



VOICES UNHEARD:

Uncovering the Mental Health Impact of COVID-19 on Native Hawaiian
and Pacific Islander and Southeast Asian American Youth



Asian American + Pacific Islander **CHARGE**

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Dignity Health
St. Mary Medical Center



EPIC
EMPOWERING PACIFIC ISLANDER COMMUNITIES



**Khmer Girls
in Action**



Educated Men with Meaningful Messages

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Executive Summary

Effects of the COVID-19 pandemic on mental health have been devastating for many, and emerging literature shows significant increases of psychological distress that range from anxiety, depression, and loneliness, among other symptoms. The pandemic uprooted the lives of families with youth from their daily schedules to routines of sheltering-in-place. The simultaneous rise in hate toward Asian Americans fueled by hate speech and violence associated with the pandemic further impacted the psychological stress of these targeted communities. While there is still much to learn and unpack on how the COVID-19 pandemic influenced mental health overall, there has been a lack of focus on the mental health status of AANHPI (Asian Americans, Native Hawaiians, and Pacific Islanders) ethnicities, particularly Native Hawaiian and Pacific Islanders (NHPI) and Southeast Asian Americans (SEAA).

NHPI and SEAA populations have been documented to experience higher rates of intergenerational trauma due to respective experiences of colonization, war trauma, displacement, and systemic racism.^{1,2,3} This report started as a research interest for NHPI and SEAA communities with the intent to capture the mental health impacts of COVID-19 pandemic on these respective communities, particularly on youth in California [CA]. The youths' experiences were recorded through surveys and interviews and gave insight into how the pandemic affected their outlook, mental health symptoms, access to care and clinical services, and risk factors for increased psychological distress. With the support and input of community members across CA, over 220 respondents participated in the survey, and focus groups of over 25 participants were conducted. This report presents new evidence on the mental health needs of NHPI and SEAA youths and illuminates ways that communities can advocate for them.

***Trigger warning:** This report discusses content that includes suicide, abuse, mental illness, identity-based discrimination and harassment, and other sensitive topics.

Recommendations for supporting NHPI and SEAA youth are as follows:

1. Collect and disseminate disaggregated racial and ethnic data specific to mental health, risk factors, school-based discrimination, bullying, and harassment.
2. Invest in culturally and linguistically appropriate mental health resources in schools, institutions, and the community-at-large.
3. Build and sustain mentoring and mental health employment pipelines through educational exposure and potential career pathways.
4. Amplify the youths' voices, their families', and community leaders' to foster self-determination at the local-, county- and state-levels.

Definitions

Culturally appropriate⁴ - Refers to services that 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 strengths 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.

Data disaggregation⁵ - Data disaggregation means breaking down large data categories into more specific subcategories. When data are broken down and disaggregated by ethnic groups, they can show the unique differences among groups and reveal significant disparities. For SEAA and NHPI, measures of educational attainment like high school graduation rates, or health indicators like insured rates and the prevalence of certain diseases, reveal challenges that uniquely impact these students, elders, and community members. With this information, we can better identify which communities need better support.

Mental health⁶ - Mental health includes one's emotional, psychological, and social well-being that impacts how one thinks, feels, and acts when coping with life. It also helps determine how one manages stress, relates to others, and makes choices.

Mental health provider⁷ - 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.

Native Hawaiian and Pacific Islanders (NHPI)⁸ - NHPI is a geopolitical identity that refers to any Indigenous Peoples of Oceania, including inhabitants and diaspora.

Southeast Asian Americans (SEAA) - For SEARAC, Southeast Asian Americans is a political identity and defined as people who share the political and historical experience of resettling in the United States as refugees from the U.S. occupation of Cambodia, Laos, and Vietnam. SEAs also include the children of refugees, people sponsored by refugee families, and more recently arrived immigrants who have come to the United States on family-based and employment visas.

Introduction

AANHPI have largely remained underserved with regards to accessing mental health support.⁹ When AANHPI receive mental health services, these communities may be concerned that the resources are not culturally relevant nor targeted equitably and appropriately. With the rise of anti-Asian hate crimes during COVID-19,¹⁰ SEARAC and AAPI CHARGE sought to understand the extent of these and other stressors on AANHPI, particularly NHPI and SEAA individuals. The purpose of this report documented the mental health impacts of COVID-19 on NHPI and SEAA youths. Additionally, we explored, identified, and offered community-defined best practices and policy solutions that can better serve these communities.

NHPI and SEAA communities are resilient in the face of trauma, poverty, and criminalization of their communities. The history of NHPI is rooted in forced migration related to colonization, imperialism, and complex political relationships.¹¹ Consequently, colonized communities have been marginalized, excluded, and othered which has resulted in conflicts with cultural identity, self-determination, and belongingness. And since the 1970s, over 2.5 million for total SEAA and over 1.1 million Southeast Asian refugees from Cambodia, Laos, and Vietnam have escaped persecution, genocide, and violence to resettle in the U.S.¹² The 2020 Census recorded the NHPI population at 1.5 million in the U.S., with about 1 in 5 Pacific Islanders residing in the greater San Francisco Bay Area of CA.¹³ By these historical accounts, CA is home to the second largest NHPI population¹² and the largest SEAA population of nearly one million people.¹⁴

However, there remains limited information regarding the achievements and challenges of SEAA because most federal and state databases do not disaggregate data by ethnicity. Due to this limitation, any research that derives from federal or state databases will report an Asian aggregate and forgo the unique experiences of SEAA. While federal standards require a separate race category for NHPI, each state determines the necessity to collect this particular data, and more detailed demographic data is also needed among NHPI. This adds a challenge to the already limited ethnic demographic data that is not present for NHPI and SEAA in mental health.

There is a lack of research and, therefore, an incomplete understanding of the mental health issues faced by NHPI and SEAA. For example, race-based discrimination was heightened during the COVID-19 pandemic for Asian American [AA] students with increased anxiety and internalized racism.¹⁵ Subsequently, this has resulted in a much lower percentage of AA students who sought support from professionals in school-based services too.¹⁶



SEARAC

Southeast Asia Resource Action Center (SEARAC)

– SEARAC was founded in 1979 and is a national civil rights organization that builds power with diverse communities from Cambodia, Laos, and Vietnam 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.

Asian American + Pacific Islander CHARGE

Asian American and Pacific Islander Coalition Helping Achieve Racial and Gender Equity (AAPI CHARGE)

– AAPI CHARGE is a statewide youth and community-centered network that works toward building the advocacy capacity of AANHPI youths, empowering them to seek equitable policy change and shift narrative on AANHPI communities. Coordinated by SEARAC, AAPI CHARGE provides AANHPI young individuals a platform to amplify their voices across CA. Furthermore, AAPI CHARGE leads the breakdown of data to uncover critical health and education disparities across AANHPI communities statewide.

1. Africa & Carrasco (2011)
2. Lee and Chang (2012)
3. Kwan et al. (2020)
4. SEARAC & Lo (2020)
5. SEARAC data disaggregation factsheet
6. National Institute of Mental Health (2023)

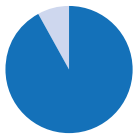
7. SEARAC & Lo (2020)
8. Boston University (2022)
9. National Institute of Mental Health (2023)
10. Lau Johnson et al. (2023)
11. Titiml and Wei (2021)
12. SEARAC (2020)

13. Loi-On & Tanuvasa (2022)
14. SEARAC (2020)
15. Cheng et al. (2022)
16. YouthTruth (2022)

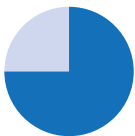
Literature Review on NHPI and SEAA Mental Health Effects

While the United States is investing in mental health supports at unprecedented levels,^{17, 18, 19, 20} the AANHPI population is generally understudied in regard to mental health. Of the available published studies, few examined the mental health effects on NHPI and SEAA ethnic groups. This literature review contains a summary of the available studies that evaluated mental health struggles among NHPI and SEAA. This summary is not exhaustive, and we hope future research opportunities will center around the historical context and cultural backgrounds for NHPI and SEAA, which are necessary to better understand the depth of mental health needs for these populations.

Current literature focuses on how and why there is not enough research when it comes to the psychological impact of COVID-19 that has fueled racism on AANHPI students, and a few focus group studies suggested that young people felt more anxious, isolated, and depressed during the pandemic.^{21, 22} In turn, these individuals yearned to be connected to culturally relevant support from adults within their ethnic communities. Yet, there was a lack of support available to provide guidance and community resources to uplift and foster mental health awareness within the NHPI and SEAA populations as a whole.



