administrators, supervisors, case managers, vocational specialists, NAMI leaders, advocates and support staff.
- Awareness of the differences, similarities and issues brought by consumers, families, practitioners, and service providers
- Knowledge about the role of culture in prevention, diagnosis and treatment interventions
- Adaptation of effective services which incorporate diverse cultural realities

Operational principles of cultural competence

- Cultural competence includes the following principles:
- Each person is a unique individual.
- Individuals exist within a cultural context.
- Treatment involves a holistic perspective of mental, social and physical health care.
- Attention to cultural details and knowledge helps to inform and facilitate engagement and retention of consumers and their families.
- Mental health treatment involves a relationship between the consumer and clinician.
- Families and support groups can promote treatment.
- Differences and similarities between people are recognized, honored, respected and validated.

Achieving cultural competence

- Achieving cultural competence depends on the following:
- Commitment displayed by policy makers, administrators, board members, and supervisors
- Clarity of the agency's goals, objectives and procedures
- Generation of support from staff and consumers

- Collaborative planning and communication
- Creation of structural mechanisms to monitor and reinforce accomplishments (e.g., advisory board)
- Identification of cultural attributes of the agency, staff and consumers
- Assessment of how cultural factors affect service delivery and utilization
- Development of and access to resources and educational opportunities
- Attentiveness to perceived spiritual/religious needs
- Utilization of culturally sensitive and relevant materials

Cultural competence involves developing an awareness that seemingly minor actions, such as voice tone, eye contact, and hand gestures may impede or maximize communication. If these components of culture are misunderstood, regarded as offensive, or simply not even recognized as communication techniques, groups may fail to establish rapport or sustain positive encounters. For example, when conducting a NAMI support group session, it is imperative that leaders practice techniques that do not violate the cultural sensibilities of participants. Chair arrangements, use of props and drawings, exercises, and other techniques should be designed from the participants' cultural perspectives.

Methods of achieving cultural competence

Multiple approaches can be used to implement cultural competence at the level of systems and programs. These include, but are not limited to, the following:

- Identify and acknowledge the needs, interests, concerns and preferences of consumers and families of color.
- Conduct cultural competence workshops for NAMI staff and leadership.
- Incorporate values clarification sessions among NAMI staff and leadership.
- Identify and utilize articulate 'cultural informants.'
- Hire a culturally diverse staff, and provide them with regular education.
- Minimize judgments of others.
- Identify and confront one's own biases and prejudices.
- Identify cultural clues which enhance cultural competence -- e.g., non-verbal communication through body language and facial clues; bi-lingualism.
- Develop methods of assessing cultural competence efforts.

Thematic summary

- Mental health services are provided and utilized within the cultural frameworks and social settings of systems, programs, consumers, families and practitioners.
- Cultural competence is a process.
- Cultural competence is not stereotyping.
- Cultural competence is not synonymous with race and ethnicity.
- Cultural competence implies awareness of one's own preconceptions and biases.
- Cultural competence requires recognition of the impact of the organization's assumptions and practices.

Cultural Competence and AAPI communities

Exerts from *Cultural Diversity Series: Meeting the Mental Health Needs of Asian and Pacific Islander Americans*. Prepared by Evelyn Lee, L.C.S.W., Ed.D. National Technical Assistance Center for State Mental Health Planning (NTAC), February 2002.

Because Asian Americans represent a broad spectrum of cultures, histories, and acculturation levels, providers need not only to expand the domain of their assessments but also to flexibly apply different treatment modalities in response to the needs of each individual and family. The following treatment strategies for working with immigrant Asian American families are presented as one of many models.

Form a social and cultural connection with the family during the first session

The most important process in working with Asian American families is “joining,” that is, initiating therapeutic intervention by building a relationship with the family. Many Asian American clients are new to therapy and may need to be prepared and “coached.” During the first session, the clinician should address the family in a polite and formal manner. Given Asian cultures’ emphasis on interpersonal relationships, the family may expect the clinician to disclose a certain amount of personal information regarding his/her family, country of origin, and academic and professional background. Appropriate self-disclosure may facilitate positive cultural alliance and an increased level of trust and confidence. Asking nonthreatening personal questions can put the family at ease. It is also important to avoid direct confrontation, to demand greater emotional disclosure, or to discuss culturally taboo subjects such as sex or death.

Acknowledge the family’s sense of shame

For many Asians, the public admission of mental health problems can bring intense shame and humiliation. The clinician may counter those emotions by empathizing with family members and encouraging them to verbalize this feeling. It is important to assure them about confidentiality and anonymity. One helpful technique is to reframe their courage in seeking help as love and concern for the troubled family member. If appropriate, mobilizing the family’s sense of obligation to receive help to achieve family harmony or for the sake of the children can be very effective.

Clarify the professional’s role and client treatment expectations

Because diverse mental health disciplines (e.g., psychiatrists, psychologists, social workers) are not widely recognized in many Asian countries, Asian Americans may lack the information or exposure to understand the roles of clinicians. The provider’s role needs to be clarified at the beginning of treatment. Since the role of a physician is more clearly understood and respected, Asian American clients may expect clinicians to act like physicians who prescribe medication. In addition, the clinician needs to explore the client’s treatment expectations.

Establish expertise, power, credibility, and authority

Many Asian clients come to their first session believing that the clinician is an authority who can tell them what is wrong and how to solve their problems. It is helpful for the clinician to establish credibility right away to ensure that the client will return. An air of confidence, empathic understanding, maturity, and professionalism are all-important ingredients.

Define the problem

A problem-focused family therapy approach with Asian American families appears to be very effective. The clinician should focus on the immediate crisis or problem that brought the family to the agency. In most instances, family members ask for professional help because of the difficulties they encounter with one particular family member (the identified patient). Family members may either be unaware of their role in contributing to the problem or unwilling to discuss those issues openly in front of others, particularly the children. For many families, working on the parent-child issue at the beginning is safer than working on marital problems that may exist.

Apply a family psychoeducational approach

Education is highly valued in Asian cultures. The psychoeducational approach based on social learning principles may be compatible with Asian values and beliefs. Such interventions focus on four major areas: (1) education about the illness or problem, for which educational materials in the patient's primary language are especially helpful; (2) communication training; (3) problem-solving training; and (4) behavior management strategies (McGill & Lee, 1986).

Build alliances with family members who have power

An accurate assessment of the power structure of the family is essential. Generally speaking, there are two types of power in the API family system: "role prescribed power" (usually given to the grandfather, father, eldest son, or the sponsor) and "psychological power" (usually maintained by the grandmother or the mother). Treatment will not be effective without permission of the leader(s). Clinicians should acknowledge and respect their power in decision-making, avoid competition, and build a therapeutic alliance using all possible means.

Employ reframing techniques

Using the technique of reframing can help to build rapport with family members who have power. For example, the clinician can reframe the mother's over protectiveness as "loving too much" and reframe the father's excessive working hours as "sacrificing for the economic well-being of the family."

Assume multiple helping roles

Flexibility and a willingness to assume multiple helping roles can enhance the therapeutic

relationship, especially in working with multi-problem families. In addition to being the counselor, the clinician should be comfortable functioning as a teacher, advocate, and interpreter. Acting as a “cultural mediator” or using a family intermediary can be an effective tool in dealing with family conflicts. Show caring by “doing” and “being there” when the family needs help.

Restructure the social support system

Asian American families usually consist of closely knit extended families and support systems. However, many families and individuals isolate themselves when they encounter problems. As soon as possible, the clinician should help them to establish or reestablish a social support network that enables the family or the individual to form friendships, vent frustrations, and learn social and problem-solving skills.

Integrate Eastern and Western health approaches

Clinicians should take advantage of the holistic model of health in Eastern cultures and integrate its elements with the best Western medical and psychological practices. For example, in the treatment of a Chinese American consumer with depression, it can be helpful to provide education on the Western biological and psychological perspectives of the illness. It may also be important to explore Eastern approaches to treatment, such as the use of Chinese herbal medicine, acupuncture, qi gong, or yoga. Indeed, it may be particularly useful to point out to consumers where these frameworks intersect, such as a mutual concern with both biological causes and energy depletion in the understanding and treatment of depression.

Mobilize the family’s cultural strengths

One of the functions of therapy is to mobilize the family’s cultural strengths. Strengths in API families may include support from the extended family, a strong sense of obligation and family loyalty, parental sacrifice for the children’s future, filial piety, strong focus on educational achievement and the work ethic, and support from the ethnic community. In many circumstances, especially when family members are coping with death, loss, or unpredictable changes, discussions of religious stories or philosophical teachings from Asian cultures can be very therapeutic.

Employ the concept of empowerment as a treatment goal

Empowerment here refers to the process whereby the clinician mobilizes the family’s ability to interact successfully with external systems. This is particularly important in working with immigrant women who have been victimized by years of sexism, loss of power due to language barriers, role reversal, and racism in the new country.

Understand the family’s communication style

In addition to determining API consumers’ primary language and dialect, providers must understand a family’s communication style. Asian Americans have traditionally been taught to employ

indirect styles of communication and to avoid direct confrontations. Negative emotions such as anger, grief, and depression may be expressed indirectly. Even positive feelings such as love are frequently not expressed in an open manner. The clinician may be expected to read between the lines in order to grasp the major issue. The family may also, on the other hand, perceive the clinician as being too blunt, pushy, or insensitive.

Applicability to Pacific Islanders

These treatment strategies described as appropriate for Asian Americans also have relevance for Pacific Islanders. Strategies with special applicability include:

- ◆ Forming social and cultural connections between provider and family, integrating Eastern (or Pacific) and Western approaches, mobilizing the family's strengths, and employing the concept of empowerment.
- ◆ Successful establishment of a provider-family relationship for many Pacific Islanders requires that providers exhibit knowledge of, and sensitivity to, native history and circumstances. For example, recognizing the political history and affiliation of the United States to Pacific islands may facilitate an understanding of cultural conflict for Pacific Islanders in the United States and in island homelands.
- ◆ There is mixed literature on Native Hawaiians' preferences for indigenous or Western mental health treatments, with early research indicating a preference for indigenous approaches (Higginbotham, 1987) and more recent and comprehensive research indicating a preference for conventional medical practices (Andrade, et al., 1994). Interestingly, the latter study also showed that Native Hawaiian adolescents identified teachers and school counselors as the best source of help for mental health problems.
- ◆ Providers who are competent in, and can flexibly employ, a range of both native and Western treatment interventions and who can collaborate with teachers/counselors may maximize their efforts at helping. Another way to enhance services is to mobilize the family's strengths in areas such as extended familial support and community networking. For example, in Hawaii the Department of Human Services utilizes an intervention called `Ohana (Family) Conferencing that brings together members of the extended family as well as individuals who are part of their neighborhood support system to collectively resolve issues of the children and family (Susan Chandler, personal communication, May 10, 2001).
- ◆ Focusing and mobilizing family strengths as part of an intervention contributes to empowerment because the family and community become active participants in the process of change (Browne & Mills, 2001). This is a key concept in work with Native Hawaiians, Samoans, and Chamorros and reflects the importance of families and communities taking responsibility for the direction of mental health services.

Finally, the use of such strategies will be enhanced if providers continually engage in self-

- ◆ awareness activities that examine their own attitudes toward racism, oppression, cultural diversity, and identity (Mokuau, 1991).

The following pages detail organizations and programs throughout the country that have successfully designed efforts specific to Asian American and Pacific Islander mental health. From national organizations to local, grass-roots efforts, what follows are meant to serve as resources of model activities to follow for those looking to begin their own outreach efforts and partnerships; as well a guide of contacts of current efforts. This is not meant to be an all-inclusive list, as there are many more organizations doing equally wonderful things, but a “jumping-off point” to get you started in the right direction. Special thanks to all of these organizations for sharing their information with us.

Asian American Federation of New York

www.aafny.org

The Asian American Federation of New York is a nonprofit leadership organization that works to advance the civic voice and quality of life of Asian Americans in the New York metropolitan area. Established in 1990, the Federation supports and collaborates with 35 member agencies to strengthen community services, promotes strategic philanthropy within the Asian American community, and conducts research and advocacy concerning critical issues.

Mental Health Project “Building Bridges and Leveraging Assets for Community Recovery”

Building on landmark Federation research, the innovative one-year program will provide accessible, culturally-appropriate mental health services to two particularly vulnerable groups that have not been served sufficiently by existing programs: elderly Chinatown residents, and New York City and New Jersey families of Asian Americans who died in the World Trade Center attacks.

Responding to findings in the Federation’s 2003 research report titled Asian American Mental Health: A Post-September 11th Needs Assessment, the new program will:

- Reach out to targeted populations and serve them in familiar, accessible settings, such as senior centers, community centers, agency offices and housing complexes, rather than in hospitals and clinics.
- Provide specialized training to help front-line staff members assess mental health needs, including those related to aging; inform individuals about mental health issues; engage targeted populations in obtaining assistance; and make appropriate referrals.
- Strengthen means of connecting people in need with suitable service providers, for example, by forming and consulting a group of experts in Asian American mental health.
- Enlarge the pool of qualified professionals available to serve targeted populations, via linkages between bilingual Asian American professionals in mainstream institutions and community agencies.

For more information, contact:

120 Wall Street, 3rd Floor

New York, NY 10005

212-344-5878

www.aafny.org

Asian American Psychological Association

www.aapaonline.org

The Asian American Psychological Association (AAPA) was founded in December 1972 by a group of Asian American psychologists and other mental health professionals in the San Francisco Bay Area. With the leadership of Dr. Derald Sue (AAPA's first President) and Dr. Stanley Sue, the first core group was formed and included educators, social workers, master's level psychologists and other mental health professionals. The group was vitally interested in Asian American psychology and mental health issues, in the training and education of Asian American mental health professionals and in collaborating and networking with their peers.

The Association advocates on behalf of Asian Americans as well as advancing Asian American psychology.

- In the 1980's, the AAPA pressed the U.S. Bureau of the Census to include Asian American subgroups in its census data, and fought against the English-only language movement in California.
- AAPA publishes journals and newsletters focused on the education and training of Asian American psychologists, Asian-American psychological topics, and methods of improving mental health services for Asian Americans.
- The Association leads and guides other professional organizations on Asian American psychology and is in the forefront of the multicultural psychology movement.

For more information, contact:

Frederick T. L. Leong, Ph.D.

