ISSUE: The lack of accurate, granular data on AANHPIs

- Lack of data makes it difficult to assess the magnitude of mental health problems
- Masks critical differences between the diverse subpopulations among AANHPIs
- Reduces allocation of resources due to lack of "proof" that a problem exists
- Makes it difficult to develop best practices models that reflect cultural and language needs of AANHPIS
- Impacts ability to develop and implement culturally and linguistically appropriate services and intervention strategies

ISSUE: The current workforce is ill equipped to provide quality care that reflects the cultural and linguistic needs of AANHPIs.

- Only 1.5% of psychologists, 2% of social workers, 0% of psychiatric nurses and .01% of marriage and family therapists are AANHPI[13]. There is no data on the number of bi-lingual providers
- AANHPIs have the lowest utilization rate for mental health services among all populations, regardless of gender, age, and geographical location. This is often due to the lack of appropriate providers.[14]
- Standard diagnostic tools frequently do not lend themselves to accurate diagnosis in evaluating psychiatric disorders among AANHPIs such as neurasthenia[15, 16]
- AANHPIs frequently somatize their problems, preferring to go to their primary care physician who may not be adequately trained to address mental health problems [10, 15]
- The inappropriate use of interpreters, including the use of children, can seriously compromise the quality of services[17,18]
- There is critical need to train par-professionals, including consumers who can provide services in a timely and cost effective manner.
- Integrated care must reflect the impact of mental health on a person's overall health and provide resources to implement programs in AANHPI serving behavioral health agencies as well as primary care settings

ISSUE: AANHPI are at risk for increased emotional and behavioral problems

- The data varies considerably but there is general consensus that there are high mental health needs among the Hmong population with a prevalence of any diagnosable mental health disorder being high at40% to 85% with 15% to 75% experiencing depression; 35%-45% general anxiety disorder (35% to 45%), and 15% 35% experiencing post-traumatic stress disorder[19]
- PTSD represents the most common psychiatric disorder, affecting perhaps 50% to 70% of the refugees in a psychiatric clinic.[20]
- 99% of Cambodians experienced near-death due to starvation, and 90% had a family member or friend murdered, 70% experienced exposure to violence after resettling in the US and 62% experience high rates of PTSD and 51% experience major depression[21]
- In a report on domestic violence in Massachusetts, 39% of the Vietnamese respondents and 47% of Cambodian respondents reported that they know a woman who has been physically abused or injured by her partner[22]
- Asian American women are at great risk for staying in abusive relationships due to obligation to family and children, limited financial and social resource and partner's promise to change.[23]
- A review of the literature points to high prevalence of domestic violence rates in AANHPI homes with 41–61% of respondents reported experiencing intimate, physical and/or sexual, violence during their lifetime[24]
- The overall suicide rate for Asian Americans is half that of the general population but AAPI females between the ages of 15-24 and those over 65 have higher rates of suicide[25]
- 2009 data indicate that Asian/Pacific Islander females between the age of 15-24 had higher death rates due to suicide than all other groups with the exception of Native Americans and in 2010 had higher suicide rates than African American and Latinos but lower than Native Americans, Non-Hispanic Whites and Whites[26]

- Asian American females grades 9-12 were twice as likely to have suicide ideation than their non-Hispanic White counterparts[27]
- More Asian American victims of bullying say that they were bullied because of their race (11.1%), compared to Whites (2.8%), Black (7.1%), and Hispanic (6.2%)[28]
- 17% of Asian American students reported being bullied. Of these, 54% said the incident occurred at school[29]
- A survey in 2007 revealed that 75% of Sikh male school children in New York had been teased or harassed because of religious identification [30]
- Native Hawaiian youth have significantly higher rates of suicide attempts than other adolescents living in Hawaii. [31,]
- In a survey of students attending high schools in Hawaii, Native Hawaiians had a significantly higher lifetime prevalence rate for suicide attempt (12.9%) than non-native Hawaiian students (9.6%)[32]
- In another survey of Hawaiian high school students, Native Hawaiians (11.5%) and Filipinos (13.6%) had more than twice the rate of suicide attempts in the past 12 months than Caucasians (5.6%)[33]