For example, in an Empowering Pacific Islander Communities ([EPIC], 2022) survey **92% of NHPI** reported that mental health was very important, yet they also shared that their mental health was not prioritized until adulthood due to generational family trauma.²³ These emerging community-based participatory research (CBPR)²⁴ studies emphasized the need to have broader mental health outreach to community members, which included elders and parents. Young people may also gain more support from adults in CBOs that specifically serve youths for culturally relevant guidance.



Additionally, AANHPI also reported lower rates of access to mental health resources: in 2020, research conducted by SEARAC revealed that **75% of directly impacted SEAA respondents** shared that they were never able to receive appropriate mental health services.²⁵ From 2014-2019 in CA, all racial groups experienced a large rise of mental health diagnoses but the greatest debilitating increase was among NHPI communities at 165%.²⁶



AANHPI individuals also experienced obstacles as they sought mental health treatments due to a lack of providers available in their native language – i.e., approximately 70 Asian American and Pacific Islander (AAPI) mental health professionals are available for every 100,000 AANHPI in the United States, while the lowest ratios of native language-speaking health care professionals were among Lao/Laotian, Khmer/Cambodian, and Hmong patients.²⁷



From an AAPI CHARGE report published in 2019, **1 in 2 youths** reported that they were bullied in school.²⁸ Although AAPI young men described how racist stereotypes attacked their masculinity, AAPI young women reported slightly higher rates [59%] to the young men [52%] when bullied. In contrast, non-binary AAPI youths, identifying as neither male nor female, experience the highest rates of bullying [69%].²⁹ Other concerns of intergenerational educational challenges were also prevalent with Pacific Islander youths where only 7% of their parents obtained a bachelor's degree or higher.³⁰



Young people from marginalized AANHPI communities experience higher rates of cultural invisibility and bullying in schools, and they do not receive culturally competent student support services required to overcome their educational challenges to succeed academically. The Stop AAPI Hate campaign received almost **11,000 reports of COVID-19 related discrimination and harassment** in which 10% came from children.³¹ SEAA respondents also reported the highest occurrence of experiencing racism.

17. CYBHI: Youth at the Center Report (2023)

18. CA Alliance of Children and Family Services (2023)

19. Office of the Surgeon General (2021)

20. California Reducing Disparities Project API Strategic Planning Workgroup (2013)

21. Cheng et al. (2022)

22. Hawke et al. (2020)

23. EPIC (2022)

24. Community-based participatory research – defined by the National Institute on Minority Health and Health Disparities as a partnership between academic researchers, organizational representatives, and community members to understand and address health disparities in socially disadvantaged population groups.

25. SEARAC (2020)

26. EPIC (2022)

27. SEARAC (2020)

28. SEARAC & CHARGE (2019)

29. SEARAC & CHARGE (2019)

30. SEARAC & CHARGE (2019)

31. The Children's Partnership (2022)

RESEARCH ON NHPI MENTAL HEALTH

There is emerging research on the effects of mental health among NHPI students, and some studies have focused on the magnitude of mental health issues. Based on survey data from community members, results suggest that within NHPI communities 1 out of 4 have high to elevated degrees of depression.³² Research in this area also directly measured mental health outcomes that contained indirect estimations of unmet needs that examined other varying factors, for example, that gendered experiences and educational attainment likely increased the severity of depression. Additionally, NHPI were found to have higher rates of depression than any other AANHPI groups.³³

From a published article by the Children's Partnership (2023), 40% of NHPI high school students in the United States persistently felt sadness or hopelessness in the past year. About 1 out of 5 (21%) of NHPI high school students heavily contemplated on suicide while 1 in 10 attempted suicide.³⁴ This is all the more upsetting when considering that the vast majority of NHPI teens (67%) did not receive any type of psychological, mental health, or emotional well-being counseling services.³⁵

In CA, NHPI communities do not have sufficient access to translative services and resources. CA also does not have materials about NHPI communities and their language in publicly available government documents. These conditions pose substantial barriers to the already insufficient funding to study the NHPI population.³⁶ Additionally, based on statewide data obtained from the EPIC report (2022), there are significant gaps and underrepresentation on NHPI. Of the top ten counties with the most underrepresented NHPI communities, four are located in the Central Valley and five are in Southern CA.³⁷

RESEARCH ON SEAA MENTAL HEALTH

SEAA experience higher rates of mental health challenges, including major depression, anxiety disorders, and post-traumatic stress disorder, compared to the general population due to experiences of war, genocide, and displacement.³⁸ A study by Han (2005) investigated the intergenerational trauma of Khmer/Cambodians and Lao/Laotians. Han found that parents who experienced trauma impacted their children's mental health and sense of self. SEAA youth may already inherit intergenerational trauma from their parents' war-torn lives, which affects their sense of self, sense of coherence, and other mental health struggles unique to this population of refugees.³⁹ Specifically, another study on Cambodian refugee families found that silence from family survivors impacted their children's sense of belongingness to a community and this transmitted a continued pattern of avoidance and silence altogether.⁴⁰

Mental illness can negatively impact physical health, and many SEAA refugees often wait for physical ailments to emerge before seeking medical care from their primary care providers.^{41, 42, 43} Limited data have addressed the impact of mental health conditions on physical health self-management practices and outcomes among SEAA. Therefore, community-based information on cultural beliefs, self-care practices, general health access, and mental illness models for SEAA may support targeted interventions that involve the interconnection between physical and mental health.

As future research emerge for these populations, we are learning more about barriers to access mental health services and other issues. For example, existing research found that the psychological impact on mental health access is lacking in current studies on SEAA students.⁴⁴ They found that there are more interventions for culturally relevant clinical/provider tools, but there are not as many resources available regarding community health outreach specific to students.⁴⁵

Literature also exists on how social determinants⁴⁶ affect SEAA youths' mental health. During the early years of resettlement, most SEAA refugees were placed in low-income neighborhoods with high rates of crime, violence, and under-resourced schools. Substantial research shows that economic insecurity can have a direct impact on mental and physical health. Particularly in CA, SEAA children have the highest rates of poverty: 42% for Hmong and 33% for Cambodians when compared to 23% of all children statewide.⁴⁷

32. Subica et al. (2019)

33. Ta et al. (2008)

34. Center for Disease Control and Prevention Youth Risk Behavior Survey, 2011-2021

35. The Children's Partnership (2023)

36. Silk et al. (2022)

37. EPIC (2022)

38. Lee & Chang (2012)

39. Han (2005)

40. Lin et al. (2009)

41. U.S. Dept of Health & Human Services' National Diabetes Education Program (NDEP) (2006)

42. Mekong & NYU Center for the Study of Asian American Health (2015)

43. Mekong & NYU Center for the Study of Asian American Health (2015)

44. Havewala et al. (2022)

45. SEARAC (2019)

46. Social determinants of health - defined by the U.S. Department of Health and Human Services (2023) as environmental factors that have major impact on people's health, well-being, and quality of life (i.e., safe housing, transportation, neighborhoods among factors like discrimination, access to education, and language).

47. The Campaign for College Opportunity (2015)

Overview of the NHPI and SEAA Mental Health Research Project

The COVID-19 pandemic and rise in anti-Asian hate created a need to understand the mental health challenges and experiences of AANHPI youths, in addition to the existing research previously noted. AAPI CHARGE convened in early 2021 in a collaborative movement to discuss this research gap on how NHPI and SEAA youths navigated their mental health during the pandemic. From these convenings, AAPI CHARGE, made up of regional AANHPI organizations and partners in CA, decided to survey and conduct focus groups on AANHPI youths in the fall of 2021. The population demographics encompassed NHPI and SEAA youth ages 12-26 across CA.



Mental Health Survey and Youth Focus Groups

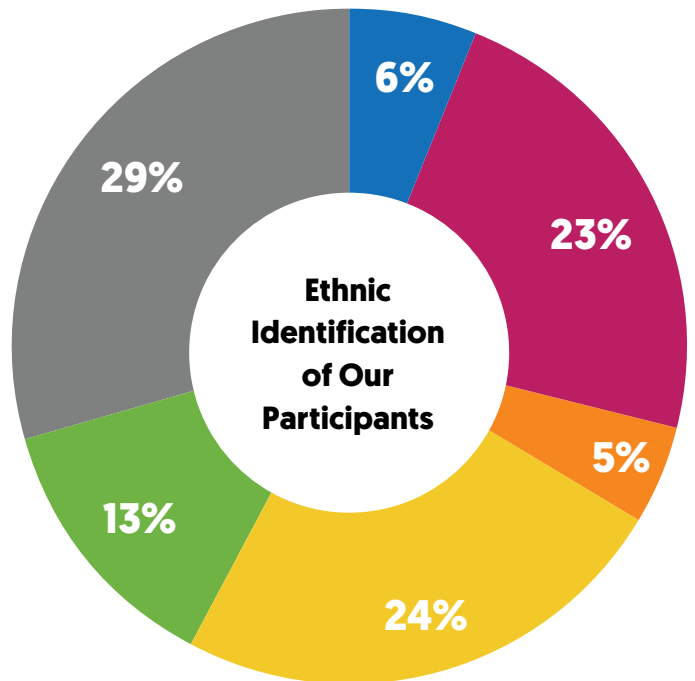
MENTAL HEALTH SURVEY

SEARAC and AAPI CHARGE created and administered a survey on mental health symptoms and accessibility issues to over 200 youths. The survey contained 20 multiple choice questions through a Likert scale and open-ended questions. The results revealed trends in how the pandemic affected youths' mental health, disaggregated by ethnicities surveyed.