President, Asian American Psychological Association (2003-2005)

University of Tennessee

307 Austin Peay Building

Knoxville, TN 37996-0900

865-974-8796

www.aapaonline.org

Asian and Pacific Islander American Health Forum

www.apiahf.org

The mission of APIAHF is to enable Asian Americans and Pacific Islanders to attain the highest possible level of health and well-being. It envisions a multicultural society where Asian Americans and Pacific Islander communities are included and represented in health, political, social, and economic areas, and where there is social justice for all.

APIAHF has a variety of programs:

- API Health Information Network: A network for disseminating and sharing health information, resources and policy issues amongst individuals and organizations that provide health services to the Asian and Pacific Islander American communities.
- API Center for Census Information and Services: Designed to serve the census data needs of organizations concerned with identifying, defining, targeting, and serving the Asian and Pacific Islander communities throughout the United States.
- API HIV Capacity-Building Assistance: Provides capacity-building assistance to community-based organizations and health departments providing HIV prevention education targeting Asian & Pacific Islander populations.
- The Asian & Pacific Islander Institute on Domestic Violence: A national coalition working against domestic violence in The Asian & Pacific Islander communities through networking, sharing resources, and influencing policies and research.
- Asian & Pacific Islander Chronic Disease Program: The Asian & Pacific Islander Chronic Disease Program consists of the tobacco education programs and cancer survivorship programs.

For more information, contact:

450 Sutter Street, Suite 600

San Francisco, CA 94108

415-954-9988

www.apiahf.org

Association of Asian Pacific Community Health Organizations

www.aapcho.org

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national association representing community health organizations dedicated to promoting advocacy, collaboration and leadership that improves the health status and access of Asian Americans, Native Hawaiians and Pacific Islanders within the United States, its territories and freely associated states, primarily through our member community health clinics.

Formed in 1987, AAPCHO advocates for policies and programs that will improve the provision of health care services that are community driven, financially affordable, linguistically accessible, and culturally appropriate. As a unified voice of its membership, AAPCHO shares its collective knowledge and experiences with policy makers at the national, state and local levels.

Activities of National Significance:

- Advocacy for policies and programs to improve health status for APIs
- Promotion of multilingual primary care service delivery models
- Development of programs to improve access to care for the underserved
- Data collection and analysis related to Asians and Pacific Islanders in primary care
- Training conferences for health professionals and paraprofessionals
- Technical assistance for the establishment and expansion of community health centers serving Asians and Pacific Islanders

The AAPCHO web site hosts a wide range of fact sheets, resources and newsletters; as well as information about membership. The web site is meant to be used as a vehicle for AAPCHO and other organizations to share their expertise in providing culturally competent, linguistically accessible and affordable primary health care services to Asian Americans and Pacific Islander across the country.

For more information, contact:

300 Frank H. Ogawa Plaza, Suite 620

Oakland, CA 94612

510.272.9536

www.aapcho.org

Chinese-American Mental Health Network

www.camhn.org

CAMHN offers a broad range of services to the Asian American community in the San Francisco Bay Area. Among them are:

- **Asian American Mental Health Directory**

An on-line and printed directory of agencies, hospitals, and private-practice professionals who provide services to the Asian-American populations in the Bay Area.

- **Chinese American Mental Health Network Newsletter**

A bi-annual publication, this wonderful resource provide articles from mental health professionals on treatment and medication; as well as information about culturally competent local services and initiatives for the Chinese population of San Francisco, CA. Published in Chinese, the newsletter offers stories of hope and announcements to keep this community well-informed and active.

- **Chinese Helpline**

8 professionally trained volunteers take calls.

- **Mental Health Seminars**

In the past 2 years, CAMHN has hosted more than 30 seminars and support groups for over 2,500 participants, hosted by bilingual/bicultural mental health professionals who speak of mental health awareness, treatment, prevention, and encouragement for all individuals to seek help.

- **Scholarships**

With the help of generous donors, CAMHN has raised over \$130,000 for scholarships to benefit over 30 college students pursuing a professional degree in the mental health field and have demonstrated commitment to the Chinese community by working at various community based organizations.

For more information, contact:

3200A Danville Blvd. Suite 101

Alamo, CA. 94507

www.camhn.org

Indo-American Psychiatric Association

www.iapa.org

Mission Statement

The Indo-American Psychiatric Association (IAPA) provides a forum for psychiatrists of Asian-Indian origin to consolidate professional identity, develop skills in addressing the bicultural mental health needs of the Indo-American community, establish a network for the exchange of information, obtain mentorship in fulfilling professional aspirations in the larger psychiatric community of North America, and leave a legacy for subsequent generations of Indo-American mental health professionals.

Goals

- To promote professional and social cohesiveness among psychiatrists of Asian-Indian cultural backgrounds.
- To promote learning and research in areas related to personality development, coping skills and psycho-pathology in people of Indian origin.
- To educate individuals and families of Indian origin about mental health services.
- To advocate for the special needs of psychiatrists of Asian-Indian origin.
- To establish close ties with related professional societies, such as the American Psychiatric Association (APA), Indian Psychiatric Society (IPS), American Association of Physicians of Indian Origin (AAPI), organizations serving International Medical Graduates, and organizations addressing the mental health needs of Indo-Americans.
- To publicize professional achievements of Indo-American psychiatrists at all career levels.
- To establish funds and awards for outstanding Indo-American psychiatrists making significant scientific and service contributions.
- To leave a body of scholarly work and a professional organization to serve subsequent generations of Indo-American psychiatrists and the Indo-American community.

For more information, contact:

855 Bruce Drive
East Meadow, New York 11554-5148
(516) 292-9741

National Asian American and Pacific Islander Mental Health Association

www.naamimha.org

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health services Administration (SAMHSA) - Center for Mental Health Services (CMHS) sponsored an Asian American Pacific Islander Mental Health Summit July 10-12, 1999 in Washington, D.C. A Strategic Planning Committee was formed and in July 2000, the National Asian American Pacific Islander Mental Health Association (NAAPIMHA), became a reality.

NAAPIMHA focuses on five distinct but interrelated areas. The effectiveness of each builds on the success of the other. The underlying assumption is that a national organization should advocate on behalf of each of the following areas and that cultural competency will be reflected at all levels.

1. Enhance collection of appropriate and accurate data
2. Identify current best practices and service models
3. Increase capacity building, which includes providing technical assistance and training of service providers, both professional and para-professional
4. Conduct research and evaluation
5. Work to engage consumers and families

NAAPIMHA advocates on behalf of AAPI mental health issues, serves as a forum for effective collaboration and networks among stake holders of community based organizations, consumers, family members, service providers, program developers, researchers, evaluators and policy makers. Moreover, NAAPIMHA works with direct service providers, such as nonprofit community-based organizations, to augment this effort. NAAPIMHA works in collaboration with other national organizations designed to address related AAPI issues such as health and substance abuse so as not to duplicate efforts.

Activities and Deliverables:

- Annie E. Casey Foundation – Best Practices Directory
Early funding for NAAPIMHA came from the Annie E. Casey Foundation to compile a directory of promising and best practices models of programs that provide services for AAPI youth and families. NAAPIMHA identified ten programs from around the country that represented various ethnic specific programs designed to work with AAPI youth and families.
- Annual Youth Best Practices Conference
NAAPIMHA received a CMHS Conference Grant for fiscal years 2002-2003 and 2003-2004 with the hope of this becoming an annual event. The intent of the conference is to develop a national network of service providers and evaluator to develop best practices models in working with at risk AAPI youth and families. Historically, agencies have only been able to meet with other agencies if they receive the same federal funding. The format provides for active

exchange of program design, implementation strategies and evaluation efforts. There is also a youth track to develop national leadership among the youth who have been involved in various programs themselves.

- Workforce Training

Workforce development is a major focus of NAAPIMHA's efforts. In 2003, NAAPIMHA received one of four Workforce Training Grants from CMHS to reduce disparities in quality care for diverse populations. The *Growing Our Own* curriculum is the first national effort to develop a core training curriculum for AAPIs. It is cross disciplinary in nature and encompasses psychiatry, psychology, social work and counseling and is being implemented at six sites in Hawaii, Seattle, Denver, New York City, and two sites in San Francisco.

NAAPIMHA, in conjunction with the UCSF Medical School is also developing an evaluation tool that utilizes Standardized Patient (SP) protocols that can be used to assess the clinical skills of the interns. Often utilized in medical school training, the SP has yet to be tested in the mental health arena and holds great promise to be an effective tool in assessing cultural competency for the therapists in training. Preliminary results from the evaluation are very promising. The *Growing Our Own* curriculum is based on the DSM IV Cultural Formulation that provides a rich theoretical framework in making culturally appropriate assessments, diagnosis, and treatment plans. The model can serve as a template for training efforts of NAMBHA in an effort to help address the workforce problems faced by the communities represented by the Alliance.

- Fact Sheets

Fact sheets on schizophrenia, bi-polar disorders and major depression have been translated into Vietnamese, Chinese, Khmer, Korean and Hmong. Based on sheets developed by consumers and the Texas State Department of Mental Health and Mental Retardation, the fact sheets are designed to be consumer friendly and easily understood by non-clinicians.

- Glossary of mental health terms

Building on the compilation of glossary of mental health terms in various languages developed by The Queensland Transcultural Mental Health Center in 2000, NAAPIMHA has made the glossary available in English, Chinese, Italian, Spanish, Korean, and Laotian.

- Bibliography of Articles on AAPI Mental Health

NAAPIMHA has compiled an annotated bibliography of over 1500 citations from psychology, psychiatry, social work and counseling from 1990-2003. Citations can be cross-referenced by author and key words; eg: ethnicity, trauma, women, etc.

- Call to Action: Platform for Asian Pacific Americans National Policy Priorities 2004

NAAPIMHA worked with other national AAPI organizations to develop a national platform to inform elected officials on the urgent health, mental health, housing, employment, labor, immigration, and civil rights needs of the communities.

- AAPI Consumer's Advisory Board
NAAPIMHA is developing a national Consumer's Advisory Board. Focus groups were held at each of the training sites for the Workforce Training grant. Feedback from the consumers provided the foundation for the *Growing Our Own* curriculum and evaluation. It is the intention of NAAPIMHA to develop a stronger consumer voice.
- Technical Assistance
NAAPIMHA provides technical assistance to community based organizations on the design, implementation and evaluation of culturally competent service programs and interventions. TA includes doing a systems needs assessment, developing an appropriate logic model, identifying appropriate training goals, objectives, and outcomes as well as learning how to write grants that focus on the mission of the agency and address a critical need in the community.

For more information, contact NAAPIMHA:

1215 19th Street, Suite A
Denver, CO. 80202
303-298-7910
www.naapimha.org

National Asian Pacific American Families Against Substance Abuse

www.napafasa.org

National Asian Pacific American Families Against Substance Abuse (NAPAFASA) is a private, non-profit, 501(c)(3) membership organization dedicated to addressing the alcohol, tobacco, and other drug issues of Asian Americans and Pacific Islanders (AAPI). Founded in 1988, NAPAFASA involves service providers, families, and youth in efforts to reach API communities to promote health, social justice and reduce substance abuse and related problems.

NAPAFASA Services

- **For the General Public:**
 - Free information and referral regarding substance abuse, mental health and related services to API populations.
- **For NAPAFASA members (individuals and agencies):**
 - Linkages to other local NAPAFASA organizations and members.
 - Opportunities to be involved in nationwide prevention, research, and advocacy efforts for Asian and Pacific Islanders.
- **For Service Providers, Government Agencies, and Private Organizations**
 - Technical assistance/consultation on topics such as Alcohol, Tobacco and Other Drugs (ATOD) and mental health prevention and treatment;
 - Culturally sensitive services and historical/cultural understanding of API communities.
 - Management/Coordination of multi-agency API ATOD-related projects.

Description of Selected NAPAFASA Projects

Asian and Pacific Islander Substance Abuse Technical Assistance and Training Project, State of California (Current).

Funded by the California Department of Alcohol and Drug Programs, this NAPAFASA project offers to API organizations and service providers on-site technical assistance, including program planning and clinical training.

Asian and Pacific Islander Substance Abuse and Mental Health Service Agency Capacity Needs Assessment (Past).

This is a study of the nature of ATOD and mental health services provided to Asian and Pacific Islanders nationwide. Some 30 API human service agencies in 11 were surveyed. A final report with policy recommendations is due in spring 2000. This project was funded by the Center for Substance Abuse Treatment, the Center for Substance Abuse Prevention, and the Center for Mental Health Services through a cooperative agreement with the Office of Minority Health.

For more information, contact:

340 East Second Street Suite 409
Los Angeles, CA 90012

(213) 625-5795

The National Research Center on Asian American Mental Health

psychology.ucdavis.edu/nrcaamh

The National Research Center on Asian American Mental Health (NRCAAMH) was established in 1988 with a grant from the National Institute of Mental Health. NRCAAMH prides itself as a national and multidisciplinary leader in the study of Asian Pacific American mental health research.

Historically, attention to Asian Pacific American concerns in the delivery of mental health care has been minimal. NRCAAMH was founded out of a need for programmatic research devoted to Asian Pacific American mental health concerns. The Center aims to contribute theoretical and applied research that will have a valuable impact on mental health policy and service delivery to Asian Pacific Americans.

Ongoing Research

- Cultural Competence in Children's Mental Health Services
- Sexual Aggression Project
- Adolescent Health and Mental Health
- Sociocultural Influences on Gambling and Related Issues
- National Latino and Asian American Study (NLAAS)

Research Studies

- Chinese American Psychiatric Epidemiological Study
- Cognitive Match in Therapeutic Relationships
- Effects of Sex, Ethnicity, and Teacher Referral Patterns and Perceptions on Student Pathology
- Ethnic Specific Mental Health Services
- Filipino American Community Epidemiological Study
- Los Angeles County Mental Health Service Delivery
- Loss of Face
- Social Networks of Cambodian American Families

Proposed Research

- Defining and Assessing Outcomes in Asian Americans
- Cultural Competence and Treatment Outcomes
- Clinical Effectiveness of Empirically Supported Interventions for Asian Americans

For more information, contact:

University of California , Department of Psychology
 One Shields Ave
 Davis, CA. 95616-8686

National Asian Women's Health Organization

www.nawho.org

NAWHO is a national non-profit health organization with a mission to achieve health equity for Asian women and families. Their goals are:

- To raise awareness about the health needs of Asian Americans through research and education;
- To support Asian Americans as decision-makers through leadership development and advocacy;
- To strengthen systems serving Asian Americans through partnerships and capacity building.

