SOUTHEAST ASIAN AMERICAN MENTAL HEALTH IN CALIFORNIA

THE RIGHT TO HEAL

SEARAC

Southeast Asia Resource Action Center & Lee Lo

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ABOUT

The Southeast Asia Resource Action Center (SEARAC) is a national civil rights organization that empowers Cambodian, Laotian, and Vietnamese American communities to create a socially just and equitable society. As representatives of the largest refugee community ever resettled in the United States, SEARAC stands together with other refugee communities, communities of color, and social justice movements in pursuit of social equity. Visit www.searac.org.

ACKNOWLEDGMENTS

SEARAC would like to thank the community-based organizations and individuals that contributed their experience, expertise, and direction on the production of this report. Without their passion and commitment to the Southeast Asian American community, this project would have not been possible. SEARAC is grateful and humbled to work with community members and leaders across California to improve the wellbeing of our Southeast Asian American community.

SEARAC

COVER ART

ARTIST: *Kuab Maiv Yaj, Koua Mai Yang*
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SPECIAL THANKS TO THE FOLLOWING ORGANIZATIONS AND INDIVIDUALS:

Asian Health Services

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Fresno Interdenominational Refugee Ministries

The Fresno Center

Hmong Cultural Center for Butte County

Hmong Innovating Politics

Iu-Mien Community Services

Khmer Girls in Action

Laotian American National Alliance

Stone Soup Fresno

United Cambodian Community

Vietnamese American Roundtable

Ghia Xiong

Ze Vang

Melanie Vang

Jeff Xiong

Mary Vang

Irene Van

Pysay Phinith

Su Su Maung

Thaen Saelee

UyenMy Nguyen

Survey respondents

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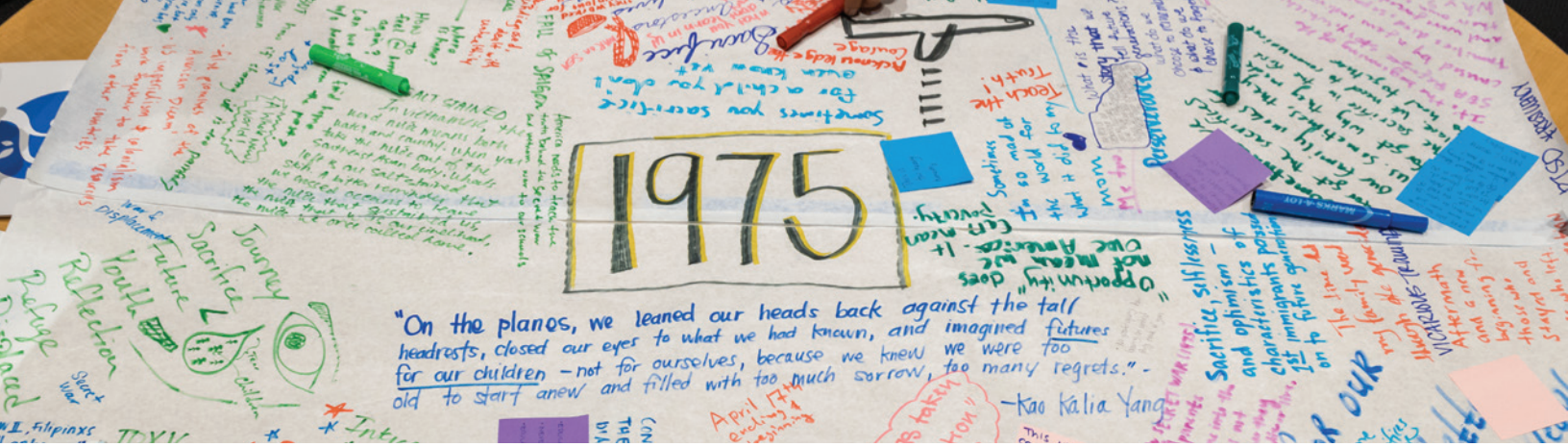

Executive Summary

From 1983-2007, more Southeast Asian refugees resettled in California than any other state. California remains home to the largest Southeast Asian American (SEAA) population with 36% of the community living in the state. However, even after 45 years of resettling, SEAAs are still struggling to access life-saving mental health care and heal from the trauma they've experienced due to war, genocide, and displacement. The consequences of unaddressed mental health challenges have resulted in newer generations of SEAAs experiencing intergenerational trauma among other mental health stressors of their peers.

To better understand the challenges SEAAs experience in accessing and utilizing mental health services in California, SEARAC conducted a community survey, focus groups, and follow-up interviews. With the support of community-based organizations and individuals, SEARAC collected a total of 247 comments from SEAA respondents from all over California to share the varying challenges they have experienced locally, by gender, sexual orientation, generation, ethnicity, and primary language.

Based on cross-referencing our survey responses, focus groups, and follow-up interviews, with existing community and academic research, three main themes emerge from this deep dive:

- Mental health care is not appropriate and accessible to SEAAs if not all areas of culture, intersectionality, intergenerational factors, healing, and language are considered.
- Access to appropriate care is imperative to healing the SEAA community and ending the cycle of trauma.
- Innovative effective community solutions already exist to address the barriers of care, but they are not practiced and invested in widely enough to provide care appropriately.

Policymakers cannot continue to ignore the urgent mental health needs of the SEAA community. Given these findings, SEARAC strongly recommends that lawmakers in California champion policies to improve access, utilization, and outcomes of mental health services for the SEAA community, such as:

1. Increasing access through targeted community education, outreach, navigation, and prevention and early intervention
2. Investing in community assets through: recognizing nontraditional mental health providers, centering healing during care and advocacy, and encouraging central community resource hubs
3. Improving the quality of care through: enforcing National Culturally and Linguistically Appropriate Services Standards (CLAS), prohibiting the use of unskilled interpreters, disaggregating data, and increasing provider diversity and cultural humility
4. Integrating mental health services through school-based Adverse Childhood Experience (ACE) screenings
5. Funding research on community-specific needs and effective services

[1] 2013 Report on the State of Cambodia Town. http://www.aasc.ucla.edu/research/pdfs/CambodiaTown.pdf.

[2] U.S. Census Bureau, 2011–2015 American Community Survey 5-Year Estimates.

Introduction & Background

Among the growing Asian American community is a resilient Southeast Asian American (SEAA)[3] community whose history, culture, and spirit has enriched the legacy of Asian Americans. In 1975, Southeast Asian refugees resettled globally to escape genocide, persecution, and the spiraling aftermath of the Vietnam War. More than 1 million Southeast Asian refugees resettled in the United States, making Southeast Asians the largest refugee community to ever be resettled in the country.[4] Today, SEAAs total more than 2.5 million throughout the United States, with the largest SEAA population of almost 1 million residing in California.[5]

In 2004, California passed the Mental Health Services Act (MHSA), also known as Proposition 63, imposing a 1% tax on personal income over one million dollars to fund mental health services across California. In Fiscal Year (FY) 2017-2018, approximately $2 billion was deposited into the Mental Health Services Fund (MHSF).[6] California's behavioral health system is complex with multiple agencies serving overlapping populations. The 2011 Realignment (Proposition 30) drastically shifted the administration of California's mental health services, eliminating the former California Department of Mental Health (DMH) and transitioning many services across the purview of other state departments and counties.[7]

SEAAs experience higher rates of mental health challenges than the general population due to their experiences of war, genocide, and displacement. In 2005, a study in Long Beach found that 51% of older Cambodian adults experienced symptoms of major depression, compared to 7% of the general population in the United States.[8] Over 10 years later, a Cambodian community needs assessment conducted in Long Beach demonstrated almost no change in the proportion of mental health needs, with 50% of participants reported having depressive symptoms.[9] Despite the disproportionally high mental health need of the SEAA community and living in a state investing $2 billion into mental health services, Asian American and Pacific Islander adults are the least likely racial group to access specialty mental health services, with just 2% of the population accessing care.[10] The current mental health system is not providing sufficient support to SEAAs to access and utilize critical mental health services. Even after 45 years of resettlement, many Southeast Asian refugees have yet to receive the appropriate care to heal from the trauma they have experienced.

The alarming percentage of mental health need, community concern, and low access rates led to the development of this report. In 2019, SEARAC collected almost 250 survey responses from SEAAs across California to share their mental health needs, the challenges they faced in accessing culturally and linguistically appropriate care,[11] and their vision for the mental health system in California. This report elevates community voices to direct policy, proposing tangible community-identified policy solutions to increase mental wellness for the SEAA community. Policymakers cannot continue to ignore the urgent mental health needs of the SEAA community. SEARAC is committed to bridging community voices to our policymakers and advancing equity and justice for our communities.