YOUTH FOCUS GROUPS

SEARAC and AAPI CHARGE organized several focus groups that delved deeper into the mental health challenges amongst NHPI and SEAA youths. Two SEAA focus groups of Cambodian and Vietnamese participants were directed by EM3, a program of Families in Good Health. SEARAC partnered with EPIC and conducted the other two focus groups, which focused on the experiences of NHPI participants who identified as Sāmoan, Chamorro, Native Hawaiian, Tongan and multi-racial. The focus groups provided us with an opportunity to directly hear from the youths and gain a deeper understanding of their experiences that was beyond the survey scope. In total, 13 youths participated in the SEAA focus groups and 13 youths participated in the NHPI focus groups.

Figure 1: A percentage ratio of self-identified ethnicity from the 200+ participants. NHPI were aggregated due to the low sample size for each NHPI subgroup, and we included all ethnicities with n-size over 10.



*Certain ethnic Chinese also have heritage in Cambodia, Laos, and Vietnam.



KEY FINDINGS

From the surveyed responses and focus groups, our data analyses revealed several key findings to better understand NHPI and SEAA youths and support them toward accessing and receiving competent mental health care. Three findings emerged from the quantitative survey and qualitative focus groups, as follows:

- 1** NHPI and SEAA youths viewed mental health and wellbeing as an important part of their lives.
- 2** NHPI and SEAA youths faced significant barriers to access mental health care at their schools and institutions.
- 3** The COVID-19 pandemic increased the need for mental health services for NHPI and SEAA youths.

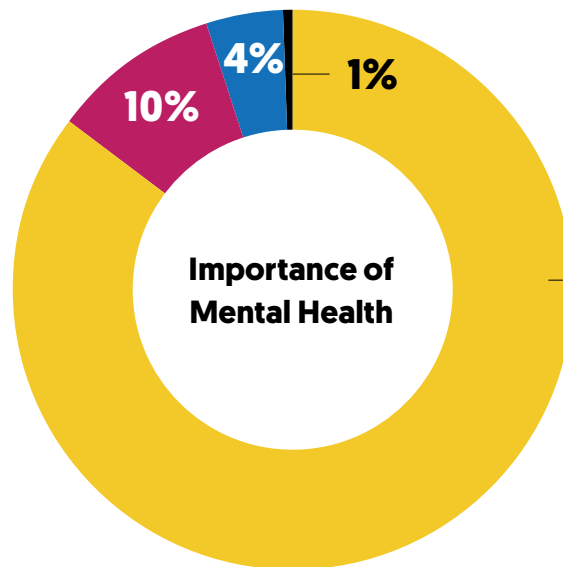


Finding 1: Importance of Mental Health Access for NHPI and SEAA Youths

An overwhelming majority of respondents revealed that mental health was very important to them, yet few have been able to access mental health services. Many valued their mental health well-being and needed support systems to manage their psychological distress. Respondents described that when they cared for their own mental health it gave them a sense of empowerment. In contrast, they felt isolated, stigmatized, and overall inauthentic without adequate and proper mental health support.

Figure 2: The importance of mental health to respondents.

- Neutral
- Very Important
- Somewhat Important
- Not Important



85%

Almost all respondents affirmed that mental health was important to them.

“Mental health is self-love.”

NHPI focus groups

“Mental health is just as important as physical health. It [mental health] is holistic health.”

Samoan participant, NHPI focus groups

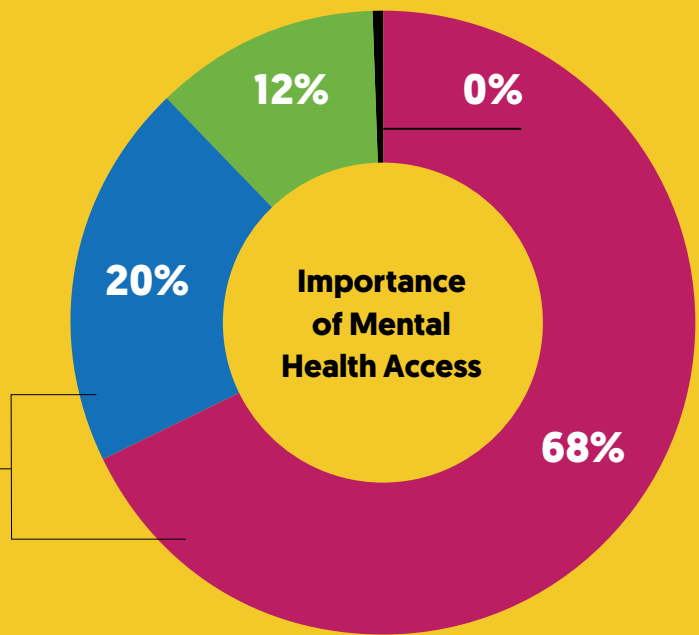
How important is access to mental health professionals or mental health services to you?

Figure 3: Importance of mental health access to respondents.

- Very Important
- Somewhat Important
- Neutral
- Not Important

88%

of respondents indicated that access to mental health is **“very or somewhat important”** to them.



“Mental health is of utmost importance. Growing up the thought of a mental health professional involved in my life never even crossed my mind. Growing out of that now and trying to heal from that experience took moving out, going to college, and becoming my own independent person, and realizing how mental health is important to me.”

Native Hawaiian participant, NHPI focus groups

“Mental health is very important. It is very good to take care of your mental health. You can go through life and it can be good, bad, however you feel, but if your mental health is not there, it’s going to be harder to just function. Having people available for you that can help you with your issues is a key component to at least trying to live a better life.”

Cambodian participant, SEAA focus groups

Key Findings

NHPI focus groups: Participants agreed that mental health is important and should be a priority. Several participants revealed that they have also sought mental health treatments after they experienced traumatic events. Regardless of treatment setbacks (e.g., negative experiences with several therapists, tension with family due to therapy stigma, etc.), these participants affirmed that the mental health care and clinical support received were helpful.

SEAA focus groups: SEAA youths shared that it was very important to them to have someone to talk to, but there was a lack of access to resources due to finances and limited information on mental health. Participants also shared that with more awareness, one can recognize the importance of mental health access and develop strategies to tackle their mental health needs.

“I have accessed mental health services. It changed my life. Having that space to just be. If you want to be healthy, you have to be proactive even when it’s hard to exert the energy needed to seek help. [You have to give yourself] permission to seek help.”

Samoan participant, NHPI focus groups

“Having family members that don’t value mental health because they don’t understand it is tough. So, I think it’s really important to have access to resources or a therapist because of the generational trauma that I’ve experienced. You know, with Polynesian families, you bottle up your emotions, or like you just take it and deal with it yourself. So, it’s kind of refreshing to be able to open up to people and not be judged.”

NHPI focus groups

“I think it [mental health] should be more accessible because it is really expensive, and there is [sic] not a lot of people who know where to go and how to access it.”