Founded in 1993, NAWHO has served as a powerful voice for the health of Asian American women and families. They provide research and information about the health of Asian Americans to the public health field, as well as critically needed health education to the Asian American community.

- **Empowering Avenues for Community Action in Mental Health: The National Collaborative for Asian American Women's Health**

This campaign seeks to:

- Lower rates of depression and suicide among Asian American women aged 18-34
- Remove stigma surrounding mental health issues through education and outreach
- Build the mental health information and referral capacity of community-based organizations
- Empower Asian American women to serve as leaders and advocates for mental health

- ◆ **Regional Information and Referral Clearinghouses for Asian American Mental Health**

NAWHO and its partners have distributed 13,810 pieces of literature about mental health issues affecting Asian Americans. NAWHO also has produced and distributed 2,012 copies of a public education kit to mental health providers, community members, and students.

- ◆ **Reports and Studies**

Breaking the Silence: A study of depression among Asian American women (2001)

The overview and literature review succinctly describe the various issues and research findings pertaining to the mental health needs of Asian American women. Provides a good basis for understanding how academic pressure, the stereotype of the “model minority”, generational gaps, gender, and stigma are issues for Asian American women college students in their awareness of mental health and seeking help for treatment.

Emerging Communities: A health care needs assessment of South Asian women in 3 California counties: Alameda, Santa Clara, and Sutter (1996)

The section on mental health (pp. 10-15) provides an overview of mental health issues of South Asian women. Other parts focus on isolation, occupational issues, generational gaps, sexuality and body image, gender discrimination, their perception of mental health providers, and elderly women.

For more information, contact:

One Embarcadero Center, Suite 500
San Francisco, CA 94111

Southeast Asia Resource Action Center

www.searac.org

SEARAC is a national organization advancing the interests of Cambodian, Laotian, and Vietnamese Americans through leadership development, capacity building, and community empowerment. Founded in 1979, SEARAC serves as a coalition-builder and leader to carry out action-oriented research project, and strengthen the capacity of community-based organizations such as mutual assistance associations and faith-based organizations. SEARAC also fosters civic engagement among Southeast Asian Americans, and represents communities at the national level in Washington, DC.

- **Advocacy and Information-Sharing**

SEARAC seeks to identify the common views of diverse Southeast Asian American populations, to raise the voice of Southeast Asian American groups, and strengthen participation in the shaping of policy. SEARAC advocates on the federal level around issues such as education and immigration that have powerful effects on Southeast Asian Americans. SEARAC also monitors and disseminates information on programs, policies, and legislation of interest to Southeast Asian Americans in areas such as health care, safety, economic development, and civil rights. SEARAC shares much of this information through their website and on e-mail list-serves that reach over 1,000 people nationwide. Annually they stage a "Leadership-Advocacy Training" that enables fifty community members to gather in Washington, DC, for four days of networking and advocacy with members of Congress and administration officials.

- **Human Rights**

SEARAC's broadest goal is to promote human rights with a focus on Americans from Cambodia, Laos, and Vietnam. Activities are directed towards securing basic human rights for our constituents, but never at the expense of the human rights of other groups.

- **SEARAC and Mutual Assistance Associations (MAAs) and Faith-Based Organizations (FBOs)**

SEARAC maintains a network of 182 such organizations, soon to be accessible through an on-line database on SEARAC's website. Through the **Values, Empowerment, Resources and Betterment (VERB)** project and the **Voting Orientation and Training and Education (VOTE)** project SEARAC provides sub-grants, training, and technical assistance to eighteen Southeast Asian American MAAs and FBOs in California, the District of Columbia, Maryland, North Carolina, Virginia, and Wisconsin. In addition, through Project SOAR (**Supporting Organizations that Assist Refugees**) they work with colleagues to promote leadership at MAAs and FBOs from many ethnic groups (from Asia and elsewhere) throughout the country.

For more information, contact:

1628 16th St., NW
3rd Floor
Washington, DC 20009

Model Programs

Organizations highlighted provide culturally competent mental health services to AAPI communities. Please note that programs listed are not inclusive of every existing program, rather examples of best-practices in the field.

Asian American Family Counseling Center

Houston, TX

Recognizing the glaring lack of mental health services geared towards the rapidly growing Asian American population in the greater Houston area, a group of professionals established AAFCC in late 1994. It obtained the non-profit tax-exempt status in October 1995. A three-year grant in 1997 from the Hogg Foundation for Mental Health enabled the agency to establish a comprehensive service seeking to connect Asian American children and families with appropriate health, mental health, and other human services resources. It has grown from a one-room donated office to its current space with two counseling rooms, a conference room and staff offices. Subsequent grants from the Houston Endowment, the Visiting Nurses Association Foundation of Houston, and the National Mental Health Association accelerated the provision of direct counseling and therapy services when demand for services became apparent.

The Asian American Family Counseling Center (AAFCC) is the only community-based agency dedicated to serving the mental health needs of the Asian American community in the greater Houston area. AAFCC provides linguistically and culturally competent counseling services, while integrating Eastern and Western approaches in all its programs.

Services provided include:

- ◆ In house bilingual and bicultural counseling and therapy services to individuals and families (Cantonese, Korean, Mandarin, Vietnamese available, other languages upon request).
- ◆ Information and referral for other mental health and social services
- ◆ Case management including interpreting and translation
- ◆ Psychological and educational testing
- ◆ Youth development programs
- ◆ Community outreach and information dissemination (including to area school districts and community agencies)
- ◆ Bi-monthly educational seminars and speakers bureau
- ◆ Student internships and practicum programs
- ◆ Partnerships and collaboration with public and private service entities

For more information, contact:

6220 Westpark Suite 228
Houston, TX. 77057
713-339-3688

Asian American Primary Care and Mental Health Bridge Program Charles B. Wang Community Health Center (formerly Chinatown Health Clinic) in New York City, New York

- ◆ **Target Population:** Chinese Americans in the greater New York area.
- ◆ **Project Goal:** Provide mental health care to Chinese Americans in a primary care setting.
- ◆ **Project Description:** The Chinatown Health Clinic (CHC) in New York initiated the Bridge Program in late 1997 to increase the utilization of mental health services by AAPIs.

The program was designed to: provide mental health care in a primary care setting; train primary care physicians to better diagnose and treat mental disorders; help patients access additional mental health services; and provide community health education on common mental health disorders.

CHC staff noted that many AAPIs knowingly and unknowingly seek treatment for mental disorders in primary care settings, due to factors ranging from the stigma surrounding mental illness to a lack of knowledge regarding the prevalence of mental disorders. Since many AAPIs feel more comfortable accessing the primary care system, CHC staff felt more mental illnesses might be diagnosed at an earlier stage if mental health services were integrated in a primary care setting.

The program consists of clinical services that are provided by a psychiatrist, psychiatric social workers, and a case manager; referral services to mental health specialty clinics and agencies; training for primary care physicians; and education outreach, such as a radio hotline and community forums in local schools and organizations.

So far, the program has served 620 patients and is being replicated at South Cove Community Health Center in Boston.

- **Languages:** English, Cantonese, and Mandarin
- **Annual Budget and Funding Sources:** The annual program budget was approximately \$270,000. The original funding agencies include The Robert Wood Johnson Foundation Local Initiatives Funding Partnerships Program, the van Ameringen Foundation, the Pfizer Foundation, the New York Community Trust, and the Sergei Zlinkoff Fund.
- **Partnerships:** Local providers, mental health clinics, hospitals, and ethnic media outlets.
- **Health Related Outcomes:** An increase in early detection of mental health disorders; a smoother transition for patients requiring more intensive or comprehensive treatment; and an increased delivery of services to patients who otherwise would not receive them. Primary care provider and patient satisfaction surveys indicate overall high satisfaction with the service.

- **Recommendations for Replication of Model Program**
 - ◆ The project director should be knowledgeable about AAPI communities, believe that the program meets a community need, have excellent communication skills, and possess the ability to motivate staff to play a contributing role.
 - ◆ Seek adequate funds to implement the program.
 - ◆ Recruit and retain competent, bilingual/bicultural staff members who are team players.
 - ◆ Conduct on-going program monitoring and staff meetings to provide updates and feedback on the effectiveness of the program.

- **Lessons Learned**
 - ◆ Lack of knowledge regarding mental disorders and the need for mental health services prevents patients from accessing existing mental health services.
 - ◆ Stigma prevents patients and families from seeking mental health services. Leveraging the status of primary care centers helps to decrease this stigma.
 - ◆ The shortage of bilingual/bicultural mental health professionals requires us to utilize the existing pool of bilingual/bicultural primary care professionals.
 - ◆ Innovative and creative solutions are required if the target population seeks assistance or services in a unique way.
 - ◆ Overutilization of primary medical services occurs when patients who have a mental illnesses seek treatment in primary care clinics lacking a structured mental health engagement and treatment system.
 - ◆ Primary care providers are still inadequately trained to deal with mental disorders and mental health issues.
 - ◆ Primary care settings can effectively serve as sites for early detection and treatment of mental disorders, and can lead to the increased delivery of comprehensive mental health services to patients who need them.

For more information on this program, contact:

Teddy Chen
268 Canal Street 6/F
New York, NY. 10013
212-378-6988

Asian Counseling & Referral Service Legacy House International Community Health Service: Seattle, Washington

- **Target Population:** Residents of Washington state.
- **Project Goal:** To offer a continuum of health and human services for AAPIs.
- **Project Description:** Asian Counseling & Referral Service (ACRS), Legacy House, and International Community Health Services (ICHS) represent three of four member health and social service agencies that comprise the International District Village Square.

International District Village Square, which opened in 1998, was created so AAPIs, many of whom were low-income, could access a one-stop-shop model of multicultural and multilingual service delivery. The Village Square, which occupies some 100,000 square feet, is a collaborative of agencies including a health clinic, child care/Head Start center, job training, counseling, and a long-term care facility.

Asian Counseling & Referral Service offers mental health services and a broad range of programs including services for the elderly, a chemical dependency treatment program, and vocational services.

The agency served 14,719 unduplicated patients in the year 2000. The Village Square's second member, Legacy House, offers long-term care to 470 independent low-income seniors. International Community Health Services is a community health center offering health care services and programs, such as a breast and cervical health program which advocates for breast and cervical health for low income, limited-English speaking AAPI women. The center served 5,851 patients in 2000.

Since the member agencies offer a single access point for service delivery, they are able to increase health access to underserved AAPIs, serve more patients, streamline their services, and consequently reduce costs. Under the one-stop-shop model, an elderly individual from Legacy House in need of health care services can be referred to ICHS' health clinic.

Together, the member agencies provide health and social services in 35 different languages to over 21,000 people every year.

- **Asian Americans and Pacific Islanders served:** Filipino, Cambodian, Vietnamese, Chinese, Korean, Japanese, Laotian, Hmong, Mien, Samoan, Thai, East Indian, Pakistani, Burmese, Tongan, Khmu, Native Hawaiian, and other multi-ethnic Asians.
- **Languages:** English, Cambodian, Cantonese, Mandarin, Toisanese, Tagalog, Ilocano, Korean, Japanese, Lao, Mien, Samoan, Thai, Vietnamese, Hmong, Khmu, Tongan, Bikol, Cebuano, Kankanaey, Anhui, Chaozhouese, Hakka, Hangchouese, Sauchouese, Shanghainese, and Taiwanese.

Annual Budget and Funding Sources: The overall budget for the International District Village

Square project was \$19.6 million, and was funded by private donations and public sources, such as the city real estate excise tax and tax exempt bonds.

The annual budget for ACRS is \$7.05 million. Funding sources for ACRS include the King County Mental Health System, the City of Bellevue, and the United Way. Legacy House's annual budget is \$1.5 million. The center's funding sources include The Robert Wood Johnson Foundation, City of Seattle Aging and Disability Services, and the State of Washington's Department of Social and Health Services. The annual budget for ICHS is approximately \$6.9 million.

- **Health Related Outcomes:** Although each agency noted individual health related outcomes within their specific programs, they all noted that the International District Village Square allowed residents and clients to improve their overall health and well-being through coordinated care management with collaborating health care, mental health, vocational and other social services. Legacy House in particular stated that intergenerational relationship between its seniors and children from the neighboring child care center enhanced self-esteem and improved seniors' overall quality of life.
- **Recommendations for Replication of Model Program**
 - ◆ Collaborations and partnerships with other organizations and communities with similar or complementary concerns is crucial.
 - ◆ An unwavering commitment to educating the general public and policy makers of the value and need for culturally competent services is vital. Though culturally competent services appear more expensive, these investments in the long run prevent more costly interventions. It is impossible to replicate the same level of care and service in a mainstream setting at the same or lower cost.
 - ◆ Diversity is an asset and a strength.
 - ◆ Combining programs may increase economies of scale.

For more information on this program, please contact Janet Soo-Hoo, (206) 695-7632.

Asian Human Services

Chicago, Illinois

- **Target Population:** The growing AAPI immigrant and refugee population in the Chicago area.
- **Project Goal:** To provide comprehensive mental health, health care and human services to AAPIs.
- **Project Description:** Asian Human Services was established in May 1978 to respond to the mental health service needs of the growing Asian immigrant and refugee populations in Chicago. The center's programs were designed to help socially, culturally, and economically disadvantaged AAPI families achieve economic and social independence.

AHS' mental health services include:

- 1) the Adult Outpatient Mental Health Services program, which provides culturally and linguistically sensitive therapy, counseling, case management, 24-hour emergency services, and outpatient psychiatric assessment and medication management;
- 2) The Psychosocial Rehabilitation Program, which teaches clients who have a mental illness the skills of daily living;
- 3) The Refugee Counseling Services program, which offers family counseling services to refugees, many of whom suffer from Post-Traumatic Stress Disorder, depression, and anxiety;
- 4) An HIV/AIDS individual and group counseling program for clients who are HIV positive or have AIDS, and their families;
- 5) Child and adolescent mental health services, including therapy, counseling, and psychiatric evaluation and medication.

The agency's mental health services are CARF (Commission on the Accreditation of Rehabilitation Facilities) accredited.