SEAAS EXPERIENCE HIGHER RATES OF MENTAL HEALTH CHALLENGES THAN THE GENERAL POPULATION DUE TO THEIR EXPERIENCES OF WAR, GENOCIDE, AND DISPLACEMENT.

[3] This report refers specifically to Southeast Asian Americans (SEAAs) who share the political and historical experience of resettling in country as refugees from the U.S. occupation of Cambodia, Laos, and Vietnam.

[4] Southeast Asia Resource Action Center. (2019). *Southeast Asian American Journeys, A National Snapshot of Our Communities.* Asian Americans Advancing Justice – Los Angeles. https://www.searac.org/wp-content/uploads/2020/02/SEARAC_NationalSnapshot_PrinterFriendly.pdf

[5] U.S. Census Bureau, 2010 SF 1, Table PCT7.

[6] California Department of Health Care Services. (2019). *Mental Health Services Act Expenditure Report – Governor's Budget.* Fiscal Year 2019-20. https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSA_Expenditure_Report-Jan2019.pdf

[7] California Department of Social Services. (n.d.). Retrieved June 4, 2020 from https://www.cdss.ca.gov/inforesources/realignment

[8] Marshall, G.N., Schell, T., Elliot, M. N., Berthold, S. M. and Chun, C. "*Mental Health of Cambodian Refugees 2 Decades After Resettlement in the United States,*" JAMA, The Journal of the American Medical Association 294, no. 5, (2005): 571-579.

[9] Cambodian Advocacy Collaborative (CAC). (2017). *Executive Summary Cambodian Community Needs Assessment.* California State University Long Beach. https://drive.google.com/file/d/1xOZ7d6__rwWJEZZRb89VlNnJLCpj1S5T/view?usp=sharing

[10] California Department of Health Care Services. (2018). *Statewide Aggregate Specialty Mental Health Services Performance Dashboard.* https://www.dhcs.ca.gov/services/MH/Documents/2018_SMHS_Dash_Combined_Report_non-ADA.pdf

[11] See glossary for the community definition.

Demographic

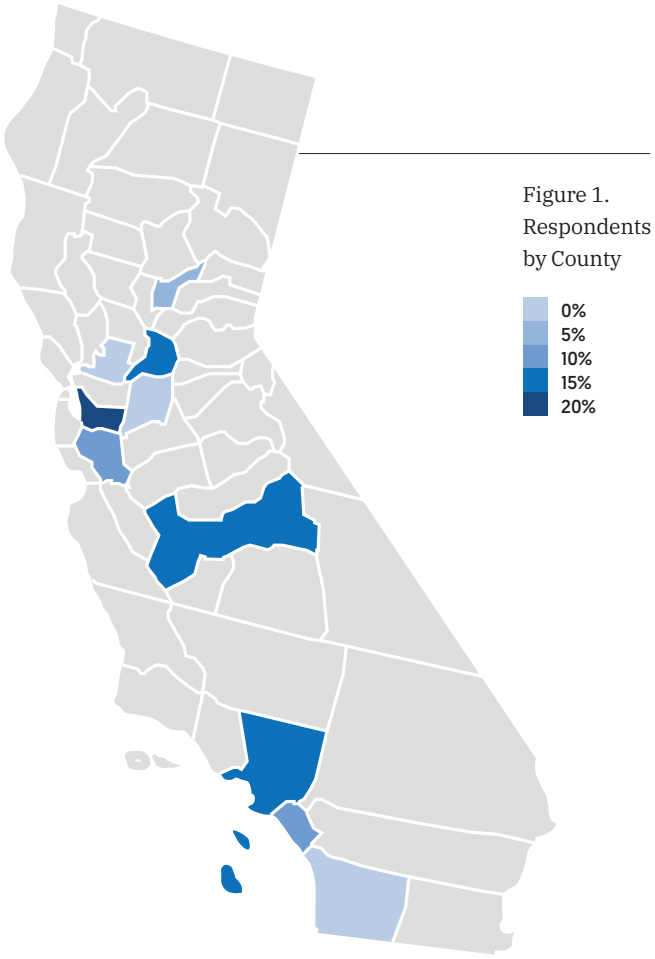

Figure 1. Respondents by County

In 2019, SEARAC launched a campaign to destigmatize mental health, collect stories from SEAAs on their experience with mental health conditions, and shape public policy in California. Leading a multiprong campaign to capture the intersectional challenges within the SEAA community, SEARAC collected surveys through an online platform and the support of SEAA-serving organizations across California to transcribe and translate survey responses.

Respondents were from various SEAA ethnic communities throughout California, including Cambodian, Cham, Hmong, Iu-Mien, Lao, Vietnamese, and SEAA-Chinese [see Figure 2]. Respondents resided in popularly known SEAA ethnic enclaves of the Central Valley, Bay Area, Los Angeles, and Orange County. The respondents in our data landed in the older age range, with the largest age group at 23% over the age of 55 years old and the second largest age group at 22% reportedly between 35-44 years old.[12]

SEARAC witnessed a larger percentage of female identifying respondents than other genders, mirroring the gender distribution of those who accessed mental health services,[13] [see Figure 3]. It would be remiss to assume women have more mental health needs than that of other gender identification. SEARAC's limited data[14] on non-gender conforming, gender queer, transgender, and others across the gender spectrum also demonstrate their often hidden nature, making them difficult to locate through random sampling methods and convenience surveys.[15] SEAA LGBTQ are faced with dual stressors of racism within the predominantly white LGBTQ communities and heterosexism within SEAA communities.[16] A 2007 study of Latinx and Asian American individuals found that suicide attempt rates for LGB individuals from these ethnic groups were four times (women) to eight times (men) that of heterosexuals.[17] Considerably for men, existing cultural stigma and toxic masculinity leads men to hold more negative attitudes toward the use of mental health services compared to women[18] that may contribute to men's underutilization.[19]

The mental health system is a large system, with many sectors and delivery systems. SEARAC aimed to capture a range of perspectives and expertise, from the directly impacted individuals themselves to the providers and community-based staff who provide mental health navigation [see Figure 4]. Through the perspectives of different stakeholders involved in California's mental

[12]To learn more about the mental health challenges in SEAA youth, consider reading SEARAC and RISE's report "*Intergenerational Trauma and Southeast Asian American Youth in California.*"

[13]*Ibid.*

[14]SEARAC acknowledges the existing data include limited data to understand the experience of non-binary, non-gender conforming, gender queer, other genders and LGTBQ+ SEAA, and is committed to working with community members, researchers and legislators to prioritize such urgent research in the future.

[15]Cochran, S. D., Mays, V. M., Alegria, M., Ortega, A. N., & Takeuchi, D. (2007). Mental health and substance use disorders among Latino and Asian American lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology*, 75(5), 785-794.

[16]Pasha, M., Seth, P., & Jamison, G. (n.d.). *First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California.* California Department of Public Health. https://californialgbtqhealth.org/about-us/out4mentalhealth/

[17]Gee, G. C., Spencer, M. S., Chen, J., & Takeuchi, D. (2007). *A nationwide study of discrimination and chronic health conditions among Asian Americans.* American Journal of Public Health, 97(7), 1275-1282.

[18]Sagar-Ouriaghli, I., Godfrey, E., Bridge, L., Meade, L., & Brown, J. (2019). *Improving Mental Health Service Utilization Among Men: A Systematic Review and Synthesis of Behavior Change Techniques Within Interventions Targeting Help-Seeking. American journal of men's health*, 13(3), 1557988319857009. https://doi.org/10.1177/1557988319857009

[19]Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). *Age, gender, and the underutilization of mental health services: the influence of help-seeking attitudes.* Aging & mental health, 10(6), 574–582. https://doi.org/10.1080/13607860600641200