SEAA focus groups

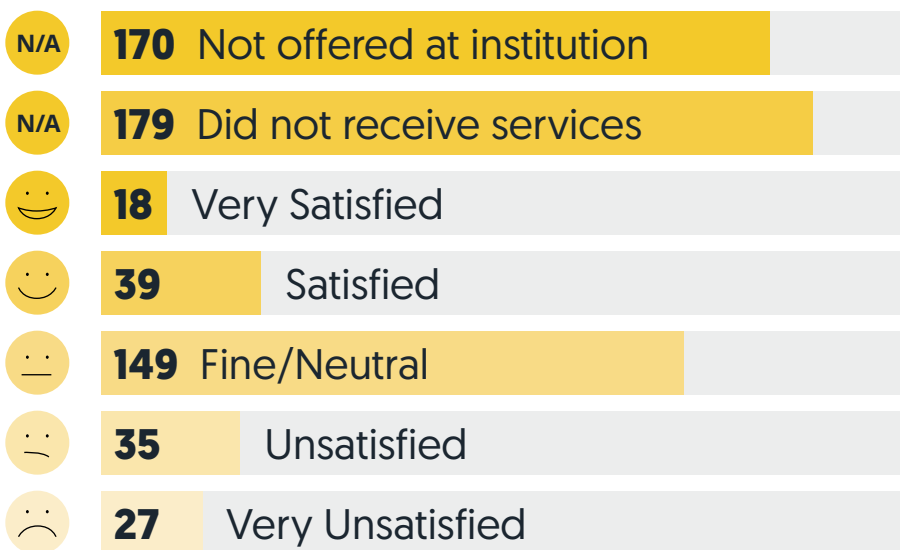
Key takeaways from the first finding indicated that a majority of NHPI and SEAA youths value mental health. Despite this, several youths responded that they neither sought nor knew how to access mental health services. This is a serious concern because earlier research found that NHPI and SEAA youths were bullied at higher rates, felt culturally invisible, along with the previously mentioned high rates of respondents who did not know how to access mental health services. Related, respondents also shared that access to mental health services was important to them. Yet, they stated that due to their cultural background and upbringing, there were stigmas attached when mental health services were received. There is a huge disconnect among the data points of NHPI and SEAA respondents who highly rated the importance of mental health, and their ability to access mental health care and utilize resources.

Finding 2: NHPI AND SEAA Face Barriers When Accessing Mental Health Care with Culturally Relevant Services

The second key finding highlighted barriers of access to mental health resources and services. This access barrier is more pronounced considering the high rates of intergenerational trauma from these communities. Respondents highlighted the need for both high quality and culturally competent care. This section explored ways in which the youths received mental health services, satisfaction within their resources, and whether their institutions were supportive when access to these services were provided.

Satisfaction with Institution’s Mental Health Services

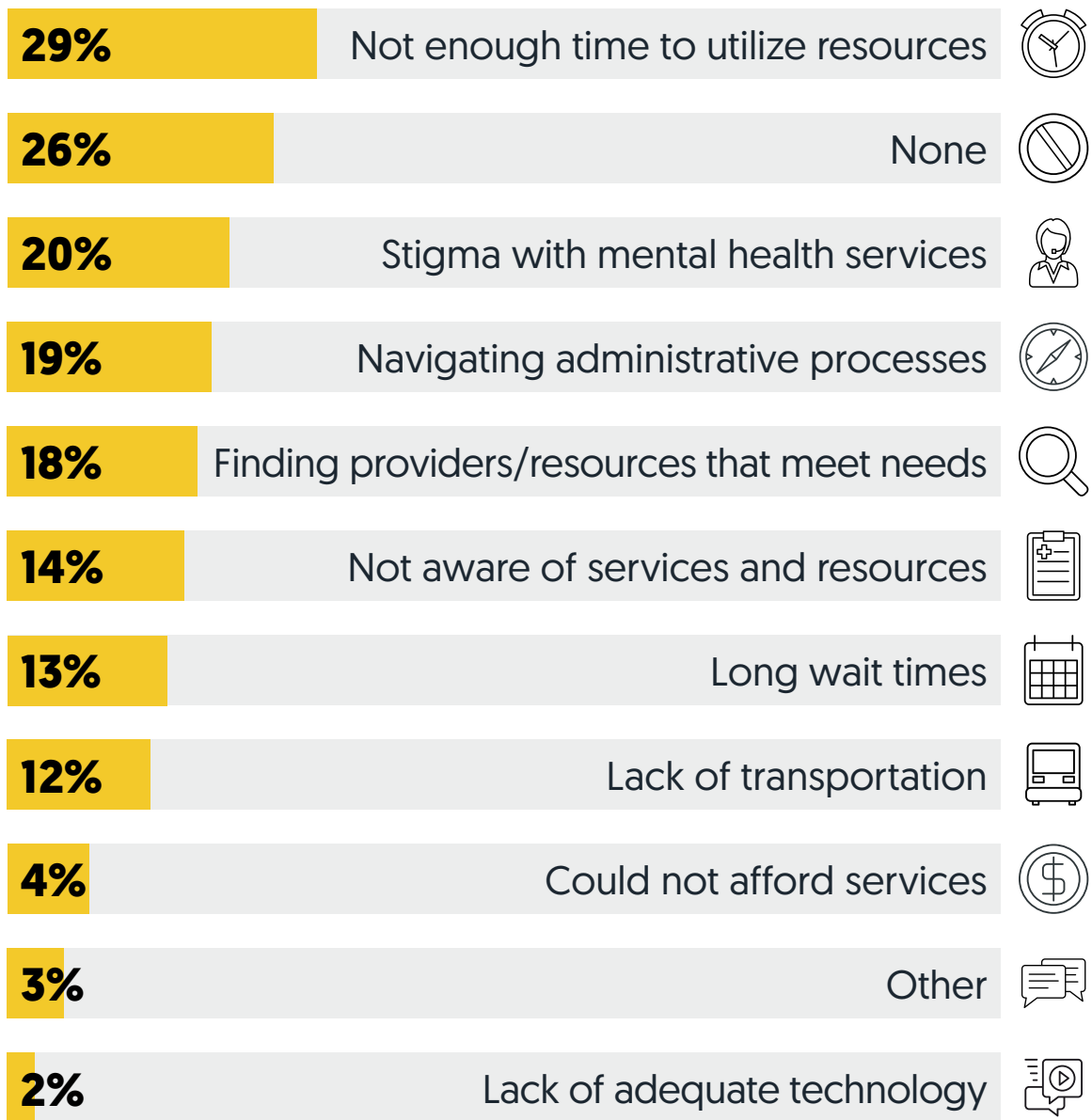
Figure 4: Respondents’ level of satisfaction to their educational institution’s mental health services. Most youths (e.g., over 100 respondents) reported that they either did not receive mental health services at their educational institution or that these services were not offered.



“It’s important to have access to mental health services where someone can help you understand and is familiar with your upbringing instead of applying a one-size-fits-all standard or mindset of how to treat someone.”

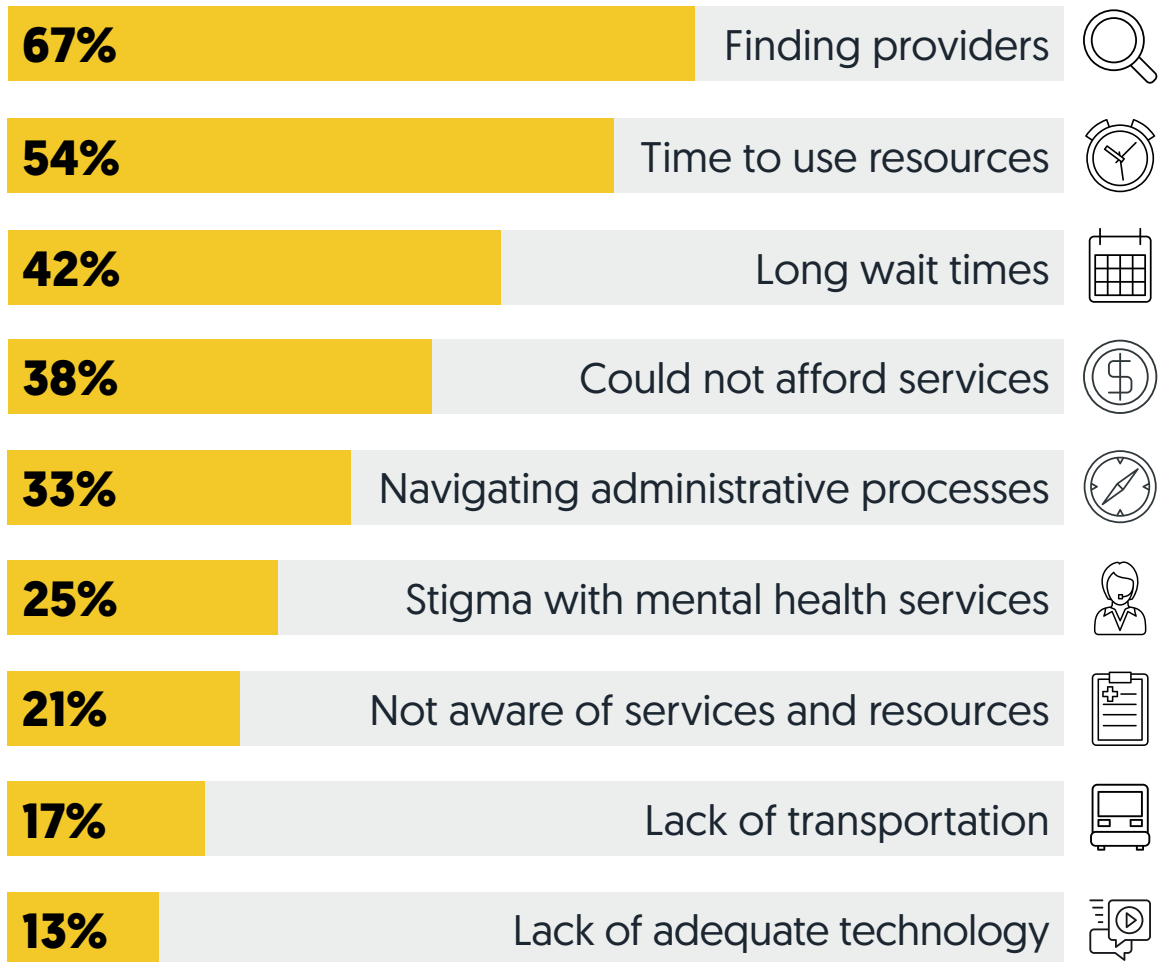
Barriers in Accessing Mental Health Services or Resources at an Institution

Figure 5: Barriers that limited access to mental health services at school or higher education institutions. At least 1 in 5 respondents indicated that stigma and the lack of time to utilize resources as barriers to seeking out mental health services. Additionally, difficulty navigating processes to access care and finding appropriate providers and resources were prevalent issues, highlighting how administrative burdens and culturally inappropriate care create further barriers.