AHS supplements its mental health services with on-site community services such as a legal clinic, medical clinic, employment services, programs for developmentally disabled clients, health education and outreach, HIV/AIDS case management and education, and youth counseling and outreach.

The mental health staff is comprised of four psychiatrists, and various mental health professionals, eight of whom have master's degrees and nine who have bachelor's degrees. There are internships available for qualified students. AHS' mental health staff serves up to 600 individuals annually.

The mental health staff is comprised of four psychiatrists, seven social workers and psychologists with master's degrees, one mental health professional, five caseworkers with bachelor's degrees, and two interns. AHS' mental health staff serves up to 600 individuals annually.

- **Asian Americans and Pacific Islanders served:** Chinese, Vietnamese, Japanese, Korean, Cambodian, Asian Indian, Pakistani, Filipino, and Thai

Languages: English, Vietnamese, Khmer, Korean, Japanese, Hindi, Urdu, Cantonese, and

- Mandarin.
- **Annual Budget and Funding Sources:** AHS' annual budget is \$3.4 million. Funding sources include the Illinois Department of Human Services/Office of Mental Health, United Way, Bureau of Refugee Services, Department of Public Aid, the City of Chicago, other government agencies and foundations.
- **Partnerships:** AHS conducts meetings with respective AAPI communities, and surveys local community agencies on a quarterly basis to determine AAPI community needs. AHS also partners with local hospitals.

Health Related Outcomes: In the Adult Outpatient Mental Health Program for FY 2001:

- ◆ 70 percent of clients partially achieved set goals
- ◆ 15 percent of clients achieved set goals
- ◆ 90 percent of clients were doing well at follow-up
- ◆ 82 percent of clients' Global Assessment of Functioning (GAF) scores, which measures both symptom level and ability to function in the daily world, improved.
- ◆ The program received a 100 percent satisfaction rating from clients

In the Psychosocial Rehabilitation Program for FY 2001:

- ◆ 90 percent of clients showed an increase in skill level
- ◆ 87 percent of clients' GAF scores improved
- ◆ The program received a 100 percent satisfaction rating from clients

- **Recommendations for Replication of Model Program**

- ◆ Hire culturally and linguistically appropriate staff.
- ◆ Partner and ally with both state and local agencies.
- ◆ Hire AAPI professionals with a strong background in the fields they are working in.
- ◆ Be mindful and respectful of both Eastern and Western mental health philosophies.

- **Lessons Learned**

AAPIs were willing to utilize mental health services if they were accessible. Language and cultural differences were the largest access barriers preventing AAPIs from seeking services at mainstream mental health centers.

For more information on this program, please contact Abha Pandya, (773) 728-2235.

Metro Boston Asian Collaborative: Southeast Asian Community Clinic in Boston, Massachusetts

- **Target Population:** Cambodian, Chinese, and Vietnamese immigrants and refugees.
- **Project Goal:** To provide culturally competent rehabilitative and support services for Cambodian, Chinese, and Vietnamese immigrants and refugees suffering from mental illness.
- **Project Description:** The Metro Boston Asian Collaborative (MBAC) is a partnership between three Massachusetts-based agencies: Southeast Asian Community Clinic (SEACC) at North Suffolk Mental Health Association (the lead agency), Dorchester House, and the Department of Psychiatry at the New England Medical Center.

MBAC, which began in 1999, was created to improve the mental health of AAPI immigrants and refugees, as well as increase their access and utilization of corresponding mental health and health care services.

Among other things, the program was designed to help individuals recover from conditions such as depression and Post Traumatic Stress Disorder, and develop skills that enable them to enter the workforce and function independently in society. MBAC has served 500 individuals since its inception.

The program pools the resources of each agency to provide a continuum of care to Boston's diverse immigrant and refugee population. SEACC is an outpatient psychiatric treatment facility, which treats severely traumatized and seriously ill refugees who have survived war trauma, genocide, and political terrorism. Dorchester House is a full service community health center, social service agency, and recreational facility. The New England Medical Center (NEMC) is a clinical teaching and research facility that houses the Asian Psychiatry Clinic.

Though all centers offer similar services such as individual and group counseling, psychopharmacologic evaluation, medication maintenance, crisis intervention, and rehabilitation services, each center also offers a unique service that may now be accessed by collaborative members' client base. For example, clients of Dorchester House may access SEACC's Vietnamese day treatment program.

The program also offers community workshops that give program staff the opportunity to hear community concerns.

- **Languages:** English, Chinese, Vietnamese, and Cambodian
- **Annual Budget and Funding Sources:** The annual budget for FY 2000 was approximately \$692,000. Funding sources include the Department of Mental Health of the Commonwealth of Massachusetts, Medicaid, Medicare, and third party insurers.

Partnerships: MBAC collaborates with other primary care providers, state and community

- agencies, hospitals, medical schools, and churches.
- **Health Related Outcomes:** Program coordinators expect a reduction in the utilization of inpatient psychiatric hospitalization, redundant or unnecessary primary care visits, and attempted or completed suicides. Early crisis intervention and greater access to appropriate care will also result in reduction of recidivism and/or serious regressions.
- **Recommendations for Replication of Model Program**
 - ◆ Hire bilingual, bicultural staff whenever possible.
 - ◆ Establish a center where the target population resides.
 - ◆ Establish linkages with primary care centers in the target population's community.
 - ◆ Establish affiliations or liaisons with ethnic community agencies and mutual support groups.
- **Lessons Learned**
 - ◆ Locating services where they can be easily accessed by the target population is essential.
 - ◆ Initiate extensive outreach services to populations that are unable to speak or understand English and are unfamiliar with urban U.S. health care systems.
 - ◆ Employ bicultural professionals whenever possible.
 - ◆ Train all professionals who are not bicultural on issues of cultural competence and sensitivity, and pair those individuals with trained bilingual, bicultural staff.

For more information on this program, please contact Thang Pham (617) 912-7500.

Southeast Asian Outreach and Kajsiab House

Kajsiab House / Tsev Kajsiab

Mission: To create a culturally and safe environment to promote well-being in the Hmong community.

Meaning of “Kajsiab”: In Hmong, Kajsiab (Ga shee’ ah) means the relief of stress and tension from worrying about the safety of loved ones.

Kajsiab House, founded in January 2000, is a program of the Mental Health Center of Dane County, Inc. Kajsiab House was developed for the Hmong community, as a place in which Hmong elders and their families can be safe, express and experience their culture, as well as increase their understanding and the ability to live successfully within an American cultural context.

Who are the Participants?

Kajsiab House participants are made up of Hmong-American veterans, widows of veterans, and adults who have severe health problems because of their services and sacrifices in America’s “Secret War” in Laos from 1961-1975. Of the 5,000 Hmong Americans living in Dane County, over 300 are war veterans or widows of veterans. A high percentage of these elders live with severe health problems, such as depression, post-traumatic stress disorder, anxiety, and chronic pain that were caused by their war and refugee experiences. In addition, their assimilation into American society has been complicated by language, cultural and transportation barriers, as well as unmet social and health problems that social services and health care providers lack the resources to address.

Program Services

Kajsiab House programs improve the lives of Hmong individuals and families:

1. **Cultural Brokering and Case Management:** Professional bilingual cultural brokers provide counseling (individual, family and group), advocacy, translation, and case management
2. **Hmong Sister Group:** Hmong women counseling and support group
3. **Psychological, Psychiatric, and Alternative Medicine Services:** Individual, family and group therapeutic services and medication consultation
4. **Social/Recreational Activities:** Field trips, social gatherings, games
5. **Transportation:** Available to Kajsiab House participants
6. **After School Programming:** Academic and social support to children whose parents are Kajsiab House clients
7. **Community Computer Room:** For academic research/job support

8. **T'ai Chi:** Healthy physical/mental activities for Hmong adults/elders
9. **Meal Program:** Nutritious breakfast and lunch
10. **Hmong and English Classes:** Weekly language classes

Impact of Kajsiab House

- ◆ Gives Hmong elders and families hope for a better life in Dane County
- ◆ Helps elders and families become active members in the community by encouraging them to participate in activities, such as assistance to victims of the 9/11 tragedy.
- ◆ Improves the mental, emotional, and physical well-being of participants
- ◆ Creates an atmosphere that fosters respect for Hmong culture and ancestral traditions while participants learn about living in American society and culture

For more information, contact:

Doua Vang
3518 Memorial Dr. Bld #4
Madison, WI. 53703
608-280-2480

Asian Pacific Counseling and Treatment Center: Reaching Out to Asian Elderly

Special Services for Groups has operated health and social services programs in Los Angeles for more than 50 years. Among its 25 programs is the Asian Pacific Counseling and Treatment Center.

Operating since 1990 at six sites, APCTC is among the county's oldest and largest mental health centers serving Asian and Pacific Islander communities. It offers outpatient services, family support, adult day rehabilitation, community outreach and case management.

In partnership with other API organizations and funding from The California Endowment, APCTC implemented a mental health program for seniors isolated by language and culture. Through aggressive community outreach — nearly 400 events — APCTC reached Chinese, Japanese, Korean, Cambodian and Thai seniors and their families.

Promotion included publicity in the ethnic media, a nine-language brochure, and presentations and information booths at cultural events and fairs. Needy seniors were identified through social outings and support groups facilitated by: APCTC; Chinatown Service Center; Korean Health, Education, Information and Research Center; Thai Inc.; and Little Tokyo Service Center.

Over three years, the program provided intensive case management to more than 200 seniors and culturally competent therapy to 80 individuals with moderate mental health needs. APCTC helped in the development of the smaller API-serving agencies it collaborated with, and today these agencies have increased capacity and trained staff to serve the API elderly.

These organizations will continue their outreach, assessments, case management, support groups, treatment services, socialization activities and other efforts to carry on the program.

**For more information, contact:
520 S. LaFayette Park Place Third Floor
Los Angeles, CA. 90057
213-252-2100**

Asian Pacific Health Care Venture: Shift to Holistic Health

The Asian Pacific Health Care Venture has been providing affordable and culturally competent health care services to under-served Asians and Pacific Islanders in central Los Angeles since 1986.

APHCV opened its primary care clinic in East Hollywood and now provides comprehensive medical and mental health services to all age groups, including family planning, disease management, health education, a school-based clinic, and HIV testing and counseling. More than 30,000 visitors per year, who may speak any one of seven Asian languages or Spanish, received these services.

Bilingual staff helps with Medi-Cal and Healthy Families applications, provide case management, and offer parent education and health education classes and CPR trainings.

APHCV, with \$300,000 from The California Endowment, developed API HealthLink, an integrated mental health and primary health care model that provides screening, treatment and support to Asians and Pacific Islanders in the Hollywood/Echo Park and Silver Lake areas. Stigma, language barriers and cost discourage Asians and Pacific Islanders from seeking help, and API HealthLink has proven effective in linking clients to mental health services. API HealthLink provided hundreds of encounters to a predominantly Thai and Filipino client population diagnosed with depression and adjustment and anxiety disorders. An end-of-treatment survey shows that patients improved their overall health, life functioning and compliance with clinical recommendations they got through API HealthLink.

To combat stigma, 10,000 brochures about mental disorders were produced in Thai and Khmer and distributed to clinics, public agencies, nonprofit organizations, and elsewhere in API communities.

The ethnic media published articles on depression, anxiety, post-traumatic stress disorder and the API HealthLink services. API HealthLink has shifted APHCV's perspective from physical health to a holistic view. Providers previously reluctant to refer patients to mental health services have done an about-face and significantly increased referrals to the licensed clinical social worker.

APHCV has become a tenacious advocate for the Asian and Pacific Islander community and is an active participant in API-led movements in this area.

**For more information, contact:
1530 Hillhurst Ave, Suite 200
Los Angeles, CA 90027
323-644-3888**

Asian Pacific Psychological Services: Bridges to Mental Health

Asian Pacific Psychological Services has served the Asian and Pacific Islander communities in Alameda and Contra Costa counties, particularly disadvantaged immigrant and refugee families, since its inception in 1996. APPS operates through a multidisciplinary team of mental health and substance abuse professionals who together speak at least 11 Asian languages and dialects.

The California Endowment funded APPS' Project Building Bridges to increase Chinese and Vietnamese immigrants' access to mental health services by integrating mental health and case management services into the primary care setting. APPS, under a memorandum of understanding with the Alameda County Medical Center's Central Health Center, served county patients who were Chinese and Vietnamese. When the county closed the Central Health Center in summer 2003 and sent the clients to Eastmont Health Center, APPS followed them.

APPS' integrated program entailed psychiatric assessment, therapy, medication evaluation, case management, treatment and referrals. At the same time, Project Building Bridges trained 72 primary care physicians to improve their skills in diagnosing mental health conditions in the two Asian populations.

They also educated the API community about mental health through the dissemination of *Out of the Shadows*, a 10-minute video about depression and post-traumatic stress among Asians.

APPS got input from the Asian Mental Health Awareness Task Force — mental health consumers, API youth and parents, API community leaders and service providers. The Task Force helped Project Building Bridges develop assessment and evaluation tools, sustainability plan and outreach materials.

The Task Force has become a model for meaningful community involvement, and APPS has created similar task forces for its other projects. The Task Force still meets regularly and makes public presentations to increase awareness of Asians' and Pacific Islanders' mental health needs.

For more information, contact:
431 30th Street, Suite 6A
Oakland, CA. 94609
510-835-2777

Cambodian Association of America: Three Ways to Healthy Minds

For three decades, since 1975, the Cambodian Association of America has been helping Cambodian and other Southeast Asian refugees assimilate to life in the United States by offering social services that address their physical and emotional needs while respecting their culture, customs and values.

CAA operates a number of programs funded by federal, state, county and city agencies and private foundations, offering services including counseling, advocacy, training, outreach, education and employment. Each year more than 3,000 Cambodians in the Long Beach area receive services.

The Mental Health Initiative enabled the association to implement the Healthy Minds Program, culturally competent mental health services for Cambodian adults. This program was a joint effort with the Long Beach Asian Pacific Mental Health Clinic. Together, the two organizations reached out to the community in an effort to de-stigmatize mental illness, trained other providers to work with Cambodian clients, and offered treatment and case management to meet individual needs. During the three-month start-up phase, CAA recruited and trained staff, developed materials, and assembled a community oversight board that met monthly to provide input on program design, implementation and quality.