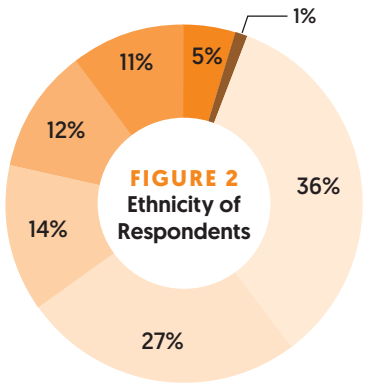

FIGURE 2
Ethnicity of Respondents

- Cham
- SEAA-Chinese
- Hmong
- Lao
- Iu-Mien
- Vietnamese
- Cambodian

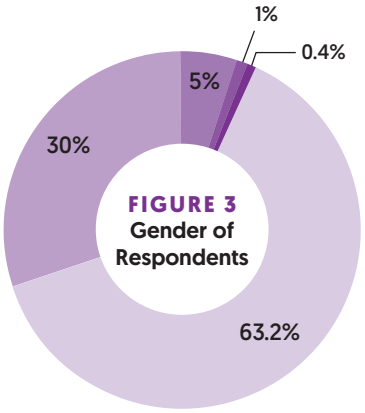

FIGURE 3
Gender of Respondents

- Transgender
- Gender queer/non-binary
- Unknown
- Male
- Female

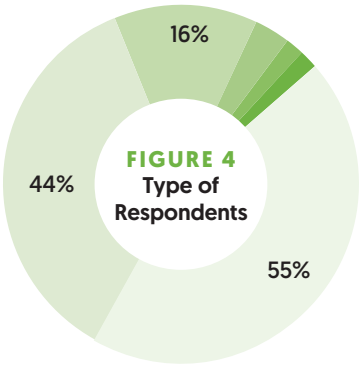

FIGURE 4
Type of Respondents

- Directly impacted
- Someone close to me is directly impacted
- Community-based org staff
- Other/unknown
- Provider/clinician
- Researcher/evaluator

health delivery system, we can better identify the gaps and opportunities. From individuals acknowledging the mental health challenges they are experiencing to the quality of care of their provider, SEARAC inspected each step and systems to better understand the existing barriers and their impact on the SEAA community. Among the collected data, SEARAC made an intentional decision to capture the experiences of those who have a close-knit relationship with a directly impacted person with a mental health condition. SEARAC acknowledges the limitations of these outreach efforts and the imposing stigma of mental health and hopes to capture even those experiences through their loved ones. By understanding the experiences of how family members, friends, neighbors, and community members have been impacted by mental health conditions, SEARAC hopes to capture broader impacts to move toward community healing.

This invitation to share the experiences of others around them, revealed further insight as to how mental health is processed in the SEAA community. Upon completing the questions pertaining to the mental health experiences of people they knew, respondents were also asked to share their experience with mental health if they had any. About 13% of respondents who initially only planned to share the experiences of someone else, later identified as having been directly impacted by mental health themselves. Through the responses, their actions can be interpreted as self-stigma, the process in which a person applies the associated stereotypes of utilizing such services onto themselves.[20] Even as respondents who so readily shared the mental health experiences of someone close to them, it was only through additional probing that we learned of their own personal experience with mental health, demonstrating a sense of self-stigma even beyond their consciousness.

Of the directly impacted respondents, 70% have accessed mental health services, 35% did not, and 4% chose not to disclose. Of the respondents who did not access mental health services, they cited "cultural and linguistic barriers inclusive of cultural stigma" and "don't know how to access mental health services" as the top reasons for not accessing care. This data gives SEARAC further insights as to the most pressing challenges SEAA communities are facing in accessing and utilizing mental health services. Of the respondents who received mental health services, 72% received services from community-based organizations/clinics. Respondents mainly accessed one-on-one therapy sessions, participated in support groups and received medicine to treat their mental health conditions.

In addition to the collected survey responses, SEARAC worked closely alongside leaders in the SEAA community and providers across California to develop a deeper understanding of the existing quantitative and qualitative data. With the contributions of their experience, expertise, and guidance, SEARAC presents the findings of the mental health needs and challenges in the SEAA community, and the path to healing our community from generations of emotional and mental scars.

[20]Corrigan, P.W., Watson, A.C. (2002). *The paradox of self-stigma and mental illness.* Clinical Psychology: Science and Practice 9:35–53

MENTAL HEALTH CHALLENGES TO CARE AND THE COMMUNITY SOLUTIONS

Trauma & the Need for Healing-Centered Practices

Upon the passage of the Refugee Resettlement Act of 1980, SEA refugees were permitted to resettle throughout the country, with many initially resettling in California more than any other state.[21] Unfortunately, many SEAAs were resettled in poverty-stricken neighborhoods plagued by violence, racial tension, and under-resourced schools that only exacerbated their declining mental health. With very little knowledge and understanding of the unique needs and circumstances that SEAs had endured due to war, genocide, and displacement, resettlement agencies left SEA refugees to cope alone with little to no resources to address their mental health challenges.[22]

SEAAs experience post-traumatic stress disorder (PTSD) at higher rates than the general population. Sixty-two percent of older Cambodian adults experience symptoms of PTSD compared to 3% of the general population. The Hmong community is at least twice as likely to experience some kind of mental health issue; particularly major depression, PTSD, and other anxiety disorders.[23] Over 60% of SEAA respondents shared that their mental health conditions were related to their experience with trauma and intergenerational trauma.[24] SEA refugees experienced immense grief and loss in the process of witnessing war, genocide, and displacement[25]—loss of home, community, separation from friends and family who may have been left behind or killed. Whether due to assimilation or political wars, SEA refugees and their children consistently experience loss and grief in the form of loss of identity, social status, language, cultural norm, and values.

> *"We do not have anyone to call when we are in need of food. Since we [have immigrated], we have been walking to get our needs because we do not have a car. We stay home most of the time. This life is poverty. My child does not listen to me. I am very poor and have nothing. If only I was still living in Thailand, I would die in Thailand."*
>
> **SEAA RESPONDENT**

The range of loss and grief that SEAAs experience often makes it difficult to conceptualize and verbalize, making it difficult to address and diagnose. There are normative losses and the accompanying grief associated with losing people, however SEAAs also experience an ambiguous loss that is difficult to articulate and identify as loss and grief.[26] There are two types of ambiguous loss: the first is a physically absent but emotionally present loss due to a lack of proof of death, such as family separation during war and deportation;[27] the second ambiguous loss occurs when a loved one is physically present but emotionally absent due to dementia, depression, PTSD, and homesickness (a longing for the country they immigrated from).[28]

[21]Report to Congress on the Refugee Resettlement Program, FY 2008

[22]Southeast Asia Resource Action Center. (2019). *Southeast Asian American Journeys, A National Snapshot of Our Communities.* Asian Americans Advancing Justice – Los Angeles. https://www.searac.org/wp-content/uploads/2020/02/SEARAC_NationalSnapshot_PrinterFriendly.pdf

[23]Thao, M., Liete, A., and Atella, J. (2010). *Hmong mental health: An assessment of mental health needs and services for the Hmong community in Ramsey County*. Wilder Research. https://www.wilder.org/sites/default/files/imports/HmongMentalHealthAssessment_6-10.pdf

[24]Intergenerational trauma: occurs when trauma is not addressed in previous generations; as a result, trauma is passed on through generations within families and communities

[25]Ballard, J., Wieling, E., Solheim, C., and Dwanyen, L. (2016). *Immigrant and Refugee Families: Global perspectives on Displacement and Resettlement Experiences*, 2nd Edition. University of Minnesota Libraries. https://open.lib.umn.edu/immigrantfamilies/

[26]*Ibid.*

[27]Boss, P. (2004). Ambiguous loss. In F. Walsh & M. McGoldrick (Eds.), *Living Beyond Loss: Death in the Family* (2nd Ed.) (pp. 237-246). New York: W. W. Norton & Company, Inc.

[28]*Ibid.*


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SEA refugees and their children experience a magnitude of loss and grief beyond comprehension and have been left to make sense of this loss and grief in silence. The extensive experience of loss, trauma, and displacement puts SEA refugees and immigrants at higher risk for clinical depression.[29]

Due to the exposure of trauma, SEAA refugee families experience financial strain, abuse, neglect, poverty, chronic illness, and increased family stress,[30] as well as a decreased ability to parent.[31] A study on Cambodian refugee families found that silence from family survivors impacted children's sense of belonging to a community and transmitted a continued pattern of avoidance and silence.[32] Key elements of intergenerational trauma includes a lasting effect that worsens with each generation, biological mechanisms, parent-children relationships, and a culture of silence that creates internal and external trauma for children and youth.[33,34] Intergenerational trauma can impact a range of psychiatric symptoms, as well as greater vulnerability to stress.[35] The cumulative impact of being exposed to traumatic events and stressors pre- and post-migration can impact a child's coping mechanisms that lead to an accumulation of stressors.[36]

Exposure to trauma can create major consequences, including low self-esteem and challenges with associative absorption, emotional maturity, the sustainment of healthy interpersonal relationships, and cognitive/mood changes.[37]

Adolescents can develop internal symptoms of trauma, such as PTSD, depression, and anxiety, as well as external symptoms of substance use, aggression, and delinquency.[38] Children of refugees were more likely to engage in peer delinquent behaviors and to have experience with serious violence and family/partner violence.[39] The responses to these mental health challenges have led to higher rates of interacting with the criminal justice system that can trigger future immigration repercussions.[40]

[29] *Ibid.*

[30] Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A., and Knafi, K. (2004). *Family consequences of political violence in refugee families.* Family Process, 43, 147-160.

[31] Gewirtz, A., Forgatch, M., and Wieling, E. (2008). *Parenting practices as potential mechanisms for child adjustment following mass trauma.* Journal of Marital and Family Therapy, 34(2), 177-192.