Barriers in Accessing Mental Health Services Outside of Institutions

Figure 6: Barriers to accessing mental health outside school or institution. Many respondents faced similar barriers to care outside of institutions, including stigma, lack of time, difficulty navigating processes to access care, and challenges finding appropriate providers and resources. Other barriers such as long wait times and the inability to afford services were even more prevalent outside of institutions.



NHPI focus groups: Youths shared stories about feeling stigmatized, trying to make connections with mental health professionals, and finding the courage to seek and prioritize health as a young adult. Several participants voiced that they grew up in a culture where seeking mental health services was frowned upon. And topics of mental health were never discussed in the home but rather, perceived as a sign of weakness or 'being crazy.' Some respondents revealed to have family members with mental illness and that they did not have meaningful dialogue about these issues. These mixed childhood experiences and cultural perceptions of what is mental health created additional barriers to access mental health at a younger age, even when it was needed.

For a few of the participants, access to mental health services encompassed beyond professional help. It sometimes meant that support was sought from trusted family members who understood their respective situation and could relate to them. Another participant shared that when they disclosed their loneliness to a sibling, the support received was the closest to mental health care they had experienced. For another participant, mental health services revolved around the creation and connectedness to a community where shared space was important. It was discussed that a mental health provider was not always needed because one had a community to talk to about cultural traumas. Relationships, community, and trust – e.g., outside of and/or in addition to – a professional space were important factors to these respondents' experiences.

“Accessibility and having a wide array of people [mental health professionals] with similar backgrounds or somebody that can really understand where you’re coming from is important.”

Samoan participant, NHPI focus groups

“I think it’s about being able to really open up to someone and having them tell you that everything you went through is valid, instead of pushing it aside and telling you it’s not important.”

NHPI focus groups

“Being able to do group community style mental health discussion in safe community spaces that are accessible was helpful. Like there’s community centers but you can’t access them all the time and I feel like that’s not helpful.”

NHPI focus groups

“When people are seeking mental health services, the person they’re meeting with [needs to be] qualified and confident in the work that they do. Quality mental health services is [sic] not like a doctor’s office, where you see them for 15 minutes. Instead, you are engaging with them and listening and offering feedback.”

Tongan participant, NHPI focus groups

Key Findings

SEAA focus groups: Several youths echoed similar sentiments to the NHPI focus groups on their perception of mental health among their communities. Specifically, Cambodian youths shared that their families did not take mental illnesses seriously. The respondents suggested that this may be due to previous generations of Southeast Asian elders who did not take their own mental health seriously either. Moreover, these youths shared that there was a gendered component when it came to their expressions. Young men shared how they were discouraged to express sadness because they were viewed as “not a man.”

Furthermore, the theme around stable long-term care from adults who regularly checked in on them was an important feature for youths. They indicated that sustained care encouraged more in-depth conversations that improved their mental health. Several SEAA youths also shared that they found mental health references and resources through their family and not at their educational institutions.

Yet in contrast, SEAA youths also lamented long wait lists to receive mental health services from a professional. They shared experiences of disengagement with their care professional via virtual sessions and that these interactions were much more impersonal.

“I’ve been on waiting lists to see medical professionals. [They] meet with me every other month and ask yes or no questions. It feels like anyone could do that, and I’m paying all this money for someone to ask me yes or no questions through a screen.”

Cambodian respondent, SEAA focus groups

“I’ve experienced in-person [therapy] and Zoom [virtual] therapy, and for me, being in-person is better. Virtually, you can have your camera on, but they may not know how you feel, unlike in-person where they can tell by your body movement. Also, you can lie about how you feel or turn your camera off, there’s a lot you can’t show, and it’s different in many ways.”

SEAA focus groups

Key takeaways from the second finding highlighted a lack of clear guidance when mental health services were accessed amongst NHPI and SEAA youths. There is a dearth of quality services as youths indicated that they received inadequate or culturally inappropriate care. Many also expressed a desire to be matched to mental health providers who were of similar cultural backgrounds or that the care be embedded in their respective communities. Because 20% of respondents cited the fear of stigma as a barrier to access mental health services, it is important to create safe community spaces and resources, which may have been lacking in schools or higher education institutions.

These statistics and quotes show how vastly NHPI and SEAA youths are underserved within and outside their institutions with regards to receiving the kind of care they need and deserve. It is further shown that NHPI and SEAA students face greater invisibility from institutions that also fail to collect meaningful data on mental health services as a whole or that outreach efforts to help students connect to resources were not as readily accessible. Youths need access to pursue these opportunities that have both short- and long-term consequences. Massive disruptions and stressors created from the COVID-19 pandemic appeared to have exacerbated many of these youths’ mental health and added barriers to services.

Finding 3: COVID-19 Pandemic Increased the Need for Mental Health Services for NHPI AND SEAA Youths

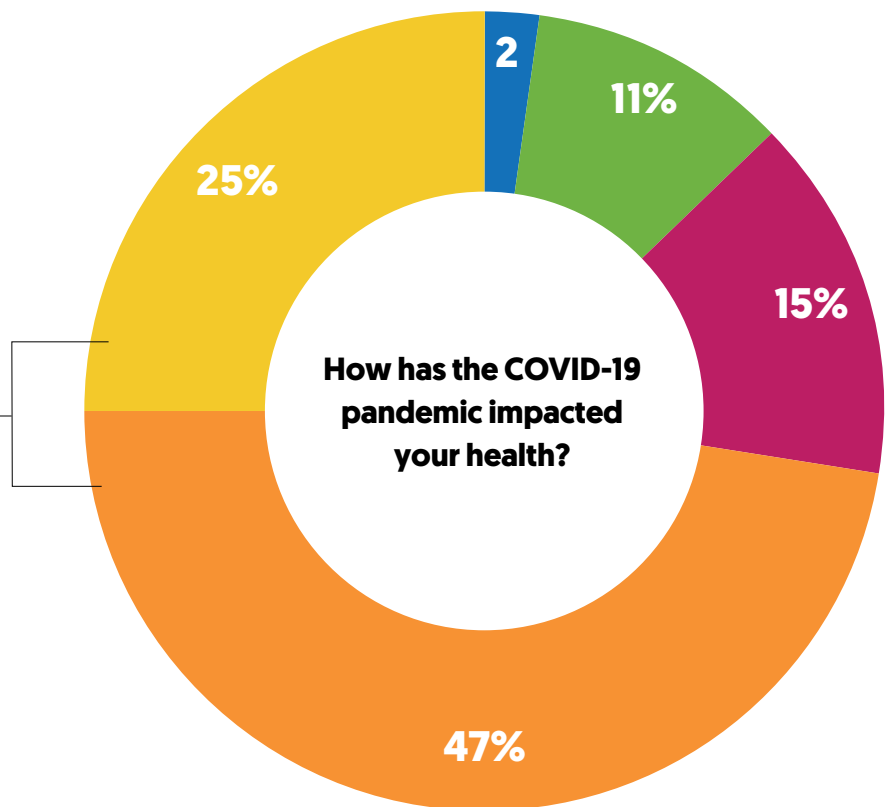
The final theme is centered around the impact of COVID-19 on youths' mental health. Since the beginning of the pandemic, young people have faced social isolation and academic disruption while navigating stay-at-home requests with their families which all may impact their mental health. Furthermore, Asian Americans were more than likely to report an increase of cyberbullying and victimization during the pandemic.⁴⁸ The data below highlight mental health challenges and barriers that NHPI and SEAA students felt within their academic institutions, households, and online.