Healthy Minds utilizes three interrelated strategies:

1. Outreach, which attempts to de-stigmatize mental illness in the Cambodian community by educating about the effects of severe trauma and promoting resources to address post-traumatic stress symptoms. Outreach was conducted at Cambodian cultural and community events, Buddhist temples, and social and public service agencies.
2. Culturally competent community training helped service providers to recognize and address the effects of the refugee experience among their Cambodian clients. Training was provided to Healthy Minds Program staff, other community-based mental health providers, and traditional Cambodian spiritual leaders.
3. Provide bilingual/bicultural case management and mental health treatment services to Cambodian clients.

Cambodian Association of America reduced the stigma of mental illness within the Cambodian community and increased providers' cultural competency.

For more information, contact:
2501 Atlantic Avenue
Long Beach, CA.
562-426-6002

Chapter 3

Formulating Your AAPI Outreach Plan

Now that we know more about Asian American and Pacific Islanders and mental illness, we can begin to take the steps necessary to formulate a successful, culturally competent outreach plan for these communities. The following steps will aid you in successfully starting an outreach plan. Take time to go through these steps with your state or affiliate leaders. Try to answer all the questions and take abundant notes.

1. Decide Whether or Not to Embark on an Outreach Effort

In order to begin planning for your outreach activities, it is necessary to develop an agreement within your organization to embark on such effort. This phase is crucial to the future development of your project. This is because outreach activities often appear attractive "in theory" to affiliate members when, in actuality, such efforts can be quite time consuming and demanding. For these reasons, it is imperative that unanimous or near-unanimous agreement exists among the membership that an outreach effort is needed and desired. It is also necessary to be clear about the amount of time, resources, and commitment that this will entail.

Steps to follow:

1. Hold a series of meetings to discuss the idea of engaging other communities.
 - Why is this important?
 - What can you group do?
 - If you have any members from diverse communities, ask them share their experiences with the group.
2. Be very clear and honest about the pros and cons of developing such an effort.
3. Be aware that some of your affiliate's members may be hesitant to openly express their reluctance or disagreement with the decision to conduct outreach activities.
4. Encourage open discussion. It is important that everyone is given a chance to express negative feelings about the potential of doing outreach, without fear of being accused of insensitivity to the needs of diverse communities.
5. Even if the group is unable to reach a consensus about embarking on the effort, you will gain awareness of which affiliate members are enthusiastic about the effort and which have some reservations. Allowing everyone's opinions to be heard will help to ensure that as many members as possible "buy-into" the plan.

Answer these questions with your state and/or affiliate members:

What does your group offer to persons or family members from diverse communities?

Does your group offer services to minority family members and/or consumers? If your answer is positive, what type of services?

Do you have special committees that address the specific concerns/issues of the minority population in your area?

Do you have materials (fact sheets, membership application forms, etc) in any languages other than English? Do these materials meet needs of local minority community members?

Do you have education programs or support groups for diverse populations?

Do you have minority members?

Approximately how many?

2. Identify Your Target Group

Be realistic and specific when choosing a community. Your outreach plan will be based on the specific segment of the community that you want to reach. For example, if you decide to reach educated and upper class African American families, the strategies that you need are different than the strategies that you would use when reaching African Americans in the inner city.

What are the demographics in your state and/or city?

What group do you want to target? Why?

What are your current resources for this community?

Do you have any members from this community who could help you?

How to find the demographics of mental illness in your state:

- Contact the Department of Mental Health Services in your local area
- United States Census Bureau
www.census.gov
- Estimated 12-month number of persons with serious mental illness, age 18 and older, by state, 2000
http://www.mentalhealth.org/databases/databases_exe.aspD1=LA&Type=ASMI&Myassign=list
- Mental Illness affects all of society
<http://atlanticville.gmnews.com/News/2001/0719/Letters/009.html>
- Mental Health Stats by subject (Mental Health)
www.cdc.gov/nchs/fastats/mental.htm
- The Henry J. Kaiser Family Foundation
<http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.gi?action=compare+category=MI>

3. Study The Community You Want To Reach

Once your affiliate has discussed and decided to reach a specific community in your area, you need to learn as much as you can about this group, its characteristics and history. The more you know about your targeted audience, the more successful you will be at engaging them in meaningful ways. Read as much as you can about your target community in order to become more familiar with it.

Learn about:

- Your target's group culture (history, traditions, values, family systems, artistic expressions).
- The impact of racism and poverty on behavior, attitudes, values, and disabilities.
- The help-seeking behaviors of this community.
- The roles of language and communication styles.
- The resources (i.e., agencies, persons, informal helping networks, research) available for ethnic minority families and communities.

Find out what prompted your current members from your target group to join NAMI and what encouraged them to remain involved.

- **What attracted them to join your affiliate?**
- **How did your affiliate reach these individuals?**
- **Why did they remain active?**
- **Are they happy with their membership? Why? Why not?**

4. Cultural Mapping

Cultural mapping is an approach used to identify the characteristics of a community's resources and features. When you finish your cultural map you will be more familiar with your target group and you will have identified some key elements for your plan.

In order to do your cultural map:

1. Identify some community members to help you navigate it and who can also respond to your questions.
 - Make sure these respondents are part of the community and that they are able and willing to share their knowledge with you. These people can help you determine where to go, who to contact, how you should interact with the group, what type of questions you can ask, what is culturally appropriate, etc.
2. Remember to enter the community with humility and be ready to learn about it.
3. It is important that you enter the community with a clear agenda of what you want to learn from it. This will help you stay focused, not feel overloaded with information, and to not seem as if you are “watching” or “studying” it.

Below are examples of questions that you should respond to in order to map the group you are targeting. **Be as specific as possible.**

Identify the location of this community

- In your city, where do members of your target community live? Which neighborhoods?
- What are the characteristics of these neighborhoods?
- Are they safe neighborhoods?
- Are they quiet neighborhoods?
- What is the neighborhood area like?
- What are the boundaries of the neighborhood?
- Is there easy access to public transportation?

Identify community organizations

- Where do community members congregate?

- Where are the schools, hospitals, community centers, and churches?
- Are there any community-based organizations?
- What types of social services are available?
- Are there any neighborhood associations?
- Are there other less formal social groups? (e.g. clubs, fraternities/sororities, gangs, book clubs, etc)
- What do these organizations and clubs do? What needs do they address?
- Who runs these organizations?
- What are some important businesses patronized by community members? (e.g. beauty salons, restaurants, grocery stores, etc.).
- What are the media outlets (newspapers, TV, radio)?

Identify community leaders

- Who are the community leaders? (e.g. pastors, local legislators, commissioners, teachers, school counselors, business owners, artists, professionals, media personalities, etc.).
- What other leadership roles are evident?
- List leaders by name and location.
- Where does your target group look to get reliable information?

Identify prevailing beliefs expressed by the community

- Is it a largely religious community?
- What are the community's symbols and ceremonies?
- What is the community's relationship with the rest of the population?
- What other characteristics and beliefs do community members have?

Identify community beliefs towards mental illness

- Is the community aware of mental illness?
- What are the levels of stigma about mental illness?
- Is there discrimination toward people with mental illness?
- Does the community have information about mental illness?

- Does the community see mental illness as an important issue?
- If this NAMI group were truly representative of the population of this community, how might its support and advocacy functions expand or change?

Identify community needs

- What are the major issues that affect this community?
- What are the priorities of the community?
- What are the biggest needs of the community?
- Where does mental health fit within the community framework?

Compile the answers to all of these and any other questions that you think may be important and share them with your group. The answers to these questions will help you in your planning and strategizing process.

5. Identify Key Community Leaders

Thanks to your cultural map, you should be able to identify key community leaders. Approach those leaders who could partner with you. Cultivate relationships with them. It might take time to gain their trust but it is essential to have their support and buy in.

These leaders are your community experts. They should be part of the entire outreach planning process. They can help you identify the community needs and how to successfully reach the group. Because they are respected and recognized by the group, these leaders can help you gain access, trust, or attention from the group.

- Who are the leaders of your target community?
- Do you have contact with them?
- How can you contact them?
- How can you establish a working relationship with them?

6. Needs Assessment

To reach AAPI communities in your area, you need to identify their needs. To perform a needs assessment, partner with community leaders that will help you understand the group's culture and guide you through cultural differences. Community leaders can help you establish bridges of communication and trust between you and the rest of the community. This will allow you to clearly identify the needs of the community.

7. Formulating Your Basic Outreach Plan

Now that you know more about your target community and their needs, you can begin a series of planning meetings to start formulating your plan. These meetings should involve members of your affiliate **along with your informants, your key community leaders** and any other members of your target community who are willing to provide you with feedback and suggestions.

It is important to involve community members at *this* stage, in order to ensure that plans are relevant, responsive to the community's needs, and as culturally meaningful as possible. It was not suggested that community members attend the initial planning meetings, because their presence may inhibit people who are opposed to the effort from making their feelings known to the group. However, at this point, affiliate members will have been given ample opportunity to air their opinions and concerns, and the attendance of community members can enrich the planning process without stifling opposition.

You could also create an outreach taskforce or committee to lead this efforts. This group should include affiliate leaders, staff, your informants and key community leaders. Do not make the mistake of only including Asian Americans/Pacific Islanders on your taskforce. They should more certainly be involved and guide the task force. Though, it is important for other leaders and staff to be involved, learn more about the group, and help with their efforts.

Questions to consider:

- When families from your target group contact you, how could you respond to their emotional support needs and provide information about mental illnesses and NAMI in a culturally sensitive manner?

- What resources are you going to provide to these consumers and their families?

8. Decide The Major Focus Of Your Activities

One of the most important parts of developing your outreach plan involves deciding on the major focus of your activities. Traditionally, NAMI's focus areas include: education (Family to Family, Peer to Peer, In Our Own Voice, Visions for Tomorrow and other education programs), support groups (family and consumer oriented), and advocacy on behalf of people with mental illness and their families, through lobbying for better services and a more responsive mental health system.

The decision about which components to include in your plans is totally up to you. It is important to solicit the opinions of your community members to help you make this decision. For example, they may feel that establishing support groups is more important than recruitment. A sole focus on recruitment may convey the impression that you are only interested in increasing the size of your dues-paying membership and not in meeting the needs of your target community. Also, members of your target group may not have the financial resources to pay affiliate dues. If recruitment is a major goal of your project, consider offering free membership for a year to demonstrate your sincerity and give people an opportunity to see what you can offer before they are asked to contribute financially. As another example, your African American advisors may feel that their community needs education more than it needs advocacy. Listen to their opinions carefully because they are in the best position to accurately assess needs.

After considering their opinions, your members' preferences, available monetary resources, and the natural talents of your affiliate's members, you will be in a good position to map out the components that you want to include in your planning.

Pages 75-81 detail different NAMI Affiliate outreach efforts and activities.

9. Identify Specific Goals

After making decisions about which components will be part of your plan, it is time to identify the specific goals that your activities will address. You should try to identify one or two goals for every component. Keep in mind that goals are statements that say exactly what you expect to accomplish through each component. For example:

COMPONENT POTENTIAL GOALS

- | | |
|--|--|
| <i>Education</i> | <ul style="list-style-type: none"> - Creation of culturally and linguistically appropriate pamphlets about the causes and treatment of mental illness. - Creation of a videotape explaining different types of psychotropic medications and their side-effects. - Compilation of a resource book containing the names, addresses and telephone numbers of all African American mental health treatment professionals and agencies in the community. |
| <i>Ethnic-Specific Support Groups</i> | <ul style="list-style-type: none"> - Establishment of an AAPI family support group. - Encouragement of attendance at a support group without requiring membership in NAMI. |
| <i>Recruitment</i> | <ul style="list-style-type: none"> - Sponsoring the first year of NAMI membership for low-income community participants. - Setting a target of increasing AAPI membership by a specific proportion. - Making a commitment to increase the representation of AAPIS on an affiliate's board of directors. |
| <i>Advocacy</i> | <ul style="list-style-type: none"> - Lobbying state government officials to increase funding for mental health services in the target community. - Making surprise visits to state inpatient psychiatric facilities serving AAPIS to assess conditions. |

The aforementioned are examples of the many types of goals that your group may identify in your planning process. The exact nature of your goals is not as important as the requirement that they be specific and realistic outcomes of your activities. Start with a potential set of goals, but do not be afraid to add or subtract goals as you proceed in your efforts.

9. Create Or Join A Community Coalition

NAMI leaders know that resources are limited. We have limited funds, volunteers, staff, and expertise. Alone we cannot fix the problems faced by AAPI community. For this reason, we must establish coalitions with local community organizations in order to unite our resources. Partnerships with community organizations will benefit NAMI as much as it will benefit these organizations. Example:

NAMI's Multicultural Partner Coalition

NAMI's Multicultural Action Center is bringing together a cadre of national and international partners to join NAMI and its members in meeting the mental health needs of individuals from diverse communities. The primary role of the NAMI Multicultural Partner Coalition is to support community organizations and NAMI organizations in grassroots activities aimed at addressing mental health needs of racial, ethnic and cultural minority groups. The NAMI Multicultural Action Center works to improve education and understanding of mental illness and to ensure access to quality treatment and services for racial and ethnic minorities and other under-served groups.

By developing and maintaining relationships with organizations that already meet many of the needs of these individuals, NAMI Multicultural Partners will provide immediate access to community members and opportunities for improved understanding and policies addressing the research, treatment, services and support needs of these communities. We are partnering with organizations with a particular interest in engaging their affiliates/ members locally to meet community needs.

NAMI Multicultural Partner Coalition members will also act as advisors to the Center on strategic initiatives and opportunities. The goal is to ensure that people from all races, cultures and ethnic groups with mental illness receive the best and most appropriate treatment and services that are available. We hope to eliminate stigma and discrimination, shape governmental policies to better meet the needs of people with mental illness and their family members and ensure that these individuals live with dignity and respect regardless of their ethnic, racial or cultural identities.