[32] Lin, N.J., Suyemoto, K.L., and Kiang, P.N.C. (2009). *Education as catalyst for intergenerational refugee family communication about war and trauma.* Commun Disord Q.;30(4):195–207.

[33] See glossary for definition.

[34] Yang, N., and Dinh, Q. Southeast Asia Resource Action Center (2018). *Intergenerational Trauma and Southeast Asian American Youth in California.* RISE for Boys and Men of Color. http://www.equalmeasure.org/wp-content/uploads/2018/04/Rise_YangDinh_R1.pdf

[35] Han, M. (2005) *Relationship among perceived parental trauma, parental attachment, and sense of coherence in Southeast Asian American college students.* J Fam Soc Work. 2005;9(2):25–45.

[36] Boss, P. (2004). Ambiguous loss. In F. Walsh & M. McGoldrick (Eds.), *Living Beyond Loss: Death in the Family* (2nd Ed.) (pp. 237-246). New York: W. W. Norton & Company, Inc.

[37] Corrado M. (2016). *Trauma narratives with inner city youth: The Storiez intervention* [dissertation, paper 77]. Philadelphia: University of Pennsylvania School of Social Policy and Practice. Retrieved from: https://repository.upenn.edu/cgi/ viewcontent. cgi?article=1080&context=edissertations_sp2.

[38] Ngo, H.M. (2007). Journal of Immigrant and Minority Health: Stressful life events, culture, and violence. 9(2):75-84.

[39] Sangalang, C. C., and Vang, C. (2017). Intergenerational Trauma in Refugee Families: A Systematic Review. Journal of imm

[40] To learn more about how mental health challenges have led additional repercussions with the criminal justice and immigration system, consider reading SEARAC and NAPAWF's report "*Dreams Detained, in her Words: The effect of detention and deportation on Southeast Asian American women and families.*"

"My struggle with accessing mental health services was due to the cultural stigma surrounding mental health within my Khmer family. The word for having a mental health issue in Khmer is 'khuorkbal' which translates to something wrong with the brain or brainless. Growing up, my mother used the word 'khuorkbal' in a derogatory term which was a term that I did not want to be associated with."

SEAA RESPONDENT

Community Solution: Healing-Centered Care

Despite the challenges, 55% of directly impacted respondents have successfully accessed appropriate mental health services. Twenty one percent of those directly cited the healing-centered[41] care they received as effective models that improved their mental health. Advocates are moving toward healing-centered care as opposed to trauma-informed care, which—though important and effective—is a deficit-based model that erases an individual's assets and autonomy regardless of the trauma experienced.[42] As a Western model of mental health, it is individualistic and using it alone cannot address the collective trauma that has drastically shifted a community's history. A healing-centered approach is a strength-based approach that holistically involves culture, spirituality, civic action, and collective healing.[43] For instance, the Center for Empowering Refugees and Immigrants (CERI) provides culturally appropriate, bilingual, and intergenerational healing centered practices to address the trauma and intergenerational trauma of Cambodian and Cambodian Americans in Oakland, California. In addition to the mental health services provided, CERI leads advocacy efforts to improve the wellbeing of its community members. For instance, they rose to provide support for families impacted by deportation due to the high rates of deportation within SEAA communities.[44] Through these advocacy efforts, families and communities develop a sense of community, healing, and hope that extends beyond the trauma they have experienced.

[41]See glossary for definition.

[42]Ginwright, S. (2018). *The Future of Healing: Shifting from Trauma Informed Care to Healing Centered Engagement.* Medium. https://medium.com/@ginwright/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c

[43]*Ibid.*

[44]*Southeast Asia Resource Action Center (2018) Dreams Detained, in Her Words.* The National Asian Pacific American Women's Forum. https://www.searac.org/wp-content/uploads/2018/09/dreams_detained_in_her_words_report-2.pdf

Cultural Stigma and the Need for Community Outreach and Education

In many SEA communities, mental health and its importance in overall wellbeing is a new concept. Translated descriptors of community members that inhibited mental health challenges were often associated with derogatory terms similar to being "crazy." Twenty nine percent of respondents shared their challenges with accessing mental health services were due to an insufficient understanding of mental health services and how to navigate the mental health system. Challenges to understanding mental health services and how to navigate its system are due to language barriers, underinvested culturally appropriate mental health education, and a disjointed health care system. Thirty seven percent of respondents indicated cultural barriers, such as stigma, discouraging family members/friends, and religion, challenged their ability to receive care.[45] The lack of understanding of mental health challenges, existing care, and cultural stigma continue to be the biggest barriers to care. The lack of understanding of mental health and cultural stigma causes many SEA refugees to avoid discussing their trauma with their family and to seek professional mental health services only rarely. SEAAs experience a double silence in their families and society, refraining from talking about their experiences within their own families and with professional mental health providers.[46]

Community Solution: The Power of Trusted Agents and Mental Health Services as a Byproduct

SEAA mental health providers have been able to bypass the cultural stigma to provide mental health education and services as a byproduct of their programs rather than the emphasis. Many SEAA-serving community-based organizations have developed innovative methods to educate and provide culturally and linguistically appropriate mental health services through community gardens, cultural art therapy, and informative field trips. For instance, the Fresno Interdenominational Refugees Ministries (FIRM) helps run the Hmong Community Garden in Fresno that has been able to provide a sense of comfort for SEAA refugees. The Hmong Community Garden is one of 56 community-based mental health programs statewide funded through the MHSA to evaluate methods that provide evidence-based results of addressing mental health conditions. Gardeners and families are encouraged to attend workshops each month that include information about mental illness and available resources in the community. The program has proven to lower thoughts of suicide in participants.[47]

[45]With acknowledgement of the limitations of a convenience survey that may attract participants already open to and understand the importance of mental health services. This percentage is not comparable to the population as a whole affected by cultural barriers and stigma.

[46]Yang, N., & Dinh, Q. Southeast Asia Resource Action Center (2018). *Intergenerational Trauma and Southeast Asian American Youth in California.* RISE for Boys and Men of Color. http://www.equalmeasure.org/wp-content/uploads/2018/04/Rise_YangDinh_R1.pdf

[47]Anderson, Barbara. (2015) "*Hmong Garden Praised for Mental Health Impact.*" Accessed on June 11, 2020. http://crdp.pacificclinics.org/news/community/08/08/hmong-garden-praisedmental-health-impact-fresno-ca

Sixty nine percent of those directly impacted praised their ability to access mental health services in a community setting, such as community-based organizations or community clinics. It is critical to develop services centered in community and in a community setting. CERI utilizes a transformative model that demonstrates how to blend Western and traditional models of mental health and healing successfully. CERI provides culturally appropriate and bilingual support groups, clinical counseling, medication management, and alternative healing. Participants mentioned that mental health services provided in a community setting made it easier for them to trust the providers. CERI's providers have spent the last 15 years building the trust of the SEAA community through their community-centered approach of allowing community voices to drive their work. Even as CERI also provides clinical counseling with which many SEAA may not be as familiar, CERI has established trust within the SEAA community that this, too, is another service provided by CERI with their best interest in mind. The critical factor in determining the effectiveness of talk therapy is the ability of professionals to build rapport and trust with clients.[48] By providing services in a community setting or in partnership with trusted agents of the communities, providers are able to establish rapport with the client effectively in a shorter time and focus on providing the mental health care the client needs. Mental health providers operating in community settings develop a stronger sense of the community they are working with and are able to provide more culturally appropriate services even when providers are a different ethnicity from the community they are serving.

Respondents shared the well-received approaches that these community-based services utilized and how comfortable the environment and people make them feel. In addition to the comforting environment, community-based services provided a range of resources that supported the respondent holistically. Seventy one percent of the directly impacted respondents who accessed appropriate care, shared that their ability to receive support in other areas of their life improved their mental health. Similarly, SEAA providers from our focus groups and follow-up interviews shared this same method and the recurring need for case management as a strategy to provide mental health services. Community-based organizations often design themselves as a "one-stop shop" to provide a range of services for the specific community they serve. Outside of the mental health services provided, community-based organizations were likely to provide support in interpretation, naturalization, and system navigation (i.e. health care, welfare, education). SEAA providers vividly described sitting in the local California Department of Social Security office and learning more about the mental health challenges their client was experiencing while waiting for their appointment. SEAA providers shared that supporting their SEAA client in this manner allowed opportunities for SEAA clients to share their mental health needs organically rather than through the unfamiliar confines of a traditional therapist's office.

[48]Gensheimer, L. (2006). *Learning from the experiences of Hmong mental health providers.* Hmong Studies Journal, 7, 1-31.

"I had to be the interpreter for my dad and his psychiatrist. They didn't have an interpreter so my dad just brought me. For the first time my dad described [his experience with] the Khmer Rouge. He described in detail; he was bawling, I've never seen my dad in this way. As his child, I felt wrong, like, I was invading some boundaries and privacy. Why is it okay to have a child interpret in this setting? Even though I didn't fully understand everything, I knew it was wrong."