Figure 7: Responses to the impact of COVID-19 on youth mental health.

- Significantly worsened my mental health
- Slightly worsened my mental health
- It did not impact my mental health
- Slightly improved my mental health
- Significantly improved my mental health

72%

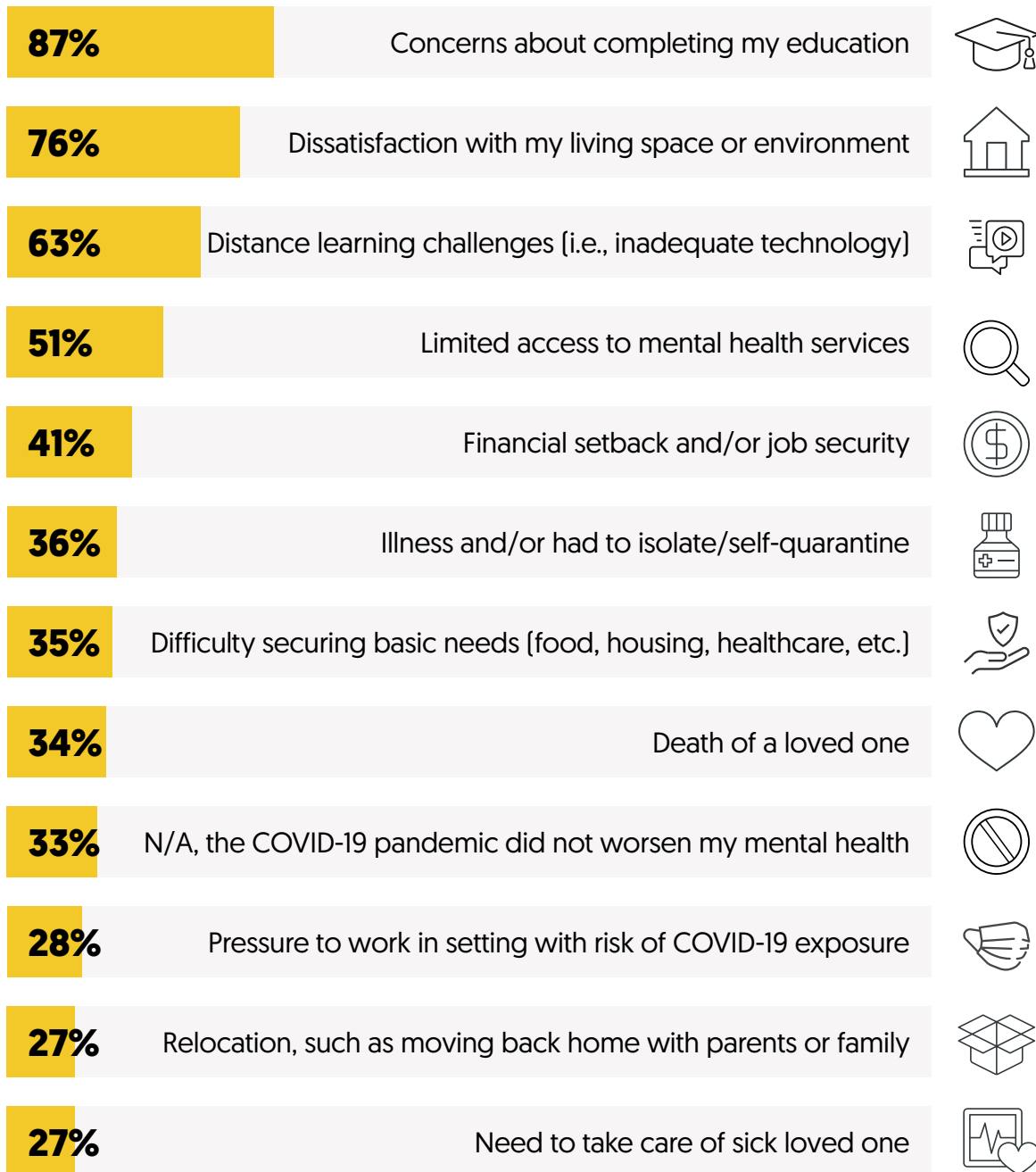
of respondents reported that their mental health was **“slightly or significantly” worsened** due to the COVID-19 pandemic.



48. Patchin & Hinduja (2023)

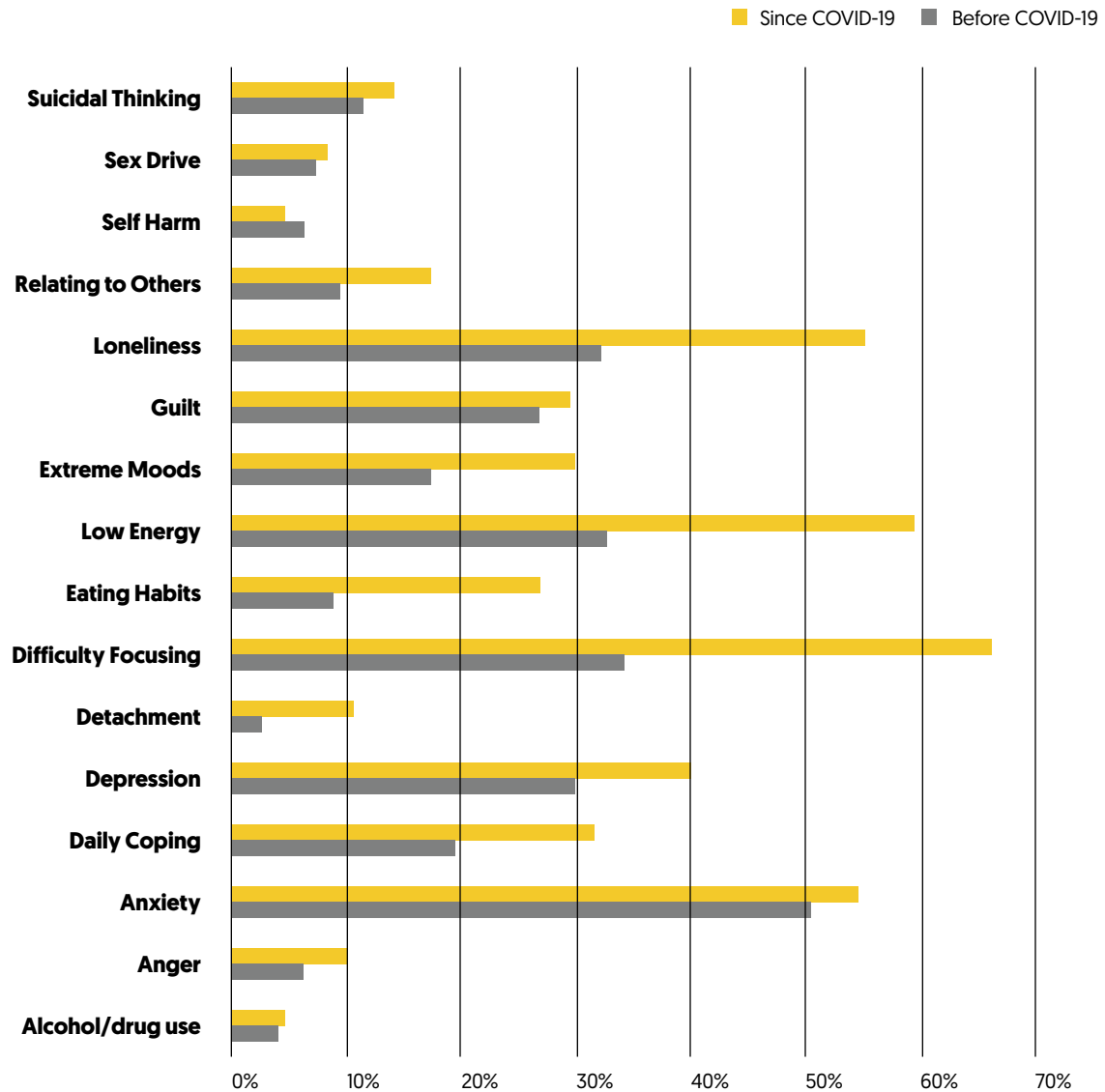
If the COVID-19 pandemic worsened your mental health, what were the contributing factors? Select all that apply.

Figure 8: Contributing factors to worsening youth mental health as a result of COVID-19. A large majority of respondents tied challenges and concerns about education to their mental health. Over two-thirds of respondents also experienced worsened mental health due to their physical environment or living space. Detailed disaggregated responses by ethnicities for Figure 8 can be found under the References section, Table 1.