Partner benefits:

- Networking with multicultural and multinational coalition members
- Assistance with addressing mental health needs of organization constituents
- Collaboration on community projects with NAMI's state organizations and local affiliates
- Use of NAMI's educational materials for coalition organization's constituents
- Collaboration on special projects
- Potential for joint funding opportunities
- Access to leading information on mental illness
- NAMI support of advocacy issues relevant to diverse cultures, races and ethnic groups
- Co-sponsoring of special events

10. Funding For Your Outreach Effort

The next issue to consider as you proceed with your planning is how you will fund your activities. This is no easy question given that funding is limited. Some options are:

- Organize fundraising efforts such as street fairs, NAMI Walks, concerts or auctions.
- Commit a proportion of the operating budget (typically derived from dues paid by members) to pay for outreach activities.
- Obtain funds from state or local (city or county government) mental health agencies, child protection, or health agencies.
- Apply for funds from the federal government.
- Apply for funds from local philanthropic foundations such as Community Trusts or the United Way.

Given the limited funding available, it is a good idea to be aware of funding issues at the outset of your planning. However, you may wish to begin developing your plan in the absence of identified funding. This way you can establish an "ideal" set of activities and fund those you find you can afford as you go along. Having plans in place puts you in a position to apply for money once you learn it is available rather than starting from scratch after you learn of potential funding mechanisms.

Do you have the necessary resources?

Have you allocated resources through strategic planning/budgeting to minority outreach, programs, etc.?

What business will support your effort?

Are there any foundations that focus on multicultural communities?

11. Dissemination And Publicity

A final aspect of your planning should cover the ways in which you are going to inform others about your activities. The most important group you want to engage is the community to which you are trying to reach. You should pay close attention to how you are going to let community members know that your program is operating and what it has to offer. Thanks to your cultural map, your taskforce, and planning meetings, you should have a good idea of what type of messages will work for your community and where you should publicize your efforts. Design all your materials and projects based on this information.

- Your coalition members can help you disseminate the information through their networks.
- Mental health professionals and mental health treatment programs serving those communities are important to your success because they, in turn, can help you reach members of your target community.
- Still other target groups for dissemination are other local community organizations such as churches, ethnic clubs, sports facilities, and public education institutions. Many people can be reached through groups such as these, and you should have identified them in the early stages of your planning process.
- If time and resources allow, make plans for a public relations campaign that accesses the media most familiar to your target community.
- Identify journalist from the community who will be willing to report on your program.
- Plan to create press releases, public service announcements, and short newspaper articles detailing your efforts.
- Consider appearing on local television programs that cover local activities and events.
- Identify media outlets that are frequently used by members of your target community; advertising your program in culturally appropriate media will ensure that information reaches the people you want to inform.

12. Evaluation

Whatever activities the group decides to include in their outreach project, they should plan to evaluate them. The basic idea of evaluation is to gain an understanding of how well activities worked and how participants perceived them. This kind of feedback can then be used to redesign program components that were unsuccessful and to improve activities that were successful. Another reason to evaluate activities is to show potential funding agencies that the project is successful in accomplishing its goals. We suggest that evaluation plans include at least the following two: client (or participant) satisfaction surveys and outcome assessments.

Satisfaction surveys

A major requirement of using a satisfaction questionnaire is that people should be easily able to receive, complete, and return it for analysis. One relatively foolproof way to administer questionnaires is by handing them out at the end of an event while people are still gathered together, asking the group to complete them, and then collecting them as people leave.

The questions or statements to which people respond on a satisfaction questionnaire are called "items." Some items force the respondent to choose between a number of pre-specified answers; these are referred to as forced-choice items. Some examples of this type of item include: true/false questions or statements with which the reader "strongly agrees," "agrees," "disagrees," or "strongly disagrees." Another kind of item asks for a written opinion or statement from the respondent; these are referred to as open-ended items. Some examples of open-ended items include: those which ask individuals to say what they liked or disliked about something and those which ask for suggestions for improvement of a program or service. It is a good idea to include both types of items in any satisfaction questionnaire you design.

Outcome assessment

Another type of evaluation to consider is to measure the degree of change that occurs as a result of the project's activities. This is a way to measure the outcome of efforts. In order to assess change, however, it is important to measure a desired outcome before the project begins and again at some point in time after activities have occurred. For example, suppose one of the project's goals is to increase the number of calls for information received from the target population. Here, an assessment will want to measure the volume of calls from Latinos before outreach efforts begin and then after efforts are underway. Another type of pre- and post- project evaluation would concern outcomes such as the proportion of people of color serving on the group's board of directors before and after the project begins or the proportion of group members who are people of color before and after your project begins.

Whatever type of evaluation the group conducts, remember that the most important considerations are that they are done accurately and fairly.

Summary

By the end of your planning process, your group will have accomplished several major objectives:

- You will have dealt with the question of whether or not to embark on an outreach program.
- Identified a target group, found a key informant, and mapped the community.
- Formulated your basic outreach plan.
- Identified potential funding for your activities.
- Planned for publicizing your efforts to target community members, professionals, and others.

What follows are brief descriptions of successful outreach strategies and exercises that will aid you in your planning process.

NAMI New Jersey Chinese American Mental Health Outreach Program (CAMHOP)

CAMHOJ-NJ is a NAMI New Jersey initiative to help people of Chinese origin (including immigrants from mainland China, Hong Kong, Taiwan, and their descendants) in New Jersey gain better understanding about mental illness as a biological based and treatable disease. CAMHOP pronounces like “Golden Crane” in Chinese. The crane is a symbol of health and longevity in Chinese culture.

CAMHOP-NJ has 4 major goals:

- Increase awareness among Chinese immigrants in NJ that mental illness can be treated and that anyone can be affected by mental illness. There are no barriers based on class, education or background.
- Help Chinese immigrants to set up local self-help groups and encourage Chinese individuals and families affected by mental illness to learn coping skills through sharing with people with similar experience.
- Provide referral service for Chinese speaking mental health providers to Chinese families and individuals who have limited English skills.
- Help mental health professionals in NJ to be aware and competent of Chinese culture vis-à-vis mental health issues and to understand the unique struggles of Chinese consumers and families in seeking services.

Self-help Group

Launched in December 2003 as the first ever self-help group in New Jersey for Chinese families and individuals coping with mental illness, this group meets once a month and is conducted in both Mandarin and Cantonese.

Outreach

In efforts to enhance awareness and knowledge of mental health and illness among Chinese immigrants, CAMHOP NJ has a bi-weekly column, “Mental Health Mailbox” in the Douwei Times, the most popular free Chinese newspaper in New Jersey. A panel of 5 mental health professionals with rich experience in working with Chinese immigrants answers questions about mental health and mental illness from readers.

For further information contact:

Maggie Luo

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732-940-0991

NAMI Massachusetts Chinese American Mental Health Outreach Program (CAMHOP)

When NAMI Massachusetts recognized the need for mental health outreach to the Chinese community, they looked no further than within the NAMI network to NAMI New Jersey's own Chinese American Mental Health Outreach Program. After contacting New Jersey's CAMHOP program coordinator, Maggie Luo, CAMHOP Massachusetts began to take shape.

To begin their efforts, NAMI Massachusetts sought two Chinese volunteers to work on the project through local university graduate programs. Both are fluent in Mandarin, and one also speaks Cantonese. Although the group is just beginning, they have already completed several projects:

- **Translation of materials**
NAMI MASS brochure
- **Accumulation of Fact Sheets in Chinese**
 - Schizophrenia
 - Major Depression
 - Bipolar Disorder
 - Myths and Facts about Mental Illness
- **Articles about mental health published in free Chinese newspapers**

NAMI Massachusetts ensures its success in their own CAMHOP program by meeting with several key members of the Chinese mental health community and continued communication with CAMHOP-NJ.

For more information contact:

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NAMI MASS
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NAMI Greater Milwaukee Partners with Hmong Community

NAMI Greater Milwaukee showed an outpouring of support and solidarity for the local Hmong community after a police shooting that took the life of Milwaukee Hmong resident Tou Yang, who had a mental illness. The shooting brought anger to the surface on a variety of issues where members of the Hmong community felt they had been discriminated against by Milwaukee police officers who are either unable or unwilling to navigate the city's ethnic and cultural diversity. As a result, members of the Hmong community organized events to make their voices heard.

At the first event, a march through the city followed by a rally, members of NAMI and the Hmong community presented a proclamation demanding plans to:

- Strengthen the training protocols for all members of the Milwaukee police department to seek peaceful resolution before using weapons.
- Strengthen the use of community resources before resorting to violence.
- Stop police discrimination and police brutality against individuals who are members of minority groups.
- Strengthen protocols for safer resolution of incidents involving people with mental illnesses.

“We implore and demand them to seek peaceful resolution before reaching for their guns, to seek community resources before taking brutal action, and to clear their hearts and minds of hatred so that individuals from minority groups and those who are mentally ill will not be the targets of police brutality,” said Lo Neng Kiatoukaysy, executive director of the Hmong American Friendship Association.

A community meeting was held as a follow-up to the rally, where 200 people were present to hear the Police Chief address the previous demands made. The Executive Director of NAMI Greater Milwaukee, Kathleen Leffler, spoke at the meeting. She reiterated Kiatoukaysy's demands for justice and challenged the city officials to take the steps necessary to ensure this sort of event does not happen again.

NAMI Greater Milwaukee was pleased to coordinate with the Hmong community in this important effort.

For more information contact:
Lo Neng Kiatoukaysy
(414) 344-6575, ext. 222

NAMI Santa Clara, California Chinese-Speaking Activities

NAMI Santa Clara, California offers programs to the Chinese-speaking population of Santa Clara. The program started when local leaders recognized the need to provide programs to this community so that they too can have equal access to information and care.

- **Support Group**

Local Asian American leaders turned to NAMI and formed a Chinese-speaking support group, which meets monthly. Formed in November 2001 with just 1 family, there are now consistently 7-8 families each month.

- **Family to Family Education Course**

NAMI's signature Family to Family Program is also offered in Chinese, with the hope of offering two courses a year.

Asian Americans that contact NAMI are always thrilled to hear about the programs offered in Chinese. Coordinator Jill Chen also publicizes these programs as she gives workshops and talks about mental illness in the community.

“These programs are increasingly successful as people gain more information and feel more fulfilled speaking in their first language about difficult issues. People are supportive to each other and feel like family. Participants get what they want out of the support and education groups, their needs are satisfied and they can ask questions and get more resources. More than anything,” says Chen, “is the chance to walk side by side with consumers and families.”

For more information contact:

Jill Chen

408-938-6755, ext. 222

NAMI New Jersey South Asian Mental Health Awareness in New Jersey (SAMHAJ)

SAMHAJ is a NAMI-NJ initiative to help people of South Asian origin (including immigrants from India, Pakistan, Bhutan, Bangladesh, Sri Lanka, Nepal, Afghanistan, and their descendants) in New Jersey gain better understanding about mental illness as a biologically based and treatable disease. “SAMHAJ” means “Understanding” in Hindi, a language spoken by many South Asians.

SAMHAJ has 4 major goals:

- Increase awareness among people of South Asian origin in NJ that mental illness can be treated and that anyone can be affected by mental illness. There are no barriers based on class, education or background.
- Help South Asian communities to set up local self-help groups and encourage Chinese individuals and families affected by mental illness to learn coping skills through sharing with people with similar experience.
- Provide referral service for South Asian mental health providers to Chinese families and individuals who have limited English skills.
- Help mental health professionals in NJ to be aware and competent of South Asian cultures vis-à-vis mental health issues and to understand the unique struggles of South Asian consumers and families in seeking services.

Self-help Group

Started in January 2002, the only self-help group in New Jersey for South Asian families and individuals coping with mental illness, this group provides support and information. The group meets once a month.

Outreach

- SAMHAJ offers education presentations and workshops on mental health issues specifically targeted to South Asian audiences.
- SAMHAJ staff members set up information tables and booths at South Asian festivals, health fairs, and cultural events
- SAMHAJ offers culture competency training workshops to mental health service providers
- SAMHAJ helps generate articles focused on mental illness in ethnic media outlets

For more information, contact:

Anu Singh

Samhaj_naminj@yahoo.com

732-940-0991

732-940-

NAMI New York City Metro

NAMI New York City is involved in a broad range of Asian American mental health-related activities.

- **Member of Coalition of Asian American Mental Health in New York:**

NAMI New York City attends these task force meetings in order to better understand the needs and interests of AAPI communities in the city.

- **Partnership and Outreach Work to Hamilton Medicine House**

NAMI NYC has successfully partnered with the Hamilton Medicine House, the largest Asian American mental health organization in New York City. At the Hamilton House's request, NAMI New York City runs bi-monthly workshops at the center with high participation on various topics such as medication, medication adherence, family and consumer topics, and anything else that is requested. Surveys are frequently distributed to determine interests. While the Hamilton Medicine House advertises to the Asian American population, NAMI New York City finds speakers and sends volunteers to events.

- **Asian American Advisory Board**

NAMI New York City is also part of a state-wide Asian American Advisory Board on Mental Health, sponsored by the Office of Mental Health of New York State. Leading programs and organizations from across the state are represented and research studies are currently being conducted about best-practices for family education programs.

For more information, contact:
NAMI New York City Metro
212-684-3264
www.nami-nyc-metro.org

NAMI Asian Pacific Los Angeles

NAMI Asian Pacific Los Angeles was founded almost 10 years ago, when a local day rehabilitation program, the Asian Pacific Counseling and Treatment Center (APCTC), came to Dean Wong, an AAPI community leader, and asked him to establish a complimenting support organization. APCTC provided Dean with the first 5 members of the group and provided meeting space, food, and logistical support.