PYSAY PHINITH, LCSW

Challenges as a Limited English Proficient Community in CA and the Need for Language Justice

The history of racism, bigotry, heterosexism, transphobia, ageism, and other discrimination in the United States was a constant source of stress that can lead to feelings of invalidation, negation, dehumanization, disregard, and disenfranchisement.[49] SEA refugees faced multi-faceted stressors of discrimination, assimilation, and poverty in their new homes, shifting cultural norms and family structures as forms of survival. Thirty three percent of respondents shared the mental health conditions was due to the pressures of assimilation and experiencing discrimination. Forty seven percent of SEAA are LEP, a rate higher than Asian Americans as a whole and other racial groups.[50] Being LEP determines which resources and services are accessible,[51] what jobs LEP are able to pursue,[52, 53] how much you are likely to earn,[54,55] and how likely you will be harassed.[56] With the leading indicator of assimilation being English proficiency, SEAA will continue to experience harassment as a result of their resistance to assimilation. In addition to the harassment, adult figures had to rely on their children who learned English in elementary schools, to serve as their cultural brokers in navigating complex health, social welfare, education, and criminal justice systems, disrupting the agreed cultural familial role as parents and children. The role reversal is disempowering for both the adult who relies on their child and the child with adult responsibilities that experiences additional stress than that of their peers from English-speaking households.[57]

Even after overcoming the cultural stigma to access mental health services, SEAAs struggle to access existing services. Over 36-50% of SEAA are LEP in California, compared to 19% of the total population.[58] However, the limiting state definition of a threshold language has left minority SEAA groups like the Hmong and Iu-Mien communities to experience even greater cultural and linguistic barriers to accessing mental health services.

Despite being in the top three languages most spoken in Butte County, Hmong isn't considered a threshold language, and as a result, CA counties are not required to translate materials or have interpreters available in Hmong.

While many health care services have addressed the language barrier, some of these techniques may not be

[49]California Pan-Ethnic Health Network. (2018) *California Reducing Disparities Project – Strategic Plan to Reduce Mental Health Disparities.* https://cpehn.org/sites/default/files/resource_files/crdp_strategic_plan.pdf

[50]U.S. Census Bureau, *2011–2015 American Community Survey 5-Year Estimates*, Table B16004

[51]Kim, G., Worley, C. B., Allen, R. S., Vinson, L., Crowther, M. R., Parmelee, P., and Chiriboga, D. A. (2011). *Vulnerability of older Latino and Asian immigrants with limited English proficiency.* Journal of the American Geriatrics Society, 59(7), 1246–1252. https://doi.org/10.1111/j.1532-5415.2011.03483.x

[52]Compared to their English-proficient counterparts, LEP men were more likely to work in natural resources, construction, and maintenance occupations (15% versus 28%), service occupations (14% versus 25%), and production, transportation, and material-moving occupations (17% versus 24%). LEP women were significantly more likely to work in service occupations (45% versus 20%), as well as production, transportation, and material-moving occupations (16% versus 5%) than their English-proficient counterparts.

[53]Zong, J. and Batalova, J. (2015). "*The Limited English Proficient Population in the United States.*" Migration Policy Institute http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states

[54]Working-age LEP adults earn 25 – 40% less than their English proficient counterparts. While less educated overall than English proficient adults, most LEP adults have a high school diploma, and 15 percent hold a college degree.

[55]Wilson, J. H. 2014. *Investing in English skills. Washington DC: Brookings Institution.* Online: http://www.brookings.edu/~/media/research/files/reports/2014/09/english%20skills/srvy_en glishskills_sep22.pdf

[56]Qin, D. B., Way, N., and Mukherjee, P. (2008). *The Other Side of the Model Minority Story: The Familial and Peer Challenges Faced by Chinese American Adolescents.* Youth & Society, 39(4), 480–506. https://doi.org/10.1177/0044118X08314233

[57]Rachele, A., Letizia, C., Linda, R., and Ira, T. (2017) *Non-professional Interpreting and Translation: State of the Art and Future of Emerging Field of Research.* John Benjamins Publishing Company.

[58]U.S. Census Bureau, 2011–2015 *American Community Survey 5-Year Estimates*, Table B16004.

"Living in America you feel like a little kid learning everything all over again. Awhile living this life there are many things to learn. You barely learned how to speak Lao, but you moved out. You learned how to speak Thai but then moved out of Thailand also. Then eventually you come to a new country like America and have to learn their language. It is very hard to keep learning new stuff and moving around."

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appropriate for mental health programs. Mental health services, for many, require an extremely sensitive and private approach to build rapport even between the provider and client. Introducing a temporary interpreter who may vary from session to session, is uncomfortable to a client disclosing sensitive experiences. Interpreters play a critical role in the directly impacted individual's experience with mental health services and contributes to whether individuals continue care. Mental health providers have also utilized online interpretation tools for a variety of services. Mental health is a sensitive subject that requires skilled interpreters to be able to utilize accurate and destigmatizing word choices. Unskilled interpreters who do not specialize in mental health have resulted in inaccurate interpretations and diagnosis.[59] Existing language barriers and a reluctant system to support LEP communities further exacerbates the existing mental health challenges of SEAA.

[59]Flores G. (2005). *The impact of medical interpreter services on the quality of health care: a systematic review.* Medical care research and review : MCRR, 62(3), 255–299. https://doi.org/10.1177/1077558705275416

Community Solutions: Language Justice

California has the largest percentage of LEP residing in the state, at 19% compared to the national average of 9%. Advocates are shifting from the framework of linguistic competence/appropriateness to language justice.[60] Language continues to serve as a gateway to accessing a plethora of resources including basic rights of comprehension, expression, and affirmation. Language justice calls on the government to ensure these basic human rights.

Due to the lack of translated materials and interpretation available in doctor's offices, SEAA-serving organizations have risen to fill in the existing gaps to ensure their community has a fighting chance. For instance, Hmong Cultural Center of Butte County (HCCBC) is one of few organizations providing culturally and linguistically competent mental health services to the Hmong community north of Sacramento, CA. Through its innovative programming blending Western and traditional cultural treatment, HCCBC has been able to support the mental health needs of Hmong elders experiencing trauma, stress, anxiety, isolation, stigmatization, and depression. Similarly, the Iu-Mien community faces a similar struggle by not meeting the threshold standards in Sacramento County, despite Sacramento having one of the country's largest populations of Iu-Mien. Iu-Mien Community Services (IMCS) is the only non-profit organization specifically serving the Iu-Mien community, providing interpretation and an array of intergenerational and culturally responsive programs and social services to address depression, stress and isolation.

[60]See glossary for definition.

[61]See glossary for definition.

In addition to providing interpretation to support the gaps of the county, The Cambodian Family Community Center (TCFCC) sought to change this gap, by leading powerful civic engagement and advocacy campaigns. TCFCC fought for county recognition of the Cambodian community in Orange County and to provide in-language resources and services to a community that didn't meet the county threshold language.[61] Through the work of TCFCC and community advocates, Khmer (Cambodian) is now readily provided throughout the county and available at county board meetings. Organizations like HCCBC, IMCS, and TCFCC are actively advocating for language justice for their communities throughout California.

Community-centered, culturally appropriate, and highly skilled interpreters in mental health services already exist. The Sacramento Cultural and Linguistic Center (Team SCLC), formerly known as the Southeast Asian Assistance Center (SAAC), specializes in providing culturally appropriate interpretation to a range of immigrants and refugees, with an extensive history of working with SEAA immigrants and refugees. Team SCLC specializes in providing interpretation for the Division of Behavioral Health Services (Mental Health Services and Alcohol & Drug Treatment Services) of Sacramento County. Team SCLC provides transformative services to immigrants and refugees with mental health conditions throughout Sacramento, but remains an underutilized resource to providers in Sacramento as a whole. California has already taken many critical steps to increase access for LEP communities but is still falling short in developing a system centering language justice for LEP communities.

The Inappropriately Served and the Need for Culturally Appropriate Providers and Services

There remain many barriers preventing or discouraging SEAAs from seeking and receiving care. Respondents shared their heartbreaking stories of failures in accessing mental health care. Among the many challenges that respondents shared, 77% of respondents mentioned that the lack of cultural appropriate services and providers discouraged clients from seeking (further) care. Twenty

nine percent of respondents mentioned that the lack of intersectional and intergenerational services and providers discouraged clients from seeking (further) care. These challenges point to the provider's readiness and experience serving diverse communities such as the SEAA community. In a follow-up focus group with SEAA providers, the participants agreed to their programs providing insufficient training, frameworks, and best practices to serving diverse communities, let alone serving SEAA clients specifically. Participants discussed

"When I was in middle school, I confided in a counselor about the severe bullying and isolation, suicidal thoughts, and depression I was feeling. The counselor called my parents to recommend that I see a psychologist for depression. My parents are refugees who do not speak English, did not understand what was happening. My parents said, 'the counselor said you're crazy,' and rejected the struggles I was facing by saying it will pass. The counselor was following protocol but it was not helpful to notify my parents, because they understood very little about addressing mental health issues."