RECOMMENDATIONS:

- Improve granular data collection that reflects diversity between AANHPI subpopulations
- Include AANHPIs in clinical trials and research efforts
- Improve the current workforce to recruit, train, and support individuals who reflect the cultural and language backgrounds of Asian Americans, Native Hawaiians and Pacific Islanders, including paraprofessionals and consumers
- Insure integrated models of care are implemented in behavioral health settings to address critical mental health needs that are often neglected or not treated adequately in primary care settings.
- Develop, implement, and evaluate training models that emphasizes a public health approach that addresses primary health, mental health, substance abuse and other critical factors including immigration, housing, education, economics, and public safety
- Implement services that are strength based and consumer/family centered
- Increase resources for prevention and early intervention efforts
- Use health information technology to collect data, increase access to services and improve training and supervision activities
- Train interpreters to work specifically in the mental health/substance abuse arena
- Require training on cultural and linguistic competence as part of certification process for service providers

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MENTAL HEALTH OF ASIAN AMERICANS, NATIVE HAWAIIANS, PACIFIC ISLANDERS AND THE NEED TO DEVELOP NEW MODELS OF INTEGRATED CARE

- Individuals with serious mental health problems die 25 years earlier than the general population ~ primarily due to related health conditions impacted by lack of proper mental health care[1]
- The burden of disease from mental disorders exceeds that of any other health condition.[2]
- There is an estimated $193 billion annual cost in lost productivity due to mental illnesses [3]
- Research shows a direct correlation between depression, diabetes, cardiovascular disease, and obesity[4].
- There is a serious lack of data on Asian Americans, Native Hawaiians and Pacific Islanders who are all but missing in clinical trials and research efforts[5]
- There is a need to change the current service delivery system to reflect a whole health, public health approach to integrated care[6]
- An integrated care approach that focuses on both primary health and behavioral health will help reduce the stigma of seeking services focusing solely on behavioral health and is more comprehensive than primary health alone[7]
- Asian Americans, Native Hawaiians and Pacific Islanders have less access to care and receive poorer quality of care when it is available[8]

Asian American, Native Hawaiians and Pacific Islanders are the fastest growing ethnic minority group in the country, yet the availability of culturally and linguistically appropriate mental health care has not kept up with the increase in need. Contrary to the belief that AANHPIs have few, if any problems, many experience serious mental health problems including high rates of depression, post traumatic stress disorder and thoughts of suicide. The stigma associated with mental health, the serious lack of trained bi-lingual, bicultural providers, the lack of affordable insurance and a system that fails to provide equitable resources for mental health services all contribute to an environment that is not conducive to an individual receiving they help they need. Mental health disparities have been highlighted in the President's New Freedom Commission on Mental Health (2003)[9], the Surgeon General's Report on *Culture Race and Ethnicity*[8] and the Institute of Medicine's Report on *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.[5] and *Integrated Care for Asian Americans, Native Hawaiians and Pacific Islander: A Blueprint for Action*[7]

Mental health impacts every aspect of a person's life including their physical health, their ability to maintain healthy relationships, being able to maintain steady employment or do well in school. Many AANHPIs have experienced trauma brought on by war, colonization, and adjusting to live in the US. They experience isolation brought on by language and cultural barriers, intergenerational conflict, anti-immigrant bias, lack of adequate employment, pressures to excel in school and the impact of reduced services brought about by cuts in funding for direct services. For many, their mental health problems may go underreported or undetected as they frequently seek help from primary care physicians and healthcare workers who are not trained to recognize mental health disorders.[10] A major challenge facing advocates and policy makers is the lack of accurate data[11,12] which takes into consideration differences in ethnicity, language, place of birth, generational status, historical trauma, and other critical variables that impact mental health/health outcomes for AANHPIs.

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