Activities

Monthly meetings initially included:

- Support groups
- Speakers: Ask the Doctor / Social Worker / Case Manager sessions
- Videos, which Dean ordered from NAMI
- Consumers telling personal stories

As attendance grew, the groups' activities expanded to:

- Family to Family Classes with translators provided
- Rallies
- Lobbying trips to LA County to support housing programs and bills

Lessons Learned

- Local organizations (in this case, APCTC) key to success in continued referring of new members and participants
- NAMI LA President's Club also referred new members and participants
- It was very important for the Asian American Pacific Islander community to first trust and know the group leader—what does he do for a living? Where is he from? Is he married? Only after they felt comfortable with the leader were they themselves willing to share personal information.
- Meet people where they are—offer rides to group meetings and events
- Offer food at all functions!
- Use humor and be proactive in finding solutions

For more information, contact:

Al Choi

achoi@apctc.org

Appendix

- I. NAMI Multicultural Action Center**
- II. NAMI Multicultural Partner Coalition List**
- III. SPIRAL - On line resources in other languages**
- IV. AAPI and Cultural Competence Bibliography**
- V. Resources in Other Languages - Saved separately, see main menu**
 - ◆ **Bipolar: Khmer**
 - ◆ **Depression: Korean**
 - ◆ **Depression: Hmong**
 - ◆ **Schizophrenia: Vietnamese**
 - ◆ **NAMI California Brochure: Chinese**
 - ◆ **NAMI Dallas Brochure: Vietnamese**
 - ◆ **NAMI New Jersey: Chinese Articles**
- VI. Western Journal of Medicine Articles - Saved separately, see main menu**
 - ◆ **Op-Ed: The Challenges of Providing Behavioral Treatment to Asian Americans**
 - ◆ **Culture and Medicine: Cultural Factors Influencing the Mental Health of Asian Americans**
 - ◆ **Mental Health Services Research in Asian Americans**



NAMI Multicultural Action Center

People of color face life-threatening disparities in access to high quality mental healthcare. Numerous recent reports, including the *Surgeon General's Report on Cultural, Race and Ethnicity* and the Institute of Medicine's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, point to the great disparities of minority mental health in this country and the resulting toll on our society. NAMI recognizes that diversity goes beyond race and ethnicity, and the Center will strive to represent and advocate for America's broad cultural and life groups that are outside the mainstream.

In response to this national crisis, NAMI created its Multicultural Action Center. This Center works to focus attention on system reform to ensure access to culturally competent services and treatment for *all* Americans and to help and support families of color who are dealing with mental illness. The Center's goals are:

- To advance NAMI's policy agenda and address issues that disproportionately affect communities of color.
- Support NAMI grassroots advocacy and outreach efforts.
- Build diverse leadership at all levels of the organization.
- Develop and promote culturally competent support programs and practices.
- Develop strong partnerships with other similar organizations.
- Decrease stigma through public education that address specific cultural barriers.

Among the Center's policy priorities are:

Health Disparities –

The significant progress made in discovering effective treatments for serious mental illness has unfortunately not translated into better services for people of color living with these illnesses. The Multicultural Action Center will join forces with other organizations and coalitions to advocate for equal access to mental health treatment for diverse communities.

Lack of Cultural Competence in Service Delivery –

Mental health providers are usually ill-equipped to meet the needs of patients from different backgrounds and often times display bias in the delivery of care. The Multicultural Action Center will address this issue by highlighting current effective cultural competence standards, promoting

promoting successful programs and institutions, and promoting the implementation of laws such as Title VI of the Civil Rights Act which requires providers to ensure that limited English proficient individuals have equal access to services. Furthermore, the Center will provide training and technical assistance to NAMI states and affiliates to ensure that all NAMI programs and services are culturally competent and available to people from diverse communities.

Lack of Bicultural/Bilingual Mental Health Professionals-

There are not enough bilingual/bicultural mental health providers. This reality makes care less accessible for people of color. NAMI's Multicultural Center will highlight and advocate for programs to promote mental health careers as viable options for youth of color.

Research –

Genetic research has highlighted significant differences among racial and ethnic groups in the metabolism, clinical effectiveness, and side effects of medications. Far too often, people of color are underrepresented in clinical trials and research studies. The Multicultural Action Center will disseminate news about existing research and advocate for increased funding for research centered in diverse communities.

Children and Adolescents with Mental Illness –

Depression and suicide rates are higher among teens of color. Youth of color face higher rates of misdiagnosis and over-institutionalization. The Multicultural Action Center will work closely with NAMI's Children and Adolescent Action Center and partner organizations to advocate for youth system reforms and to implement practices and programs appropriate for children of diverse communities and their families.

Criminal and Juvenile Justice Systems –

People with mental illness are overrepresented in the criminal and juvenile justice systems. People with mental illnesses who are from diverse communities are also overrepresented in these systems. The Multicultural Action Center will work to advocate for access to appropriate diagnosis and treatment for people in these systems, and promote culturally appropriate jail diversion programs.

*For more information about the Center please contact us at:
703-524-7600 or MACenter@nami.org*



NAMI Multicultural Action Center Technical Assistance for NAMI States and Affiliates

Story Bank: For your state office or affiliate newsletter. If you would like to include an article related to underserved populations in your newsletter call NAMI MAC to get a story.

Public Web Site: You can duplicate or link to NAMI National's Multicultural Web Site and the Spanish language site. If you want to personalize the site call NAMI MAC and we will help you create 1 or 2 paragraphs that are specific to your NAMI state office or affiliate.

Library of Resources: NAMI MAC has created a library of minority outreach resources. This library will have all the information about NAMI outreach campaigns taking place around the country. We will have descriptions of each program, contact information, samples of materials, and more. NAMI groups nationwide have generously shared all of this information with us.

Revision of Materials: You can send your multicultural outreach materials to NAMI MAC. We can review them and provide feedback and suggestions.

Speakers Bank: NAMI MAC has a list of speakers from underserved populations that have expressed interest in participating at NAMI conferences and gatherings. Contact us if you are looking for speakers.

Cultural Competence Presentations and Trainings: In order to successfully reach diverse communities, NAMIs must know, understand, respect, and embrace these communities. We provide cultural competence trainings to facilitate this process.

Materials In Other Languages: MAC currently has materials in Spanish, Portuguese, Mandarin, and Italian. You could get the electronic versions of these materials to include your local contact information.

Other Services:

- * NAMI MAC staff will conduct presentations or speaking engagements for states and affiliates.
- * Training teleconferences and town hall meetings.
- * Briefings about diverse cultures
- * On site outreach suggestions and planning.
- * Coalition of organizations from underserved population.

For more information please contact 703-524-7600 or MACenter@nami.org.



NAMI's Multicultural Partner Coalition

Action for Mental Illness (India)

Alianza Nacional por las Enfermedades Mentales (Mexico)

Alianza Nacional de Salud Mental (Mexico)

Alianza para la Depresión (España)

APOIAR (Brazil)

American Psychiatric Association

American Society of Hispanic Psychiatry

Asian Community Mental Health Services

Asociación Argentina de Ayuda a la Persona que Padece de Esquizofrenia y su Familia

Asociación Maníaco Depresivos (Colombia)

Asociación Salvadoreña de Familiares y Amigos de Pacientes Esquizofrénicos

Association of Hispanic Mental Health Professionals

Black Psychiatrists of America

Center for Capacity Building for Minorities with Disabilities Research (CCBMDR)

Center for Psychiatric Rehabilitation - Boston University

Circles of Care Evaluation Technical Assistance Center

District of Columbia Department of Mental Health

Federación Colombiana para la Salud Mental

Fundación Contener (Argentina)

Fundación Contener (Argentina)

FUCOPEZ (Fundación Costarr para Personas con Ezquizofrenia)

Fundación Luz y Vida (Paraguay)

Health Watch Information and Promotion Service, Inc.

INGENIUM – Monterrey and Mexico City (Mexico)

International Association of Psychosocial Rehabilitation Services (IAPSRs)

Latino Behavioral Health Institute

Malaysian Mental Health Association

Massachusetts Mental Health Services Program for Youth

NAMI India

National Asian American Pacific Islander Mental Health Association

National Council of La Raza

National Latino Behavioral Health Association

National Medical Association

National Organization of People of Color Against Suicide

National Youth Advocacy Coalition

New Jersey Asian American Association for Human Services, Inc.

New Jersey Mental Health Institute

New Vision Consumer Services

Richmond Fellowship (New Zealand)

Samaritans Nepal

Self Reliance Foundation

Student National Medical Association

The Alliance for the Mentally Ill of R.O.C., Taiwan

South African Anxiety and Depression Group

West Virginia Substance Abuse Coalition

Voz Pro Salud Mental (Mexico)

Zenkaren (Japan)

SPIRAL

<http://spiral.tufts.edu>

Tufts University Health Sciences Library sponsors this health resource for Asian Americans whose first language is not English. Dubbed SPIRAL for “Selected Patient Information Resources in Asian Languages,” it is a website with detailed health information in seven Asian languages. It is a unique multi-language health information site because it is for both physicians and patients.

- Segmented by language and by subject, a user – a patient, doctor, or other caregiver – can search for documents in an Asian language on health topics.
- A native speaker of an Asian language would go to the main web site, select his/her language, and then search for the information that was needed.
- Material is also provided in English so that an English-speaking physician or caregiver can see what the patients are reading.

Languages

- Chinese
- Cambodian/Khmer
- Hmong
- Korean
- Laotian
- Thai
- Vietnamese

Sample Subjects (specific to mental health)

- ADHD
- Preventing Youth Suicide
- Schizophrenia
- Drug Abuse
- Teenage Moods: What is Common and What is Not
- Domestic Violence
- Anxiety and Phobias
- Depression
- Stress
- Psychotherapy
- What is a Psychiatrist? What is a Psychologist?

February 2005

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 University of California, San Francisco
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 415-206-8984

* *Recommended*

** *Highly Recommended*

*** *Top ten*

Adams, N., & Grieder, D. M. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*. Burlington, MA: Elsevier Academic Press.

**Alarcón, R. D., Foulks, E. F., & Vakkur, M. (1998). *Personality Disorders and Culture: Clinical and Conceptual Interactions*. New York, NY: John Wiley & Sons, Inc. *An immediate classic on culture and personality disorders.*

Akhtar, S., & Kramer, S. (Eds.). (1998). *The Colors of Childhood: Separation - Individuation - Across Cultural, Racial and Ethnic Diversity*. New York, NY: Jason Aronson.

**Akhtar, S. (1999). *Immigration and Identity*. Northvale, NJ: Jason Aronson Inc. *A psychodynamic perspective on an important cultural identity issue.*

**Al-Issa, I. (Ed.). (1999). *Al-Junūn: Mental Illness in the Islamic World*. Madison, WI: International Universities Press, Inc. *One of the few books on this topic.*

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Aponte, J. F., & Wohl, J. (Eds.). (2000). *Psychological Intervention and Cultural Diversity (Second Edition)*. Boston, MA: Allyn and Bacon.

*Association of American Medical Colleges. (1998 - 2002). *Medical School Objectives Project, Part I-V*. Washington, DC: Association of American Medical Colleges. *Essential for medical student education.* (www.aamc.org)

Axtell, R. E. (1997). *Gestures: The Do's and TABOOs of Body Language Around the World*. New York, NY: John Wiley & Sons.

*Berzoff, J., Flanagan, L. M., & Hertz, P. (1996). *Inside Out and Outside In*. Northvale, NJ: Jason Aronson Inc. *Discusses impact of cultural identity variables (race, gender, class, etc.) on psychotherapy.*

*Boehnlein, J (Ed.). (2000). *Religion and Psychiatry*. Washington, D.C.: APPI Press. *An important update on issues at the interface.*

*Boorstein, S. (1997). *Clinical Studies in Transpersonal Psychotherapy*. Albany, NY, State University of New York Press. *Case-based approach from a seasoned clinician.*

Boyd-Franklin, N. (2003). *Black Families in Therapy* (2nd ed.). New York, NY: The Guilford Press.

Bronstein, P., & Quina, K. (Eds.). (2003). *Teaching Gender and Multicultural Awareness*. Washington, DC: American Psychological Association.

Brown, D. R., & Keith, V. M. (Eds.). (2003). *In and Out of Our Right Minds: The Mental Health of African American Women*. New York, NY: Columbia University Press.

Burt, V., & Hendrick, V. (2001) *Concise Guide to Women's Mental Health* (2nd ed.). Washington, DC: American Psychiatric Press.

Burt, V., & Hendrick, V. (2005) *Clinical Manual of Women's Mental Health*. Washington, DC: American Psychiatric Press.

*** Cabaj, R., & Stein, T. (Eds.). (1996). *Textbook of Homosexuality and Mental Health*. Washington, DC: American Psychiatric Press. *Very comprehensive. The standard textbook in this area.*

***The California Endowment (2003). *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals*. Woodland Hills, CA: Author. (www.calendow.org)

The California Endowment (2003). *A Manager's Guide to Cultural Competence Education for Health Care Professionals*. Woodland Hills, CA: Author.

The California Endowment (2003). *Resources in Cultural Competence Education for Health Care Professionals*. Woodland Hills, CA: Author.

[Outstanding resource document downloadable from the web. Also at the same website are resources on working with limited English proficient patients.]

California Healthcare Interpreters Association. (2003). *California Standards for Healthcare Interpreters*. Woodland, CA: California Endowment.

*Canino, I. & Spurlock, J. (2000). *Culturally Diverse Children and Adolescents*. (Second Edition). New York, NY: Guilford. *Practical guidelines.*

Cardeña, E., Lynn, S. J., & Krippner, S. (Eds.). (2000). *Varieties of Anomalous Experience: Examining the Scientific Evidence*. Washington, DC: American Psychological Association.

**Carter, R. T. (Ed.). (2005). *Handbook of Racial-Cultural Psychology and Counseling*. Ho-

Castillo, R. J. (Ed.). (1998). *Meanings of Madness*. Brooks/Cole Publishing Co, Pacific Grove, CA. *Compendium of classic readings on culture and mental illness.*

Castillo, R. (1997). *Culture and Mental Illness: A Client Centered Approach*. Pacific Grove, CA: Brooks/Cole. *Discusses assessment, therapy and cultural issues within diagnostic categories.*

***Center for Mental Health Services/Substance Abuse and Mental Health Services Administration. (1998). *Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups*. Washington, DC: CMHS/SAMHSA. *Essential for understanding systems cultural competence.* (www.mentalhealth.org. Search for "Cultural Competence Standards in Managed Care Mental Health Services.")

**Center for Substance Abuse Treatment/Substance Abuse and Mental Health Services Administration. (1999). *Cultural Issues in Substance Abuse Treatment*, Washington, D.C: CSAT/SAMHSA. *An outstanding monograph on substance abuse.*

**Chin, J. L. (Ed.). (2004). *The Psychology of Prejudice and Discrimination*. Westport, Connecticut: Praeger. A four-volume set.

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**Fadiman, A. (1997). *The Spirit Catches You and You Fall Down*. New York, NY: The Noonday Press. *An extraordinary story about the importance of cultural competence in medical care*.

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**Friedman, S. (Ed.). (1997). *Cultural Issues in the Treatment of Anxiety*. New York, NY: Guilford Press. *Essential reading for those treating Anxiety Disorders*.

*Foster, R. P., Moskowitz, M., & Javier, R. A. (Eds.). (1996). *Reaching Across Boundaries of Culture and Class. Widening the Scope of Psychotherapy*. Northvale, NJ: Jason Aronson Inc.