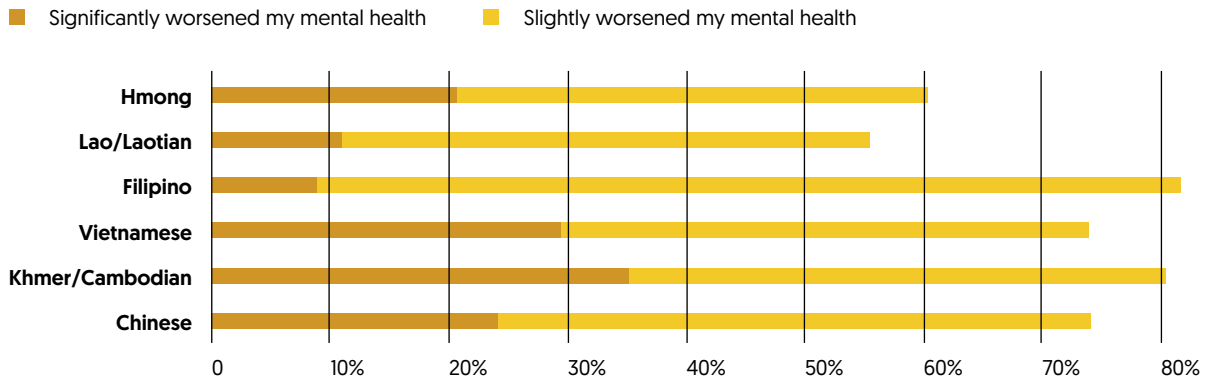
Comparing Mental Health Symptoms Before and Since COVID-19

Figure 9: A comparison of mental health symptoms before and since COVID-19. Respondents also reported an increase in difficulty focusing, lower energy, and loneliness. The bar graph shows that these three factors nearly doubled since COVID-19. Detailed disaggregated responses by ethnicities for Figure 9 can be found under the References section, Tables 2 and 3, which looks at symptoms before and since the COVID-19 pandemic.



COVID-19 Impact by Ethnicity

Figure 10: The impact of COVID-19 pandemic on mental health categorized by ethnicities. About 61% of Hmong, 55% of Lao/Laotian, 81% of Filipino, 75% Chinese, 74% Vietnamese, and 80% Khmer/Cambodian respondents reported that the pandemic “slightly or significantly worsened” their mental health.



“[Shelter in place] was a mix of positive and negative experiences. The positive side is being able to be home for a while and have time to catch up on arts and just spending time with family. The negative was that I couldn’t see outside of my house, not being able to see friends or some family. Back home, I lived around the corner from my grandparents, cousins, and aunt and uncle. And I couldn’t see them.”

NHPI focus groups

“I lost about 20 pounds... that’s a lot of weight to lose cause I’m [already] skinny.”

Native Hawaiian participant, NHPI focus groups

NHPI focus groups: Participants shared how they dealt with their mental health needs during the pandemic with heightened feelings of loneliness, depression, and isolation from the outside world and sentiments of anger and fear. The COVID-19 pandemic was a challenging era for everyone in the world, and some participants revealed how the pandemic triggered past traumatic experiences that contributed to their mental health state. Quarantine mandates and limited socialization with friends and family, as well as the inability to travel or experience anything outdoors, amplified feelings of isolation and loneliness altogether.

Given the societal unrests and escalated tensions of the Black Lives Matter movement and the increase of anti-Asian hate, several participants shared how they felt angered, helpless, emotional exhaustion, and anxiety in response to these historical events. These feelings were heightened especially when protests happened. The same participants reported that they worried about their elders and family members who were likely to experience harm due to the current events. As warned by health experts, social media and the news can add to stress and anxiety.⁴⁹ One participant talked about staying off social media and viewed the news minimally as it became a form of self-care to better cope when they felt anxious.

“Yea, I remember the shooting in Georgia in the Korean parlor. My Korean side all work at parlors, and it hit home for me. I was texting my boss because I needed a day because it was the night before. But she was saying that happened in Georgia; why are you having anxiety? White people don’t understand. My grandma is Korean, and she’s very feisty. She’s rude. I was worried about her, and she was going to start trouble, and someone is going to hate crime her.”

NHPI focus groups

“It was just a sense of a lot of heaviness. I think the whole year of 2020 you had, you know, Black Lives Matter movement and you know, the Asian hate crimes starting up. It was just a lot of heaviness, a lot of heavy emotion that I sensed.”

Tongan participant, NHPI focus groups

On a positive note, some participants found comfort with the downtime as they had more quality time at home with family members, read more often, listened to music, caught up on television, and explored new hobbies. The requirements to stay indoors created more quality home bonding opportunities through storytelling and interactive exchanges with loved ones. One participant highlighted how storytelling with family members felt like group therapy because everyone shared their experiences about the pandemic and learned how to navigate these challenges together.

49. Ritchel et al. [2023]

SEAA focus groups: Youths' experiences captured how the pandemic created drastic social isolation from their peers and disrupted daily routines. For some, the effects of the pandemic were severe enough to completely change their lives. For example, social distancing limited positive interactions with friends and teachers at school. Their home life was also negatively

affected due to greater economic instability if their parents endured employment challenges. One youth commented that others' home situations may include unemployment during the pandemic or that income may become harder to come by as expenses steeply increased.

"I think the pandemic took people out of their routines. If they had a set routine and were motivated, they are [now] like, 'I am just going to lay in bed and do my Zoom meeting... I am not going to get up and shower or clean today, I can do that tomorrow'."

SEAA focus groups

"During the pandemic, trying to maintain school and wellbeing was way harder... It changed the whole dynamic of our lifestyle."

Vietnamese participant, SEAA focus groups

"When the pandemic hit, I kind of locked myself in the room. Didn't talk to anyone, I didn't eat. I stayed in my room and slept the whole day."

SEAA focus groups

Furthermore, participants in the SEAA focus groups shared how they felt isolated and how it affected their ability to cope with challenges at home and school. Subsequently, many of the respondents shared multiple instances of self-isolation and disconnection from the world around them as well.

Similar to the NHPI focus groups, the SEAA young people also felt more concerned around race-based discrimination. While these youths shared that they did not experience race-based harassment first-hand, they worried for vulnerable family members, such as grandmothers, mothers, and aunts. This fear soared when Asian elders were brutally targeted, and videos widely circulated on the anti-Asian attacks. With so much social media coverage, students expressed frustration when anti-Asian violence was downplayed due to the model minority stereotype.⁵⁰

Key takeaways from the third theme focused on the detrimental effects of the COVID-19 pandemic on youths' mental health. The respondents reported an increase of mental health symptoms visible across all ethnicities. Symptoms such as loneliness, difficulty focusing, low energy, daily coping and

extreme moods have almost doubled since the pandemic for all youths. Many youths also shared examples of how the pandemic worsened their mental health status. **There is no mistake that impact from COVID-19 played a sizable role in deteriorating these individuals' mental health, but youths did not report an increase in their ability to access requisite services.**

Social distancing requirements allowed virtual counseling services to be available, but many of these respondents indicated that telehealth was insufficient and came with limited accessibility.

50. Model minority stereotype is defined by Cheng et al. [2022] that Asian Americans are perceived as intelligent and compliant hard workers who encounter little racism.

Recommendations

This report aims to illuminate some of the disproportionate mental health experiences of SEAA and NHPI youth during the COVID-19 pandemic, but more data and research is needed. Socioeconomic disparities, intergenerational trauma, and cultural invisibility often intersect with other challenges and barriers to mental health and wellbeing for SEAA and NHPI youth. Our recommendations below are a starting point to improving the mental health of these communities. We emphasize the need to consider all areas of culture, intersectionality, intergenerational factors, and self-empowerment.

1. Collect and disseminate more comprehensive and disaggregated data on mental health, along with risk factors that include school-based discrimination, bullying, and harassment.

- Despite limited knowledge on how specific traumatic experiences can adversely impact chronic health problems, mental health, substance use and other social and economic costs for AANHPIs, emerging research has shown that intergenerational trauma has affected SEAA and NHPI youths and families. Data disaggregation is critical to identifying hidden health, social, and economic disparities in sub-communities under the AANHPI umbrella. Data available on the unique mental health needs of NHPI and SEAA youths can help inform policymakers and create programs that work towards improving access, utilization, and outcomes.
- The California Department of Public Health is required to collect disaggregated demographic data on key physical health indicators for 21 subgroups under the “Asian” and “Pacific Islander” categories. Other statewide health agencies, such as the Mental Health Services Oversight and Accountability Commission and Office of the CA Surgeon General should also be required to collaborate with school districts to collect disaggregated data on mental health. This includes screening indicators such as symptoms of depression and anxiety, suicidal thoughts and behaviors, connectedness and social support systems, and utilization of mental health care.
- The California Department of Health Care Services currently encourages providers to receive training to screen patients for Adverse Childhood Experiences (ACEs), including paying Medi-Cal providers to screen children and adults with Medi-Cal coverage. Commercial health insurance plans are also required to include coverage for ACEs screenings if coverage is provided for pediatric and preventive care. There should be culturally and linguistically competent ACEs screenings at all levels, with ancestry or ethnicity-based data collection integrated into the practice.