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in detail the limitations of one class dedicated to covering "diverse" community needs and its juxtaposition to an entire program of Western models that catered to serving the white population.

The mental health system in California is built off of predominantly Western and heterosexual models of care that challenge providers' abilities to serve communities with different cultural values and assets. Western models of individualistic nature fail to recognize the collective trauma experienced by the SEAA community and other unserved, underserved, and inappropriately served communities. These models are likely to focus on changing individual learned behaviors without recognizing the collectivistic values and their impact on SEAAs. Many directly impacted SEAAs shared their experience of receiving care for themselves but continued to experience challenges to their mental health due to the existing stressors still found in their homes.

An analysis of education data indicates that master's level social work (MSW) and psychology programs are slowly becoming more racially and ethnically diverse, with master's level psychology programs seeing gains in the number of Hispanic/Latino, African American, and Asian American graduates.[62]However, white students remain the predominant group in these education programs at 70%.[63] Overall, only 70 Asian American and Pacific Islander (AAPI) mental health providers are available for every 100,000 AAPIs in the United States.[64] In California, Laotian, Cambodian, and Hmong Americans have the lowest ratios of native language-speaking physicians and nurses compared to all other racial/ethnic groups.[65]

To understand the low rate of SEAA providers, it is imperative to understand the educational challenges that SEAAs experience. While many Asian American ethnic groups have a higher college attainment rate than the general US population, SEAA communities have glaringly low education attainment rates with rates also differing by gender. For example, 34.3% of Laotian, 38.5% of Cambodian, 39.6% of Hmong, and 30.2% of Vietnamese American adult populations do not have a high school diploma, compared to 14.4% of US adults.[66] High school completion rates of Hmong and Laotian males are lower than their female counterparts.[67] As a result of being omitted from K-12 curriculum, many SEAA students feel that their families' individual and collective memories are invisible to their teachers, classmates, neighbors, and society at large.[68] This contributes to SEAA students' sense of belonging or exclusion in the education system.

[62]The Public Health Institute. (2008). *Diversity in California's Health Professions: Current Status and Emerging Trends – The Connecting the Dots Initiative: A Comprehensive Approach to Increase Health Professions Workforce Diversity in California.* University of California Berkeley School of Public Health. https://futurehealthworkforce.org/wp-content/uploads/2017/08/2008-ctd-diversity-in-californias-health-professions-current-status-and-emerging-trends.pdf

[63]*Ibid.*

[64]National Alliance for Mental Health Multicultural & International Outreach Center. 2003, accessed June 16, 2017, http://www. naminys.org/images/uploads/pdfs/Asian%20American%20Community%20Mental%20Health%20Facts.pdf

[65]Tseng W., McDonnell D.D., Takahashi L., et al. (2010). *Ethnic health assessment for Asian Americans, Native Hawaiians, and Pacific Islanders in California.* Berkeley, Calif.: UC Berkeley School of Public Health. Retrieved from: www.apiahf.org/sites/ default/files/PA-factsheet06-2010.pdf.

[66]US Census Bureau, 2011-2013 *American Community Survey 3-Year Estimates.*

[67]Teranishi R. (2010). *Asians in the ivory tower: dilemmas of racial Inequality in American higher education.* New York: Teachers College Press.

[68]White House Initiative on Asian Americans and Pacific Islanders: Education [online]. (n.d.) Retrieved from: https://sites.ed.gov/%aapi/education/

"Vietnamese language interpreters could not (or were 'uncomfortable') translating gender/sexuality terminology. The few times my family member/s were allowed to be in the room were not helpful for these reasons. Not having access to culturally appropriate mental health services have almost permanently created distance between myself and some of my family members. Considering the importance of community and community resources for first-generation immigrants, this has impacted my survivability, connections to my own SEA identity/hxstory/culture, and ability to navigate my mental health experience."

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As a result, only 15.8% of Cambodian, 14.2% of Hmong, 10.4% of Laotian, and 29.5% of Vietnamese American adults in California, 25 years and older, hold a bachelor's degree or higher, compared to 49% for the general Asian American population.[69]

Academic challenges aside, SEAAs experience multiple layers of challenges in pursuing a profession in mental health that their white peers do not. SEAA providers shared their parent's disapproval to pursue a career in mental health. In conjunction to the cultural stigma of mental health services as a client, there was a distaste to pursue a career in an undesirable field by the community's standards. SEAA providers shared the taxing process of navigating a complex system with very little mentorship and guidance as an SEAA and emotional stress of having to justify and convince their families of the importance of their career. Also, the demanding cost of pursuing a career in mental health with very little promise of a comparable income, challenges SEAAs to reconsider such a career. Moreover, if they do pursue such a career, many consider private practice rather than providing community based services because of a felt responsibility to provide for their families. Cambodian, Laotian, and Hmong Americans have the lowest per capita income in California compared to all the racial groups.[70] Sixty percent of Hmong Americans in California are low-income, and more than one in every three live in poverty.[71] For SEAAs, it is a tough decision to pursue a career in mental health given its projected income.

[69] US Census Bureau, 2011-2013 American Community Survey 3-Year Estimates.
[70] U.S. Census Bureau, 2011–2015 American Community Survey 5-Year Estimates.
[71] *Ibid.*

Community Solutions: Strengths-Based Care and an SEAA Provider Pipeline

The history of racism, bigotry, heterosexism, transphobia, ageism, and other discrimination in the United States was a constant source of stress that can lead to feelings of invalidation, negation, dehumanization, disregard, and disenfranchisement. SEA refugees faced multi-faceted stressors of discrimination, assimilation, and poverty in their new homes, shifting cultural norms and family structures as forms of survival. Thirty three percent of respondents shared the mental health conditions was due to the pressures of assimilation and experiencing discrimination. Forty seven percent of SEAA are LEP, a rate higher than Asian Americans as a whole and other racial groups. Being LEP determines which resources and services are accessible, what jobs LEP are able to pursue, how much you are likely to earn, and how likely you will be harassed. With the leading indicator of assimilation being English proficiency, SEAA will continue to experience harassment as a result of their resistance to assimilation. In addition to the harassment, adult figures had to rely on their children who learned English in elementary schools, to serve as their cultural brokers in navigating complex health, social welfare, education, and criminal justice systems, disrupting the agreed cultural familial role as parents and children. The role reversal is disempowering for both the adult who relies on their child and the child with adult responsibilities that experiences additional stress than that of their peers from English-speaking households.

Due to racism and cultural mistrust, mental health clinicians must be willing to embrace and employ clinical assessments and interventions that are contextual and multidimensional, honoring the complex historical experience of each patient of color and not oversimplifying and reducing their experiences.[72] Best practices mentioned thus far utilize innovative approaches to capitalize on community assets and community-defined practices to increase access to mental health services regardless of looming challenges. Culturally appropriate care includes recognizing the strengths of the community and empowering their utilization. A community draws strength from its culture, heritage, and traditions. Community gardens work because gardening and farming have long been associated with the lifestyles of SEAA, pre-migration. Music and art therapy work because embroidery and songs have always been forms to express the journeys of SEAA lives. By increasing a provider's cultural humility and cultural fluency of SEAAs, providers are able to identify the strengths of the community they are serving and to provide empowering strengths-based models that honor the client's culture rather than condoning it for its differences.

The Fresno Center (TFC) serves as a great example of increasing providers' cultural humility and developing an intentional pipeline to support the increasing need for diverse providers. Like many of the community-based organizations previously mentioned, TFC also provides a range of services to address the holistic needs of the SEAA community it serves. More specifically, TFC's Living Well Center provides multi-prong services in increasing the wellness of the SEAA community. The Living Well Center provides culturally and linguistically appropriate mental health services to SEAA clients, blending cultural spiritual healing practices into Western models of care. In addition to the innovative care it provides, the Living Well Center has developed an intentional pipeline of SEAA providers, working with SEA non-licensed/waivered mental health clinicians, under clinical direction and oversight by licensed clinicians, to increase capacity of persons served and the volume of specialty mental health services to the SEAA community in Fresno. The Living Well Center program intentionally builds on the strengths of the SEAA community and utilizes these strengths to support a pathway to increasing the number of SEAA mental health providers. The Living Well Center program is a prime example of addressing both the need for cultural fluency and the need for more diverse mental health providers.