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Fukuyama, M. A. and Sevig, T. D., (1999). *Integrating Spirituality Into Multicultural Counseling*. Thousand Oaks, CA, SAGE Publications.

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**Johnson-Powell, G. & Yamamoto, J. (Eds.). (1997). *Transcultural Child Development: Psychological Assessment and Treatment*. New York, NY: John Wiley & Sons, Inc. *Comprehensive update of the 1983 classic *The Psychosocial Development of Minority Group Children*.*

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** Kleinman, A. (1988). *Rethinking Psychiatry*. New York, NY: Free Press. *The most important conceptual work in cross-cultural psychiatry - a classic.*

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*Kurasaki, K., Okazaki, S., Sue, S. (Eds.) (2002). *Asian American Mental Health: Assessment Theories and Methods*. New York: Plenum.

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*Lipson, J. G., Dibble, S. L., & Minarik, P. A. (Eds.). (1996). *Culture & Nursing Care: A Pocket Guide*. San Francisco, CA: UCSF Nursing Press. *Essential for nursing care of culturally diverse patients.*

*Lopez, A., & Carrillo, E. (Eds.). (2001). *The Latino Psychiatric Patient: Assessment and Treatment*. Washington, DC: American Psychiatric Press. *The only volume that reviews specific issues from specific Central and Latin American countries.*

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Journals

There are three major journals exploring these areas. They are Transcultural Psychiatry (published by Sage); Culture, Medicine, and Psychiatry (published by Kluwer) and Cultural Diversity and Ethnic Minority Psychology (published by the American Psychological Association).

Videotapes

“The Culture of Emotions” is a 58-minute training videotape (2002) that discusses the DSM-IV Outline for Cultural Formulation. It features twenty three multidisciplinary experts in cultural psychiatry commenting on sections of the Outline. It was written, produced, and directed by Harriet Koskoff and is available through Fanlight Productions (www.fanlight.com). A Study Guide and annotated bibliography are available as downloads from the webpage describing the videotape. [Click “Study Guide” on webpage describing the videotape to download a 1995 chapter on the Outline for Cultural Formulation]. Also, Harriet Koskoff and Francis Lu have created two 17-minute videotapes: “A Visit with Irma Bland, MD: Discussing the DSM-IV Outline for Cultural Formulation” and “A Visit With Evelyn Lee, EdD: Working With Asian-American Immigrants and Refugees.” Both of these pioneers in cultural competence passed away in 2003.

Websites

1) ***"Mental Health: Culture, Race, and Ethnicity," U.S. Surgeon General:
www.surgeongeneral.gov/library/mentalhealth/cre/default.asp

2)*** The Institute of Medicine (www.iom.edu) has published since 2001 a series of important books that have impacted on moving health care policy. Academic psychiatry can benefit from utilizing these perspectives. "Crossing the Quality Chasm" (2001) focused on 6 aims for improving health care: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity. The IOM is currently working on a report adapting it to mental health and addictive disorders; input is welcome at the website. "Health Professions Education: A Bridge to Quality" (2003) suggested 5 core areas for education that would enhance quality. "Unequal Treatment: Confronting Racial + Ethnic Disparities in Health Care" (2002) has clearly established the importance of this area in health care policy. "Speaking of Health: Assessing Health Communication Strategies for Diverse Populations" (2002) addresses the challenge of improving health communication in a culturally diverse society. "Health Literacy: A Prescription to End Confusion" (2004) recommends that health care systems should develop programs sensitive to cultural and language preferences that reduce the negative effect of limited health literacy. If patients cannot comprehend needed health information, attempts to improve the quality of care and reduce health care costs and disparities may fail."Research Training in Psychiatry Residency: Strategies for Reform" (2003) has sparked efforts within AAP, AADPRT and NIMH for change. "Behavioral and Social Sciences in Medical School Curricula" (2004) has relevance for our teaching in medical school both within and outside psychiatry. Finally, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce" was published in 2004. You can read it online as well as purchase the PDF or hardcopy text at <http://iom.edu/report.asp?id=18287>. "...The report examines institutional and policy-level strategies -defined as specific policies and programs of health professions schools, their associations and accreditation bodies, health care systems/organizations, and state and federal governments - to increase diversity among health professionals. Addressed in the report are an assessment and description of the potential benefits of greater diversity among health professionals and an assessment of strategies that may increase diversity in five areas including:

- § admissions policies and practices of health professions education institutions;
- § public (e.g., state and federal) sources of financial support for health professions training;
- § standards of health professions accreditation organizations pertaining to diversity;
- § the "institutional climate" for diversity at health professions education institutions; and
- § the relationship between Community Benefit principles and diversity...."

Table of content: Executive Summary 1 Introduction 2 Reconceptualizing Admissions Policies and Practices 3 Costs and Financing of Health Professions Education 4 Accreditation and Diversity in Health Professions 5 Transforming the Institutional Climate to Enhance Diversity in Health Professions 6 Reconceptualizing Admissions Policies and Practices 7 Mechanisms to Garner Support for Institutional and Policy-Level Appendix A: Data Sources and Methods Appendix B: Committee and Staff Biographies Commissioned Papers Contribution A: Increasing Diversity in the Health Professions: A Look at Best Practices Contribution B: The Role of Public Financing in Improving Diversity in the Health Professions Contribution C: The Role of Accreditation in Increasing Racial and Ethnic Diversity in the Health Professions Contribution D: Diversity Considerations in Health Professions Education

B: Committee and Staff Biographies Commissioned Papers Contribution A: Increasing Diversity in the Health Professions: A Look at Best Practices Contribution B: The Role of Public Financing in Improving Diversity in the Health Professions Contribution C: The Role of Accreditation in Increasing Racial and Ethnic Diversity in the Health Professions Contribution D: Diversity Considerations in Health Professions Education

3) *** "Achieving the Promise: Transforming Mental Health Care," New Freedom Commission on Mental Health:

www.mentalhealthcommission.gov/reports/reports.htm www.mentalhealthcommission.gov 2003
"Elimination of Disparities" is one of 6 goals.

4) *** "Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups," Center for Mental Health Services:

<http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA00-3457/default.asp>

5) ***"Assuring Cultural Competence in Health Care: Recommendations for National Standards," Health and Human Services' Office of Minority Health: www.omhrc.gov/clas/

6) ***"A Family Physicians Practical Guide to Culturally Competent Care." This is a web-based CME training about the 14 Cultural and Linguistic Appropriate Services (CLAS) Standards from the HHS Office of Minority Health. Although intended for practicing family physicians, it is useful for any health professional or trainee. Available on DVD. December 2004. <http://cccm.thinkculturalhealth.org/>

7) "Setting the Agenda for Research on Cultural Competence in Health Care." This project looks at the question of what impact cultural competence interventions have on the delivery of health care and health outcomes, and investigates the opportunities and barriers that affect how further research in this area might be conducted. August 2004
www.omhrc.gov/cultural/cultural18.htm

8) "Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies: Final Report." December 2003
http://www.omhrc.gov/cultural/LPHAs_FinalReport.pdf

9)*** HHS CMS (Centers for Medicare & Medicaid Srvs) at www.cms.gov/healthplans/quality/project03.asp provides information and downloads for three outstanding recent cultural competence guides from HHS:

a) "Providing Oral Linguistic Services: A Guide for Managed Care Plans"

b) "Planning Culturally and Linguistically Appropriate Services: A Guide For Managed Care Plans"

c) "Best Practices for Culturally and Linguistically Appropriate Services in Managed Care Conference: June 3 and 4, 2002 in Research Triangle Park, North Carolina."

The first two items were the principal material for the handout at 3 national CLAS trainings given by the University of North Carolina School of Public Health in 2003. Information about the HHS Culturally and Linguistically Appropriate Services (CLAS) Standards can be obtained at www.omhrc.gov/clas.

10)*** "Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile." The Lewin Group for DHHS, Health Resources and Services Administration, April, 2002. <http://www.hrsa.gov/omh/cultural1.htm>

"How do we know cultural competence when we see it?" is the central question that prompted the Health Resources and Services Administration (HRSA) to sponsor a project to develop indicators of cultural competence in health care delivery organizations. The Assessment Profile builds upon previous work in the field, such as the National Standards for Culturally and Linguistically Appropriate Services (CLAS), and serves as a future building block that advances the conceptualization and practical understanding of how to assess cultural competence at the organizational level.

The Assessment Profile is an analytic or organizing framework and set of specific indicators to be used as a tool for examining, demonstrating, and documenting cultural competence in organizations involved in the direct delivery of health care and services. At a general level, the Profile can help organizations frame and organize their perspectives and activities related to the assessment of cultural competence. More specifically, it can be used in routine performance monitoring, regular quality review and improvement activities, assessment of voluntary compliance with cultural competence standards or guidelines, and periodic evaluative studies.

11)***"The Provider's Guide to Quality and Culture," HRSA at <http://erc.msh.org/quality&culture>. An outstanding web-based training on clinical cultural competence.

12) Many of the National Institutes of Health have written strategic plans to reduce health disparities. Ones by NIDA, NIAAA, OSSR (approx sp.) + others can be found at <http://healthdisparities.nih.gov/working/institutes.html>. I could not access the NIMH one, although I have done so in the past.

13) The National Center on Minority Health + Health Disparities can be found at www.ncmhd.nih.gov

14) "National Healthcare Quality Report" and the "National Healthcare Disparities Report." The reports present data on the quality of and disparities among services for seven clinical conditions and provide "a snapshot of the American health care system." The reports are available at <http://qualitytools.ahrq.gov>

In a February 10, 2004 hearing before the House Committee on Ways and Means, Department of Health and Human Services (HHS) Secretary Tommy Thompson admitted that his department made a mistake in revising a December 23, 2003 report from the Agency for Healthcare Research and Quality (AHRQ) on

In a February 10, 2004 hearing before the House Committee on Ways and Means, Department of Health and Human Services (HHS) Secretary Tommy Thompson admitted that his department made a mistake in revising a December 23, 2003 report from the Agency for Healthcare Research and Quality (AHRQ) on racial and ethnic disparities in health care. Secretary Thompson told the committee that HHS would release the original version of the "National Healthcare Disparities Report," in its unaltered form, "without any changes whatsoever." On January 13, Representative Henry Waxman and seven other House members complained to Secretary Thompson that the first publicly released version of the report was a "watered-down" version of the original findings and that "HHS substantially altered the conclusions of its scientists" in order to portray a less pervasive national health disparities problem.

15) *** The California Endowment at www.calendow.org has 3 very important monographs:

- a) "Principles and Recommended Stds for Cultural Competence Education of Health Care Professionals"
- b) "Manager's Guide to Cultural Competence Education for Health Care Professional"
- c) "Resources in Cultural Competence Education for Health Care Professionals"

Also other important monographs on interpreters and an annotated bibliography "Multicultural Health 2002"

16) "The American Psychological Association Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychology" are available at www.apa.org/pi/multiculturalguidelines.pdf. This is a landmark document. Also, you can search "disparity" on the APA website at <http://search3.apa.org/results.cfm>.

17) The American Medical Association efforts on disparities can be seen at www.assn.org/ama/pub/article/2403-7066.html. Also you can check www.Ama-assn.org/go/diversity/healthdisparities.

18) The Association of American Medical Colleges (AAMC) sponsors a campaign to reduce health care disparities. The Henry J. Kaiser and Robert Wood Johnson foundations, along with the AAMC and nine other co-sponsoring health care associations, have launched a \$1 million campaign to reduce racial and ethnic disparities in health care. This national initiative includes an outreach effort to engage physicians in dialogue; an advertising campaign in major medical publications; and a review of the evidence on racial/ethnic disparities in healthcare. The campaign begins with a focus on cardiac care and, as part of the effort, the American College of Cardiology and the Kaiser Foundation recently released a report listing racial and ethnic disparities in cardiac care. Information: Go to <http://www.kff.org/content/2003/6067>. Also www.aamc.org, then "diversity" section of the site has additional resources.

19) Massachusetts General Hospital Office of Multicultural Education. Has a search engine for updated

- 19) Massachusetts General Hospital Office of Multicultural Education. Has a search engine for updated literature at www.mgh.harvard.edu/healthpolicy/cchc.htm
- 20) McGill Department of Psychiatry Division of Transcultural Psychiatry Cultural Consultation Program: Ww2.mcgill.ca/psychiatry/ccs/eng/finalreport/toc.html
- 21) "Ensuring Linguistic Access in HealthCare-Settings: Legal Rights and Responsibilities, 2nd Edition," August 2003, National Health Law Program at www.calendow.org
- 22) The American College of Mental Health Administration Summit March 2003 focused on "Reducing Disparity: Achieving Equity in Behavioral Health Services."
www.achma.org/Summits/summit_2003.htm
- 23) "Strategies for Diversity of the Health Professions" (2003). Funded by the California Endowment, it focuses on California. At the UCSF EQOP website <http://www.ucsf.edu/senate/0-committee/g-eop.html>, the PDF document is at the bottom of the page under "Documents of Interest."
- 24) "Cultural Competency for California Public Health Staff." As part of the OMH State Partnership Initiative, the UC San Francisco Center for the Health Professions has completed a report that outlines a cultural competency curriculum specifically for public health staff. The report, Cultural Competency for California Public Health Staff: Train-the-Trainer State Partnership Project, was written for the California Department of Health Services' Office of Multicultural Health. September 2004
http://futurehealth.ucsf.edu/pdf_files/Final%20OMH%20Report.pdf.
- 25) "California Multicultural Health Disparities," April 2003
www.dhs.ca.gov/hisp/chs/OHIR/Publication/OtherReports/MHD051703.pdf. "Health for All: California Strategic Approach to Eliminating Racial and Ethnic Health Disparities," Nov. 2003 at www.preventioninstitute.org/healthdis.html.
- 26) State of California Department of Mental Health Office of Multicultural Affairs: www.dmh.cahwnet.gov/multicultural
- 27) "State of California Task Force on Culturally and Linguistically Competent Physicians and Dentists Final Report to the Legislature Pursuant to AB 2394" is available at www.dca.ca.gov/cltaskforce or www.dca.ca.gov/reports.htm
- 28) San Francisco Department of Public Health Cultural Competence
Website: www.dph.sf.ca.us/CLAS