2. Invest in culturally and linguistically appropriate mental health resources in schools and institutions.

- AANHPI students face disproportionate impacts of race- and ethnicity-based bullying yet are less likely to seek mental health services due to cultural stigma and lack

of appropriate support. Schools should collaborate with community-based organizations, youth development programs, and mental health professionals with culturally relevant experience to develop and fund programs that recognize the diverse needs of AANHPI, including the unique experiences of NHPI and SEAA students. Community solutions that have been effective can be integrated into schools as a supplemental support. This in turn can strengthen youths’ interconnectedness to their respective communities, multigenerational families, cultural practices, and native language access as a vital part in healing through comprehensive mental health services.

- Educational materials and resources should be accessible in native languages targeted to NHPI and SEAA populations. This is a critical component to providing community and family support for mental health care and awareness.
- Mandate mental health education and screening in schools, provide prevention strategies and resources to better identify issues, and refer students to the appropriate care. Youths should learn about the core principles of mental health, including community-based organizations that provide evidence-based care, awareness on stigma, and how social determinants of health impact their personal lives and academics. Empowering students with this knowledge can strengthen their capacity to self-advocate and look out for their peers as well.
- Fund school-based peer counseling training and services. NHPI and SEAA youths voiced that the majority of their mental health support came from their family members or friends at school. To offer such services in an informed manner serves as a bridge between young people and their families and friends to better access and foster healthier relationships with their loved ones.

3. Build and improve the provider pipeline by establishing mentoring or employment programs in CBOs.

- There is a need for more culturally appropriate care by trained mental health counselors both inside and outside of schools. Respondents reported that they were seen by entry-level counselors (i.e., post-grad unlicensed clinicians who are completing statewide requirements towards licensure) and the counselors lacked understanding of their AANHPI family backgrounds or history of intergenerational

Recommendations

trauma. CA should fund grant initiatives that retain AANHPI behavioral health providers. CBOs that serve a high concentration of individuals with limited English proficiency should be a priority grant recipient.

- Direct resources to develop and recruit AANHPI students to develop career interests in the behavioral health workforce. Create an educational pipeline for NHPI and SEAA students to have empowerment of their racial and ethnic identities and lived experiences tied to their community history, and how this is an advantage when entering social work, counseling, behavioral health, and similar career paths; provide meaningful resources for youths to engage and explore professions within the mental health sector. Additionally, invest in community mentoring programs that connect youths to NHPI and SEAA clinicians.
- Require cultural competency training for behavioral health providers, including school staff, to build diverse mutual cultural understanding and integrate community-

defined best practices in care. More so, providers who specifically serve NHPI and SEAA youths should develop a broader understanding of historical milestones, recognize experiences of trauma, oppressive systems, and cultural barriers that these respective communities face in consideration of trauma-informed care.

4. Centralize youths' voices that include these young people, their families, and community leaders to collectively foster self-determination on an individual and community level.

- As implementation continues for the California Youth Behavioral Health Initiative, all components must honor and trust these young individuals to decide how healing is right for them and enable caregivers to offer meaningful support that meets the environmental needs inside and outside of school. Community engagement that targets AANHPI youths must also be inclusive of NHPI and SEAA youths' perspectives, such as the intersectionality of racism, criminalization, and intergenerational trauma.

Conclusion

NHPI and SEAA youth faced unique and substantial mental health challenges during the COVID-19 pandemic that stemmed from their racial and ethnic backgrounds as well as the rise of anti-Asian discrimination that occurred simultaneously. These findings help to illuminate discrepancies in accessing mental health care and aim to reduce the barriers faced by these groups.

While other studies have separately evaluated AANHPI mental health status and impact from the rise of anti-Asian hate during COVID-19, no current studies have combined these two elements that specifically called out and documented the lived experiences from SEAA and NHPI youths. This report offers new evidence that NHPI and SEAA youths struggled to access quality mental health services before and since the COVID-19 pandemic.

SEARAC and CHARGE partners support current legislative efforts that addresses the inequities and disparities in mental health services, which includes: CA Assembly Bill 1110, to improve Adverse Childhood Experiences (ACEs) screenings for cultural and linguistic competence amongst providers that includes AANHPI-based data disaggregation⁵¹; CA Assembly Bill 289, to strengthen the representation of youths and youth-serving organizations, as well as representatives from racially and ethnically marginalized communities to be involved and plan how Mental Health Services Act (2004) fundings are spent⁵²; CA Assembly Bill 665, to reduce minor consent barriers for Medi-Cal recipients who need to access critical mental health services⁵³; and CA Senate Bill 551, to require Mental Health Boards to have youth representatives.⁵⁴

Educational awareness on how to destigmatize mental health may provide insights to better understand NHPI and SEAA communities. By providing culturally appropriate and trained mental health providers from AANHPI backgrounds to connect to these youths, more competent treatment may be available to them. Finally, respondents reported a rise in feeling burned out, helpless, and frustrated. Providing resources on self-care and healing, in addition to creating safe spaces to share and connect is important for this population.

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Appendix and References

Table 1: Contributive factors that worsened respondents' mental health status because of COVID-19. Table 1 complements Figure 8 as it shows a breakdown of how each ethnic group experienced these factors on their mental health.

Table 1 complements Figure 8

Factors to worsening mental health	All Respondents (n=190)	NHPI	Khmer/Cambodian	Hmong	Laos/Laotian	Vietnamese
Basic Needs	18%	20%	35%	17%	22%	15%
Financial setback	22%	30%	35%	25%	11%	7%
Dissatisfaction with living space	40%	20%	51%	38%	22%	41%
Concerns about completing education	46%	40%	59%	46%	56%	41%
Distance learning challenges	33%	40%	41%	23%	22%	30%
Illness	19%	0%	31%	23%	33%	11%
Death of loved one	18%	20%	24%	25%	0%	15%
Care for sick loved one	14%	30%	10%	19%	11%	11%
Mental health access	27%	10%	33%	19%	0%	33%

Table 2: Mental health symptoms before COVID-19 per each ethnicity. The top three mental health symptoms across all groups were: anxiety, difficulty focusing, and low energy. A key feature is that over 50% of participants stated they experienced anxiety.

Table 2 complements Figure 9

Mental Health Symptom BEFORE COVID-19	All Respondents (n=190)	NHPI	Khmer/Cambodian	Hmong	Laos/Laotian	Vietnamese
Loneliness	32%	30%	29%	33%	56%	41%
Anxiety	51%	30%	59%	46%	56%	63%
Depression	30%	30%	25%	38%	0%	41%
Difficulty Focusing	34%	40%	41%	33%	33%	48%
Increased Guilt	27%	10%	24%	29%	22%	48%
Low Energy	33%	20%	41%	38%	11%	19%
Daily Coping	3%	0%	2%	4%	11%	4%
Eating Habits	19%	10%	18%	29%	33%	33%
Extreme Moods	17%	0%	20%	19%	11%	30%
None	25%	30%	12%	29%	22%	15%

Table 3: Mental health symptoms post COVID-19 and disaggregated by ethnicities. The top four symptoms across all respondents were: difficulty focusing, low energy, increased loneliness and anxiety. For NHPI, the biggest change in mental health symptom development was low energy which was reported at 20% before to 60% since COVID-19. Another tied feature was that this group felt lonelier and more anxious after COVID-19, also recorded at 60%. For all SEAA groups on average, difficulty focusing, loneliness, low energy, and anxiety, were the core symptoms experienced. The symptoms were most pronounced for Khmer/Cambodians and Vietnamese, reporting elevated levels of 50-70%.

Table 3 complements Figure 9

Mental Health Symptom AFTER COVID-19	All Respondents (n=190)	NHPI	Khmer/Cambodian	Hmong	Laos/Laotian	Vietnamese
Loneliness	55%	60%	69%	46%	56%	70%
Anxiety	55%	60%	61%	42%	44%	52%
Depression	40%	30%	47%	38%	11%	48%
Difficulty Focusing	66%	50%	76%	48%	56%	70%
Increased Guilt	29%	10%	33%	23%	22%	37%
Low Energy	59%	60%	73%	40%	56%	59%
Daily Coping	32%	10%	43%	25%	33%	30%
Eating Habits	27%	0%	39%	17%	44%	30%
Extreme Moods	30%	0%	37%	21%	22%	33%
None	11%	10%	4%	15%	11%	7%

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