[72]Suite, D., La Bril, R., Primm, A., and Harrison-Ross, P. (2007). *Beyond Misdiagnosis, Misunderstanding and Mistrust: Relevance of the Historical Perspective in the Medical and Mental Health Treatment of People of Color.* Journal of the National Medical Association. Vol. 99. No. 8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2574307/pdf/jnma00207-0025.pdf

"I remember feeling judged and attacked by them and not willing to be fully vulnerable around them. I feared they wouldn't understand. One of them made me cry, and the appointment lasted less than 10 minutes - I remember feeling wrong on my journey to mental healing and confused... I had such a bad experience that I couldn't go back for my one-on-one sessions for three weeks in fear of running into her again.. I felt like that one encounter made me regress. These two people made me feel judged and instead of acknowledging my want to be better, they made me feel like I wasn't doing enough. They made me feel the way my parents made me feel."

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Impact of (In)Appropriate Care

Unfortunately, these community solutions are not practiced as a whole and the quality of mental health care that SEAAs can access varies county by county. Due to the challenges SEAAs face in accessing mental health services, 75% of directly impacted respondents indicated that they were never able to receive appropriate mental health services, with 15% of respondents indicating a delay in the mental health services received due to the challenges expressed thus far. Furthermore, 60% of directly impacted individuals shared that the multitude of challenges they experienced discouraged them from seeking (further) care. Respondents also shared that their inability to access culturally appropriate mental health services and/or experiencing harmful mental health sessions, led to their declining mental health or regression.

In addition to the direct impact of mental health conditions on an individual, are the impacts to their relationships with other people. Mental health challenges have a "ripple effect" on families, creating tension, uncertainty, troubled emotions, and big changes in how people live their lives. Amongst the collected data, respondents shared their experience of having someone close to them struggle with mental health challenges. Of the respondents who shared their challenges with SEARAC, 51% said their relationship with an individual was negatively impacted when that person was not able to receive appropriate care. In addition, 60% of respondents shared that their own mental health suffered as a result of the directly impacted individual's inability to seek care. Maintaining a relationship with someone who hasn't received mental health services for their condition

can be extremely stressful. Coping with that stress may lead to various mental health conditions, such as loss of appetite, anxiety, depression, guilt, fear, and changes in attitude and social withdrawal.[73] Being unable to access care for the past 45 years has had a collective impact on the SEAA community.

On a hopeful note, respondents shared the positive impacts of being able to access appropriate mental health services. Of those who indicated they have successfully received care, 91% specifically mentioned how appropriate mental health services helped improve their conditions, and 53% indicated how it gave them a sense of hope and provided a positive outlook on mental health. When directly impacted individuals are able to receive care, it also improves the relationship and mental health of those around them. Respondents sharing the impact of knowing someone with mental health challenges said that the person's ability to access care greatly improved their relationship (45%) and improved their own mental health (52%). Witnessing others successfully access mental health services and its impact, lowers the cultural stigma and has also inspired respondents to access mental health services themselves (45%).

> *"It feels like regardless of how many tattoos I get that symbolizes mental health I will not be courageous enough to share my experience with mental health due to the stigma surrounding mental health. I believe if they had a culturally and linguistically competent mental healthcare team that their knowledge on mental health would allow them to seek treatment for themselves and my family, so we can all be healthy individuals."*
>
> **SEAA RESPONDENT**

> *"Hearing my friend's success story of finding a counselor that she connected with motivated me to make my first counseling appointment because it helped erase some stigma for me."*
>
> **SEAA RESPONDENT**

[72]Suite, D., La Bril, R., Primm, A., and Harrison-Ross, P. (2007). *Beyond Misdiagnosis, Misunderstanding and Mistrust: Relevance of the Historical Perspective in the Medical and Mental Health Treatment of People of Color.* Journal of the National Medical Association. Vol. 99. No. 8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2574307/pdf/jnma00207-0025.pdf

[73]Shamsaei, F., Cheraghi, F., and Esmaeilli, R. (2015). *The Family Challenge of Caring for the Chronically Mentally Ill: A Phenomenological Study.* Iranian journal of psychiatry and behavioral sciences, 9(3), e1898. https://doi.org/10.17795/ijpbs-1898

CONCLUSION

Policy Recommendations

- From political refugees to established politicians, the SEAA community has flourished despite their circumstances. The SEAA community is a resilient community that has persevered through the traumatic experiences of war, genocide, and displacement. However, without culturally appropriate, intersectional, intergenerational, healing-centered mental health services, the SEAA community can never move from a community in survival mode to a community of wellness and abundance.

- While many community organizations have implemented innovative community-defined practices across the state, these services are underfunded in proportion to the population size they are expected to serve.[74] More broad-based support is required to sustain and expand these models and adapt them to serve other underserved populations.[75] Based on cross-referencing our survey responses, focus groups, and follow-up interviews, with existing community and academic research, three main themes emerge from this deep dive:

- Mental health care is not appropriate and accessible to SEAA if not all areas of culture, intersectionality, intergenerational factors, healing, and language are considered.

- Access to appropriate care is imperative to healing the SEAA community and ending the cycle of trauma.

- Innovative effective community solutions already exist to address the barriers of care, but they are not practiced and invested in widely enough to provide care appropriately.

- Given the findings of this assessment, the following are recommendations to build partnerships, increase effective models of care, and improve the mental health service delivery system, and improve access, utilization, and outcomes of mental health services for the SEAA community.

POLICY RECOMMENDATION #1:

Increase access through community education, outreach, 27 navigation, prevention, and early intervention

- **Fund culturally and linguistically appropriate outreach:** SEARAC recommends the state legislature funds the Department of Health Care Services, with the oversight of the Mental Health Services Oversight and Accountability Commission (MHSOAC), to develop culturally, linguistically, and LGBTQ appropriate prevention and early intervention outreach materials for the five target populations identified through the CRDP Project.[76] The outreach materials should be developed in partnership with consumers and community-based providers from the target population. Community

[74]Cunningham, P., McKenzie, K., and Taylor, E. F. (2006). *The Struggle to Provide Community Based Care to Low-Income People with Serious Mental Illnesses.* https://doi.org/10.1377/hlthaff.25.3.694

[75]California Pan-Ethnic Health Network. (2018) *California Reducing Disparities Project – Strategic Plan to Reduce Mental Health Disparities.* https://cpehn.org/sites/default/files/resource_files/crdp_strategic_plan.pdf

[76]*Ibid.*

based-providers should be funded to participate in the development, dissemination, education, and evaluation of the outreach materials. Much hesitation for mental health in the SEAA community is due to the cultural stigma and how little is understood about mental health and the mental health system. Investing in proactive initiatives to educate and support the navigation of a disjointed health care system will provide the foundation for bypassing the cultural stigma.

POLICY RECOMMENDATION #2:

Invest in community assets

- **Recognize nontraditional mental health providers:** SEARAC recommends county departments of mental health fund and support the identification and recognition of community health workers, community healers, spiritual healers, and indigenous/non-traditional practitioners to ensure an effective, culturally appropriate mental health and primary integrated care structure.[77] These mental health providers have not been a part of the traditional public mental health system; however, they are essential in providing holistic culturally appropriate services to the SEAA community.

- **Invest in healing-centered care to increase capacity for community engagement and advocacy:** SEARAC recommends county departments of mental health fund healing-centered care and community-based services for their advocacy work. Funding healing-centered care means encouraging mental health clients to take an active role in improving the systems that caused the mental health challenges they experienced. Existing funding streams are limited in funding the direct mental health services and provide very little capacity for community-based services and community members to engage in advocacy to improve the mental health delivery system. Investing in healing-centered care is investing the community experts' capacity to develop a more culturally appropriate mental health delivery system and mental health programs and services that are responsive to the community's needs.

- **Encourage co-location of services and integration:** SEARAC recommends locating mental health services in community settings, such as community-based organizations, community centers, social service organizations, and faith-based organizations, to maximize the strengths and traffic of community oriented spaces. Co-locations are mutually beneficial to community entities and providers, increasing access to culturally appropriate mental health services overall. SEARAC recommends that county departments of mental health develop partnerships with community centers and providers.

POLICY RECOMMENDATION #3:

Improve the quality of care

- **Ensure language access through translated materials:** SEARAC recommends the enforcement of the National Culturally and Linguistically Appropriate Services Standards (CLAS),[78] accounting for LGBTQ affirming language. The enforcement of CLAS will increase access to mental health services for LEP SEAA.

- **Enforce the usage of skilled interpreters specializing in mental health:** SEARAC recommends prohibiting the use of interpreters without adequate training in mental health terms with considerations of culturally and linguistically acceptable word choices. Providers may not utilize bilingual staff, children, friends, or families as interpreters who are not trained or have not been evaluated for language proficiencies.

- **Develop a pipeline to increase SEAA mental health providers:**[79] SEARAC recommends funding community-specific mentorship programs. Such a pipeline shall include, but is not limited to, connecting SEAA youth and young people to practicing SEAA mental health provider or providing supervision for non-licensed/waivered SEAA mental health clinicians under clinical direction and oversight by SEAA licensed clinicians. Exposure and mentorship are critical in pursuing a career in mental health and can encourage more SEAAs to embark on such a pathway.

[77] *Ibid.*

[78] See glossary for more on CLAS.

[79] *Ibid.*

- **Require cultural humility training and community immersion internships:** SEARAC recommends cultural humility training and community immersion internships as part of mental health care training at all academic levels, from certification to advanced degrees. Cultural humility increases the provider's cultural congruence with best practices to serving diverse communities. Community immersion internships are necessary for providing field experience and guidance to work with diverse communities. Community immersion internships shall include, but are not limited to, providing services at a SEAA community-based clinic.

- **Require the collection and reporting of disaggregated data**: Counties do not currently disaggregate data. This causes challenges when working toward revealing true health disparities in our communities. SEARAC recommends policies urging data collection and reporting that allow us to inform equitable health policy solutions.

POLICY RECOMMENDATION #4:

Integrate mental health services

- **Require early periodic screening of Adverse Childhood Experiences (ACEs):** SEARAC recommends requiring regular periodic screenings of ACES conducted in the public school system in order to identify mental health conditions sooner. The mental health system has adopted many promising initiatives to serve unserved, underserved, and inappropriately served populations like the SEAA community; however, the mental health system still needs to adopt policies with integrated, intersectional, and culturally appropriate services at its core, in order to serve a larger population of the SEAA community.

POLICY RECOMMENDATION #5:

Fund research on community-specific needs and effective services

- **Fund additional research on the variances within the SEAA community:** SEARAC acknowledges the limitations within the collected sample size, inhibiting a thorough understanding of the experiences of underreported. With limited research on the mental health challenges that SEAAs experience, policymakers and providers lack the direction necessary to improve access, utilization and outcomes of mental health services for SEAAs. Therefore, SEARAC recommends the state legislature dedicate funding to the Department of Public Health to authorize and conduct research on the varying experience with mental health conditions due to their intersectional identities, inclusive of but not limited to LGBTQ, gender, and generation. In addition, SEARAC recommends further research on the variance in satisfaction of care by the location care was received. Further research will reveal distinct differences in coping with mental health conditions and provide insight of how to better serve SEAAs through an intersectional lens. Investing in community-specific research provides a template on effective models of care for the SEAA community.

- **Fund the development and implementation of culturally appropriate evidence-based practices:** SEARAC recommends the state legislature provide similar if not additional funding to the Office of Health Equity to continue evaluating the effectiveness of community-defined practices as executed through Phase II of the California Reducing Disparities Project. Sustaining this successful initiative is fundamental in increasing and introducing and multiplying these effective community-developed, culturally appropriate evidence-based practices into mainstream mental health services, making these culturally appropriate mental health services much more accessible for the SEAA community.

GLOSSARY

- **CULTURALLY APPROPRIATE:** services are developed and/or provided with the understanding and integration of how an individual's cultural values, religion, intersectional identities, roles, customs, and community history impact the mental wellbeing of the individual, family, and community. Services are affirming and draw on the strength from the culture, heritage, and traditions. This model is based on the idea that cultural competence is ever-evolving. Providers and services must continue to learn the changing culture and the differing values of each individual and family to improve the quality of care.
  - The definition was derived from survey respondents indicating the most important elements of culturally appropriate care:

- **DIRECTLY IMPACTED INDIVIDUAL:** an individual with direct experience of mental health conditions.
- **GENDER:** A social construct used to classify a person as a man, woman, or some other identity. Fundamentally different from the sex one is assigned at birth.[80]
- **HEALING-CENTERED:** Healing is strength-based, advances a collective view of healing, and re-centers culture as a central feature in well-being. Healing from trauma is found in awareness and actions that address the conditions that created the trauma in the first place. When people advocate for policies and opportunities that address causes of trauma, such as lack of access to mental health, these activities contribute to a sense of purpose, power and control over life situations.[81]
- **INTERGENERATIONAL TRAUMA:** occurs when trauma is not addressed in previous generations; as a result, trauma is passed on through generations within families and communities.[82]
  - **Lasting effect that worsens with each generation:** Trauma has been shown to have a lasting effect on communities, where unresolved trauma becomes more severe each time it is passed onto subsequent generations.[83]
  - **Biological mechanisms:** Research has also shown that epigenetic modifications to DNA expression have emerged as key biological mechanisms contributing to intergenerational transmission.[84]

[80]Lesbian Gay Bisexual Transgender Queer Intersex Asexual Resource Center, University of California Davis (n.d.). Glossary. Retrieved June 6, 2020 from https://lgbtqia.ucdavis.edu/educated/glossary

[81]Ginwright, S. (2018). *The Future of Healing: Shifting from Trauma Informed Care to Healing Centered Engagement.* Medium. https://medium.com/@ginwright/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c

[82]Duran E. (2006). *Healing the soul wound: counseling with American Indians and other native peoples.* New York: Teachers College Press.

[83]*Ibid.*

[84]Devakumar D., Birch M., Osrin D., et al. (2014). *The intergenerational effects of war on the health of children.* BMC Medicine, 12(1):57; doi: 10.1186/1741-7015-12-57.

- **Parent-child relationships:** Some research has proposed that parents who experience trauma may have difficulty establishing secure attachments to their children, which results in impaired parenting capacities and poor self-image by children in relation to their surroundings.[85]
- **Culture of silence creates internal and external trauma for children and youth:** The culture of silence within families who have experienced trauma prevents healing and leads to children internalizing the silence and their parent's trauma.[86]

- **LANGUAGE JUSTICE:** Language access is a fundamental right to services and resources and a responsibility of the government to ensure that any and all material, information, and services are delivered in-language, with reasonable considerations of comprehension, literacy, culturally appropriate, and sexual orientation gender identity affirming diction.
- **LIMITED ENGLISH PROFICIENT:** Census data of persons who speak English less than "very well."
- **MENTAL HEALTH PROVIDER:** the definition utilized in this report is inclusive of but not limited to psychologists, therapists/clinicians/counselors, clinical social workers, prevention and early intervention program coordinators, community healers, and spiritual healers.
- **NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES STANDARDS (CLAS):** CLAS standards pertaining to communication and language assistance include the following:[87]
  - **Offer language assistance** to individuals who have limited English proficiency, low literacy, and/or other communication needs, at no cost to them, to facilitate timely access to all health care services.
  - **Inform all individuals of the availability of language assistance services** clearly and in their preferred language, verbally and in writing.
  - **Ensure the competence of individuals providing language assistance,** recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
  - **Provide easy-to-understand print and multimedia materials** and signage in the language commonly used by the populations in the services area.
- **SOUTHEAST ASIAN AMERICANS (SEAAS):** Southeast Asian Americans who share the political and historical experience of resettling in the country as refugees from the U.S. occupation of Cambodia, Laos, and Vietnam.
- **THRESHOLD LANGUAGES:** Threshold languages are those that are spoken at a high proportional rate within a geographic region of the state and as such may contribute to obstacles of understanding and access for those seeking mental health services. California Department of Mental Health defines beneficiaries with threshold languages as "the annual numeric identification on a countywide basis and as indicated on the Medi-Cal Eligibility Data System (MEDS), from the 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, in an identified geographic area, whose primary language is other than English, and for whom information and services shall be provided in their primary language."[88]
- **TRAUMA:** emotionally and physically distressing experiences that challenge an individual's ability to cope.[89]

[85]Daud A., Skoglund E., and Rydelius P. (2005). *Children in families of torture victims: transgenerational transmission of parents' traumatic experiences to their children.* International Journal of Social Welfare, 14(1):23-32; doi: 10.1111/j.1468- 2397.2005.00336.

[86]Danieli Y. (1997). *International handbook of multigenerational legacies of trauma.* The National Center for Post-Traumatic Stress Disorder PTSD Research Quarterly, 8(1). Retrieved from: https://www.ptsd.va.gov/professional/newsletters/researchquarterly/v8n1.pdf.

[87]U.S. Department of Health and Human Services, Office of Minority Health. (2014). *National Culturally and Linguistically Appropriate Services Standards Implementation Initiative.* Retrieved from: https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

[88]Language Access, Department of Mental Health, Office of Multi-Cultural affairs, July 2009

[89]Wilson A., Rich J., Rich L., et al. (2009). *Healing the hurt: trauma-informed approaches to the health of boys and young men of color.* Philadelphia: Center for Nonviolence and Social Justice and Department of Medicine at Drexel University. Retrieved from: www.unnaturalcauses.org/assets/uploads/file/HealingtheHurt-Trauma-Rich%20et%20al.pdf.

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